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EDITORIAL BOARD

Articles selected for publication in *Global Ageing* have been reviewed by members of the Editorial Board whose suggestions and guidance enable the IFA to offer a journal that provides the insights and analyses of experts on policy and practice issues important to those who promote the well-being of older adults throughout the world.

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Persistent Realities

Africa is emerging from the era when European powers colonized and exploited vast regions of the continent into a time when poverty, hunger, and civil strife constrain the possibilities for development and democracy. With the recent and tragic development of widespread illness and death due to a pandemic of HIV and AIDS, African nations are hard-pressed to find the resources to address problems that beset them.

*Global Ageing* is pleased to provide readers with informative and poignant articles describing the persistent realities facing Africa’s elders—people largely ignored by international aid organizations and little served by national policies. The grave problem of displaced older people is graphically described by Gina Bramucci and Susan Erb in “An Invisible Population: Displaced Older People in West Darfur.” They describe how HelpAge International is urging governments and NGOs to face their obligations to deal with the plight of Africa’s elders.

Two articles portray the difficulties of ensuring appropriate care, both medically and in the community, for older persons with dementia. In “Community and Family Care Responses for Persons with Dementia in Eastern Nigeria,” Richard Uwakwe and Ifeoma Modebe report that dementia is often seen as “. . . the result of a spiritual attack on the older person by an enemy, especially if the affected individual is an older woman, or as evidence of her engagement in witchcraft.” That gerontologists are finally seriously studying causes and effects of culture and traditions on the care of older persons bodes well for future generations of elders; unfortunately, readers will be left with the feeling that for all too many elders, relief and understanding will not come in their lifetimes. “Hospital-Based Care of Patients with Dementia in Ibadan, Nigeria” offers a promising perspective on efforts to enable elders with dementia to receive the medical care they need, despite severe resource constraints and cultural perspectives that undermine such interventions. This paper by Adesola Ogunniyi and Isabella Aboderin discusses approaches for reform, in practice and policy, affecting persons with dementia in Africa.
In an intriguing paper written with the tools of a social anthropologist, Sjaak van der Geest shares insights from extensive field work in Ghana on complaining. Elders needing both help and understanding face the added insult of loss of dignity when they complain; they thus choose to remain silent, even when their needs are clear. The investigator’s conclusions in “Complaining and Not Complaining” are relevant for those working with older people throughout the world.

“Between a Rock and a Hard Place,” an article on migration challenges facing dispossessed and displaced elders in Kenya by Gloria Chepkeno and Alex Ezeh, captures the frustration of many elders who, due to so many crises, find themselves unable to return to their homelands in rural Kenya and barely able to survive in urban slums. Reading through the entire journal issue, as I have more than once, has left this editor with an appreciation for the burdens African elders bear and for the challenges of developing effective policy and practice responses. The lack of personal resources and the absence of responsible social and economic policies mean that many elders survive in great need, often isolated and with little hope.

Monica Ferreira’s personal tribute to Gary Andrews highlights this esteemed leader’s efforts to assist African leaders in ageing to build a supportive network, influence policy and improve practice. With new opportunities to strengthen their scholarship and increase their advocacy skills, African scholars and advocates are working together to enable elders to receive relief from the terrors of growing old with little community and, most sadly, family support, and to achieve the place in society they deserve.

Fortunately for Global Ageing readers, Guest Editor Isabella Aboderin accepted the challenge to identify scholars and advocates willing to share their research findings and their insights. Her introductory essay, “Development and Ageing Policy in Sub-Saharan Africa: Approaches for Research and Advocacy,” offers a fresh perspective on the dynamics of ageing in Africa and the underpinnings for policies and practices so critical to the well-being of African elders. Her keen perceptions, scholarly work, and leadership skills place Isabella Aboderin at the cutting edge of ageing policy development, not only in Africa but also globally. Thank you, Isabella Aboderin.

Jim Sykes
Editor
jtsykes@wisc.edu
With sadness, we pay tribute to Gary Andrews, a world-class leader in gerontology and geriatrics who left us in May 2006, long before his time. His generous and important contributions encouraged the expansion of knowledge about ageing in Africa. He helped forge a network of specialists and researchers on ageing in the region, who in turn have shared their insights in global arenas.

Gary was a dear friend and a valued colleague. We first got to know about him from his substantial work in five south-east Asian countries, a body of knowledge that was projected globally. For the first time, African researchers could identify with the dynamics of ageing in other developing regions.

Gary frequently invited African scholars to present their perspectives on African issues in various forums. His leadership led to South Africa’s admission to the International Association of Gerontology (IAG), the first member society from Africa, in 2001. In Salsomaggiore, Italy in 2000, I worked with Gary, then IAG President, and the expert group to finalize the UN Research Agenda on Ageing for the 21st Century. In 2002, Gary organised the Valencia Forum which ratified the UN Research Agenda and he presented it personally to the Second World Assembly on Ageing in Madrid. He urged Africa and other world regions to develop their own research agendas.

In Cape Town in 2003, Gary shared leadership of a workshop to draft an African research agenda, in which regional issues of ageing and research priorities were deliberated seriously and disseminated widely. In Rio two years later at the IAG World Congress, Gary co-hosted a meeting to update
the four regional research agendas; two days before his death, Gary finished writing the report from that meeting, his daughter, Melinda Andrews, reported.

In April of 2005, when the Oxford Institute of Ageing organized a conference on *Research on Ageing, Health and Poverty in Africa: Forging Directions for the Future* to launch the African Research on Ageing Network (AFRAN), Gary was with us. By this time, he had become a dedicated Africanist, understanding and committed to African ageing issues. Later that year in Malta, Gary worked with us again—this time on AIDS in Africa and elsewhere, to draft the Valletta Declaration.

Gary taught the world much of what we know about ageing. It is especially sad, therefore, that he will not have an opportunity to enjoy the fruits of his insights from his lifetime work in old age. Nevertheless, we—his colleagues, students and friends—will advance his agenda for a world in which elders receive care and respect and achieve self-fulfilment.

We will forever value Gary’s contribution to ageing and his commitment to Africa. He believed in and supported AFRAN; he promoted the region and encouraged African leaders in ageing to become active around the globe. Gary’s vision and energies were boundless. He energised us, always with self-effacing humour. Gary was good for a laugh—and a couple of glasses of wine. We wish he were still here so that we could continue to collaborate, appreciate his humour, and enjoy his friendship.

We will never forget you, Gary Andrews. So long, mate. *Hamba kahle!*

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*Monica Ferreira*

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Development and Ageing Policy in Sub-Saharan Africa: Approaches for Research and Advocacy

The publication of this Global Ageing issue dedicated to sub-Saharan Africa (SSA) signifies the growing awareness that population ageing poses particular challenges in this region (Harper, 2006; UN, 2002b).

And yet, to much, if not most, of public and policy thinking in sub-Saharan Africa, ageing is clearly not an issue of any great concern.

Africa¹, after all—in contrast to the old societies of Europe and North America, and the rapidly maturing populations in Asia and Latin America—is, and will remain (in the foreseeable future) a continent of the young.

SSA’s societies are the youngest in the world, with 65% of the population under the age of 25, and only 5% aged 60 years or above². These proportions will stay relatively unchanged until 2025 and only shift gradually thereafter, given the persisting high fertility (currently 5.14 children per woman) and high mortality rates (UN, 2005; UNECA, 2006).

Central Development Concerns in Sub-Saharan Africa

Indeed, it is the millions of African children, youth and young adults and the pressing questions over their survival and life chances—against a background of poverty, unemployment, conflict, lacking education and health provision, and the HIV/AIDS crisis—who are at the forefront of popular and policy concerns in the region.

Similarly, Africa is vesting its hopes for future progress and development—including a potential competitive advantage against graying economies—in its large number of young.
To this end, for example, the 2006 African Development Forum, organized by the United Nations Economic Commission for Africa (UNECA, 2006), focused on the theme of *Youth and Leadership in the 21st Century*, and the 2006 African Union Summit adopted a new African Youth Charter. Both stressed that

*Political stability, social solidification, and economic prosperity [in Africa] lie in harnessing the capacities of the youth*

and that

*The pace, depth and scope of [such] development depend on how well its youth resources are nurtured, deployed and utilised* (p. 1/2).

More generally, Africa’s concern with the young echoes the thrust of the international community’s agenda for poverty reduction on the continent. This agenda, of course, took centre stage in 2005—the proclaimed year for Africa—when unprecedented levels of dedicated international policy attention and public campaigns were reached. Readers may remember the pledges on aid and debt cancellation made at the Gleneagles G8 Summit, the Live8 and Make Poverty History campaigns and, in the UK, the work of the Commission for Africa (ADB, 2006; CFA, 2003).

At the heart of these initiatives and ensuing programmatic plans for Africa (which, in 2007, under Germany’s dual G8 and European Union presidency, are again to be at the top of the agenda) is the drive to achieve the Millennium Development Goals (MDGs).

The MDGs, distilled by the key international agencies (World Bank, International Monetary Fund, Organisation for Economic Co-operation and Development, and specialized United Nations agencies) from the OECD International Development Goals, are meant to encapsulate what the international community, in its Millennium Declaration, posited as the most pressing responsibility of leaders in the 21st century: to uphold the principles of human dignity, equality and equity at the global level, and thus a particular duty to:  

. . . all the world’s people but especially the most vulnerable and, in particular, the children of the world, to whom the future belongs (UN, 2000, emphasis added).

To this end, the MDGs call for the achievement of eight specific targets by 2015:

- Halve the proportion of people whose income is less than $1 a day, and the proportion of those who suffer from hunger.
- Attain universal primary education in all countries.
- Eliminate gender disparity in primary and secondary education and at all levels of education.
- Reduce by two-thirds mortality among children under 5 years.
- Reduce by three-quarters the maternal mortality ratio.
- Halt and begin to reverse the spread of HIV/AIDS and the incidence of malaria and other major diseases.
- Halve the proportion of people without access to safe drinking water and, by 2020, achieve a significant improvement in the lives of at least 100 million slum dwellers.
- Develop a global partnership for development.
As part of the overall agenda for sub-Saharan Africa, the international community has also emphasized the specific need to address the grave problems of armed conflict in the region, such as the ongoing crisis in Darfur. This reflects a recognition that conflict is an important cause and result of poverty in Africa and that it severely undermines the effort to promote human development, such as expanding health or education in the region (Porteous, 2005).

In the face of the focus on the young, there has been a growing concern with issues of ageing and old age in sub-Saharan Africa—albeit only by a small community of international and African NGO and UN actors and researchers. This interest has intensified since 2002, amid a rising international focus on ageing in the developing world, which was fuelled by the UN Second World Assembly on Ageing in Madrid that year. Indeed, this Global Ageing issue follows a series of recent initiatives that have been dedicated to the advancement of research and policy on ageing in Africa.

Aims
My aims in this essay are to chart recent developments and to reflect on the state and effectiveness of current thinking and action on ageing policy in Africa. Based on this, I then propose some ideas on new approaches and raise key questions that researchers and advocates on ageing in Africa need to address in coming years.

In developing these suggestions I wish, first, to encourage debate and exchange among scholars, practitioners and policy makers in Africa and internationally. Second, and importantly, I wish to provide a broad context within which the articles in this issue, and the insights they offer, may be considered.

Developments on Ageing in Africa Over the Last Decade
The last ten years have seen an expanding, though limited, body of research on older people in Africa, conducted by international and African scholars (see Cohen & Menken, 2006; Ferreira, 1999; Ferreira, 2005), and an increasing volume of NGO programmes, research and advocacy for older people in the region, especially led by HelpAge International.

In 2000, the combined effects of advocacy and research efforts, aided by the 1999 UN International Year of Older Persons, impelled the African Union (AU) to formulate a policy framework and plan of action on ageing for Africa (ratified in July 2002).

The framework and plan, which the AU developed in partnership with HelpAge International, was intended to oblige and guide member countries in formulating national policies on ageing. To ensure its operation, the plan called for the establishment of an African Advisory Council on Ageing (AU/HAI, 2003).

The AU’s deliberations on ageing in Africa, furthermore, fed into the preparatory consultations for the drafting of the 2002 UN Madrid International Plan of Action on Ageing and the 2002 World Health Organization Policy Framework on Active Ageing, both of which aimed to advance ageing policy in the developing world (UN, 2002a; WHO, 2002).

What arguments and evidence have motivated calls for new policies on ageing in Africa?

Policy Arguments and Evidence
The starting point for policy considerations is the projected demographic ageing in sub-Saharan Africa. While the proportion of older people will remain low (rising to 8% by 2050, compared to 24% for Asia and Latin America), the absolute number of older people in SSA is set to rise dramatically: from currently 36.6 million to 140.9 million in 2050, a more rapid increase than in other world regions (see Table 1).

Moreover, and contrary to common misconceptions, older people in Africa will typically live many years beyond 60. Their life expectancy at 60, currently 16 years, does not differ greatly from that in other world regions (UN, 2002b).
The main concern with demographic ageing in SSA has not been the changing age structure of populations—unlike in Europe or North America or some rapidly maturing Asian societies where questions over ageing workforces and the sustainability of social security systems stand in the foreground (see Harper, 2006). Instead, African ageing policy initiatives have concentrated almost exclusively on the welfare of the rising number of older people as a particularly vulnerable group that makes important contributions to development and needs to be supported by policy.

Thus, the AU plan asserts that “apart from children, old people are the social group most vulnerable to the numerous ills facing Africa: poverty, food insecurity, civil strife, armed conflict, violence, inadequate social welfare services, to mention but a few” (p. 5). Similarly, the plan emphasizes older people’s valuable roles and contributions to the well-being of their families and communities.

Given this situation, the plan calls for responses to meet the individual and collective needs and guarantee better living conditions for older people—as a matter of human rights and as an integral part of overall development and poverty reduction efforts (AU/HAI, 2003; HAI, 2003). Simply stated, ageing is a development issue for Africa.

Indications of older people’s vulnerability and contributions mainly derive from:

- small qualitative, often participatory, studies on purposively selected samples, especially of poor older people,
- small-scale surveys,
- data from routine national surveys (e.g., Living Standards Measurement Surveys) which infer older people’s situation from the characteristics of their households, and
- national censuses, which usually provide little detailed information (see Cohen & Menken, 2006; Velkoff & Kowal, 2006).

Drawing on these studies, but also on conjectures from theory (especially modernization theory) or anecdotal evidence, the vulnerability of older Africans to poverty and ill health, and their greater vulnerability, compared to younger adults and youth, is typically seen to rest on four main factors:

- That older individuals, by virtue of the physical, mental, physiological and social changes associated with ageing, have a diminished capacity to engage in productive work and to care for and support themselves. At the same time, having experienced a life of poverty, they have few, if any, physical or material reserves to draw on in old age (see, e.g., Gorman & Heslop, 2002).
- That the customary African family support mechanisms through which younger relatives traditionally cared for and protected their older...

### Table 1. Projected Population Ageing in Major World Regions 2005 to 2050

<table>
<thead>
<tr>
<th>Region</th>
<th>Population 60+ (% of total population)</th>
<th>Population 60+ (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2005</td>
<td>2025</td>
</tr>
<tr>
<td>Europe</td>
<td>20.7</td>
<td>28.0</td>
</tr>
<tr>
<td>Northern America</td>
<td>16.8</td>
<td>24.2</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>4.9</td>
<td>5.5</td>
</tr>
<tr>
<td>Asia</td>
<td>9.3</td>
<td>14.9</td>
</tr>
<tr>
<td>Latin America &amp; the Caribbean</td>
<td>8.8</td>
<td>14.5</td>
</tr>
</tbody>
</table>

Source: UN, 2005
kin have come under increasing strain, and family support has become increasingly inadequate due to interactions between prolonged economic hardship on the one hand and rapid socio-cultural change on the other; and, more recently, the devastating impacts of the HIV/AIDS pandemic (see, e.g., Aboderin, 2006).

- That older people, as a result of the HIV/AIDS crisis, are increasingly called upon to care for their ill or orphaned younger kin, frequently at great cost to their own material, physical and emotional well-being (see Cohen & Menken, 2006; Ferreira, 2004; Knodel, Watkins, & VanLandingham, 2003).
- That, in spite of the above, older people are often denied access to health services and, in most countries, typically have no recourse to pensions or other formal social security provisions. Where such provision does exist, moreover, it typically provides only insufficient protection.

Older people’s contributions to development, meanwhile, are seen to arise in four key areas, namely their:
- participation in the informal economy as well as unremunerated work, including in the household and subsistence agriculture,
- role as guardians of traditions and cultural values which are passed from generation to generation,
- sharing resources, including pensions, with younger, poor family members, and
- critical role as carers for younger family members diseased or orphaned by the HIV/AIDS epidemic (see AU/HAI, 2003; Ferreira, 2004; HAI, 2004; Knodel, Watkins, & VanLandingham, 2003).

Lack of Policy Action
Despite the appeals to governments to recognize older people’s vulnerability and contributions and to protect their fundamental human rights and despite the fact that all African nations are signatory to the AU and Madrid Plans, concrete and comprehensive policy action has, for the most part, not ensued. While several countries have drafted national policies on ageing, there has been little resource mobilization for their implementation.

This lack of policy action is conspicuous particularly today. Five years after the Plans’ formulation, the United Nations will review the steps countries have made in implementing the Madrid Plan of Action, and the African Union is planning for a similar appraisal of progress made in the realization of its Plan (see UN, 2006). However, the question in much of SSA is not how much progress has been made but, rather, whether governments are in fact ready to implement the plans.

What may explain this lack of policy action? Although no research has explored this, indications are that the following reasons are most important:
- governments’ assumptions that older people, on the whole, receive adequate care and support
from their families or, in any case, are not worse off than younger age groups;
• competing priorities for public spending, for example, on younger age groups and macroeconomic improvements; or
• simply, a lack of awareness of or interest in issues of older people (see Apt, 2005; Asagba, 2005).

These reasons are telling, especially if one considers that the large majority of Africa’s leaders are in, or close to, old age themselves. What they reveal is the lack of authoritative information that could allow national governments to gauge the scope of older persons’ individual and collective needs and contributions and their relevance to broader national policy and development aims.

This lack of information reflects the dearth of research on older people in Africa. Specifically, very little evidence exists that is able to provide a germane, representative understanding of older individuals’ situation in national populations, and a longitudinal picture of the changes in their circumstances. Indeed, the AU and Madrid Plans themselves explicitly recognize the urgent need for more research to support their implementation.

In response to this acute research gap, international and African scholars have in recent years organized initiatives to promote research to inform policy action on ageing in Africa (see Box 1).

Filling Research Gaps
The remarkable surge of initiatives to advance research on ageing in Africa has delineated areas that need to be illuminated in order to generate appropriate definitions of old age, and a fuller, and more representative understanding of older people’s changing situation, especially regarding their health, poverty, the impact of HIV/AIDS, and family support. In addition, the emergent agendas have called for research to document older people’s contributions to family and society, and to establish the feasibility of programmes and policies in Africa.

Finally, some frameworks have identified basic methodological considerations that need to be brought to the design of research on ageing in Africa (Aboderin, 2005) and, specifically, to the measurement of older people’s health, economic or support status (Cohen & Menken, 2006).

However, the agendas pay little attention to the crucial question of how to ensure that research responds incisively to broad policy and development questions in Africa today.

In other words, recent initiatives have largely failed to address what, in many ways, is the most pressing challenge for research and advocacy on ageing in Africa: to elucidate issues of old age as they relate to national development endeavours and goals.

In light of this omission, I have developed some initial proposals on basic approaches that research and advocacy need to consider in the quest to encourage appropriate policy action on ageing in Africa.

In forming these ideas, I draw on earlier work on older people’s experiences in the developing world (Lloyd-Sherlock, 2002), the capability perspective on development (Clark, 2006; Sen, 1989; Sen, 1999), and recent work on policy and quality of life for older people in the UK (Grewal et al., 2006).

My suggestions relate to key features that in many ways characterise the policy context in SSA countries. However, it is crucial to bear in mind the tremendous diversity that exists among and within the region’s major 50 countries (all with more than one million inhabitants) and the need to tailor approaches to each of these nations.

Renewed Approaches for Research and Advocacy

Key Task
The first, and basic task that research and advocacy on ageing in Africa needs to address is to clarify the case for policy action. This demands, as a prerequisite, an appreciation of the key constraints and realities that shape governments’ policy making, especially in the social sectors.
The resources available for financing development and social efforts are severely constrained, reflecting, among others, persistent shortfalls in North-South development aid (CFA, 2005). As a result, governments face the inescapable need to set priorities and make choices, for example between development needs or population groups, when allocating their scarce resources (UN Millennium Project, 2005).

The directions for national domestic policy in the coming years are largely set by countries’ Poverty Reduction Strategy Papers (PRSPs) and underlying priorities of the international donor community, in particular those of dominant agencies such as the World Bank and International Monetary Fund (IMF), upon whose aid African states are heavily and increasingly reliant (ADB, 2006; Deacon, 2007 forthcoming). PRSPs set the framework for macroeconomic, structural and social domestic policies and programmes that countries will pursue to promote growth and reduce the pervasive poverty in their populations. In all but two SSA countries, more than 50% of the population live below $2 per day; in 13 countries, it is 80% or more (UNDP, 2006). Conceived in 1999 by the World Bank and IMF as a tool for granting debt relief or concessional loans, PRSPs have become the key vehicle for the coordination of all major development assistance to African states. In many countries, PRSPs now form the basis for the formulation of national budgets and medium-term expenditures, or have merged with national development plans (IMF, 2005; UNFPA, 2005).

The policy directions set by the PRSPs focus on achievement of the Millennium Development Goals. Indeed, the MDGs have become the yardstick with which a country’s progress in poverty reduction and the effectiveness of aid and debt relief are measured (ADB, 2006). To this end, national policy making includes the following:

- Measures promoting economic growth and employment opportunities, through infrastructure development, reform of public governance institutions, enhancement of the investment climate and efficient markets; and
- Direct investments in the social sectors, especially in education and health, with a primary focus on the young (i.e., the key MDG-related

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**BOX 1. Recent Initiatives to Promote Policy-Relevant Research on Ageing in Africa**

2003 First workshop (under the auspices of the UN Programme on Ageing and the International Association of Gerontology) was convened to develop an African regional research agenda that supports the implementation of the UN Madrid Plan in Africa.

2004 African Conference on Ageing (organized by the Union for African Population Studies in collaboration with the Department of Social Development and the Human Sciences Research Council of South Africa) developed a plan of research and action to assist African governments in responding to international resolutions on ageing.

2005 Oxford conference on Research on Ageing, Health and Poverty in Africa: Forging Directions for the Future noted the limited utility of earlier research agendas. The conference provided a strategic framework for developing research and capacity on ageing in Africa (see Aboderin, 2005). A key outcome of the conference was the forging of the African Research on Ageing Network (AFRAN). The network brings together members from African and international academia and civil society and is a coordinating mechanism and a platform for forging partnerships that promote training and research on ageing in Africa (see AFRAN, 2007).

2006 US National Academies report, Aging in Sub-Saharan Africa: Recommendations for Furthering Research, drawing on discussions held at a US-led workshop in South Africa in 2004, explored and made recommendations on “ways in which to promote US research interests [on ageing in Africa] and to augment sub-Saharan African governments’ capacity to address the many challenges posed by population ageing” (see Cohen & Menken, 2006).
areas of primary education, maternal and child health, HIV/AIDS and other infectious diseases). In doing so, countries aim to tackle the dismal human development indicators in education and health that now set SSA apart from other world regions (UNDP, 2006) (see Box 2).

• The present focus of social sector policies undoubtedly reflects governments’ prime concern with alleviating deprivation and suffering among the young. However, it also reflects more instrumental considerations: improving the health and education of the young is intended, in the long term, to raise societies’ human capital and labour productivity and thus, ultimately, economic growth:

The MDGs are ends in themselves, but . . . they are also capital inputs—the means to a productive life [and] to economic growth . . . A healthier worker is a more productive worker. A better educated worker is a more productive worker. So, many of the Goals are part of capital accumulation (UN Millennium Project, 2005).

This view, of course, rests on underlying assumptions about the greater productivity and dynamism of the young compared to older age groups (see Barrientos, 2002; UNECA, 2006).

• Despite efforts, most SSA countries are far off track to achieve most or all of the MDGs (UN Millennium Project, 2005). Given this, the short term policy priority is to be on measures to bring about (a) quick wins in education, maternal, child and reproductive health, HIV/AIDS, gender equity, slum upgrading and rural development that “could start countries on the path to the goals,” and (b) the removal of immediate constraints to achieve the “desired spurt in economic growth in the short run” (ADB, 2006; UN Millennium Project, 2005). For the medium to long term, attention is shifting to the need for policy to enhance the human capital of youth to become productive workers, family heads, citizens and community leaders (World Bank, 2006).

• While most PRSPs typically mention the value of extra measures to protect the most vulnerable groups in society through targeted safety net protection schemes, this area has received minimal attention. Moreover, while several PRSPs identify older people as a vulnerable group, they also distinguish others, including children, women, AIDS sufferers, child workers, street children, orphans and landless poor. Given the thrust of the MDGs, any protection scheme would likely consider these groups first.

• Older people, a small share of the population, do not constitute an important voting block (there are also more general doubts over whether older people are able to vote, and whether elections are free and fair in many countries). Ageing, moreover, is not yet a political issue in SSA, despite growing media attention. The lack of policy action on ageing is thus unlikely to affect public ratings of governments.

Key Questions and Possible Approaches
Against this background, the research and advocacy endeavour on ageing in Africa must develop compelling, and dispassionate, answers to two key questions that national policy makers will ask:

• Why implement and fund policies to meet the needs of older people, given that our resources are constrained and our prime concern lies with achieving the MDGs?

• If we were to implement such policies, which actions should we focus on as a priority?

Which priority actions?
Research and advocacy have provided few responses to this question. Ageing policy agendas, such as in the AU Plan, have typically involved a list of numerous policies that governments are asked to implement to improve the quality of life of older persons.
Current NGO campaigns are concentrating on the introduction of social pensions (HAI, 2006), motivated by evidence that such pensions have worked (e.g., in South Africa). However, there has been no systematic appraisal on a country-by-country basis of which policy actions should be high priority. Such an appraisal is needed and should identify priorities for policy action on the basis of the values and aspirations that older people bring to conceptions of their quality of life. However, we presently know very little about these. Policy proposals usually refer to older persons’ need for “income security, participation, access to health care or specialized living environments,” or for “custody and company of their children and grandchildren” (AU/HAI, 2003).

These dimensions are undoubtedly relevant to older people’s quality of life. However, as recent UK research on older people’s quality of life perceptions illustrates (Grewal et al., 2006), they do not capture important distinctions among:
• the attributes or activities older people aspire to and value as essential to the quality of their daily lives,
• the abilities they need to achieve these, and
• the key factors that might obstruct their gaining access to these abilities.

Consideration of these dimensions ought to form the principal starting point for policy action. To be germane to development debates, moreover, the dimensions may be usefully framed by drawing on the increasingly salient ‘capability’ approach (Sen, 1989; Sen, 1999). This approach, which sees the goal of development as expanding the freedom of individuals to pursue the life “they have reason to value,” considers two main dimensions:
• what people have reason to value doing or being (their valued functionings) and
• people’s abilities, freedom or opportunities to pursue or achieve these functionings (their capabilities) (see Alkire, 2002; Clark, 2006).

Using Sen’s approach (as Grewal et al., 2006 illustrate), we can interpret the most essential attributes and activities that older people aspire to as their most essential valued functionings, while the abilities or opportunities they most essentially need to pursue these are their essential capabilities. The main factors impeding their possession of essential capabilities could be termed key constraints.

Two considerations are important in thinking about older people’s most essential valued functionings and capabilities:
• that they might be non-selfish, i.e., relate to a wish to benefit others—in particular their younger generation kin (see also Sen, 2006) and
• that they may differ between older people in different circumstances or societies.

Indeed, the capability approach does not prescribe which functionings or capabilities are to
be valued to allow for diversity in aspirations and views (Clark, 2006).

Applying the capability approach to clarify priority areas for policy action on ageing in SSA will require careful research to illuminate and untangle poor older people’s essential valued functionings, essential capabilities, and the key influences and obstructions affecting their possession of these capabilities.

This complex task can be facilitated by considering two principal influences on older people’s capabilities delineated by Lloyd-Sherlock (2002), drawing on a life course perspective:

- their internal capabilities (e.g., work skills that they developed through life) shaped by the functionings they were able, and chose, to pursue earlier in their life (e.g., whether they received education or worked) and
- present structural or external constraints or opportunities imposed by their external environment (e.g., whether employment opportunities exist).

These influences highlight two principal levels of policy that need to be considered when attempting to clarify priority areas for action:

- First, policy aimed at the present generation of poor older persons, focusing on the removal of external constraints to older people’s essential capabilities, and
- Second, policy aimed at the next generation of older people, focusing on enhancing the internal capabilities that today’s younger people may develop over the course of their lives. This means supporting or modifying current MDG-related or youth-focused strategies and seeking to complement long-term effects.

This requires research to elucidate the likely life course impacts of such strategies aimed at the young and how beneficial effects (e.g., on health or other resources in later life) may be enhanced (see Joshi, 2006; Kuh, Ben-Shlomo, Lynch, & Hallqvist, 2003).

A further, important point to note is that enhancing the capabilities of today’s young people (e.g., to escape ill-health or unemployment) can, through intergenerational mechanisms, also benefit today’s older people. It may:

- increase the capacity of the young to provide support to their elders and
- reduce the burdens on older persons who are presently using their meager resources to support their younger kin.

Ironically, measures directed at tomorrow’s generation of older persons have so far received little attention from advocates for African ageing policies, despite the fact that most appeals take the projected rise in the number of older people over the coming decades as their basic starting point.

**Why implement such policies, given the constrained resources and prime concern with achieving the MDGs?**

So far, calls for policies on ageing in Africa have pointed to older persons’ human rights, their substantial vulnerability in relation to health and poverty, and their contributions to development, and simply have appealed for older people to be supported as part of mainstream PRSPs. These arguments, as noted, have met with little success.

The perspectives developed above may point to avenues for more effective responses, as described below.

Policies for the next generation of older people may well overlap with the MDG focus on
younger age groups and, as such, may require little argument.

Any claims for policies to support today’s older people need to acknowledge:

- the diversity and possible inequalities within the older population in sub-Saharan African countries, and thus
- that different groups of older people, in different settings, will have different types and levels of need, and that some will require no policy support.

Few arguments may be needed to convince policy makers of the case for enhancing the essential capabilities of today’s poor older people, if these capabilities relate to benefits to the young, and especially where:

- older people, by virtue of their position and role in families, are in fact in a unique position to provide such benefits, and
- these benefits can be shown to aid the human capital development among the young, especially in education and health for children, and the five youth transitions—learning after primary school age, starting a productive working life, adopting a healthful lifestyle, forming a family (i.e., readiness and ability to invest in one’s children), and exercising citizenship (World Bank, 2006) which are now at the centre of attention.

The greater challenge is to make a compelling case for policies to remove constraints on older people’s essential capabilities where these do not directly benefit the young. The apparent limited effectiveness of emphasizing older people’s human rights illustrates the fact that governments can easily respond with inaction to such appeals given the ambiguities over the term: Are rights something that must be actively provided? Or are human rights something that simply should not be removed? Moreover, even where governments were prepared to act, they would again face the question of priorities: old and young citizens have fundamental economic, social, cultural and political rights. Given constrained resources, whose rights have priority?

Perhaps a more fruitful approach to policy arguments may be through considerations of equity. The need for equity, within and among nations, is increasingly emphasized by international donors, not only as valuable in itself, but also as instrumental to economic growth. Thus, for example, the theme of the World Bank’s (2005) World Development Report 2006 is ‘equity and development,’ with a focus on both the equality of opportunities individuals have to pursue a life of their choosing, and “the avoidance of deprivation in outcomes, particularly in health, education, and consumption.”

At the national level, individual SSA countries, such as Nigeria, have based proposed social sector policies (e.g., in reform of the health sector) on the principle of equity.

To be sure, discussions of equity focus mainly on inequalities or deprivations among younger people—those deemed to have productive potential—on the basis of race, class, gender and caste. However, considerations of equity on the basis of age may offer an avenue for making the case for policy to benefit today’s older people. Indeed, the UN Madrid Plan of Action on Ageing makes explicit reference to the need for “equity across generations.”

This approach would hinge, essentially, on a country-by-country examination of the extent to which poor older people are in fact worse off—in terms of outcomes—than poor younger age groups. The crucial question, of course, is on what outcomes to base such comparisons.

This complex issue may be understood better if we were to compare older and younger people with respect to their degree of deprivation in basic or minimally essential capabilities.

One method would be to base such a comparison on the degree of deprivation in certain agreed upon, shared essential capabilities (e.g., the capability to be well-nourished and healthy), although in practice this would mean different things for different age groups. Another mode would allow for the fact that old and young might value different capabilities as minimally essential.

Whichever the approach, the first step must be
to illuminate the aspirations and views of older and younger people on what their essential valued functionings and capabilities are. This requires providing opportunities, through research and public discussion, to enable them to reflect on and articulate these values (see Alkire, 2002; Clark, 2002; Clark, 2006; Uyan-Semerici, 2006).

We must, of course, entertain the possibility that comparisons of the degree of deprivation between old and young may not generate sufficient equity grounds for policy to meet poor older people’s needs. Even if shown to be equally bad off, the young would likely be given higher priority.

This raises one last important question: To what extent would older persons, convinced that resources are constrained, in fact support the intuitive priority that governments are giving to the young, even if it is to their own detriment? Older people are certainly putting such a priority into practice, by sharing their pensions or caring for HIV/AIDS affected children or grandchildren, even at great cost to their own well-being. Moreover, where research has asked, older people have clearly espoused what they see as the natural priority of the needs of the young before those of the old. The reason they give—in remarkably similar terms to the Millennium Declaration—is that

*If you have no money, you have to save the young ones because they are the future* (see Aboderin, 2006).

This does not imply that all older people in Africa share this view. Rather, it points to a final, but crucial, task for research and advocacy on ageing in Africa: to explore and give voice to older people’s views on policy priorities and fairness between old and young.

**Concluding Remarks**

This paper’s reflections on approaches to thinking about policy on ageing in sub-Saharan Africa are preliminary and incomplete, but they are offered to stimulate further discussion and work. They point to the great challenges that researchers and advocates face. Specifically, applying the capability approach in the broad ways suggested will necessitate conceptual elaboration and clarification, as well as careful investigations and participatory initiatives.

This is daunting, especially given the lack of funds for work on ageing in Africa. However, such an endeavour can and should build on the efforts that scholars, activists and policy makers in the development field are making to employ the capability approach in practice (see Clark, 2006; HDCA, 2007).

Finally, we should appreciate that small steps are being made. Recent initiatives and this *Global Ageing* issue on Africa are tributes to this. To document the experiences and perspectives of older people in diverse settings, and to report the evaluations of practitioners working with the aged in different sectors, are essential building blocks for informed policy developments. The papers in this issue are part of this endeavour.

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In this paper, I use the term Africa to mean sub-Saharan Africa.

The United Nations’ definition of old age is 60+ years. This definition of old age is increasingly used in the debates and discussions of old age in Africa and will also form the basis of the discussions in this paper. However, it is important to bear in mind that many questions exist about the appropriateness, in the sub-Saharan African context, as in other cultures, of such a chronological definition of old age or the specific age of 60 itself.

The number and duration of conflicts are much greater in sub-Saharan Africa than in other developing regions (Luckham, Ahmed, Meggah, & White, 2001).

These are, notably, HelpAge International, the United Nations Department of Economic and Social Affairs (DESA), the World Health Organization (WHO) and UNFPA (the United Nations Population Fund).

The concern with ageing in Africa, as in the developing world, goes back to the first UN World Assembly on Ageing in Vienna (1982), driven by humanitarian considerations and underpinned by modernization theory assumptions about the fate of older people in developing nations (see Aboderin, 2004; Aboderin, 2006).

Formerly, Organisation of African Unity (OAU).

Ratified at the UN Second World Assembly on Ageing in Madrid in April 2002.

The tenets of modernization theory (which have not been borne out by evidence) surmise that family support is high in traditional, pre-industrial societies but breaks down as societies become progressively industrialised, urbanised and westernised. The expanding influence of individualistic and secular values is said to lead to a demise of the traditional extended family (to be replaced by the modern nuclear family) and to weaken customary values of familism and filial obligation, leaving older people abandoned and dependent on the state. (For a critique of the use of modernization theory in African thinking on ageing, see Aboderin, 2004; Aboderin, 2006; Ferreira, 1999.)

Only five SSA countries have a social pension scheme (Senegal, Namibia, South Africa, Botswana, Mauritius). In most other countries, pension schemes exist for the small minority of former public, military and large-scale private sector employees. A few countries, including Ghana, have implemented schemes to enhance older people’s access to health care, although these programmes are very limited in scope (see HAI, 2004).

Between 50% and 60% of orphans are estimated to live with grandparents in Namibia, Botswana, South Africa, Malawi, Zimbabwe and Tanzania (HAI, 2004).

A notable exception has been the South African Older Persons Act, ratified in 2006.

Such assumptions seem to reverberate with common Western perceptions about the situation of older people in Africa (van Dullemen, 2006).

At the time of writing, 72 out of 90 African leaders (i.e., presidents/prime ministers and their deputies for whom information was available) were aged 50+; 51% were 60 years or older.

The specific US research interest in issues of ageing in Africa also led to the convening of a conference on Aging and Social Change in Africa, by Georgia State University, Atlanta, Georgia. The conference exposed American scholars and students to ageing issues, created opportunities for national and international networking and collaboration between and among US and African scholars on ageing, and provided a forum for dissemination of findings of African ageing research.

28 out of the 32 countries classified as having low human development are in SSA. However, there are clear differences among countries in the level of their human development, with some, such as Gabon, Namibia, and Botswana, having markedly better conditions than others (UNDP, 2006).

African governments are urged to develop such policies in view of the coming window of opportunity from about 2020 onwards, as fertility levels begin to fall and before the older population significantly increases (World Bank, 2006).

The capability approach, which was developed by Nobel Laureate Amartya Sen (1989, 1999), provided the foundations for the current notion of ‘human development’—which is central to the UNDP’s annual Human Development Report and is reflected in the Millennium Development Goals. With its focus on expanding human freedom as the goal and means of development, the capability approach has emerged as the leading alternative to the neoliberal approach of key institutions, such as the World Bank and International Monetary Fund, which focus primarily on the achievement of economic growth and higher incomes. Given its intellectual and ethical force, the capability approach is currently in the process of leading a
paradigm shift away from the so far dominant neoliberal approach (see Clark, 2006; Jolly, 2003; Kuonqui, 2006; UNDP, 2006).

The life course perspective views conditions in later life as shaped, not only by contemporary circumstances, but by exposures and conditions earlier in life (Elder, Kirkpatrick Johnson, & Crosnoe, 2003).

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Ageing and Emergencies in Africa

In the coming decades, the number of older people in sub-Saharan Africa is projected to increase more than three-fold from currently 36.6 million to 140.9 million in 2050—a more rapid increase than for any other age group (UN, 2005). Available evidence suggests that the majority of older people in Africa, as in other developing world regions, reside in rural areas (UN, 2002). Similarly, older people constitute an increasingly larger share of the rural population due to the out-migration of younger people in search of economic opportunities and employment.

A second factor that will likely characterise the African context in the coming years is the occurrence of complex political emergencies, such as that in Darfur, and natural disasters, such as the recent droughts in Niger and the Horn of Africa, whose impacts are typically felt most strongly in rural areas. Such crises have devastating and lasting impacts on people’s lives, affecting severely the most vulnerable groups.

Too little attention has been paid to the impact of emergency situations on older people and on how international relief operations respond to their plight. With the public gaze typically on children and (younger) mothers, older people, it is fair to say, have been largely invisible. Similarly, while the academic community has slowly expanded its research on older people in Africa over the past two decades, virtually no studies have investigated the circumstances of older people in crisis situations.

HelpAge International’s Work in Complex Emergencies

However, HelpAge International has, over the past decade, begun to examine and address the conditions of older people in emergency situations. Its research undertaken in 1999 in Asia, Africa, Europe and the Americas showed that planners and humanitarian agencies frequently overlooked
older persons’ most basic requirements, and that older people faced difficulty in accessing support and services (HelpAge International, 2000). However, the findings also highlighted that older people’s experiences in such circumstances differ according to their gender, social status, age, and functional capacity.

The research found, in particular, that older people who were socially or physically isolated due to the emergencies were at an increased risk of being excluded from humanitarian assistance and care, with negative consequences for their chances of survival.

In response to such situations, HelpAge International has attempted to act as a catalyst to help relief agencies identify and meet critical needs of older people, thus enabling them to rebuild their lives and livelihoods. Specifically, it works with international bodies such as the United Nations High Commission for Refugees (UNHCR) and has lobbied governments and other international non-governmental organisations (NGOs) to:
- recognise older people as a vulnerable group and implement approaches in emergency response programmes that support older people,
- establish mechanisms that support older people to access entitlements,
- develop social protection schemes, including small, regular cash payments to older people,
- support vulnerable older people to establish secure livelihoods,
- create opportunities for older people to participate in decision-making, and
- collect data disaggregated by age and gender to identify older people’s needs.

Since 2004, HelpAge International has been engaged in direct response and rehabilitation programming in the complex emergency in Darfur.

This paper presents evidence and insights gathered over the past three years that provide a picture of the circumstances and experiences of older people in Darfur, and suggests effective approaches to good practices in humanitarian and relief programming.

Darfur: A Prolonged Humanitarian Emergency

Since its beginning in 2003, the conflict between black African Christian rebel groups and Arab militias (Janjaweed) in Darfur, a semi-arid western region of Sudan, has claimed an estimated 200,000 lives. Millions of people who fled their homes are now living in internally displaced people (IDP) camps, dependent upon international food and humanitarian aid. In mid-2006, the number of civilians living in IDP camps across the Darfur region was estimated to be 1.6 to 2 million, with an additional several hundred thousand Darfuran refugees living in neighbouring Chad. Despite international efforts and the brokering of a peace deal in 2006 (which not all parties signed), the situation in Darfur remains extremely unstable, with reconciliation a distant prospect. In fact, violence has increased in recent months in a climate of massive re-armament, and attacks in and around IDP camps have continued with impunity.

In this deteriorating context, humanitarian agencies and international donors have found it increasingly difficult to deliver aid. At the same time, they have begun to view the displacement in Darfur as a care and maintenance situation—one that shows neither immediate signs of improvement nor the promise of large-scale returns of internally displaced people to natal villages. HelpAge International works in seven IDP camps in West Darfur: Ardamatta, Gokar, Kerenek, Krinding I, Mornei, Riyadh and Sisi. In addition, the organisation has intervened in the urban camps of Abuzar and Madina Hujaj, and in the Habillah area of south-western West Darfur. In the first year of its engagement, its activities included providing non-food emergency items, developing older people’s organisations, and carrying out awareness raising activities. Since late 2005, however, it has focused its efforts on providing social protection services to older people in IDP camps through its continued presence and advocacy as well as through direct health and nutrition interventions.
Since 2003, the conflict in Darfur has claimed an estimated 200,000 lives

Given the general lack of reliable statistics to inform its humanitarian work in Darfur (both the UN Office for the Coordination of Humanitarian Affairs and the UN World Food Programme still use population figures from 2004), HelpAge International began in 2004 to assess the situation of older people in the camps. A first and crucial issue addressed was the question of how to define old age in the Darfur context. While the UN defines an older person as aged 60 years and over, adherence to this definition can be problematic. Life expectancy and cultural norms vary among cultures, and chronological age may often be less relevant in developing world societies, where people may not know their exact date of birth and where age may be defined according to a person’s social roles or status (Wells, 2005). Moreover, a conflict-related emergency can usher in changes in life expectancy and societal roles, that may further complicate defining an older person.  

In its work in West Darfur, HelpAge International defines older people as those 55 years and older. This criterion was determined according to both average Sudan life expectancies as well as the early age of child bearing among Darfurian women. Based on this definition, sample surveys of smaller camps and targeted areas of larger camps estimate that older persons constitute 12.5% of the total camp populations, twice the ratio (5.6%) of elders in the Sudanese population (UN, 2005). The quantitative and qualitative assessments of older people’s situation conducted in five camps by the organisation included, initially, a health and nutrition survey on a sample of 234 older residents and their households conducted between November 2004 and January 2005. This was followed by four assessments conducted according to the UNICEF/State Ministry of Health/World Food Programme (WFP) standardised criteria for determining sample size and selection:

- A comprehensive vulnerability assessment (October 2005 to January 2006), which involved structured questionnaire-based interviews with over 4,000 older individuals to explore their level of access to, and use of, health services with a special focus on nutritional needs and intake.
- A rapid nutrition survey (May 2006), on a sample of 2,200 older people, which assessed older people’s health and nutrition status along with social vulnerability risk factors. Anthropometric measures, specifically Mid Upper Arm Circumferences, were used for the rapid physical assessment carried out on a house to house basis along with follow up focus group discussions.
- A collection of 60 in-depth interviews with older persons living in IDP camps (March to July 2006). These examined nutritional issues in detail, including the number of daily meals and types of food eaten by older people.
- A questionnaire-based survey among 13 leading international agencies operating in West and South Darfur (2006) to explore the extent of focus and consideration of older people in their programming.

Further details on the methods employed in the various assessments are available from HelpAge International. Besides these formal investigations, the organisation has engaged in continuous, informal consultations with other agencies involved in medical and general relief work in the region.
Findings: The Situation and Visibility of Older People in West Darfur

The findings of the various assessments broadly echo and expand on the picture that emerged from earlier investigations (HelpAge International, 2000).

Health and Well-Being of Older People

The Darfur research showed that sizeable proportions of older persons have multiple unmet needs and lack access to humanitarian assistance provided by relief agencies. The 2004-2005 health and nutrition assessment found that between 20.5% and 26% of older internally displaced people have no access to WFP food rations; and 43% lack adequate shelter (according to Sphere minimum standards²). Moreover, a majority (61%) suffered from chronic conditions, such as cataracts or arthritis, that needed specialised treatment or drugs. Twenty-nine percent of respondents were caring for orphaned children.

The 2005 and 2006 investigations confirmed this picture. The nutritional assessment showed nearly 40% of older people to be at risk of malnutrition. The vulnerability assessment showed that 51% lack access to health services, despite the presence of NGO clinics in all the surveyed camps. Major barriers to older persons’ use of clinics included long waiting times and the associated physical strain. Twelve percent of respondents, moreover, were found to lack a WFP ration card and were unable to register³.

Overall, 61% of older people were identified as suffering from a considerable degree of vulnerability. Those who were socially isolated (31% of respondents), living with dependants (30%), or had limited mobility (61%) or total immobility (7%) showed greater levels of vulnerability.

In addition to these physical concerns, the vulnerability assessment showed that a third of the older respondents felt socially isolated, neglected and spent the majority of their time alone. Furthermore, HelpAge International’s field work found that many older persons living in IDP camps had less social interaction than before they moved to IDP camps.

Such separation from kin and community is common in conflict situations, where families and households are depleted as a result of members being killed or taking refuge in different locations. The extent of household depletion in Darfur was highlighted by a 2005 Physicians for Human Rights audit of IDP camps in West Darfur.
Rights report, which drew on interviews with 558 households in three villages. The findings suggested a drastic fall in household members from 12.1, before conflict-related violence began, to 6.7 (PHR, 2006).

Older people’s separation from immediate kin and communities of origin was found to be a key contributor to their physical vulnerability and exclusion from relief services, as they received little, if any, support from other camp members. Nearly 50% of respondents reported receiving only limited support (such as cooked food or assistance with collecting water) from the IDP camp community, and over 40% said they received no support at all.

Their reports were affirmed by relief workers, who noted that although lone older people are often adopted by non-related families during camp registration—to boost household size and thus aid entitlements—they seldom receive their share of aid once it is distributed to the household (UN Office for the Coordination of Humanitarian Affairs (OCHA) field officer interview, May 2006). Those elders insufficiently strong to fetch their own water, to carry home food from the distribution sites, or to walk to health clinics when sick, are forced to wait for aid (if any) to be delivered. The lack of assistance given to older people by other camp members likely reflects the stress and resource constraints of prolonged life in the camps which force IDP camp residents to think first of their own and their immediate families’ needs, thus reducing the likelihood that older people detached from their families will receive support. This was underscored by humanitarian staff who noted that while, during the first six months of displacement, families and neighbours tried to support the most vulnerable, including older people, this soon changed as the displacement became prolonged (OCHA field officer interview, May 2006).

This situation, interestingly, appears to contrast with the situation in war-affected communities not living in IDP camps. During visits to such nomadic communities in West Darfur, HelpAge International personnel saw older people who were relatively well cared for, despite being separated from their families. With the original community largely intact and living in the same location, traditional support networks remained in place.

Social isolation, fostered by the separation from immediate kin and home communities, may then be seen as a principal risk factor for older people enduring prolonged displacement. Besides the negative effect of social isolation on older individuals’ health, hygiene and nutritional status, it also erodes their mental and emotional well-being. This, as respondents pointed out, is linked in particular to four key areas of social loss that have accompanied their separation from kin:

- loss of the role as head of household and, therefore, loss of community status;
- loss of economic power and the ability to sustain or protect one’s family;
- loss of a sense of belonging to an extended social network; and
- loss of control over individual destiny, livelihood and care (including care of children and grandchildren).

Further evidence from the assessments and indications garnered through HelpAge International’s work in the camps suggest that the impact of losses differs for men and women. While both older men and women suffer from isolation and the sense of hopelessness that has come with it, older men appear to be more affected by the loss of community status. Women have customarily created community in the immediate vicinity of their homes and, to a limited degree, this community has been recreated in the camps, as older women sit outside weaving, or chat with one another while queuing for water. Older men, on the other hand, have lost the traditional structures that help enforce community status: their sons, their place of worship and their livestock.

**Relief Responses and Older People**

What has been mainstream relief agencies’ response to older people?

HelpAge International’s research among, and ongoing consultations with, aid agencies repre-
sented in Darfur clearly suggest that older people have received very limited attention from such agencies’ programmes and, as indicated in earlier research (HelpAge International, 2000), elders have remained largely invisible. None of the 13 international NGOs that responded to HelpAge International’s questionnaires reported that they directly target older people in Darfur. The common perception was that, among vulnerable groups, older people are typically triaged last. The NGOs’ responses highlighted the following reasons relief agencies fail to consider older people:

- First, humanitarian agencies may erroneously assume that programmes targeting households will reach all beneficiaries in the households. However, as discussed above, the separation of nuclear family units, the prolonged nature of the displacement and the struggle for even limited access to livelihoods, have often undermined the sense of family and community cohesion.

- A second factor underlying aid agencies’ lack of focus on older people in Darfur was the absence of aged individuals during the early population movements and displacement after fighting escalated in 2003. Younger generations were the first to abandon their villages and move to IDP camps, but older people often initially refused to leave their ancestral homes (UNICEF and OCHA field officer interview, May 2006). They believed that the displacement would be short-lived, and leaving the villages would allow nomadic groups to occupy the land, destroying hope of returning. This was highlighted in interviews with older people carried out by UN field officers following fighting and displacement both in 1998 and 2003, and supported by INTERSOS (Humanitarian Aid Organisation) monitoring in 2005-2006. In the interviews, older respondents often expressed a sense of resignation to whatever fate would visit them on their own land: “This is my land. I will not leave it. I will die on it.”

As the conflict grew more entrenched in Darfur and hope of returning immediately faded, those who had remained in the villages and were physically able, gradually began moving to IDP camps. This was not a mass movement; they trickled into the camps little noticed and were often unable to relocate their families.

- A further, broader reason for the limited consideration of older people in the humanitarian responses in Darfur has been the common emphasis on the protection of vulnerable women and children. While this emphasis echoes the general priority given to the needs of these groups in mainstream development agendas (see Aboderin, this issue), certain factors have made it particularly important in Darfur. These include, above all, the inordinate number of women who are direct targets of physical and sexual violence and children who have witnessed violence or been orphaned by the war and displacement.

Given the emphasis on younger women and children, Darfur has been served by many agencies, such as UNICEF, that are driven by organisational mandates to focus on these groups. The tremendous pressure of responding to their needs for protection and support (through women’s centres and child-friendly spaces, firewood collection patrols) in addition to providing basic services has left little capacity...
for addressing the needs of vulnerable older people, and in particular older men. While older women have arguably benefited to some degree from the emphasis on women, neither young nor older men have access to specialised protection services.

- One reason older people have not been specifically targeted for core services (such as water, sanitation and health care) to the camp population is agencies’ assumption that older people will seek services. This explanation fails to consider older people’s:
  - mobility limitations,
  - lack of familial support,
  - infirmity, and
  - lack of information.

**Approaches to Meeting Older People’s Needs**

In response to the emerging evidence on the situation of older people in the IDP camps of Darfur, HelpAge International has undertaken to ensure that the needs of this group are considered and met by humanitarian relief efforts. In addition, the organisation has provided targeted assistance.

**Access to Health Services and Nutrition**

Based on the 2005-2006 vulnerability and nutrition assessments, as well as experiences from previous emergency work with older people (Wells, 2005), HelpAge International identified older people’s lack of access to health care and the risk of malnutrition as priority areas for intervention. In response, and employing a vulnerability scale that was developed from the assessment, the organisation designed and implemented targeted quick-impact interventions. Interventions were facilitated by a network of community health workers who receive training in issues related to the health, hygiene and needs of older people in camps where HelpAge International operates.

Network members are responsible for referring sick older people to health clinics and for following up patients in their homes. Their involvement covers each step of medical referral, from assessing and addressing the needs of each person, including nutritional, non-food and psychosocial needs, to bringing comprehensive services to the older person. A donkey-cart ambulance programme, financed by HelpAge International, assists older people who require clinical care. In addition, HelpAge International and the WFP have distributed supplementary food baskets to older persons identified as at risk of malnutrition and those caring for several dependants. In one camp, a social nutrition centre provided freshly cooked meals to vulnerable older people three times per week.

A mobile eye clinic was provided in two urban camps and the Habillah area of West Darfur, offering services to nearly 2,000 people with surgical sight-restoring interventions or medicines. Fetching water, collecting firewood, preparing food and cultivating a garden were among basic daily activities that were once again possible for those who received treatment for cataracts, glaucoma or trachoma. Some older carers reported being able to send their children to school for the first time, as they were no longer dependent on their help in the home.

In addition to these interventions, HelpAge International, through advocacy, has made certain that five key medical agencies in West Darfur (Medair, Médecins Sans Frontières - France, International Medical Corps, Comité d’Aide Médicale, and Save the Children - US) now designate certain hours or days of the week as priority referral times for older people. This simple move has reduced waiting times at health clinics, a major barrier identified by older people in explaining lack of access to services.

These initiatives have addressed some of the main physical health-related risks facing older people. The greater challenge, however, as the displacement persists, is to address social and emotional dimensions of older people’s vulnerability, particularly their isolation.

**Addressing Social Isolation**

Older people’s sense of isolation in the IDP camps continues, despite their prolonged displacement.
Although large numbers of people have moved to the camps, indications are that the displaced persons in general, and older IDP camp dwellers specifically, have not forged a sense of a cohesive, supportive community.

This situation has multiple causes. One is the wide scattering of villages and families in various camps. Additionally, older people expressed a fear of attack or the fear of informants or spies, as well as the lack of familiarity with the surrounding community. Most of the 80% of older people who reported limited social interaction cited security threats or conflict-related factors as the major reason.

In addition, as relief workers pointed out, there are few meeting places or facilities for social interaction among older people. “Older people don’t have places to meet. In the village community, the elders normally have a place . . . where they go in the morning and in the evening to chat. With the IDPs, I haven’t seen such a thing.”

(OCHA field officer interview, May 2006). In an attempt to respond to this, many of HelpAge International’s quick impact interventions have created a space and provided a reason for older people to gather and engage socially.

For example, a pilot programme in Krinding IDP Camp selected older people on the basis of both nutritional needs and social isolation for attendance at a social nutrition centre. Their thrice-weekly attendance at the centre enabled them to share nutritionally enriched food and spend time telling stories and interacting with camp-based volunteers and staff. Older people greatly valued this opportunity for social engagement and, while the hot meal programme proved logistically unsustainable, the local community has sought to retain the centre’s social impact by converting the kitchen into a community-run canteen serving hot tea and high-nutrition snacks to vulnerable older people.

In other camps, social livelihood and activity centres have been developed, providing a space for older people to gather, share news and stories, and rebuild the sense of community missing in the camps. In addition, older men and women engage in small income-generating handicraft projects in the centres. While the sale of products has produced a small income, participants have made clear that the opportunity for social interaction has been the primary benefit to them. Monitoring of these centres, through HelpAge International’s field work, has revealed that the forged connections are being continued and extended beyond centre meetings: older people now meet socially in the evenings and mention visiting each other in their homes.

Fostering Intergenerational Connections

While these initiatives foster a sense of community among older people in the camps, they have not addressed older people’s loss of engagement with younger generations, a result of their separation from kin and home communities. In addition to this loss, many older people—even those who are involved in care of grandchildren—have expressed a sense of alienation from youth and...
an anxiety about future interactions with a generation that, in their eyes, has not been raised with the same tradition, culture and respect for elders. While this is a common and, indeed, age-old complaint (see, e.g., van der Geest, this issue), it is likely exacerbated by camp circumstances and, in particular, growing violence carried out by armed youth.

With the steadily deteriorating security situation in Darfur, UN security officers have noted that incidents of banditry and carjacking are increasingly carried out by armed youth. Such adolescents, frustrated by the lack of productive outlets, may feel they have nothing to lose by seeking material gain through violence. In light of the above, HelpAge International and several youth-focused agencies have begun to consider the need to facilitate and foster connections between young and older people. Working across the generations echoes intergenerational approaches increasingly pursued in other settings (Hatton-Yeo & Ohsako, 2000; ICIP, 2007; Larkin, Friedlander, Newman, & Goff, 2005), and it will help to create cohesion in what has become an extremely fragmented society.

To be sure, thinking about ways to reinforce intergenerational links in the context of the IDP camps is only in its inception. However, as a first step, HelpAge International has begun to build into its programmes support for interactive spaces for young children and older people as well as the development of components where adolescents will work with and on behalf of older people. Ideas discussed in this regard with other aid agencies in West Darfur include the following:

- including older people as storytellers and animators in child-friendly spaces operated by child-focused agencies;
- involving adolescents in the social activity centres initiated by HelpAge International, providing young people with a place for social interaction with their elders, while providing basic income;
- engaging and including older people in women’s centres operated by partner agencies, particularly in areas where HelpAge International is not working; and
- bringing together young and older people in such activities as cooperative gardens and livestock regeneration efforts where all share the benefits of the work.

The appropriateness and success of such initiatives will depend on a sound understanding of the forms, dynamics—and tensions—that characterised intergenerational relationships in Darfur prior to the conflict. Widespread, yet possibly simplistic assumptions of mutual respect and cohesion between old and young, as well as an esteemed role of older people in pre-conflict Darfurian societies need to be treated with caution and carefully examined (see Aboderin, 2004; Ferreira, 1999; Nydegger, 1983). The success of such activities will also depend on the active involvement of child and youth focused UN and NGO agencies, and the support of donors. Progress, however, will likely be slow as social programming is not a first-wave priority in an emergency. However, as the conflict and mass displacement are prolonged, humanitarian agencies will need to address the negative long-term social impacts on the people and communities of Darfur.

Conclusion: Taking a Long View: And Recommendations for Good Practice

This paper has presented a picture of the situation of older people in Darfur, based on HelpAge
International’s research and engagement in the emergency situation since 2003. The insights and evidence point to two conclusions.

- Confirming prior evidence, older people, especially those separated from their immediate kin and with functional capacity limitations, often are neglected by or lack access to humanitarian programmes. Reasons for this service gap include:
  - the absence of older people in the initial refugee flows;
  - mistaken assumptions that most older persons are adequately cared for by their families or can access relief services; or
  - simply, a priority focus on younger age groups.

Humanitarian agencies acknowledge the gap in their services. This recognition, one may hope, will be followed by efforts to include older people in all phases of the humanitarian programme cycle, from initial assessment to planning, monitoring, impact assessment and accountability. Providing appropriate services for older persons’ health needs, including chronic conditions, is a priority. While such interventions may not be life-saving, they are life-changing and can have an impact on the ability of older persons to access assistance and independently to care for their own needs.

- Advancing the understanding of older persons’ experiences in emergency contexts, the evidence discussed indicates that social isolation—caused by separation from families and communities—is perhaps the principal risk factor for older people. Isolation not only contributes to psychological and emotional distress, but also deters older people from receiving relief services and threatens their physical health.

Older people’s social isolation is the result of their lacking connections on two levels: the absence of contact with peers in conditions where little opportunity for social interaction exists and their lack of engagement with younger generations. As the conflict in Darfur draws on, the disconnection of older people from the young becomes an increasing problem, not only for the old, but arguably, also for the social cohesion and peace of the camps themselves. This points to the need for long-term strategies on the part of humanitarian agencies that have focused on providing emergency relief. Approaches to humanitarian assistance need to be adapted to respond to the increasingly permanent nature of the conflict and the displacement. Specifically, efforts will be required to address issues of social and intergenerational cohesion.

Social programming, to date, has typically focused on younger children and women, certainly important groups. However, HelpAge International contends that the adoption of a cross-generational approach would serve to mitigate the long-term impacts of conflict and societal upheaval. For agencies mandated to address the needs of specific groups, such as children, women and older people, this would mean forging stronger links with each other and developing inclusive and joint strategies for programming. These would have the potential of not only helping individual groups, but also promoting cohesion within the camps. Specifically, cross-generational approaches could foster community coping mechanisms and conflict resolution processes that previously involved several generations; in doing so, community members could bolster their desire for peace within their communities. It is critical, however, that such programmes are based on a solid understanding of how intergenerational relationships and processes operated before the conflict. Reliance on assumptions of generational harmony and respect for the old in pre-conflict traditional societies would be inappropriate and, potentially, counterproductive.

Darfur is the site of only one of several ongoing conflict-related emergencies in Africa—conflicts
that have proven politically complex, longer lasting and more entrenched than expected. Others, in the Greater Horn of Africa, include southern Sudan, northern Uganda, and eastern Democratic Republic of Congo. The lessons learned and recommendations for improving services to vulnerable persons in Darfur are relevant for displaced elders in all parts of Africa, indeed, the world.

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NOTES
1 Although 95 agencies were contacted, only 13 responded, despite multiple attempts to contact them.
2 The minimum standards for shelter as defined by The Sphere Project (Humanitarian Charter and Minimum Standards in Disaster Response) draw on the human right to housing. For details, see The Sphere Project, 2004.
3 HelpAge International has since provided the names of all individuals lacking food ration cards to WFP to facilitate registration.
4 Interviews and questionnaires conducted with West and South Darfur agencies in 2006. “The underlying principle of triage is allocating limited resources in a manner that provides the greatest health benefit to the greatest number” (The Sphere Project, 2004, p. 287).
5 UNICEF field officer interview, Geneina, West Darfur, 3 May 2006; OCHA field officer interview, Geneina
6 Quotation from field work shared during interview with OCHA field officer, Geneina
7 Questionnaires conducted with West and South Darfur agencies in 2006
8 Wells, 2005, pp.11-16
9 Interview with OCHA field officer, Geneina, West Darfur, 7 May 2006

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Research on dementia in sub-Saharan Africa is extremely rare, with few studies having been conducted (Ineichen, 2000; see Aboderin, this issue). In Nigeria, Africa’s most populous nation with close to 150 million inhabitants and over six million older persons (Mba, 2001; UN, 2005), only one research centre, in Ibadan in the south west of the country, has investigated the epidemiology of dementia through the Ibadan Dementia Research Project (IDRP) (see Ogunniyi, this issue).

The emerging IDRP evidence shows that prevalence rates are substantial, but lower than in developed countries, possibly reflecting a higher mortality of affected persons or differences in dementia risk factors. The findings further suggest that, among the prevalent dementia types, Alzheimer’s disease is the commonest, accounting for approximately three of four cases (Hendrie et al., 2001; Hendrie et al., 1995).

Beyond this, however, no comprehensive information exists on the spread, forms and impacts of dementia in other parts of Nigeria. Virtually no formal health care is available, and little is known about the care and circumstances of persons with dementia in the population.

This paper, drawing on experiences gained through an eight-year project to support older dementia sufferers and their families in Eastern Nigeria, documents community contexts, care responses, and impacts of the disease and discusses implications for future programmatic approaches to dementia care. The project was coordinated by Nnamdi Azikiwe University Teaching Hospital (NAUTH), a tertiary institution for health care delivery, training and research, located in Nnewi in Anambra State, one of Nigeria’s 36 federal states. NAUTH, together with four community-based primary care branches, provides the only public health services for the entire Anambra State population. Much of Anambra State is essentially rural with NAUTH primary care posts located in remote villages of the state.
Understanding and Responding to Dementia in the Nigerian Socio-Cultural Context

The lack of evidence on dementia in Eastern Nigeria is accompanied by a pervasive lack of public awareness of the disease as a medical condition. In Nigeria, as in other African nations, early stages of dementia are typically assumed to be part of the normal ageing process (compare Hinton, Franz, Yeo, & Levkoff, 2005).

As the disease progresses and behavioural and psychological symptoms begin to attract attention, family members and the public do not view these as the manifestations of physical disease. Rather, they interpret them as the result of a “spiritual” attack on the older person by an enemy, especially if the affected individual is an older woman, or as evidence of her engagement in witchcraft.

Such spiritual “diagnoses” — examples of widespread spiritual causal perspectives of chronic disease in Africa (see de-Graft Aikins, 2005) — are typically supported and encouraged by Christian religious leaders who, in Eastern Nigeria, enjoy extraordinary influence, such that their opinions on health matters are taken as final.

Typical Care Responses

Once religious leaders describe a person’s dementia as being “of evil spirit,” they advocate spiritual treatment, not orthodox medical care (Uwakwe, 2000). In the first instance, therefore, older dementia sufferers are likely to be taken to spiritual or traditional healers who are generally widely patronized in Nigeria.

When family members do come to accept the physical (rather than spiritual) nature of dementia, they demand instant and permanent cure. In desperation, families have been known to travel hundreds of kilometers and spend considerable resources on private (rather than public sector) health treatment in the hope of finding a cure. After rounds of fruitless searching, they abandon efforts to treat the condition and resolve to let the older person stay (and, eventually, die) at home rather than in a health institution (Uwakwe, 2001).

This preference reflects customary cultural perspectives in Nigeria, as in other African societies, which see the care and support of older persons as the primary responsibility of the family (Aboderin, 2006). This obligation extends to the material realm: the great majority of older Nigerians have no access to formal income security or health insurance and thus rely on financial support from their family members, on their own typically low, if any, savings or income from work. Even the minority (mainly former public sector employees) who currently receive pensions often depend on their families, as retirement benefits are typically poor or paid with severe delays (Ogwumike & Aboderin, 2005).

Partly as a consequence of families’ care decisions, the hospitalization rate of older persons with dementia, and older people in general, in Eastern Nigeria is very low. In the 750-bed NAUTH, only 3% of the 7000 referrals to the department of internal medicine in the period from 1995 to 1998 were of patients aged 60 and above, and among these only one case of dementia was documented.

This low treatment rate, however, is not solely due to cultural preferences for spiritual and family-based care. It also, and importantly, reflects the profound lack of public health services’ responsiveness to dementia and other diseases of old age. This is expressed in the virtual absence of specialized geriatric and long-term care services, training, expertise or policy in Nigeria as in other poor developing countries (Akanji, Ogguniyi, & Baiyewu, 2002; Barreto, Kalache, & Giatti, 2006; Keller, Makipaa, Kalenscher, & Kalache, 2002).

As a result, there is a pervasive lack of awareness of dementia among health care professionals. Primary care health physicians, in particular, many with no postgraduate qualification, often fail to identify the disease, especially in its early stages. This is compounded by the often extremely limited time that doctors have available for outpatient consultations. Diagnoses of conditions in old age often require comprehensive assessments and can be difficult even for doctors with geriatric training. Without adequate time,
Dementia is often seen as the result of a “spiritual” attack on the older person

physicians make misdiagnoses and fail to make appropriate referrals.

The poor responsiveness of Nigeria’s health services to older people’s needs is a symptom, on the one hand, of the severe resource constraints in the health sector and the priority given to infectious diseases and maternal and child health as part of the country’s broader development agenda (FGN, 2004; NFMOH, 2005; and see Aboderin, this issue). On the other hand, it reflects enduring assumptions among policy makers that older people, on the whole, are adequately cared for by their families with little need for public provision (Asagba, 2005).

Issues in Family Care for Older Persons with Dementia

To be sure, given the customary preferences and health service limitations, virtually all older persons with dementia or other long-term conditions are cared for by their family members. However, there are emerging indications that this care is often characterized by significant shortcomings and strain.

On one level, there is some evidence that the care older dementia sufferers receive may not always be appropriate or sufficient, or may even involve an element of neglect. Family members, for example, embarrassed by their older kin’s changing cognition, emotional expression and behaviour, have been known to lock up such persons in the house to avoid their getting lost or being seen by the public (Uwakwe, 2001). Moreover, especially where older persons reside with an adult child rather than in an extended family set up, they may be left alone during the day as adults go to work and children go to school. Sometimes older persons with cognitive impairment and depressive symptoms have, in the belief that they are possessed, been forced to make fictitious confessions to their own ridicule. Anecdotal evidence and media reports further indicate that older persons with cognitive disorders have been ‘treated’ by starvation, beating, or the application of pepper to their skin; or they have even been stoned to death as a payment for the “evil they accumulated while young.” While Nigerian tradition requires decent and elaborate burial and funeral ceremony for deceased older persons, these rites may be denied those who die while suffering from cognitive disorders.

On another level, research evidence shows that caregiving for persons with dementia can have negative impacts on the caregivers. As in developed societies, Nigerian caregivers have been found to experience stress and consequent emotional and physical difficulties (Baiyewu et al., 2003; The 10/66 Dementia Research Group, 2004; Ukpong & Makanjuola, 2003; Uwakwe, 2001; Uwakwe, 2006). Unfortunately, support services that provide relief to caregivers in other settings (see Flint, 1995; Matsuda, 2001) are virtually non-existent in Nigeria.

The Project

Within this context, the project Support and Care for Persons with Dementia was conceived in 1999 by a group of clinicians at NAUTH. It was to be based at NAUTH and Ukpo Dunukofia Community Health Centre, the largest of the primary health care branches attached to NAUTH. The key purpose of the project was to improve the health and well-being of older persons with dementia, their family members and other carers. To this end, the project pursued four specific aims:
• To establish two specialist geriatric clinics with emphasis on dementia, to be run by, or under close supervision of, a consultant psychiatrist. The clinics were intended to provide comprehensive assessment, accurate diagnoses and appropriate treatment for older patients.
• To establish support groups that provide support, counseling and advice to family members and other carers of older patients.
• To provide home assistance and advice to older dementia patients and their families regarding practical aspects of care, utilizing volunteers.
• To collaborate with religious organizations in raising awareness and supporting the activities of the project.

Such collaboration was deemed necessary, given churches’ enormous authority and the difficulty of mounting a successful programme in Eastern Nigeria without involving the clergy.

Approaches to Implementation
From its inception, the project was run in partnership with the Alzheimer’s Disease Association of Nigeria. This affiliate of Alzheimer’s Disease International has provided substantial support to the scheme, mainly in the form of training materials, events and technical advice.

The first preparatory step towards project implementation was the organization of a public awareness campaign in Dunukofia community. This involved an inauguration ceremony, supported by the traditional ruler of Dunukofia and endorsed and attended by representatives of major churches in the community. This endorsement by religious leaders, resulting from prior efforts to inform and assure them of the value of the project, was critical in ensuring the community’s acceptance of the venture. Following the inauguration ceremony, a symposium on the health of older persons was held and, thereafter, the opening of the two specialist geriatric clinics was widely announced in the region’s churches.

The Clinics
Medical officers and specialists at NAUTH Nnewi were notified and requested to refer persons aged 60 years and over to the geriatric clinic at either Ukpo Dunukofia or Nnewi. The clinics were set up to offer a range of outpatient services including:
• Standardized clinical assessments, including mental status, physical and neurological examinations.
• Treatment for mental illness and minor medical diseases, including identification of depression and delirium and the use of commonly available antidepressants.

For older persons who have had psychotic symptoms since their younger age, moderate doses of antipsychotics are advised, whereas for those first developing psychosis in old age, extreme caution is recommended. In cases of suspected dementia, use of Donepezil (a widely used drug to treat the symptoms of mild to moderate Alzheimer’s disease) is rare. Initially, additional attempts were made to provide modified psychotherapy; however, this was soon discontinued, as patients and their family members made clear their disinclination to engage in ‘long talks.’

• Where indicated, referral to social agencies or other medical services for treatment of common chronic conditions such as diabetes mellitus and hypertension.

At the Ukpo clinic, the above services were provided by health centre medical officers who had previously received basic training in the care of older persons, under the supervision of a community health physician and a psychiatrist. At Nnewi, assessments and treatments of older patients were performed by the clinic psychiatrist.

Older persons referred to the geriatric clinic at NAUTH were registered and received services through the University hospital at their own expense. Patients coming directly to the Ukpo Dunukofia clinic paid a token registration fee as well as a standard fee for check-ups.

Family Support Groups and Volunteer Assistance
Through the clinics, family members of older patients diagnosed with dementia were recruited
into support groups and encouraged to attend meetings coordinated by an experienced psychiatric nurse. At meetings, members were encouraged to share experiences and make suggestions on how best to address the care needs of the ill older person. In addition to such support derived through mutual exchange of perspectives, group members were given access to educational and information material on dementia.

To augment the support to dementia patients and their families, some members of the Alzheimer’s Disease Association of Nigeria approached the dementia sufferers’ church congregations to enlist volunteers to provide assistance to caregivers in their homes. The congregations were viewed as key targets for garnering volunteer support, as many have formed groups devoted to performing charity work.

A further source of volunteers that the project considered were young adults who have completed secondary school, but are either unable to find employment or to gain admission to universities. Every year, more than one million Nigerian youths apply to enter the universities, but only 20% may be admitted. It was believed that such youth could be recruited to perform voluntary work either for free or for minimal stipends. However, the project did not approach these potential volunteers as the funds for such an initiative were lacking.

Additional Activities
In addition to running the geriatric clinics and family support activities, the project has conducted special activities on the 21st of September of each year to mark World Alzheimer’s Day. On that day, efforts are made to pay home visits to dementia sufferers and their families. During such visits, printed dementia materials are distributed and discussions are held about the health and behaviour of the person with dementia. Where possible, modest financial and material assistance is given to the family and such domestic chores as washing the older patient’s clothing or bedding are performed. More generally, family members are encouraged to take an active part in the support group programme, and efforts are made to foster an understanding of dementia as a universal, physical disease. Direct costs associated with support group meetings, home visits, printing of materials, payment of volunteer workers, and gifts to patients and families have been wholly borne by the project.

Success of the Project
Since its inception eight years ago, responses to the Support and Care for Persons with Dementia project have been mixed and its success, unfortunately, has been modest. One achievement has been to raise some awareness of dementia as a disease among both public and health professionals, where previously there was virtually none. Moreover, 20 women and 36 men have been diagnosed with dementia in the clinics and have benefited from the assessments, treatments and referrals offered.

However, these 56 patients very likely represent only a fraction of the number of dementia sufferers in the target communities, suggesting that many persons with dementia and their families have not been reached by the project. The likely reasons for this have been the insufficient intensity of the awareness campaigns and the fact that they were not sustained. Moreover, many community-based organizations such as town unions or village clubs, which would ordinarily be helpful in fostering community engagement, did not actively support the campaigns which they viewed with suspicion. As the project provided no financial benefit to the community, they erroneously perceived it as a scheme by the project organizers to make money from foreign donor agencies.

In addition to the limited reach of the project, there has also been a high drop out rate of older patients from the clinic programme. Sometimes an older person attends the clinic only once. Follow up of drop outs is financially prohibitive, making it difficult to know what happened to those who fail to return. In any given year, the drop rate is about 70%.

Initially, responses to the two specialist clinics were positive. Especially older persons at Ukpo
community were enthusiastic and approached the service not expecting to have to pay for registration or for the assessments or treatments offered. Unfortunately, their expectations could not be met as the NAUTH management did not allow for a waiving of geriatric clinic fees.

There was also particular interest from older people’s adult children who lived either abroad, specifically in the UK or US, or in other Nigerian cities, who learned of the project during home visits. Typically, such adult children, wishing for their parents to attend the clinic, were also prepared to provide financial resources; however, financial support tapered off, once their stay in Dunukofia had ended.

More generally, attendance began to decline with only older patients referred by medical doctors either at NAUTH or the primary health care centres coming to the clinics. Typically, family members who initially brought their older kin to the clinic ceased to do so after one or two visits, once they realized that no instant or lasting cure for the illness was going to be provided.

In other words, many families who were reached by the project have, nonetheless, refused to accept that dementia has no permanent cure. This stance has been particularly common in cases where families’ churches did not engage with the programme, viewing acceptance of the disease’s incurability as faithlessness. In such instances, family members often received advice, urging them to take the older person elsewhere, where total “deliverance” is assured. Such “healer shopping,” a commonly observed practice among chronically ill persons in Africa (see de-Graft Aikins, 2005), has often led to multiple visits to various alternative treatment centres with consequent expenditure of enormous resources. Unfortunately, in most of the cases, we have not been able to establish the eventual outcome for persons with dementia who left our service.

The high drop-out from our project highlights a major shortcoming: its failure, despite various and repeated awareness raising efforts, to engender community acceptance and understanding of dementia as a chronic physical disease and an appreciation of the value of palliative treatment. In large part, precisely because of dementia’s chronic nature, which the clinics amply illustrated, spiritual perspectives on the condition have persisted. The continuing belief is that every condition afflicting an older person is either a direct curse from God or an attack of evil spirits sent by enemies. Medicines or “talk therapies,” including behavioural methods, have no place in such situations. Spiritual problems require spiritual solutions, and medical problems require medical solutions. To prove the point, the case of malaria is often cited as an example of an illness that has a definite physical basis and which, therefore, nearly always responds to medical treatment within two days.

The view is that if dementia, too, were truly a medical problem, it should also disappear within a few days of applying western medicine. The fact, however, that such a cure does not occur is taken as proof of the spiritual nature of dementia. Such spiritual afflictions, in contrast to physical illness, are accepted as taking a longer time to resolve. Resolution is through:

- sustained and fervent prayers,
- deliverances,
- exorcisms, and
- intercessory activities, such as prayers and sacrifices offered in behalf of dementia sufferers in remote places, even without the person knowing it.

Patients with mental disorders—viewed as spiritual disorders—are expected to stay in church treatment from six months to five years. When, however, such patients are taken to receive orthodox medical care, discharge is requested within one to two weeks.

Limited success has also characterized the family support groups. The groups have largely failed to provide continued support to family carers, largely due to members’ weakening interest. In initial group meetings, most family carers showed enthusiasm and were keen to share experiences with others. However, their interest soon waned due to their feeling that coming together solely for the purpose of talking does not pay, for at
the end of the day, the dementia remains. Family members made it clear that they see little value in speeches or pep talks and certainly no justification for spending time and money on attending. Support groups, therefore, have not been sustained.

The other aims of the project, too, have met with great difficulties. Despite the large number of potential volunteers, the project has had little success in enlisting unpaid helpers to assist dementia sufferers and their families. The main obstacle to their recruitment has been the lack of resources to reimburse helpers’ outlays; while unemployed volunteers are willing to offer their time and energy, they are largely unable to make financial sacrifices, such as paying for transport costs or other expenditures incurred as part of their service. Home visits, too, have been made less frequently than initially anticipated, due to logistic problems, including the lack of volunteers and transport through rough terrains, especially during the rainy season, which make such visits extremely difficult.

Overall, the minimal success of support group and volunteer schemes can, in part, be seen as a consequence of the project’s lack of funding. These resource constraints ensued from the project’s exclusive reliance on voluntary contributions. Such contributions, perhaps not surprisingly in the general Nigerian context of economic strain, have been irregular and insufficient to adequately support the project’s activities.

Discussion
The point of departure for the project Support and Care for Persons with Dementia was the lack of responsiveness to the medical care needs of older people with dementia in the Eastern Nigerian health system, which has meant that virtually all care is provided in the family and community context. Unfortunately, the inadequacies and difficulties in the system of family care, both in terms of strain on caregivers and lack of appropriate treatment and attention for dementia sufferers, leave a person living with dementia with neither medical nor adequate family care.

The project’s experiences, especially its areas of limited success, point to key lessons and challenges for the future.

• The enthusiastic initial response to the project indicates the existence of considerable need for services to support and improve the well-being of older dementia sufferers and their families in the community. The actual extent of this need is not known due to the lack of reliable data on dementia prevalence and care circumstances. However, it is expected to increase due to the rise in the number of older people in Nigeria (UN, 2005) and the unlikelihood of significant improvements in public health systems’ responsiveness to dementia in the near future. Therefore, expanded efforts to support and improve dementia care at the community level will be required.

• However, the project’s limited success in achieving full inclusion and sustained engagement of dementia sufferers and their families, clearly suggests that new and more effective approaches are needed.

• Educational approaches designed in the West (US) to raise awareness of dementia have clearly been ineffective, indicating the imperative need for materials and models
appropriate to Nigeria. Critical barriers to the provision of medical care and support to dementia sufferers and their families need to be overcome, including powerful Christian spiritual perspectives and teachings in Eastern Nigeria, which regard dementia, like other incurable conditions of older persons, as a spiritual affliction, to be dealt with through spiritual means and faith. The consequent skepticism and rejection of western medical treatment, unfortunately, will persist as long as psychopharmacological efforts do not find a cure for dementia.

What is required is the development of educational approaches that can engender community understanding and acceptance of the existence of chronic medical conditions, including dementia. Such an understanding would foster realistic expectations regarding the benefits of medical treatment. To ensure their effectiveness, such approaches would need to be designed and formulated in consultation with major Christian bodies represented in the community.

• An appropriate and culturally sensitive approach is needed to support dementia sufferers, their families and other carers. Models, such as support groups, that have proved successful in enhancing the quality of life of family carers in the West, appear to have little value for families in Eastern Nigeria (see Flint, 1995).

A key requisite for the design of appropriate models, however, is greater appreciation of what families do and the difficulties they experience in caring for kin with dementia, how affected individuals fare, and the adequacy of care they receive. More generally, better understanding is needed of how vulnerable the family support system has become, given social and economic circumstances and the unreadiness and inability of families to provide effective care to dementia sufferers. Population-based research that explores and illuminates dementia issues is urgently required.

• Funding arrangements in Nigeria and generally sub-Saharan African countries face pervasive economic strain. Reliance on voluntary contributions, or an expectation that beneficiaries will be prepared to pay for direct or indirect costs of care are unrealistic. Successful and sustainable projects will require external funding—a considerable challenge given national and international funding priorities.

Concluding Remarks
This paper has highlighted the need for the development and provision of culturally appropriate, community-based services to provide support to dementia sufferers and their families. While the discussed findings apply strictly only to Eastern Nigeria, a need for such services exists more broadly in Nigeria and other sub-Saharan African countries. Without such efforts, many older persons with dementia will suffer physical and psychological symptoms without adequate care. Similarly, families, living in challenging economic circumstances and in the absence of social support services, will experience strain associated with the care and progressing disease of their affected kin. If families were provided assistance, that strain could be reduced. A major goal of the project group is to conduct research and develop service models, building on the lessons learned.

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Dementia, simply described as brain failure or loss of the mind, is a public health concern. The most consistent risk factor for the disease is advanced age. Current estimates suggest that 24.3 million older individuals worldwide suffer from dementia, and the number is predicted to rise to 81 million by 2040 (Ferri et al., 2005). The numbers of dementia sufferers will increase more rapidly in developing countries than in developed countries, given the rapid ageing of developing world populations and the consequent increases in the numbers of people reaching older ages (Ferri et al., 2005; Kalache, Barreto, & Keller, 2005; UN, 2005). Today, almost two-thirds of people with dementia reside in developing countries, where health systems are typically less well equipped to respond to chronic, age-related disease (Kalache, Aboderin, & Hoskins, 2002; Unwin et al., 2001; WHO, 2006). This is especially the case in the poorest regions such as sub-Saharan Africa, where health systems are faced with the double burden of high mortality and morbidity due to infectious diseases, and the growing rates of non-communicable diseases (WHO, 2006).

To date, the only reliable evidence on dementia prevalence in Africa comes from the Idikan community study carried out by the Ibadan Dementia Research Project (IDRP) in Nigeria, and from the Assiut Province of Egypt, where prevalence rates of 2.29% and 4.5% respectively were reported (Farrag, Farwiz, Khedr, Mahfouz, & Omran, 1998; Hendrie et al., 2001; Hendrie et al., 1995). These figures are much lower than the dementia prevalence estimates for North America and Europe, which range from 3% to 12% among individuals aged 70-80 years to 24% among those aged 85 or more (Ferri et al., 2005). The less frequent occurrence of the disease in Africa has been variously attributed to differences in risk factors and higher mortality rates in persons who have dementia (Hendrie et al., 2001). However, little
attention has been given to the treatment of African dementia sufferers and to outcomes from medical care of this population. This article, drawing on over a decade of practice experience in hospital care of patients with dementia at the University College Hospital, Ibadan (UCH), reflects on the present reality and policy contexts of acute medical care for older dementia sufferers in Nigeria, and on ensuing challenges for advocacy and research.

**Care Provision for Older People with Dementia in Nigeria**

In Nigeria, older persons with dementia (as is generally true for older people with other chronic debilitating diseases) are typically cared for by their families in the home or within an extended family residence (see also Uwakwe & Modebe, this issue). Those families that can afford to may hire professional nursing help and domestic helpers, usually young women or girls. The family provides care, on the one hand, because few facilities for long-term care exist, and, on the other hand, because of the cultural stigma of destitution and neglect attached to institutionalizing older people (Akanji, Ogunniyi, & Baiyewu, 2002). Nigerian elders expect and prefer to die at home in the midst of family members rather than among ‘strangers’ in an institution. As the illness progresses, individuals with dementia gradually lose functions that they could previously perform, such as bathing, dressing, toileting and feeding. Their growing dependency and care needs often overwhelm their family care providers, thereby increasing dementia sufferers’ susceptibility to further medical conditions. Specifically, such individuals become vulnerable to self-imposed injuries or road accidents, nutritional deficiencies and infections, due to poor diet and hygiene.

Older people with dementia are typically only admitted to hospital when they have seizures or falls at home, or when they develop ailments that require acute care, such as gastroenteritis with severe dehydration or shock, acute chest or urinary tract infection, congestive cardiac failure, or stroke. The latter two conditions are usually prompted by long-standing, but uncontrolled hypertension, the most common chronic disease risk factor affecting older persons in Ibadan (Ogunniyi et al., 2001). However, as a result of families’ ignorance or preference for alternative treatment (see Uwakwe & Modebe, this issue), older dementia sufferers are typically brought to hospital too late, with grave consequences for their prognosis. By the time they arrive, their illness is likely to be advanced with serious complications.

**Hospital Admission of Dementia Sufferers: Sources of Patients**

Given families’ preference for alternative care, the number of individuals with dementia admitted for hospital care is relatively limited. At UCH, the premier teaching hospital in Nigeria, only 37 cases were documented over the period from 1998 to 2003. Of these, 28 were male. This gender pattern clearly contrasts with that observed in the community-based Ibadan dementia study. Here, more females than males were diagnosed with dementia, a gender difference attributed to women’s greater longevity and thus higher risk of dementia.

The predominance of men among admitted dementia sufferers echoes that among hospital patients in general and likely reflects the greater economic resources of men compared to women in Nigeria as in other sub-Saharan African societies (Ogunniyi, Lekwauwa, Falope, & Osuntokun, 1993; Tamale, 2003; Uroh, 2005).

Over the past fifteen years, dementia patients admitted to UCH have come from two main sources:

- The first, and perhaps the more important one, is the cohort being followed in the Ibadan Dementia Research Project (IDRP) which started in 1991 and involves a cross-cultural, longitudinal, community-based study involving a comparison of elderly Yoruba and African Americans who are 65 years or older (Hendrie et al., 2001; Hendrie et al., 1995). Since the study’s inception, more than 200 study
participants have been diagnosed as having dementia, with Alzheimer’s disease accounting for approximately 75% of the cases. The other types encountered include vascular dementia, dementia with Parkinson’s disease, Lewy body dementia, dementia associated with depression and non-specific type (Henderson, 1994; Hendrie et al., 1995).

An important feature of the research is the incorporation of medical care, including hospitalization, for those diagnosed with dementia. In order to detect a deterioration of their health, relating to existing or new medical problems, periodic home visits are conducted by field interviewers. When medical ailments are reported, additional monthly meetings are held with family caregivers; physicians and nurses are informed. When the situation is considered sufficiently serious, and after family members’ consent has been obtained, arrangements are made for hospital admission. Through this process, approximately 20 older people were admitted to the hospital for acute care between 1998 and 2003.

- The second source of dementia patients is referral to the hospital’s neurology clinic. UCH attracts referrals from all over the country, given UCH’s status as the National Center of Excellence in the Neurosciences with close working relationships among neurologists, neurosurgeons and psychiatrists. Moreover, given that the institution is the base of the Ibadan Dementia Research Project, UCH has acquired a reputation for expert handling of patients with the disease. However, dementia sufferers can also be managed for acute medical conditions in any of the other (approximately 50) tertiary health institutions in Nigeria.

**Care Approaches**

Once patients are admitted, the main aims of hospital care and management are to (a) treat the causes of the acute deterioration in the patient’s health and (b) prevent or address possible complications at presentation or those developed while in the hospital. Early detection and management of such complications as pressure sores, chest infections or clots in blood vessels due to prolonged immobilization, inadequate fluid replacement and sluggish blood flow in the legs are crucial, as the effects can be fatal. An undetected, dislodged blood clot, for example, can cause pulmonary embolism and sudden death. As regards the dementia itself, little therapy is provided, unless there are extreme behavioral problems, which warrant anti-psychotic medication.

Typically, a close member of the family, either the spouse or one of the adult children (usually a female), is allowed to stay by the bedside and assist in providing care. Experience shows that without the presence of a familiar person, older dementia patients, being unfamiliar with hospital staff and surroundings, may not cooperate with required treatment procedures. Having a relative in attendance improves the patient’s situation. Moreover, by being in the hospital, family members are able to learn or refine such caregiving techniques as feeding, toileting and turning the patient—important skills for home care. Finally, the presence of kin facilitates obtaining a patient’s prescribed medications or other items from home.

**Issues and Limitations in Hospital Management**

Despite the pervasive resource and infrastructural constraints that characterize the Nigerian health system (NFMoH, 2004b), UCH has the key diagnostic, laboratory and pharmacological facilities needed to treat acute problems or complications that dementia patients may present. In addition, support treatments such as physiotherapy and occupational therapy are available. In practice, however, patients are commonly unable to access these diagnostic and treatment services, thereby limiting the chances of achieving the objectives and desired outcomes of hospital care.

The primary factor constraining access to care for three out of four patients is their or their families’ failure to pay for laboratory services,
Two scenarios usually underlie patients’ or families’ failure to provide the requisite funds to purchase the necessary care:

- The first and most common scenario underlying failure to pay is a genuine lack of financial capacity. The little evidence on the situation of older Nigerians reveals that a majority lack income or live below the poverty line (Baiyewu, Bella, Adeyemi, Bamgboye, & Jegede, 1997; Ogwu & Aboderin, 2005). Only a small minority of older people (Baiyewu and colleagues estimated 6.4%) are eligible for pensions: those formerly in public or large private sector employment. The majority of older people who worked in the informal sector have no access to an income security scheme. Those who receive pensions, moreover, face frequent payment delays of up to 12 months. Patients with dementia are often even further disadvantaged, given their loss of both cognitive and functional independence and thus their ability to manage their finances.

Consequently, older patients depend on the support of adult children or other family members to meet their health care needs. However, their kin often face financial difficulties themselves due to unemployment or under employment, low incomes and rising living costs in Nigeria (FGN, 2004; Ogguniyi et al., 2005; UNDP, 2005). Moreover, as a result of their poor economic situation, many younger adults have migrated to other countries in search of better incomes. This can compromise the funds available to families until migrants have made sufficient economic gains to remit money home (see Black, Ammassari, Mouillesseaux, & Rajkotia, 2004; World Bank, 2006).

- The second and much less common scenario underlying failure to pay for diagnostic and treatment services for people with dementia is their families’ unwillingness to pay for such services. The family may regard the acute ailments of the dementia sufferer as incurable and terminal. As a result, they consider it wasteful to spend money on hospital treatment for their older relative. Instead, they prefer to spend their resources on what they deem more valuable, which may include their own needs. In such situations, family members typically either refuse to pay for further treatment or request the premature discharge of the patient. The worst—though fortunately relatively rare—circumstance follows when families desert the older patient in the hospital. Approximately one in ten patients are abandoned in hospitals mostly because their relatives are frustrated as hospital bills increase and the patient does not improve.

In response to the pervasive problem of families’ inability or unwillingness to finance the care of the older person, some very limited mechanisms of external assistance have been created. These include some discretionary exemption from payment of hospital fees for basic investigations from the hospital authorities, and the provision of limited financial assistance from charitable organizations or sources such as the Alani Fund in our own institution. The aim of such assistance is to enable the older patient to receive reasonable, basic care and to prevent him or her from suffering unjustly. However, given the great limitations on support funds, gaps remain in the care that dementia sufferers are able to access. In cases
of abandonment, hospital social workers usually attempt to trace and persuade patients’ relatives to continue to support the older person.

**Issues of Length of Admission and Discharge**

In addition to issues of cost, barriers to the adequate treatment of individuals with dementia arise in relation to length of admission and discharge. The favored UCH practice regarding dementia patients is to keep the admission as short as possible, in order to minimize the disruption and discomfort to the patients. In addition, a short hospital admission also results in fewer complications developed and avoids the abandonment of patients by their families. Admitted patients who are properly discharged are typically followed-up on an outpatient basis. IDRP study participants additionally benefit from periodic home visits after hospital discharge. Despite the policy to minimize hospital admission, families sometimes request a premature discharge of the patient against medical advice. This usually occurs when there is a sudden change in the condition of the patient and families fear that death is imminent. Requests for premature discharge may follow advice from others to seek alternative care or for spiritual intervention. Others may prefer that the older person die at home, thus avoiding autopsy and the bureaucracy and bottlenecks that may occur when claiming the body. Early discharge also ensures prompt burial at home, a religious requirement for Muslims. Unfortunately, no follow-up to ascertain the outcomes for prematurely discharged patients has been possible.

**Discussion**

The above description of current acute medical care provision for older people with dementia in Nigeria has highlighted the frequent inability of individuals to access timely and adequate care. Limited access crucially affects one’s chances for improvement and survival and thus likely contributes to the suspected higher mortality of dementia sufferers in Africa compared to the developed world (Hendrie et al., 2001). Three key factors—at the family and health systems levels—have emerged as major constraints to access.

The first, at the family level, is the limited caregiving competence or capacity. Many families lack the ability or skills to care for dementia sufferers in a way that reduces their susceptibility to acute ailments or complications. At the same time, carers’ inability to recognize emerging acute conditions and the need for timely treatment means that individuals with dementia frequently receive medical attention too late to prevent death.

The second family-related factor is the inability or unwillingness of older individuals or family members to expend resources on treatment, especially prolonged treatment. This constraint may hinder hospital admission altogether, especially for older women, who may be less able than men to command resources, or may limit the amount of care one receives after admission.

Both inability and unwillingness to seek care may be seen as direct or indirect consequences of the pervasive economic strain and widespread poverty in Nigeria (DFID, 2004; FGN, 2004). While many families genuinely lack the resources to pay for treatment for older patients, others may prefer to use their scarce resources for more “productive investments” in the younger generation (see also Aboderin, 2006).

This family-level financial barrier is inextricably linked with the major health systems-level obstacle to dementia sufferers’ access to care. In tertiary institutions such as UCH, this barrier is *not* (as might be expected) the absence of equipment or drugs. All required facilities are available.
developments, part of Nigeria’s broader health sector reform, aim to “achieve equity in health care and health for all Nigerians” and provide a “minimum package of health services to all citizens” (NFMOPH, 2004c).

Despite these universal objectives, most fee deferral or exemption schemes have focused on maternal and child health in line with the overarching priorities in Nigeria’s health sector reform and development agenda (FGN, 2004; PATHS, 2007; see also Aboderin, this issue). Virtually no consideration has been given to similar initiatives for older people despite Nigeria being signatory both to the Madrid International Plan of Action on Ageing and the African Union Policy Framework and Plan of Action on Ageing (AU/HAI, 2003; UN, 2002).

**Improving Medical Care Provision for Older People with Dementia**

In this context, efforts to improve access to medical care for older people with dementia (as well as older people more generally) face two key challenges.

First, there is a need for strategies to improve the care provided to dementia sufferers in the family context. This requires the development of targeted education efforts to impart essential caring skills and, where needed, the provision of practical, financial or infrastructural support to family carers. Specifically, carers need to be enabled, as far as possible, to prevent the development of acute ailments and to recognize—and respond appropriately and promptly—to symptoms. Such efforts need to be complemented by broader public enlightenment campaigns to raise awareness of the nature of dementia and the fact that many dementia sufferers’ acute conditions can be treated and their previous health status restored through timely interventions. The challenge (as Uwakwe & Modebe, this issue, show) is to develop carer support and awareness raising strategies that are appropriate to local cultural and caregiving contexts and that can be financially sustained.
Second, and crucially, there is a need for active and concentrated advocacy efforts to promote the development and implementation of public policies to remove older people’s financial barrier to health services. Various approaches may be considered for this, including:

- targeted fee deferral or exemption schemes, such as those in Ghana;
- more direct, targeted financial support to poor older people, for example, through non-contributory pensions as exist in a few African countries such as South Africa, Senegal, Mauritius, Namibia or Botswana (see HAI, 2004); or
- the institution of health insurance schemes accessible to poor older people (see Bloom, 2005).

Given constrained public resources, and the clear priority given to the pressing problems of maternal and child health, the challenges for such advocacy efforts are two-fold:

- first, to clarify and highlight the relative degree of older people’s exclusion from needed health services compared to younger age groups, and relate this to equity considerations and population ageing projections; and
- second, to explain the feasibility of various schemes by drawing on examples of successful practice from various settings.

Both challenges highlight the crucial need for research to provide a sound evidence base upon which advocacy efforts can build. Initiatives to foster research on ageing in Africa that have begun in recent years are encouraging (see, e.g., AFRAN, 2007; Cohen & Menken, 2006).
There is an extreme paucity of population-based research and thus representative evidence on prevalence and incidence rates of dementia in the developing world. Estimates of the numbers of dementia sufferers in these regions, therefore, are derived from applying prevalence rates found in published (non-representative) studies of dementia to UN population estimates and projections (see Ferri et al., 2005).

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Older people in Ghana often complain: about the lazy and disrespectful young people of today, the breakdown of the family, the lack of support they receive from their children, everything being expensive and harvests being poor. They even complain about the weather. Life was better and people were more kind and respectful when they were young. Yet in Ghana, the rules for being respectfully old stipulate that an older person should not complain. This article, drawing on extensive fieldwork in rural Ghana, reflects on older people’s attempts to grow old with dignity and their strategies of silence or carefully choosing the audience for their complaints to retain respect or affection from the young, as well as asserting their moral authority.

Fieldwork
The older people who figure in this essay lived in Kwahu-Tafo, Ghana. I say “lived” because none of them is alive today. I devote these lines to them, as a tribute to their determination to live as honourable and respected elders in a period when they were losing some of their most cherished values and securities. Kwahu-Tafo is a rural town of about 6,000 inhabitants on the Kwahu Plateau in the Eastern Province of Ghana. The local population calls itself Kwahu, a subgroup of the Akan who constitute about half of Ghana’s 20 million people. The Akan, who speak Twi, have a matrilineal kinship system, which despite various inroads still stands, both in rural and urban Ghana.

The paper is drawn from a research project on the social and cultural meaning of growing old, carried out intermittently between 1994 and 2004. The research is based mainly on conversations with 30 older women and men and some of their relatives. I found these people by asking friends about older people in their neighbourhood. The concept “old” was not clearly
defined; I simply chose people who were described by others as old. In fact, old proved to be more a term of respect than of one’s calendar age. People were selected to ensure variation in the sample in terms of gender, economic and social status, marital situation, religious affiliation and number of children.

Usually a conversation with an older person circled around one topic, for example, one’s life history, the concept of old, the ability of older people to bless and to curse, the care they received and gave, their ideas about a successful and unsuccessful life, respect and reciprocity, security, love, loneliness, sex at old age, death and funeral.

These topics were not planned beforehand, but grew naturally out of earlier conversations. Often one topic was discussed with one person and another topic with another. With some of the older people, I only had one or two conversations, with others, many. In addition to the long conversations, there were frequent casual meetings with the older people, such as short visits to greet or to deliver a message. Observations during these visits constituted a crucial element of the research, as they added depth and context to verbal accounts. All of the longer conversations were taped, translated, transcribed and discussed with my Ghanaian friends and co-researchers and, at times, with the elders.

Dutch Beginnings
Anthropological research starts with autobiographical concerns. My interest in the experiences and views of older people in Ghana was directly related to conditions of older people in my own society, The Netherlands. Older people constitute an uncomfortable segment of our population. They carry the burden of a rather negative label: old stands for decay and loss, however healthy they may be. Many older people, therefore, live in constant denial of their own old age and emphasize that they are still young. Old are only those who are above the age of the one speaking. The negative stereotyping and social marginalization of old age in Dutch society are exacerbated by present concerns about the rising costs of a rapidly growing population of pensioners. The future of the welfare state has become uncertain, and the generous allowance system for older persons is a key political issue, as one can read almost daily in the newspapers.

Exploring conditions of older people in an entirely different setting seemed to be an attractive way to reconsider old age in my own society. Indeed, there is hardly anything in Dutch society that is more amazing and shocking to Ghanaians than our manner of dealing with older people. Some pointed at our lack of respect and care for older people as a proof of the dehumanization of our society and assured me that they would never allow this to happen in Ghana.

The theme of this paper, complaining and not complaining, also found its beginnings in experiences in The Netherlands. On the one hand, many older people have lots of reasons to complain about the present time. They may have lost their dearest possessions, values and relatives and feel nostalgic for the world of their past. They would like to express their sadness and resentment and complain about the lack of understanding and compassion from the new generation. But they try not to, because, on the other hand, complaining (klagen) is one of the most negative qualities attached to older people in The Netherlands. By always complaining, Dutch older citizens make themselves unattractive, boring and irritating.
to younger people. Complaining, an attempt to draw attention and sympathy, turns out to be self-defeating: it chases people away. Wise older people, therefore, rather keep their complaints to themselves and take on a stoic appearance in order not to alienate their children and grandchildren. By ‘not being a burden’ (in that sense) to their children, they hope to keep their children’s affection.

Research among Dutch older people (e.g., De Jong, 2004; Rietveld, 2002; Von Faber, 2002; Von Faber, unpublished) shows that older people actively try not to complain. By dissociating themselves from others who complain, they present themselves as successful and attractive in their old age. An 87-year-old widow who had been suffering from severe stomach pain told Von Faber (unpublished):

They [her children] did not even know how sick I was. I never told them. I have hidden my problems from them. I thought: if I tell them, they will think: “She is nagging (ze zeurt). All people at that age complain.” If they came to visit me, I tried to be as good as possible. After they went home, I went straight to bed. If they phoned and asked me how I was doing, I turned the conversation to another subject.

Not complaining is not only a matter of keeping silent and being stoic, but also a strategy to attract others and to keep up one’s social network. One should maintain an active interest in the life of the younger generation. Older people who want to remain popular should not always talk about the good old days (and implicitly condemn the present age), but keep themselves informed about today’s developments and show an interest in the experiences of the young.

African Observations: Complaint Discourse

Older people in Africa have been shown in many ethnographic and other studies to have similar complaints to the ones I have outlined for older people in The Netherlands, including bodily pains, general weakness, loneliness, and lack of attention and respect. However, the literature on the extent and manner in which older people articulate these complaints in Africa points to an approach that seems to differ from that in The Netherlands. Starting from my personal experiences, I was surprised to read in African ethnographies about complaining as a strategy by older people to negotiate for more respect, attention and care.

- Rosenberg (1997), in an article that appeared in 1990, wrote about the constant complaining by !Kung San elders in Botswana as a way to “mark their continued presence in the world” and to remind their children: “I am still alive” (p. 39). She notes that many complaints are fabrications contradicted by facts. One of her older informants admitted: “Old people have long complained; it is an old thing. Even if the child did everything for them, they would complain” (p. 33). Rosenberg explains—and illustrates with various quotes and observations—that ‘competitive complaining’ is a common and popular way of communicating among !Kung San people. She suggests that complaining is not typical of old age. Everybody complains. It is a levelling discourse and reminds people of reciprocal obligations. It is “public exhortation to keep goods and services circulating” (p. 39). “We have to talk this way. It’s our custom,” one older woman explains to the anthropologist.

- Cattell (1997; 1999), in her studies of older people in Kenya, a society where complaining is not generally practiced by all age groups, speaks of a “discourse of neglect”: older people complain that they do not receive the care they deserve. It is not clear, however, to whom they complain. Do they, in fact, direct their complaints at their children and others whom they blame for neglecting them, or do they reserve their worries for the anthropologist who asks them about their feelings in old age? Cattell’s
claim that older people complain to “ensure or maximize support” is not substantiated by her observations. She reports several examples of family neglect, but does not provide any observations of older people expressing their discontent and frustration directly to their caregivers.

• The same inconclusiveness about complaining as a strategy by older people to have their needs fulfilled is found in an article by Sagner (2002), set in Xhosa society, South Africa. Sagner quotes older people complaining bitterly about the way they are treated by the young and contrasting this with their respect for elders when they were young. “When we were young, we used to honour old people, but today . . . ” Sagner interprets these complaints as a way for older people to air their frustrations and claim moral superiority over the young. However, their complaints are revealed to the researcher, and it is not clear whether they are also addressed to the young.

• Further studies from South Africa that highlight older people’s complaints fail to clarify to whom these are directed (Cloete & van Dongen, 2004; Makoni, 2002; Møller & Sotsongayaye, 2002).

Other current studies from the African continent, in contrast, point to older and younger people censoring their complaints:

• De Klerk, working on a study (unpublished) of older people in Kagera, Tanzania, heard older people urging each other to ‘tolerate’ (kwegumisirisa), to accept their suffering without complaining. Everyone has problems, so it is better not to complain. They say: “You die with your worries in your heart.”

• Ringsted (unpublished) heard long stories from young women in Kenya about how their husbands and relatives had unfairly treated them. The stories often ended with sentences like: “But I said nothing” or “I kept silent.” They could do little else than complain to Ringsted or to their friends, but at the same time, they emphasised their moral superiority by holding back their complaints before their relatives.

The above findings bring into relief critical, but so far little considered questions in exploring the significance of older people’s criticisms of the young in Africa:

• Who is the intended audience of older people’s complaints?
• And how does this relate to the purpose of these complaints?

More specifically:

• Are the complaints directed at the young who are the subject of the grievance?
• Are they a strategy aimed at rectifying the ills, such as lack of respect or support from the young?
• Or do they serve a different purpose?

In the following discussion, these questions are explored, based on my research and experiences with older people in Kwahu, Ghana.
Complaining and Not Complaining in Kwahu

My research in Kwahu, Ghana failed to produce evidence of older people complaining to the young about their lack of respect and care. They complained to me about the young. I was a safe audience for them. I know that elders in Kwahu prided themselves on not complaining, as Dutch older people did in the study of Von Faber (2002; unpublished).

In Kwahu, old age is an inherently positive concept. The most common, and probably only adequate, Akan term for ‘old’ referring to human beings is expressed through the verb nyin, which means “to grow.” The correct Akan translation of the English “I am old” is manyin, “I have grown.” Nyin indicates a process and suggests a linear type of development: growing, increasing in age, experience and wisdom. Manyin does not sound like a complaint; older people rather boast that they “have grown.”

The most popular title older people apply to themselves is ôpanyin (elder). “Ôpanyin” represents all that is beautiful about old age. The elder receives what is most highly regarded in Akan culture: respect. The ôpanyin is civilised, kind, composed and wise (van der Geest, 1998). Several proverbs and local sayings mention the expected behaviour and virtues of the ôpanyin. He is different from younger people because he thinks before he speaks, is capable of giving advice, has good manners, and is self-disciplined. His activities are directed at the well-being of others and, therefore, he deserves respect from the younger generation.

Not complaining is one of the outstanding signs of being an ôpanyin. The following excerpt from a conversation I (S) had with an elder (N) illustrates this. I asked the old man about the meaning of a proverb, Ôpanyin mpere ôkom (The ôpanyin does not complain of hunger):

**N:** It is not good for an ôpanyin to complain about hunger, as it will make the young disrespect him.

**S:** Nana (grandfather), I know you are now old and not healthy and at times you find life very hard. Would it still be wrong for you to complain?

**N:** Yes, it is very wrong for an elder to complain much, especially about hunger. If you do that, the young will not respect you . . . No matter the ordeal you may be passing through, you have to keep it to yourself because you are an ôpanyin. It is only children who complain.

**S:** But Nana, during our conversation you were complaining about your health and you said you wished to be treated [in hospital] if you had the money. What about that?

**N:** I wouldn’t do that in the house in the presence of my grandchildren and nephews. In the house, I do not complain. If I have money, I just call the children to buy me food. But if my niece or grandchild sees that I don’t send anyone to buy food, they provide me with some. I know they will never let me go hungry, so I don’t complain.

In a conversation about another proverb—Ôpanyin yam advansa aduasa (Inside the belly of the elder are 30 sheep)—a Kwahu elder commented:

**You [as an elder] know that you should eat the food brought to you to your fill, but this child of yours has nothing to eat. So you tell him to eat it. I will chew kola and get satisfied . . . The elder has lived his life. He has eaten so much in this world. (Wadi wiase yi mu biribiara.) Therefore, there is nothing left for him to do other than guarding the people in the house.**

Hunger is a taboo topic, but complaints about other inconveniences of old age are also unmentionable. Loneliness is an intriguing example. At the beginning of my fieldwork, older people usually said that children and grandchildren often came to them to listen to their stories about the past and to seek their advice. By saying this, they implied that they were respected and admired for their wisdom. It slowly became clear to me, however, that most elders were hardly consulted for
their wisdom and superior knowledge. By pretending they received frequent visits, they were in fact keeping up appearances. With time, they began to admit that they felt lonely and disrespected and started to complain to me. I had the following conversation with an old man about the disinterest of the youth in his knowledge and wisdom.

**G:** Yesterday, I was complaining to someone that I don’t understand why my grandchildren and the young people in my house don’t come and greet me and ask me about a lot of things I know.

**S:** Why don’t they come?

**G:** I don’t know. I want them to come and ask so that I tell them, but I don’t get them. If you don’t come, well, I will die and take it along (Mewu a na medekɔ).

**S:** So you will go with it?

**G:** Yes, my head is full of things, but I will go with them because they won’t come.

One day, one of my friends went to see the old man and found him conversing with a woman. The following conversation ensued:

**G:** This woman is just a friend. She often comes to keep me company whenever she visits her farm nearby.

**B:** What about your relatives? Do they pay you visits or do you visit them?

**G:** I have many relatives, but they don’t visit me, except on rare occasions; they don’t care much about me, especially the young ones. You know I am the eldest of all the people living in the family. Thus, it is my desire and wish that the young educated ones will come to me so that I will impart my rich knowledge about our clan and my life experiences to them. But they will not come.

**B:** If they will not come, why not go to them?

**G:** It is against my principles and also against the tradition to do so. If they will not come, it is they, and not I, who will lose in the long run.

Another elder expressed the same complaint in a conversation Kwame Fosu and I had with him.

**F:** You have many proverbs. Do people come to you to learn proverbs from you as well?

**A:** They don’t come.

[A woman from the house had come closer to listen. When we asked her whether she had learned some proverbs from the old man since she was living with him in the same house, she answered in the negative.]

**A:** She will not learn proverbs, because the proverbs will not earn her money, but in future it will help you. When you are entering a town and you hear on the abɔmmɔa drums: Nammɔn tenten reba, nammɔn tenten reba, nammɔn tenten reba, the drummers are informing the executers that there is someone to be executed. If you understand the proverb (on the drum), you will not be caught and executed. You will run away to save your life. But if you don’t understand the proverb, you will be caught and killed.

Many of my conversations with older people ended in such complaints about lack of interest and respect from the younger generation, resulting in feelings of loneliness and redundancy, but I never witnessed that such complaints were communicated directly to the young.
Complaints about decline of respect and family support are stronger in urban places. Aboderin (2004; 2006), who conducted research on a three-generational sample of respondents in the capital Accra, concludes that young adults often fail to provide their parents with the care they would like to give, as they also face problems in feeding their own family. Moreover, they can now afford to withhold support that they do not want to give, because sanctions for failing to provide care for one’s parents have lost their impact on the young (2004: s135). The older people she interviewed complained freely to her, the researcher, about the attitude and lack of support of their children:

> When it comes to contributing . . . to me, she [the daughter] will say: “Oh, I don’t have money” . . . But the thing is that she buys expensive things . . . so she is always in debt . . . and . . . there is nothing left to give to me . . . But if she had respect, she would keep the money and give to me (2004: s133).

Older people also accused the young of no longer fearing God:

> Look, I can tell you that the younger ones now, they don’t fear God, they don’t fear him how we used to fear him (2004: s134).

Older parents who suspected their children of being able to give more than they were giving, did express their requests for more to them:

> My son like this, he doesn’t give me anything. I have asked him to give me, I have asked him three times, four times, but he doesn’t mind me (Mr. Mensah, G1) (2006: 109).

However, there was little evidence that older parents directly criticised their children for their lack of respect and support.

Studies in other settings, for example among older Bengali migrants in Britain (Gardner, 2002), have suggested that older people’s open complaining about the lack of support received, may be an effective tool to get more help from the state. In Ghana, this certainly cannot be older people’s intention: the state has nothing to offer to them. However, it is possible that the researcher was to some extent seen not only as a safe person to address one’s complaints to, but also a possible source of ‘charitable’ support.

### Is Not Complaining a Strategy?

Reference has been made to literature about “complaint discourse.” Authors, including Rosenberg (1997), Cattell (1997; 1999), and Sagner (2002), argued that in general terms, “the language of complaint of older people should be read as instrumental and symbolic practice, as a medium of expressive action and as an attempt to intervene in the social process” (Sagner, 2002: 44). More specifically, they describe older people’s complaints variously as letting off steam, as a strategy to maximise support (Cattel, 1997), or as desperate attempts to maintain their self-respect and faith in their own moral superiority—a form of resistance. Sagner (2002: 57), following Meyhoff (1978), notes that complaining linked the claim of moral superiority to structural inferiority. However, what these authors have left unclear is the crucial question of the audience and its relationship to the aims, purpose or significance of the complaint.

My exploration of this issue has shown that older people in Kwahu complained to me—the researcher—about the lack of support from and interaction with the young, which made them feel lonely and left with unfulfilled needs. They did not, however, voice these complaints in public or to the young. To them, not complaining—not openly engaging in a complaint discourse although their hearts were full of complaints—was a conscious act. This act was intended, on one level, to ensure respect from the young upon whom they depended for material and emotional support—support they were powerless to enforce.
In other words, it was not complaining that was a strategy to maximise or ensure continued contact with and support from the young. This clearly echoes the Dutch situation described earlier. In Kwahu, not complaining may be seen as a response to cultural ideal: the Ṫpanyin, the respected elder, which stresses that complaining, certainly to the young, does not befit an elder. This may be seen as part of what Apt (1996)—with references to two classic authors of Akan culture, Rattray and Danquah—calls “the principle of responsive ageing which underpins Ghanaian attitudes to old age and holds that an older person who has nothing to offer the young forfeits the respect reserved for the elders” (p. 24).

In this context, complaining to the young clearly becomes a self-defeating strategy. It is a call for attention that is likely to be counter-productive, as it undermines the respect accorded to the old by the young, and likely makes them unwilling to fulfil their support tasks.

Complaining to the young about their shortcomings towards them, will cost older people their admiration and affection, even though the young are too polite and careful (or afraid?) to openly show their disrespect. Moreover, as complaining conflicts with the ideal image older people cherish about themselves, one would expect that it also diminishes their self-respect. As we saw in their own statements, by complaining to the young, they humiliate themselves. Thus, and consistent with the Dutch situation as well as that described for Tanzania and Kenya, not complaining may also be a strategy of older people to maintain their moral superiority vis-à-vis the young, in relation to whom they are in a weaker position.

What, then, was the purpose or significance of older people’s complaints to me, the researcher? It might be, as Sagner asserts, simply an opportunity to relieve their hearts of the grievances they harboured. On the other hand, or in addition, these complaints to me, an outside observer of their society and a potential evaluator of its moral and structural hierarchies, served an aim similar to one of the purposes of not complaining to the young: i.e., to assert their moral authority and self-esteem vis-à-vis other people’s evaluation.

In this sense, then, both complaining and not complaining, depending on the audience, could be seen partly as a strategy of older people’s resistance (as Sagner interpreted it): resistance against a moral devaluation on top of their inevitably diminished structural position and dependence.

Conclusion

My exploration highlighted the importance of not complaining to the young as the best way for older people in Kwahu to maintain good relationships with, and thus support from, the younger generations. Authors, including Cattell and, in particular, Sagner, have discussed complaining as an act of resistance on the part of older people. It is possible, however, that this apparent contrast is merely a function of these authors’ omission to clarify the audience of the complaints. All of us have found that older people do complain to us—the researchers. I contend that these complaints may well be seen as a form of resistance. However, it is a resistance or protest that needs to be hidden from younger generations in their society, if it is to have the desired effect. Indeed, care-
ful reading of Cattell and Sagner shows that they, too, are aware of the risks of open complaining for older people. Sagner (2002: 61), for example, notes that for young people in South Africa, the language of complaint by older people encouraged “negative stereotyping of old age.”

There is, then, a delicate balance that older people try to keep in situations that threaten to render them powerless and lonely and deprive them of their dignity. Not protesting often appears the best option, even if their hearts are full of complaints.

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These conversations have resulted in a large number of articles (see, for example, van der Geest, 1998, 2002a, 2002b, 2004). Some of their ‘stories’ have been collected in a booklet, Life, Love and Death. Conversations with Six Elders in Kwaahu-Tafo, Ghana (Atuobi et al., 2005).

While writing this paper, I received an e-mail from a Ghanaian friend whose wife spent six months in the United States to work as a caregiver for older people: “Afu [pseudonym] finally arrived home yesterday after six months of offering her services to a nonagenarian in America. She pities Americans and Europeans for abandoning their aged in the care of outsiders!”

REFERENCES


NOTES

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The mid to last quarter of the 20th century witnessed a large influx of rural migrants to cities in sub-Saharan Africa that resulted in rapid rates of urbanization, largely fuelled by gaps in real wages between urban and rural areas (Todaro, 1996; UN, 2004). This fast pace of urbanization, however, has not been accompanied by economic growth. The 1980s and 1990s, especially, witnessed a fall in per capita incomes, reduced public expenditure in service provision, deterioration of urban infrastructure, and a general decline in the standard of living in urban areas (Ogura, 1991; Potts, 1995). This has led to increased poverty in urban areas and, consequently, the mushrooming of informal settlements and slums.

Nairobi, the capital of Kenya, a regional economic centre and home to approximately three million people (Republic of Kenya, 2001), exemplifies this situation. Nearly two-thirds of the city’s residents live in slums that occupy about 5% of the residential land (Matrix Development Consultants, 1993). These slums are home to people who typically are unemployed, impoverished and in very poor health and lack basic services. A representative cross-sectional survey of slum households in Nairobi in 2000 by the African Population and Health Research Centre shows that the mean number of rooms used by one household is 1.2; close to 40% of the households have three or more persons in one-room houses that serve multiple purposes. Morbidity and mortality among slum children is higher, and access to health services is much lower than in other areas of Kenya (APHRC, 2002).

Indications are that such slums, and cities, are increasingly becoming home to older people who are typically first-generation rural-urban migrants (Ezeh, Chepngen, Kasiira, & Woubalem, 2006; Gugler, 2002; Hashimoto, Kendig, & Coppard, 1992). Their presence and continued stay...
in urban areas reflect a changing context of ageing in Africa where the majority of older persons continue to reside in rural areas (UN, 2002).

**Expected Return-Migration of Older People**

A widespread assumption in the migration literature is that older first-generation migrants in cities, in their old age, wish to—and actually do—return to their rural origins, prompted by changes that typically occur in later phases of the life course. These include poorer health status, fewer employment options, and changed marital status with consequent modifications in household composition and size (Ritchey, 1976; von Reichert, 2001; Wiseman & Roseman, 1979). Those who return following retirement include both those who are successful in accumulating wealth or achieving their reasons for migration as well as “failed” migrants (Leavey, Sembhi, & Livingston, 2004; Peil, Ekpenyong, & Oyeneye, 1988). The expectation of such return-migration among older migrants in African cities is underpinned by studies, which show migrants’ strong affiliation to their rural homeplace and their expressed intentions to return there (Peil, Ekpenyong, & Oyeneye, 1988) and which document the actual return-migration of migrants (of all ages), most notably in Zambia's Copperbelt region (Potts, 1990; Potts, 1995; Potts, 2003; Stoller & Longino, 2001). These findings indicate that the majority of African rural-urban migrants consider their city residence as temporary and intend to return to their rural place of origin (Kruger, 1998; Lesetedi, 2003).

**Factors Motivating and Facilitating Return-Migration**

In the western international migration literature, debates on factors generally motivating and facilitating return-migration to previous places of residence emphasise, above all, the key role of continued ties and strong attachment to the place (Aguilera, 2004; Frey, Liaw, & Lin, 2000; Stoller & Longino, 2001; Walters, 2000). Such ties are shown to be strengthened by the continued presence of family, friends and kin in the place (Frey, Liaw, & Lin, 2000; Ritchey, 1976; Stoller & Longino, 2001; Tiemoko, 2004; von Reichert, 2001; Walters, 2000) and, as far as urban-rural links are concerned, by frequent visits and remittances (Lesetedi, 2003; Ley & Kobayashi, 2005; Ogura, 1991; Stoller & Longino, 2001).

In sub-Saharan Africa, additional factors come into play in shaping rural-urban migration. Evidence suggests that continued linkages between urban residents and their rural home have been an integral and important aspect of the urbanization process, and have operated at both individual and community levels (Potts, 1995; Lesetedi, 2003; Trager, 1998). Individuals maintain ties with their family members in the rural home while, at the community level, urban-based networks and organizations whose members share a common origin maintain links with their rural community through participation in social and developmental activities.

In Kenya, as in other African nations, such links have often become resilient and dynamic and represent an important strategy for both urban and rural residents to cope with contemporary economic and political strain and circumstances (Geschiere & Gugler, 1998; Geschiere & Nyamnjoh, 1998; Gugler, 2002; Kruger, 1998; Lesetedi, 2003; Potts, 1990; Potts, 1995). In urban areas, growing and pervasive unemployment, falling income levels, losses in formal employment, and reductions in public spending for services create major stress (Potts, 1990; Potts, 1995; Stoller & Longino, 2001).

In this context, older Africans’ actual or intended return-migration may be driven by factors other than those typically emphasised in the literature. Specific “push factors” in urban slum settings may include the onset of retirement when residents are unemployed and lack income security and basic social services. “Pull factors” in rural areas may include the prospect of economic and instrumental support from kin, lower living costs, and more amenable living and social conditions (Lesetedi, 2003; Peil, Ekpenyong, & Oyeneye, 1988).
In contrast to the dominant assumption of return-migration to rural areas in old age, some authors have argued that attachment to rural areas of origin is likely to decline with prolonged residence in urban areas, with the urban residence more likely to be permanent. Building on empirical evidence from older Irish migrants in London, these authors suggest that older people’s expressed intention to return is a myth or an illusion because it is never actualised (Leavey, Sembhi, & Livingston, 2004). Rather, it represents part of their attempt to compensate for the lack of total assimilation in the host community.

These contrasting views and assumptions about return-migration in old age raise important questions about the continued presence of older people in urban slums. Why do they still reside in the slums and why have they not returned to their largely rural areas of origin? Are there gender differences in intentions to migrate and actual migration? What are their perspectives on return-migration, rural and urban residence? And what are the implications for policy? This paper aims to explore these questions, building on empirical evidence of the views and experiences of older people living in two slum communities in Nairobi: Korogocho and Viwandani.

**Data and Methods**

The evidence is based on a qualitative study which investigated health and living arrangements of older people in these two communities. The research employed Focus Group Discussions (FGDs) and in-depth interviews (IDIs) with slum residents as the main methods of data collection. The FGDs followed a guide of areas for discussion, seeking participants’ views regarding the presence of older people in urban areas as opposed to their returning to rural areas. In total, 24 FGDs with community residents were conducted which were constituted to represent different age and gender groups (see Table 1). Only the FGDs with people aged 50 years and older are included in this analysis.

The IDIs followed a semi-structured topic guide aimed at providing an in-depth look into the lives and experiences of older people. The information collected included their life histories, experiences living in the slums, current circumstances, and future migration aspirations. A total of 32 IDIs were conducted with older people aged between 51 and 91 years. IDI respondents were purposely selected to include men and women, as well as those with different life experiences and circumstances, including:

- those who had experienced the death of an adult child,
- those who were taking care of orphans,
- those living with a disability or chronic illness, and
- those living alone in a one-person household (see Table 2).

The FGDs and IDIs were conducted by research assistants with prior experience in conducting qualitative studies. The purpose of the study was explained to the respondents before seeking their consent to participate. In most cases, consent was obtained verbally, with only a few respondents signing consent forms, either due to inability to read and write or because of not being at ease with signing any document. All FGDs and IDIs

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number of Groups by Sex of Participants</th>
<th>Total Number of Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 - 24</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>25 - 49</td>
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<td>8</td>
</tr>
<tr>
<td>60+</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>24</td>
</tr>
</tbody>
</table>

Table 1. Number of Focus Group Discussion (FGD) Groups by Age and Sex
were audiotaped and transcribed by the research assistants who conducted the interviews and were then coded thematically by the principal investigators using a software program (QSR N6<sup>®</sup> package) for coding and analysing qualitative data.

The discussion of the findings in this paper draws mostly on evidence emerging from FGDs conducted with slum residents (aged 50 and over) and from the in-depth interviews. Key points are illustrated with verbatim quotes as well as with summary statistics and with case studies of IDI respondents. To ensure respondents’ anonymity, “Res1,” “Res2” and so on are used to denote statements from different respondents with questions and comments from the moderator denoted by “Mod.” Given the restricted sample base, the findings make no claim to a wide generality. Rather, they aim to highlight key emerging issues or patterns that can be explored in further, larger-scale research.

**Findings**

**The “Ideal” of Return-Migration**

Almost all study participants, reflecting on their personal lives, viewed return-migration to rural areas as the preferred and ideal migration move for an older person in an urban area. As Table 3 shows, of the 29 IDI participants for which clear information was available, 25 said they would prefer to relocate. However, although a return-migration to rural areas is the ideal for most, it is a realistic option only for a small minority. The majority of respondents felt unable to realize their wish to return to their rural homes or places of origin. Among the IDI participants who expressed a wish to return, less than half saw the possibility and had concrete plans to make such a move. Of these, however, only three reported being able to relocate at any time. The majority (8) was unable to return in the near future due to factors that made such a move nearly impossible.

As Table 3 shows, there were gender patterns in respondents’ perspectives: The majority of men who wished to return had concrete intentions to do so (though they felt hindered in the short term). The large majority of women, in contrast, despite wishing to return, saw no possibility of doing so. Furthermore, men were among the few who preferred life in the city. These divergent situations of older men and women reflect gender specific differences in the factors that hinder older...

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**TABLE 2. Composition of In-Depth Interview Respondent Sample**

<table>
<thead>
<tr>
<th>Marital status</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
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<tbody>
<tr>
<td>Never married</td>
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<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Married</td>
<td>7</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Divorced</td>
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<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Widowed</td>
<td>7</td>
<td>8</td>
<td>15</td>
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<table>
<thead>
<tr>
<th>Age distribution</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
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</thead>
<tbody>
<tr>
<td>Mean age</td>
<td>69</td>
<td>75</td>
<td>72</td>
</tr>
<tr>
<td>Minimum age</td>
<td>59</td>
<td>61</td>
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<tr>
<td>Maximum age</td>
<td>92</td>
<td>91</td>
<td>92</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal experience</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living alone</td>
<td>7</td>
<td>3</td>
<td>10</td>
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<tr>
<td>Caring for orphans</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Experienced a death</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Physically disabled</td>
<td>5</td>
<td>4</td>
<td>9</td>
</tr>
</tbody>
</table>
people’s return-migration either in the short term or altogether.

Several factors were identified as impediments to return-migration, including:

- financial constraints,
- access to land,
- inheritance and lineage systems, and
- severed ties with rural homes.

Highlighted with case studies, we explore below how these factors, singularly or in combination, informed and influenced older people’s decisions on return-migration.

Financial Constraints to Return-Migration

The key factor that respondents described as constraining older people’s plans to relocate to their rural places of origin, in the near future, is lack of financial resources to pay for the costs of such a move, including setting up a home in the rural area as well as the actual cost of moving. The inability of older migrants to afford these expenditures reflects their lack of savings, low income, or the lack of retirement benefits. Having nothing to show financially for their many years of city life may further discourage some older persons, especially men, from returning. The case study below illustrates how an older male migrant’s financial incapacity impedes his relocation to the rural home.

CASE ONE
Male, Korogocho Community

Born in 1934 in Siaya District, Nyanza Province in the western part of Kenya, he works as a security guard. His wife and children live in the rural area, and he supports them by sending money. He has, however, not been able to send any money because his salary has not been paid for six months. He has lived back and forth between his rural home and urban areas. He first came to Nairobi in 1984, having lived in Mombasa, a large coastal city. Before returning to live in Nairobi’s Korogocho slum in 2001, he had migrated to the rural area where he tried out farming for two and a half years. He intends to return to his rural area after saving enough money to enable him to settle down. His irregular salary payment has hindered his effort to relocate to his rural area. When asked, “Do you plan to go back to the
and private institutions. Thus, displaced people were either assigned to temporary settlements or squatted on public land and open spaces, some of which mushroomed into slums and informal settlements. Some people in slum settlements are, therefore, not rural-urban migrants in the strict sense, and have no rural homes or land to return to. FGD participants (60+ years female FGD group one, Korogocho) described older people in the slums who lack claim to rural land as follows:

**Mod** I would like to know why older men continue living here instead of going back to rural areas.

**Res2** We have many people who have no land in the rural areas. Some have been born here and have stayed here throughout their lives. This is the only home they have.

**Res6** Yes, there are old men still living here. They have no land back home in the rural areas. They have stayed here all their lives and have raised their children here. They have nowhere to go.

**Res9** There is nowhere to go. You do not have land where you can build a house and settle. The colonialist took our land. After independence when land was divided, we were not given any. Therefore, we do not have land in the rural areas.

Others had access to land, but had lost it to family members who remained in the rural areas. This situation was mentioned as the main hindering factor by five of the 14 IDI respondents who reported having no option of returning.

Such loss of land to kin, as respondents explained, could occur either because migrants sold them their share when relocating to urban areas or because family members had at some point illicitly or forcefully acquired the land to complement their own small portion. The latter ensued in particular with migrants’ prolonged absence from rural areas, accompanied by little or no communication with their family there, or where migrants were pressured to give up their...
parcels of land in order to increase the acreage kin had available for farming. The case study below provides an example of an older migrant who lost his land to those left behind in the rural areas.

CASE TWO
Male, Korogocho Community
He was born in 1939 in Siaya District, Nyanza Province, which is in the western part of Kenya. In search of employment, he left his birth place and crossed over to Uganda, a neighboring country. He settled in Uganda and worked as a casual labourer in people’s farms for several years and even started a family there. He returned to Siaya, his birth place, in 1976 after his marriage ended and also because of political unrest in Uganda. On his return, he found his parents had died and his relatives had taken over his share of land allocated by his parents as his inheritance. Having no land in Siaya, he migrated to Nairobi in 1979 and has been living in Korogocho community since 1982. He says he has no intention of returning to the rural areas. When asked, “Do you plan to go back to your rural home?” he responded, “To go and do what? There is no land for me there. What will I go to do in the rural area? When I die, that is where I will be ‘thrown’ (buried).” He relies on well-wishers, especially the Catholic Church, for his upkeep as he is not engaged in any livelihood activity. He previously worked as a security guard and as a casual labourer in construction sites. He lives alone and he never remarried.

Finally, there are those who have claim to land in the rural areas, but are deterred by its size. As a result of the continuous sub-division of land in rural areas, older people typically only have access to very small parcels of land that are not viable for farming. This had often been a factor motivating their original migration to the urban area and, by the same token, discouraged their return, as a very small parcel would provide no sustainable means of livelihood.

Inheritance and Lineage Systems
Older women’s lack of access to land was shaped by the customary inheritance rules and lineage systems that operate across most ethnic groups in Kenya. These customs and the resulting lack of claim to land were mentioned as the key prohibiting factor by all female IDI respondents who wished to return but saw no real option of doing so. Similarly, it was raised as a factor in 16 of the 24 FGDs.

Virtually all ethnic communities in Kenya follow the patrilineal lineage system with patrilocal residence, where descent and inheritance rights are traced or passed through the male line. The descent system is important in determining property rights, access to resources, as well as in determining expected obligations towards and by each family member. In patrilineal systems, women inherit family property, including land, only through marital rather than natal rights. Single (never married or divorced) women and single mothers are therefore disadvantaged since they cannot claim rights to land in their biological parents’ home. Such women, therefore, when they become older, do not have a rural home to go to unless offered by their maternal kin. Their children are equally disadvantaged, especially if they are male as they may not have any linkages to their own biological fathers. Other women who have given birth to children from different men, cannot settle in any of the men’s rural homes. Those married to men who themselves have no land are similarly disadvantaged. Female FGD participants (60+ years female FGD group, Korogocho) especially, vividly described such situations in their group discussions as shown by the excerpt below.

Res2 Surely, my daughter (referring to the moderator), if your husband himself did not have land, where do you, as a woman, get land to go back to? We are forced to stay in town because our husbands did not inherit land back home and our children are born and brought up here . . .
Her land was sold by her brother-in-law and she has no intention of returning to the rural areas. She says, “I stay here because I don’t have a place to go. My land was sold, where will I go? Whose place will I go back to? My husband’s brother sold everything. He only left a place where his house stands. I hear the wife doesn’t even have a place to farm. Now, where can I go? I can’t go back to my natal home either. What will I be going to do?” She says she can go back to her natal home only if the dowry that was paid to her matrimonial home is returned. She added, “My mother is already dead and the home is deserted. Yes, here (Viwandani) is where home is. This is because I don’t have land anywhere. I don’t have a place to go. If I have money, I would buy land.”

The importance of inheritance customs and lineage systems in return-migration decisions, especially for never or formerly married women, has been documented for Kenya and other sub-Saharan African countries (Gugler, 2002). Such women, in the absence of a spouse, will have little or no attachment to rural areas and will continue to live in urban areas, not out of choice, but because they have no place to return to.

Severed Ties with Rural Areas

Another factor that emerged in both the in-depth interviews and FGDs as contributing to older people’s inability to return to their rural home areas is the severance of ties with their kin in rural places of origin. On one level, broken ties, through conflict or prolonged lack of communication, can lead to older migrants’ loss of access to rural land. On another level, as respondents suggested, the dissolution of links with the rural home and the circumstances surrounding such events may themselves be the major reason for remaining in the city.

Cases may arise where older migrants have committed crimes in their rural areas and are scared of going back, or where they have been
declared outcasts and cannot return. In addition, older people may have disconnected ties to their rural areas through changing or abandoning some of their cultural practices and adopting urban lifestyles. Migrants may avoid relocation for fear of condemnation or rejection by their rural kin due to their acquired lifestyle. Other reasons respondents gave for some migrants’ inclination to stay in the city included the following:
• the availability of amenities in urban areas, such as electricity, water, and health and schooling facilities,
• harsh climatic and environmental conditions in some rural settings, and
• the perceived lack of livelihood opportunities in rural areas.

Discussion
Drawing on the perspectives of older slum dwellers in Nairobi, this paper explains why people are not returning to their rural areas in their old age. Most of the current cohort of older people living in most cities in sub-Saharan Africa are first generation migrants, having moved from rural areas during the pre- and immediate post-independence periods in African states. Ties that bind urban migrants to their rural homes are assumed to have persisted in many cities with the expectation that these migrants would make a return-migration, most probably in their old age. The absence of such a move for many of the older people raises the need to understand why this return-migration is not taking place.

While return-migration to rural areas is still considered the ideal option by older slum residents, many, and in particular older women, are unable to realize this ideal due to prohibiting factors. Most of the reasons given by older people for remaining in the city do not match classical migration literature notions about the operation of push and pull factors.

Low wages and lack of savings, in a context where extended family support is lacking, “push” the wish to return to rural homes. However, these factors, as well as the lack of access to sufficient rural land, and weakened ties to rural kin, create formidable obstacles to a return. Customary inheritance rules and lineage systems often exacerbate the situation women face.

The central effect of weakened ties to rural kin in impeding return-migration (either in their own right or by facilitating the loss of access to land) echoes findings in the international literature, which show that urban migrants who have not maintained ties or contact with their rural homes are generally less likely to return in their old age (Aguilera, 2004; Gugler, 2002; Lesetedi, 2003; Ogura, 1991; Peil, Ekpenyong, & Oyeneye, 1988).

Together, the obstacles to older migrants’ return may be seen as the consequences of a lifetime of living in poverty. In other words, they reflect the migrants’ lack of success in achieving the urban dream of wealth and fame and their failure to accumulate savings to independently acquire land in their rural homes. As a result, the economic or family-related push factors that led to their urban migration persist as factors now prohibiting their return.

A comparison of this situation with the frequent actual return-migration of urban migrants in countries such as Ghana or Zambia points to the important role that Kenya’s land tenure system may play in underpinning the lack of return. In Kenya, land is highly commercialised and privately owned. In Ghana or Zambia, in contrast, land is largely still customarily owned and only sparsely populated, and can thus be more easily acquired by urban residents (Potts, 1995; Potts, 2005).

The nature of the circumstances impeding the return-migration of older Nairobi slum residents and the fact that these circumstances are unlikely to be altered in the foreseeable future suggest that their urban migration may be more permanent than is typically anticipated. This finding reverberates with some arguments in the international migration literature (Leavey, Sembhi, & Livings-ton, 2004) that ties to rural homes are likely to weaken with a prolonged residence in the city.
and that migrants’ expressed wish to return is never realized. Ongoing longitudinal research will ascertain whether the older slum residents’ aspiration to return will, indeed, remain an illusion.

The potentially permanent stay of older slum residents in the city raises questions about a possible old-age return-migration among their children in the future. Compounded by their parents’ continued residence in Nairobi, these second generation migrants are unlikely to develop strong ties to their rural homes and may consequently have little desire or the option to return there. Expectations are, therefore, that the growing number of middle-aged adults currently living in urban slums, too, will remain in the city for the rest of their lives.

**Conclusion and Recommendation**

The reasons why older persons continue to live in the slums instead of returning to their rural areas are complex and multi-faceted, and point to the fact that while a minority of older people remain in urban areas out of choice, most, given their lack of sufficient resources, simply have no alternative. These unsuccessful migrants are resigned to dying and being buried in the city. The slum settlements will likely continue to be home to a large majority of poor older people, and their offspring as they age. This calls for the development of policies and targeted programs to address their needs including, perhaps, facilitating their return-migration. Further research on older migrants’ situation and aspirations is required to inform such initiatives.

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NOTE

1 Widow inheritance, also referred to as levirate marriage, is a customary tradition practiced by several ethnic groups in sub-Saharan Africa where a widow is remarried to one of her deceased husband’s brothers or close relatives, generally as a form of social protection to the widow and her children, although the forms and reasons for the practice vary across different ethnic groups.

REFERENCES


