Journal of Social Development in Africa (1990), 5,2, 25-43

The Quality of Life of the Elderly Living in Institutions and Homes in Zimbabwe

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ABSTRACT

This paper is based on a study that showed that most institutions and homes for the elderly in Zimbabwe are found in urban areas, and that there are more homes for Europeans than Africans. Most respondents were born outside Zimbabwe, but had lived in the country for a considerable period. Most respondents were widows. European respondents in homes were much older than their African and Coloured counterparts, and were also more educated and had better jobs than the other respondents. They tended to live near their previous place of residence and therefore had more contact with relatives and friends. They were more satisfied with their lives in institutions than their African and Coloured counterparts.

Introduction

In order to understand how the needs of the elderly are met in Zimbabwe today, it is important to look at the social support systems of traditional Zimbabwean society. This will provide some insight into the institutional structures which once met the basic needs of the elderly, and which may still do so today.

Until the intervention of colonial rule in Zimbabwe, the elderly were relatively secure in their positions. Rwezaura (1989) argues that whereas all animals including man possess an instinctive drive to care for their dependent off-spring, they do not possess a similar instinct when it comes to the care of the elderly. Hence, Simmonds (1970) has noted that respect for old age has resulted from imposed social discipline and not nature. In most cultures children are trained from an early age to obey and respect their parents and other elderly members of the community.

Respect for the elderly was a core value in the cultures of the people living in what is now called Zimbabwe. Older people had a clear role to play within the rural community, and the responsibility of local villages to provide for the physical and emotional security of the aged was recognised. Kinship systems based upon

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consanguinial ties facilitated the absorption of the elderly within caring networks. However, urbanisation and industrialisation in Zimbabwean society, with a concomitant emphasis on the nuclear family, has resulted in a loss of security and prestige for a growing proportion of the nation's aged. This, according to Rwezaura (1989), has far reaching effects on junior/senior relations in society.

In a large measure the respect accorded the elderly in 'traditional' Shona and Ndebele societies was based upon their prominent position within the politico-economic system. As Clarke (1977) notes, these societies were gerontocracies in which the elderly wielded considerable power. Their influence was exercised through the control of land, food and cattle. Additionally they determined the distribution of women through the society. Rwezaura (1989:7) explains this in the following way:

> "the most significant source of security was the elders' control over strategic as well as scarce resources, such as land, livestock, essential skills and ritual power. The elders often used these resources in a manner which ensured that economically active members of the community remained bound to them".

Kinship ties provided an institutional framework through which the elderly made legitimate claims upon the labour power, property and services of junior relatives, and also through which the latter made reciprocal demands on the elders. The aged had a crucial role to play in the production system.

Economic change, new forms of social and political control, and new religions, all threatened the dominant economic position of the elderly in Zimbabwe. State policies to promote investment in the mining industry and commercial agriculture forced the migration of rural workers to staff expanding European enterprises. With the departure of the ablebodied work force from the local villages, rural Zimbabwean society began to lose its economic viability. As the household became increasingly dependent on the market for its basic needs, there was a corresponding decline in the system of economic reciprocity and the loosening of social cohesion. As Hampson (1982) explains, the rural village came to be regarded as a labour reserve that absorbed the cost of reproducing the labour force and provided for the subsistence needs of the aged, sick and destitute who were no longer needed by the industrial sector. In this process, the status and power of the traditional gerontocracy waned.

In Zimbabwe, until Independence, pension coverage followed racial lines. Until 1980 all non-Africans who had reached retirement age and had assets less than a certain maximum, or earned below a certain amount, could receive a pension of Z$93,00 per month (now Z$126,00 per month). Although the scheme has been discontinued pensions that were in existence in 1980 continue to be paid. Government coverage for elderly Zimbabweans now consists solely of assistance by the

Ministry of Labour, Manpower Planning and Social Welfare through a public assistance scheme for the destitute. Only a tiny fraction of the nation's elderly come within this coverage. As regards private pensions, Riddell (1980) noted that 70 per cent of the European work force are covered by pension sechems, but the African work force in general is very poorly served. Only 17 per cent of the agricultural work force, and 44 per cent of all Africans in formal sector employment, are covered by pension schemes. Even those that are covered are not likely to receive substantial benefits. The study noted that only 1,3 per cent of urban Africans in wage employment will receive pensions above the Urban Poverty Datum Line (PDL). The extent of destitution for both black rural and urban elderly is considerable.

A few far-sighted efforts to provide financial security for urban workers upon retirement were met with opposition from various interest groups, including the so-called 'native commissioners'. The assumption was that African workers were only temporary migrants in towns, urban life was for whites. When the 'native' ended his period of employment he was expected to return to his rural home.

The economic hardships of the elderly were, and still are, not fully appreciated by most African states (Rwezaura, 1989). It is often supposed, for example, that the local community in Africa still provides old-age security, when, in fact, its economic role has been attenuated. This attitude also meant particular hardship for those workers who migrated from neighbouring countries like Malawi, Zambia, Angola and Mozambique. For the most part employed in commercial farms, mines and in domestic service, these workers had no rural home to return to in Zimbabwe once they had ended their period of employment. The colonial policy of repatriation shifted the costs of retirement for these individuals onto their country of origin.

As a result of the declining rural economy and the lack of an adequate social security system in urban Zimbabwe, many of the nation's elderly face severe economic hardships. Most of the elderly interviewed in various Zimbabwean studies were found to be destitute (Muchena, 1978; Hampson, 1982; Brand, 1986; Sagomba, 1987; Nyanguru, 1987). In particular, they were without the resources to pay rent or buy food, clothing and other necessities. Many residents reported that they had no one to look after them and that they slept in the open. Others had to be placed in institutions for the aged. These researchers reported an increasing lack of accommodation and access to health services, as well as rising levels of incapacity and loneliness among the elderly. Thus there is a growing consensus among service professionals and community leaders, as well as the elderly themselves, about the need for a residential care system. The demands for such a system are likely to increase over time.

In attempting to construct a comprehensive policy for the care of the elderly, the Government of Zimbabwe has built upon the foundation laid by the colonial

government. The old regime had established a very efficient and rather humane system of care for the elderly in the European section of the community. Waterston (1982) (referring to the European population) writes that Rhodesia, as it was then, had the highest percentage of its elderly population in residential care in the world, over four times the comparable rate for the United Kingdom. Individuals were accommodated within one of four programmes depending upon their physical well-being.

For those living at home there were pensions, day care centres, visiting district nurses and well-person clinics catering for the needs of the elderly. For a slightly frailer population, the 'A' Scheme was developed. This provided for sheltered accommodation in which individuals lived independently in their own homes but had access to a local warden in case of need. 'B' Schemes or hostel accommodation provided meals, a laundry service and general care for residents. Finally, 'C' Schemes were instituted for the very handicapped and provided nursing care and assistance with the activities of daily life such as toileting and dressing. Homes established for the black population have followed this pattern, although they are still few in number. As the number of indigent elderly increases, the necessity for the establishment of a comprehensive programme geared to the particular needs of the Zimbabwe population has become a clear priority. It should be emphasised here that a timely recognition of the economic hardships sufferd by the elderly is essential so that Zimbabwe can construct an institutional framework for social security provision for the elderly.

The Effects of Institutions on the Old

To live to an advanced old age may be a blessing, but it may also be a curse. According to Tobin and Lieberman (1976), living through the eighth and ninth decades of life can bring both personal deterioration and social loss. When less drastic efforts to adapt to these misfortunes fail, elderly persons and their families are often forced towards the more drastic solution of seeking institutional care.

Elderly people who enter longterm care institutions do so to ensure survival, by retarding further deterioration, maintaining residual capacities, and restoring lost functioning. Tobin and Lieberman (1976) further argue that these various therapeutic goals are congruent with a residential setting that aims to provide health care within a structured social environment. Yet, long term care institutions for the aged have been charged with creating an 'institutional personality syndrome' in older people. The literature is replete with descriptions of the institutionalised elderly as disoriented, disorganised, withdrawn, apathetic, depressed and hopeless. These characteristics are frequently ascribed to the singular effects of institutional life. Townsend (1962:117) succinctly summarises the general view:

> "In the institution, people live communally with a minimum of privacy, and yet their relationships with each other are slender....Their mobility is restricted, and they have little access to society. The social experiences are limited, and the staff lead a rather separate existence from them. They are subtly oriented toward a system in which they submit to orderly routine, non-creative occupation, and cannot exercise as much self-determination".

Townsend (1962) goes on further to suggest that the elderly are deprived of intimate family relationships and this results in a gradual process of depersonification.

Talents they possess atrophy through disuse and they may become resigned and depressed, and may display no interest in the future or in things not immediately personal. However, in some smaller and more humanely administered institutions, these various characteristics seemed to be less frequently found, but they were still present.

One of the most compelling statements of the reasons for the effect of institutions has been offered by Goffman (1961) in his characterisation of the 'total institution', which dehumanises its inhabitants. Goffman emphasised that a basic characteristic of total institutions is the breakdown in the barrier between sleep, play and work, so that all three of these activities of everyday life take place in the same setting with the same people. He developed a classification of five general types of total institutions in modern society, including homes for the incapable and the harmless (including homes for the aged and the indigent), those who cannot look after themselves but can be a threat to the community (mental hospitals, jails and concentration camps), army barracks, boarding schools, and training institutions for religious organisations (such as monasteries and convents).

Goffman's criteria of totality has encouraged other writers (Coe,1965; Bennet,1963) to assess the degree of totality of various institutions for the aged. Pincus (1968) and Kosberg and Tobin (1972), for example, have added other dimensions to this, for example "resource-rich" versus "resource-poor". The Homes studied in Zimbabwe provided extraordinarily good physical and medical resources, as well as high staff/patient ratios.

The Study

The study reported in this article was aimed at identifying what residential accommodation is provided for the aged in Zimbabwe at the present time, and how this accommodation varies from area to area; and at describing the lives of the people once they enter institutions. It also attempted to investigate what role these institutions play in Zimbabwean society, the reasons why old people enter these particular homes, and the adequacy of the services provided. An attempt was also made to explore some alternative methods of caring for the aged and to make recommendations for the future.

Methodology

In the early months of 1988, a letter was sent to all authorities (superintendents, wardens or matrons) with responsibility for residential accommodation in Zimbabwe, acquainting them with the purposes of the research and seeking their cooperation in the study. So far as could be ascertained, there was no central organisation with up-to-date national information - this included the National Council for the Aged. The authorities approached were also asked to provide a list of the residents in each institution, to facilitate the identification of a 10% random sample of residents to be interviewed. There were also visits to residential homes in Harare to collect lists and explain further the purpose of the study.

There was a lot of resistance, and a lack of co-operation, from the authorities who ran the institutions for Europeans. These Homes are privately owned and the authorities indicated that the residents did not want to be disturbed by being asked questions about their private lives. Cooperation was finally obtained from these Homes with the assistance of the late Sir Athol Evans, then Chairperson of the National Council for the Aged. Eventually only 10 out of 81 institutions and homes for the aged in Zimbabwe were not visited - three because the authorities refused permission, six because of time, money and distance considerations, and one because it had been registered wrongly as a Home when in fact it was a building comprised of flatlets owned by an association.

African authorities were particularly generous in affording every possible facility. No one in charge of an institution refused to allow a visit to be made. In fact, they used the research visits as an opportunity to bring their needs to the fore and to seek help financially and otherwise.

In carrying out the programme of visits the first step was to seek an interview with old age visitors (the Social Welfare Officer in the area). Questions of policy and the administration of services for the aged were discussed. These officers were not only generous with their time, but many provided statistics, annual reports and other documents, and also formally introduced the researchers to the Homes.

Each Home was then visited. The matron or warden was interviewed with the help of a questionnaire, and asked about the running of the institution; its amenities, staffing and routine; the infirmities of the residents and their occupations; etc. The buildings were toured and notes taken on equipment, furnishings and toilet facilities. Every resident in the 10% random sample was interviewed if they had been in the institution for at least 4 months

The task of interviewing the old people was treated as the most important single task of the research, and was carried out by the author and a research assistant. A pilot study was carried out in a number of institutions in Harare and Chitungwiza (the capital and a city 25 kms from the capital) among black and white institutions. The questionnaire took about 60 minutes to administer. It included questions on

home, family, physical health and capacities, occupation, social contacts, reasons for entering the institution, and reactions to the life it provided. Problems were experienced with a number of mentally and physically handicapped persons (especially in 'C' Schemes) who were not able to answer some of the questions. Certain details, for example about mobility and special disabilities, had to be checked by personal observation, and information was obtained from the matron or members of staff on questions of age, family, health, and reasons for admission.

Socioeconomic Background

A total of 71 schemes (institutions and Homes for the elderly) were visited in the course of the study. Of all the schemes, 27% are 'A' Schemes, and 58% and 15% are 'B' and 'C' schemes respectively. Most homes and institutions are found in the major towns and cities of Zimbabwe, with Harare (the capital city) having 44%, Bulawayo 18%, Mutare and Marondera 7% each, and Masvingo 4% (see Table I). Some smaller towns (for example KweKwe) have one or two homes caring for the elderly. Of all the schemes, including 'A', 'B' and 'C', 68% were basically those of the European community, 28% African, and 4% Coloured. Further analysis showed that of the 'A' Schemes, 89% basically served the European community, 6% African and 6% Coloured. Of the 'B' Schemes, more than half, 56%, accommodated Europeans, while 41% and 3% accommodated Africans and Coloureds respectively. The findings show that there are more homes and institutions caring for the elderly in the European section of the community than for both the Africans and Coloureds put together. This could be because, as Rwezuara (1989) and Hampson (1985) point out, there is a belief that the African elderly can still be looked after by their kin. Most elderly Africans, when they retire, go back to their communal lands. There are fewer African elderly in residential care than the general population aged 60 and over would suggest (ie Africans are in the majority), signifying that a number of African elderly are still being looked after outside institutions, presumably by their families (See Table 2).

A total of 139 elderly people of all races were interviewed - 47% were Europeans, 49% Africans and 4% Coloured. While Africans form the largest percentage of elderly in Zimbabwe, the number of Africans in institutions is about the same as Europeans. This supports the contention that Europeans are over represented in homes and institutions for the elderly in Zimbabwe (Hampson, 1985). There are no Asians in homes for the elderly in Zimbabwe.

Table 3 indicates some of the features of the residential population as a whole. The proportion of persons living in institutions rises steeply with advancing age, eg 20% of males are aged 75 and over and 53% of women. Second, there are less men than women living in institutions, and these men are mostly below the age of

75. There are more women in the age group 75 and over. Third, there are relatively more unmarried and widowed persons and fewer married persons. Only 11% of the sample are deserted, divorced or separated. There is a high number of bachelors among the men and widows among the women.

Of the respondents, 31% indicated that they were single, 11% married, 47% widowed, and 11% divorced, separated or deserted. Widows represented 54% of the female respondents and 41% of the whole sample. Single men represented 52% of male respondents and 17% of the whole sample. Interestingly 60% of the widows have been so for more than 30 years. This has significance for their quality of life, in that they might have had to fend for themselves and their children alone for a long time. These findings may also suggest that most elderly women are widows.

Table 4 indicates that most European residents are much older than their African and Coloured counterparts. Further analysis of the data shows that while16% of the Europeans, 58% of the Africans and 75% of the Coloureds in the sample are aged between 60 and 74 years, 80% of the Europeans, 43% Africans and 25% of the Coloureds are aged 75 years and over. This means that there are more 'old-old' elderly people among Europeans in institutions than other racial groups. Four of the European residents were centurians, while the oldest among the Africans was estimated to be 90 and the Coloureds 91 years old. These findings support a suggestion that Europeans in Zimbabwe generally live longer than Africans - possibly having a life expectancy similar to people in the developed world (Waterston,1982). The fact that most of the Europeans in Homes are very old has significance for the type of care they require, ie they need more care as is found in 'C' Schemes in which more resources (in terms of capital, other material and personnel) are required.

Of the respondents, 30% were Zimbabweans by birth and 70% came from other countries. Of those from other countries, 26% came from United Kingdom, 19% from South Africa, 13% from Mozambique, 8% from Malawi and 4% from Zambia, Australia, St Helena and West Germany. The majority of the Europeans came from the United Kingdom or South Africa, while most of the Africans immigrated from Mozambique or Malawi as migrant labourers. Only one African respondent came from South Africa. His parents came as guides to the coloniser, Cecil John Rhodes. The majority of the immigrant elderly (84%) have been living in Zimbawe for over 30 years, and over half (50%) have been living in the country for more than 60 years. This suggests that most of them came when they were very young.

When the respondents were questioned about remarriage, only 19% entertained the idea, while 81% did not Most of those who said yes were elderly African men, who believe (in terms of their culture) that they can marry at any age. Most reported

that they could not marry because they did not have money to pay for the *lobola.* However, two respondents married when they entered the institution.

Forty two per cent of respondents reported that they had no living children, 22% had one child, 16% 2, 8% 4 and 4% more than five children. Children are an important source of care for aged parents. They give material, psychological and other support to parents even when they are in homes or institutions. Failure to have children therefore also has great significance for the quality of life of the elderly in institutions. Of those respondents who had reported having children, only 29% had children living in Zimbabwe. This is important when discussing the availability of family members, a section to be discussed later in this paper.

These findings might support, contrary to Hor (1988), the stereotype of the elderly being cut off from contact with their children. Most children of the Europeans had emigrated to South Africa or Europe soon after Zimbabwe's independence, and did not take their parents with them. For the Africans the situation is different. The majority left their families and children in their countries of origin when they immigrated to Zimbabwe originally. They did not marry in Zimbabwe, but had informal relationships with women. They have, however, lost contact with their families back home and cannot be repatriated. Horl's (1988) findings in Vienna were that 83% of all elderly people with children can reach them within one hour and 58% within half an hour; 13% live with a child in the same household or in the same block.

Education and employment background

Although a certain amount of variation in educational attainment was evident among the Europeans in the sample (16% had some primary school education only, 73% secondary school education and 11% post secondary education), all the respondents were literate. One respondent was a medical doctor, while another had two degrees. The Coloureds were also all literate. By contrast, only 11% of the Africans were literate - 87% had never been to school and were illiterate, while 13% had attended primary school. A strong association was indicated between level of education obtained and place of birth. The majority of the aliens interviewed had never attended school, as compared to only 15% of the Zimbabweans. This finding is consistent with the historical development of the colonial educational system in Zimbabwe and the neighbouring territories. Ramji (1987) found similar results among Mozambican elderly refugees in camps in Zimbabwe. Only 9% of the men were literate, and no females could read or write.

As could be expected, most of the respondents in the study had considerable employment experience in the formal sector. The 15% of the Europeans who

indicated that they had not been engaged in the formal sector were either commercial farmers or self-employed in private business. Among the Africans 18% who indicated the same were either peasant farmers or housewives. Ninety eight per cent of the African respondents indicated that they had been engaged in unskilled work, mainly as labourers on farms, mines or in domestic service. This is consistent with previous studies by Nyanguru (1985) and Hampson (1985). Only one respondent among the Africans had a skilled job, as a carpenter. In contrast, and probably related to their educational background and the discriminatory policies of the colonial government, both the Europeans and Coloureds had skilled and professional jobs - 71% of the Europeans had skilled jobs, while 20% had professional jobs, the sample included teachers, nurses and a doctor. The Coloureds had skilled jobs, in the main clerical work or in health and educational institutions.

The issue of pensions is relevant here, but has already been discussed in the Introduction.

Other issues

Previous residence and distance of institution from original/previous home

Of the European residents interviewed, 71% were owner occupiers of their homes, while only 13% of the Africans owned their homes. The majority of African home owners were communal farmers living in the communal areas. The rest of the Africans had been squatters, living on mine and farm compounds, or in domestic service. The rest of the Europeans (29%) had been tenants, generally renting flats in towns. The situation of the Coloureds was similar to that of the Europeans, with 67% owner occupiers and the rest tenants.

Over 70% of respondents of all races had been living alone before entering the Home. A few of the residents, however, had lived with their relatives or spouses. Most of the respondents had provided their own midday meal, with a few getting meals from relatives, spouses or meals-on-wheels. Four African respondents reported that they had picked up food from bins in the streets.

Most European (42%) and all Coloured residents were within 10 kilometres of their former residence, with the advantage that friends and relatives can visit easily. This has a historical background in that these communities built homes for their elderly residents.

By contrast, 53% of the Africans lived more than 50 kilometres from their original place of residence, and only 28% live within 10 kilometres of their former residences. This latter figure is larger than may be expected, possibly because a

large percentage of the African elderly were once squatters in urban areas. Most residents had lived far from these institutions on mines and commercial farms.

Admission and length of stay in the institution

A sizeable percentage of all residents were accompanied to the Home - 62% of the Europeans, 50% of the Coloureds and 87% of the Africans. In response to the question who accompanied them, 86% of the Europeans reported that they had been accompanied by their relatives; while 83% of the Africans were accompanied by a social worker or the police. This finding strengthens the assertion that most elderly Africans in institutions are destitute before entering them.

By contrast the Europeans have long-term plans for entering a home. They might have been placed on a waiting list and only waited to enter the home when the time was opportune, for example when a spouse dies, a child has emigrated or the elderly person has become so ill he or she cannot look after himself/herself. They appeared to have a choice about whether to enter a home or not as they were still able to look after themselves.

A number of the African residents are still quite young, and therefore seem to stay in the institutions longer than the Europeans and Coloureds before they die. While only 29% of the Europeans had lived in the institution for more than five years, 47% of the Africans had done the same. Only one Coloured respondent had lived in an institution for longer than five years.

Reasons for admission

Reasons for admission into Homes for the elderly were varied, but a major issue for the European respondents (49%) was security. Most of the elderly had found it unsafe to live alone. The elderly have been targets of break-ins and robberies. Some have even been murdered, as has been reported in local newspapers. Some elderly people reported that they had built security fences around their homes, but this did not give them the security they needed. One elderly European woman reported that insurance companies had refused to insure her because she had had so many burglaries. She had become too risky to ensure. No African elderly entered Homes for security reasons. Amongst the Coloureds, however, one respondent entered a home for this reason.

The majority of the African (92%) and Coloured (75%) elderly had entered Homes because of destitution. None of the Europeans gave destitution as the reason for entering a Home.

Other reasons given for entering Homes included physical disability, strained relationships with relatives (for example daughters-in-law, children, etc), the

houses they were living in were too big for them (Europeans only), loneliness, ill-treatment by husbands, and to be near relatives.

Social Contacts

Social contacts and relationships are very important for people in Homes for the elderly. Table 5 shows that a high percentage of European respondents had relatives and friends who visited them in the Home. However, very few Africans had had visitors since they had entered the Home.

Among the European respondents, 81% had a relative who had visited at least once a month. As many as 41% had a relative visiting once a week. Some respondents reported that they had more than 5 visits from relatives a week. This might support the earlier finding that most Europeans lived near their former homes and relatives. But even for those who live further away, relatives can visit often because they have better means of transport than their African and Coloured counterparts. One respondent, for instance, had a child who flew in his own aircraft from Binga to Bulawayo monthly. The Europeans who had a few or no relatives visiting (13%) had relatives living outside Zimbabwe.

Most of the African respondents did not have any relatives visiting - probably because as migrants they had no relatives in Zimbabwe. Only 6% had had visits from relatives at least once a month (in fact, onece in 3 months). A number of respondents, mostly Zimbabweans, reported that they had relatives who lived far away from the Home, or who did not know that they had been placed in a Home. As noted earlier, Homes for the African elderly are far away from their previous residences.

In the absence of relatives, friends are an important source of social contact. The same pattern of visits from friends emerged as has been seen for relatives - 87% of European and 75% of Coloured respondents had a visit from a friend at least once in 3 months as compared to 2% of the Africans. In addition, 79% of the Africans had not had a visit from friends since they had entered the Home. This percentage is very high compared to both Europeans and Coloureds. However, the African elderly have more visits from friends than from relatives, possibly because they may have cultivated friendships within the community surrounding the Home (author's impression from informal discussions). Some respondents reported that they had joined social clubs (like burial societies) whose membership was of people from their countries of origin.

One source of social contact among the elderly are visits outside the Home, to visit relatives or friends. Table 6 show some similarity with the results of the frequency of visits the elderly receive from relatives and friends. However,

generally the elderly visit outside the Home less often than they receive visits from relatives and friends. This could be they are less mobile (a number are bedridden). The Europeans visit relatives and friends more often than the other two ethnic groups. Interestingly, however, there is a large percentage of European elderly who have not visited relatives (24%) or friends (41%) since they arrived in the Home. African respondents make few visits outside the Home, and may have not visited relatives (92%) or friends (85%) since their arrival.

The reasons given for this included that they wanted to help themselves, they enjoyed living alone, and did not want to bother their children who had their own lives to live.

In one institution for Africans, the residents were not allowed to receive visitors or to visit outside the Home.

Another source of social contact among elderly residents in Homes are fellow residents. When asked whether they had friends in the Home, 81% of the Europeans reported they had friends while 57% and 75% of the Africans and Coloureds respectively reported the same. Friends in the Home are very important to reduce loneliness and enhance the quality of life of the elderly in Homes. Friends could also help invalid inmates with chores they can not perform unaided.

Contentment with personal situation

Table 7 shows how respondents felt when they were asked whether or not they had made the right decision to enter a Home. The majority of the European elderly (78%) felt that they had definitely made the right decision to enter a Home, and that they were satisfied. Only 15% and 25% of the Africans and Coloureds felt the same. A percentage from each ethnic group were uncertain as to whether they had made the right decision - 47% of the African and 4% of the European respondents felt that they had not made the right decision and were totally dissatisfied with their lives.

A number of European respondents thought that it was not a good thing for the elderly to live with children. They wanted to live with people of their own age group. A majority of the Africans and Coloureds also felt this. A number of respondents reported that they had never been given a choice as the decision to enter a home had been made for them by social welfare officers. One respondent said "A person in jail is better than one in this Home! I have no eyes, I can't see. If I had eyes I would go back where I was before". However, there were a few who were satisfied with their lives in the Home. One reported, "I should be a squatter. I am very happy. I thank God for affording me this accommodation".

Conclusion

The results of this study clearly show that most institutions and Homes caring for the elderly are found in urban areas, and that there are more homes for Europeans than Africans. Harare and Bulawayo, for instance, have among them 62% of the homes, suggesting that most homes cater more for people living in urban areas than in rural areas.

The results also show that Europeans in homes are much older than their African and Coloured counterparts, and a number are 'old-old' who need nursing care, ie they need a scheme that takes up more resources than other types of care. Most respondents were born out of the country, but the majority have lived in the country for more than 30 years. Most of the respondents were widowed and either did not have living children or the children had emigrated. Most Africans did not have children in the country because they were immigrant labourers.

In terms of educational background, the Europeans were more educated, and had had professional jobs in which they earned more and so had more social and economic security in their old age. By contrast the Africans and most Coloureds had low educational levels and had had hourly paid unskilled jobs from which they could not save for a rainy day. They also did not have a pension to fall back on when they retired, or were forcibly retired due to age. This has significance for the choice of a Home and the reasons for admission. While the Europeans and some Coloured respondents could go to a home of their choice - for reasons such as security or the house being too big - the Africans entered homes because of destitution. They are often picked up in the streets by the police or Social Welfare officers. Most often their previous residences are kilometres away from the Home because they are, for example, ex-miners or farm labourers. By contrast the Europeans lived within the community and have prepared for their stay in the Home.

Europeans, therefore, had more contact with relatives and friends than their African counterparts, and could visit more out of the Home. For most Africans relatives were not available, or if they were they were very far away.

The majority of the Europeans were happy with their stay in the Home. By contrast only a quarter and a tenth of the Coloureds and Africans felt the same. The majority felt that they had been forced into these institutions because of destitution.

The study reported on here was an exploratory one, but it has highlighted some socioeconomic characteristics of the elderly in institutions in Zimbabwe, including their educational background, work experience and remuneration, and their reasons for entry into Homes Another paper will look further at how the people

live, what facilities are afforded them, what health facilities exist, their food, etc. It is hoped that the information from these exploratory studies will help policy makers to look at this most vulnerable group and commit resources to their welfare, and so enhance the quality of life of the elderly living in institutions in Zimbabwe.

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Table 3
Old People in Zimbabwe living in Residential Institutions and Homes, by Age, Sex and Marital Status (%)

Sex	Age	Unmarried	Married	Divorced Deserted/Sep	Widowed	All Persons
Men	60-64	2.15	-	1.07	-	3.22
	65-69	2.15	1.07	-	-	3.22
	70-74	3.22	1.07	-	2.15	6.45
	75+	9.69	3.22	5.37	2.15	20.43
Total		17.21	5.36	6.44	4.30	33.32
N		24	7	9	6	46
	All Ages	68.10	30.3	1.1	0.6	
Women	60-64	4.30	2.15	1.07	3.22	10.75
	65-69	2.15	1.07	1.07	2.15	6.45
	70-74	1.07	1.07	-	1.07	3.22
	75+	6.45	1.07	2.15	37.64	46.61
Total		13.97	7.44	6.51	38.73	66.68
N		19	8	7	50	93
	All Ages	58.9	34.2	2.4	4.5	

Table 1
Old People's Institutions and Homes visited by Area, Scheme and Race (%)

Area	Scheme	Race			Sub-Total	Total
		Europeans	Africans	Coloured		
Harare and	A	9.9	-	-	9.9	
Chitungwizha	B	19.7	2.8	1.4	23.9	
	C	7.0	1.4	1.4	9.8	43.7
Bulawayo	A	1.4	1.4	1.4	4.2	
	B	7.0	2.8	-	9.9	
	C	1.4	2.8	-	4.2	18.4
Mutare	A	1.4	-	-	1.4	
	B	1.4	2.8	-	4.2	
	C	1.4	-	-	1.4	7.0
Masvingo	A	1.4	-	-	1.4	
	B	-	1.4	-	1.4	
	C	1.4	-	-	1.4	4.3
Gweru	A	-	-	-	-	
	B	1.4	1.4	-	1.4	
	C	-	-	-	-	2.8
Chivhu	A	1.4	-	-	1.4	
	B	1.4	-	-	1.4	
	C	-	-	-	-	2.8
Kwekwe	A	1.4	-	-	1.4	
	B	-	1.4	-	1.4	
	C	-	-	-	-	2.8
Chinhoyi	A	1.4	-	-	1.4	
	B	-	1.4	-	1.4	
	C	-	-	-	-	2.8
Karoi	A	1.4	-	-	1.4	
	B	-	-	-	-	
	C	-	-	-	-	1.4
Melfort	A	-	-	-	-	
	B	-	1.4	-	1.4	
	C	-	-	-	-	1.4
Dete	A	-	-	-	-	
	B	-	1.4	-	1.4	
	C	-	-	-	-	1.4
Rusape	A	1.4	-	-	1.4	
	B	-	1.4	-	1.4	
	C	-	-	-	-	2.8
Marondera	A	1.4	-	-	-	
	B	1.4	2.8	-	-	
	C	1.4	-	-	-	7.0
Bikita	A	-	-	-	-	
	B	-	1.4	-	1.4	
	C	-	-	-	-	1.4
Total		67.6	28.1	4.3	100	100
N		47	21	3	71	71

Table 2
Population by Age and Racial Groups 1982 (%)

Age	Race:	African		European		Asian		Coloured	
		Male	Female	Male	Female	Male	Female	Male	Female
60-64		50.64	42.79	3.09	2.96	0.16	0.09	0.13	0.05
65-69		45.60	45.78	4.09	4.01	0.05	0.09	0.20	0.10
70-74		45.91	45.91	3.23	4.41	0.06	0.09	0.18	0.13
75+		43.08	49.08	2.52	5.00	0.02	0.01	0.08	0.12

Source: 1982 Census, Main Demographic Features of the Population of Zimbabwe, 1985.

Table 4
Age of Respondents by Race or Ethnic Group (%)

Age	Ethnic Group			Total
	European	African	Coloured	
Below 60	2.08	-	-	2.08
60-64	1.04	6.25	2.08	9.37
65-69	3.12	15.65	1.04	18.77
70-74	3.12	6.25	-	10.43
75-79	7.29	9.37	-	16.54
80+	30.30	11.45	1.04	42.70
Total	46.88	48.96	4.16	100.00
N	65	68	6	139

Table 5
Visits to Respondents by Relatives and Friends by Ethnic Group (%)

Frequency of Visits	European		African		Coloured	
	Relatives	Friends	Relatives	Friends	Relatives	Friends
Twice or more a week	8.1	5.4	-	2.1	-	25.0
Once a week	32.4	21.6	-	-	-	-
Once a month	40.5	32.5	6.3	-	25.0	50.0
Once in 3 months	-	27.0	-	-	-	-
Once in 3 months and above	5.5	8.1	8.5	19.2	75.0	-
None since arrival	13.5	5.4	85.2	78.7	-	25.0
Total	100	100	100	100	100	100
N	65	65	68	68	6	6

Table 6
Number of Visits by Respondents to Relatives and Friends Outside the Homes by Ethnic Group (%)

	European		African		Coloured	
Frequency of Visits	Relative	Friends	Relatives	Friends	Relatives	Friends
Twice or more a week	2.7	5.4	-	-	-	-
Once a week	35.1	37.8	-	-	25.0	25.0
Once a month	32.4	13.5	2.2	4.2	-	-
Once in 3 months	10.8	2.7	4.3	2.1	25.0	-
Once in 3 months and above	-	-	-	2.1	-	-
None since arrival	24.3	40.5	91.5	85.1	50.0	75.0
Total	100	100	100	100	100	100
N	65	65	68	68	66	139

Table 7
Respondents Who Feel They Made the Right Decision to Enter Home by Ethnic Group (%)

Response	European	African	Coloured
Yes, definitely	78.4	14.8	25.0
Yes, on the whole	5.4	12.7	50.0
Uncertain	8.0	8.5	25.0
No, on the whole	4.1	17.0	-
Definitely No	4.1	47.0	-
Total	100.0	100.0	100.0
N	65	68	6