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The Health Problems 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 European women and African men have more health problems than African women, European men and Coloureds of both sexes. Generally, European women were older than any other group. As a proportion of the population under study, Africans, particularly African women, are under represented.

The number, nature and effects of health problems were studied. The major areas studied were mobility, ability to negotiate stairs, and handicaps, particularly deafness and blindness. African males tended to report more ill health and handicaps at an earlier age than other groups. The residents' assessment of their own health tended to be positively over reported, particularly by European women as could be expected from studies from other parts of the world. Europeans had better access to good medical facilities. Africans had a greater anxiety about death and dying because they were aware that they were not going to be afforded culturally appropriate burials. The policy implications of the findings are also briefly discussed.

Introduction

The World Health organisation (WHO, 1946) defines health as "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity." Health is identified as a basic need. Other basic needs are 'inputs' in the process which 'produce' good health. African countries have few resources to devote to health care and progress in primary health care has concentrated on maternal and child health and contagious diseases. The problems of an aging population have not been seen as important because the aged are such a small part of the population. However, life expectancy has increased and the proportion and

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number of elderly people is growing. Hampson (1985) says African societies are 'greying', but such societies are still much younger proportionally than those of Europe or North America. Zimbabwe is a good example of the contrasts, as seen in the demography of the European and African populations. In 1969 the European aged (60 years old and over) formed 9,5% of the European population, and the African aged 2,69% of the African population. In 1982 the elderly African population of Zimbabwe was estimated at 213 000, some 2,8% of the total African population; whereas the white elderly were 24 500, or 13,3% of the total European population. The small percentage change in the proportion of African elderly tends to hide the fact that in actual numbers the elderly African population increased 72% in 13 years.

The study reported in this paper focused on health issues of the elderly living in homes and institutions, because very little is known about this aspect of their lives. It also looked at some misconceptions surrounding the health of elderly people in general, and those in institutions in particular, and looked at policy suggestions which could be used by policymakers to enhance their quality of life. Most of the studies which have been carried out in Zimbabwe (Hampson, 1982, 1985; Tarira, 1983; Sagomba, 1987) have looked at elderly living in the population, yet a sizable percentage of the population is institutionalised. Before Independence about four times the number of whites in the population were in institutions, and the breakdown of the extended family system, and migrant labour, has meant that blacks too are now entering homes for the elderly.

There is no clear policy on the African elderly in Zimbabwe. Until Independence pension provision was based on racial criteria. Hampson (1985) writes that until 1980 all non-Africans who had reached retirement age, and had less than a certain maximum asset value, or earned below a certain amount, could receive a pension of Z$93 per month. Although the scheme was discontinued in 1980 pensions that were in existence at that time continue to be paid. Government provision for elderly Zimbabweans now consists solely of public assistance though the Ministry of Labour, Manpower Planning and Social Welfare. Only a tiny fraction of the nation's elderly come within this coverage. Private pension schemes exist, but Hampson (1985) notes that, although 70% of the European workforce are covered by pension schemes, the African Workforce is very poorly served. Only 17,0% of the agricultural force, and 44% of all Africans in formal sector employment are covered by pension schemes. Even those that are covered are not likely to receive substantial benefits. Riddell (1981) noted that only 1,3% of urban Africans in wage employment will receive pensions above the urban Poverty Datum Live (PDL). Since Independence, however, there has been talk of a social security act which would also cover the elderly, but this has not yet materialised.

According to Adamchak *et al* (1990), from 1960 to 2020 there will be a 40 to 48% increase per decade in the number of elderly in Zimbabwe (See Table I). Given a continuing high fertility in the 1970's and 1980's, and an increasing life

expectancy at birth of nearly 15 years in the period 1980 to 2020 (reaching 70 years at the latter date), the elderly increase during the 2030 to 2050 period will be tremendous. Both the 60 and 65 and over populations will triple between 1990 and 2020, although during the 1980-2000 period the elderly population will increase slightly less than the total population. However, the elderly will increase more than the total population during the 2000-2020 period.

Kasere (1990) contends that the extended family and the community still constitute primary sources of care for the elderly, maintaining traditional responsibility for providing the elderly with the necessary shelter, clothing, food and health care. However, a number of authorities (Rwezaura, 1989; Hampson, 1985; Nyanguru, 1990) feel that trends in urbanisation, industrialisation and modernisation are progressively weakening those traditional support systems.

Institutional care for the elderly in Zimbabwe is entirely provided by Non Government Organisations (NGOs). Before Independence the country had one of the highest rates of institutional care in the world for its European elderly population, over four times the comparable rate for the UK. Old People's Homes in Zimbabwe are of three types, with Model A, the sheltered or cottage type; Model B, hostel accommodation with meals, laundry services and general care; and Model C, a hospital home for the very disabled and frail, where assistance is provided for daily living activities and nursing care is available.

There are presently 81 homes in Zimbabwe, with 2 200 residents. Before Independence the homes were almost exclusively occupied by Europeans, but there are now two Model C, 14 Model B, and one Model A scheme for Africans. Almost all other accommodation is occupied by Europeans. This *de facto* segregation is the result of a number of factors, including the cost to the elderly of institutional care, cultural and psychological barriers between social groups, and dietary, social and linguistic differences. Efforts to have multiracial residential living are presently being tried in two homes in Harare. Some homes are very large, accommodating as many as 200 residents in the different schemes, and others are very small, accommodating only 7 residents. Some homes for Europeans only accept certain groups, for example the blind, people who belong to their religious order or association (eg Jews), or only women or men.

The study

In early 1988, a letter was sent to all authorities responsible for residential accommodation in Zimbabwe acquainting them with the purposes of the research proposed and seeking their cooperation. At the time there was no central organisation, including the National Council for the Aged, with up-to-date national information on the elderly. The authorities approached were asked to provide a list of residents in their institutions, 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 lack of cooperation, 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 with 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 71 out of 81 institutions and homes for the aged in Zimbabwe were visited. The 10 not visited included three in which the authorities refused permission, six because of time, money and distance considerations, and one because it had been registered incorrectly as a home.

African authorities were particularly generous in affording the researcher every possible facility. No one in charge of an African institution refused to allow a visit to be made. In fact, they used the 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 out the old age visitors (the Social Welfare Office in the area) to discuss questions of policy and the administration of services for the aged. These officers were generous with their time, and provided statistics, annual reports and other documents, and formally introduced the researcher 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 and routine of the home, the infirmities of the residents, and their occupations. 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 four 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 city and a city 25km from the capital), among African and European institutions. The questionnaire took about 60 minutes to administer. It included questions on home, family, physical health and capabilities, access to health facilities, attitudes to death and dying, etc. 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 and members of staff on age, family, health and reasons for admission.

Of a total of 139 elderly people of all races interviewed, 47% were Europeans, 49% Africans and 4% Coloureds.

Table 2 shows that the European elderly population is fairly evenly distributed among the schemes: 21,53% in A, 47,70% in B and 30,77% in C schemes. Among the Africans only 8,82% live in A schemes, while the majority 77,94% live in B schemes and 13,23% in C schemes. Among the Coloureds one third live in A schemes, while the rest live in B schemes. There are no Coloureds living in C schemes. There were no Asian elderly living in institutions or Homes for the elderly. While Africans make up the largest percentage of the elderly in Zimbabwe, the number of Africans in institutions is about the same as Europeans. This supports the contention that Europeans are proportionally over represented in Homes (Hampson, 1985).

Mobility

As the type of scheme suggest, the A schemes have residents who can still live independently and are likely to have only a few health problems. Those living in the B schemes are likely to have more health problems and needed laundry, cooking and other services from the home or institution. As could be expected very few residents in the A schemes reported problems with mobility. Only one European lady was bedridden in the A schemes. The 98 year old widow of a Rhodesian businessman had lived in the home since 1975. She was also blind. She could live in the A scheme home only because the facilities were very good and she received help from the matron and staff. She was preparing to enter a C scheme home which cared only for blind people. The majority of the elderly in the A schemes were mobile, and many of the European respondents owned cars and could drive in and out of the homes at will.

Table 3 shows that the majority of all races living in A schemes had no problems with mobility, except for one European elderly lady mentioned earlier. Of the fourteen Europeans living in A schemes, thirteen reported that their mobility was unlimited. Among the Africans four out of the six reported the same while both the Coloureds living in this scheme reported they did not have problems.

In the B schemes there were significant differences by race and sex. European elderly women were more likely to report problems of mobility than men, while African men were more likely to do so than their female counterparts. However, 22,05% of African males living in B schemes reported that their mobility was unlimited as compared to 14,15% of the European elderly females and 5,82% African females. This may be because African men enter homes at a much younger age than other groups, because of destitution rather than old age or illness (Nyanguru, 1990). They are then likely to be more mobile than the rest of the sample.

A sizable percentage, 13,53%, of elderly Europeans (both male and female) living in B schemes reported that their mobility was limited to outside their room.

These residents were quite old, and the majority were over 75. If it were not for the very good medical facilities offered by the homes, these respondents would have been placed in C schemes. The European homes also generally have all three schemes together, and residents are moved from one scheme to another according to their medical condition. Of the African elderly, 14,70% (10,29% and 4,41% males and females respectively) had their mobility limited to outside their rooms. This is probably because most Africans do not have mobility aids such as wheelchairs, walkers and crutches or specially adapted vehicles able to lift the physically disabled to a place of meeting or specialist services. Most of these aids are taken for granted by their European and coloured counterparts.

There was no difference in the state of mobility between Coloureds of both sexes and between European men and African women. Due to advanced age, and their state of health, 10,76% of European women in the B schemes have their mobility limited to their room, as opposed to 1,53% of their male counterparts, 1,47% of African women and 2,94% of the African males. Most African males who had mobility problems had their mobility severely limited, the percentage in this group was larger than in any other group in the sample. This is probably due to a lack of C schemes for the African elderly. A number of elderly who should have been in C schemes remain in B schemes because there is nowhere else to place them. The need for more nursing homes for elderly Africans is illustrated by the number of blind and severely physically incapacitated elderly in B schemes. The Europeans have homes which cater specifically for the blind, and one home caters only for blind female European elderly.

The situation in C schemes was somewhat different (see Table 3). In most C schemes, the staff/resident ratio is very high, often one to one because of the medical condition of the residents. Most European residents employed a maid for their personal care, including turning the wheelchair or adding another pillow, etc. The study indicates that 7,69% of the Europeans have no mobility problems, 15,38% had mobility limited to their room, and 7,69% were bedridden.

By contrast 2,94% of the African elderly had no mobility problems, 1,47% had mobility limited to outside the room, 1,47% had mobility limited to their room, and 7,35% were bedridden. As expected, the elderly in C schemes had more health problems (mobility problems) that those living in either the A, or B schemes.

When asked to rate their health as excellent, good, fair, poor or bad, 7,7% of the European elderly rated themselves in excellent health (see Table 4). Among these was one female aged 81 years of age. This could be an example of overreporting health status. Pathak (1985) observed this tendency in a study in India. As a medical researcher looking at all aspects of aging, he observed that older people regarded themselves as satisfactorily healthy although, in fact, they suffered osteoporosis, kyphosis, stooping posture, cloudy vision, cataract, giddiness,

atherosclerosis, inefficient heart, laboured breathing, poor appetite, malnutrition, weakness and similar handicaps.

An interesting feature of the results is that 41,5% of European elderly and 23,54% of African elderly reported that they were in good health. More European women reported this than males. Most of these women were over the age of 75, and could be described as 'old-old'. A possible reason for this could be that the European elderly have access to good medical facilities, an issue to be discussed latter in the paper.

Surprisingly, a notable percentage, 18,7%, of African males reported that they were in good health. This could also be overreporting, as most elderly male looked sickly, malnourished, and had very poor health. Only three homes among the African sample had a resident matron who was a trained nurse. In some homes, health facilities were nonexistent or inaccessible. One particularly extreme case was that of an elderly man who was dying but could not be taken to a hospital or clinic (some 50 kilometres away) because the local rural bus had broken down two days previously.

There seemed to be no difference in the percentage of Europeans, Africans and Coloureds who reported that they were in fair health, 32,30%, 32,35% and 33,33% respectively. However, twice as many African elderly (35,29%) as Europeans (17,0%) reported that they were in poor health, and two thirds (66,6%) of the Coloureds. A larger percentage of Africans (8,82%) than Europeans (1,59%) reported that they were in bad health. No Coloured reported bad health.

Table 5 shows that a sizable number of the elderly in institutions can negotiate stairs freely. The majority are below the age of 84. However, a number (8,32%) over the age of 85 do freely negotiate stairs. One of these was a centurian. A slightly large percentage (49,22%) of European elderly than Africans (38,23%) had difficulty in ascending and descending stairs. The majority (41,53%) are elderly white women more than 75 years of age. A sizable number of African elderly men (30,88%) are in this category as well. Of the European elderly women in the over 75 year age group, 12,34%, could neither ascend nor descend stairs without help. There was no significant difference in numbers between the African elderly men and women in this category.

Types of handicap or disability

Results of the study indicated that most elderly people living in A schemes have few health problems or handicaps. However, a sizable percentage (19,4%) of the European elderly women had moderate handicaps, mostly deafness (10,2%) or blindness (9,2%). The majority of these elderly are in the 65-74 year age group. Among African male and female elderly living in these schemes 2,2% had moderate handicaps, 1,1% deafness and 1,1% were physically crippled.

For those living in B schemes, 12,51% of the European elderly were deaf or partially deaf, 16,68% were partially blind or blind, and a small percentage, 4,17%, physically crippled. A number had severe handicaps in sight 4,17% and hearing 5,46%. A number were severely physically crippled 4,17% and were generally over the age of 75. They continue to live in B Schemes, as has already been mentioned, because medical facilities are available and very good. Very few European men had any noticeable handicaps, but were fewer in number.

By contrast, 12,51% of elderly African men are partially deaf or deaf and 13,90% are partially blind or blind. A few 2,78% are physically crippled. Most of these men fall in the 65-75 year age group. These men have health problems or handicaps similar to those of European elderly women who are much older that they are. This could be because elderly African men were exposed to harsher living conditions (working on mines, in domestic service and on farms) for little pay, and were very malnourished (Hampson, 1985).

A comparison with Tout's (1989) study in Potosi, a poverty stricken mountain region in Bolivia, is useful. He found life expectancy of around 30, with many cases of miners incapacitated by industrial disease dying by the age of 30. The 'Potosi effect' is a remarkably low survival rate, combined with early disability. Various factors, including high altitude, endemic malnutrition, industrial diseases, and excessively heavy labour cause this debility. Many people in their early 30's are physically unable to continue working as the only type of labour available locally is mining. Potosi results may explain the situation of elderly African males in institutions, although they are obviously older than those Tout studied.

Similar results have been found by Ekpenyong (1987) in a study in Nigeria, and Brown (quoted in Ekpenyong, 1987) in a study among Ghanaians. In a recent study among the elderly living in urban, communal and commercial farming areas in Zimbabwe, Nyanguru (1990) found that 65% of respondents experience some sort of difficulty with free movement, a complaint more significantly common in females than males (females are more involved in physical work, eg the collection of water, firewood, etc). The commonest movement complaint was stiff joints (35%), followed by stroke weakness, and burning feet (7%). The latter could be a significant symptom indicating peripheral neuropathy. Other major problem areas were bowels, vision and chewing. In all these there were differences by community type, showing that the rural elderly were worse off than elderly living in commercial farming and urban areas. Of the respondents 28% were aware that they had hypertension, 23% experienced falls, (9% of them weekly) and 17% had difficulties in hearing conversations. The least frequently reported difficulties were bowel and bladder problems and incontinence (feacal incontinence 7%, urinary 2%). Similar results were found by Ekpenyong *et al* (1987) in Nigeria. Given the higher prevalence of these symptoms in Western communities, Wilson

(1990) argues that these low figures indicate either a cultural reticence to admit such dysfunction, or that the onset of these problems may lead to a rapid decline in health with the early demise of the sufferer. Pathak's findings have relevance here. His explanation is more appealing in this discussion, as most African elderly in homes still live independently, are more mobile, and are younger than their European counterparts.

Results from the Europeans and Coloureds seem to be similar to Tout's (1989) study of the Vilcabamba Valley situated in Loja Province of Ecuador: 39,3% said they never suffered from illness, 34,2% complained of rheumatic problems, 8,9% suffered from malaria, 9,6% had liver complaints, and 9,6% did not seek any medical attention because of a fear of modern medicine. Tout explains the Vilcabamba effect as an extraordinary longevity related to environmental conditions. An unpolluted, temperate environment and unpressured rural culture are particularly conducive to survival. Persons in their late 60's and 70's are not considered as old. Many people of 90 and 100 are still active and lucid. These results are similar to the European elderly in the Zimbabwean study who are still fit and active when over 80 years of age. According to Hampson (1982) and Dawson (1976) the life expectancy of the European elderly is the same as that of the elderly in developed countries.

Pathak (1985) recorded among his sample, the following disabilities:

Disabilities	Number
Blind or partially blind	16
Bed Ridden or permanently housebound	21
Lesser mobility, mentally ill or other chronic illness	18
Total reporting disability	61
Total not reporting disability	60.

The non-disability cases, according to the researcher, had come to seek solutions to socioeconomic needs rather than medical needs. The illness report was subjective, so some of the non-disability individuals might well have been diagnosed as ill if there had been a medical check-up. Further distinctive problems of older women's health, emerging from Pathak's educated assumptions, are the high proportion of gynaecological complaints (specifically the deterioration of female reproductive organs) compared to the incidence of common complaints shared by both sexes, an incidence of eye diseases 50% more frequent in women than in men, effects of earlier malnutrition where men traditionally eat first or choose better cuts, and the lower number of women seeking hospital admissions (30% over 60, compared to 70% of men).

This study did not specifically look at the gynaecological complaints of elderly women, but a number of the elderly women mentioned these when asked if they had any other health problems. There may have been significant underreporting

of these problems, especially among elderly African women as they do not feel comfortable discussing sexual issues.

Most Coloureds did not have any major handicaps. They lived, presumably, in more comfortable environments than their African counterparts, although they were regarded as second class citizens by the colonial government.

Elderly European women in C schemes had problems with hearing (14,1%), sight (11,2%), and liability to fall (4,17%). Incontinence was a problem for 8,34%, and other handicaps included burning feet. Over 90% of these women were over the age of 80, the 'old-old', and needed a lot of medical attention.

By contrast African elderly men who lived in the C schemes had severe handicaps, 5,60% were deaf, 9,10% blind, and 2,78% incontinent. Observations and staff reports indicate that a number of residents also seemed to have mental problems. The incidence of mental problems and mental illness in homes for the elderly in Zimbabwe is an area which needs further research.

This study did not directly look at the number of teeth that elderly in institutions still had, although this is an important because it determines the person's ability to chew food, and affects choice of food, and therefore level of nutrition. It may also have an effect on their physical appearance, and their ability to communicate because of the effect on pronunciation. This study did, however, find that a number of elderly African men and women did not have all their teeth, and a number did not have a single tooth. One elderly man had a grinding stone which he used to grind meat to make it easier to swallow. Similar results were found by Andrews *et al* (1986) and Pathak (1985). In Andrews' study in the Western Pacific a considerable proportion of the sample had problems chewing (60%, 57%, 48% and 33% for the various countries studied).

Access to health facilities

Loewenson (1990) writes that the government policy **Equity in Health** (Ministry of Health, 1984), which was a significant departure from colonial policies of health care, defined qualitative changes in health care which included:

* redirecting the majority of resources to those most in need.
* removing the rural/urban, racial and class biases in health and health care.

This policy derived, she says, from the popular and democratic aspirations of those who fought the liberation struggle, faced a number of challenges after Independence. The continued inequalities in ownership of wealth and in incomes continued to generate huge differences in the type and extent of morbidity in different social classes in Zimbabwe in general, and in the elderly in institutions and homes in particular. Race is no longer a deciding factor in most aspects of health status or access to care, but it continues, says Agere (1990), to play a role because most European elderly are well off and receive pensions while most Africans are poor.

This is a major reason why elderly Africans enter institutions (Nyanguru 1990). Class has become an important determinant of health outcomes, interacting with rural urban/status.

This study showed that elderly Europeans had better health facilities than either Africans or Coloureds. There are thirteen nursing homes for elderly Europeans and two for Africans. The two homes for Africans are in Harare and Bulawayo, and cater for the whole country. Even those elderly Europeans who were not in nursing homes had medical facilities easily available to them, as over 79% had personal doctors or were on private medical aid. None of the African elderly had a personal doctor or private medical aid. Often the homes were far away from the clinics or hospitals and calling an ambulance in an emergency was difficulty because the African homes did not have phones. It is particularly difficult to get help at night.

Some European institutions have convalescent wards, where the elderly sick are looked after until recovery. There is only one such facility for Africans (in Bulawayo) and none for Coloureds. Agere (1990) summarises these inequalities in health care by class as the 'inverse care law', the wealthy who need care least absorb the greatest expenditure on health, while the needy poor get the poorest care. This is also evident in the allocation of personnel within the health sector in general, and in institutions in particular.

Death and dying

Death is inevitable, but it causes anxiety when people discuss it. Everyone wantsto be buried honourably, and according to ritual. Most elderly Africans in institutions are destitute and require a pauper burial from the government. Many are from neighbouring countries and have no relatives or friends to bury them (Nyanguru, 1985, 1987, 1990). Pauper burials mean burial by prisoners. Authorities in some homes increase the anxiety of residents by not even telling residents that one of them has died. The police are called to sign the death certificate and burial order, and the corpse is 'whisked away' for burial. Some residents, even 'believers', are not given church services. Because of this anxiety, the majority of elderly Africans reported that they did not discuss death in their social gatherings. Most of their feelings about death were negative. One elderly man reported that when he dies his tradition and culture require him to be buried in a *vlei* (a marshy area) as with children. He knew that this would not happen and was, therefore, very anxious.

In order to rectify this situation some elderly Africans have formed burial societies, or joined churches, with the hope that people will give them a proper burial. One elderly man reported that he had joined a burial society with other members from his country. He had a friend who joined the same burial society, and they had agreed that in the event of one of them dying the other would quickly go

to the burial society members to inform them about the death. These members would then intercept the corpse at the police station and take it for a decent burial. He reported that he did not want to be "buried like a pig".

The Europeans and Coloureds did not show the same anxiety about dying. They felt that death was inevitable or did not fear death. A major reason for this lack of anxiety could be that most of them know their relatives and friends will bury them, as they usually live in institutions close to their previous homes (Nyanguru, 1990). In addition, when a resident dies other residents are told, and often invited to the church service and subsequent burial. Most homes for Europeans also have a Chapel. There is only one home for elderly Africans where the dead are buried at the home by the residents. Most of the European respondents in the sample felt that they would be buried in the way they wanted. Most wanted to be cremated. One had donated her corpse to the University Medical School in Harare

When asked what they would do with their personal belongings when they died, most elderly Africans (who did not own much) said they would leave these in the institution, to which the clothes and articles belonged anyway. In fact, some clothes had the name of the institution on them. Some respondents felt that they could leave their belongings to a *Sahwira*, a burial friend, when they died. Most Europeans and Coloureds in the sample had wills and had already instructed their lawyers what to do on their death. Most had relatives who would get something from them. Others reported that they would leave substantial amounts of money to the home or institution. A study by Braithwaite (1986) had similar results. When the European elderly were alone most thought of God (32,9%) or the cost of living (21,5%). Only 7,1% regularly thought about their past life, and 5,70% about death.

Tout (1989) has argued that AIDS is already beginning to have an impact on certain communities, mainly in Africa and Latin America. It has already had a tremendous impact in Zimbabwe. It might be thought that, since epidemiologically it affects the sexually active age groups, it is not likely to have a major impact on the elderly. However, in some Third World communities, including Zimbabwe, AIDS will adversely affect lives of older people, especially grandmothers, as young parents require nursing and care, and grandchildren will need to be cared for.

Policy suggestions

An alternative approach to shelter and accommodation for elderly Africans is operating at a small farm about 40 km from Harare (Hampson, 1985; Nyanguru, 1985). The project revolves round the agricultural output of the active elderly and a few younger able bodied destitute. The elderly members of the cooperative, both men and women, contribute their labour so far as they are able, and in return receive

a subsistence allowance plus a 'dividend' accruing from the the sale of agricultural produce. They also work generally on the cooperative. The members participate in all aspects of running the home and are free to come and go as they wish. The atmosphere is not imposing and does not resemble the 'total institution' (Goffman, 1961). They also bury their own dead, reducing the anxiety associated with dying. This model of care could be replicated countrywide and in other developing countries. It has been tried in Zambia, at the Ecumenical Centre of Makem, where old people need rehabilitation for daily living activities after leprosy treatment. One organisation has tried to replicate this model in Zimbabwe, but unfortunately exploits the elderly who are made to look after chickens, dairy cows and work on a 79 hectare farm without benefiting from the exercise. All this is done in the name of 'God'.

Many writers have discussed the negative aspects of institutional care. The literature is replete with descriptions of the institutionalised elderly as disoriented, disorganised, withdrawn, apathetic, depressed and hopeless. Tobin and Lieberman (1976) and Townsend (1962) further suggest that the elderly in institutions are deprived of intimate family relationships which lead to depersonalisation. Talents they possess atrophy through disuse, and they may become resigned and depressed.

To avoid this the elderly must not be placed in institutions. Brand (1986) and Sagomba (1987) found an overrepresentation of the elderly among people in the informal sector. Hampson (1985) rightly suggests that the elderly in this sector could be helped by making them contribute to a National Provident Fund to help meet their basic needs, whether health, nutrition, all other needs, and provide an alternative to entering a home. Most elderly Africans in homes are destitute (Nyanguru, 1990).

These proposals could increase the qualitative and quantitative aspects of health care for the institutionalised elderly. The government has already guaranteed free health care for those earning less than Z$150,00 per month, but most elderly Africans are still disadvantaged. There is need for an increase in geriatric wards and beds in the country (Hampson, 1985). Young (1960) recommended the same to the then Southern Rhodesian Government after a study of institutions caring for the elderly in Sweden and Britain. However, few mission and general hospitals would like to keep elderly people for a long time as they block beds for other sick people.

Pathak (1985) makes an interesting case for expanding geriatrics as a medical discipline in developing countries. He argues that children suffer from acute infections which are quickly cured or fatal, but the elderly are prone to chronic diseases uncommon in younger years. He says this fact alone is sufficient argument to introduce geriatrics, like pediatrics, as a separate discipline, academically and practically in Third World countries, including Zimbabwe.

There is also need to train people who work with the elderly in institutions (Hampson, 1985). They need simple physiotherapy skills, simple occupational therapy skills, general supervision of the elderly to prevent malnutrition, etc. Tout (1989) argues that there is need for better understanding of what constitutes proper nutrition for older people. Currently, the recommendations on dietary allowances for people over 50 are based on studies done on young adults. However, nutritional studies carried out by Tapila-Videla and Parrish (1981) relate to the problems of older people (often the cooks for the entire family) who have emigrated to urban or different rural settings where their traditional food stuffs are not available. Mutamba (1986) had suggested a need for a nutritional survey of the elderly in Zimbabwe, none have been carried out to date.

Public beliefs and attitudes about health, according to Coppard (1985), require more attention, as not enough is known about elderly people's beliefs and attitudes regarding health. In some cultures, for instance, it is assumed that illness results from sin or witchcraft. Coppard (1985) argues that the myth that illness and disability are inevitable results of growing old is prevalent in developed and developing countries alike. In the face of such attitudes, it seems better to vary treatment rather than hope to educate older people to new attitudes.

Conclusion

The research on which this paper was based was an attempt to look at the health problems of the elderly in institutions in Zimbabwe. The results have shown that elderly women have more health problems than men, but are generally older than their male counterparts. The study has specifically revealed that the elderly living in A schemes have fewer health and mobility problems than those living in either B or C schemes where a number are bedridden, as could be expected. There were also a number of elderly Africans with severe handicaps in the B schemes, because there were no nursing homes for them. The study also revealed that elderly European women had the same health problems as elderly African men who were much younger than them, at times by a whole generation.

There was also a marked difference in the accessibility of health care facilities and trained health personnel between races and schemes. Elderly Europeans had better access to health facilities than their African counterparts, and better access to the services of medical doctors and private medical aid schemes.

Most elderly Africans and Coloureds had poor access to medical facilities. Very few homes had resident trained medical personnel. Most elderly Africans had negative feelings about death and dying. They were very anxious because they feared a lack of cultural procedures in their burials which were often pauper burials. They were also not involved in the burial of their fellow residents. In order to counteract this anxiety some had joined burial societies to ensure a proper burial.

The elderly Europeans and Coloureds felt that death was inevitable and showed less anxiety. They knew that they were going to be buried by relatives and friends according to their traditions. They also felt that their belongings were theirs and could be dispensed of as they wished.

Any new homes to shelter and accommodate the elderly should be of the type found at Melfort, where the elderly live in some form of cooperative. The project revolves around the agricultural output of the active elderly and a few younger ablebodied destitute. The members participate in all aspects of running the home and they also bury their dead, reducing the anxiety associated with dying.

It is also suggested that the elderly in the informal sector contribute to a national provident fund to help them meet their basic needs and provide an alternative to entering homes. There is also need to train people who work with the elderly in institutions. They need simple physiotherapy skills, simple occupational therapy skills, and general supervision of the elderly to prevent malnutrition, etc.

There are areas of research into the health care problems of the elderly which need urgent attention. These areas include food and nutrition, mental and psychological problems, and gynaecological problems. It is hoped that the information from this research will help to enhance the quality of life of the institutionalised elderly in Zimbabwe.

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Table 1
Number and Percent Change for Population Aged 60+ and 65+ and Life Expectancy at Birth: Zimbabwe, 1960-2020

	60 Years and Over			65 Years and Over			Life Expect
Year	No	%Decade Change	%Tot Pop	No	%Decade Change	% Tot Pop	
1960	159 000	38,3	4,4	97 000	31,1	2,7	46,5
1970	234 000	47,2	4,4	144 000	48,5	2,7	51,5
1980	324 000	42,7	4,4	202 000	40,3	2,7	55,8
1990	454 000	40,1	4,3	287 000	42,1	2,7	59,8
2000	641 000	41,2	4,2	411 000	43,2	2,7	63,7
2010	911 000	42,1	4,2	90 000	43.6	2,8	67,1
2020	1 348 000	48,0	4,7	867 000	47,0	3,0	70,0

1980-2000, % increase
60+ = 97,8
65+ = 103,5
Total Pop = 105,3

2000-2020, % increase
60 + = 110,3
65 + = 110,9
Total Pop = 91,4

Source: World Population Prospects as Assessed in 1984 (United Nations, 1986)

Table 2
% Respondents by Race and Scheme

	European		African		Coloured	
Scheme	Number	%	Number	%	Number	%
A	14	21,53	6	8,82	2	33,33
B	31	47,70	53	77,94	4	66,67
C	20	30,77	9	13,23	-	-
Total	65	100,00	68	100,00	6	100,00

Table 3
% Mobility by Scheme, Race and Sex

	Scheme	European		African		Coloured	
	Mobility	Male	Female	Male	Female	Male	Female
A	Unlimited	4,65	15,35	2,94	2,94	16,67	16,67
	Limited to Outside Room	-	-	2,94	-	-	-
	Limited to Room	-	-	-	-	-	-
	Limited (Severe)	-	-	-	-	-	-
	Bedridden	-	1,53	-	-	-	-
	%	4,65	16,88	5,88	2,94	16,67	16,67
	N	3	11	4	2	1	1
B	Unlimited	1,56	14,15	22,05	5,82	-	16,67
	Limited to Outside Room	3,07	10,46	10,29	4,41	16,67	16,61
	Limited to Room	1,56	10,76	2,94	1,51	-	16,66
	Limited (severe)	-	3,07	19,11	5,88	-	-
	Bed Ridden		3,07	5,88	-	-	-
	%	6,19	41,51	60,27	17,62	16,67	49,99
	N	4	27	41	12	-	-
C	Unlimited	7,69	1,47	1,47	-	-	
	Limited to Outside Room	-	-	-	-	-	-
	Limited to Room	15,39	1,47	-	-	-	-
	Limited (severe)	-	-	-	-	-	-
	Bedridden	-	7,69	1,47	5,88	-	-
	%	-	30,77	4,41	8,82	-	-
	N	-	20	3	6	-	
Total	%	100	100	100	100	100	100
Total	N	63		68		6	

Table 4
Self Perception of Health Status: % Self-Perception of Health by rate and race

	European		African		Coloured		Total	
Rate	Number	%	Number	%	Number	%	Number	%
Excellent	5	7,7	-	-	-	-	5	3,59
Good	27	41,5	16	23,54	-	-	43	30,96
Fair	21	32,3	22	32,35	2	33,34	45	32,37
Poor	11	17,0	24	35,29	4	66,66	39	28,05
Bad	1	1,5	6	8,82	-	-	7	5,03
Total	65	100	68	100,00	6	100,00	139	100,00

Table 5

% Ability to Negotiate Stairs by Race, Sex and Age

State	European		African		Coloured		Under 65		65-74		75-84		84+		N Total	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Negotiable Ascend/Descend	6,15	30,76	36,76	5,88	33,33	50,00	2,60	2,20	5,40	7,60	7,60	8,00	6,22	2,10	58	41,72
With Difficulty Neither Ascend	7,69	41,53	30,88	7,35	-	16,67	2,12	1,00	4,70	4,30	8,71	14,11	2,40	5,4	59	42,44
Nor Descend	1,53	12,34	10,29	8,82	-	-	-	2,08	-	2,10	1,00	5,40	3,18	2,08	22	15,84
Total	15,37	84,63	77,93	22,07	33,33	16,67	4,72	5,28	10,10	14,00	17,31	27,51	11,50	9,58	-	100
N	10	55	53	15	2	4	7	8	14	19	24	38	16	13	139	100