PROGRAMME Brief

AGEING, AGENCY AND HEALTH

PROJECT DETAILS

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UNI BASEL

UNIVERSITY OF DAR ES SALAAM
ADVANCING KNOWLEDGE, CREATING FUTURES
1961 50th Anniversary 2011
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Swiss TPH
Swiss Tropical and Public Health Institute
Schweizerisches Tropen- und Public Health-Institut
Institut Tropical et de Santé Publique Suisse

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SWISS NATIONAL SCIENCE FOUNDATION

BACKGROUND

This research project builds on the findings of the "Cure to Care"-Project expands and deepens our qualitative approach to health, care and ageing both geographically and topically. The geographical reference frame has been broadened to the whole city of Dar es Salaam and to the city of Zanzibar. To deepen our approach, diverse forms of agency in response to problematic situations in elderly people's everyday experience of health and care will be explored and mirrored against Western discourses of Active Ageing.

This research project aims at gaining a deeper understanding of
1) older persons' everyday experience of health, illness and frailty, and of
2) their social agency in response to critical health moments.

100 households with at least one older person have been selected through transsects in 8 different residential areas of Dar es Salaam and Zanzibar City. 100 elderly have been interviewed in a first round by using an interview guideline with open-ended questions.
Based on these findings, 10 older persons in each city, will be selected for further in-depth case studies of inter-generational transformations.

MAIN FINDINGS

Many older persons in Zanzibar City and Dar es Salaam do not receive a **pension** and the few who do can hardly live on the small pension amount. Even fewer old persons do benefit from a **formal health insurance** of their own. Yet, some are able to profit from an insurance of a spouse or child.

Free health care for people above 60 years includes diagnosis and consultation, however, only few older persons benefit from this exemption policy. In case of free treatment provision, the elderly patients struggle to pay for the prescribed medicine. After visiting a health facility, patients' knowledge about their health problem(s) may have increased but nothing can be done due to lack of means.

Even in the city, **physical access to health care** is not guaranteed for many elderly urban inhabitants. Ill or frail elderly face even more difficulties than adult or young patients to reach a health facility or hospital with public transport (*daladala*). Most of them cannot afford a taxi. There are no mobile medical services or home-based care services available for elderly at their home.

Caregivers at home face sometimes difficulties in giving "the right" care. Although family members may try their best to care for older persons, they lack knowledge in geriatric care and are challenged to provide adequate care for ageing family members. The same applies to medical staff in the health facilities, since few health providers have geriatric knowledge.

Non-kin forms of care provide alternatives. One example are housemaids (*dada*) who take over responsibilities in caring for elderly persons. They do not have professional training.

HEALTHY OLD AGE

Older informants who have more financial means tend to describe themselves as "still having strength". They are not only capable of doing many of their daily activities, but engage actively in taking care of their own health. The available financial means within the family seems to enable their active role in health promotion, prevention and care. Therefore they are not only able to prevent health problems through regular checkups at the hospital, but are also usually able to cope with chronic conditions, such as diabetes or high blood pressure.

TRANSNATIONAL

Many older people, especially in Zanzibar but also a smaller number in Dar es Salaam, have children or other family members abroad. Some elderly do get monthly remittances from their relatives in Oman, Dubai, USA or UK; others receive support only in case of unforeseen expenses (e.g. health costs, operations). Children abroad may influence the older persons' ideas about ageing, care and health.

EXPERIENCE OF HEALTH

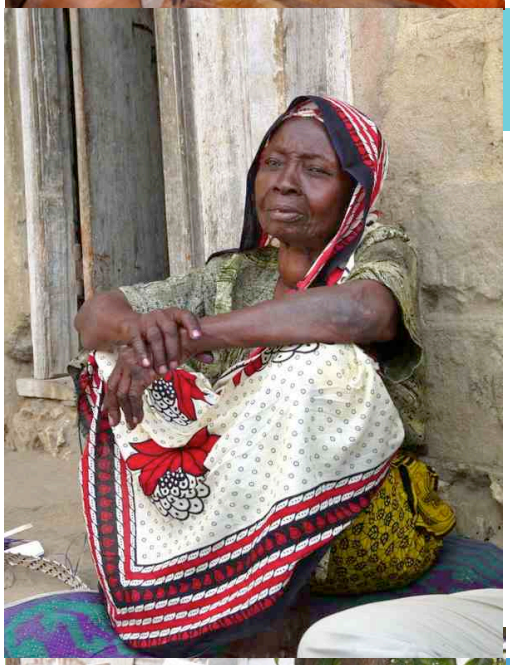
Asked about their health, the elderly often referred to their strength (*nguvu*).

"NINA NGUVU" – I HAVE STRENGTH

Profile: Mostly between 60-70, often male, still conducting income-generating activities, finding ways to help themselves.

Health: Rather active elderly, some of them suffering from eye problems or "blood pressure". They consider themselves as having strength because they are dealing with their problem successfully. They say that their strength is not as much as in young age but still enough. Mirrors local understandings of "active ageing".

Mzee Ally is 63 years old and stays only with his son in the city. His wife and two daughters are living in the countryside, where he grew up. In the city he has his own tailor business and therefore he is able to send money to his family every month. He also pays for the school fees of his son. He is conducting the daily household activities by himself, only for food he usually goes to the restaurant.



"NINA NGUVU BAADHI YA WAKATI" – I HAVE STRENGTH SOMETIMES

Profile: Largest and most heterogeneous group of older people. Mostly women and some men between 65-80 years.

Health: Active but sometimes troubled by age-related and/or health problems which limit them in performing daily activities. Some of them suffer from acute illnesses such as malaria, others from chronic diseases like "blood pressure", diabetes or rheumatism. Eye problems are widespread.

Bibi Zainabu, who is 70 years old, goes to work every morning although her eyes are getting worse and her hand is troubling because of the osteoarthritis. In the afternoon she is looking after her grandchildren, while her daughter does some household activities. With her money, she does not only pay for the food, but also for the school fees of her grandchild of a late daughter. At the moment she is suffering from malaria, that is why she says she has no strength.

"SINA NGUVU" – I DO NOT HAVE STRENGTH

Profile: Older people without strength and often aged above 75 years. They are not able to contribute much to the daily household work and need support for basic activities like walking, eating and bathing. However, some elderly without strength remain the main financial care provider of their family through the collection of rents (mainly in Dar es Salaam).

Health: Mostly (untreated) chronic problems that get worse with age: eye problems, diabetes, "blood pressure", numbness, tumor, ulcer, confusion, heart problems, joint problems, prostate problems, and feet problems.

Mzee Mhina is already 90 years old. Due to his age he is very frail, and in addition to his problems with eye sight, his prostate problem became lately more severe. Mzee Mhina is staying together with his wife, two daughters and some grandchildren. Every morning, his wife or one of the daughters carries the hot water to the bathroom for him. The wife and daughters are responsible for the daily food, while the he contributes through his income generated from the rents he collects from his tenants.

LIVING AND CARE ARRANGEMENTS

With whom older people in Dar es Salaam and Zanzibar City live together and who is taking care of them is often corresponding but there are also many cases where certain persons in the household and others who are not staying in the same household care for an aged person.

Most of our elderly informants live in a multigenerational family household together with children and grandchildren. Women stay in diverse living arrangements but often with a (divorced or married) daughter. Out of the 50 interviewed older women almost none is staying together with a husband. Men usually stay with a wife especially if they feel they still have strength. In Zanzibar City, frail elderly men often stay without a wife but with their children (both daughters and sons). The interviewed frail men in Dar es Salaam are cared for by their wives as main caregivers, while the majority of elderly women seem to be cared for by their daughters and granddaughters, sometimes also sons. In cases where our informants need a lot of support, families sometimes develop plans when the older person stays with whom in which house – or they rotate among the persons who are coming into the house and who are providing care of the elderly. Often sons give financial and daughters physical support. If the children stay abroad, many daughters do also help financially.

If a man or a woman does not have biological children and grandchildren, he or she has to find other ways to receive care. Throughout their lifetime they develop close ties with others, for instance by bringing up foster children or by establishing strong relationships to neighbours or distant relatives.

Besides the care through close relatives some families are employing household helpers, for instance, to clean, wash or cook. In (health) emergencies neighbors assist through e.g. driving sick people to the hospital, bringing food or just paying a visit to the older person.

Elderly people do not only receive care but also give care if they still have strength. Aged women may take care of their husbands and also grandchildren or contribute to the family earnings, while older men are sometimes still the main income providers in their household.

GENDER

Gender makes a big difference in ageing. Not only do older men age differently from aged women, gender roles are also defining who should take care of elderly and in which way. These differences are visible in the living and care arrangements.

CONCLUSIONS

Qualitative research provides insights into elderly health and care where quantitative studies cannot reach. The project found that meanings of “active ageing” have to be examined in local contexts. In the study areas, these meanings are strongly linked with experiences of “strength”. It has further shown that care for elderly is very much organized within family and kin networks that in turn get hardly any support from the state and from the slowly expanding privatized home-based care system.

RECOMMENDATIONS

Home care arrangements for older persons should be carefully monitored to provide evidence for policy makers. Booklets and magazines providing instructions for good geriatric care should be developed for family members who act as care givers. Care for older persons should be systematically included in the national guidelines for home-based care. Health staff should be trained to support family care givers in geriatric care.