The potential of Community Based Healthcare in a Community undergoing Societal Transitions; the Case of Old Igbo People

A Qualitative Study Conducted in rural Imo State of Nigeria

by
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"Anaghi acho ihe na-akpa onye na-acho ihe"

You don't look for something in the pocket of someone who is looking for something

Old Igbo proverb

This study is dedicated to
Mama Grace Nmaezi Egbeocha (late)

ABBREVIATIONS

AFRAN: African Research in Ageing Network

AU: African Union

CBHC: Community Based Health Care

CBHF: Community Health Financing

CBHIS: Community Based Health Insurance Scheme

CBO: Community Based Organisation

CCHBHC: Comprehensive Community- and Home Based Health Care

CD: Communicable Disease

CDU: Community Development Union

CHEW: Community Health Extension Worker

CHO: Community Health Officer

CIOMS: Council for International Organizations of Medical Sciences

COPC: Community-Oriented Primary Care

EDL: Essential Drug List

EML: Essential Medicines List

FBO: Faith Based Organisations

FGD: Focus Group Discussion

FMoH: Federal Ministry of Health

FTC: Federal Capital Territory

HIS: Health Information Systems

MDG: Millennium Development Goal

NAFDAC: National Agency for Food and Drug Administration and Control

NCD: Non-Communicable Disease

NEEDS: National Economic Empowerment and Development Strategy

NEPA: Nigerian Electricity Power Authority

NGN: Nigerian Naira

OOPE: Out of Pocket Expenditures

PHCC: Primary Health Care Centre

PoA: Plan of Action

PPP: Public-Private-Partnership

SMoH: State Ministry of Health

SSA: Sub-Saharan Africa

UN: United Nations

UNDP: United Nations Development Programme

UNICEF: The United Nations Children's Fund

WHO: World Health Organisation

WMHCP: Ward Minimum HealthCare Package

NGO: Non-Governmental Organisation

NSHDP: National Strategic Health Developing Plan

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ABSTRACT

The potential of Community Based Healthcare in a community undergoing societal transitions: the case of old Igbo people in rural Imo state of Nigeria.

Background: Awareness of ageing in Africa emerged in the early 1980s and was launched by the 1st UN World Assembly on Ageing (WAAI) in Vienna in 1982. Lack of progress in policy action led to the 2nd UN assembly on Ageing (WAAII), the ensuing Madrid International Plan of Action on Ageing in 2002, and the African Union Policy Framework and Plan of Action on Ageing in 2003. The AU plan recognises the ongoing demographic shift that will represent a major resource challenge for African countries in years to come, where the proportion of old people is expected to rise from 8% to 19% by 2050 and the proportion of children expected to fall from 33% to 22% (UNDP, 2009). Moreover, an epidemiologic transition is ongoing where non-communicable diseases will represent an increased challenge to public health.

Nigeria in a health-political context: The Federal Republic of Nigeria, comprising 36 federating States and 744 local government areas (LGAs) are each responsible for all financial aspects and the provision of Primary Healthcare (PHC) Services. In spite of the Bamako Initiative (1987), the Draft Nigeria National Policy on the Care and Well-being of the Elderly (2003), the Ouagadougou- and Abuja declarations (2008), issues of human development and health, least of all that of older persons, have remained a low priority. Today, key social determinants to ill-health and a deep-rooted culture of corruption challenges the implementation of the Nigeria National Strategic Health Developing Plan (NSHDP) 2010-2015 aim to improve the health situation of Nigerians by strengthening their access and availability to PHC services, especially at the grass-root level.

Identified problem areas: A changing societal environment, influenced by a demographic and epidemiologic transition, impacts the health-needs and the provision of quality healthcare to members of households and the community as a whole. In addition, there is an ongoing, steadily increasing rural-urban migration which challenges the extended family systems traditional role as healthcare provider for old family members. In a country with weak PHC structures, mainly financed by out of pocket payment, old people are dependent on functioning informal structures in times of illness and ill-health. A society in transition impacts on the vulnerability of old people and increases their need of social protection and provision of healthcare services that are socio-cultural acceptable and sensitive to local traditions, norms and values.

The autonomy of State- and LGAs on how to prioritise and implement strategies for PHC services are emphasised in NSHDP. One of the strategies is to empower communities, and to stimulate for community participation and ownership, despite lacking a clear policy framework where the Draft Community Development Policy is yet to be finalised. Interestingly, ongoing social, demographic- and epidemiologic changes are only limited discussed and reflected in the NSHDP. This opens for exploring the potential of Community Based Health Care and how the model could be suited to assist old Igbo people, through services and healthcare, complementary to that of family care, within their communities and homes.

The main aim of the study is to explore the potential of Community Based Healthcare (CBHC) services to elderly Igbo people, complementary to that of family care, in a rural community undergoing societal transitions. **The study design** is explorative and descriptive. **The methods** comprise semi-structured in-depth interviews and conversations with different groups of participants holding various roles, and focus-group discussions with old Igbo people. **The study is conducted in** a LGA in Imo State of Nigeria. **Findings:** Elderly Igbo people experiences a marked decline in family care and support, inconsistent with their needs. CBHC as a method is found to be viable, and regarded highly acceptable by old people. It can easily be adapted to normative traditions of care, and is therefore culture-sensitive. However, there are identified huge barriers to the implementation of the model. These are rooted both in its principles and practicalities. **Conclusion:** There are several challenges ahead, needed to be solved, before considering elderly people as group equally entitled to healthcare as for the youths, women, and children.

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A qualitative study conducted in rural Imo State of Nigeria.

1. INTRODUCTION

This study is inspired by my visits to the rural villages of Imo State, Nigeria. I have since the mid 1980s observed rural community life to be influenced by rapid societal transitions, out migration of young people, and the increasing burdens of formal caregivers to adequately care for old family members. The non-existence of formal social security systems and limited initiations and implementations of community health programs have left the old ones completely dependent on a functioning extended family system; a system that currently is under increasing constraint. I have also witnessed how especially women have to give up formal work, being separated from their husband and children, remain unmarried, or cut down on education in order come stay with their old mother or father in the village. This imposes hardships of life, creates problems, limits opportunities to improve and progress, and makes it harder to cope with the many challenges to life that an African society offers to its people. Within such contexts, elderly people become fragile and vulnerable, health wise, financially and socially, as their existence and wellbeing very much depends on their continued abilities to stay productive, and their opportunities to turn to family members for support in times of situational difficulties and ill-health.

Having been given the opportunity to conduct research, it was natural to return to the rural villages of Imo State in order to explore how the elderly Igbo people are coping in today's society. In the process of exploring the literature associated with my area of interest, several of my concerns related to their wellbeing, social- and health situational realities became clearer, and along the way I became increasingly aware of the many questions that still remains unanswered. Based on my understanding of the various challenges that currently exists and affects old Africans within their living environment, I have chosen to draw

attention towards the potential of Community Based Healthcare, as an option to improved health, care and assistance for old Igbo people, complementary to that of their families.

This study brings the reader into the rural villages of the Igbo people, residing in the eastern part of Nigeria. Part One and Two of this study explores how it is to become old within a family and community, essential in order to identify and understand dynamics determinant for old people's experience of health or ill-health. It looks at caregiving mainly in the perspectives of old people and addresses how they regard the changes of society to impact on themselves, and their families' abilities and motivation to care for them. It moreover addresses reciprocity and the impact of patri-lineal systems, and explores whether the care of elderly Igbo people exceeds beyond the boundaries of their household to also include assistance from the community and community groups. It takes into account some of the socio- political perspectives that impacts on social life and rural development and identifies factors that can help explaining some of the challenges to rural life that makes old age difficult to live.

Part Three focuses on health, mainly in the perspectives of old Igbo people, and explores their understanding of healthcare. It presents their opinions on formal health interventions as a plausible option to care complementary to family care and explores how services could comply with normative and cultural traditions of caregiving. It takes the reader into the health-political and social-political context of the study site and presents the limitations but also the potential of the existing PHC system to involve the grass-root level. It finally identifies implications for the implementation of Community Based Healthcare where the guiding principles and practicalities of the model is extensively is explored, analysed and discussed.

While writing the thesis, I have used different terminologies when referring to old people, such as elderly, older, elders etc. However all terms refers to "old" as defined by old Igbo people themselves, presented in the first chapter of Part One in the section that presents the findings of this study.

Finally, this study can be regarded as my contribution to improved health and wellbeing of old Igbo people, hopefully conveyable to other African contexts.

2. THE STUDY AIM AND OBJECTIVES

The overall study aim is:

> *To explore the potential of Community Based Healthcare services to elderly Igbo people, complementary to that of family care, in a rural community undergoing societal transitions.*

Following the aim of this study, the objectives are threefold and closely integrated.

Firstly, this study aims to gain knowledge on how it is to become old in an Igbo community and within the context of a family and local community. This involves exploring areas related to old age identity, role and recognition, and to assess how these influences on the extent of care and support expected to be provided by the children of old Igbo people, accommodating their sense of psychological wellbeing and health. Furthermore, to assess family support and care and whether this has shifted over the years based on the normative and social changes that take place within the society making other arrangements such as formal healthcare interventions a plausible option complementary to that of family care.

Closely integrated into the above goals is the investigation and identification of societal and structural implications impacting families' abilities to care for and support old Igbo people. It also aims to learn whether belonging to community groups and associations benefits elders in times of need, beyond that of family care. The study seeks moreover to gain knowledge on development and structural issues in general and explores how it affects the health system and provision of health services in rural communities. The latter involves investigating how leaders of community groups view themselves as important actors improving access to services within their communities through community participation and mutual collaboration with Local Government representatives.

Lastly, a major part of this study is dedicated to explore how elderly Igbo people are recognised and included when health interventions at the primary level are being planned for. It takes account of several of the previous perspectives when assessing their opportunities to access health services as it appears at the study site. This study moreover investigates how health political priorities and practises affect health system development at the grass root level, and whether health programmes are in line with the intentions and

recommendations of current health plans. This implicitly involves identifying how health authorities recognise leaders of community groups as essential collaborators and partner decision-makers when initiating activities in health at the primary level. Closely integrated into these aspects are to explore how Community Based Healthcare as a concept is understood and its components assessed by the study participants to be feasible, practically and principally, and represent aspects of care and assistance, culturally acceptable for old Igbo people to receive complementary to that of family care.

3. PREVIOUS AND PRESENT KNOWLEDGE RELATED TO THE TOPIC UNDER STUDY

Literature review

Global awareness on ageing in Africa

Internationally, awareness on ageing in Africa emerged in the early 1980s, much due to United Nations (UN) efforts that aimed to draw attention to population ageing in less developed countries. These efforts were launched by the first UN World Assembly on Ageing (WAAI) in Vienna in 1982 and the ensuing Vienna International Plan of Action on Ageing. In 2002, the second UN assembly on Ageing (WAAII) called attention to the lack of progress in policy action on ageing in the developing world, affirmed in the African Union Policy Framework and Plan of Action on Ageing (AU Plan) (AU/HAI 2003), to which all sub-Saharan African countries are signatory, and where the AU Plan of Action (PoA) aimed to guide policy formation for African member states.

The Madrid International Plan of Action (2002) initiated comprehensive measures and actions aimed to enable older people to age with security and dignity and to continue to participate fully in their societies as citizens with full rights. In order to achieve this, old people should be recognised when policies and practices are planned and implemented. Such strategy called for a change in attitudes of policy-makers, authorities and stakeholders, to include elderly people when planning programs aiming at improving life conditions for population groups. This calls for special emphasis on the provision of health and reduction of poverty, where the reaching of MDGs before the year 2015 stands as essential targets (WAAII, 2002). However, due to the lack of actions to commitments made by UN member states, particularly among developing countries, a guiding framework and tool-kit for practitioners and policy-makers was prepared by the Department of Economic and Social Affairs of the United Nations Secretariat in 2008. This framework and tool-kit aim to assist member states with information and suggestions on how to create a society for all ages, and how to implement strategies into programmes and policies (Department of Economic and Social Affairs of the United Nations Secretariat, 2008).

There is a rapid demographic and epidemiological transition happening in the world today, specifically in developing countries. Globally, average life expectancy at birth has increased by 20 years since 1950 to 66 years, and is expected to increase by another 10 years by 2050. From this, it is estimated that the number of people over 60 will increase from 600 million in 2000 to nearly 2 billion in 2050, and the number of those over 80 is likely to quadruple to nearly 400 million by then (UN, 2009).

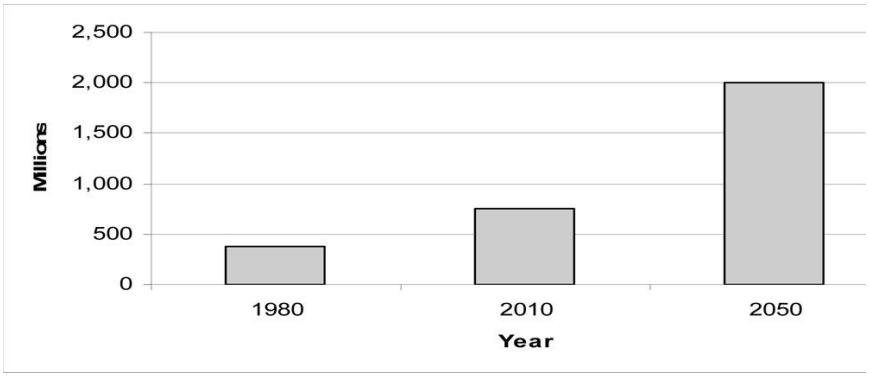


Figure 1: Population aged 60 and over; 1980, 2010, and 2050

Source: United Nations Population Division (UNDP) (2009). *World Population Prospects, 2008 Revision*

The increase will be greatest and most rapid in developing countries. Although the African continent still will be among the youngest continent in regards to its population worldwide, the demographic shift will present a major resource challenge for African countries in the years to come, when the proportion of old people is expected to rise from 8% to 19% by 2050 and the proportion of children is expected to fall from 33% to 22% (United Nations Population Division (UNDP) (2009).

A reinforcing factor challenging social and health provision planning and interventions, is the demographic composition which is highly influenced by the ongoing rural-urban migration in African countries. Already the proportion of older people living in rural African settings is higher than those of urban. The rural-urban migration is expected to continue resulting in an increased proportion of older people living in rural areas in the future. Changes in demographic composition may therefore have great implications on the lives of the elderly residing in rural areas as there often is lack of formal social security networks, inadequate- and out of pocket financed healthcare provision, and lack of economical support systems, such as pensions, which make old people extensively dependent on well functioning familial systems (Ogwumike and Aboderin, 2005; WPA 2009 Working Paper UN Elderly, 2009).

In addition to demographic change and the change in demographic composition, there is an epidemiological transition happening in all regions of the world; from communicable- to non-communicable diseases. African countries are moreover facing a double burden of disease patterns, with emerging and re-emerging communicable diseases (CDs), such as Malaria, TB and HIV/AIDS in parallel with an increasing prevalence of non-communicable diseases (NCDs). The aging of the African population contributes to enhancing this trend, which further challenges policy-makers' priorities anticipating the health needs of its population (United Nations Report of the Second World Assembly on Ageing Madrid, 2002; WPA 2009 Working Paper UN Elderly, 2009).

Demographic and epidemiological transition in Sub-Saharan Africa

The Sub-Saharan African (SSA) population is ageing and is projected to rise from 37.1 million in 2005 to 155.4 million in 2050. Life expectancy at birth in SSA is at average expected to increase from approximately 45 years to 63 years by 2050, but with some considerable variations between countries (African Research on Ageing Network (AFRAN) Policy-Research Dialogue, 2008; UNDP, 2009). For those who reach the age of 60, men can expect to live for another 15 years and women for another 17 years, whereas in developed countries, life expectancy at age 60 is 20 years for men and 24 years for women (UNDP, 2009).

SSA encompasses 43 main countries. It is therefore important to take cultural and contextual variations into account when attempting to define common approaches to population ageing in SSA. These are represented by a magnitude of societal contexts expressed through the diversity of languages, cultural expressions, social organisations and environmental variations, which have to be considered. However, there are a number of cross-cutting aspects that support common dynamics and contexts of population ageing in SSA. The most important factors include: the impact of the ongoing HIV-Aids epidemic where old people take on responsibilities for grandchildren, poverty and material deprivation, and ill-health and marginalisation from health services (Understanding and Responding to Ageing, Health, Poverty and Social change in sub-Saharan Africa, 2005).

Within West Africa, population ageing will be most marked in Nigeria and Ghana. Ghana has experienced the most rapid rise in the proportion of older people in the population, whilst Nigeria will experience the greatest impact in terms of sheer numbers. Half of all old people

in West Africa live in Nigeria, and their number is expected to increase from 7,6 million in 2009 to 27.7 million in 2050 (UNDP, 2009; Aboderin, 2009).

There is several health implications of aging in SSA in addition to a marked increase in NCDs. Available data suggests that heart disease and stroke are the leading causes of mortality among old people in this region. Non-terminal muscular-skeletal conditions, visual impairments and mental disorders represent other conditions of concern (Unanka, 2002; 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Non-Communicable Diseases, WHO 2008,). Gureje et al. (2008), who investigated determinants of quality of life (QoL) of elderly Yoruba people in Nigeria, uncovered that limited opportunities to social integration and engagement, fostering reduced emotional attention, were the most important factors leading to psychological ill-health and depression, impacting their overall perception to be healthy. However, further investigations are still needed in order to understand the magnitudes, patterns, dynamics and social factors determining the experience of health and ill-health among old people across SSA.

Nigeria in a historical perspective

Like so many other countries in the developing world, Nigeria is the creation of British Imperialism. The country is named after the great River Niger and is located in West Africa. Nigeria has a land mass of 923,768 Km^2 and is the most populous country in Africa with a projected population of 149,107,132 million, as of 2009. The modern history of Nigeria as a political state encompasses 250 ethnic groups with additional sub-groups, with varied cultures, languages and modes of political organisation, and dates from the completion of the British conquest in 1903 and the amalgamation of northern and southern Nigeria into the colony and Protectorate of Nigeria in 1914. Nigeria gained her Independence on the 1st of October 1960 and Dr. Azikiwe became Governor General of the first Federation of Nigeria (http://en.wikipedia.org/wiki/Nigeria).

Since her independence, Nigeria has experienced a number of successful and attempted military coups d'état and a brutal civil war. The Nigerian Civil War (Biafra War) broke out on 6 July 1967, where the south-eastern population of Nigeria, consisting predominantly of the Igbo people, aimed at forming an independent state: Biafra. The war ended 14 January 1970 with the surrender of the Biafra Army Commander Chukwuemeka Odumegwu Ojukwu. The

war represented the culmination of an uneasy peace and instability that had troubled the Nation from independence in 1960. Such situations had their origins in the religious orientation, geography, history, culture and demography of Nigeria. Several lessons were learned from the war and these have helped in the unification, political, military and economical progress of the country up until today where Nigeria has progressed from military dictatorship to democracy (Abubakar, 1992).

Contextualising Nigeria is not complete without pointing to challenges in combating corruption. In spite of economic growth, where Nigeria earned well over 600 billion USD on oil export alone in 2008, Nigeria ranks as one of the poorest countries, and is estimated to have the 3rd largest population of the poor in the world. Huge revenues earned have not been converted into substantive development, which can be attributed largely to corruption. Over the years, a culture of self-interest, fostering accountability, responsibility and transparency problems has been developing. There is a widespread opinion among common people and officials that local revenues are siphoned off for private gain by local politicians (Iyayi, 2009).

The settling of conflicts and ethnic violence over the oil producing Niger Delta region is another huge challenge, which involves ecology and environmental issues in addition to fair distribution of benefits and resources from oil production to the population in the region. Moreover, there are frequent riots in some northern states between Muslims and Christians on control of fertile farmlands and for economic, religious and political power. Inadequate infrastructures such as electricity, information systems, roads and transportations systems are underdeveloped which have major implications for the further development of the country and delivery of services to the population (Iyayi, 2009).

Today, Nigeria is a Federal Republic operating a Federal System of Government with three levels: the Federal, the State and the Local Government Areas/Councils (LGAs). There are 774 LGAs within 36 States in addition to the Federal Capital Territory (FCT) Abuja. The States and the FCT are grouped into six geo-political zones: the South-South, the South-East, the South-West, the North-East, the North-West and the North Central zones. Nigeria is listed among the *"Next Eleven"* economies, and is a member of the Commonwealth of Nations. The economy of Nigeria is one of the fastest growing in the world, where the International

Monetary Fund projected a growth of 9% in 2008 and 8.3% in 2009 (Nigeria National Strategic Health Development Plan (NSHDP) 2010-2015).

ADMINISTRATIVE MAP OF NIGERIA

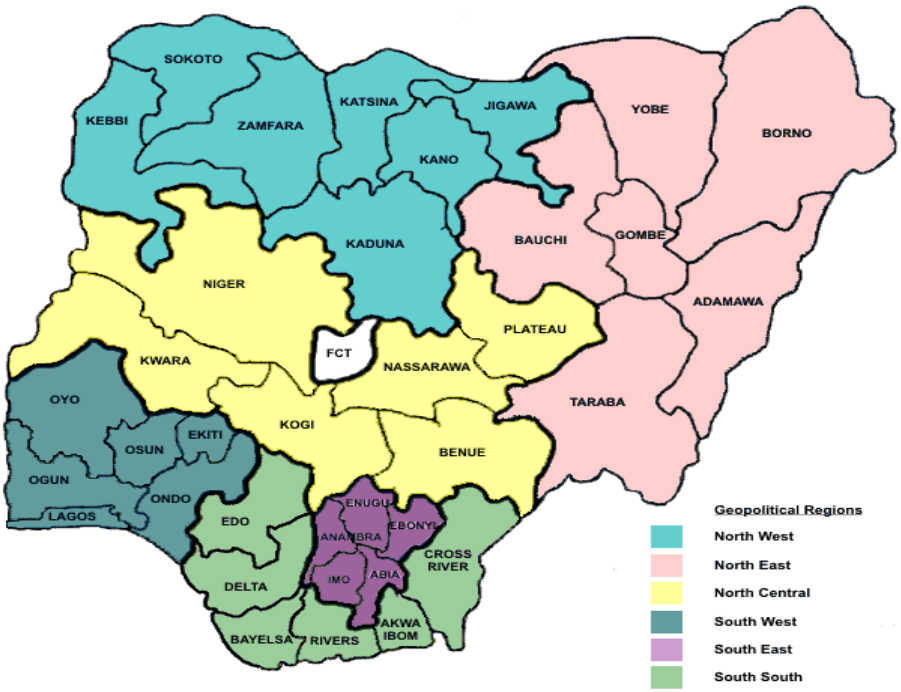


Figure 2: Administrative Map of Nigeria

Archaeological findings have proved that the history of the Nigerian people extends far back in time. The early existence of dynamic societies and well developed political systems had an important influence on colonial rule. The independence in 1960 continued to shape the independent Federal Republic of Nigeria where the modern society and political landscape have been strongly influenced by three regionally dominant ethnic groups; the Hausa in the North; the Yoruba in the West and the Igbo in the East (Chapin Metz, 1991).

There are several dominant themes in Nigerian history that are essential to understanding contemporary Nigerian politics and society. The slave trade, both across the Sahara Desert and the Atlantic Ocean, had a profound influence on all parts of Nigeria. Furthermore, the colonial era, after the amalgamation in 1914, contributed to a rapid change in the socio-political climate with its full impact still felt in the contemporary period of today. It supported a growth of nationalism in the society, and the emergence of political parties was

based on religious and ethnic/tribal diversities rather than national interests, essentially impacting on the vision of unification of all Nigerian people (Chapin Metz, 1991).

During the period of the slave trade and the colonial era, Islam and Christianity have become significantly consolidated and rooted among the different ethnic groups in Nigeria, and are highly reflected in political, cultural, social life and decision making today. The spread of Islam in the north began a millennium ago. On the other hand, the south and the east are predominantly Christians. Easy acceptance and adaption to religions among Nigerians can be explained from the strong influence that traditional beliefs and religion since ancient time have played, where spirituality is interwoven in activities of everyday life (Chapin Metz, 1991).

Missionary and church activities have played an important role in politics and social lives of Nigerians over time and influence significantly the lives of people in communities. It is important to understand the impact of religion on people in order to understand their priorities, behaviour and attitudes in social life and politics. Moreover, how different religious orientations guide decision-making that further impacts the socio-cultural development of a country and a community. Consequently, and from my own experience, religion has become a major industry in Nigeria, continuously aiming to recruit new members. Church leaders expand their power and influences beyond that of parish work, and increasingly influences the political- and socio-economic climate in the country.

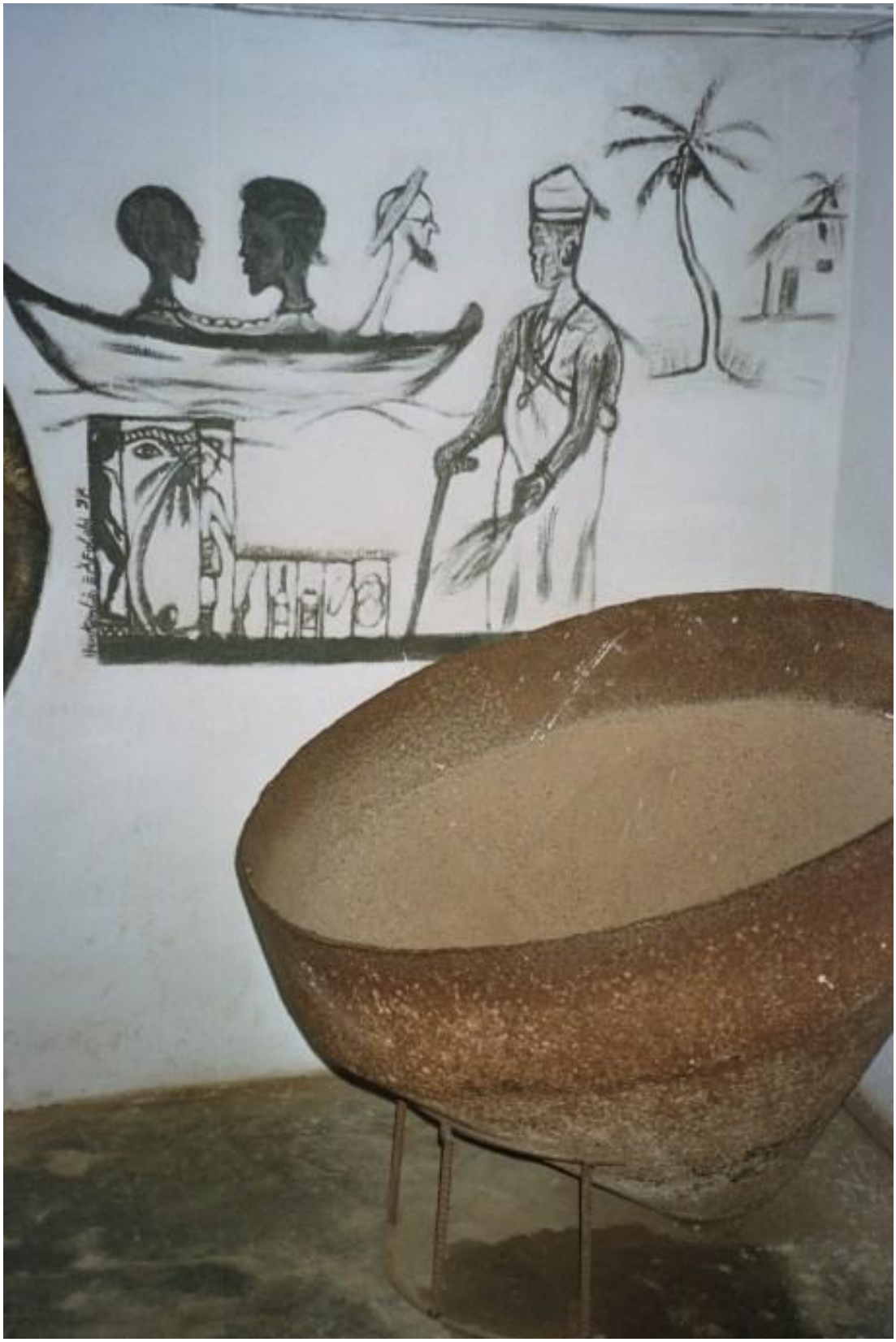


Figure 3: The slave museum at Baghari located by the estuary of river Niger: Slaves drinking tray. Photo: Heidi Olsen.

The Igbo people of Nigeria

Igbo people have their origin in the south-eastern part of Nigeria comprising of 5 States, respectively Abia, Anambra, Ebonyi, Enugu and Imo State. Close to 70% of the population in this region live in rural areas. The most densely inhabited belt stretches across the region from Onitsha through Awka-Orlu-Owerri to Calabar, with the density falling away both to the north-east and to the south-west, except for the urban city of Port Harcourt. This area is one of the most populous regions in the country. Other demographic characteristics of the population include a high birth rate, a declining death rate, a gradual increase in life expectancy and a declining illiteracy rate (Okali et al. 2001).

Figure 4: Igboland

Source: www.sitesatlas.com/custom/Igboland.jpg

Igbo people speak Igbo, a Kwa language of the Niger-Congo family. This language ties them historically to regions east and south of their contemporary locations. Social structures are quite complex and the organisation of local and regional society reflected by community groups, families, individuals, kinships and neighbourhoods (Okali et al. 2001).

A typical characterisation of an Igbo involves personal advancement and participation in local affairs aiming to bring progress and success into life. Eldership, wealth, modern education and political power are all recognised as means by which people, especially adult males, distinguish themselves from others. Igbo people are quite unlike other Nigerians as they prize competitiveness for success. Children are encouraged to progress and if they do so skilfully, people believe that rewards of high status await them. Such encouragement is to a large extent being manifested through the increasing rate of migrating young Igbo people taking place in contemporary time, where they move to urban cities or abroad in search for improved opportunities and a better life (Chapin Metz (1991).

Social structures and association ties

Okali et al. (2001) have extensively described community organisations and association ties among the Igbo people in the south-eastern part of Nigeria in their study *"The Case of Aba and its region, south-eastern Nigeria"*. Though Aba is the capital of Abia State and regarded as a commercial centre, similar social structures can be found among the Igbo people residing in rural Imo State as well. The social structure of a village group is based on a patri-lineal descent and regards each village group as a patri-clan, descendants of a common ancestor. A mutually dependant relationship between a kinship and the village structure is therefore closer among the Igbo people than many other Nigerian tribes. Most urban dwellers from south-eastern Nigeria belong to rural-based community groups and age-grades, regardless of their city of residence. Age-grades are an important component of community organisation as well as representing the social infrastructure of a town or village. In all community organisations and association ties, the payment of dues and levies involved is taken very seriously in order for group members to benefit from their memberships (Okali et al. 2001). Apart from the mentioned aspects, belonging to community groups and association ties for those who travelled out secures access to land in their paternal village, opens opportunities for housing and employment, provides inclusion in social security-networks, maintains cultural identity, as well as ensures the flow of local information between social group members (Okali et al. 2001; Ibem, 2009).

Associations of civil society have often operated as *"shadow governments,"* taxing themselves to provide many of the facilities that government has failed or neglected to

provide for in their local communities. Group members hold regular meetings where different tasks of importance are decided upon and carried out for the best of their families and the community at large. In addition to carrying out smaller or larger scale projects, belonging to community groups also involves financial help to members in need, monitoring of the behaviour of others, or cautioning those who commit wrongful acts (Ibem, 2009; Okali, 2001).

Through the formation of Community Development Committees (CDUs), the structural organisation of age-grades and community organisations, such have considerably contributed to the establishment of education- and health facilities, water, electricity, roads and transport systems, and markets and postal facilities. In many cases the community provides the infrastructure while the Local Government manages the operation of facilities and services. Consequently, the participation and inclusion of social association ties and community groups in government projects contribute extensively to the development of rural areas as they increase the potential of projects to be successfully implemented. However, right from colonial times there has been a tendency of governments to exploit these associations in order to mobilise development efforts. Nevertheless, interaction and collaboration between formal- and village structures seems important in order to improve service deliveries, which includes community healthcare through community participation in a society where resources are scarce (Ibem, 2009).

Migration

As earlier referred to, migration is important in the Igbo-speaking areas of south-eastern Nigeria as it is viewed to bring about an opportunity progressing in life. Millions of people have migrated to the north and other parts of the country as temporary or seasonal migrants (ibid) as well as overseas. According to Okali et al. (2001) inequality of opportunities for economic advancement is seen as the major factor encouraging rural-urban migration. Another factor leading to rural-urban migration is the governmental neglect of developing infrastructures in rural areas. Many people have moved to the city for better economic or educational opportunities due to a lack of markets, good transportation facilities, schools, health facilities, etc. in the village. Characteristics such as age, gender, ethnic background, socio-economic status, educational status and religion influences one's

decision to migrate to the city and whether to return to the village at a later time. Many Igbo families encourage members to migrate, believing that staying in the village inhibits financial success. Such views are further manifested by the constructions of luxurious houses of those who have moved out and up through their spending of money earned overseas or in urban areas. Such examples serve as a constant reminder proclaiming: in order to move up, one has to move out (Okali et al. 2001).

Interestingly, older respondents participating in this study pointed to the notion that young women have begun to migrate to towns in search for opportunities in about equal numbers to those of men, unlike in past generations. They explained this change to be due to an increased exposure of women acquiring a formal education, which has eliminated many of the cultural barriers against them which previously limited such opportunities. Old people regarded these trends as modern processes contributing negatively to transforming existing social values by watering down previously cherished principles. Consequently, they perceived the ruling principle in contemporary time to become *"everyone for himself; only God for us all"* (Okali et al. 2001).

Figure 5: Igbo Masquerade. This mask represents a bush cow (Atu Ejeogwu) and is typical of the north eastern part of Igboland. Photo: Eli Bentor

Challenges in family care impacting on the health and wellbeing of old people

Research on familial support to old people in developing countries has gradually evolved during the last century. Such support is threatened, however, by a rapid ongoing societal transition, where the industrialisation of society has led to increased urbanisation and modernisation. The gap between the rich and the poor has become bigger, where rural families especially are facing increased economic constraints, impacting their responsibilities and obligations to care for old family members. Such trends put old people at risk by making them extremely vulnerable in times of ill-health, and to poverty. Several African countries have recognised these factors to be reinforced by the demographic and epidemiological transition manifesting itself through the increasing number of old people and a rise in the prevalence of non-communicable diseases (NCDs) (Asagba, 2005; Ajomale, 2007b). This view is supported by Aboderin (2009), where she adds that lack of social service provision and inadequate health care services are to be some of the challenges that urgently need to be addressed in order to alleviate old people's increasingly troubled situation. Very little empirical research has, however, been conducted on the long term effects of such transitions in the welfare of elders, but there are several reasons to believe that traditional caring and support for old people are under increasing constraint (Ogwumike and Aboderin, (2005); Powell, 2010; Aboderin, 2009).

Familial care: studies from Nigeria, Ghana and Botswana

Peil et al. (1989) addresses care giving to old people already in the early 1980s, when they conducted a study among the Yoruba people in Nigeria. The aim of the study was to investigate familial services received by elderly Nigerians over 60 years of age. The results of this study uncovered that old people in general received some economic help, whereby 80% of daughters and sons gave various forms of gifts. Only 20% of the children, irrespective of gender, provided direct services to their fathers while less than 10% helped their mothers with services. Observations revealed more fathers having children and/or younger wives living at home helping. Such findings can be explained by the patri-lineal tradition existing within the Yoruba culture fostering expectations of reciprocal activities, especially between fathers and sons, involving inheritance and ownership of properties. Interestingly women over 85 were most likely to live alone. There were expectations from elders in the villages

that the government should improve access to healthcare by establishing village health clinics nearby, which would increase availability of healthcare services and reduce the cost of medical care for old people. However, the main source of assistance in times of ill-health was still found to be family or household care, but old people expressed concern about less help to be rendered now compared to the past decades due to the changing of societies and gender roles, increasing living expenses and poverty. This view was more marked within urban areas than rural and explained to be due to rural life and its more traditional patterns, and the increased cost of living in urban areas (Peil et al. 1989).

A few years later, Nana Arabia Apt (1993) conducts a study on the care of the elderly in Ghana. All studies were undertaken during field works in the period of 1990-1991, and the scope directed towards the investigation of social and economic conditions influencing on the care of elderly in Ghana. This involved: defining the problems of the aged, indicating the care-taker of the aged, and indicating traditional beliefs and practices having mitigating effect on the care of old people.

In line with earlier research of similar scope, Apt was concerned about the ongoing irreversible social and economic transition impacting the situation of old people. She referred to indications from the Hospital Welfare Services in Ghana that pointed to an increasing trend involving the abandonment of old people after their discharge from hospital care. In Ghana's capital Accra along with other major African towns, elderly destitution was found to increase along with homelessness. There was no formal care for old people in times of ill-health, or a formal social security system. According to Apt, the family continued to be the only source of caring for elders. Similar to the Yoruba culture of Nigeria, care for old people was seen as a reciprocal activity that was earned, usually by the previous support rendered to children. In spite of such reciprocal tradition, findings from this study uncovered that old people were likely to suffer from inadequate care or no support at all, stigmatisation, poverty and malnutrition. The existence of a permanent primary caretaker was found to be scarce, and responsibilities were taken on temporary or shared between family members, depending on the ones who were accessible and willing. The availability of caring arrangements often reflected and depended upon a family's financial situation. Healthcare services were perceived as expensive and not easily available, and some elders received help only through the advisory support from neighbours and friends, and by using

traditional medicine. Apt concluded that formal interventions have to be initiated in order to make longer lifespan worthwhile to live (Apt, 1993).

A single phase cross-sectional survey is conducted by Uwakwe et al. in 2009. The survey was undertaken in a rural community in Anambra State in south-eastern Nigeria and aimed to describe the prevalence and determinants of dependence in old Nigerians, and its associations with informal care and health service utilisation. The results of this study support largely those of Apt (1993). 68% of elders in need of care received such mainly from children and children in-laws. Next to children, wives were found to be the main caregivers for their husbands. Women represented by daughters and daughters in-law constituted 63.2% out of those caring for elderly family members on regular basis. Strikingly, more than one third reported to give up, or reduce formal work in order to cope with their caring obligations.

Uwakwe et al. found nearly 20% of the old respondents to suffer from a combination of cognitive, mental and physical ill-health, where memory loss (10.7%), reduced physical capacity (12.7%), stroke (4.1%) and depression (29.9%) constituted major conditions requiring support in activities of daily living (ADL). Depression was frequently related to social isolation and physical disabilities became a threat to continued participation in family- and community activities enhancing social isolation. These findings is supported by Gureje et al. (2008) where he found depression to represent the single most important determinant contributing to disability and thereby dependency on caregivers. Both Uwakwe (2009) and Gureje (2008) highlighted the economic and social vulnerability of dependent elderly people which they attached to the economic difficulties of caregivers, impacting on their abilities to adequately provide social and financial protection for old family members. In spite of old people's need for care and formal healthcare interventions, only 2.8% reported to have visited a primary healthcare facility within the previous three months due to the expenses involved, consequently making alternative care providers such as traditional healers their only option in times of ill-health (Uwakwe, 2009).

Shaak Van der Geest (2002) looks into caring and sees this as a concept with two meanings, emotional and practical/technical. He states that western traditions defining the concept of caring should be handled with caution because different social, cultural and economic

environments define caring differently. In his study, he investigates respect and reciprocity in the care of elderly people in Ghana, and explores the kind of care old people receives by seeking answers to the following questions: who are the main care providers, on what basis do people care for the old and do they feel obliged to do so, and finally what are the changes taking place in the field of care for old people?

According to findings presented in this study, children again become the only solid basis from whom old people could expect support, which however depended on whether children were around, whether they had the financial capacity, and the extent of care children themselves received at younger age (reciprocity). Challenges related to the caring for old people was described to involve a growing ambiguity around family solidarities with an emerging shift from lineage to nuclear family compositions. The increase of rural-urban migration was further found to reinforce this trend, which often resulted in caring from distance. Findings uncovered a shift in the appreciation of old people's acquired wisdom and they were no longer consulted by the descendents. Based on the latter, elders were found to be lonely and bored, and weaker old people got the least company. The psychological effect of being excluded from performing roles traditionally carried out by old people are therefore consistent with the findings of Uwakwe et al. (2009) and Gureje et al. (2008), where social isolation were found to cause emotional distress and depression.

Interestingly, van der Geest (2002) suggests the traditional way of paying respect to old people to be more or less based on learned lessons and demonstrated politeness manifested through occasional visits and services from family members rather than them sitting down, actively listening and conversing. He further suggests that funerals play an increasingly important role in which the arrangement of big events is seen as an expression of care, of which the extent of the ceremony itself comes to represent appreciation for the diseased. He interprets such to reflect an evolving African etiquette, important for family members to comply with, in order to prevent sanctions and haunting from people and community. Consequently, van der Geest raises the question whether caring is just to prevent social criticisms rather than reflecting care as an act of love based on earned respect. His interpretation of the concept care, and the uncovering of context specific etiquettes in the caregiving of old people, becomes therefore a topic of particular consideration when

involving informal caregivers in healthcare provision targeting the health and wellbeing of elderly Africans.

In the Batswana culture of Botswana, Sheila Shaibu and Margaret I. Wallhagen (2002) looks further into family caregiving of the elderly by exploring boundaries of culturally acceptable options and resources. They conducted 24 in-depth interviews with caregivers, and found that caregivers' decision-making processes regards to the rendering of acceptable and non-acceptable assistance is guided by three categories: stigma, appropriate versus inappropriate forms of care, and sense of place.

Interestingly, in Botswana, formal socio-economical support systems were introduced by the government through an old age pension and a destitute program. Apart from the latter, no other formal interventions such as healthcare programs targeting old people exists. One of the findings in this study uncovered the unwillingness of family members to utilise destitute support, due to fear of being embarrassed or stigmatised by family or community members. This study also explored and brought forward the complexities of social and cultural norms and values guiding caregiving to old people in the way it was perceived by the participants to be acceptable and appropriate, or not. New conceptual categories that derived from this study uncovered that general assistance and care was appropriate when it included food contribution, but its quality depended on whether food represented traditional staple food or was based on westernised food traditions, regarded as highly non-nutritious by the old people. Visits were also valued as care along with family remittances. When caring, gender mattered, in particular in regards to intimate care, and the care should be provided within the caregivers' home environment. Highly unacceptable were family visits without family remittances, destitute help, old age homes, western types of food, and hired help for intimate care. Old people were found to resist change, and wanted to live a traditional life affirming continuity with the past. It was perceived to represent themselves with respect to their identity, reflected through daily activities, personality and role, and function at the social level. As such, the findings of this study include several of the socio-cultural components viewed as essential in the caregiving to old people in similar African contexts. Shaibu and Wallhagen emphasises the importance of formal programs targeting the healthcare of old people to provide culturally acceptable services sensitive to cultural norms and values. This could be achieved by involving both caregivers and old people in the

planning and initiations of health projects aimed at improving the health and wellbeing of this group. (Shaibu and Wallhagen, 2002).

Elders abuse, an unaddressed issue in Nigeria

Olayinka Ajomale (2007a) discusses in his paper the emerging issue of abuse of old people in Nigeria. The issue has not previously been properly addressed as it has not been recognised as a serious matter within societies. Ajomale states in this paper the rights of elderly people to demand respect, and to be protected by the society against all forms of rights' denial and abuse.

According to Ajomale (2007a), abuse[1] is a complex issue that often is linked with other problems in society, including age-discriminating attitudes. He connects abuse to neglect, which according to him involves abandonment, isolation and social exclusion. He further assesses abuse within the perspectives of the human, legal and medical rights of the elderly. Based on previous research within the field of gerontology, he has classified abuse according to the identified experiences of elderly Nigerians and attached importance to their own definitions. Abuse as a phenomenon was consequently found to include: physical, psychological and emotional abuse, neglect and abandonment, sexual and financial abuse, societal and cultural abuse, and finally structural or institutional abuse. He understands- and assesses all components as individually severe, but also interacting, as violation of one consequently will affect the elders' full state of mind, impacting their physical and psychological wellbeing and health (Ajomale, 2007a).

The level of respect towards old people in Nigeria makes it uncommon to have cases of beatings and deliberate inflicted injuries. However, there are reported cases of e.g. ritual-related sexual abuse, where sons seek spiritual power by raping their mothers and cases where old people living alone are exposed to rape in cases while becoming victims of armed robbery. Moreover, there is evidence from the literature that elderly Nigerians frequently suffer from psychological and emotional abuse that touches their self-dignity. Ajomale (2007a) found such events to usually happen through the inappropriate acts of caregivers causing fear, or by family members' insults and jokes on behalf of the old person. Elderly

[1] Elder abuse can be defined as a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person (International Network for the Prevention of Elder Abuse (INPEA).

women could moreover be exposed to accusations of witchcraft due to their aging bodily stature and the use of helping aids. The latter example was particularly found to impact on the support that could be expected from family members and kinsmen (Ajomale, 2007a).

A study by Okoye and Obikeze (2005) addresses stereotypes and perceptions towards elderly. Findings were based on information given by youth residing in an urban city in south-eastern Nigeria. By representing a distinct social group, old people were found to face the risk of being marked out as subjects and victims of negative stereotypes which reflected a deep seated uneasiness and distaste of growing old. According to the findings of this study, which reflects similar threats to old age life, dignity and identity as those emphasised by Ajomale (2007a), old people experienced fear of becoming powerless or useless, and consequently a burden to others. Such fear was closely interrelated with young people's perceptions of old age images, where they were associated with low socioeconomic status, poor health, loneliness, senility and death. In spite of the above, major findings suggest that Nigerian youths do not see elderly as a group making too many demands on their children, but respondents possessed though a number of ageing stereotypes such as: elderly behave like children, are lazy, always sickly, conservative, suspicious and secretive (Okoye and Obikeze, 2005).

Argumentatively, attitudes towards specific groups of people may sometimes develop to represent the general view among people living, acting and working at different levels of the society. Lack of addressing underlying normative and structural components - and to directly focus on the societal and cultural environments that form people's attitudes may therefore consequently turn into structural abuse. Typical examples point to the inadequate and irregular payment of pensions to old people in African contexts, inaccessible and unavailable government services including health care provision, lack of social and welfare policies, and possible harassment and marginalisation from those who are assigned to serve the general population, including the elderly. Consequently, attitudes may impede policy formulation from benefiting elderly people resulting in age discriminating policies and practices.

Strengthening SSA health systems through Community Oriented initiatives

Dan Kaseje (2006) addresses the cross-cutting issue of healthcare in Sub-Saharan Africa (SSA) by identifying challenges, opportunities and an emerging model for the improvement of healthcare provisions within such contexts. In his introduction, he communicates concerns on the many troublesome constraints affecting health sector development in this region. One of his worries is directed towards the experiences of some civil, public, and health sector reforms which he found to be externally driven and consequently unsustainable as regards to a nation's ability to successfully carry out the intentions of proposed reforms. He stresses that the implementation of health reform processes in SSA must be done carefully because of their possible unresponsiveness to the diversity of stakeholders involved and the health problems of its populations. He is further of the opinion that health sector reforms are inherently political and cannot be sustained unless based on a political consensus and a legal framework. He consequently calls for a stronger involvement from several partners in order to strengthen and utilise already existing health systems. Such strategy could in his view preferably involve partners such as: universities, militaries, PPP, the target population itself and traditional healers (Kaseje, 2006).

In order to improve the sustainability of African health systems, current strategies require a paradigm shift in the way health services serve communities. For reforms to meet with the health needs of its SSA populations, they should be modelled based on research, theories and experiences from others with knowledge of similar contexts. Kaseje (2006) is highlighting the theories of Paulo Freire[2] (1968), the model of Community Oriented Primary Care which originated from the rural areas of South Africa, and the investment in social capital by expanding people's capabilities of fostering improved quality of life and dignified living. He further stresses the importance of health reforms to be flexible in order to adapt strategies and methods to local contexts. Communities should be included as joint problem solvers through the establishment of participative structures where training and orientation

[2] Paulo Freire (1921-1997); A Brazilian and perhaps the most influential thinker about education in the late twentieth century, Paulo Freire has been particularly popular with informal educators with his emphasis on dialogue and his concern for the oppressed (http://www.infed.org/thinkers/et-freir.htm).

on skills such as leadership, relationship-building and communication, helps to ensure joint action in health and improved health status for people (Kaseje, 2006).

PHC development strategies in Nigeria and its sensitivity to the health problems of old people

The Federal Republic of Nigeria, comprising of 36 federating States and 744 Local Government Areas (LGA's) are each responsible for all financial aspects and the provision of Secondary- and Primary Healthcare Services to Nigerians. In spite of the Bamako Initiative (UNICEF, 1987), the Draft Nigeria National Policy on the Care and Well-being of the Elderly (2003), and the Ouagadougou (2008)- and Abuja declarations (2001), issues of human development and health, least of all that of older persons, have remained a low priority. It is worth underlining that health is not mentioned as an issue or service in the 1999 Nigerian Constitution and consequently health objectives have been absent, resulting in Nigeria's overall health system performance being ranked as 187th among the 191 member states by WHO World Health Report 2000. Today, key social determinants, and a deep-rooted culture of corruption may therefore challenge the further implementation of Nigeria's first National Strategic Health Developing Plan (NSHDP) 2010-2015.

In spite of several propositions and agreements made towards improving the health of old people, such have never been ratified by the National Assembly (Asagba, 2005; Ajomale, 2007b) in spite of the speech by senator Iroegbu in June 2007, where he stated:

> *"While this has been recognised in developed countries, it is only recently that the phenomenon [(...) we live in an ageing world (...)] has been fully acknowledged in Nigeria (...)"* (NEEDS, 2004).

When reviewing parts of the National Economic Empowerment and Development Strategy (NEEDS, 2004) relevant to the topic under study, I was unsuccessful finding any specific strategies targeting old people specifically, except where the document addresses the extreme poverty situation in the country, where 70% of the population were estimated to have an income less than $1 a day in 1990, and the figure risen since then. In response to this serious situation highly influential on the welfare of old people:

> *"NEEDS calls for replacing the pension scheme, which is in crisis, with a contributory scheme. It proposes special programmes targeting people who have the weakest*

> *political voice and who are most vulnerable to the ravages of poverty. Laws and programmes will be implemented to empower women, children, the disabled, and the elderly"* (NEEDS, 2004).

In spite of intentions as outlined in NEEDS 2004, it is a fact that previous and current governments seem to struggle with regular payment of pensions to a retired workforce, which as for now only covers disbursements to former civil servants, military- and government officials (Casey and Dostal, 2008) apart from an ongoing pilot in Ekiti State Nigeria where the presently elected Governor recently initiated a cash transfer scheme for the elderly. The scheme is an unconditional, non-contributory pension scheme for citizens of the state, aged 65 years and over, that currently do not receive pensions. The schemes monthly contribution is at present time set to 5000 NGN (Olajide et al. 2013). There is however no general Social Security Scheme policy in force targeting old people who have to be kept in mind when assessing the accessibility of health- and social services in general, and the potential for health strategies to meet the needs of an ageing population in particular.

The need for healthcare services to a growing proportion of elders residing in rural areas

In 2002, Unanka conducts an explorative and descriptive study among the Igbo people in Imo State. The study objectives include critically examining social and health service related issues of ageing from the perspectives of a rural community. The study drew upon results from previous studies on familial care similar to the ones presented earlier. It was further inspired by challenges related to demographic change and longevity among populations in African nations and on such basis, called for attention towards improved health programme implementations.

Unanka (2002) refers to a common assumption existing among the most developed countries in the world where the caretaking of old people in African contexts are seen as safeguarded by the extended family. He concludes that the availability of family support reported not necessarily translates into actual support due to the physical distance of their children. As such, old people are particularly vulnerable in situations of illness. Common acute illnesses are identified to include: the suffering from malaria, severe headache, flu and sleeping problem; while the four most prevalent chronic illnesses are found to be rheumatism/arthritis, failing vision, general weakness and hip problems. The growing

proportion of old people in the population, combined with an ongoing demographic and epidemiological transition are seen as contributing huge challenges to the health system in Nigeria in future times to come. Chronic old age illnesses requiring long term care are expected to increase, which highly justifies the initiations of Home- and Community Based Care as viable forms of caregiving complementary to that of family care. Unanka (2002) suggests African policy makers to draw some lessons from this study and include old people when health- and social policies are to be designed and programmes implemented in order to meet the UN's vision of a *"Society for All Ages in the 21st Century"* (Unanka, 2002).

The Nigerian National Strategic Health Development Plan 2010-2015; structure and potential

The Nigeria National Strategic Health Development Plan (NSHDP) 2010-2015 focuses on eight priority areas: Leadership and Governance for Health, Health Service Delivery, Human Resources for Health, Financing for Health, National Health Management Information System, Partnerships for Health, Community Participation and Ownership, and Research for Health (NSHDP, 2010-2015).

The priority area Community Participation[3] and Ownership is in particular interesting as it explores opportunities for involvement in health within the concept of Community Based Healthcare. Participation can be viewed as an empowerment process[4] where process exercises involve the rights of community members to play an active and direct role in identifying health determinants and suitable strategies of implementing health services according to local needs, consequently fostering empowerment.

According to Egboh (2009), Community Participation should be promoted as a basic approach to health development, as it supports local perceptions of health needs, creates

[3] Community Participation can be understood as a process of dialogue in a structured manner – being viewed as equals – building a team between program managers and community members to jointly understand health problems – to find common solutions – act together in solving them – using as much human and material resources from community as possible (Ministry of Health, Ghana 1997).

[4] Participation as empowerment can be described as the process and outcome of those without power gaining information, skills and confidence and thus control over decisions about their own lives, and can take place in an individual, organisational and community level. Builds self-esteem and encourages responsibility (WHO, 1999).

awareness on the potential of community involvement in health development projects, and breaks the bounds of dependency. Community Participation places health development into appropriate contexts and is consequently responsive to the basic needs of people in local communities, increasing the possibilities of health programs to be implemented successfully. As a strategy, this form of intervention in health projects have the potential to complement ordinary formal health service deliveries by extending coverage and by intensifying the impact of health sector investments. However, as reflected by Egboh (2009), one should be careful not to initiate community involvement in health as a strategy where the local population absorbs the costs of healthcare development. Such contributions should rather be assessed as a sound strategy that could challenge the existing social, political and economic system, which often deprives ordinary people of control and influence (Egboh, 2009).

Nigerian health system infrastructures; opportunities and constraints to sound and affordable healthcare deliveries

The current health system in Nigeria includes both public and private health services, and the Government emphasises strengthening the Primary Health Care System. In spite of the good intentions of the Government on Federal- and State levels, the availability and accessibility of health facilities and quality health service deliveries are inadequate in rural areas. Public health facilities are, to some extent, subsidised in order to provide reasonable health care services, but the quality of care and service provision are considered to be poor among the population. This leads to an increased use of private clinics, where out of pocket payment appears to be the norm (Adeyemo (2005); Chukwuani et al. (2006); Amaghionyeodiwe (2008); Iyayi, 2009).

According to Amaghionyeodiwe (2008), the mean monthly income of a Nigerian household ranges from 4.885 to 58.106 Nigerian Naira (NGN), and the monthly health expenditures of a household ranges respectively between the spending of 507 to 2.198 NGN in 2008. He found therefore cost, distance, and quality of care to be important determinants when choosing health care providers in Nigeria. However, as old people are considered amongst the poorest, sometimes the poorest of the poor, formal health care provision was rarely an option of choice, as they usually depended on other affordable and available services existing within their communities. Help and advice from family and neighbours were highly

valued and utilised at the first entry of any illness combined with self-treatment and treatment provided by traditional healers (Amaghionyeodiwe, 2008).

The autonomy of the State- and LGs on how to prioritise and implement strategies for sustainable Primary Healthcare (PHC) deliveries are emphasised in NSHDP 2010-2012. As mentioned earlier, one of the strategies is to empower communities by promoting community participation. Such intention is strongly communicated in spite of having a clear policy framework in which the Community Development Policy Draft (2003) is yet to be finalised (Asagba, 2007). Interestingly, ongoing societal, demographic- and epidemiological changes, which heavily impact the health status- and availability of health care services to old people, are also limited, discussed, and reflected in current health plans.

However, NSHDP 2010-2015 clearly outlines the roles and responsibilities of Local Governments to develop suitable strategies in health service deliveries anticipating the health needs of its local populations. The Nigerian 1976 Local Government Reforms as enshrined in the 1979, 1989 and 1999 Constitution of the Federal Republic of Nigeria defines the function of Local Government as:

> *"Government at the local level (...) established by law to exercise specific powers within areas (...) [and] to initiate and direct provision of services and to determine and implement projects so as to complement the activities of the state and federal government in their area"* (Nigerian Local Government Reforms, 1976).

Its specific responsibilities and relevance in regards to health service provision, as stated in the 1999 Constitution section 7 (1), is apart from a PHC initiative: the maintenance of cemeteries burial ground and homes for the destitute or infirm, registration of births and deaths, pets and food control, provision of public conveniences and maintenance and regulation of slaughterhouses, to mention some (Adeyemo, 2005).

Over the years, focus on PHC services have been increasingly recognised as the preferred entry point of the health care system, consequently implying the provision of health care at the primary level to largely be the responsibility of Local Governments. There are three levels of operation of PHC in LGA: the village level, the district level and the Local Government level. The essence of transferring the responsibility of PHC to Local Governments was principally to make the management of PHC services more effective and

closer to the grassroots. However, the challenges to such principles were later found to be numerous.

In a case study assessing Local Government and Healthcare deliveries in Nigeria conducted by Adeyemo (2005), several constraints were identified; insufficient numbers of healthcare personnel with an uneven distribution between rural and urban areas, poor accessibility, lack of transportation to carry out services, and inadequate financing. Moreover, the cornerstone of PHC: community involvement and participation had to a large extent become a crisis hidden problem throughout Nigerian Local Governments. Inconsistency in health policy decision-making processes combined with misuse of scarce resources were perceived as adding on problems to those already identified, constraining the implementation of PHC in rural areas (Adeyemo, 2005). Findings from this study are later confirmed by Chukwuani et al. (2006) and Meremikwu et al. (2011). Respectively, they conducted a baseline survey of the PHC System in South Eastern Nigeria and a review on the overall health care interventions in Nigeria. Their result is alarming.

Data from the baseline survey conducted by Chukwuani et al. (2006) gives evidence information uncovering several issues of concern. People using PHC facilities perceived services rendered to be fair to poor. People commonly experienced lack of drugs and equipment, suffered from incompetent services of health workers, and experienced long waiting hours. Private clinics were preferred to public ones and hospitals were often the first entry of admission. It became evident that the grass-root level health facilities lacked both the capacity and the availabilities of skilled personnel in order to provide a minimum package of essential services as identified in the national health policy. In several health facilities, service provisions consisted of only antenatal care and immunization of children, often provided by donor driven programs. The coordination between public and private health facilities was moreover poor, and private PHC facilities were found to outnumber public ones. Other challenges ahead involved inadequate organisational set ups, including the financing, planning and coordination of different health programs. Data from this health survey revealed for instance that health decision-makers and program managers rarely projected adequate budgets covering the expenses needed per health facility in order for services to meet the health needs of its target population. The authors recommends closer collaboration between private and public actors by establishing Public-Private-Partnerships

(PPP) in health and through such initiations increasing the accessibilities and availabilities of sustainable PHC services. They emphasise the potential for outreach programs to be carried out from Community Health Centers, which, through improved community participation, could stimulate and stratify initiatives to be in accordance with community needs and people's demands for healthcare services (Chukwuani et al. 2006).

The review of Meremikwu et al. (2011) uncovers similar cross-cutting issues to those of Chukwuanli et al. (2006). In addition they point to an urgent need to incorporate patent medicines, educational interventions of patient knowledge, the use of guidelines relevant to common health problems and to improve the quality of health related practices. Moreover, they uncover a compelling need to understand traditional medicine practices and to evaluate the effect of faith-based interventions on patients' uptake of available services and adherence to therapy. They are also of the opinion that the prevalence and effect of non-communicable diseases (NCDs) on populations needs to be further investigated through research, as they found the treatment of NCDs to be a neglected area of concern. Nigerian health authorities are therefore advised to increase their attention on NCDs in order to achieve health equity among rural population groups in Nigeria (Meremikwu et al. 2011).

Community Based Healthcare Financing

Adinma and Adinma (2010) evaluate in a review the chronic underfunding of the healthcare system in Nigeria on the basis of reported poor public health performances. Within this context they examines the opportunities of Community Based Health Financing (CBHF) to represent a plausible option improving the provision of healthcare services to people at the grass-root level through joint private-public efforts.

They define CBHF as;

> *"Voluntary contributions made by individuals, families, or community groups to support the cost of healthcare services, with particular emphasis on primary health care"* (Adinma and Adinma, 2010).

According to Adinma and Adinma (2010), community contributions could involve cash, kind or labour. It was seen as an opportunity for community groups to: donate money privately, host fund-raising events, and initiate income generating schemes and individual fees for

service in form of pre-payment, standard payment for all services, or payment for cost of materials, medicines etc.

They understand the strengths of CBHF as a strategy to involve mutual aid and foster social solidarity among community members, as it builds on traditional patterns of social support mechanisms already existing among members of communities. CBHF would therefore be sensitive also to people normally working within the informal sector, usually left out from accessing public, private or employer sponsored health insurances. The strategy was moreover assessed as appropriate in accommodating social equity by covering healthcare provision for vulnerable groups such as the elderly and the chronically ill.

The initiation of CBHF builds on community participation by enabling financial access and resource mobilisation through community efforts. Its aim is ultimately to reduce out-of-pocket payment and thereby increase utilisation and accessibilities of healthcare services. Closely linked to such aspects are the communities' involvement in defining their needs, priorities and community members' abilities to pay. In order for such initiations to be encouraged and successfully implemented, rural people should have a stake in the election of scheme managers as it would enforce transparency and accountability of the program. (Adinma and Adinma, 2011).

The major constraints of CBHF are by Adinma and Adinma (2011) related to its sustainability over time. The successful implementation of the scheme could be threatened by social, managerial, political and financial instability and lack of institutional development. At the community level, the sound implementation of CBHF could be constrained by disputes among community leaders, inadequate leaderships of community groups, and resistance from health workers to execute services, based on the idea of lost income previously earned through user fees. Parallel systems purchasing CBHF medicines and non-CBHF medicines could moreover create additional problems for health workers implementing the scheme. However, CBHF is recommended as a viable strategy improving health sector performances within Nigeria, which moreover would be in line with strategies of healthcare financing as outlined in the National Strategic Health Development Plan 2010-2015 where the Nigerian Government (through the National Health Insurance Scheme), currently pilot Community

Based Health Insurance Scheme in 12 states of the country with similar pilots on-going in the private sector (Adinma and Adinma, 2011; NSHDP, 2010-2015).

Utilising social capital in community-led development projects

The capabilities and capacities of communities initiating- and implementing community-initiated development projects are well described in a study conducted by Ibem (2009). He examines how Community-Based Organisations (CBOs) are filling the gap created by the partial withdrawal of the State government by drawing on social capital. By examining social capital within the context of community development, the study investigates the role and function of CBOs and the extent to which they involves themselves in addressing challenges to infrastructure provisions through the establishment of self-help groups.

Ibem (2009) explains social capital as norms, cultural practices, networks and connections existing among community group members and between community groups. He underlines the role and importance of Community Development Unions (CDUs) operating as government-recognised umbrella organisations for all CBOs, such as Age Grades, Youth- and Women Groups. In order to understand mechanisms leading to the formation of self-help groups, Ibem referres to Afigbo (2000) and his notion where;

> *"self-help effort represents a development strategy involving people's participation in promoting community development, based on self assessment of the people's capacity to bring positive changes into their environment"* (Afigbo, 2000 in Ibem, 2009).

Ibem (2009) points to several projects initiated by community groups themselves, or through collaborative partnerships with the Local Government (LG) and Faith-Based Organisations (FBOs). Communities' participation in small scale projects often involves the making of classrooms blocks, concrete drains, culverts and small bridges while participation in major projects often comprises the financing of electricity projects, secondary school projects and health projects. He uncovered that communities carried out projects costing between 0.3 million and 30 million NGN within their respective LGAs, facilitating ownership status in projects, and prevents the "*abandoned project syndrome"* (Ibem, 2009).

Gaps in previous research and contextual knowledge on the topic under study

After extensive literature search, which included the reading and assessment of relevant literature, policy documents and health plans, I found there is still limited contextual knowledge on my topic of interest. Familial care for old people in African settings is widely explored and described through the last century, mainly through anthropological studies. However, there seems to be a gradual awakening of the international community on the need for improved attention and knowledge of elders' increasingly troubled situation in developing countries, which has evolved from the recognition of several issues influential on their health and wellbeing. Some issues worth mentioning are: recognition of an increasing number of elders taking on responsibilities as caregivers for grandchildren whose parents have died from AIDS; lack of social security- and adequate pension schemes making old people extremely vulnerable to poverty; a gradual shift in epidemiological patterns, where an increasing prevalence of NCDs are emerging; the demographic composition of rural areas, where elderly constitutes an increasing share; environments undergoing rapid societal transitions threatening traditional customary care systems; rural-urban migration and; structural constraints caused by inadequate political leaderships (AU Policy Framework and Plan of Action on Ageing, 2003; Understanding and Responding to Ageing, Health, Poverty and Social Change in Sub-Saharan Africa, 2005; African research on Ageing Network (AFRAN), Policy-Research Dialogue, 2008; Ogwumike and Aboderin, 2005).

Based on the above recognition, research on the care and wellbeing of old people in African settings are now shifting from focusing on family care alone and calls for exploring opportunities for formal health interventions and the utilisation of social capital, taking local social-cultural norms and values into account. According to Monica Ferreira (2006), several studies highlight the need for formal involvement, but research on intervention programs targeting the health and wellbeing of old people in SSA is still scarce. She states that limited knowledge exists on the situation of old people in SSA and that studies typically have been small, piecemeal and uncoordinated. Efforts in collecting data have also been hampered by the unsuitability of Western standardised instruments for use in African settings (Ferreira, 2006).

According to the African strategic framework and plan for research (Understanding and Responding to Ageing, Health, Poverty and Social Change in Sub-Saharan Africa, 2005) research on ageing in African settings is still limited and carried out by a small and fragmented number of researchers or institutions. The complexity and diversity of familial caring constellations, socio-cultural, socio-economical and health-political contexts varies great within regions, countries and geo-political zones within a country. This challenge the generalisation of research findings and conclusions which have implications for the planning and implementation of health programs targeting old people living within different African contexts. Further research is needed to promote awareness, sensitivity, interest and engagement among those responsible for the planning of programs and the implementation of health services to also cover the needs of elderly people. Moreover, research should identify health policy options and implementation approaches involving all stakeholders, with particular focus on the representation of CDUs- and CBOs, informal caregivers, and elders themselves. Research should go beyond descriptions alone and towards a deeper analysis of the nature, causes and the implications of societal change by exploring structures, contexts and experiences of old people and its impact and implications for the individual, family and for societies. Future research should preferably, by considering such aspects, generate *"Africa-based"* contextual interpretations and theoretical perspectives on individual and social ageing that meaningfully addresses information needs and generate scientifically relevant insights to support and inform country specific policies on ageing (Understanding and Responding to Ageing, Health, Poverty and Social Change in Sub-Saharan Africa, 2005; African research on Ageing Network (AFRAN), Policy-Research Dialogue, 2008).

The Research Agenda on Ageing for the 21st Century (2007) is high-lighting similar issues to the above, where critical research areas in need of urgent attention involve: economic security; societal change and development; poverty; care systems; changing family structures; social participation and integration; and policy design, implementation, monitoring and evaluation. One of the key methodological issues in promoting research on ageing is participatory research in partnership with old people living in communities in order to supplement quantitative study results (Research Agenda on Ageing for the 21st Century, 2007 Update).

Within the above perspective, exploring the potential of Community Based Healthcare services to elderly Igbo people, complementary to that of family care, seem appropriate. Findings may considerably contribute to understand the health needs of elders and how these can be accommodated by joining community involvement with formal efforts in healthcare provision. As for now, Aboderin (2009) states that there is inadequate knowledge on the actual levels and patterns of intergenerational family support provided to old people, and also on how the existing levels of support relates to old people's actual needs. The results of my study may consequently provide health decision-makers with contextually sensitive and appropriate tools helpful in the designing of formal community health programs in accordance with normative traditions, culturally acceptable and in agreement with old people and their caregivers.

Up until today, most of the research on old peoples' health and well-being in Nigeria is conducted within the Yoruba speaking areas. The most important and comprehensive study may well be the Ibadan Study of Ageing (Gureje et al 2008). I have only been able to access a few studies conducted among the Igbo people, exploring factors influential on old people's experience of health and wellbeing. Some of the studies that explore areas associated with my research topic have earlier been presented in the literature review chapter such as Unanka (2002), Uwakwe et al. (2009), Chukwuani et al. (2006), Okoye and Obikeze (2005), and Okali, et al. (2001). My topic of interest and the aim of the study seem consequently to be justified also from a within-country perspective.

The contribution of this study for old people, old age health policy formulation and science

The contribution of this study provides stakeholders with knowledge on factors influential on elderly Igbo people's self-perceived health and wellbeing, and how family care-giving are perceived as health-bringing activities. This research further provide one with increased knowledge on the structural and socio-political environment at the study site that helps understanding challenges to familial care, based on the views of old people and opinions of other participants participating in this study. This study provides moreover specific insights into activities in health that by elders are assessed considerably helpful, normative and culturally acceptable in times of need, which moreover takes into account opportunities,

limitations and constraints for such activities to be accommodated within the recommendations of current health plans and health-political priorities.

This study informs health authorities and health political decision-makers on the ongoing societal transition and how it impacts on the health, needs, wellbeing and social security of old Igbo people. By communicating findings to health authorities and stakeholders, it may hopefully motivate those holding senior positions to consider the health situation of old people as important when developing strategies for healthcare deliveries in rural areas. It is a wish that the results of this study will increase the chances of old people to be included in the health political agenda and reflected in Community Based Health approaches, where Community Participation is accommodated, and where community members and health workers share mutual responsibilities in the provision of community healthcare to rural people, including those of old people.

Scientifically, this study provides one with improved knowledge on old Igbo people's need for suitable and culturally sensitive community healthcare services, complementary to that of family care. It does so by considering and analysing aspects that generate within country specific contextual interpretations and theoretical perspectives on individual and social ageing. The results meaningfully address information needs and moreover generate scientifically relevant insights to support and inform the development of an old age health policy at the Nigerian national level and to mainstream the needs of elderly people into other policies and plans, avoiding the *"add on"* syndrome. By acknowledging elders, taking into account their rights to equally benefit from public services in health, the outcome of this study may moreover motivate an interest to include the field of gerontology and geriatrics in professional medical- and nursing programmes.

4. THEORETICAL INSPIRATION AND CONSIDERATIONS

Modernisation and Ageing Theory vs. Material Constraint Theory

The *"Modernisation and Ageing Theory"* and the *"Material Constraint Theory"* (Aboderin, 2004) are the prevailing theories often reflected within this field and are commonly used in explaining the ongoing decline in family support for elderly people. During the reading and assessment of relevant literature and theories on ageing in SSA, I found myself to be inspired by the views of Isabella Aboderin (2004) where she questions the extensive use of these theories as frameworks providing meaningful understanding on the issue of ageing in SSA and on changes taking place within the area of family caregiving causing decline in family support to old people. In this article published in Ageing and Society (2004) pp 29-50, she argues:

> *"(...) in recent years, the "Material Constraints" notion has increasingly been cited in developing world discussions. Rather than an explicit critique of, or alternative to, the modernisation model, however, it is typically presented alongside, as a second (or the main) explanation for observed inadequacies in material family support for older people* (Aboderin, 2004).

According to Aboderin (2004), the modernisation model supports theories on ageing where a prevailing notion links the decline in family care to old people to normative change among the younger generation. As a result, old people experience their role and social status to be degraded, and the filial obligations of children to be weakened, reflected through changed attitudes, where the traditional involvement of sentiments between generations are found to be watered down and the strong ties previously existing between family members to diminish. This is reflected through the extended family system, now overtaken by nuclear family constellations. These changes are usually linked to – and explained by the increasing urbanisation and industrialisation taking place in developing countries fostering alternative ideas, where the younger no longer want to provide care for their older kin.

According to Aboderin (2004) however, the material constraint model aims to present theories based on the observed economic stagnation and increasing hardship people are facing within the context of which they live. The declines in customary care for old people are therefore not driven by normative, social- or cultural change, but rather by family

members' financial incapacities, and poverty. The absence of suitable pension schemes and social security systems only adds on challenges to old age life. The family consequently remains the primary source of support at old age where many, in spite of the hardships, continue to live with relations and with the broad cultural values of intergenerational support still intact.

However, Aboderin (2004) points to the limitation of each model and its incapacities to provide adequate explanations to material- and normative factors contributing to the decline in familial support for old Africans. None of the models incorporate alternative aspects, e.g. historical, in order to provide deeper insights into the dynamics guiding family care and its effect on elderly people. She is also of the opinion that both models fail in addressing and considering the inter-relationships between material and normative change.

By critically examining the content of both models, she therefore exposes both conceptual and epistemological limitations of the models. She furthermore claims that none of the models provides any substantial contextual understanding of the nature and causes of the many threats to familial support that in times of today considerably affects the life of old people. This is essentially because neither is grounded in evidence taking account of individual perspectives, meanings and actions, and consequently people's intentions, motives and relationship with the wider structural contexts. Such aspects have to be explored further in order to contribute any meaningful explanations of existing social phenomenon that affect the wellbeing of elderly Africans and consequently in the case of this study; also their health conditions. Aboderin (2004) therefore concludes that:

> *"(...) it is required to provide an interpretive understanding on the basis and patterns of old age family support in the relevant "past" and relevant "present" and to systematically compare the two within similar environmental contexts in order to provide a life course perspective base-line from which the development of new theories can build on- and be informed by"* (Aboderin, 2004).

Unanka (2002) places family support for old Igbo people within perspectives of their living arrangements, and health into a theoretical framework where he understands family support to be a reciprocal activity that can be explained by a *life-time intergenerational exchange/wealth flow model* where exchanging of wealth between generations, from parents to children, appear as exchange for care at old age. Based on such models, old

people are being cared for not as an act of charity but duty, and aging is a blessing. It builds on respect and honour fostering care. These theories may be interpreted as to support a structural-functionalist model of the motivational basis guiding family support for old people living in *"traditional"* societal contexts as presented in Aboderin (2004). Following Aboderin, she relates such understanding to explanations provided by the modernisation model which seems to form the basis of the theoretical perspectives on family care to old people presented in Unanka (2002). However, Unanka connects also the above reasoning to theories on *Old Age Security*, which emphasise the importance of having children in order to secure dignity and wellbeing at old age. These theories raise and discuss important aspects of socio-cultural traditions in societies where no formal social well-fare institutions or old age economic security systems exists (Unanka, 2002).

This study explores the situational realities of old Igbo people and how they perceive family care to meet with their needs for care and support and whether this has shifted over the years. It takes account of the wider social and normative contexts in which they live and aims to investigate and identify structural implications impacting families' abilities to care and support old Igbo people making formal interventions a complementary option. Many of the objectives of this study come to anticipate areas in need for further research, as communicated by Aboderin (2004) and Unanka (2002), and moreover reflected in the Strategic Framework and Plan for Research (2005). As modernisation- and material constraint theories provide different explanations on the many constraints affecting family care and support to old people in the developing world, both models agree that societies in transition impact the level of customary care currently rendered to old people in developing countries, where the concept Community Based Healthcare may represent a viable option to care and support, in a society where care givers finds it difficult to socially protect the elderly ones from suffering.

The next chapter is dedicated to the understanding of the concept Community Based Healthcare. I will present two models that originated from South Africa and India, and assess similarities and disparities between them. This includes looking into the intention of CBHC, to consider factors viewed as essential guiding the implementation of CBHC activities and to assess its conceptual relevance to the topic under study.

Community – Oriented Primary Care vs. Community- and Home Based Health Care; two conceptual models from respectively South Africa and India

In 1940, Sidney and Emily Kark travelled to live and work in the Zulu tribal reserve called *Pholela* in the province of Natal in South Africa. On this location they set up a system of health service deliveries, *Community-Oriented Primary Care (COPC)*[5], for a population that previously had received little benefits from Western medicine. COPC as a model facilitated for practicality through the cooperation between public health strategies and primary health deliveries, and principles through community participation in health care decisions. The linking of public health with COPC was assessed to considerably strengthen health promotion and disease prevention, consistent with later PHC concepts. The process of COPC entailed six elements including: community definition, community characterisation, prioritisation, detailed assessment of the selected health problem, intervention, and evaluation. The process could be assessed as a cycle of strategic activities (Mullan and Epstein, 2002).

According to Mulland and Epstein (2002), a major barrier to the implementation of COPC activities is the component where health activities are initiated based on perceived health needs in local communities. These can be considered to not necessarily be required when assessed within perspectives of traditional standard of care. Community initiations may consequently foster financial implications where commercial and pro-profit health service providers reject such initiatives. Formal public health service providers may be receptive to such a strategy, due to their fixed budgets, which at least include social aspects and community involvement processes.

After assessing both practicalities and principles of the concept COPC, I found such strategy to be supportive to- and in accordance with one of the key strategies outlined in current Nigerian health plans (WMHCP 2007-2012; NSHDP 2010-2015), where community participation, self-assessed health-needs and ownership is emphasised. However the implementation of COPC may be challenged due to the fact that more than half of all health

[5] Community-Oriented Primary Care (COPC) is defined as a continuous process by which primary care is provided to a defined community on the basis of its assessed health-needs through the planned integration of public health practices with the delivery of primary care services (Mullan and Epstein, 2002).

care facilities at the primary level in Nigeria is private, donor- or NGO/CBO/FBO driven, running *"stand alone"* programs, and pro-profit oriented. However, COPC has the potential of being a sound instrument enforcing quality management and transparency in healthcare provision. It could, with some contextual adjustments, easily be integrated and further developed into local primary healthcare structures at the study site, and as such be sensitive to cultural contexts and the health needs of rural people, including those of old people.

A *Comprehensive Community- and Home-Based Health Care Model (CCHBHC)*[6] was developed in India in 2004 by people assigned to work at the World Health Organisation's South-East Asia Regional Office. Based on changes in epidemiology and demography, including increased life expectancy and an ageing population, the recognition of changing health-needs in the population led to the development of this model. By acknowledging informal caregivers and the care they provided to people in the community, they identified an unutilised resource group that could extensively contribute to strengthening the healthcare provisions for people if they were supported and integrated into local healthcare structures and programs. The philosophy behind the development of this model was threefold: to initiate a holistic approach in healthcare, to extend such approach beyond healthcare facilities alone, and thirdly, to shift focus from curative care towards health promotion and protection. The aim was to meet local needs as agreed with communities. Principles were rooted in quality; partnership; equity; effectiveness; and efficiency. In order to anticipate such principles, action was taken in order to involve all stakeholders and call for political commitment and support ensuring the practical implementation of the model. Practical strategies involved to mobilise and manage resources, building on the existing system, and finally to develop and implement appropriate health information systems (HIS) (World Health Organization Regional Office for South-East Asia, 2004).

As a conclusion, both models encourage bottom up approaches rather than top down, but the latter model may reflect approaches to be implemented in a more structural manner consistent with health priorities outlined by international organisations and agencies, such as WHO and UN, in line with current health plans in Nigeria. However, both models give

[6] A Comprehensive Community- and Home-Based Health Care Model (CCHBHC) is defined as an integrated system of care designed to meet the health-needs of individuals, families and communities in their local settings (World Health Organization Regional Office for South-East Asia, 2004).

opportunities for sound health systems development of rural areas which realistically open the possibility of exploring the role of Community Based Healthcare strategies in the care and support of elders, (which in this case involves old people living in rural Imo State of Nigeria).

5. METHODOLOGY

Introduction

This study is explorative and descriptive. An *abductive* theory of scientific method is attempted, where some structure is applied through the introduction of certain themes by asking semi-structured open ended research questions. I decided such method to be most suitable as it allowed me to go beyond predefined thematic ideas and assumptions, coloured by personal experiences, knowledge and philosophies, and rather be open to- and pursue new emerging themes of importance facilitating for the establishment of contextually-based data patterns.

Hernandez (2009) refer to phenomena as objective, stable features of the world, while in contrast data is ephemeral or short lived, pliable and context dependant. As such the latter can be attached to Aristotelian philosophies of *"Virtue Ethics"* and introduction of the concept *"Phronēsis"*[7]. Phronēsis can be understood as *"practical wisdom"*, relevant to bear in mind when attempting to apply the above mentioned methodology. The relevance of Aristotelian philosophies to this study has its origin in the ancient time of Greek Philosophy, where Aristotle challenged Platonic ethics. He disagreed in Plato's assumption that ethics in most aspects could be guided by a set of rules and laws, applicable to situations that occurs in a society where people live and perform their daily duties. Contrary to Plato, Aristotle argued that practical action often is uncertain in its results because people are vulnerable to forces present in their environment which may be uncontrollable. However, he supported the idea of having principles as rules of thumb, but was of the opinion that rules rarely give specific guidance to action. He further believed the consequences of our actions to be highly unpredictable because of the circumstantial influences of society in which one act. Contexts becomes as such determinant for the outcome of our actions, as each context represents a particular or unique situation. Aristotle emphasised therefore on the importance of gaining knowledge of the environment and the particular context in which one act in order to strengthen one's ability to engage in contextual reasoning (Mattingly, 2005; Kvale and Brinkmann, 2009).

[7] **Phronēsis** (Greek) is an ancient Greek word for wisdom or intelligence. In Aristotelian Ethics, Phronēsis is distinguished from other words for wisdom, as it reflects the virtue of practical thoughts, commonly referred to as "**practical wisdom**".

Based on the principles of Aristotelian philosophy, one has to be aware of one's own pre-understanding of people and environments as people's responses to any situation can be understood as reflecting cognitively constructed realities, with their own associated properties, characteristics, and meanings (concepts), based upon its co-existence and integration of any context. This becomes particularly important when drawing conclusions from dialogues with study participants as it challenges one's ability to see and describe events in their value-laden contexts and judge accordingly. From this, responses from participants have to be considered as reflecting cognitively perceived realities at a specific point, which at the same time are originated from the cultural and social construction of societies in which they live, act and interact, built and guided by norms, values and traditions, and formed over decades. Then the ability of the researcher to engage in contextual methods of reasoning becomes important when conducting research because one's ability to capture the pliability of data provided from participants and to place them into existing contextual settings has implications for the final results and conclusion of a study. This becomes considerably important in order for results to be comparable and applicable to other settings reflecting similar realities and contexts to those of the study site.

Applying a qualitative research design

I considered a qualitative research design to represent an appropriate strategy exploring the topics of this research project. It would allow me to use methods bringing me in close contact with the research participants in their natural settings, important in order to gain a deeper understanding of locally occurring phenomena and through such understanding give priority to its meanings according to the perceptions and opinions of participants. I saw this as a great opportunity to explore contextual specific data patterns and how data consequently could contribute to answering important research questions. It would moreover provide me with contextual knowledge complementary to existing information on the topic under study, helpful during the analysis of data.

The further benefits of applying a qualitative design was expected to give opportunities of accessing areas not easily accessible in quantitative research, and its methods suitable investigating areas that previously has received little exploration or attention, such as my topic under study. Techniques commonly used are observation (participant, partly

participant or non-participant), in depth interviews, FGDs, consensus methods and case studies (Pope and Mays, 1995).

An essential characteristic of a qualitative research design is the inclusion of a relatively small number of participants, and Silverman (2008) suggests that qualitative researchers are prepared to sacrifice scope for detail. The selection of participants to my study are consequently purposive but also twofold, as I wanted to identify groups of participants that on one hand had specific experiences relevant to the topics under discussions and on the other hand access those that could provide additional knowledge on aspects influential on such experiences, which could serve as explanatory and comparative to the perceived realities of the former groups of participants. I was aware that the above selection technique could sometimes lead to the changing of size samples during a study due to incongruent information, or the emerging of new issues that need to be pursued further.

In qualitative research, the validation of results is essential. In order to increase the validity of this study I decided to combine several methods through triangulation, and also to re-examine tentative results by returning to participants to validate my perception and understanding of a certain topic under discussion. The process could therefore be assessed as a dynamic interaction between the different phases of the research process. Silverman (2008) argues the importance of scientifically demonstrating that the chosen methods applied during the entire research process are used appropriately in order to strengthen the validity of final conclusions.

Qualitative research design can be applied as a *"stand alone"* design, or as complementary to quantitative research (or the other way around). Pope and Mays (1995) states:

> *"Where qualitative design is applied exclusively, it can be of great value especially related to health service research in times of policy and organisational change, because it allows the exploration of private views of decision-makers, professionals, managers and patients and moreover allows the researcher to get behind participants formal public statements and behaviour and thereby uncover personal perceptions, meaning and actions"* (Pope and May, 1995).

Consequently, I will be accessing the specific reality and experiences of a research participant by applying various methods. However, it is important to bear in mind that any

method has its ethical implications which continuously has to be considered and decided on along the entire research process, in order to be sensitive to people, contexts, norms and situations.

The selected tool-kit; Focus Group Discussions, Interviews, Non-Participant Observations and Informal Conversations

In my research proposal, I suggested my chosen tool-kit to comprise FGDs, interviews, non-participant observations and informal conversations. After arriving at the study site, I continued with my initial plan, as the combination of methods seemed suitable acquiring in-depth understanding of the topic under study and provide answers to important research questions.

Focus-group discussions (FGDs) and interviews allow one to access how participants view their world within a specific cultural, normative, social, and political context (Hennink, 2007; Silverman, 2008; Ryen, 2006). I decided to apply both methods due to the contrast between them. FGD seemed to be the most suitable method seeking a range of views on a topic, evolving from discussions among people sharing some similar characteristics. I assessed the method to be particularly useful in collecting community information in contrast to interviews, where individual perceptions of an issue are more focused on. I hoped a discussion setting would facilitate gain for information on social behaviour, cultural values and practices, and also general community opinions. Moreover, by supporting the dynamics of a group discussion I wanted to facilitate gain for the evolvement of unexpected issues to emerge and to encourage further elaborations on these issues among group members.

In contrast to FGDs, interviews are personal conversations with a purpose, where the perspectives of the participant would help understanding individual experiences and perceptions related to their life situation. I assessed interviews as particularly suitable when exploring issues of sensitive and complex nature which in a group setting most probably would remain unexplored. Face to face communication would therefore hopefully gain opinions, where the past and present experiences of the participant would help me in conceptualising and place social- and cultural life experiences, including inter-human relationships, into a wider context which consequently would foster increased

understanding and in-depth knowledge of the topics under study (Silverman, 2008; Ryen, 2006).

Non-participant observation is a method useful to complement information obtained through interviews and FGDs (Fangen, 2008). It is particularly suitable in the observation of human expressions, body language and other non-verbal communications occurring when interacting with participants and people in general, essential when analysing information given at a later stage. I furthermore assessed non-participant observation to contribute extensively to my understanding of social processes and the behaviour of participants in their local environment. It would as such contribute in improving my conceptualisation of the study site at large and give valuable additional information helpful during the analysing processes.

Apart from the above methods, I decided to use any opportunity occurring to have informal conversations with people in general. Its importance was related to the collection of contextual information which could be historical, political, religious, cultural, social and economical sensitive to the study aim and objectives. I considered such information to be important and to add on to my present knowledge of the topic under study and as such contribute to improved socio-cultural- and political reflexivity when meeting with people in general and study participants in particular.

The next chapters aim at presenting the study site, people who helped me during the research process and participants participating in this study. I will highlight strategies and processes decided on, and ethical challenges and considerations made during the field work. The learning process was steep, and included adherence to cultural contexts and codes of conducts different to those familiar to me. This journey both challenged and tested my organising skills and my ability to engage in contextual reasoning. To illustrate the processes undergone in the field, and to bring the reader closer into the local contexts of the study site, I have decided to include some of my field notes and to describe realities by the telling of short stories when finding such appropriate and informative.

The journey

Introduction to the study site

This study was implemented in one rural Local Government Area (LGA) in Imo State of Nigeria. Imo is located in the South-Eastern part of the country, and consists of 27 LGAs with a total population of 3.927.563 people. The LGA in mind has 130.575 inhabitants, residing in several villages and towns, with an estimated population aged 60-64 years of 4.2% and an age-group 64+ of 9.5% (Nigeria National Bureau of Statistics, 2009). The inhabitants of Imo State consist mainly of Igbo people speaking different Igbo dialects, though English is the official language in Nigeria spoken by most people. However, old people with no formal education may only speak Igbo.

The LGA in mind was mainly chosen due to my knowledge of the district through previous visits and my attachment to the area through my life-partner, who is an Igbo man born and breed in one of the villages included in this study. During my visits over the years, I have become aware of an ongoing societal transition affecting rural areas impacting traditional family constellations. I experienced such to be influential on the caregiving and the support old people receive which consequently put their wellbeing at stake. The idea of exploring this issue further has therefore emerged gradually until I finally found myself in a position where I could carry out this project. The matter is of great concern as I have observed old people facing an increasingly troubled situation, accelerating over time. This project has therefore come to represent my contribution to a scientific field which can be assessed as under-prioritised, and as such received little attention at the health political arena, nationally and internationally.

In order to limit the possible biases of my familial attachment to the village, I decided to include another two villages located within walking distance to the village mentioned. There were unfortunately no accessible statistics on the proportion of elders in the population of these villages, so I was left with the estimations referred to above.

The three villages of the study site were located approximately an hour drive (using public transport) from the state capital Owerri where I was advised to base. Owerri was considered to be most convenient in regards to the availability of general amenities and services, and importantly; security. The latter was a matter of major concern throughout my stay, and I was continuously reminded about this aspect which included the risk of kidnapping. This concern resulted in limiting my access to cultural events taking place at evening time, as no

one was willing to accompany me after 7 pm. Even my *tuc-tuc* driver cautioned me when I sometimes arrived back from field work at late hours.

In spite of the distance from Owerri to the villages, I was able to access the study site by public transport on daily basis, and I considered the travelling time to not constrain the progress of the field work.

Figure 6: My tuc-tuc driver. Photo: Heidi Olsen

Getting settled

As stated earlier, I was fortunate to connect with an already established social network at the area of the study site, where some of my friends and in-laws also resided in the state capital Owerri. They helped considerably in facilitating practicalities and connecting with people at the Medical Department of Imo State University before my arrival. They were available and supported me continuously throughout my stay, and contributed extensively to the successful implementation of my research project by providing practical guidance and assistance, and company in times of need.

I arrived at Owerri, the state capital of Imo State, 6th Sep. 2011. After a 10 hours journey by bus, from Lagos to Owerri, I was met by friends at the bus park. I planned to stay three months, which I believed was sufficient in order to accomplish the data collection phase and initial analysis of data. Further analysis and the writing of my Master Thesis would continue after returning to Norway, resulting in a final report, originally planned to be submitted before June 2012.

The process of finding secure accommodation for this period was problematic, but solved with the help of my brother in-law and other helpers before my arrival to Owerri. Their efforts included securing a leasing contract, renovation of a small house, installing electric cables and the digging of a new soak pit.

After arriving I spent the first couple of weeks solving practical issues involving the furnishing of my new residence and purchasing some basic necessities such as a generator, fridge and water containers. I had to check access to- and means of public transport, access to safe water, the security systems within the estate I lived, and to establish an academic contact network etc. apart from getting started with the main purpose of my visit: conducting the study. In order to accomplish my mission in the field, I immediately started preparing a preliminary work plan. By continuously considering and adding new work tasks into the plan, this helped me to stay focussed and structured throughout my stay in Imo State.

Figure 7: My new home for the next three months. Photo: Heidi Olsen

Connecting with an academic network

I had already before leaving Norway tried to establish contact with the Imo State University, by sending an introductory letter to the Pro-Chancellor where I informed about myself and the study. The introductory letter included also an enquiry appointing a co-supervisor. After a long and complicated process, I finally succeeded by the help of friends to establish contact with the acting Dean of the Medical Dept. of Imo State University. When having our first meeting, he told me that he already had facilitated a contact at the Imo State University Teaching Hospital in Orlu through the Provost, Prof. Jiburum. After a quick phone conversation with Prof. Jiburum, he scheduled a date and time for a first meeting.

When arriving at Orlu, I was welcomed by Prof. Jiburum and a small delegation of doctors. After a short introductory meeting, I was introduced to Dr. Diwe who was holding the position as Head of Community Department. He had been appointed as my co-supervisor, and I was informed that he would be available and to my assistance throughout my stay. We developed a fruitful and friendly relationship, and met regularly in his office at the University Teaching Hospital every second Friday.

Figure 8: Dr. Diwe, his wife and I. Enjoying our meal. Photo: Hyginus Eze

Establishing a research team

Before leaving Norway, I had decided to appoint and train one research assistant sensitive to the socio-cultural contexts of the study site. His or her help was considered to be crucial especially when conducting interviews and FGDs with Igbo speaking participants. Additionally, I considered assigning an interpreter who could assist translating during meetings and interview sessions conducted in Igbo. However, the latter assignment depended on whether the cost involved was manageable within my limited budget.

I started preparing the appointment process before leaving Norway by writing an advertisement and sending it by e-mail to a contact in Owerri. The distribution of the advert was done with the help of in-laws and friends, who posted it at strategic places.

Notes Sep. 16;

> *I am thinking about my advertisement for a research assistant and whether the requested skills will meet with my need for human qualities and preferred skills. In retrospect, I found my ad to be too academic and not attractive to people with the right attitudes, interests and motivation from which I and the topic under study could benefit from. This is really a concern and I know it will be puzzling my head until solved and settled.*

My concern on the issue arose due to a comment made by my co-supervisor Dr. Diwe, who earlier that day had emphasised the importance of a research assistant's local language skills and moreover his or her cultural sensitiveness to people and traditions at the study site. This made me to search for guidance in Monique Henning's book on International Focus Group Research (2007) where in the chapter *"Recruiting a field team and selecting a moderator"* she highlighted some ideal characteristics of a moderator.

My initial advertisement had provided me with 5 applicants. I was now sitting assessing their qualities and interest in the position, and comparing these with the recommendations of Hennink. Apart from one, they were all focusing on their academic skills, experiences working with NGOs, and prospective opportunities for high salaries. Only one stated a particular interest in the topic under study and knowledge of qualitative research methods. I decided therefore to post a new advertisement, reflecting Dr. Diwe's advices and recommendations. In this ad, I particularly encouraged women to apply, as all the current applicants where men only.

I realised the language skills of a moderator to be crucial, especially when developing the thematic question guide and translating it into Igbo. I was also concerned about the managing of focus group discussions, where the discussions were to be conducted in Igbo. This would make me considerably dependent on the research assistant's sensitivity and ability to capture the essence of a discussion combined with his or her knowledge and understanding of the local dialect spoken at the area of the study site. This was particularly important in order to ensure a mutual understanding of terminologies and concepts used in discussions and conversations.

The second attempt did not give any result, and I was left to appoint one of the applicants from the first round of interviews which during the research process proved itself to be a fruitful decision. By his humble personality and quiet sense of humour he possessed all the qualities required and contributed extensively to the successful implementation and accomplishment of the study.

After successfully assigning the research assistant, I got the opportunity to be supported by a person willing to act as an interpreter. Later experiences revealed his extensive capacities as a door-opener into the communities. This person was a member of my family in-law, a wise and knowledgeable person who assisted me considerably throughout my stay. His knowledge of socio-cultural structures existing in the villages, guidance in code of conducts and information of whom to approach in order to rightly access local communities was of extensive value, as it prevented initial mistakes and saved time. In addition, his advice and in-depth knowledge of the area assisted with introducing the study to community members in an appropriate manner which secured the implementation of the research project. I was aware of the possible bias having an interpreter with close connections to people in the villages, and approached such challenges by repeatedly communicating- and conversing on ethical principles guiding research projects, to him and also the research assistant. Both signed a declaration of confidentiality before proceeding with their tasks.

Figure 9: The research team on its first mission. Photo: Heidi Olsen

Developing the thematic interview guide

I developed the thematic interview guide in close collaboration with my research assistant. It was later presented and explained to the interpreter. The guide was inspired by McCracken's recommendations of conducting long interviews (McCracken, 1988). The thematic guide consisted therefore of two parts where the first part focussed on the background, and past and present situation of each participant participating in FGDs and interviews, relevant to the topic under study. The second part addressed commonly used concepts aiming to reach inter-subjectivity between us on the understanding and meaning of *"old", "health", "ill-health", "healthcare", "family support" and "health system".* The guide further addressed selected themes on issues that were to be further explored and discussed in order to properly address and anticipate the study aim and objectives. These were introduced to the participants through open ended questions (ref: Annex 4).

Each interview guide was adjusted to accommodate the role of specific groups of participants (receiver/provider of support, care, services etc), but they were identical in terms of thematic issues. My aim including comprehensive background information from each participant was mainly to assess and compare data evolving from thematic discussions with information given individually. I considered such approach to increase the quality and validity of the overall information provided by participants.

Our plan was therefore to separately conduct a short interview collecting background information from each participant that chose to participate in FGDs. This decision was taken in order to adhere to principles of confidentiality of private past and present life situations that did not necessarily have to be shared with other focus group participants. We also considered the comfort of each participant to be better accommodated in a one-to-one situation which hopefully facilitated trust and openness between us. In regards to the participants participating in interviews, gaining background information was included in the initial part of the interview. In spite of its contribution to the study, revealing such information was of course based on each participant's willingness to voluntarily share private life events with us, and we would therefore continuously inform them about their rights to abstain from answering all- or some of these questions.

Before approaching any prospective participants, I also developed a short guide to be used as a thematic reminder when having conversations with people holding key positions in the local community or within the health system. This guide included some brief biographical data such as the position/role of the person, and some thematic issues to be discussed relevant to the person's position and role in society, and the objectives of the study.

All background- and thematic questions were prepared in an English and Igbo version. The invitation letter to the study and the consent form prepared at an earlier stage, were also translated into Igbo in order to accommodate participants preferences. After accomplishing the above tasks, we prepared sufficient copies of all the documents, and were ready to approach the field.

Implementing a research project into local communities

Notes, Sept 22;

> *I'm sitting thinking about my conversations with the interpreter and research assistant on how to best introduce my research project to the communities. During our conversations, I have learned this to not be a straight forward act, but rather an act that have to comply with certain socio-cultural and structural procedures, involving and including people considered as influential gate-keepers. The next couple weeks are certainly going to be challenging. Will the community leaders accept me, an outsider? Or will my attachment to the villages through my life partner be of any help, but at what price? Are they at all interested in having a research project implemented at their door steps, and would they accept the topic to be studied within their local environments? These questions are puzzling my head this late evening.*

Through my conversations with the interpreter and research assistant, I learned that the 3 villages selected were located in the same district but in two different autonomous communities, each governed by their respective Eze (king). I was told that the Eze most certainly had to be approached and informed before my entering into any of these communities as he had to give approval for the study to be conducted in his area of *"governance"*.

I raised the question of whom to approach next after hopefully getting approval from the Eze. This question brought about heavy discussions on whether to visit the traditional Chiefs or the Chairmen of the respective villages. It developed to involve arguments with my life-partner in Norway through an extensive exchange of text messages. He resolutely said that the Chairmen were the appropriate men to approach, not only in seeking approval but also

in regards to their abilities to act as facilitators for the project to be introduced to the communities. We finally decided to double check on these issues with other matured members of the communities at the study site before proceeding further. It turned out to support my life partner's arguments.

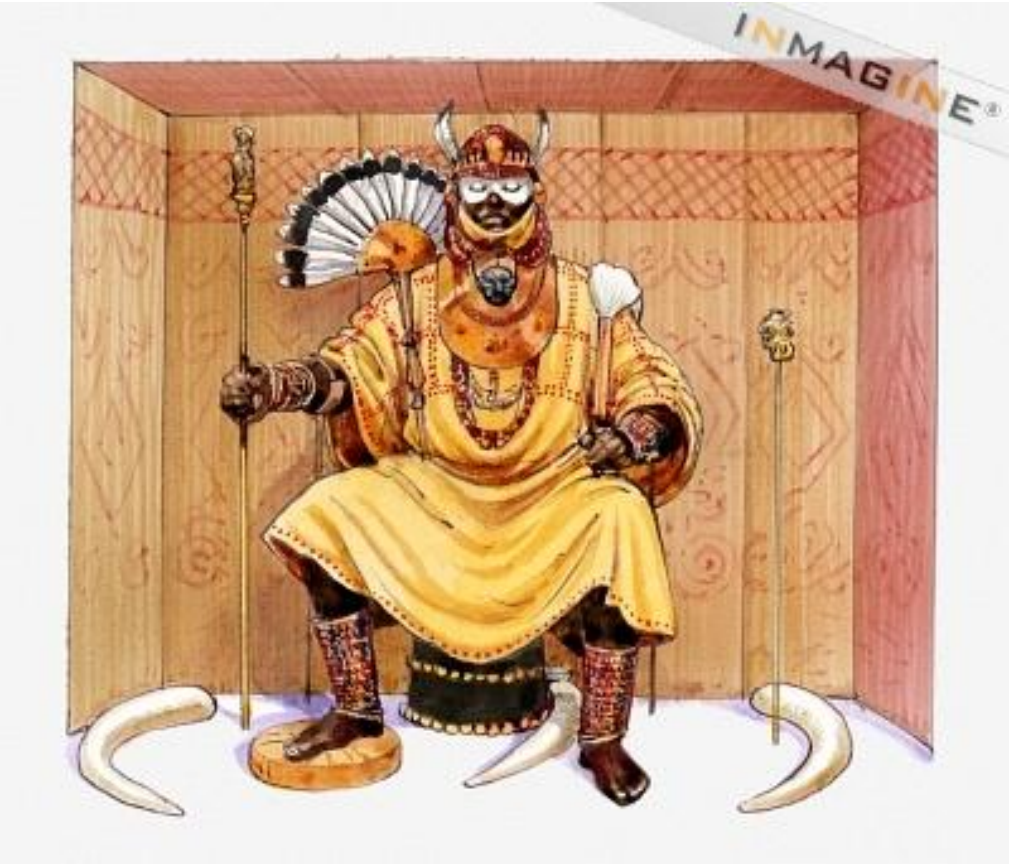
After solving the initial difficulties, we were finally able to schedule meetings with the two Eze. Fortunately, both of them approved the research project to be implemented within their respective areas. They anticipated the problem under study as relevant and important, and were both informed about the study aim, methods, benefits and that confidentiality would be ensured for those participating.

After getting approval from the Eze, we approached the Chairmen. They were easily accessible, and scheduling for individual meetings was not a problem. The only question asked was if the two Eze were informed and whether they approved. After clearing this issue they suggested to call for community meetings. They saw this as essential in order to sensitise and inform other community group leaders and villagers in general on the prospective implementation of the research study. They offered their help facilitating such meetings to take place at their respective Village Halls.

When planning for community meetings with the Chairmen, we discussed the importance of conducting such meetings in accordance with customs and normal practises. We agreed therefore on buying kola nut/bitter kola, garden apples, cabin biscuits and palm-wine, to be served at the meetings. Adhering to traditional customs was particularly important to us in order to avoid prospective expectations from study participants that conflicted with ethical principles of conducting sound research.

While discussing practicalities of the forthcoming community meetings with the Chairmen, some asked if they could participate in FGDs, as they saw themselves falling into the group of mature people. I somehow expected this question to arise. I explained the unintended effect of authority persons to participate in group discussions and mentioned that their contributions to a discussion sometimes could prevent other group members from sharing their views and opinions in a free and open manner. However, I promised that there would be opportunities for separate conversations later, which they all accepted.

The research assistant, interpreter and I had now used the last 3 days un-locking doors accessing the communities. Everything was set for community meetings to take place the coming week. I had worked closely with the research assistant in order to prepare the information to be given in a simple manner that hopefully would capture the interest of villagers and generate prospective study participants. During our discussions, we saw the forthcoming community meetings to give opportunity of sensitising community members on the topic under study, to give clear information about our intentions and to clarify what to be expected from my visit. In order to achieve these tasks, we decided to give the information verbally in English, where the research assistant simultaneously translated my presentation into Igbo. I reminded myself to use an informal tone and simple words in order to allow dialogues and questions to be asked. Before entering into my mosquito doom that night, I added some additional points to my notes in order to remember to ask the Chairmen to explain the structures of each village.



Traditional image of an Igbo Eze
Ref: *http://images.inmagine.com/img/aspireimages/drk003/drk003680.jpg*

The process of selecting and inviting participants

The scope and nature of this study is as stated in the introduction threefold. The scope influenced the selection and inclusion of participants in order to properly address and explore issues related to the topic under study. In order to anticipate the intention of my study, I decided the invitation processes on one hand to include accessing people holding key positions in the local community and within the health system, willing to provide quality information, and on the other hand access information, experiences and stories from old people and informal caregivers living in the villages.

Selecting participants for FGDs

I decided to conduct 3 FGDs including 6-8 old people in each group, one FGD with female participants, one with male only, and one mixed. My purpose was to validate data, and prevent one sex to dominate the other, and moreover to compare data from the homogenous groups with the heterogeneous one (internal validation). Participants should preferably to be of the age 65+, but during the selection process I found chronological age to not necessarily be determinant in describing the concept *"old"* among the Igbo people. I ended up therefore selecting those whom by physical stature looked as an aged person combined with those whom in virtue of their perception characterised themselves as *"old"*.

In the process identifying old people as prospective participants in FGDs, I had initially planned to ask the traditional Chiefs and the leaders of Women Groups to identify the oldest people in the village, mentally and physically capable of participating in discussions. Based on their recommendations, wanted to visit old people, introduce myself, the study aim and to clarify expectations related to their participation. Based on their responses and my own assessments, I would invite those willing to participate in focus group discussions. Their selection could therefore be assessed as purposive, though their educational, familial and socio-economical background was to be considered before final inclusion in order to minimize selection bias.

However, we immediately learned the differences between theoretical planning and practical realities.

Notes on Sep 30; Supervision with Dr. Diwe.

> *Advise on the selection of older participants; we are advised to make our selections in the village by approaching different kindred to avoid picking participants form the same family. Hmmm… this is going to be more complicated that initially planned……*

Based on the recommendation from Dr. Diwe, we asked the Chairmen to draw a map of each village. One of the maps came out particularly specific due to this Chairman's extensive knowledge of the village and its historic settlement of people. The mapping was accompanied by an interesting cultural-historical lecture. While drawing, he was pointing out the various kindred and their names to us, and we saw immediately that kindred with identical names were found at different locations in this village. The Chairman explained this to be due to ancient times when people fought war with other communities. When men from one kindred won a battle, they would settle with their families at this site and kindred with the same name had therefore come to be found at different locations around this village.

He continued explaining using his village as an example; […] Village consists of 4 different kindred. The name of each kindred has originated from the first person that settled within the area. *"Umu"* mean children of […]. This […] has 4 *"children"* that makes up the 4 kindred.

Within each kindred, there are numerous families living. In this area the norm is usually to live in clusters of three to six houses located within a compound hosting a family. Each compound is traditionally headed by an elder *"the father of the compound".*

We agreed on the importance of mapping as it led to increased understanding of resident patterns which consequently could guide us in the selection of participants. It considerably helped us to avoid selecting participants from the same compound and family. Based on information given by the Chairman, we decided to select two participants from each kindred, which according to him also reflected how representatives were selected into the Village Council.

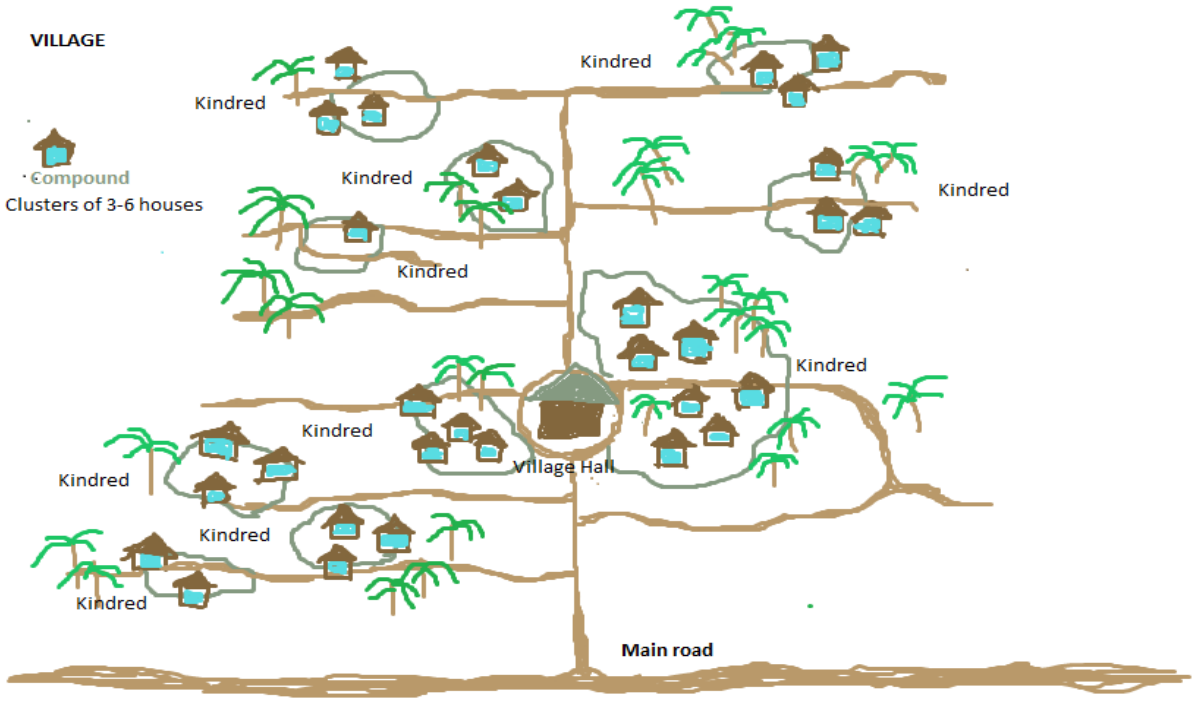


Figure 10: Example of structural resident patterns in a village.

We decided to select eight old women for participation in FGD in this village. The decision of selecting women was based on observations from the community meeting held earlier. During this meeting, women were seated at the back of the Hall and men in the front. Responses from community members were mainly from men, and they played a more active role asking questions than women. We decided therefore to account for the voices of women to be heard in this village.

The composition of participants selected for the other two focus groups was based on similar observations obtained during community meetings. We finally ended up with the following groups consisting of:

Village 1: *eight old women*
Village 2: *six old men*
Village 3: *five old men and three old women*

To differentiate each participant in a village from those of the other two villages, and moreover to ensure confidentiality, we coded their identities. Participants participating in FGDs will therefore be referred to according to the following codes; P1V1 which refer to participant 1 in village 1; P3V2 which refer to participant 3 in village 2 etc.

Selecting participants for interviews

Notes on Oct. 15:

> *During our selection of old people for participation in FGDs we have become aware of different caring constellations where some elders stay with a hired helper, others with daughters in-laws and daughters, and some alone by themselves. When selecting and inviting informal caregivers for interviews, we have to attempt this variety to be represented among these participants. Ok, just another challenge.....*

Apart from anticipating the above intention, informal caregivers were selected based on recommendations and the *"snowball"* effect of our walks and talks with people in the villages. They were as such both purposely and randomly selected. However, one criterion for their inclusion in this study was their responsibilities for old family members in terms of support and care in daily activities and in times of ill-health.

We finally ended up conducting interviews with five informal caregivers representing:

One wife
One daughter
Two daughter in-laws
One hired helper

They were about equally distributed between the three villages of the study site and were coded into respectively; CT1-CT5 with additional references to their village of residence. Consequently, an informal caregiver would be referred to as: CT1V3 referring to an informal caregiver residing in village 3.

We approached formal caregivers by visiting the public health centres/clinics nearby, private health facilities existing within the LGA, and also the Community Department of a tertiary level Hospital within the State. A criterion for the inclusion in this study was their knowledge- and experience of providing community health services to rural people. Eight formal caregivers finally agreed to participate in this study. They consisted of the following people:

Two community doctors
One traditional practitioner
Four nurses of which
Two worked as community nurses;
One worked as a HIV/AIDS community consultant and
One was in charge of a technical nursing education programme, training young women and men as community nurses
One social- and development worker

They are coded as CT1-8 formal, and referred to as e.g. CT4 formal. I have decided to refer to their profession when quoting as I want their opinions and experiences to be attached to- and understood in virtue of their various roles as healthcare providers. I find this to not conflict with the ethical principle of confidentiality.

Selecting participants for "informal" conversations

As we proceeded initiating the study, what was meant to be informal conversations turned into semi-structured conversations with a purpose involving seven key persons from the villages of the study site. All key persons from the villages were leaders of various community groups and association ties except from one, and consisted of:

Three Chairmen
Two Chairladies
One Leader of a Youth Group
One Traditional Prime Minister

They are coded respectively as K1-K7 and a reference to a village added. As such key persons are referred to as e.g. K1V2 referring to him or her as a key person with reference to village 2. Also in this case I have decided to refer to their role when quoting as I want their opinions and experiences to be attached to- and understood in virtue of their responsibilities as community leaders.

Finally three government representatives from two different levels of government agreed to participate in this study. They were all approached through our visits to their offices. Two of them were assigned to positions within the PHC system at the State- and LG level, and one was holding a key position at the State health governmental level. Informal conversations were conducted in a rather structured manner and issues of relevance to my topic under study extensively discussed.

I considered some delicacy to be attached to some of their opinions and elaborations on certain issues. Based on my considerations as regards to possible prospective reactions on their contributions to this study, I finally decided to code their representation as G1-G3. However, their attachments to the level of governance are referred to when quoting.

I missed out on having informal conversations with healthcare providers from NGOs, CBOs and FBOs involved in health projects in the area, and moreover representatives from health development committees and boards. This was mainly due to their non-existence in the area of the study site, but also due to time constraints which prevented me from searching for such structures in other nearby areas. Limited time constrain also prevented, to some extent, the follow ups and return to pervious participants to further explore or confirm new information. However, I managed to return to some of the participants, who consequently contributed to clarifying issues in a more detailed and elaborative manner.

Conducting FGDs and interviews

All FGDs were conducted in Igbo and took place at the Village hall, whereby the Hall was nicely prepared by most Chairmen. Discussions were moderated by the research assistant, while the interpreter and I were seated at the far end of the table taking on an observing role, only intervening when necessary. We were happy that the selected participants were able to attend the group discussions. In this area, there are four market days in a week, and we had in advance planned to not interrupt with important activities carried out on these days, a decision that contributed extensively to secure the attendance of participants in all three FGDs.

When the first FGD was about to start the old women came dressed up, arriving one by one. Some alone, and some accompanied by a younger female. Relatives left before the start of the discussion and would come back after a couple of hours bringing the old ones safely back home.

Before the start of the discussion a prayer was said. I thereafter distributed bottles of water. The research assistant opened the meeting by reminding the participants why we were gathered and the overall aim of the discussion. He started by letting everyone introduce themselves and continued addressing the first topic. Throughout the entire session, he was

managing the discussion in a sensitive and polite manner and was observant to include- and encourage everyone to participate. Consequently, all participants gave their contributions to the discussions, but the "younger" ones had a tendency to speak longer and more frequent than the oldest. We tried our best to level this tendency without pushing. The interpreter was simultaneously translating in my ear, and I intervened only when discussions were taking a direction not relevant for the topic under study.

During the FGD I reflected on the group dynamics and was thinking that it came to represent a group interview more than a discussion. This may have been due to our request of having only one person speaking at the time which was adhered to, but impacted also on the flow of discussions. This made us reconsider this aspect in the following FGDs. Moreover, when addressing concepts in the initial part of the discussion, thematic issues to be introduced later were brought up- and elaborated on. Participants were therefore a bit confused when themes already discussed were re-introduced later. I solved this by advising the research assistant to be flexible and explore topics as they came and to not be too concerned about following the thematic order of the discussion guide.

Acting as an observer, and not controlling the dynamics and progress of discussions was a challenge. It basically meant that I had to trust the research assistant's skills as a moderator and his perception and understanding of the study aim and objectives. It further included his abilities to guide discussions in a manner that would provide answers to the research questions. We therefore spent some time evaluating the outcome of the first FGD, quite valuable as we improved considerably in the next FGDs.

Apart from the above aspects, the first FGD was carried out the best we could at the time. However, we learned that we had to improve time-management, as the discussion lasted for two and a half hours whereby two of the oldest women fell asleep closer to the end. It resulted in closing up before the last topic was sufficiently addressed and discussed.

At the day of the second FGD, we faced some considerable constraints. The weather was unstable, and rain was on its way. I had, through earlier experiences, learned that as far as rain was involved, nothing worked again. Everybody would stay at home, or take shelter somewhere.

I was right. When we arrived at the Hall, no one was there. We had to track down the Chairman for him to come and open the Hall. After some time, the traditional prime minister came along. Time was passing and it was getting closer to noon, and it was raining heavily now. I was worried that the FGD would never take place. We finally decided to make a last attempt gathering people at the Hall, whereby we sent the Chairman, accompanied by the prime-minister at the back of his small motorcycle, to take a trip around the village in order to clarify whether the old men would attend the meeting or to postpone it to another day. I was aware that such decision did not exactly comply with the rules of conducting sound research, but what to do?

They eventually came back and told us that all the old men were on their way. Around after 1pm, they came walking, one by one. We suddenly found out that there were only four chairs available in the Hall, and more were not available, so the interpreter had to call a friend and ask him to use his motorcycle and fetch some more chairs from his home. While waiting, the interpreter went to the home of a blind participant, to accompany him to the Hall, as was earlier agreed. However, the old man decided to abstain from participating, as he was not feeling very well that day. That was unfortunate, because from a previous visit to his house I got the feeling that he could contribute extensively to the discussion through his wisdom and experiences. Finally, six old men gathered around the table and we were ready to start. The dynamics of the discussion improved considerably from that of the previous FGD.

The last FGD was conducted with the attendances of all selected participants. It was fruitful, and we did not experience the old men trying to dominate the old women in any part or aspects of the discussion. Interestingly, members of this group brought up additional issues that previously had not been addressed by the other groups. I am not sure whether this was due to the composition of group members, where both men and women participated jointly, or that we now were more experienced as moderators, and therefore had become sensitive to identify and pursue new issues relevant for the study aim and intention.

As earlier stated, interviews were conducted either at the office/work place of participants, or in their compound. Except from one, I was met with willingness from people who clearly showed an interest participating in this study. During the interviews I emphasised facilitating

a friendly and accommodating atmosphere, where I particularly expressed my interest in what was communicated by being aware of my body language, my use of words and facial expressions. I did as such welcome their contributions in an accepting manner, and avoided commenting on their statements by introducing my own opinions on matters that were brought up during dialogues. However, as the study progressed, I quite frequently introduced issues which were considered as essential by other participants, in order to further explore the views on the matter from different people holding various roles. I encouraged each participant to elaborate on their statements and experiences, in order to gain an in-depth understanding of the issue under discussion, but was sensitive to not pursue a topic further than where the participant clearly showed discomfort or was unable to give clear reasons for a specific opinion. I quite frequently used humour when appropriate, which clearly was appreciated by participants, and contributed to "loosen up" the formality of the interview setting. Before proceeding with an interview, I usually introduced myself by giving some personal information about myself, relevant to the situation of a participant. When having dialogues with informal caregivers, I could refer to myself as a mother with children, or when meeting with formal caregivers give references to my previous work as a nurse. My aim was to establish at least some common preferences that could level the role between us and their possible perception of me being an outsider, influencing on their openness and sincerity.

All interviews, except from one, were conducted in English. However, both the research assistant and the interpreter were available during most sessions helping in clarifying thematic questions perceived by a participant to be problematic to understand by providing explanation in Igbo. Through learning by doing, I improved introducing thematic issues in a simpler way as we proceeded with the study.

All in all, I sensed the participants to have a specific interest in the problem under study as they all expressed strong opinions on several issues that were brought up during our conversations and discussions. They were all eager to come forward with statements and stories. Moreover, their knowledge and perceived understanding of impacting factors on the topic under study, such as traditions, society, structures and systems, were reflected through detailed and elaborate discussions and by the telling of stories, valuable for this research, but also which left the researcher (me) with a big collection of data.

Implications of conducting interviews and FGDs while using a digital recorder

Most conversations and all the interviews and FGDs were recorded with the consent of the participants. The use of a digital recorder seemed to have no negative impact on the participants' urge to come forward with opinions, experiences and stories, quite contrary to my assumptions. Interestingly, the majority of participants emphasised the importance of using such a device in order for their opinions and meanings to be properly reflected and referred to in the final paper.

However, there were several considerations to be made and decided on when using a recorder as this easily could cause information given to be recognisable, increasing the risk of violating the ethical principle of confidentiality and protection of privacy. As to anticipate such challenges, I decided to depersonalise data right from the start when transcribing the interviews. All participants were informed about methods securing confidentiality in the final report, and were particularly told about the use of codes. When reaching home to Owerri after a day's field work, recordings were immediately transferred into my computer, with a back up copy to an external disk, and thereafter deleted from the digital recorder. I usually locked my computer inside my bedroom with keys I only had access to. I moreover protected my computer with a password which I changed regularly, and papers and notes were kept in files locked into my suitcase.

Adhering to ethical principles guiding research; Theory vs. practical reality

Cheryl Mattingly (2005) is in her article *"Toward a vulnerable ethics of research practice"* addressing challenges related to rules of *"ethical right thinking"*. She discusses how rules of ethical right thinking are reflected, presented and referred to in ethical guidelines such as those of the Council for International Organisations of Medical Sciences (CIOMS, 2002) and Nuffield Council of Bioethics (2002), and moreover how they are set as standards to guide researchers in conducting research that are ethically sound and safe for participants. Her conclusions on the matter are closely connected to those of Kvale and Brinkman (2009) who emphasise the skills and abilities of a researcher to engage in contextual methods of reasoning rather than calculating from abstract universal principles even though standard ethical guidelines are of importance and useful as frameworks.

A timely question to be asked is therefore whether universal principles of research ethics provide guidance within frameworks also applicable to qualitative research, or whether such principles basically support ethical standards that have emerged from western ideals of practical and ethical reasoning?

I have come to understand that ethical behaviour cannot be disintegrated from any other practical action that is performed, as actions involving human beings always will include ethical reasoning, making its consequences visible at the end of an act. Researchers should therefore strive not only to *"do good",* but to do *"the best good"* for a particular situation. It is therefore interesting to assess how recognised ethical principles reflects, anticipates and integrates moral and ethical reasoning, such as e.g. reflected in Aristotelian Virtue ethics of practical rationality, in guidelines aimed at protecting participants in research studies. Moreover, whether recognised ethical guidelines demonstrate *"absolutes"* or *"rules of thumb"* that is applicable and provide support to researchers in regards to ethical reflections that are flexible and adaptive to specific contexts also in the field of qualitative research.

CIOMS (2002) recognises that there is a challenge to international research ethics by applying universal ethical principles to biomedical research in a multicultural world, but upholds that research involving human subjects must not violate universally applicable ethical standards. Within this stand there is also recognition of the needs to take account of cultural values which should be recognised while one at the same time respects absolute ethical standards. Three general ethical principles are of importance: *respect for persons, beneficence, and justice*. Such principles are also reflected and discussed extensively in Nuffield Council on Bioethics in: *"The Ethics of Research Related to Healthcare in Developing Countries"* (2002), and presented as:

> *"(...) the duty to alleviate suffering; the duty to show respect for persons; the duty to be sensitive to cultural differences; and the duty not to exploit the vulnerable".*

It further points to the ongoing debate on the sensitivity of these principles to practically *"fit"* different research settings by its further statement:

> *"Although the various international guidelines on research related to healthcare have provided some broadly based guidance, they have proved to be somewhat difficult to reconcile and apply in practice".* (Nuffield Council of Bioethics, 2002).

How flexible are the above principles in terms of being *"absolutes"* or *"rules of thumb"*? It may be tempting to suggest that different schools within science represent different mind-sets fostering perceptions which consequently lead to diverse opinions on how ethical reasoning could be applicable to the variety of research conducted in different contextual settings. Is ethical reasoning and behaviour therefore something one can adapt to by reading, and consequently start acting as an ethical proficient person, or does it involve, as Kvale and Brinkmann (2009) emphasise, the anticipation of the researcher to engage in contextual methods of reasoning rather than calculating from abstract universal principles?

Obtaining voluntary informed consent from participants participating in my study

The requirement obtaining voluntary informed consent from individuals before they participate in a study is one of several fundamental principles guiding research ethics. CIOMS define informed consent as:

> *"A decision to participate in research, taken by a competent individual who has received the necessary information; who has adequately understood the information; and who, after considering the information, has arrived at a decision without having been subjected to coercion, undue influence or inducement, or intimidation"* (CIOMS, 2002).

My efforts adhering to ethical principles and reflections on the same could best be illustrated by telling the following story. It aims at describing processes of selecting and at the same time obtain voluntary informed consent from prospective old people that wanted to participate in FGDs;

Oct 10, 2011.

> *When we arrived at the village, time was closer to 11:30 am due to being delayed at the LG HQ, transport not easy to get and distance far. We brought out our map, and started approaching the first kindred. We entered into a compound and presented ourselves to the few persons present and referred to the community meeting held last week. They remembered, and led us to an old woman sitting outside of a house made up by clay and mud-bricks and with a thatched roof. We explained why we came, and the study in brief and simple words and asked if she would like to participate in a FGD the first coming Wednesday at the Village Hall. She said she was too busy farming, so she could not come. One younger woman sitting next to her tried to convince her to participate, but she still refused. We supported the old lady and said that participation is voluntary based.*

We moved on to the next compound located in the same kindred and at the same time checked with people that our map of kindred was correct. We did the same introduction now, and were led to an old woman sitting cracking palm cannels outside a similar house to the first one. A younger woman was present also at this location. We introduced ourselves and presented the study in short to the old woman, and she agreed to participate. The first challenge occurred when I brought out the invitation letter and consent form for signing while at the same time explaining the study in more detail to her. Seeing all the text and being asked to sign was quite obviously a constraint of formality which easily could have led her to change her mind. I sat down with her, and explained that the paper contained the same information already given to her orally. The research assistant was busy translating into Igbo.

In spite of our efforts, I could see that the information was reaching the limit of getting too complicated for the old woman. She "stiffened" and I could see her facial expression to change and her eyes to suddenly look elsewhere than at me. I decided that when approaching the next prospective participant, I had to make this simpler. Anyway, the younger woman sitting next to us was an educated and reasonable person, and she calmed the situation down, saying that she could sign as a witness due to the illiteracy of the old woman. I decided to leave the invitation letter behind and attach two copies of the consent form for them to discuss later in order to better understand what was involved by participating in the study. I would return the next day to collect the signed consent form.

Our initial plan (as novices) was to obtain consent and then conduct a short interview collecting some background information on each participant that was of more private nature. But with these fresh experiences in mind, we realised that we had to go slow and take one thing at a time. We decided to do the background interview when returning the next day. This session had taken some considerable time, and when proceeding to the next prospective participant we were asking ourselves whether we could round up approaching eight participants as planned in time to get back to Owerri within reasonable time after dark. It was not safe to travel at night and transport was scarce. Anyway, we proceeded with our new strategy.

In the next compound, I presented the study in simple words, and told the old women that what I just explained was also written on a paper. I said that we needed a signature from her or somebody she trusted in order to confirm her voluntary participation. This time I finished the talking before bringing out the paper. It seemed to work better. But to find someone who could sign was a problem. This turned out to be a recurrent problem as all the older women agreeing to participate were illiterates except from one. Moreover, several other household members present were reluctant to sign, and the younger children could not be asked due to their age. So we left papers behind, scheduling to come back the next day, hoping that within 24 hours or so, someone they trusted had signed on their behalf.

When time was getting closer to 8:00 pm we had approached seven old women whom all agreed to participate. We had tried to reach women from compounds reflecting different economic statuses, at least by its material appearance, in order to anticipate some variety in socio-economical status within the group. We had moreover emphasised selecting participants of different ages within the range of 64, up to the oldest old. Since very few knew

their actual age, the selection was done according to their appearances and how they assessed themselves as "old".

There is no electricity in the village, so we proceeded from place to place in an environment of green vegetation and narrow village roads in a rapidly reducing light ending in a sudden complete darkness only lit by the tiny lights of two mobile phones. In the villages in these areas you will find a phenomenon called sun-flies. They enter the arena around 6 pm and are some blood sucking small creatures. You may not notice their bites until later. The villagers are used to them, and are not bothered, but I am not used to them and neither resistant from reacting on their bites. When returning back home to Owerri late that night, I looked at myself and saw that my arms, legs and back was completely eaten up, at least I must have more that 500 bites. I looked as a person suffering from a serious outbreak of measles or scabies. I knew from earlier visits that this would cause a problem of serous itching that could last for at least a week, and that same night it started. Terrible! The next three nights, I hardly slept.

The next day, we returned to collect what we thought were signed consent forms. Only two returned a signed form. However we managed to locate trusted family members for the rest except for two that proposed to bring papers along to the Village Hall the next day where the FGD was to be hosted at 10:00 am. They would try to locate someone trusted along the way for him or her to sign as a witness.

Figure 11: To obtain informed consent in the dark. Photo: Heidi Olsen

Adhering to the principle of confidentiality while doing qualitative research

The ethical principle ensuring confidentiality and anonymity, and protecting the privacy of participants fosters several challenges to a researcher conducting qualitative research, especially when interacting with people in a relatively small environment.

As a *"white"* researcher in a rural African setting, I become quite visible, and my contact with people for introduction and help identifying prospective participants opened already at this stage for violation of their anonymity as it consequently was immediately known to the entire community who agreed to participate in my study. Of course knowing the identity of participants does not necessary violates the protection of information given in an interview or issues discussed in a FGD unless other family members are present at the time.

Consequently the issue of protecting the privacy of participants had to be reflected and acted upon in each unique situation, where I continuously had to consider socially and culturally acceptable codes of conducts and weigh this against behaving as an ethical and proficient person, adhering to ethical standards of conducting scientifically sound research. Such reflections did not only apply to me alone, but involved also the ethical reasoning of the research assistant and interpreter. The Code of Ethics of the American Anthropological Association (1998) states in section A; paragraph 2 and 3 the following;

> *"Anthropological researchers must do everything in their power to ensure that their research does not harm the safety, dignity, or privacy of the people with whom they work, conduct research, or perform other professional activities.(...)".*
>
> *"Anthropological researchers must determine in advance whether their hosts/providers of information wish to remain anonymous or receive recognition, and make every effort to comply with those wishes. Researchers must present to their research participants the possible impacts of the choices, and make clear that despite their best efforts, anonymity may be compromised or recognition fails to materialize" (*American Anthropological Association, 1998).

As stated earlier, all participants signed a consent form that also included information about my duty to protect their privacy, and to secure anonymity and confidentiality. However, several participants expressed an interest in abstaining from these principles and to be recognised in the final paper. In order to increase the validity and reliability of the study, I later decided to abstain from complying with these wishes. This decision was made during

the analysing process where I became aware of the possible risk of letting some voices dominate others, causing undue influence and power imbalance between the statements of different groups of participants. Another reason was to voice the opinions from old people and informal caregivers equally with those of other participants.

Based on the information given at community meetings, all villagers were well aware of the ongoing research project. We were also quite visible when walking the different villages. On our way, we were often stopped and greeted by people welcoming us. As such, securing anonymity of a participant was hard to comply with during the selection process. However, interviews, conversations, and FGDs were conducted in places suitable ensuring the principle of confidentiality, respected by most family members. All FGDs were conducted in the Village Hall, a natural place to gather people for discussions according to customs. Interviews with informal caregivers were conducted in their homes in a secluded place within their compound, where the only interruptions were children playing, or people passing to greet. Conversations with community leaders usually took place in their houses or outside of their compound in a suitable place as to avoid interruptions. Formal caregivers and government representatives were interviewed in their offices or at their workplace. The only challenges that occurred were related to the collection of background information from some elders. In order to not breach any cultural codes of conduct, it was a bit difficult to ask family members around to leave, for us to be alone with the old person. Luckily I was in the possession of two wise and culturally sensitive colleagues who solved these issues in a (hopefully) respectful manner. During all our talks with old people, it was therefore only a couple of times we experienced daughters in-law (to old men) to be reluctant to move very far away from the site of a conversation.

In addition, all participants were informed that I would use quotations from conversations and discussions in order for their views and opinions to be reflected in the final paper without compromising their identities.

The benefits and risk involved for participants participating in this study

The benefits and possible risks involved for participants participating in my study were articulated in the invitation letter. The benefits participating in this study were mainly targeting old people, but other participants would have their transport expenses covered if

needed (ref: annex 5). The following short story illustrates the benefits provided to elders participating in FGDs. I want to use one of the FGD as an example. Apart from the incentives reflected below, no other benefits were given, nor asked for by other participants.

Oct. 11, 2011;

> *Already after the initial community meeting, we asked the Chairman's wife if she could assist us in preparing a meal to be served right after the end of the FGD, while we were all seated together. Moreover, I wanted to serve some assorted drinks. She approved the request and we agreed to prepare a traditional dish that older people would appreciate. We finally decided cooking a dish of cow meat cut in smaller pieces mixed with marrow bones and skin, served as a stew. I made a point of boiling the meat to be soft (teeth are not always strong at old age). As complementary dishes she would prepare steamed pumpkin leaves, peppers and onions, and rice. We also bought assorted types of drinks and water. The total budget was estimated to 12.000 NGN which would leave the "chef" with some small profit. In addition, as stated in the invitation letter, I would give an incentive of 1000 NGN to each participant after discussions. I have to mention that these treats were not verbally communicated to prospective participants when invited to participate in the study.*

Oct. 12, 2011, notes from the first FGD with old women

> *(...) (...)Due to poor time-management, two of the oldest women had fallen asleep closer to the end of the ongoing discussions, but they both woke up when I announced that food was on its way. All the old ladies seemed to appreciate the treat. Before eating, I discretely gave them the incentive of 1000 NGN and thanked them for contributing to the study by using their valuable time and energy. The money disappeared in a mysterious way somewhere into their wrappers and out of sight. During the meal we were socialising commonly and after eating they said they wanted to leave. In spite of all constraints and insect bites with their considerable itching, the rest of our small team and I were happy with the outcome of our first FGD.*

To my understanding, there was no risk of physical harm in this study. However, during our interaction with participants, we were particularly aware of the risk violating the integrity and privacy of any person. When conducting background interviews especially, we emphasised being sensitive in not pursuing topics where the participant hesitated to answer or when body language clearly expressed a feeling of discomfort. However, such reaction was only experienced twice and occurred when addressing two elders respectively, asking of their children's current residence. In such situations, we repeated that the participant was free to decide which question to answer and which one to abstain from answering. We were

also aware to not misuse trust in order to obtain information irrelevant for the study aim and objectives, and to not mix our role of being personal with that of becoming private.

Figure 12: Food on its way:) Photo: Heidi Olsen

Analytical considerations and the process validating data

Analysing data

I started the analysing process in the field as soon as I came across information relevant for the study aim and objectives. This helped me considerably to be aware of contextual data patterns, and to identify topics inadequately explored and addressed in FGDs, interviews and conversations.

After returning to Norway, I finished writing up the verbatim transcriptions, and used NVIVO to categorise data in order to keep track of data sources and references. Using NVIVO gave me an opportunity to return to the original transcript in order to check coded categories more carefully and to relate text to contexts. I ended up with 17 main categories, from which I finally used 14, all considered relevant for the topic under study. From each category, themes and issues were later identified.

The analysing process was guided by two important aspects: to be truthful about the participants' contributions, which involved their views, perceptions and experiences on the topics under discussion and to carefully consider the study aim and objectives which included having the interview guide in mind when categorising and identifying themes. I tried to work in a rather flexible manner in order for my mind to be open for inputs of thematic issues that later could prove themselves important, clarifying and explanatory to issues already identified. My aim was to be sensitive to what was happening in the data material and moreover to identify broader processes and concepts useful for the later development of theories, but still recognisable by the evidence in the transcripts. At the same time I wanted analysis to reflect and inform how participants cognitively constructed their realities and how this manifested itself within the existing contextual setting of the study site. Local contextual findings would thereafter be placed and assessed with its wider contexts, which implicitly involved using information acquired through the reading of literature, drawing on knowledge and experiences from my own professional work, previous visits to Nigeria, observations, and lived life.

Before starting this process, I was looking for some tools to think with, allowing me to handle all the information in a sensible and constructive manner. I become particularly inspired by McCracken (1998) and Hennink (2009). The latter author has developed a

method called *"descriptive counting",* where she describes how to use such method as an analytical tool when approaching considerable quantities of texts commonly evolving from conducting qualitative research. Being inspired by both authors, I started optimistically on the analytical process by setting up matrices, one matrix for each category. Such strategy allowed me to identify focal themes such as: topics, issues, concepts, influences, explanations, events or ideas evolving within each category. I decided to convert and reformulate what was being communicated by participants into statements. This helped me to identify whether opinions on an issue reflected a general point of view, was self experienced, or referred to others but not self experienced. These processes were challenging, but also learning and interesting.

Having advises of McCracken (1998) and Hennink (2009) in mind, I identified categories with its attributed focal themes as they emerged across the whole data set. I, at the same time, looked for recurrence in thematic responses between- and within groups of participants, and between participants in general, irrespective of group belonging. This enabled me to connect and compare issues discussed. In order to visualise the statements of participants "belonging" to different groups, I applied group names in a head row of a matrix while focal issues were applied in a head column. The benefit was to me the visualisation of what was going on in the data material and to see who contributed to its patterns and the appearances of focal issues. By looking into the matrices at the end, I was able to identify important and marginal themes, and the consistency, occurrence and reoccurrence of an issue between participants, between groups and within groups of participants. However, I also had an eye open for experiences and opinions expressed solely by one or two participants as their contributions could be equally enlightening and informative when assessed within the broader perspectives of the data material. As an example, opinions from a single participant could e.g. prove itself valuable when assessed in virtue of a person's role in a community or society, or based on acquired work experiences, and would therefore naturally be included and analysed based on its contributions to the wider understanding of a particular thematic issue.

Collected background information from old people and informal caregivers were displayed into Excel spread sheets. This contributed to valuable information complementary to information displayed in the matrices. The integration of information given as background

information combined with that of FGDs and interviews contributed extensively to develop sensitivity to- and understanding of people's experiences and opinions, leading to the identification of main findings, contributing extensively to the final conclusions of the study.

Validating data

My initial aim was to invite participants to read the transcriptions of an interview, or when not feasible, at least to summarise the information given in an interview in order to validate its contents. However, due to time constraints, this was not possible. I was only able to return to some participants in order to clarify and elaborate on issues insufficiently understood, and to provide additional information on issues that I wanted to pursue further.

We faced, however, some practical constraints which involved the research assistant's obligations as regards to his regular occupation. He was in principle in-between projects for the time being. However, his regular employer frequently gave him some work tasks to perform, which consequently occupied some of the time meant to be used on the research project. This prevented him from transcribing and translating FGDs and the one interview conducted in Igbo into English, parallel with the progress of the field work. However the contents were made accessible to me through to the interpreter's oral translation during each session, and through extensive analytical discussions afterwards. As regards to the interviews conducted in English, I transcribed them simultaneously with the ongoing field work. This gave me time to reflect and to actively use information from previous participants in forthcoming interviews. This was useful and allowed me to further explore and compare different opinions on matters discussed, and to pursue new issues emerging, relevant to the study. I believed this strategy to strengthen the overall validity of data in regards to the internal validity of data representing perceptions and opinions within a group of participants, and the external validity by investigating data patterns between groups of participants of various characteristics holding different roles in society.

I also made use of visual observations acquired during the field work, and in addition information broadcasted through media addressing the political environment in general, specific health political initiatives and general health promotion advertisements. Themes of particular interest to me were programmes and newspaper articles addressing governmental aims and strategies on the improvement of various developmental issues beneficial for

Imolites[8], initiated by the newly elected Governor, and strategies aiming at improving health in general among populations.

I was also fortunate to be given access to freely copy current health plans, facilitated through the cooperation with governmental authorities and civil servants at the SMoH- and LG level. Such contacts usually brought about informal conversations and talks useful for gaining increased knowledge on the political health situation in Imo State, but also on people's perspectives on factors influential of the development of health infrastructures and the implementation of healthcare services.

The inclusion of different groups of people holding various positions and roles, combined with the applying of several research methods, allowed me to validate data through triangulation. I was continuously reflecting on my chosen methods and how to properly apply them during the entire field work as I was aware of its implications on the validity of data which consequently would impact on the overall reliability of the final results and conclusion of this study.

After returning to Norway, the research assistant sent me the transcriptions of the FGDs and interview, now translated into English. In order to ensure its validity I made use of my life partner's extensive knowledge of standard Igbo language in order to check the accuracy and quality of the transcription and translation. This was solely based on him listening to recordings while reading the English transcripts without compromising the identities or locations of any participant. The consistency and accuracy between recordings, transcripts and translations were found to reflect discussions and to be of good quality.

The influence of my attachment to people at the study site on the study results

Throughout the implementation of the methodology applied in my research, I have been reflexive on aspects that positively or negatively could impact on the validity and reliability of the final outcome of the research paper. I have tried my best acting as an ethical proficient person, adhering to scientifically sound principles and to be sensitive to cultural codes of conduct whenever interacting with people in general and participants in particular,

[8] Residents of Imo State refer to themselves as *"Imolites"*.

which hopefully facilitated for mutual respect and good communications between us. However, there is one aspect of importance that unintentionally may have influenced the research process and final conclusions of this study. I have been conscious and reflexive about its possible bias to this research, from the planning phase, throughout the field work and during the analysis process. The issue in mind is reflected and elaborated on below.

My area of interest is old people. As a nurse, I have been working in the field of geriatrics for a great number of years, combined with an international engagement in global health, where I have gained professional work experience within the provision of Primary Health Care and Community Health in African contextual settings. However, through my life-partner, a Nigerian and an Igbo, I have also been fortunate to be introduced to another culture, different from that of my own. Through my visits to the villages and towns in the Igbo speaking part of Nigeria, and moreover through my interaction with family members and friends, I have witnessed an ongoing societal change impacting cultural customs and familial traditions in the care of old people, affecting their health status and general wellbeing. These observations have inspired and influenced me when deciding on the research topic, the aim and objectives guiding this research project.

By visiting this area regularly for almost three decades, I have improved my knowledge and acquired increased insights and understanding of the Igbo culture. I have participated in socio-cultural activities and events, and through visits, interacted with people and family members from the area, also where this study was conducted. However, my own conception and understanding acquired through experiences may nevertheless only to a certain level be identical with the ones of village people. This aspect could therefore have caused some implications on the mutual understanding between us in spite of customs defining me as their *"wife"* married to their *"brother",* and my home considered my husband's village.

While carrying out the research project, my perception of realities in situations and contexts might have been taken for granted by participants in this study, where they consequently would leave out providing elaborative clarifications on issues discussed. Contrary to the latter, people could have been reluctant to share their constructs of realities with me, because some still considered me as an outsider. On the other hand, I may have perceived to capture the meaning of information due to my attachment to people at the study site and

consequently not asked for more elaborative details. I was right from the start aware of these potential biases, and in order to anticipate sensitiveness on the matter, I focussed my attention in particular on how to ask and formulate questions, and to assess both verbal and non verbal responses. I was trying to facilitate an atmosphere where the interaction between the participant and me reflected the reciprocity of an activity where the foundation of communication was built upon trust and respect, an exchange of views non-judgemental and open minded, and opinions reflecting interest and receptivity. However, my attachment to people at the study site may still have influenced the quality of data as their interest participating in the study could have been guided by alternative motivations to those of mine, and ultimately the intention of the study. Their participation could as such solely reflect goodwill in order to pay me respect, but also to provide me with a picture of realities, where their contribution of information given was controlled, intentionally or unintentionally. The latter could as such have limited access to information addressing underlying customary processes in family care influencing caregiving to older family members, where the perception of a loving family was upheld and the need for formal interventional services unnecessary. On the other hand, participants could have painted and coloured experiences in a manner that, by their perception and understanding of the research intention, would facilitate for prospective *"good things to come".* The latter aspect could be interpreted as to represent the uneven power balance between the participants and me, where I first and foremost was looked at as a representative from the resourceful and developed western world rather than a *"wife".*

As I proceeded with the fieldwork, I became increasingly aware of the massive responsibility I have taken on conducting research in another country and culture, within contexts very different from the ones I have grown up with myself. The ethical considerations reflected on in previous chapters became suddenly clearer in their meanings and intentions, and I learned about the importance of possessing the ability to engage in contextual reasoning.

In regards to me as a person and my interactions with villagers, I thoroughly explained my role to be strictly professional throughout my stay, with limited opportunities for private visits and attended private gatherings due to time constraints. The initial community meetings contributed greatly in communicating messages to community members, and I perceived these to be understood and respected. In order to avoid speculations of beneficial

expectations, I behaved in strict compliance with my research protocol, information given in community meetings and information given in invitation letters to participants, however still facilitating for a personal atmosphere but not private. I was careful not mixing my profession as a nurse, caregiver and "problem solver" with the role of a researcher. This was respected by all participants and never attempted exploited during FGDs, interview sessions or conversations. However, outside of this setting, some villagers approached me, asking me to assess a sick child or give advice on a health matter of concern. I anticipated gladly such approaches whenever having the opportunity and time, as a reciprocal service meeting with their accommodating kindnesses and welcoming attitudes.

In order to mellow down the appearance of being white and "rich", I emphasised on utilising resources also available to common villagers. This implied travelling by public transport, to dress casually and sometimes traditionally, and to visit women at sites where they offered traditional home cooked food through their local catering businesses. When arriving at the village we walked by foot around in the three villages, which sometimes caused surprise among villagers. However, after some time, they become used to seeing us walking from location to location within each village, and we were met with smiles and frequent stops for pleasant small talks.

Ethical preparedness throughout the research process may increase awareness, but not all ethical dilemmas are foreseeable. However, by spending time reflecting on my attachment and relation to people at the study site, I have managed to anticipate the ethical challenges of uncertainty by addressing them wisely when occurring, and in an appropriate manner proving itself valuable for the final conclusions of this paper.

6. FINDING AND ANALYSING CONTEXT SPECIFIC DATA

Introduction

Although this study is about old Igbo people, they cannot be known in isolation. In order to fully understand how it is to be old in an Igbo community, one has to look into mechanisms contributing to their recognition within the context of their family of which is part of their local community and society at large. Any health initiatives at the primary level targeting the health and wellbeing of elders should consequently be sensitive to prevailing traditional norms and values for such services to be perceived as acceptable and welcomed. Exploring the potential of Community Based Healthcare services as a strategy anticipating contemporary challenges to their health and wellbeing must therefore be assessed within perspectives of the familial and societal contexts of which an old person lives taking account of the socio-cultural environment and its traditions.

As presented earlier, the objectives of this paper are threefold. Consequently this section contains three parts. Part One and Two of this study explores how it is to become old within a family and community, essential in order to identify and understand dynamics determinant for old people's experience of health or ill-health. It looks at caregiving in the perspectives of old people and how they regard the changes of society to impact on their families' abilities and motivation to care for them. It addresses reciprocity and the impact of patri-lineal systems, and explores whether the care of elderly Igbo people exceeds beyond the boundaries of their household to also include assistance from community groups. It takes into account some of the socio- political perspectives that impacts on social life and rural development and identifies factors that can help explaining some of the challenges to rural life that makes old age difficult to live.

Part three focuses on health, mainly in the perspectives of old Igbo people, and explores their understanding of health and healthcare. It presents their opinions on formal health interventions as a plausible option to care complementary to family care and how services could comply with normative and cultural traditions of caregiving. It takes the reader into the health-political and social-political context of the study site and presents the limitations but also the potential of the existing health system at the grass-root level. It finally identifies

implications for the implementation of community based healthcare where the guiding principles and practicalities of the model is extensively is explored.

The following chapters include quotations, presented as verbatim extracts from conducting FGDs, interviews and conversations with participants. The use of quotations facilitates an authentic glimpse into how participants representing different groups cognitively perceive realities to be, reflected through the cultural and social construction of societies in which they live, act and interact. Quotations are marked using inverted commas. Missing words are replaced with ellipses, and words inserted by me in order to complete a sentence or meaning, marked with brackets. My aim is to strengthen the relationship between the reader and the study participants and to the various contexts of the study site which facilitates a journey that leads to a deeper understanding of circumstances determining the health situation of elderly Igbo people. I believe the use of quotations helps in gaining in-depth understanding of the many issues under discussion, guided by the aim and intention of this study.

PART ONE; Old Igbo people in the context of their families and local community

Introduction

The first chapter is dedicated to the understanding of the concepts *"old", "health"* and *"ill-health"*. Moreover to gain knowledge on expectations related to old peoples' roles and functions within a family setting, facilitating for their recognition. The latter aims to acquire knowledge on opportunities and constraints attached to their performances of activities, involvement in decision-making and to what extent they are enabled to influence matters important to their well-being and health.

During the FGDs with old people, but also when conducting interviews and having conversations with informal caregivers and key persons, I asked them particularly to explain and elaborate on their understanding of the above concepts. The aim was to reach contextual consensus between us on its meanings and attached properties. Moreover, I wanted to know more about circumstances impacting on the body and mind contributing to their experience of "*health"* or *"ill-health".*

Becoming old in an Igbo community

When you have reached a certain age in an Igbo community, you are entitled to call yourself *"Okenye"*, an elder. An elder is a person having gained experience and wisdom in life, utilised for the betterment of the family and the society through his or her advisory and consulting role. The oldest old is called "*Ndi agadi".* When they are addressed, you call a woman; "*Agadi nwanyi*", and a man; "*Agadi nwoke"*. Both "*Ndi okenye"* and "*Ndi agadi"* participates when important meetings are called for in the family, kindred or community. An old man has traditionally been the head of the family; *"Onye isi Ezinaulo"*. Though the man is important, especially for the continuation of patri-linage and heritage, both gender emphasised particularly on their advisory roles. The concept *"old"* can therefore be attached to characteristics involving age (chronological), to have an advisory role to play by being a senior person in the family and to have gained extensive experience in life. This view was supported by the majority of the participants and there was consistency between groups.

Within the context of a family and community, ageing can reflect both positive and negative perceptions about a person that can be of psychological or physical nature. Findings suggested psychological aspects to involve the ability of elders to manifest their roles through the execution of expected duties, as this contributed to the perception of being valuable and useful facilitating a positive state of mind. Recognition becomes essential, as an old person, through the performance of traditional activities, earned respect. These were found to represent essential qualities as they supported the identity and self-esteem of an elderly person contributing to a sense of well-being and experienced health: *"Ahu ike"*. Physical aspects were often linked to the degeneration of human body and mind, contributing to ill-health: *"Oria".* This involved the occurrence of illness which by old people was regarded as a threat to their own role and function as elders impacting on their value and usefulness, consequently perceived to affect the appreciation and support from family members. An old woman illustrated these aspects in a FGD when we talked about what it meant to be an old person:

> *"How to know an old person, I hope you don't mean people who cannot come out from their houses"* (P5V1).

This quotation may indicate that she distinguish being only old from being both old and sick.

Many of the elderly people and informal caregivers participating in this study pointed to the particular function of old women to advise small children, daughters and daughter in-laws while old men mainly attended to children and young boys. Advises seem to be directed towards the teaching between good and bad and to not do evil, to be a good Christian and to meet up with the expectations of God. This was further related to their notion of not all children being good, which often referred to a mother's capability and capacity as a caretaker for her children. An old man shared his reflections on his advisory role by saying:

> *"Those who are matured will listen, or whom their mother milked well will listen"* (P7V2).

The statement underlines that even if they perceive that old people have their role in raising children and youth, their role is still secondary to the role of the mother (or parents). Old people often referred to an old Igbo proverb stating: *"Eweta enye"* which meaning is: *"you get what you deserve".* The above quotation can therefore be seen as reflecting the importance of caring and training children well, as an investment and a security for the future.

Closely integrated into the latter is the passing of traditional norms and values and to give information to new members of the family. Each village had traditions that were slightly different from those of other villages, and to pass on customs as part of cultural heritage was viewed as essential. When an Igbo woman marries, she marries into her husband's family from another village. She will be considered a wife of her new village and included in the household, taking on responsibilities and performing duties of everyday life involving practical work, caring, and participating in income generating activities. In order to carry out such activities in an appropriate manner, daughter in-laws were trained to adapt norms, values and customs of their husbands' family and village. A daughter in-law explained:

> *"The old ones, because you know, they know about what is happening in the village. So that we can understand and how we can work in the village. And they direct us how to shape our mouth while talking in the public. That is what they do"* (CT1V3).

According to observations, women's income generating activities often involved farming, trading, tailoring, hairdressing, catering activities and charity work. Several of these activities were performed within the context of community- and church organisations existing in their

local community while others were performed and executed individually but still beneficial to their family.

Another essential function attached to old age was elders' knowledge of land properties. Ownership of land can be assessed as closely related to heritage and family wealth, and information should be passed on to children before death. The patri-lineal continuation of family line and the importance of having sons become essential. Next to his father, the oldest son has obligations and responsibilities on the welfare, development and progress of his family. He is also the one with the right to overtake and make decisions on family compound and land. Securing the information of family land to future generations was by old people regarded as an act of love. Therefore, elders were usually called to attend meetings and consulted when land disputes occurred in a family or community, and they were consequently expected to know what to do in order to retain peace among family- and community members. Old people saw the retaining of peace as an act fostering expectations of reciprocity from children in return, expressed through love and care, securing opportunities for dignified living at old age.

To be given respect was an act particularly appreciated by the elderly. It was viewed to secure opportunities of performing duties and responsibilities of their kind, strengthening their identity as old and valuable. Respect could be taught to any person through disciplinary actions, or be earned by an old person. Based on the latter, old people emphasised the importance of being good role models, which involved being truthful and thereby trusted by family members and people in the community, and by possessing such qualities, respect was earned. It was a common opinion that trust facilitated being loved by people, and most importantly by God. Both old men and old women shared this perception.

Old people participating in FGDs saw the degeneration of human body as a major threat to their recognition. This involved the onset of an illness and the experience of mobility limitations due to old age. This is similar to what was mentioned earlier, that being only old was perceived differently from being both old and sick. Bad health was not only seen as a threat to their wellbeing, but also to challenge their capacity and capability to execute their roles within a family and local community. The participants mentioned fear related towards becoming physical disable which would prohibit them from moving around and to

participate in meetings, and thereby limit their opportunity to influence on matters viewed as important to the family, kindred or community.

One may therefore presume physical disabilities to represent major threats to old people's psychological well-being by constraining participation in areas where their consultancy role traditionally has been appreciated. Such abilities seem to be a pillar guiding familial recognition which moreover facilitated respect among fellow villagers confirming their status as valuable and appreciated. Physical disabilities can therefore be assessed within their broader perspectives, indicating physical illnesses to also prevent a person from cognitively participating- and contributing within areas that traditionally fall under his or her domain. This may also be the reason why old people seemed reluctant identifying themselves with the old ones suffering from major illnesses, and it indicates an attitude where old people segregate themselves from those unable to perform their traditional duties due to reduced physical capacities. Such segregation may be based upon experienced responses from the surrounding environment towards this group. Responses may reflect implications related to their recognition and appreciation, and for prospective care and support to be made available within the familial context. Consequently, physical disabilities can be assessed to initiate fear to rise among elders leading to their distancing from *"(...) those who cannot come out from their houses"*. The concept *"health"* and its meaning becomes again interesting as *"ahu ike"* directly can be translated into *"body-strength"*, indicating *"health"* to be associated with physical aspects of health in order for one to be considered as healthy and functional. However, it was difficult to reach a consensus on the term, as several elders assessed this concept to also reflect a state of general well-being which as well included psychological and mental conditions.

Not unexpectedly, old people were in particular concerned about experiencing increased physical weakness. In their opinions, weakness not only impacted their social function and status, but also on their capacity and capability to participate in physical labour. It was also perceived to largely affect their abilities to contribute in income generating activities and work, beneficial to themselves, their family or local community. An old woman shared her concerns about old age and the experience of physical weakness:

"What we used to know is old is that you will not be strong. What you can do in a day

can take up to a week" (P4V1).

Old people's fear of physical weakness can be assessed in conjunction with the structural inadequacies at the study site expressed through the lack of functional welfare systems. This contributes to reinforcing old people's dependency on viable support mechanisms existing within a family. Having a government represented by politicians, who to a great extent have failed developing welfare systems beneficial for people in need, leaves old people extremely vulnerable to poverty. According to the literature, Nigeria has introduced a pension scheme some years back, which only accommodates those working in the formal sector to be eligible to receive pensions. As a result, the majority of people are left without any prospective hope of economic security at old age as most, and especially women, have been working within informal sectors. The lack of attention towards these groups has forced old people to continue working throughout their old age which largely explains their fear of physical weakness and the onset of illness, preventing them from participating in income generating activities. Background information collected from elders revealed a majority of them to still be involved in some kind of labour securing minimum income, while some had to supplement income generating activities with the assistance from others, mainly family members. The following diagrams presents sources of income in respective of gender.

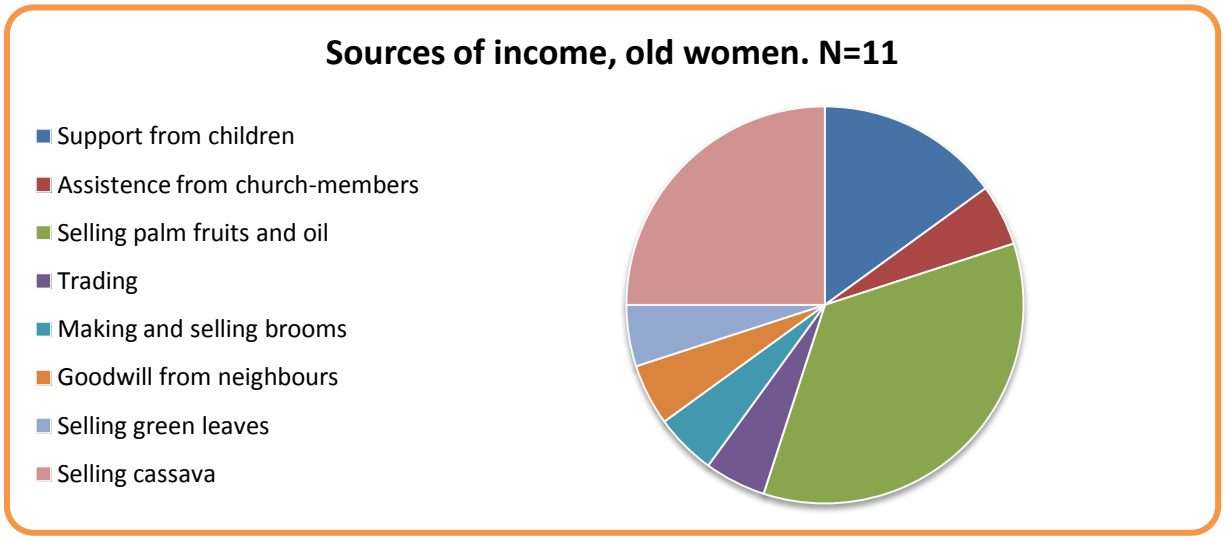


Figure 13: Main sources of income for old women.

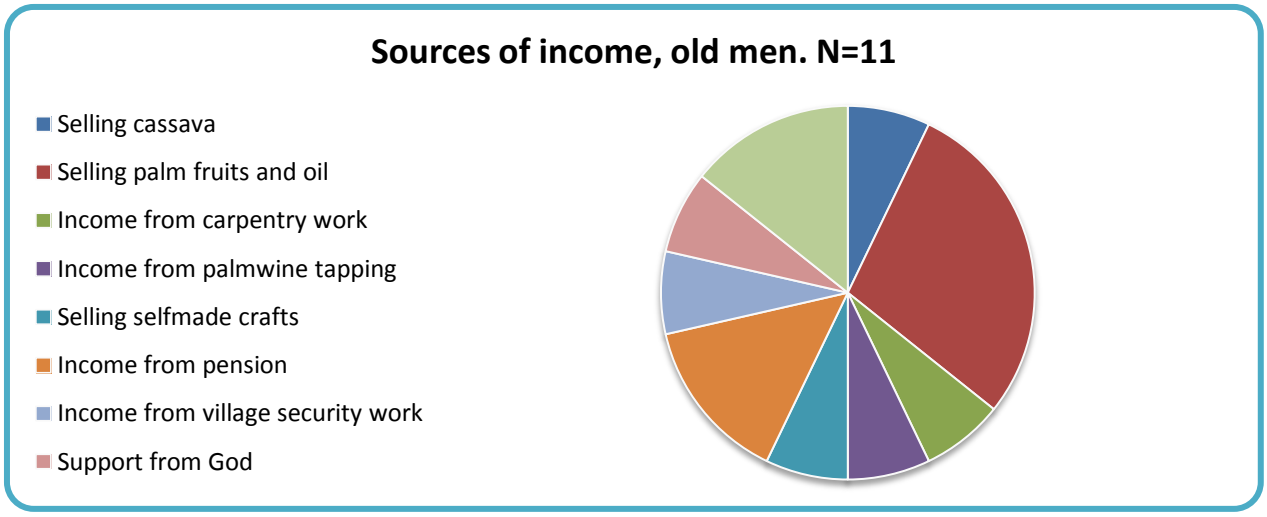


Figure 14: Main sources of income for old men.

These diagrams give information about sources of income where the processing and selling of palm oil represent an important income source for old men and old women. Generally, women seemed to be involved in agricultural work more than men which can be explained by their level of formal education. Background information informed only 2 out of 11 old female to have received some formal education, while 9 out of 11 older men attended educational institutions up to school cert level. Old men seemed therefore to be involved in more diverse income generating activities requiring technical skills than old women. Those limited by physical weaknesses seemed to depend on supplementary assistance from members of their belonging church community, the support from children and family members, or God.

Old age with its gradual reduction of physical strength will at some point bring about an old person's need of regular assistance from family members, which especially comprises help in activities of daily living. When discussing the need for assistance at old age, an old woman described it as a situation depending on the help from others:

> *"(...) the food he eat and water he drinks is being given to him by another person. At times, they cannot bath themselves"* (P2V3).

The statement is interesting as it seems as she through her self-perception distances herself from those in need of advanced care by talking about *"he"* and *"they"* rather than *"I"* and *"we"*. Such interpretation can be linked to their fear of becoming physical weak and concerns related to the introduction of chronic illnesses, challenging their capacities coping

with duties of everyday life securing dignified living at old age.

While old people were concerned about the physical aspects of old age, informal caregivers on their side seemed to care more about old peoples changing of character and mindsets. A daughter said the following about her mother:

> *"At times they behave like children, like my mother when she came now, she didn't even (…), she supposed to keep quiet because we are busy doing something, she said this world will (...) pass me o', or something like that, the way she is or behave, is quite different from our own now"* (CT1V1).

Another young woman, hired by a family to assist an old woman said:

> *"Ahh (...) old person like now, aha, from the old person like when the person have more 60-70 years, maybe the character they formed before are not the character they formed that time [now]"* (CT2V1).

She continued explaining:

> *"Like me now, this can talk normal for you, you'll hear me. Maybe that old woman can talk another thing, maybe you can't understand, you'll say; Ahh! This old woman can talk rubbish, but maybe rubbish is due to being old. That the old age would make her to talk another wrong thing, and that is from that time I will conclude this woman is old because she changed her mind"* (CT2V1).

Although this study brings evidence of old people being respected due to their age and advisory role, there are some contrasts and differences in opinions among informal caregivers on the importance and usefulness of such advises and whether they are listened to or not. The majority of elders reflected these views by referring to changes in behaviour and customs among younger people. They attached such to new norms and values prevailing in contemporary time being different from that of old times. But it could also be because the health conditions of the old people who participated in the study were different from the old people of whom the informal caregivers had experiences from.

Figure 15: An elderly woman weeding. Photo Heidi Olsen

Figure 16: An elderly blind man playing his instrument to earn a few Naira. Photo Heidi Olsen

Caring for old people within an extended family system facing societal constraints

Introduction

The following chapter explores family support and care to old people within the context of their extended family and local community. This includes gaining increased knowledge on the concept *"family care"* and moreover on activities viewed by elders to be necessary and essential in order to facilitate their well-being and prevent ill health from occurring prematurely at old age. It becomes particularly important to seek answers on how old Igbo people assess care and support from family members to be adequate and according to identified needs, or whether a shift in customary responsibilities among family members could make other arrangements such as formal healthcare intervention an acceptable option complementary to family care. The above involves understanding mechanisms guiding family care and support, and how a traditional value system[9] may be under constraint, influenced by a society undergoing transformation between its collective past and more individualistic future fostering contemporary living arrangements.

Family care and support to old people; an expected responsibility

A majority of participants representing all groups expressed opinions of the care to old people to preferably be rendered by the wife, children or daughters in-law. Old people in particular viewed this to be an expected responsibility anchored in their perceptions of values and traditional norms apparent within the Igbo culture of this area. One old man wanted to speak during a FGD:

[9] **Prof. Shalom H. Schwartz** at The Hebrew University of Jerusalem has in his paper; "Basic Human Values: An Overview" aimed at presenting a theory on human values based on the scientific tradition of various psychologists, anthropologists and sociologists (i.e. Rokeach, 1973; Kluckhohn, 1951 and; Williams, 1968). These theorists view values as the criteria people use to evaluate actions, people and events. According to Schwartz, main features of the conception of basic human values can be summarised as followed:

- **Values are beliefs.** But they are beliefs tied inextricably to emotion, not objective, cold ideas.
- **Values are a motivational construct.** They refer to the desirable goals people strive to attain.
- **Values transcend specific actions and situations.** They are abstract goals. The abstract nature of values distinguishes them from concepts like norms and attitudes, which usually refer to specific actions, objects, or situations.
- **Values guide the selection or evaluation of actions, policies, people, and events.** That is, values serve as standards or criteria.
- **Values are ordered by importance relative to one another.** People's values form an ordered system of value priorities that characterise them as individuals. This hierarchical feature of values also distinguishes them from norms and attitudes (Schwartz, S.H. 2011).

> *"Yes I have something to say. The most important thing when you talk about support in old age is if you are an old woman or old man, if you have husband or wife, they will boil hot water for each other to take their bath, even cooking of food, will be done by the nearest person who is the husband, wife or the children. This is the first step of support even before you look for a doctor if the support from the family is not [a]helping matter. It is important that before people get too old, they should make sure they are married and also have children who will take care of you in times of trouble"* (P5V2).

His opinion was reflected by several others and it was consistency between groups of participants. However, within the group of elderly, there were some disagreements among participants on whether such norm were being adequately reflected through practical actions. Several expressed that family care was insufficient and a few felt that there was an overall lack of support from their families. Such cases could be an illustration that family members did not fulfil the old people's expectations. Regarding the expectations between spouses, where care between married couples was perceived as certain, an interesting observation became evident when assessing background information given by old people. All old female participants were widows while old men still had a living wife. By obtaining such knowledge, one may suggest a prevailing strategy to exist at the study site where men marry younger women in order to secure care at old age. On the other hand, by over living their husbands, an old woman may be more vulnerable due to her dependency on children and the extended family's ability and will to care for her. The latter may suggest old women to be at higher risk facing inadequate care and support at old age compared to that of old men.

On the basis of old people's different experiences as regards to support, I wanted to gain a better understanding on the meaning of "*family care"* as a concept and how such was understood within contexts of their environment. This involved exploring properties attached to the concept and how these reflected values viewed as accommodating for the care and support expected to be provided at the familial level. The concept was extensively discussed with old people and introduced in in-depth interviews and structured conversations with other participants as well.

Consequently, when addressing the concept *"family care"* in FGDs, several issues was brought up in the following discussion. However, some of the perceptions attached to this

concept can be interpreted as desirable goals rather than properties to the concept. From old people's point of view, these included; social acceptance, recognition and inclusion; psychological and emotional care and attention; physical support; and practical help. Family wealth and access to money was seen as closely integrated into the fulfilment of these dimensions. The retaining of peace within a family confirming the love between parents and their children seemed essential in order for family care to be made available, which according to elders also constituted a prerequisite for the extent of care that could be expected at old age.

Social acceptance, recognition and inclusion at old age

According to old people's statements, social acceptance, recognition and inclusion can be interpreted as dimensions of life strengthening their identity and self-esteem, supporting an old person's sense of psychological well-being. To be involved and recognised in virtue of being an elder and as such included in decision-making through consultancy, seem to be important qualities. Such recognition reflects respect for an elder, and acknowledges his or her wisdom and experiences acquired through a long lived life.

There are strong indications in the data material supporting old people's perceptions when they experience a gradual decline in their execution of traditional roles which they felt impacted on their recognition and appreciation within a family. Old people explained this in particular to be reflected by changes in attitudes and behaviour by the younger generation, inspired by societal development, urbanisation and improved education. They experienced attitudinal changes to touch their identity and dignity, and their feelings of usefulness, social function and value to be degraded.

Conversantly, several primary schools, both public and missionary exist in the area of the study site. A secondary school located close by offers education within various practical and technical disciplines. The newly elected Governor is currently implementing exemption strategies aiming to secure children education in public schools without the payment of school fees. The general views of rural people are to give children education as a mean which in return would secure them a better life in future times to come. This can be understood as a reciprocal investment between parents and their children. However, as many youngsters want to improve their educational skills, they move out from the villages to

go for higher education, seeking prospects of self realisation, freedom and success, rarely returning to rural areas with its perceived lack of opportunities. Consequently, elders experienced the younger generation to increasingly distance themselves from old traditions, norms and values that through the years guided a person's duties and responsibilities towards his or her family. Old people and informal caregivers commented particularly on the changes in behaviour and attitudes among young people. They saw new attitudes to especially be reflected through lack of respect affecting their role as advisers. A young caregiver hired to help an old woman explained:

> *"So from that school life they [children] learn another guess, they change so they make anything for her mind. So if they see, they learn from it so any old person talking to them will not listen because they look other things they see. Maybe that thing they see would make them [older people] moralist. They [children] will not care for that person to hear what the person to say"* (CT2V1).

According to formal caregivers and key persons of younger age, village life was by many perceived to be old fashioned and the younger generation increasingly concerned about changing their image from traditional to modern. Urbanity and education was assessed to bring knowledge of contemporary lifestyles, refined by western influences, enforcing rapid adaption to values guiding individuality rather than collectivism and solidarity.

An interesting finding, though only reflected by a community nurse participating in one of the interviews, was related to her experiences where some villagers were found to oppose the returning of young people and their resettlement in the village. This caregiver was an experienced community nurse who had worked in rural communities over time, making her familiar with the diversities of norms and values guiding village life. According to her, migrating young people were often referred to as *"Wahala",* Pidgin English meaning *"those bringing difficulties".* This may on one hand indicate villagers' preconceptions on the effect of urbanisation on youths to bring along problems (many villagers attached urban life with criminal acts), but may as well reflect scepticism to the introduction of new ideas acquired through new experiences and education, not easily merged with old traditions. A social- and development worker who reflected on issues concerning education and urbanisation within the perspectives of old traditions said:

> *"Also I would say, I would say, I don't know how to put it (…), there is the cultural shock. The coming of civilisation and our own traditional way. There has not been a blend, a very good blend. You know, everybody is chasing the modern world, the civilisation, which is gradually taking [over] the traditional way of living (...) there has not really been a good blend, that's why some things, like which the older people fall under, some of those things has been neglected. It boils down to societal change, we are not (…), I think we are trying to go faster than (…), we are not taking the changes at a time"* (CT6 formal).

These very important statements were reflected by informal caregivers and old people as well but it meanings expressed by the use of other words and examples. Elderly people focused extensively on the effect of societal change which they felt impacted the inter-relationship between them and their children. Several findings relate to their concerns of not controlling their children again as they were perceived to be influenced by new ideas originated from interaction with urban people which also included worries for their children to be involved in criminal activities. They experienced not having the right to talk or to ask questions, and some explicitly expressed fears of abusive responses from sons. An old woman spoke about her concerns in a FGD:

> *"People use bad words on the elderly ones (…) if you ask your children where they were coming back from, they will be angry with you"* (P1V3).

An old man from another village had similar experiences:

> *"Although the old person will talk no matter how difficult it is and what usually happen now is that the young will visit those old persons in the right to beat them"* (P3V2).

Based on statements of similar character, some elderly people perceived the effect of social change and urbanisation to consequently bring along changes in children's attitudes towards them. They feared that attitude change would considerably influence the quality of care and support they could expect to receive in times of need and also to degrade their position and status within a family, making them feel disrespected. On the other hand, one might question whether their perception of attitude change is an actual change, or whether their perceptions are different due to their own status of being old.

Based on their self-perceptions and experiences, several old people emphasised having the ability and capacity of walking around in the neighbourhood (kindred) visiting friends, where his or her role as an elder could be confirmed through conversations with age-mates. One old lady said:

> *"Truly, family support is good. We that are old women now lived in peace with our mother in-laws but the newly married women these days are not doing that. They will say that your own time is gone. So what we do is to look for our own age mate to discuss in the family. It is good to relate well in the family. Give them advices, if they like let them take it or not"* (P7V1).

The majority of old people specifically emphasised the importance of being seen and consulted as they perceived familial and social recognition to facilitate a sense of well-being leading to experienced health. This underlines how the positive aspect of being old is socially constructed and re-constructed.

Psychological and emotional care and attention supporting the identity of an old Igbo

A majority of the elders emphasised factors closely related to the experience of psychological well-being where social acceptance, recognition and inclusion were viewed as integrated components. In order to consolidate their sense of well-being, older people explicitly stated emotional care and attention from family members to be crucial in order to have rest of mind. Emotional care can be interpreted as the desire to be noticed and through people's acts perceived as equally valuable and important with others, within and outside of a family setting. The essence of emotional attention was also brought up as an issue by some informal caregivers as it was perceived to bring happiness into old people's life. Conversantly, older participants focus on emotional care and attention may be linked to- and viewed as a result of the ongoing decline in social recognition as described earlier. It may as such contribute to the understanding of why the importance of being seen stands as essential, which could be accommodated by having conversations and to be greeted by their children through physical visits but also by neighbours and friends. However, old people's perception of being seen and valued could also be anticipated through phone calls from sons and daughters.

An aspect quite frequently brought up, which moreover can be viewed as closely related to the psychological dimension of health, was the importance of family members, and also villagers knowing about an old person's well-being. According to old people, lack of such knowledge influenced largely on the accessibility of support and care in times of need, and in particular when illness stroke. Consequently, gaining information on children's whereabouts and means of contacting them become crucial. One old man came forward with his experiences on the above issues during a FGD:

> *"Young people now don't even look at the old people. If you came back from somewhere, they will not even welcome you or even greet you. The worst is that you will not even know where and what they are doing or even when they will come back to the house"* (P1V2).

Another old man continued:

> *"Yes, he said the right thing. That is why I said that the world is changing. Children of nowadays don't even want to know if their parents were sick or not. Before these children come back, they might have eaten somewhere before coming back to the house. They are not taking care of us at all"* (P2V2).

Among some old women participating in another FGD, there were some disagreements regarding these issues. These are reflected in the below arguments:

> *"None of them is coming back to look after us"* (P1V1).
>
> *"It is when you call them on phone, they will come"* (P5V1).
>
> *"No, some of them will wait until you are dead before they will come back"* (P3V1).

The question remains, however, whether these viewpoints again reflects real attitude change among younger people, or whether it is an expression of how the old people experienced that they are gradually being perceived differently as they are getting older.

The elderly participants who participated in this study had all sons and daughters whom several have migrated out of the villages and some elders could not account for their children's whereabouts. Particularly old women expressed concerns regarding the absence of children which brought about the question:

> *"What will happen to me?"* (P6V1).

When conducting background interviews with the older participants, I was asking them about the whereabouts of their children. The following two diagrams reflect information provided by each of the older participants:

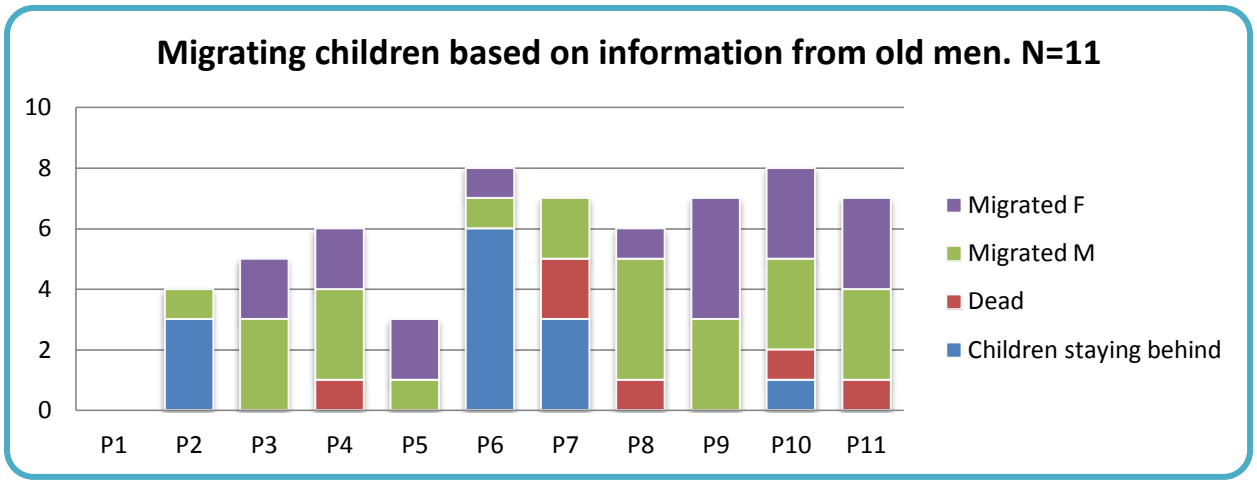


Figure 17: Information is based on the total number of children of each participant. Note; P1 wanted to abstain giving information on children's whereabouts. We learned from his wife that their oldest son just died.

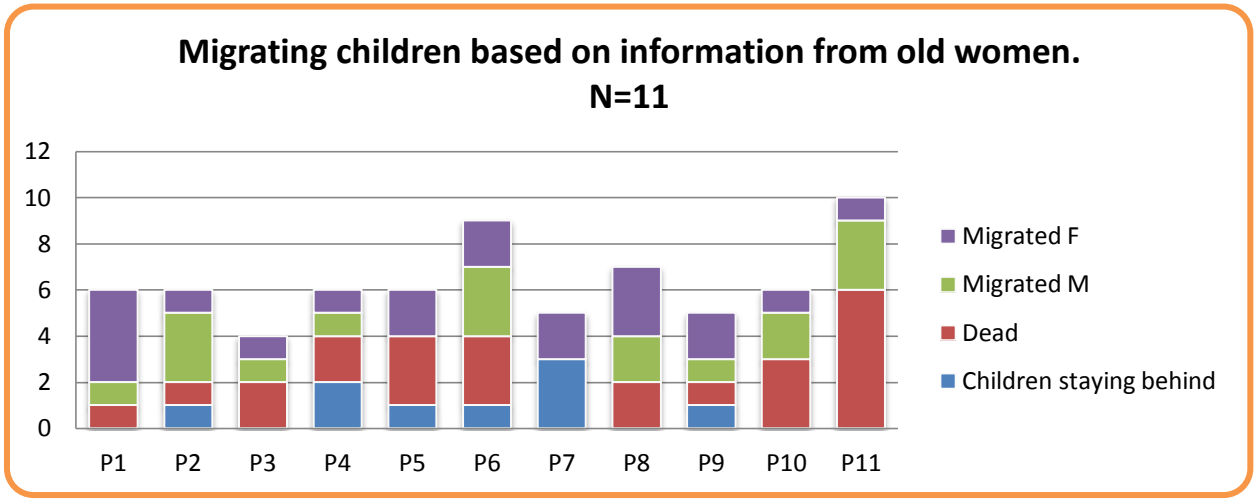


Figure 18: Information is based on the total number of children of each participant.

According to the background information provided by elders, there seem to be more old women not knowing the whereabouts of a son than old men. As presented earlier, not knowing the whereabouts of a child brought about great concern, and some old people were reluctant to talk about it. Some said they have not heard from a son for several years and are sure of neither his occupation nor quality or state of life. Those knowing about their son's whereabouts could tell stories about some of them not visiting for the past five –or even up

to twenty years. Daughters' absence was perceived by old people to be more acceptable and was understood in the context of them marrying into their husband's family (patri-lineage). As such, their duties to support elders were directed towards their family in-law before their own paternal family.

An old man expressed his worries on nobody coming to see him. Such uncertainty was clearly being related to factors causing mental stress where they expressed lack of happiness to cause physical discomfort. Especially *"Obara Mgbalielu"* (hypertension) and *"Isi Owuwa"* (headache) was rampant and looked at as serious conditions. As such, psychological symptoms of ill-health was related to- and explained using terminologies involving physical conditions, which is interesting having their understanding and interpretation of the concepts *"ahu ike"* (health) and *"oria"* (ill-health) in mind.

The old people made a clear distinction between having supporting family members nearby, or having supporting family members living away from them. They felt unsure of whether the help would arrive soon enough when they would need it at most. This view was also supported by caregivers staying with old people as several of them were dependent on monetary help, especially from their brothers living outside of the villages or abroad. A daughter explained:

> *"If I ask they will send whether big or small (...). If they give any money, I'll accept it. [Laughing] (...) when I feel it is difficult (...) I will pray so that God will help me. And if I pray, God answers me yes"* (CT1V1).

An interesting finding in the data material seemed to support an assumption where sons' loyalties in terms of sending money seemed to be closer directed towards their fathers. One key person residing in one of the villages said:

> "*Then I send money for her [Mama] to feed, though my Dad was alive then"* (K1V1).

This can be understood as a reciprocal activity fostered by values guiding mutual responsibilities between fathers and sons where support involves prospects of inheritance, and access to assets and properties as earlier mentioned. Based on such norms, old women might find themselves eligible to mostly receive support from sons while their husbands are still living. Consequently, old widows may more frequently turn to their daughters for help

and support rather than their deceased husband's extended family. Such assumption was to some extent confirmed by a formal caregiver, illustrated through his following reflections:

> "(...) *we are talking about somebody having maybe 4-5 children. 3 has migrated. Maybe the daughter remain, may she is a teacher in the nursery-school, with maybe school cert. She cannot stay seeing the mother suffering. She'll cry to maybe manage the little she have to see that the mother is feeding. Maybe after to-three days, when the mother is crying of pain, pain, pain; she will go and manage and buy a card of Paracetamol, containing 12 tablets to please the mother, you know. And the brothers and sisters, the other three, are all (...) From time to time she'll send message to them, they don't come. She calls on phone, they answer, no proper response. The lady will be bitter. (…) (…) And maybe they have come empty handed. She will not be happy again, she will even swear and God make me to be the only daughter of my mother, because having brothers and sisters who are not helping this my mother, who bear me, took care of me until I walked to this age, the woman is now suffering. She is now sharing the suffering of the woman with the woman alone"* (CT5 formal).

From this, one may suggest economic support from brothers and sons not always to meet with expectations as several turned to God for help through prayers. Old people emphasised the connection between lack of support and sons not progressing. An old man and old woman participating in their respective FGDs said:

> *"Not progressing is a disease by itself"* (P2V2; P6V1).

Some of the insecurity that old people expressed therefore reflected concerns about whether their family members, and especially sons living in other places, were able to earn enough to provide them with support. Such concern could sometimes be felt as overwhelming causing mental distress that led to the experience of ill-health. Their worries and expectations may definitely put heavy burdens on the shoulders of any son. By being unable to meet up with expectations, several may consequently avoid visiting or ultimately make themselves unavailable to reach through phone or by other means. An old woman shared her worries in a FGD:

> *"You cannot be at rest when you don't see your child or receive any message from him or her especially when you are sick."* (P1V3).

Among the elders, there appeared to be an acceptance to receive help from <u>any</u> caregiver in the absence of a child or close family relation. This could be a hired help, assistance from

neighbours or fellow villagers, from a distant relation or a true philanthropist. However, the most common strategy was to ask for a younger family relation to come and stay with an older person by assisting doing practical work. This could be a child of a *"sister"*[10] married into another village, but several old people expressed opinions on younger children not always being available. The following is an old man's reflection on receiving support from a hired helper:

> *"Why is it important that such thing should happen [hiring help] is that if my children are not at home and I am not strong enough to come out to find something to eat, my children may be they have gone abroad should provide a helper that will support me in terms of running errands and as well cook for me"* (P3V2).

One key person residing in another village had this to say on the matter:

> *"Here now, if somebody like myself and my wife, we are getting old, so what they [their family] can do practically is to send one or two of their own children to help us doing those small things we cannot do. Or go out and hire somebody elsewhere. Bring that person near us, to be helping us fetching firewood's, fetch small water things like this"* (K1V3).

Even if they agreed to receive care from different people, they remained clear in their view that the provision of care was primarily the responsibility of their children.

However, there seem to be different views on what could be expected from neighbours and fellow villagers in terms of support. One old lady brought up the issue during a FGD and her arguments reflected the following:

> *"Praise the Lord, Alleluia. Family support is, our people [the villagers] does not support each other. You might be sick but the people around [fellow villagers] instead of helping, they will remind you to call your child that is in Sokoto to come and buy medicine for you. You might be ill for a long time but nobody will care for you until you borrow money and go to the Hospital. When you are well they [villagers] will come around to say; so you did not die again. Our problem is jealousy. But when your child comes back, all of them [villagers] will gather to eat the bread*[11] *your child brought for you"* (P5V1).

[10] Women are often referred to as sisters, and men as brothers. It does not necessarily build on family relationship and could therefore in this case refer to a woman of the same kindred or village, or to a friend.
[11] Money is often referred to as *"bread".*

In spite of the arguments above, some of the old people residing in one village experienced support from fellow villagers while others did not. In the other two villages, none experienced such support.

Even though it seemed to be a trend of hiring people to take care of the elder people, very few of the informal caregivers brought up the issue of hiring a person to care for the old ones in a family. This may suggest that they still view care-giving to old people to be the responsibility of close family members and deviating from such norms may contribute to a negative reputation among fellow villagers. When I asked about family care to one of the key person in a village, he replied:

> *"You know, some here, what they do is, when their parents are old and maybe their sons are outside, they will hire someone to stay with their mother or with their parents, to take care of them. They only send money"* (K1V1).

I continued to ask him whether he experienced several families to hire carers as a strategy compensating for family members absence. On this question he replied:

> *"I don't want to mention names here"* (K1V1).

This statement further confirms the involvement of shame when family members are unable to provide direct care for an old mother or father, and seek for others outside of the family to attend to their need for care.

A finding in the material was that none of the older participants expected to receive emotional care and attention from a distant person or an outsider, supporting their sense of psychological well-being. Such care seemed only to be accommodated through the interexchange of emotions between old people and their children, and possibly by the care of close family members. However, old people still related happiness to the availability of any caregiver in order *"not to die quick".* Such positive emotion may not necessarily be explained by the presence of a helper, but can rather be interpreted as emotions directed towards family members efforts securing practical help and by doing so, confirming their concern and love for the old one.

Practical help and physical support in activities of daily living

According to old people, they need practical help of different kind that they no longer have the strength to carry out by themselves. It may comprise giving a helping hand in farming activities or assisting an elder in other income generating activities. It could also involve maintenance- or construction work in a family compound and to participate in projects initiated by the community by contributing physical labour on behalf of the old person. Within the familial sphere, practical help usually involved assisting an old person with the fetching of water and firewood, doing laundry, cooking, cleaning and sweeping, going to the marked to buy food and medicines, and escorting an old person to a doctor when needed. Practical help was therefore viewed as essential in order to prevent ill-health causing premature old age and the introduction of chronic illnesses. Several old women participating in the FGDs said the following about *"Oria"* (ill-health):

> *"Oria comes when there is too much work and you will get old before your time"* (P2V1; P5V1; P1V3; P4V3).

Old men were concerned about the effect of ill-health on their ability to cope executing essential activities viewed as important to them:

> *"Oria is when you cannot do anything, even prevent you from eating and visiting"* (P2V2; P5V2; P8V3).

This may suggest a difference in self-experience and perceptions among old women and old men on the relation between physical work and health. Old women seemed to be more concerned about the heavy burden of physical work which they perceived enforced ageing processes, making them more vulnerable to illness and dependency on family members. Contrary to the old women, old men feared reduced health to limit their abilities to perform various activities which could confirm their status and self, restricting their abilities to mingle with fellow mates, and consequently prohibiting their opportunities to participate in businesses and ongoing projects. This may indicate gender differences in the roles and duties normally performed by old women and old men, where there existed expectations towards old women to be involved with physical labour while on the contrary, there seems to be an acceptance for old men to perform and participate in more diverse activities and interests, if not threatened by reduced health, physically and mentally.

Physical support was most often related to the assisting in activities of daily living where the strength, capacity and capability of elders were reduced due to advanced age, disabilities or ill-health. According to participants residing in the villages, this involved helping an old person with personal hygiene, feeding and mobility. Traditionally women were perceived to be the main providers of such caring activities. Duties were usually performed by daughters and daughter in-laws, but when exploring these issues thoroughly, it seemed as if men contributed in such activities as well. It was, however, hard to reach a consensus based on participants' opinions regarding the nature of care and general assistance that could be provided to old people on the basis of gender. Informal caregivers, who all were women, told me that they were the only ones who could help an old person with personal hygiene, dressing, cooking, feeding and laundry. Daughters and daughter in-laws commonly viewed themselves to be the main person expected to stay with a sick Mama or Papa in a hospital.

As mentioned earlier, about half of the old people said that help and support could be rendered by anyone available in the absence of close family relatives, although hired helpers only were mentioned in relation to practical assistance. Apart from this, they also expressed diverse opinions related to the intimacy of an activity rendered by their children. A son would be welcomed to bath his mother if no female was around but some old women said that their sons could not see them naked, while some men said that neither their sons nor daughters could see them naked. A daughter in-law supported the opinions of old women, but on a question related to the appropriateness of sons accompanying a mother to the toilet, she answered:

> *"Yes. Yes. When my husband came back, I did not do that. It is my husband that did that. It is just when he travelled to Aba, then I would take proper care of my Mama"* (CT1V3).

Moreover, discussions revealed that the old people could accept a son to feed an old person, to cook, clean and do laundry, though this was rarely experienced and not expected by participants in this study. Consequently there seemed to be no clear norms prohibiting sons and daughters from performing caring activities on the basis of their gender in general, but gender seemed to matter when there was an intimacy aspect of the activity. The exception was between a husband and a wife where there were expectations of mutual support in all caring activities.

Despite the well-defined gender roles in the communities, a generational shift seemed to evolve among younger women. They were perceived to increasingly pursue their own careers, a factor that may challenge men's traditional function within a family. The strengthening of women's independence through education and formal employment may implicitly foster prospective expectations of support involving both money and care, adding on duties traditionally seen as their area of responsibility.

An important observation supporting the latter arguments was noticed by a community doctor and a governmental representative. Such observation seemed to be related to new strategies of coping with obligations that could indicate that there was an ongoing widening of women's areas of responsibility. In order to comply with traditions of caring and at the same hold on to formal jobs, women approached doctors to get statements justifying their absence from work when problems arose. The community doctor explained:

> *"Yes, it is happening, yes. I have seen just a few, like those working in some other LGAs, that want to be absent from work; could you please give me a letter to show that I'm here to look after my father or I'm here to look after my mother. Just some few. In fact, it is a matter of conscience of the employer, not myself, but if you tell me, because you brought your mother to the hospital and looking after her, I will write; to whom in may concern, this is to certify that so, so, person brought the mother to the hospital and is looking after her. It is a formal way of giving a medical report"* (CT2 formal).

This example points to the opportunities for women to combine carrying out their professional work alongside with the caring for old family members. Moreover, it indicates a shift from what traditionally has been prevailing norms and introduces strategies adapting to contemporary lifestyles. However, female caregivers living in rural areas seemed to be more influenced by old traditions, adhering to traditional norms of caring, which often were experienced as impacting on their professional training, causing a gradual transition from formal paid work towards the performance of small scale activities within the area of where they lived. One young daughter in-law who recently married and consequently had to give up an education in process, shared her personal experiences:

> *"I married in this big city [hometown of the daughter in-law] where I was being trained as a [yyy]. But because of hard time, he [her husband] suggested that I moved to the village to sit with his Mum, so that he will build house before he comes and*

> *take me back to the city. He will not build in the village, because he is no more staying here. He wants to prepare, that is sit well and get money before I go back. But I will stay with Mama for two years in the village before I will go back to the city, because Mama is very sick, so I have to take proper care of her, then when Mama get about safe [dies?], I will prepare to go back to the city"* (CT1V3).

This quotation could be seen as an example on the remaining strength in traditional gender roles and expectations. Because a young woman receiving education still has to adhere to the expectations to give up her education and instead move to her mother-in-law to take care of her.

Young caregivers remaining in a village may consequently be forced to rely on collective support mechanisms and depend on husbands. As a result, changing values of society can be expected to cause gradual persistent changes in customary support for elderly people that moreover contribute to create gaps between women living in urban areas compared to those residing in villages regarding prospects of self-development, identity, independence and availability of resources.

Children, an asset and prerequisite for the experience of health and well-being at old age

As one may have learned so far, the majority of elders participating in FGDs perceived family support to insufficiently meet their expectation and need for care. Moreover, they said that the bringing of a distant relation or an outsider (hired help) as replacement for family members' absence, necessarily involved access to money. According to general information given by villagers, costs of living were generally high in this area. Therefore, spending money for an external person to come and support an old family member was not always seen as a priority. Consequently, the economic viability of a family and their priorities was perceived to largely impact old people's opportunities of having someone around supporting them. Elderly explicitly mentioned lack of family wealth to be one of several constraining factors impacting their livelihood, involving their abilities to accommodate for basic needs and managing the day to day life. According to participants residing in the villages, wealth of a family should traditionally benefit all family members and wealth was closely related to how a family's buoyancy was assessed among fellow villagers and as such influencing family status. However, the buoyancy of a family could be strengthened by having someone in the

family who had moved out, attaining success by securing a job; good friends with goodwill to lend out money when needed and perhaps most important; access to land. An old man participating in a FGD had this to say on the matter:

> *"Every family in our village here have something that can be sold to help people [family members]. Each individual has theirs. Whatever you have in your family, it is your wife or your husband that will bring those things to take care of you"* (P4V2).

The extended family system is closely interwoven with issues of family wealth. The family network was looked at by participants residing in the villages as an opportunity for support in general and by elderly, securing care in times of old age. Consequently, being married before getting too old and to have children was important. When I was collecting background information from informal care-givers, some told me that they were not the first wife of their husbands. The main reason given was that their husbands wanted to remarry due to previous wives' inabilities to conceive. When such facts became evident, she sometimes had to leave or was sent back to her paternal village and family. This custom was said to be changing, at least to some extent, but in a society without formal welfare- and security systems, children are heavily considered an asset to future care and wellbeing and importantly, the progress of a family.

A cultural phenomenon becomes apparent when discussing issues involving the latter with a key person residing in one of the villages. The Igbo people of this area are practicing an ancient caste system based on family linage. If a person cannot refer to any family linage, the person is named *"Osu"*, which means being an outcaste. This system relates to old times' practising of slavery, where those better off bought or kidnapped young adults or children to come and serve the richer ones. These people become as a result people without caste, which accumulates through their children, referred to as *"Omu"*.

The belonging to a caste, where you can refer to an ancestor, has in the Igbo culture, in this area, influence for who you can marry, and family line being investigated by prospective in-laws. Interestingly these traditional practices are not openly discussed within families in general and opinions are rarely shared with outsiders. Even in times of today, the family line is being checked by prospective in-laws and influences extensively whether a person will be accepted as a future son- or daughter in-law. The origin of such practice was traditionally

initiated to prevent evil blood from regenerating through the children. In contemporary time, the evilness attached to this phenomenon has developed to be linked to juju[12]. With the introduction of Christianity, religious leaders tried to stop such practice and way of reasoning, but it is still prevails within communities today. It contributes to intricate the relationship between women and men who intend to marry each other, and may lead to enmity within a family and separation of family members if a person decides to act contrary to advice. The implications of the latter decision are numerous and can be assessed as to influence on a person's right to inheritance and to benefit from family wealth through belonging to a family network. It may further deny them prospective support and care from relatives as the upholding of such traditions consequently prevents some people from getting married and from having children. They are likely to be left to manage life the best they can on their own and to face hardship especially at old age, without the support from a child or close family members.

The importance of having children, as an asset and prerequisite for the experience of well-being and health at old age, became also evident when I, quite unexpectedly, came across another cultural phenomenon. An ancient norm prevailing in the villages where this study took place is the opportunity for an old woman without close family relations to *"marry"* a young woman for her to give birth to children, re-establishing a family network in order to secure future times to come. This tradition seems to have faded in contemporary time, but I possibly observed this arrangement during a visit to an old woman living alone. When entering her small compound, there was a young lady with a baby present, rounding up the laundering for the day. She kept herself at a distance and did not greet us when arriving, which is quite unusual according to customs. However, I saw her frequently glance in our

[12] *Juju* can be defined as a sequence of ritual actions that are culturally edified, which address people's needs in social, cultural, religious, economic and political scenarios of day to day lives (Patrick Iroegbu, Ph.D. (2012): JUJU MEDICINE: Reality and Meaning in Igbo and Nigerian Political Culture. http://chatafrik.com/articles/nigerian-affairs/item/868-juju-medicine-reality-and-meaning-in-igbo-and-nigerian-political-culture.html

According to observations made at the study site, ju-ju is most often being linked to harmful practices and ancient spiritual ceremonies conflicting with contemporary Christian doctrines. People who dedicate themselves to exercise its rituals are usually perceived as people dissociated from the norms and practices that generally guide the preferred behavior and life of village people. They are likely to be expelled from participating in community- and church activities.

direction and after a short time, she left with the baby. The old woman did not give any explanation on her presence and we did not ask. The situation appeared to me as quite unusual, without the introductions and greetings, and I was later told by my interpreter that this young lady most probably was *"the wife"* of that old woman.

Both the latter and the previous observations are interesting as they reveal the existence of cultural specific phenomenon impacting prospective opportunities for care assessed within perspectives involving wealth, inheritance and security at old age. Unfortunately, due to time constraints, I did not get the opportunity to explore the latter phenomenon further. However, it stands out as interesting, as such constellation seems to facilitate reciprocal activities between humans at different life stages and in different life situations, of which they both could benefit from, the old woman living alone, and the young woman with a child.

Figure 19: Traditional village house. Photo: Heidi Olsen

Those elderly ones, likely to fallout……

When discussing family care to old people with participants residing the villages, I gradually became aware that a specific group of elderly was likely to be excluded from the care and support of their family. My awareness was initially based on vague indications given by participants participating on one of the FGDs, but became clearer and more visible through a self-experienced observation. I have therefore decided to introduce the last chapter of this part of the thesis by telling the following story:

> *"One morning, I was walking with my research assistant and co-assistant/interpreter in one village. We were trying to locate the different kindred in order to approach old people to participate in one of the Focus Groups. The weather was cloudy and humid and it seemed like rain soon would start falling. This part of the village is not very populated and green vegetation was flourishing all around us. It was all very beautiful. When passing one huge compound fenced by a brick wall, I noticed an old woman sitting outside in the bushes, but close to the fencing. She was sitting on an old wooden stump trying to make fire of old palm leaves. Beside her there was an old rusty pot. I was first thinking; how can she make a fire out of those damp leaves? Then I became aware of the appearance of the woman. She seemed very old, extremely skinny and dirty, dressed in filthy clothes consisting of a wrapper and a tore t-shirt with no slippers on her feet. She was sitting there with no shelter and I was concerned about what would happen to her when the rain starts falling. Those palm leaves would certainly not catch fire and she would be very cold. My co-assistant shouted to her, asking the direction to one particular kindred. She answered and pointed the direction. We continued walking. I asked the co-assistant whether he knew the old woman and what brought about her staying in the bush outside of the compound fence, and in such poor condition. He told me, yes, he knows the woman. She was once the oldest wife of Papa, owner of the land where the compound now was rebuilt in the name of the oldest son. Papa was dead for a long time and this wife was now considered mad by the family, pushed out and abandoned. The day had suddenly turned to its greyer shades and my heart was aching".*

This story indicates an existence of complex traditions among the Igbo people with the possible impacts on traditional support mechanisms affecting the care of old family members. There may be multiple causes to an old person's possible fallout from family care. Some old people had, through their participation in FGDs, indicated lack of family care and support to be influenced by family members' opinions about old people to engage in old rituals and spiritual practices, contributing to label some elders *"Amosu"* (witch). When

meeting with a key person in one of the villages, I decided to address this issue directly and asked her to explain the phenomenon. The key person acknowledged my question and recognised the phenomenon to exist, but made it clear at the beginning of our conversation that she strongly dissociated herself from those villagers engaged in occultism and ancient spiritual thinking and practices. After making such clarifications she explained the phenomenon *"Amosu"* to most often be attached to the reputation of a woman. Such could be influenced by lack of adherence to traditional norms of behavior, including change of mindset, being considered as *"wicked"* and to cause problems, change in status involving being a widow, having no children or not having them around, buoyancy, or disfigurement of the body. Surprisingly, the onset of a sudden illness could also contribute labeling a woman *"Amosu"*. According to this participant, all these mentioned aspects of life could cause a woman's possible fallout from family care.

She continued sharing her own philosophy on the matter with me by explaining the following:

> *"There is nothing like witch. "Witch" is thoughts, thinking, fear. You think like this; this woman who is as yellowish as this [referring to my complexion] may be a sister to the queen that goes in the ocean. And I may look at you and say; Ah, ah! This type of yellowish, hey, this one o', I fear you! And then when they are coming, I will be dodging myself. Because why I have sent somebody whom my spirit is telling me that you are a sister or a friend to the queen of the coast. Who made you queen of the coast? Is it God or herself [the person] who thinks you are? How did she [the person] come to know? It is an imagination, it is what it is; an imagination!" (K2V1).*

For a person like me, born and bred in a western society, mind-sets supporting the existence of spiritual specific phenomenon as explained above may not be instantly understood. So I asked the key person to elaborate further on these issues. She continued:

> *"Amosu*; *You can be rich. People here are ungrateful. You can be rich today, [people will come and] eat with them [you], enjoy with them [you], doing anything with them [you], maybe you are unfortunate to not get any child. Uhh? Only your money finishes? When you don't have money again, they start to give you assorted names. Are you hearing me! This person is Amosu this and that. They [people] can give anybody a new name. It is a forgery thought. Maybe it is because she has no money. They don't get whatever they want from her. "Witch" is because she has not agreed*

> *with people (…)? So it is nothing like Amosu, it is just from selfish mouth made it"* (K2V1).

Apart from the understanding and opinion presented by the key person referred to above, a Social and Development Worker who participated in my study introduced similar issues in an interview conducted later. He told me about his observations when practicing in an Old People's Home in a neighbouring state a couple of years ago:

> *"Because there was a particular case of a woman, that had been brought there by her children. The reason was that she was stigmatised to be a witch in the village, so they brought her there. There is still another, it still boils down to this our own traditional ways too (...) religious, that small religious or fetish, anyway it has to do with traditional*" (CT6 formal).

He continued:

> *"(…) they [children] will be sending funds to take care of them. At the end of the day, they will not really keep into their own parts of the bargain the way they should be doing (...) and it was a really pathetic situation"* (CT6 formal).

These statements may explain why elderly people in general, and especially the old women, expressed fear of being taken to *"Old people's Home".* Without their explicit confirmation on the following reasoning, one may nevertheless assume their resistance to receive care in institutions to stand strong as it not only could be related to how they were appreciated and valued as humans, but also attached them to activities involving witchcraft and the labelling witch. Such allegations would put the love, care and support expected to be received from family members at stake as well as their inclusion in a family.

The Social- and Development Worker continued giving other examples, where he also referred to his practice in a Psychiatric Hospital. During his work there, he experienced several old people to be hospitalised on the basis of family members' characterisation of the old ones to be *"mad".* I asked him to elaborate on his observations and to reflect on the possible motivations for family members to hand over the care of old family members to caregivers working in Psychiatric Hospitals. He responded by saying:

> *"(…) then the social workers will look at the emotional needs and some other situational problem, because it was discovered that most of them, they didn't require drugs, they were just not taken care of socially. So that was what was given cause to*

> *their mental case, given rise to their relapses, you know. (…). I know of an old woman there. And her own case was, she was labeled a witch. I know of that particular case. She was labeled a witch, so she was brought there by the family. And at her own case, she was abandoned, that particular one. Because I asked personally about family people, because they said she has been there for a while. And she has been having steady relapses. You know in the village, because she was brought from the village, and maybe the family wanted to, just in the way of maybe, removing her from the village, so that there won't be any problem within the village"* (CT6 formal).

In this quotation he points to two factors, respectively emotional care and social inclusion, earlier found to be essential supporting old people's experience to have health. Lack of emotional care and attention and not to be included socially were therefore by the Social- and Development Worker found to cause mental distress, in this case associated with *"madness",* which however at the same time also was linked to the labelling *"Amosu";* a person creating *"problems"* in the village that possibly could damage the reputation of a family. There may of course be more than one explanation why family members transfer old family members from family care and into institutional care. People may for instance hold inadequate knowledge on the multiple factors causing mental and psychological distress, and how reasoning, behaviour and attitudes gradually could change in an old person due to the influence of people living around-, and the environment in which they live. Situational realities hard to cope with over time may consequently contribute to the manifestation of illness. But it may also be that changes in an old person's attitude simply occur due to the person being old. The decision made by family members to hospitalise elderly people, in these cases old women, could therefore be motivated and conditioned by their traditional and cultural reasoning, influenced by their educational level, but also by the advice of people trusted in the community. Another, though speculative, reason could be that the abandonment or exclusion of an old person based on labelling would be accepted by people in the communities and represent an alibi in cases where the children no longer have the capacity or are unwilling to provide care and support for them. Their actions may then be perceived as justified, whereas the shame involved could be avoided and their reputation could remain intact. As a result, old people's psychological responses to situational challenges, perceived incompatible with the cultural expression of old age code of conduct, may consequently leave them vulnerable to the decisions and responses from those meant to safeguard their wellbeing throughout their old age.

Lack of attention directed towards cultural specific phenomena affecting life at old age combined with lack of alternatives in socio-economical systems, complementary to that of the family, increases also their risk of experiencing extreme poverty at old age. This involves not only those labelled *"Amosu"* but includes also the implications of the traditional caste system. Consequently, norms, values and beliefs guiding caregivers' motivation in the care of old family members ultimately influences the pillar of old age support mechanisms which at present time only seems to be facilitated through their belonging to a family.

The phenomenon referred to above needs to be explored further in order to fully understand its implications and impact on older family members and particularly old women. However, such investigation is not within in the scope of this study. Nevertheless, having acquired knowledge on culture specific phenomena where at least some old women face their destiny as *"Amosu"* and other to fall under a traditional caste system naming them *"Osu"* and *"Omu"* is still important. It tells one that phenomena occurring within these communities have to be considered and taken into account whenever formal initiatives anticipating care and services to old people are being planned for and implemented.

Findings in this part have so far provided one with increased understanding of the components of family care viewed by old people to be necessary and essential in order to facilitate their well-being and health, and prevent ill-health from occurring prematurely at old age. However, most elderly people experienced a decline in the care and support from their children that earlier could be counted on, making life harder to live and to increase their vulnerability to ill-health. Many were also experiencing living their life alone, not having family members around to support them, and only some few enjoyed the help and support from close relations who shared household with them on regular basis. This was explained by an increasingly ongoing rural-urban migration enforced by poverty and competitive environments undergoing societal transitions. Their abilities to work become important, and ill-health was perceived as a major threat to their abilities to sustain life and uphold their livelihood.

Closely interwoven into the above perspectives was elderly people's perception of younger people, where they experienced the new generation to have changed life-styles and attitudes, from traditional- to contemporary living, watering down pervious values and

norms that earlier guided reciprocal duties and conducts between children and their ageing parents. However, in order to adapt and respond to new challenges in a rough society, younger people may not only be forced to reconsider their value priorities in order to survive, but they may also choose to do so as a result of improved education and status. Despite parents' investments in their children, where education was encouraged and their progress highly welcomed, the accompanying value change was not appreciated as it was perceived as conflicting with values affirming continuity with the past, determinant for the care and support one could expect from their children. The different situational realities of young and old people can as such be seen as examples of how human values are motivationally constructed as to guide ones actions and consequently support life situations at different life stages.

PART TWO; Characteristics of rural communities where this study is conducted

Infrastructures and its impact on rural development

As one has learned in the previous chapters, the ongoing societal transition was, particularly by the older participants, perceived to impact family members' abilities and will to care for them. This has been expressed through their experiences of having migrating children, many not fulfilling expectations of progress, where old people sometimes also were indisposed from knowing the whereabouts, especially of their sons. It has moreover been expressed through their perceptions of the younger generations' change of attitudes and behaviour towards them, where being respected and recognised in virtue of being elders were perceived to decline.

The urge of young people to move to urban areas seeking prospects of progress was basically linked to- and explained by the inadequate development of rural areas. These issues were clearly of concern and all participants shared strong opinions on the matter.

Participants residing in the villagers explained developmental inadequacies to reflect the Government's negligence- and failure accommodating the needs of rural people as regards to availability of public services, educational institutions and access to amenities, welfare services and development of infrastructures. Inadequate development of infrastructures was

in particular mentioned in connection with lack of work opportunities. Old people, but also other participants believed lack of clear decentralisation policies to be one of the main causes contributing to the hardships of rural people.

According to my own observations, villages lack reliable support of electricity, which has been a constraint over the years caused by the Nigerian Electricity Power Authority (NEPA). Such authority has completely failed to sufficiently develop and extend sustainable power supplies to reach rural areas, consequently causing people to buy generators and spending money for fuel. Moreover, there is lack of water and sanitation systems whereby most people have to depend on the goodwill of people supplying villagers with water from privately owned boreholes and wells. This involves people lining up for hours, carrying heavy water containers to their households, and to pay, in order to access safe water. The alternative is usually to walk far distances fetching water from a stream, increasing their risk of being infected by waterborne diseases. I experienced village roads to be unpaved with huge pot holes, making transportation difficult and tedious. Consequently, the inadequate development of infrastructure can be assessed to largely influence the viability of rural communities and their opportunities to perform income-generating activities. One key person shared his concerns and said:

> *"Right now, we needed a borehole here in this village. We don't have that except for individual boreholes. But the community ought to have their own".*

He continued:

> *"(…) if there is something like this eh (...) small scale industries, the borehole will have to give a helping hand. Isn't it? Aha! Like electricity, the small scale industries requires electricity, road and water. All these things are developments. And today in Nigeria, government doesn't do anything for us. The communities do all these things by themselves"* (K2V2).

Consequently, lack of infrastructure constituting a basis for the establishment of sustainable development projects causes people to invest in urban areas rather than closer to their villages. Poverty expressed through limited purchasing power may additionally impact on the sustainability of small scale businesses as villagers assess themselves to be people of poor economy. Inadequate access to infrastructure was also being related to lack of governmental efforts bringing companies to establish industries in rural areas; especially key

persons and formal caregivers saw this as a major constraint contributing to unemployment and poverty among people. One formal caregiver reflected on these issues and said:

> ”*Because if the government will decentralise development from the cities, and take the development to the villages, to some rural parts, they need to go to the cities will reduce, if there are companies, industries within the rural area, you know , like how it should be. (...). So thereby, people can always stay back home and still take care of the older people. I think it has to do with uneven spread of development”* (CT6 formal).

Argumentatively, lack of governmental efforts investing in infrastructures can therefore be assessed as explanatory, contributing to companies' reluctance establishing themselves in rural areas. Such reluctance encompasses implications related to accrued cost investing in technologies thus ensuring access to communications, electricity, water, sanitation and roads. Additional costs can be seen as affecting sustainably and competition with other companies' priority programmes targeting similar sectors. Inadequate political focus on decentralisation strategies may therefore lead to downward tendencies discouraging developmental initiatives, and extensively encourage migration draining people out of their villages. Participants emphasised extensively the consequences involving lacks of work opportunities but also the inadequate provision of welfare services. They communicated strong opinions on the inadequate attention towards the development of sustainable pension and social security schemes, and the provision of healthcare services which was perceived unaccommodating the needs of rural people causing *“under medic care”* or *“self-treatment”*.

I was therefore eager to gain knowledge on how community groups and social association ties assessed their role and function to be essential as to meet the challenges of rural communities through their involvement in activities and initiations of projects. Moreover, whether such involvements were initiated on the basis of the progress of individuals, or reflected acts of solidarity beneficial for members of the community at large, including those of old people.

Community groups and social association ties, their roles and functions within rural communities

Introduction

At the study site, as well as in several other African societal contexts, rural districts and villages have their own community organisations and association ties which constitute the 4th tire of governance[13]. According to general conversations with villagers and interviews with participants, the 4th tire is recognised and assessed by bridging community structures with formal Local Government structures. One important function seems to be directed towards the facilitation for community participation and collaboration in development projects consented to by the two governmental bodies or among community members alone.

Eze

In the area of the study site, the Eze[14] of each district, jointly with the President of the Town Union Council[15], constitutes legally elected representatives recognised to represent people of their respective districts in meetings headed by the Chairman of the Local Government. In addition, Eze are being called to participate occasionally in meetings at the State Government level and to bring information about future projects down to his respective communities. The Eze has a cabinet consisting of Traditional Chiefs[16] were also Chairmen of the villages participates. In some districts a traditional Prime Minister is appointed to help coordinate the activities of the Eze.

[13] **The system of governance** is divided into; the Federal-, State-, Local and Community levels, where the community level constitutes the 4th tire of governance acknowledged and recognised by the State Governor.

[14] **Eze** is the traditional king of a district. He can hold such position through the inheritance from father to oldest son. If people of a community are disappointed by the Eze's execution of his obligations and duties or such body does not exist within a district due to political the reorganisation of a community, they have the opportunity to elect a new Eze to represent them.

[15] **Town Union Council** is the highest level of governance in a district, headed by a President, elected to sit for four years.

[16] **Traditional Chiefs** of contemporary times are usually being involved in matters comprising traditional cultural activities i.e. traditional weddings, cultural celebrations, burials etc.

Chairmen and Chairladies

The executives of the Town Union Council are represented by the Chairmen of villages. A Chairman is the elected representative of a village and every village has a Village Hall where meetings and elections are conducted. He is elected by adult men by the show of hands and sits for four years, heading the Village Council. Women undergo the same process, whereby a Chairlady is elected by married women, and sits for the same period of time heading the Village Women's Group. Traditionally the Chairmen and Village Council supersedes the Chairlady and Women's Group. However, the Chairlady and her executives have their own seats in the Village- and Town Union Council where they execute roles and duties through the Women's Wing. As such, they are seen as an integrated body of the community structures existing within a village and district. Those not eligible to be grouped under these structures such as unmarried women and men, belong to Youth groups. Irrespective of group belonging, most villagers are members of the various Church groups existing in the area of the study site.

The function of community groups and interaction between them are various and multitude. Participants looked at the role and performances of groups and social association ties as vital especially when assessed within the perspectives of State- and Local Governments inadequate efforts improving the life of rural people.

Chairman; his function and responsibilities

After being elected, the Chairman's duties are numerous, of which one is to be the chair of village meetings. One of several important issues discussed in such meetings seemed to be the settling of disputes between villagers, frequently related to the possession of land. Retaining peace is therefore not only essential at the familial level, as elaborated in the previous chapters, but also at the community level in order to facilitate good interactions between villagers. Moreover, Chairmen frequently attend meetings and celebrations when invited, and normally head the implementation of development projects consented to by villagers. A key person gave examples on his numerous duties during a conversation:

> *"Yes, if people misunderstand themselves by dragging boundary adjustments, we settle that. If we hear that there is a theft somewhere, we try to fish out who might have done the wrong and then settle that. We also see that the village is in neatness.*

> *We keep the environment clean, both road leading to the streams and the road leading to the marked square and our own village square. You see. There are so many things that we do which I cannot also remember exactly"* (K3V2).

A Chairman's duty was also to secure directives coming from the Local Government via the Town Council as attended to and executed. Such could be of environmental nature or involve giving information to other community groups where an activity seemed closer to their domains. An example of the latter was the passing of information to members of the Women's Group on forthcoming immunisation campaigns for children.

Age-grades; their role, function and responsibilities

From conversations with villagers I learned that the age-grades traditionally have acted as the government of a community since ancient times. They have traditionally organised community development, solved problems among the villagers and defended the community in times of problems. In spite of being less recognised due to the introduction of formal governmental structures, men still tie themselves into different age-grades. Women do not usually form age-grades in this part of Imo State, but wives commonly benefits from their husbands belonging to an age-grade.

I was in particular interested in exploring the role and functions of age-grades, as they still seem to be appreciated and recognised due to their function within a village and their influence on developmental issues. Moreover, I wanted to learn more about the mutual support mechanisms existing within a grade, and if there was reciprocal support mechanisms existing between members of younger and older grades. My aim was of course to find out whether belonging to an age-grade also could benefit men of old age in times of need.

Age-grades elect their leaders and executives democratically and have laws on how to behave correctly and rights to control members behaviour. According to information given by male participants residing in the villages, age-grades commonly initiate village activities and development projects, which involve decision-making, solidarity acts and consultations. They ensure that information is exchanged among themselves and to those living outside. Belonging to an age-grade would therefore secure a person with a network particularly important for problem solving, but also participation in prospective businesses beneficial for themselves and their family. During the conversations, I learned that belonging to age-

grades secures a man and his family access to land, which also gives them right to be buried in the land of the paternal ancestors with the support and attendance of all villagers. If the man is not a member of an age-grade, the person or his family would have to pay for the grave space where one wishes to be buried.

As an age-grade grows older, they continue to decrease in number and the support mechanisms among them gets weaker. The remaining members of a grade could therefore not depend on being supported from fellow age-mates in times of need, and I found support between younger- and older age-grades to not be a prevailing norm. Consequently old people were left depending on their families. However, even if a grade consisted of only one member, it was still regarded as an age-grade and functional. The remaining person was not expected to manage development projects, but would be consulted in virtue of being an elder.

Interestingly, age-grades did not appear as a community structure in two out of the three villages visited during the field work. However, in one village, villagers were in the process of reinstating age-grades, while another village had established what they called the Aladinma[17] group. This indicates the importance attached to such community structures, as this structure still was considered a pillar governing the life of rural people which traditionally has helped securing both collective and individual interests.

In spite of the traditional norms guiding the role and functions of age-grades, age-mates nowadays seem to increasingly direct their focus towards internal matters viewed as beneficial for their grade only. According to some of the key persons and formal caregivers participating in this study, activities reflecting solidarity with fellow villagers or efforts improving the livelihood of community members in general were becoming scarcer. An age-grade's ability to carry out projects improving the lives of its grade members alone was as such becoming more important. Consequently some age-grades were considered stronger than others, often based on the financial capacities and capabilities of its members. This may point to an ongoing socio-cultural transition affecting traditional consensus methods where those with fewer resources may find themselves having less influence on discussions and

[17] According to the older participants residing in one of the three villages at the study site, **Aladinma** stands for *"the betterment of the people of the land".* Both men and women could be members.

decision-making compared to those better off. This is perhaps why a key person explicitly advised men to carefully select their belonging age-grade.

Women's group: role, function and responsibilities

While groups of men seem to be more concerned about activities related to projects generating prospective incomes, Women's Groups are mostly occupied with activities closer to their domains. As earlier mentioned, women do not form age-grades similar to those of men, but commonly group themselves into *"Youngsters"* (newly wedded), "*Mothers"* (married with children) and "*Mamas"* (elderly women).

Women's Groups seem to be founded on traditional systems reflecting the roles of village women. However, women experienced their association ties to be weaker than in earlier times, as younger women commonly wants to settle in urban areas rather than staying in the village. Female participants residing in the villages told me about several important meetings which consequently had to be postponed until members come back for holidays. Some meetings are occasionally held jointly with women representing Umuada[18], especially in the planning of activities during festive seasons.

Women of younger age still experienced older women executing their advisory roles within the Women's Group and acting as mediators in disputes, according to old traditions. The solving of group members' problems was viewed as important as women often experienced competition, jealousy and suspicion to rule among them. When women sometimes failed to solve their disagreements, they turned to their husbands and their groups for assistance. If the case still remained unsolved or was seen as particularly grave, the case could be brought forward to the Village Council for final settlement.

Apart from the mediations and settlements of disputes, women occasionally engaged themselves in income generating projects. A key person referred to an ongoing project:

> "*(…) the women council, after organising them, one of our daughters brought to us the cannel cracking machine, the men abandoned it, it was there for over 20 years.*

[18] **Umuada** is a compounded word obtained from "umu" a plural prefix depicting many, and "ada" meaning daughter. Umuada collectively refers to native daughters, the daughters of a common male ancestor or "daughters of the soil". It equally refers to a collection of all daughters of a particular clan, village, town, state or country, young, old, single, married, separated, or divorced. Ref: www.**umuadaigbo**nigeria.com

> *It's now repaired and we are using it. This happened after I was elected. Whatever I tell them to contribute, they bring the finances before two days no matter the amount. So we are now making palm oil. We called the men, but very few came to cooperate to repair"* (K2V1).

This gives information about women's capacities where they can be strong together without being supported by men. Any income from projects, such as the one mentioned above, was seen as welcomed as it supplemented other incomes such as the paying of levies. It would consequently strengthen the group's ability to manage and implement various activities and to buy commodities viewed as necessary. According to female participants, these commonly involved celebrating rites of passage such as the birth of a child, traditional weddings and burials, and helping out arranging festivals such as the celebration of *"Iri-iji"* (new yam festival) jointly with men.

Apart from the above activities, women frequently discussed family issues related to problems with children, and marital difficulties. The following illustrates the nature of one case:

> *"One time when a woman broke the head of her husband, and she was sent to jail at Owerri, but I called the women to contribute money, we went to Owerri, and we made sure that we settled it and we brought her out"* (K2V1).

This case gives an example of prevailing solidarity acts among women, but interestingly also the influence of money within the Nigerian judicial system. Apart from the latter, several female participants residing in the villages told me that they generally support each other financially through a reciprocal system which resembles the one existing within an age-grade. The basis of establishing such a system was to alleviate the burdens of difficult situations among fellow women. This could be the payment of hospital bills, drugs, transport, or the hosting of funerals or other events. However, when a woman becomes old, she has to turn to her family for help and support and not the group she belongs to. According to old women and informal caregivers, her age mates would usually continue visiting, but rarely give food or money due to the poor economic status prevailing among elderly people.

Figure 20: The serving of kola, bitter kola and garden apples, an important cultural tradition. Photo: Heidi Olsen

Youth Groups: role and responsibilities within local communities

According to the general views of participants residing in the villages, the role of the Youth Groups are mainly to collaborate with- and support leaders of community groups and social association ties. Youth are also committed to help implement and accomplish projects decided on in meetings at the Village Hall. However, they independently involve bringing projects initiated by the Local Government home to their villages. A leader of a Youth group explained such efforts to be executed in virtue of the mandate given to them as representatives of the Youth Wing seated at the Town- or Village Council. He further experienced the younger generation to be inspired by innovative strategies enhancing opportunities for new projects to be established within their area. Integrated into these processes, he pointed to the importance of *"knowing people"* that was assessed as influential in the society, and as such could impact on the successful implementation of projects.

While waiting for greener pastures, youth involved themselves by initiating small scale income generating activities, essential in sustaining daily life and supportive in times of problems. One of their aims was to secure younger people work in order to keep them from engaging in criminal acts. They also looked at themselves as important actors upholding traditions, particularly those related to festive celebrations, where young people involved themselves in cultural activities such as masquerades and dancing.

The role of Church and influence of Church Leaders

Apart from being grouped within their social organisations, people also group themselves under the umbrella of their respective Church congregations. The Catholic- and Anglican Church are the most influential religious institutions at the study site, but as religion increasingly occupies a greater share of people's life, several Pentecostal Churches are being established. Occasionally community groups are invited to carry out projects jointly with the Church. According to participants residing in the villages, such involvements were usually limited to the building of missionary schools in the area. Collaboration between villagers and church leaders in projects were sometimes perceived to bring about conflicts, either between different parishes and members of the parish councils, or between people

belonging to different congregations. Conflicts were often reflecting problems in regards to the accessibility of land, or the location of a new establishment.

However, old people participating in FGDs were more concerned about the inadequate services rendered by the Church, as church leaders were perceived as money conscious rather than showing concern for the general welfare of people. Based on their experiences, elderly people perceived services to only be available for those with abilities to pay their dues. An old man participating in a FGD said cheerfully:

> *"Everybody, church attendants, supply the church fund, but to see somebody who is in need of help, they will not do it. They will only take the money for their own use. Is it not true? It is what is being seen around here. That's why we get very many, many churches in our area, because tomorrow, if I see where to get or build a house now, I put church there, me and my wife and children to go there and worship god (…)"* (P6V2).

He continued to talk about previous times when the church was less concerned about money and more concerned about charity. Therefore, old people living in the villages did not expect much to come from their congregations in times of need. However, some had experiences with members of church groups who occasionally distributed food items, clothes or soap to elderly people in need. This usually happened during festive seasons. Some elders also perceived some Church congregations to give out small amounts of money to the less privileged, but most commonly they experienced church leaders and fellow church members to only visit and pray for a person.

As presented in this chapter so far, the belonging to an organisation or social group do not secure an elder, or his or her family, with prospects of support from fellow group members in times of need. Old men participating in a FGD confirmed such understanding by stating:

> *"There is no way" (P2V2)*
>
> *"Our people does not do it" (P4V2)*
>
> *"At all, at all. They don't" (P5V2).*
>
> *"Everybody minds his family except if it comes to the Council. As I am here now, if I am dead, my family will inform the Chairman that I am dead, then he will inform the*

> *entire village and they will gather to discuss about my funeral or burial but not in hard times and ill-health" (P2V2).*

Based on the findings, it seems as the belonging to community groups and social association ties becomes beneficial only when a person is functional and able to contribute through his or her performances securing the viability of their belonging group, which also includes their abilities to pay dues and levies. The role and functions of community groups seem to be directed towards dealing with internal matters, upholding of cultural norms and traditions, and participation in projects giving prospects of progress for its members. The individual capacities and capabilities of group members seem therefore to play an important role as such qualities secure influence on matters discussed in places such as the Village Hall, and consequently decision-making and initiation of activities. Through all the conversations conducted with participants residing in the villages, none mentioned efforts directed towards the initiations of health projects, aiming at securing access to healthcare services and improving the health conditions of village populations. Such was also recognised by one of the community doctors participating in this study. He referred to community groups' general lacks addressing and prioritising health issues. He illustrated his view by saying:

> *"I always tell people; if you are not healthy, you have no other projects for the year"* (CT5 formal).

Interestingly, there was also another issue people never came together to discuss. This was related to implications affecting families' abilities to care for old people. I found this to be a bit strange as people frequently came together to discuss family problems such as adultery, involved themselves extensively in discussing morality issues related to the behaviour of group members, and to the solving of marital problems between married couples. Explanatory considerations can possibly be attached to prevailing norms and values as they traditionally have manifested expectations of reciprocity in care between generations. Consequently, inconsistency with such traditions may give rise to shame threatening a family's pride and dignity, which could explain why constraints related to the caregiving of old people never was discussed nor at the agenda of village meetings. One community nurse said wisely that before such matters could be brought forward in community meetings, a re-orientation of social organisations' aim and objectives was needed, which by her opinion could be anticipated through the enlightening and encouraging of community members.

Rural community groups and association ties assessed within socio-political perspectives

As one has learned so far, health projects were not within the scope of community groups' interests and priorities at the study site. When I was seeking reasons for their lack of involvement in health projects, a key person explained:

> *"We can. But the most important thing is drugs. As a chairman, I can organise my people to put up one or two rooms or three rooms apartment for health care centre. But what about the drugs? You cannot go the government to [ask them to] provide that for you. I don't think they will collaborate, since it is not government approved"* (K1V1).

This may reflect constraints related to collaboration with formal bodies on projects initiated *"bottom up"* rather than *"top down".* Moreover, it may indicate a lack of arenas such as Ward Development Committees[19] where leaders of village organisations and local

[19] **Description of a Ward**; the ward is the smallest political structure, covering a geographical area with a population range of 10,000 to 30,000 people. There are on average, ten (10) wards per LGA, each headed by an elected councillor. The main rationale for selecting a Ward as an operational area for delivering a minimum health care package was to mobilise political commitment to health service delivery as a requisite for social development.

Structurally, each ward has a Ward Development Committee composed of the following:

- A Ward/Clan Head as Patron
- An elected Chairman
- Secretary,
- Chairmen of village/community development committees,
- Headmaster of school,
- Senior agricultural extension worker,
- Community Development officer,
- Representatives of occupational groups (which includes VHW/TBA, NGO/International Organizations, Religious Groups, Women and Youth groups, chairmen of patent medicine and store dealers, traditional healers),
- Heads of facilities in the area.

Functionally, each Ward Development Committee is responsible for the following:

- Identification of health- and social needs of the Ward and planning solutions
- Mobilisation of resources (human and material)
- Supervision, monitoring and evaluation of health activities in the Ward
- Mobilization for community participation in health, and other health related programmes
- Liaison with Government, NGO and other partners in the implementation of health programmes
- Forwarding plans from villages and the wards to LGA/PHC Development Committee and providing feedback
- Supervision and support to TBA/VHW/CHEWs
- Support the establishment of health facilities and overseeing their functions at ward level

(Source: Operational Training Manual and Guidelines for the Development of Primary Health Care System in Nigeria, NPHCDA, 2004; WMHCP 2007-2012; pp 9-10).

government representatives meet and jointly discuss and solve matters of public concern. I questioned these issues in conversations with several key persons in the villages, and there seemed to be consistency in their views on the following, which in this quotation is reflected by one of the key persons in a village:

> *"We are structured under the Town Union and the Government and the Local Government deals with the Town Union. They don't deal with the village. Then the Town Union deals with the village. (…) if the need arises, but we don't (...) in fact we don't have anything in common with the Government here. Let me say; we are a Government of our own. I have told you now how we weed our road, how we go on closing the pot holes, and all that. It is by our own making, not Government. Government does it whenever they want to grade the roads, they use their caterpillars and enter any road. Like these ones now [village roads], you can't come in. We do all these ones. We do them, not Government. We don't ask Government to come. They come when they want to come and if they don't want to come, you can't get them, even if you write from now till next tomorrow* (K1V1).

He continued explaining:

> *"They cannot collaborate with the village, like I said (...) they always go through the Eze, the Town Union. Now, the Town Union will call the village Chairmen and say; this is information from the Government, take it home. Then we will now take it to our different villages. We call them [villagers] (...) that is where I say we'll now involve men and women. We say; this is what the Government wants. Example; they want us to build a health care unit in this village. They want us to contribute 5 Naira, 10 Naira to help to achieve this aim. Then after relating the this thing to the village people, whatever they say will now go back to the Town Union President and report back. Town Union President will now go to the Local Government to tell them; this is what the people have said. You get my point now"* (K1V1).

Based on these considerations, one may presume leaders of community groups to be disregarded as direct interlocutors when projects are discussed. Such attitude may deprive members of village organisations from gaining knowledge of policies and plans guiding political aims and intentions reflected through formal priority programmes including those of health. Consequently, they miss opportunities impacting strategies viewed as essential in terms of rural development, affecting the life of villagers. On the other hand, formal bodies miss opportunities streamlining programmes according to population needs. The opinions and experiences of community leaders may therefore come to reflect manifestations of formal acts contrasting political resolutions, which legally have acknowledged community

representatives to have the right to be involved and to influence strategies affecting rural communities. The effect may become visible through the evaluation of project activities' impact on the target population, as political intentions and priorities not necessarily have to comply with the perceived needs of people.

As for now, the building on social capital through the involvement of community leaders and members of rural organisations seem to be a neglected source of capacity. Argumentatively, such negligence may continue manifesting the gap between rural communities and the society at large as community group performances in rural areas primarily seem to facilitate cooperation on internal matters. People's perception of not trusting people representing the government combined with government representatives' reluctances towards the integration of social capital in decision-making processes are therefore likely to foster continued structural stagnation of rural areas.

Rural areas may consequently face the risk of becoming sub-societies within the larger societal contexts, ruled and guided by the Eze as head of *"shadow governments"* and Chairmen as responsible executives. When assessed within such perspectives, rural village life may continue to lag behind more contemporary development processes taking place in societies at large. Without prospective mutual re-orientation of mind-sets between parties, leaders of the 4th tire of governance may therefore find themselves left with the internal challenges of their respective villages.

PART THREE: Old Igbo people in the context of the existing health system

Introduction

In the previous two parts, one has learned about old Igbo people at the study site, how they are characterised, recognised and what their main functions are within their family and local community. Moreover, one has gained improved knowledge and understanding on factors advocating for their health and wellbeing, and learning about threats contributing to their experience of ill-health. Findings so far have uncovered that old people perceived family

support to decline and be insufficient according to needs, and some elders experienced an overall lack of support and care.

One has also gained insights to the social- and structural aspects of rural life, which several participants perceived to enforce hardships in the life of elders, and to influence the viability of families. As a result, several old people experienced their children and close family members migrating to urban areas in search for work and progress, where they adapted to urban life styles influencing norms and values that traditionally had guided support mechanisms among family members. Such transitions were experienced by elders to influence the care one could expect to receive in times of need. Interestingly, the situational conditions of elders, including close family members' abilities to provide care, were found to be an issue not discussed in meetings at the community level, and activities supporting the wellbeing and health of elderly people were found to be the responsibility of families alone. Community groups seemed to be more concerned about internal matters and the initiation of- and involvement of projects giving opportunities for the progress of its members, or projects aiming to develop rural infrastructures. They did not engage health projects and collaboration with Local Government in projects unlikely to be attempted.

My intention in this part of the thesis is particularly to explore opportunities for formal interventions to be implemented in order to improve the wellbeing and health conditions of elders through sustainable deliveries of community health services, complementary to that of family care. Moreover, to investigate what extent current health services at the primary level are available and accessible to old people in times of need, and whether services meets with their expectations. The latter involves looking into factors that contributes to what several participants perceived as *"under medic care"* and/or *"self treatment"*.

Closely related to the above is to investigate how participants perceive politicians' accountabilities and commitments to impact health system development at the grass-root level. Such an aspect includes looking into the cost of health services, funding mechanisms and priority programs. The latter is important as it will provide one with information on how participants perceive prevailing strategies to be reflected through access to- and availability of quality healthcare services and whether programmes are designed and implemented to also safeguard the health needs of elderly people.

It may be important to note that I use the two prevailing health plans: Ward Minimum Health Care Package (WMHCP) 2007-2012 and the recent National Strategic Health Development Plan (NSHDP) 2010-2015 as sources of information, complementary to the views and opinions of participants participating in this study. My aim is to advocate for more comprehensive perspectives on governmental plans, programmes and initiatives in the provision of healthcare deliveries at the primary level, and relate such to how realities are experienced by participants to be. It is worth mentioning that both plans are based on the concept of PHC[20] and builds on the Ward Health System, introduced in Nigeria in 2006. The latter can be assessed as a tool contributing to strengthening the implementation of PHC services where the overall aim is to improve the establishment of sustainable health services with full and active participation of people at the grass root level. Based on the aims and intentions as outlined in the Ward Health System Policy, I want investigate the potential of including community groups as counterparts in health system development at the grass-root level, which through mutual collaboration with formal bodies could secure improved access to health services for villagers in general and old people in particular.

Formal healthcare services; are they meant for old people as well?

Introduction

Old people participating in this study recognised ill-health as *"Oria"*. As elaborated on in the first part, *"Oria"* can be understood as physical, social- and psychological aspects of life that threatens their wellbeing and consequently their perception of having health *"ahu ike"*. According to old people participating in this study, hypertension, headache, arthritis, stroke, eye problems, diabetes, cancer, Malaria and Typhoid fever were perceived to be the most prevalent illnesses causing them to seek treatment from available healthcare providers.

[20] The ultimate goal of primary health care (PHC) is better health for all. WHO has identified five key elements to achieving that goal:

- reducing exclusion and social disparities in health (universal coverage reforms);
- organising health services around people's needs and expectations (service delivery reforms);
- integrating health into all sectors (public policy reforms);
- pursuing collaborative models of policy dialogue (leadership reforms); and
- increasing stakeholder participation. (Ref; http://www.who.int/topics/primary_health_care/en/)

Mental- and psychological disorders were not an issue directly introduced and openly discussed in FGDs. However, old people's concerns related to the suffering from headache and hypertension may give indications of experienced psychological ill-health, which was expressed through their focus on psycho-somatic symptoms. Their reticence of explicitly talking about mental- and psychological conditions could as such point to feelings of uneasiness which manifest a state of un-healthiness that could threaten their inclusion in a family, and consequently their opportunities to receive care within a familial environment. Findings presented earlier have pointed to cultural specific phenomena existing within the Igbo culture where family members relate changed mental- and psychological behaviour and reasoning among elders to spirituality, and where some has been admitted to Old People's Homes and Psychiatric Hospitals due to being stigmatised *"mad"* or *"Amosu"*. Learned experiences, not only from family members, but also villagers' reactions and actions towards elderly struggling to cope mentally or psychologically, could therefore explain old people's reluctances at addressing psychological ill-health directly in discussions, as they not only would manifest its prevalence but also the threats involved.

Within the perspectives of an ongoing societal transition combined with extensive rural-urban migration, leaving a growing proportion of elderly people behind in rural areas, one may assume old age illnesses, including those of mental and psychological character to increase and to represent a major share of the total prevalence of non-communicable diseases (NCDs) occurring in the area of the study site. The overall increasing prevalence of NCDs in Nigeria at large is moreover recognised and referred to in current health plans, where it is stated:

> *"(...) [NCD's] represent an increasing share of Nigerians' burden of disease (...) and incidents of these NCD's is increasing alarmingly"* (NSHDP 2010-2015, pp; 32).

Formal caregivers participating in this study recognised such evolvement through their practices, whereby one community doctor explicitly linked the increasing prevalence of NCDs to the prolonged life expectancy of people:

> *"But from my practice, because I practice outside here [Governmental Hospital] too, as a consultant, I'm a consultant, we have come to notice that NCD are becoming more prevalent than they used to be. So all these (...) like diabetes, hypertension, (…) arthritis and other NCD, cancers, they are becoming more common now than they*

> *used to be. And probably because people are now a bit (…) despite the fact that the life expectancy of Nigeria is about forty something, you still have people living longer than before"* (CT2 formal).

According to the experiences and opinions of participants residing in the villages of the study site, healthcare provision were perceived unresponsive to the needs of rural populations and to not be in accordance with their demands for services. Moreover, the availability and accessibility of both primary health services and healthcare providers were regarded as largely inadequate. Such opinions are supported in the NSHDP 2010-2015 where it is stated:

> *"Availability and distribution of functional health facilities and other health infrastructures vary across the country where many new PHC facilities being built are not strategically sited"* (NSHDP 2010-2015, pp; 32).

Moreover;

> *"Available services by private and public providers are clinic based, with minimal outreach, home and community based services. (...) available evidence suggests that health services throughout Nigeria are delivered through a weak PHC system (...) often bypassed in favour of higher level care facilities (...)"* (NSHDP 2010-2015, pp; 33-34).

Within these contexts, it becomes essential to look into particularly how old people assess healthcare services to be of help supporting their wellbeing and state of health within environments increasingly reflecting structural constraints contributing to the absence of informal caregivers and support in times of need. The next chapters address participants' views on healthcare provisions and explores whether or not old people are considered as equally important when formal health interventions are planned for. But before entering into the contexts of healthcare provision, I want to share the following observation with the readers:

> *"My research assistant and I went one day to visit one PHC clinic in order to ask formal caregivers to participate in the study. The first and second attempt was unsuccessful, as we found the clinic closed. However on our third attempt we were lucky to be directed to a community nurse when passing the market square. Though she was a bit sceptical to participate in an interview, she finally agreed to talk to us after been given proper information about the study and what was expected from her. We scheduled for day and time.*

When returning a few days later for our appointment, we found the clinic closed and the nurse absent. After waiting for some time, a woman came running towards us. She told us that she had been sent as a replacement for the one we initially made the appointment with. Well, that was quite acceptable as she also worked as a nurse at the clinic. We repeated the information about the study and she gave us her consent.

When she unlocked the doors of the clinic, we found the rooms almost empty. She explained that there had been a robbery a couple of weeks ago, where the equipment, some medicines and furniture had been stolen. She experienced the clinic not being patronised by the villagers in spite of raising issues of security with Women's Group leaders.

However, we sat down on two old iron beds and the one plastic chair remaining in the room. Before starting the interview she stated that she was short of time, and could not stay for long. That made us to skip certain background questions and rather focus on the main areas we wanted to address and discuss with the lady.

During our talk, a child of the age of 9-10 came along with what I assumed was her parents. The girl had a nasty wound on her ear that needed to be attended to. The parents told the nurse that they earlier had seen the chemist, but as the wound now had become worse, they decided to see a nurse. The community nurse went into the back room. I went along with her. This room was also close to empty, but the nurse pulled out a 50 ml bottle of iodine from a corner shelve. She cleaned the wound with a small piece of gauze, and explained to the parents that she had to go to the chemist to by antibiotics and dressing materials. Then she asked them whether they had money to pay for the services, which they confirmed. After returning, I helped the nurse to dress the wound, and to ensure that the parents had understood how to administrate the antibiotics. When they were about to pay, there was an argument arising between the nurse and the parents. However, they settled and the parents left with the young girl. We continued with the interview. No other patients approached the clinic during our visit, and the nurse closed it up before leaving in the direction of the market square.

Figure 21: An example of a rural health clinic. The latrine, at the left, seems unused, the windows are shut and the clinic closed. Photo: Heidi Olsen

These observations are interesting as they point to- and reflect the inadequacy of healthcare provisions at the grass-root level, with direct references to challenges as described in current health plans. Moreover, and perhaps more interesting is the illustration of how community members desist from engaging in the management and guarding aspects of this health facility. This may, firstly, indicate lack of participatory processes when the health clinic was set up, which implicitly involves missing out opportunities of establishing ownership to the facility among community members. Secondly, that health services provided at the clinic were perceived not to reflect the health needs of the rural population at the study site combined with irregularity of opening hours, and cost of services.

For care to be recognised as healthcare

In order to improve my understanding of participants' mind-sets when they talked about healthcare services, I started by asking a very basic question to elders, informal caregivers and key persons participating in this study; what is healthcare? Their responses reflected various opinions based upon their understanding of- and expectations towards what they characterised as sound healthcare provision. A majority of these participants explained that healthcare preferably should involve having a hospital or a health centre near to where one live, where people could be correctly diagnosed and receive treatment. They emphasised the availability of sufficient numbers of skilled doctors and nurses. Treatment was most frequently related to be given the right drugs at a price they could afford. Moreover, health facilities should be open at night, based on the experiences that severe illness often occurred at night time. Some elders also emphasised a need to call a doctor when illness struck, and to have laboratories to test for diseases. However, more than half of the elderly people participating in FGDs explained healthcare to involve the availability of a good caregiver. During the discussions, they did not explicitly specify whom this preferably should be, but emphasised rather that the caregivers possess certain qualities. These qualities were described to include noticing an old person's sickness and to look after the sick one, making the provision of food and medicines available, and to heat an old person with fire when needed. Caregivers should also secure the availability of water and support with practicalities. These findings are quite interesting, as they define qualities in healthcare to be consistent with that of family care, and expectations of services and care provided to them to be similar to those expected from family members. This may indicate the concept of

healthcare to be understood- and assessed within a wider perspective than just the treatment of a disease alone, as it attaches importance to practical, psychological, emotional, and social dimensions of human life as well. Consequently, in order for care to be recognised as healthcare one can interpret their understanding of healthcare to constitute a system of caring activities consistent with western traditions of holistic care[21] which, through the supporting of human basic needs, helps individuals meet their own self-care demands and through such activities, promotes a sense of wellbeing and ultimate health. Old people linked the extensiveness of healthcare activities provided to them to reflect the extent of which they perceived to be loved, affecting opportunities of being cared for within or outside of a family setting. Based on such interpretation, one recognises components of care leading to experienced health and psychological wellbeing as presented earlier in the thesis to also be applicable in regards to formal interventions in order for care to be recognised as healthcare.

To be noticed or becoming unnoticed: implications on old people

The findings presented earlier in this thesis can be interpreted as pathways of familial care anchored in values cherished by old people, and points to the inter-relationship between familial components of care leading to experienced health and psychological wellbeing. Of particular interest is the desirable goal anticipating social acceptance, recognition and inclusion. Old people have earlier explained the fulfillment of such goal to support their identity and self-esteem. It fosters respect and an experience of being useful. As elaborated on in Part One, to be useful reflects an elder's ability to participate in activities where his or her role, function, and contributions are recognised as valuable for the family and community, usually by transferring cultural knowledge, norms and customs on to future generations, through consultations and by giving advice in matters of concern. Consequently, one may suggest the upholding of such functions to be particularly important in order for old people to be noticed, as their recognition socially and culturally facilitates being counted in and assessed as valuable members of a family and community, fostering rights and responsibilities. Earlier findings have pointed to a trend where such recognition

[21] Holistic Health Care: "A system of comprehensive or total patient care that considers the physical, emotional, social, economic, and spiritual needs of the person; his or her response to illness; and the effect of the illness on the ability to meet self-care needs" (Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier).

seems to decline, especially within the context of their family, enforced by societal transitions and contemporary lifestyles among the younger generation. Along with a falling appreciation of old people's roles and functions, old people's fear of not being able to perform duties traditionally close to their domains can be understood in a wider context where becoming less useful consequently brings about the perception of becoming less noticed and thereby neglected.

Such understanding introduces perspectives where old people increasingly are assessed based on their abilities to contribute physically in order to sustain the viability of their family, which involves being productive. Physical strength becomes essential, manifested through an old person's capacity and capability of generating income, as family member's abilities to perform work becomes preferred and necessary qualities in rural communities facing increased hardships. Family norms and priorities seem to be shifting from customs traditionally beneficial at old age, and elderly may easily become a burden due to reduced physical strength and falling resilience impacting their abilities to cope with challenges of everyday life. Combined with being less productive, previous findings have indicated their traditional role and functions as advisors and consultants to not receive the same appreciation as in previous generations. They may therefore consequently face the risk of being less noticed and not adequately considered within contexts of their family and local community when their physical strength gradually declines. This may explain why elders participating in FGDs expressed great concerns in regards to the physical degeneration of the body impacting their abilities to perform work, and the onset of illnesses to further escalate processes affecting their recognition, inclusion and function within a family setting. The above analysis provides one with an understanding which could explain why old people saw it as crucial to differentiate those being only old from those being both old and sick.

Based on the above reasoning, it seems old people are becoming more vulnerable within a family setting who traditionally have safeguarded their wellbeing at old age. Customary changes, reinforced by societal constraints and undeveloped social- and welfare systems, seem to make them an increasingly unprivileged group within the societies they live, where they face the risk of becoming an unnoticed and neglected group also at the system level. Their opportunities to be counted in- and recognised as valuable members of their communities, entitled to services of their kind, seems to be limited unless they are in the

possession of strong spokesmen voicing the increase of hardships old people are facing generally, and particular their vulnerability in times of ill-health. Lack of policy makers focus on ongoing societal transitions impacting familial customary care and support mechanisms affecting old people becomes evident also when assessing priority health programmes initiated at the system level. Vulnerable groups in need of improved attention and formal healthcare interventions are in current health plans defined as:

> *"(...) women and children < 5 years (...)"* (WMHCP 2007-2012, pp; 33).

It is tempting to interpret such as representing manifestations of general opinions where public services are being channelled towards groups considered as an asset and investment to the future development of society through prospects of productivity, utilisation of skills and intellectual capacities. Based on such interpretation, the concept of human life value becomes essential. Is human life value appreciated solely on its intrinsic value, or is human life value increasingly being measured through its economic value in its relation to other lives, young vs. old etc.? Does policy makers' assessment of human life value influence governmental efforts in regards to the provision of services being made available for specific groups, leaving other groups unattended to?

In spite of the many ethical reflections that can be attached to human life value, it is tempting to allege such to also involve considerations impacting the formulation of health policies consequently affecting the designing of programmes and interventional strategies directed towards groups pre-defined as preferred recipients of healthcare services. Such could also most probably be linked to cost-utility assessments, where the extent of benefits and substantial "gains" in terms of health related quality of life for defined groups are measured against the cost of health interventions beneficial for other groups.

Policy makers' assessments of human life value and its relation to the cost-utility aspects of interventional programmes may consequently contribute in providing alternate explanations to preferred health programmes currently reflected in Nigerian health plans, where the WMHCP 2007-2012 explicitly states that its focus should be directed towards:

> *"(…) health interventions and/or services that address health and health related problems that result in substantial health gains at low cost"* (WMHCP 2007-2012; pp 12).

Of course, such focus can be understood as aiding coverage- and economical sustainability strategies in health, improving the health conditions of larger groups of people with less use of resources. The drawback is however that other groups of people, such as the elderly and disabled may be counted out, as many suffer from chronic conditions and NDCs. They require other forms of healthcare services which rarely are seen integrated- and prioritised as strategies at the primary level through PHC interventions. Consequently people with health needs that requires rehabilitation, habilitation, long term curative care and close follow up over time, may be found to be given lower priorities and to represent groups unattended to at the system level as such health activities commonly are regarded as more resource demanding.

When discussing these issues with a community doctor, he offered his reflections on the matter:

> *"Yes, well, the trend if you remember Maslow's law. You see, needs, hierarchy of needs. I think, quite all right, the proportion or percentage of NCDs are increasing. But at the moment, it has not really overwhelmed, overcome, overtaken you know, CD itself. Because we are still battling it, even Polio, TB, even imagine Malaria, HIV/AIDS. So these things still tends to occupy our time, energy and resources. With the result that, and coupled with the level of poverty, unemployment, we don't have that extra, we appreciate the problem, we agree it is there. Nobody is doubting it. But you see, we need to see to the majority of the people, still weighed down by things that are preventable, that can be managed with less resources than, you know the counter-groups. But we don't have to wait until it overwhelms us. We should start early, you know, to have it in our health policies"* (CT5 formal).

He continued humorously:

> *"As for at now, we have cancer institutes being established inside Nigeria here and there. It is a recognition of, you know, problem of NCD, before it wasn't so. And you know, high profile people have died from NCDs, that's why they now are talking about it at Abuja, not at the community level. There is no cancer here, but it is there at Abuja, [laughing]"* (CT5 formal).

He continued by elaborating on factors contributing to the high prevalence of CDs which in his opinion had to be seen in conjunction with the inadequate development of infrastructures in rural areas. He pointed to the paradox that several CDs easily could have been prevented if basic infrastructures such as safe water, sanitation, roads, transport and electricity were in place, as it would strengthen people's opportunities of living healthy lives, and their opportunities to access available health facilities in times of need to improve. He emphasised the role and duties of health officers at the local government level, and believed that improved governmental commitments and efforts directed towards the expanding of infrastructures to also reach rural areas as a result would positively influence the prevalence of CDs, and the extent of resources used to combat such diseases would be less. As a result, this would initiate increased attention towards health related problems prevalent among other groups of people when future health policies are to be formulated and approved, allowing also elders to benefit from health services.

When I further explored the situational conditions many old people live under at the study site, and asked formal caregivers and government representatives about their opinions on the matter, I found that there existed awareness among them on social- and structural constraints impacting traditional customary systems. They pointed particularly to the ongoing societal transition which was perceived to affect old people's wellbeing and health conditions by the absence of close family members, and the irregularity of support increasingly manifesting itself due to the physical distance between those holding responsibilities as carers and the old ones in need of regular care and support.

In spite of such awareness, the recognition of older people's vulnerability to societal changes has not yet contributed any focus among health decision-makers when community health interventions are planned and implemented. This may indicate that there is little attention among stakeholders directed towards old peoples' terms of living and moreover that data from health surveys fails to adequately inform about the health situation of elders and constraints on families, affecting their abilities to care for old people. Lack of such attention is likely to result in inadequate knowledge of their need for improved support and care, and opportunities to healthcare. Moreover, there seems to be limited evidenced based knowledge on what activities and health services elderly themselves perceive to be of importance in order to aid their potential to self-care, which also would help supporting

their dignity and identity as elders. Findings presented in this study so far can therefore be assessed as base-line information, which preferably should be considered when channelling attention towards this group, aiming to improve their wellbeing and health through community interventions. One key person said:

> *"Government doesn't know if my mother is sick or not sick"* (K1V1).

Consequently, old people seem to uphold their status as a family responsibility and are as such likely to continue constituting an unnoticed group at the system level. According to information given in FGDs, interviews with informal caregivers and conversations with key persons, the possibility for community health interventions to be initiated complementary to that of family care was perceived as unlikely to happen. Two government representatives responsible for the implementation of healthcare services at the State- and Local Government level said respectively:

> *"Unfortunately I (…), let me say that we tend to ignore the problems of the aged person most often, because at the end of the day, we still have a community arrangement where the aged person belongs, a family arrangement. They belongs to a family. And we expect that the family takes care of the dads and grand-dads, mother at home so that we haven't come to a stage where we think of old folks homes, where they can be congregated and get services of their kind rendered to them"* (G2).

> *"(…) caring for older people is a family responsibility and the threats to [inadequate support from] the extended family system is due to poverty"* (G1).

Based on findings and considerations presented so far, it may be appropriate to question whether health services at the primary level are meant to accommodate the health needs and wellbeing of an old person.

Governmental commitments reflected through access to health services

Except from a proposed initiative initiated by the presently elected Governor, where he aims at establishing *"Old People's Club"* in every district of the State, the only healthcare services directly including old people was those involving doctors from abroad. The following is a short story told by a key person in one of the villages:

> *"Sometimes our son and daughters in America, they come here [to one hospital]. They come once in a year, every March, they will come. Send doctors from America. They will come there. Whatever sickness you have, you go there, have your treatment, both the old and (…) that is the only free this thing that I know that these old men enjoy. But it is difficult because, you know, the whole crowd will be there, and when you get there, you pity for some of these old people who have nobody to help or assist them. But I always thank those doctors and the people that they came with. Some of them they come and look for those ones that have nobody to assist them. They will pick them first, the old men first. Then take them inside, solve their problems and bring them out. I really thank those Americans, those that are sons and daughters of here"* (K1V1).

Interestingly, this story reflects an existing awareness among some of the Igbo people living abroad which anticipates the challenges of old age life where they may also recognise their limited access to primary healthcare services in times of ill-health. Such recognition seems to foster those with capacities and capabilities to arrange for occasional provisions of free health services to villagers that also include specific attention to old people. I was told that such arrangements were usually done in collaboration with one private hospital located in some distance to the study site. Apart from these occasional initiatives, most participants perceived healthcare provision to be largely inadequate in the area of the study site, not only in terms of services that could benefit old people, but the rural population at large.

According to my own observations, combined with information given by participants residing in the villages of the study site, there exists only one public health clinic meant to serve the overall population of the area. In addition, there is a small private maternal facility in one of the villages manned by a birth attendant. However, available healthcare services are found to primarily target women and children < 5 through ante-natal care services and immunisation campaigns as reflected in PHC programmes. According to a community nurse working at the local health clinic, the proportion of old people visiting the clinic was estimated to be less than 5%.

In principle, a system is established under the umbrella of Primary Health Care where Community Health Extension Workers (CHEWs) are included. Their task is to render basic services to village people in collaboration with community volunteers whose performances are supervised by formal healthcare providers. However, such a system was perceived by a community nurse to lack both community- and government commitment and involvement,

and funding to be limited. With the little resources available, current aims were directed towards preventive interventions targeting pregnant women and children < 5. Community mobilisation was attempted in order to raise awareness on CDs such as TB, HIV/AIDS and Malaria, and preventive efforts initiated and executed through health talks in community meetings. When I asked the community nurse to what extent CHEWs are essential and their number sufficient in order to carry out PHC services, she explained:

> *"We have them here, from different villages. Like government, we do receive medicines from the LG, so when our sister brought it here, so we called the village health workers, because we have their names and can call them though phone. They will come and we give them some training pertaining to the drugs. Then we share it, so that they will go to their villages and distribute. All of them, they are about seven. They work on voluntary basis and are not paid. They are from different villages, one from each village. That is the strategy from the LG. But we need more, but there is no money for remuneration. That was the decision from the LG. We train them here but it would have been good to have more. But now, the few of them that refused to work as village health workers are compensated. When we have Measles campaign, immunisation, you know, the government will give small amount of money to those village health workers. We will choose them first before choosing others [train additional] so that they will receive that small amount of money after each immunisation. That is how they are being compensated. So if you choose many of them, not all of them will benefit from it. So these are the only ones who carries out healthcare within the villages here"* (CT4 formal).

This is consistent with views reflected by old people and key persons residing in the villages where they pointed to aspects involving the relationship between the availability of health services and available resources. They were aware of the existence of CHEWs and perceived their mandate to be related to the immunisation of children under the umbrella of Local Government (LG) health programmes. However, they also perceived their visits to be less frequent over the last years, and the only visits experienced to be more regular were Sanitation Officers coming to check on the sanitary condition of households and the village environment at large. None of the elders and key persons had ever experienced any initiatives to come from LG representatives where they invited community members to join forces in order to improve availability of health services to serve a larger part of its population. Based on such experiences, there were huge expectations towards a new primary healthcare centre (PHCC) being constructed nearby. This PHCC had come about with money allocated from the Government at the Federal level and its location chosen and

decided on under the influence of a previous LG Chairman with attachment to one of the villages in the area. Most participants were happy with this initiative as they trusted the Federal Government to bring along doctors and nurses, to ensure availability of equipment and medicine into the facility, and moreover to secure salaries for employees. The construction of this facility gave village people hope of prospective work opportunities and improved healthcare for all. Interestingly, when I asked officers presently working at the LG health department about their involvement in this project, they were reluctant to give me any clear answers about the future management of this particular health facility.

When addressing the availability of healthcare services, participants in general talked about several private health facilities established within the LG area, ranging from small clinics to health centres offering a diverse package of healthcare services, also those of curative nature, and one private District Hospital. These were places old people could visit, but the larger majority of participants experienced such services to be costly, and the distance far. The inadequate availability of health facilities located in the immediate range of their villages forced old people, (especially) to visit the District Hospital in times of need. However, such choice was only an option for those who possessed the abilities to pay the bill, which usually involved support from family members. The lucky ones were those having relatives with abilities to take them to the secondary- and tertiary level of the health system. One community doctor and a nurse told me about their respective experiences:

> *"Actually, I should say up to 40% of my patients are older people. The proportion has not changed much over the last few years. In our society the younger ones rarely go to the hospital. It is only when they have serious ill-health, then they go to the hospital. If they have, what they may call minor fever, they go to the chemist and buy drugs. But it is the older people who will tell their children and relations that they are sick, and those are the ones that visit the hospital"* (CT2 formal).

The community nurse shared her experiences by saying:

> *"(…) but now, they [old people] are really coming, because when you get to general patient department, I have seen many of them, or at medical out-patient department I see many of them. It is always one disease or the other, they have hypertension, diabetes (…) one and the other (…)"* (CT1 formal).

However, according to information given in FGDs and interviews with caregivers, most of them experienced the majority of elders to visit the chemist buying a card of drugs or a few tablets of a kind they perceived helpful. The chemist was usually their option in times of ill-health due to lack of money. According to my own observations, there existed at least five chemists around the market square and their businesses seemed busy offering a wide range of services including the dispensing of drugs and *"blood tonics"* administrated per oral or through injections, to more sophisticated services including the management of intravenous (i.v.) rehydration- and chemotherapy treatments.

Only a few elders admitted using services rendered by traditional practitioners, but about half of the informal caregivers told me about their usefulness particularly related to the treatment of certain diseases, such as stroke and Malaria. However, groups of old people and informal caregivers perceived the availability of skilled traditional practitioners to have declined and been replaced by young, money-conscious commercial healers offering a variety of remedies not to be trusted. Two formal caregivers said explicitly that traditional practitioners constituted a serious constraint to western medical treatment, worsening the management of diseases, causing people to take decisions inconsistent with treatment procedures.

Based on experiences as described above, the majority of participants residing in the villages expressed concerns in regards to LG representatives' lack of attention towards the health conditions of villagers, and distance, time and cost to impact on their opportunities to utilise health services perceived to be of good quality. The closest privately managed District Hospital most frequently visited by old people was located approximately a 20 minute drive from the three villages of the study site. In order to visit this facility, elderly had to search for transport. According to old people and informal caregivers, this aspect was considered a major constraint in times of need which moreover involved cost and consequently mobilisation of family members. According to my own observations, there are no ambulance services existing in the area of the study site and moreover no substantial system of local public transport. Private companies' initiatives consist of a more or less organised system of private vehicles and mini-buses passing several villages at the main road at irregular times during the day and evening time, but they never enter inside of the villages. People's only

option was usually to call for *"Okada"* which is a motorcycle service, privately initiated and run by young men. The daughter of an old lady told me:

> *"I'll take Okada with my mother, I'll hold her and sit back and take her to hospital. It takes 20 min from here. The Okada will come to the house"* (CT1V1).

A hired caregiver was not very sure of how to transport a sick old person to a health facility:

> *"Maybe they [the old person's family living in the city] call for this small-small lorry to take her for hospital"* (CT2V1).

When informal caregivers were not lucky to have relations around having access to a car, the above was usually their option in the case of an old person illness. However, none of these services was perceived to be accessible at night time mainly due to drivers' and people's fear of being exposed to armed robbery and kidnapping. Inadequate development of infrastructures including security can therefore be assessed impacting the accessibility of healthcare services as well.

As time most commonly can be related to the distance to a health facility, time becomes essential also in terms of waiting time. According to old people, time involved delaying opportunities to treatment by waiting for support to arrive from family members living outside of the villages; waiting for someone to arrange for transport to arrive in time as well as; waiting for admission- and to be attended to by health workers at a hospital or a clinic. I have previously elaborated on older people's experiences of family members not being around, and their inability to support them adequately in times of need. An old man's statement becomes relevant when he said:

> *"Before support from a family member arrives, he is most likely to be dead"* (P5V2).

Generally, old people participating in FGDs were of the opinion that family members often chose to delay- or completely avoid coming when notified due to caregivers' expectations of financial support in the case of an old person's illness.

However, financial support was not only related to acute illness but also their prospects of accessing general health services, as a visit to a health facility involved cash payment for consultations. As referred to earlier, the District Hospital was quite frequently the health facility of choice as it was located nearer, but the expenses involved made people to name it

"iga ebuli" meaning *"can you carry the load,"* an aspect that extensively influenced old people's abilities to access healthcare in times of need.

Figure 22: On my way to Orlu by "Okada". Photo: Hyginus Eze

"Iga ebuli"

Findings presented in Part One and Two have clearly stated that villagers perceived themselves to be poor people. Elderly people, with reduced resilience to cope with challenges of life sustaining their livelihood and wellbeing, found themselves to be particularly vulnerable to poverty, also affecting them health wise. I have earlier elaborated on their risk to constitute a group increasingly unattended to at the familial level and unnoticed at the system level, and their situational conditions and quality of life to be perceived worsening. Inadequate government efforts directed towards the development of rural areas and the absence of social security- and welfare systems culminating in an overall lack of public services, including those of health, can therefore be seen to continue reinforcing such experiences. Without sufficient economic resources and reduced resiliency to fight situational problems, combined with old age vulnerability to ill-health and the suffering from chronic diseases, elderly people seem consequently to be inhibited from utilising services provided by an increasingly money driven healthcare business when needs arises.

Within such contexts, it is interesting to notice that the Nigerian National Strategic Health Development Plan (2010-2015) addresses and recognises the constraints poor people are facing, whereby it states that the increasing poverty among people makes health services highly inaccessible for larger groups of the population due to cost and out of pocket payment. Presently, politicians are working on strategies that include the initiation of targeted exemption schemes or free health services for vulnerable groups, where they interestingly not only mention pregnant women and children < 5 years, but also the elderly. However, after reviewing current health plans in Nigeria in more depth, I found that elderly people are left out when health intervention strategies at the grass root level are designed, as strategies still boil down to anticipating primary prevention healthcare services and the combating of communicable diseases. Consequently healthcare services accommodating the health needs, care and treatment of elders still becomes a matter to deal with for families, private clinics and secondary- and tertiary public health facilities. Programmes targeting curative treatment and the implementation of health related services at the community level are given low priorities. As a result, access to formal healthcare provisions including

those supportive to the health needs of elderly people becomes an issue that depend on the size of one's wallet.

One daughter caring for her old mother gave the following estimate on the expenses involved when her mother was in need of treatment in the district hospital:

> *"We pay. That's the bill, the medicine, consultation, talking to doctor and the transport. It is big money. For one visit at times we pay like 7000 NGN, it is not [pause] 7000NGN, like 5000, like 7000, or 10000NGN sometimes 12000. Depends on how many days she will stay"* (CT1V1).

A hired helper caring for an old woman said:

> *"Like my Mama, example Mama, maybe she will be sick more. Maybe when they [family members] take her to hospital, first they will pay deposit like 2000 NGN, so before she will enter you pay. After, she will have bed, after the bed they check her to lab for blood test. When they check everything, and the result come they tell the son or the daughter this is the result. And from that moment, whether fever or other thing, they starting from that result and continue to give her drugs. After then, when the woman is ok, after 2-3 days, they check the bill. Maybe the bill must be 8000 or 10000 NGN only for one visit or stay. They charge for lab test, blood test, maybe the woman needs drip, they will give and for all drugs, they check everything and add it together and charge"* (CT2V1).

Argumentatively, one learns that it is not unusual to charge up to 12000 NGN for a hospital stay of 2-3 days. Such amount should preferably be assessed within the perspectives of the income of a person. According to information gained during the field work, minimum wage is recently set to 18000 NGN a month. However, not all people have the opportunity to earn such an amount as many are out of work, while others work in the informal sector causing irregularity of income. This coupled with lack of functioning welfare systems and inadequate pension schemes have to be seen as contributing hugely to old people's reluctance seeking help until the sickness overwhelms them and premature death sometimes becomes the likely outcome. Elders participating in FGDs stated that hospitals charged disproportionally with people's income and moreover that treatment only was given according to the money people brought with them. They added that such payment usually was collected by health attendances after negotiating on the final bill. Health expenditures related to hospital treatment usually caused the majority of participants living within the villages to rather seek

help from the chemists, which they said often resulted in *"under medic care"* and *"self treatment."*

Health political strategies targeting high cost and the burden of OOPE

PHC services should preferably be free of charge, but as one governmental representative stated:

> *"Free medical care is done for children and pregnant women in some local governments. Not all LGs are running free medical care programs"* (G1).

The majority of government representatives and formal caregivers participating in this study acknowledged this situation and recognised it to be due to insufficient and unsustainable funding of PHC services. They informed for instance that medicines and other necessary equipment should be provided by the government, but irregular and insufficient provisions caused healthcare providers to charge money for treatment and medicine as they frequently had to purchase such themselves. Several formal caregivers expressed frustration on how new health programmes were being initiated by newly elected politicians, just to vanish when their period was over, taken over by the next one introducing a different initiative as part of their political campaigns. Consequently, formal caregivers experienced programmes to be fragmented, costly, unsustainable and not in line with policies, enforcing the further demolition of an already weak PHC system. This may well be the prospective result of the initiative referred to in a previous chapter, where the current elected Governor wants to establish *"Old People's Clubs"* in each district of the State, and where he, through the stimulation of public-private partnerships (PPP), wants to improve availability of health services rendered to the older population. In spite of the good intention, the question attached to this initiative is whether or not it will contribute to improved health and reduced cost of healthcare services for the targeted group.

Figure 23: Medicinal Plant in the botanical garden of the Traditional Practitioner. Photo: Heidi Olsen

To improve the health status of all Nigerians and alleviate the burden of high cost of public healthcare services, the Federal Government wants to introduce Community Health Insurance Scheme for all Nigerians, particularly targeting poor and vulnerable populations. In order to achieve such goal, the NSHDP (2010-2015) informs about the following strategy:

> *"Establishing pro-poor financial protection systems, including provider incentives to implement free exemptions for the poor and vulnerable groups and appropriate risk pooling mechanism such as social and community health insurance"* (NSHDP 2010-2015, pp; 11).

The strategic health plan further reflects processes where:

> *"(...) some of the recent initiatives by States to reduce out of pocket expenditures (OOPE) include the establishment of targeted exemption schemes or free health services for vulnerable populations such as pregnant women, children < 5 years, elderly, etc."* (NSHDP 2010-2015, pp; 35).

It is interesting to note that in spite of the aims and good intentions acknowledging the problems of vulnerable groups of people, OOPE has also earlier been identified as a major constraint to these groups' access to healthcare deliveries. As a specific example, WMHCP 2007-2012 was introduced with the aim of funding to be directed towards the Ward level of the health political system in order to secure and strengthen healthcare deliveries at the grass root level. The strategy was primarily initiated to encourage and facilitate community mobilisation and participation, and through community involvement, improve availabilities of affordable services according to population needs. In addition, it aimed at reaching vulnerable populations through pro-poor financial support systems and to bridge the gap between different levels of the health system by encouraging financial initiatives to health workers working in harsh environments (WMHCP, 2007-2012). However, elders, informal caregivers and key persons participating in this study perceived such focuses to not yet have contributed any measureable improvements as regards to the accessibility of healthcare services.

As this study is not about health system financing, it may still be useful to inform about perspectives and opinions on this issue communicated in conversations and interviews with participants. The political initiation establishing Community Based Health Insurance Schemes (CBHIS) is becoming a central concept in achieving the goal *"Health for all,"* which seemed

to facilitate strong opinions on the matter especially among formal caregivers and governmental representatives. Current strategies involve a proposal where each Nigerian pays 500 NGN as a monthly contribution allocating financial resources towards the grass root level. Its aim is to increase the availability of quality of health care services, and to improve accessibility for groups living in rural communities with special emphasis on vulnerable groups.

A key government representative at the state level confirmed the Government to be in a process developing CBHIS strategies. I wanted to know more about how such a scheme was planned to be implemented, coupled with his perceptions on the willingness and abilities of rural people to be conducive to the paying of fees through governmental collection. He had this to say on the matter:

> *"That will be (...) to the specialty of the health maintenance organisations [HMO's]. It is contracted out to these organisations. And you may be surprised how much they know about these communities, community invol(...) or the other has a forum of internal ship. So these HMO's, (...).of course for the civil servants, as you said, it is just very easy, a certain percentage of their salary. But for those (...), for the organised private sector, it is also easy because they are organised you can easily reach them. For the informal sector, (ehhh), however informal they may be, there are always structures that these HMO can dig out and make sure the fund is collected. But then expect that some people may be so poor that they exempt from the scheme. So far as payment is concerned"* (G2).

At the LG level, a key representative responsible for the implementation of PHC services made these comments:

> *"I am not aware of the health insurance scheme of 500 Naira. For the 500 Naira Scheme, it would be difficult for people to pay unless it is the civil servants which can be deducted from their salaries whether they like it or not. Also the fear of where the 500 Naira would go and how it would be utilised, will make the policy not to work. There are poor health facilities; no doctors; no infrastructures; nowhere to consult; so people will query the 500 Naira. Paying the money cannot be possible. How many people live in the communities in each government? The government plan <u>for</u> the people instead of people planning <u>with</u> the government. And because of this, it will not work"* (G1).

It is interesting to note the diverging statements from representatives representing the two levels of governance, especially as the latter representative represents the implementing part responsible for ensuring fund allocations to be transformed into improved PHC services. Having the above statements in mind, two community doctors said respectively:

> *"(Ehhh), health insurance is good if it well organised and implemented. And then you know, that this health insurance, you have to consider different groups of people. Everybody is not yet provided for in the health insurance. It is only government workers that are provided for. Even those who are provided for, it's so limited that it is not useful when you really have a serious health matter. In a situation where the [proposed]national health insurance cover, say only minor ailments, which any person can take care of by her own business, the mean is not very (ehhh) you know, effective. And then, like the unemployment rate now, you know what it is like in Nigeria, ehe! So how do you cover those people in national health insurance? How do you cover the community people? So these people are not yet covered. The disabled, they are not covered under the (...) those that are covered just those under government employment. And then, those who are under the government employment, what percentage of the population are they?"* (CT5 formal).

The second community doctor had recently participated in a workshop addressing Community Based Insurance Schemes. In retrospective he reflected on the matter:

> *"Like they [government] were talking about the national health insurance scheme. The day we talked about it at the conference (…) they called us to a kind of workshop, they told us they want to do this, want to do this, want to do this (...). People suggested a lot of things. Even people suggested a kind of community thrifts, you know that kind of thing (...) a lot of things were suggested. So, (ehh) by the time we ended this thing, they said ok we are going to implement it with this 500 Naira (...) per head, but they have not asked the people they want to implement it for whether they actually will accept it, whether they will or believe for it. This is a problem. Because the first thing our people, I mean, the way they will see it is that; Who is bringing this new one? Is it another political "wahoo"? That is how they talk it here. Is it another political fraud? This is what they would say"* (CT2 formal).

The latter comments made by a community doctor were also reflected by elderly people and key persons residing in the villages. They perceived themselves to have little or no influence on governmental strategies targeting community members at the grass roots level. This actualises the statement made by a governmental representative referred to earlier again where he said that the Government plan for the people instead of people planning with the

Government. His statements are likely to reflect criticisms directed towards government executives and their failing anticipating strategies of community involvement and participation. Inadequate attempts making community members opportune to voice their opinions was clearly of his concern, which he believed affected community members' level of trust towards politicians and government initiatives in general.

Born and bred in a society reflecting mentalities of money consciousness

By listening to opinions and statements communicated in FGDs and interviews, I learned that there existed a fundamental scepticism among elders, key persons and informal caregivers towards the trustworthiness of local government representatives, health officials and interestingly, formal healthcare providers. Lack of trust was particularly becoming noticeable when discussing money in relation to government development strategies including those aimed at improving healthcare services. Such scepticisms could most likely be explained by a persistent and deeply rooted tradition where government people and civil servants were believed to be corrupt whenever they saw an opportunity of getting their hands into where money was accessible.

Lack- or improper attention towards mechanisms and mentalities fostering corruption may therefore also jeopardise CBHIS implementation processes i.a. due to inadequate efforts involving community leaders in the planning and implementation of healthcare strategies through their participation in Ward Health Committees. Apart from participating in health programming, their involvement can help combat transparency and accountability problems attached to the use of funds. Failing to anticipate and to solve the effect of corruption on health programming may extensively lead to missed opportunities of sound health system development, prolonging implementation processes and consequently delaying vulnerable groups from having access to treatment and care in times of ill-health.

In the wake of the above, key persons in the villages, formal caregivers and one government representative experienced health policies to only be paper based without leading to any significant improvement in the availabilities of healthcare services at the community level in rural areas.

I made the following observations when visiting a couple of governmental representatives in their offices. Apart from scheduling for interviews, my aim for coming to there was to ask for copies of current health plans in force, and a plan of action (PoA) on local health programme implementation. However, none of the representatives had these easily accessible. When returning later to conduct an interview, I was surprisingly given the implementation guide *"Bringing PHC under 1 Roof".* This guide was built on the current health plan: WMHCP 2007-2012, which could be available to me at the Ministry of Health in Owerri. During this process, I wondered about the likeliness of health activities to be implemented and executed without having the current health plan itself at hand. I asked the representative about these issues, whereby he expressed his frustrations on heading an office without sufficient resources enabling him to carry out his work properly. As such, he assessed the health plan to be just another piece of paper without any value beyond pointing to political intentions which he was unable to execute. He was showing me the implementation guide, and informed that he was given the task of distributing the guide to other districts of the LG. However, due to no funding, he was not willing to use his private money ensuring the document to be passed around.

During the further conversation with him, he tried to explain the complexity of constraints prohibiting healthcare services to sufficiently reach rural communities. He said:

> *"(…) corruption being a part of the problem. The economy is bad and the philanthropic individual is no longer giving money for development. (…). Planning from the office without considering the needs of the community make them [the policy makers and executives] provide what the community doesn't need. They should come to the community to know what the people need, give money to the community; monitor and supervise them to ensure the money is used for what it is meant for"* (G1).

In regards to insufficient and inadequate budgets, he explained the budgetary approval process to me, which in his opinion reinforced the uncertainty and instability of resource allocation to reach the health sector at the primary level. He was concerned about opportunities of funding to be channeled towards the wrong recipients. The following pictures his concerns as regards to these issues:

> *"Each department makes their budget and send it to planning and research statistics who [some persons] takes the budget to Owerri [state capital], and they will defend the budget on behalf of the different departments, but it will not be on the interests of those departments. It is better for the departments to defend their budgets themselves to ensure it gets approval. Frequent change in government at the local government level also hinders the implementation of the budget, as every Chairman will bring his own program"* (G1).

These opinions were similarly communicated by a community doctor. He referred to the Nigerian health system where he saw it to necessarily reflect the political system in general. He believed a deep rooted tradition of corruption to be the main obstacle to health system development. He elaborated further by saying:

> *"Contrary, when a system works well it will reflect down on services executed and implemented though proper management and reporting, facilitating for transparency which at the end will be beneficial for the people"* (CT5 formal).

Corruption, viewed as a challenge to health system development, was well recognised among other groups of participants as well, and perceived to accelerate towards the lower levels of governance. A prevalent and common experience among participants residing in the villages was related to those considered *"better off"*. This group was perceived to register and participate in political campaigns during elections, proposing the implementation of various programs only to *"make a name"*. Anecdotally, it is worth mentioning that Nigeria has approximately 63 different political parties, which may reflect some of the problems arising at different levels of the political system. It may help explaining some of the prevailing challenges related to political cooperation, commitment and accountability in regards to the implementation and execution of programs in line with approved policies and plans. Unfortunately the result becomes particularly visible for those considered *"worse off",* and in most need of improvements.

In this very complex interaction between various structures, there was consistency in opinions among different groups of participants on the following issues; State Government allocations of funds, materials and equipment meant to support the less privileged in rural areas was seen to fall into the hands of those in positions to secure themselves and their relatives through access to benefits made available through their possessing positions. Such experiences were understood to have their origin in the mind-sets of politicians, guided by

their mentality involving greediness and money consciousness, ultimately fostering corruption and betrayal of people. Such perceptions made two old men participating in their respective FGDs to state:

> *"Our rulers now only work for their pockets. That is why we need leaders and not rulers"* (P3V1; P6V2).

The mind-sets of politicians were perceived to influence mentalities downwards on the system fostering adaption to bad practices among civil servants, including formal caregivers. Corruption can therefore be assessed to become a phenomenon representing the norm and accepted in spite of its negative effects. Rather than people opposing against such practices it becomes integrated into the system and interwove with aspects of society where prospective opportunities of personal enrichment becomes a priority before the collective wellbeing of a population.

Elderly participating in FGDs elaborated particularly on the poor qualities of healthcare providers, and their concern was directed towards receiving insufficient treatment and to be given fake or expired drugs, causing another sickness in them. In spite of Nigerian Governments' efforts regulating an expanding pharmaceutical industry through NAFDAC[22], one formal caregiver said:

> *"But if you have the cash, somebody can lay hand on about 400.000 Naira now, you go and register one product"* (CT 6 formal).

Several elders wished for doctors who were specially trained, possessing an understanding of the plight of the elderly. In order to receive quality care, they talked about the importance of knowing somebody working in a health facility. This should preferably be local people, but they scarcely experienced them to be employed at any health facility within their district. Quite often these positions were taken by the relatives of people holding key positions in the

[22] The **National Agency for Food and Drug Administration and Control** (NAFDAC) is a Nigerian government agency under the Federal Ministry of Health that is responsible for regulating and controlling the manufacture, importation, exportation, advertisement, distribution, sale and use of food, drugs, cosmetics, medical devices, chemicals and prepackaged water.
Ref: **en.Wikipedia.org**
VISION: Safeguarding public health
MISSION STATEMENT: To safeguard public health by ensuring that only the right quality drugs, food and other regulated products are manufactured, imported, exported, advertised, distributed, sold and used. Ref: www.**nafdac**.gov.ng

society, enabling them to employ family members. This contributed largely in reducing the quality of care, as several employees were perceived by villagers to work as caregivers without any formal skills. Based on such experiences elderly would, with the help from a relative, try accessing quality medicines from nurses operating from small pharmacies in the cities alongside their formal work in a health facility.

During my field work I acquired information about the current State Governor's initiative of screening civil servants working in the formal sector. His aim was to identify and exclude *"ghost"* workers. Positions becoming vacant during this process were reopened for assignments according to recognised and transparent procedures. Such initiation points to a political will starting the cleaning up of the system, but there are many challenges ahead and socio-political complex issues. Taking the intricate health political system into account, where existing PHC deliveries on one hand often seem to be guided by alternative political motivations and on the other comprise financial constraints and implications related to funding, healthcare services in rural areas seem to continue being largely unavailable and its quality poor. Costs of services are therefore likely to continue representing a persistent constraint affecting its accessibility, considerably impacting the poor and vulnerable groups, where old people constitute an increasing share.

Health system infrastructures and access to Primary Health Care

Introduction

In the current WMHCP 2007-2012 one can read:

> *"Nigerian National Health Policy identified primary health care (PHC) as the main focus for delivering an effective, efficient, quality, accessible and affordable health services, to a wider proportion of the population (…)"* (WMHCP 2007-2012; pp 9).

Such shall be ensured through the initiations of four approaches where one is the promotion of community participation in planning, management, monitoring and evaluation of the local government health system i.e. the PHC system. Services shall be provided to people from PHC facilities classified as; *Health Posts and Dispensaries (type I); Primary Health Clinics (type II); Primary Health Centres (type III) and; Comprehensive Health Centres (type IV).* Each community is expected to have one Health Post, and a population of 2000 to have one Primary Health Clinic. In regards to the availability of Primary Health Centres in LGAs, current

health plans state that such is not equitable within and between the various geo-political zones in the country, and their number consequently not quoted (WMHCP 2007-2012; pp 49).

The minimum health manpower requirement for a type I facility is the availability of a Junior Community Health Extension Worker (JCHEW), while a type II facility should ensure the availability of 2 Community Health Extension Workers and 4 JCHEW's. In a type III facility, considered as a Ward Health Centre, there should be availability of; 1 Community Health Officer (CHO); 1 Public Health Nurse (PHN); 3 CHEWs who are respectively responsible for statistics, medicines and equipments; 6 JCHEWs, 4 Nurses/Midwives and 1 Medical Assistant (optional) (WMHCP 2007-2012; pp 47).

Having the previous findings in mind coupled with the above information, the following chapters investigates participants' views on the existing health system and its function, and explores particularly how participants looks at its potential accommodating community based initiatives and interventions targeting old people.

Villagers understanding of the health system and its function

In order to gain knowledge of old people and informal caregivers understanding of the health system, I explicitly asked them to elaborate on its intention and function. The majority of informal caregivers faced some troubles defining such while several old people participating in FGDs had clear opinions on the matter. They said that a well-functioning health system reflects strong and healthy populations, provides services for all groups of people, and allows people to choose services according to their conditions and needs. Based on their understanding, a health system should consequently offer numerous of services, including the visiting and assisting of old people through the availability of sufficient numbers of skilled health workers. They particularly emphasised the importance of decentralising the health system to reach to the grass-root level fostering access to functional health posts within their respective villages. Old people's emphasis on visits and consequently to be noticed was again raised as important issues. This may strengthen the value of earlier arguments made, where societal transitions and socio-economic constraints were experienced to weaken family support mechanisms leaving several elders to cater for themselves the best they could. As an old man, participating in a FGD, said:

> *"You know, Government has never cared for the old people"* (P3V2).

His opinion was supported by the majority of old people participating in FGDs, whereby they perceived governmental ignorance to enforce the hardships on elders. They explained such viewpoints to have originated from learned experiences on the basis of authorities' inadequate efforts implementing suitable and comprehensive well-fare systems, where the needs of elderly scarcely was considered equally with others. Based on the fact that most old people were not eligible recipients to pensions, the majority of them wished for healthcare services to be free of charge. They drew parallels to initiatives directed towards children where the implementation of recent governmental strategies had exempted families from paying school fees.

As initially stated in this chapter, informal caregivers faced some problems defining the health system, but they had opinions on its usefulness in times of need. Previous findings presented in this paper have suggested that the hiring of a helper could involve shame, threatening a family's pride and dignity, conflicting with customs of expected responsibility that traditionally had safeguarded the wellbeing of elderly family members. Moreover, that the cost involved made this an option only for those *"better off".* However, the majority of informal caregivers expressed welcoming opinions on being assisted by formal caregivers. But before such assistance could be accepted they emphasised on the importance of clarifying the two parties' roles and motivations in order to avoid barriers and a feeling of insecurity in a situation giving outsiders opportunities to exploit a family, or an old person. The majority of informal caregivers believed however such assistance to considerably alleviate their burden of duties, giving them improved opportunities to perform other important activities beneficial for themselves, and also their family. As an example on how expected obligations could influence on young caregivers future prospects, a young newly wedded daughter in-law told me about how she had to leave her plans pursuing higher education due to being expected to care for an old mother in-law. When asking her about the convenience of being supported by formal caregivers, she said:

> "(...) *someone that will help Mama, then can be free of myself to do whatever I plan to do. That is during the daytime. That is the only thing"* (CTV3).

Consequently one could link health system development to societal perspectives of human life. The possible impact of channelling adequate health interventions towards old people can be therefore assessed within perspectives of empowerment, supporting rural women by strengthening opportunities of self-realisation through education and work, lessening their dependency on others.

When discussing the existing health system and its potential for including services to elderly people, a community nurse was of the opinion that there is an indisputable need for structures to be established within the health system to anticipate their care. Her opinion was based on observations acquired from community work. She attached such needs to an ongoing societal transition affecting families' caring abilities, the hardship of life many people are facing, change of mentalities among the younger generation and inadequate expensive healthcare services, hard to cope with for rural families. Several participants representing groups of old people, informal caregivers and key persons in the village were aware of health structures targeting the care and well-being of elders to be established in the *"developed world".* Others had knowledge about likewise initiatives in a neighbouring state [Anambra] where old people could receive services of their kind, free of charge. However, participants in general agreed on the limited capacity of the health system existing at the study site. Formal assistance was neither experienced nor expected unless rendered by some few philanthropists outside of the formal health system. Their views seem to support strategies guiding the Governor's initiative where he has decided to establish *"Old People's Club"* in the districts. According to information given by government representatives, philanthropists within the Catholic Church seem to be the lead organisers and funders of such projects, where services are expected to be rendered mostly by Reverent Sisters rather than skilled health workers.

Community groups as resourceful counterparts in local health system development

When I conducted interviews with formal caregivers and key persons, I particularly addressed the role and function of village organisations in health system development at the grass root level. I asked them if they assessed community involvement to give improved opportunities for rural people to receive healthcare services whereby also elders could

receive services of their kind in times of need. A community nurse shared her personal views with me by saying:

> *"The introduction of care assisting older people, where the government are involved one way or the other, would set an example which may lead to families encountering this as a good idea. However, such initiatives must involve the Eze who should be noticed about the increasingly troubled situation older people are facing and initiate actions which involves the community"* (CT1 formal).

Her statement points to three areas of importance: the need for sensitisation and awareness among stakeholders on the situation elderly are facing; the influence of community leaders on community mobilisation; and the mutual involvement of local government representatives and leaders of community groups in projects. However, when raising the same question in a conversation with a governmental representative, he categorically said:

> *"Health facilities don't take care of the elderly as it is the responsibility of the family members to take care of old people. The community doesn't see any needs of taking the old ones to others in order to take care of them"* (G1).

I don't know whether his reluctance to directly answer my question reflected his ignorance on the topic under discussion, or was guided by alternate motivations. Nonetheless, his response is still interesting as he can be perceived to deliberately evade questions addressing the role of community involvement in health system development, and moreover renounce responsibility on the wellbeing of elderly to be the concern of health political decision-makers and health officials.

Based on their diverging answers, it is interesting to assess the question in the perspectives of current health plans in force, where strategies aim at strengthening the link between the formal health system and existing community structures by:

> *"(...) promote community participation in planning, management, monitoring and evaluation of the LG health system i.e. the PHC system"* (WMHCP 2007-2012, pp; 9).

Current plans describe that community participation and involvement in health activities particularly shall be encouraged at the Ward level of the health political system and preferably carried out through community member's participation in Ward Development Committees. In order to facilitate for such processes:

> *"(...) the Federal-, State-, and Local Government would provide the necessary manpower, infrastructure and logistics to enable the Ward perform its role"* (WMHCP 2007-2012, pp; 10).

Moreover, community groups that initiate the establishment of local health facilities should be encouraged and supported by the Ward Development Committee. Such initiatives should be based upon identification of disease patterns and environmental conditions causing ill-health among populations, fostering a need for improved health services (WMHCP 2007-2012).

The NSHDP (2010-2015) has taken the emphasis on community participation and local ownership further where aims are reflected through the following specific objectives:

> *"(...) to build capacity within communities to "own" their health services; to empower communities with skills for positive health actions (...) through the building of their capacities and knowledge; (...) a re-orientation of community development committees and community-based health care providers regarding their roles, responsibilities and resources mobilised and allocated for funding for community level activities and; [strengthening] community dialogue between community and government structures (...)"* (NSHDP 2010-2015, pp; 52-53).

When assessing the opportunities for community participation in health projects at the study site, findings presented earlier have clearly informed that such involvement is in need of a re-orientation of stakeholders focus and priorities. In order to improve the current situation, local health authorities could preferably initiate actions that motivate leaders of community groups to be involved in community health projects, and to facilitate forums where the health issues of rural people could be addressed and the potential of community based healthcare services discussed. Instead, the present situation continues to manifest the huge gap existing between leaders of community groups and those appointed to work for rural development and improved access to public services, constraining any collaborative efforts. In order to change this rather unfruitful situation, key persons participating in this study called for improved attention towards governmental accountability, commitment and transparency before involving themselves in any prospective mutual projects. One community doctor informed:

> *"Here people will give land for developmental projects and they are willing to contribute their quota if they are being carried along. People are not consulted when*

> *plans are being made. There are poor statistics, poor record keeping and no baseline surveys before projects are being carried out"* (CT2 formal).

His views were partly supported by the elders participating in FGDs and key persons residing in the villages. Their response to questions addressing opportunities of community participation in health projects was most commonly reflecting skepticisms, and any co-operational aspect limited to the provision of land. Moreover, any approach for collaboration in health projects should come from the government and be introduced to the community through the Eze. However, participants residing in the villages expected to be given assurance of the sustainability of projects before contributions such as the provision of land could reach consensus among villagers.

In spite of their rather pessimistic responses, I continued to pursue the issue of community participation when having conversations with key persons participating in the study. I asked them how they would assess themselves as resourceful counterparts in governmental health projects, and the role they could play in i.a. the building- and management of local health facilities. Their answers were again conditional. First of all, villagers had to be ensured that health structures were being built in the name of a village. If such reinsurance was to be trusted, they were willing to make it functional by taking on responsibilities such as construction, security and maintenance work. However, the sharing of responsibilities had to be clarified in advance. A key person stressed on the following:

> *"But government will also help to make it functional by taking care of running expenses, providing drugs, all the necessary things that we need to work there and otherwise to make that health centre functional"* (K1V1).

Several key persons were acquainted with government initiations of projects where contractors started working, just to leave an unfinished job. Consequently, they perceived governmental representatives to not be loyal to agreements made, be ignorant of their duties and to run away from responsibilities. On the other hand, participants representing the government perceived community involvement in projects to be difficult due to the focus of village people where one governmental representative perceived them to:

> "(…) *only be concerned about internal matters"* (G3).

Another believed any collaborative attempts to bring along additional problems such as:

> *"(...) misunderstandings among community members on for instance where to site a health facility"* (G1).

The opinions reflected by people representing different groups of participants contribute considerably in explaining some of the gap existing between government bodies and community organisations, making joint actions in health a complex task to achieve. It seem to involve a need for reorientation of mind-sets among all stakeholders, to strengthen efforts bringing people representing various institutions at the grass root level together, and to arrange for forums where people could meet and discuss.

The next chapter takes indentified challenges into consideration and investigates whether strategies outlined in current health plans only are theoretically based, or if they also facilitates for the practical implementation of structures, feasible and sustainable in order to support health system development at the community level, and principally with full and active participation of community members.

The Ward Development Committee: a meeting point facilitating for community involvement in health at the grass-root level

An essential health political initiative aiming to bring community organisations and formal bodies together, ensuring community participation in health and ownership to health services is the establishment of Ward Development Committees. As earlier referred to, such initiative is thoroughly described in the briefing package for sensitisation on the Ward Health System, 2006. Closely embedded into the Ward Health System, and presented as a strategic goal, is to stimulate for Community Based Healthcare initiatives in local environments.

When I asked key persons residing in the villages whether a Ward Development Committee had been established within their district and moreover their understanding of its role and functions, only two of them were aware of the existence of such Committees. However, none knew about its main functions and role. When I raised the same question in interviews and conversations with other groups of participants, more than half of the formal caregivers had knowledge of such Committees and its function. All government representatives were well aware of the Committee, its function, and composition of belonging members. One of them explained:

> *"(…) this is a policy developed to ensure that health services reach the door step. It contains an organisation chart headed by the local government chairman and the health coordinator which is the secretary with involvement of community leaders. They meet either monthly or bimonthly working in Wards. This LG has 15 Wards and 27 autonomous communities [preferably] headed by a committee. The committee should comprise village heads; village health workers; volunteers; staff from health posts and community health clinics"* (G1).

However, when I asked how the formation of such Committees consequently could stimulate for Community Based Healthcare initiatives and the participation of community members, he revealed the following:

> *"In regards to Community Based Healthcare, it is not an issue to discuss at all, because there are no money or budget or funding to be used to implement PHC services at low level within each community; no funding for logistics; no money to fuel cars; no money to pay people to go around to sensitise communities; no money for staffing those building capacities, planning, monitoring and reporting. One thing is being on the paper, another thing is the implementation. Corruption has to be viewed as part of the problem which also contributes in failing to secure community participation. Economy is bad and the philanthropic individual is no longer giving money for development"* (G1).

Similar constraints were experienced by a community doctor, where he stated that his office was meant to be at the LG Headquarters. From there he would be going to different health centers to consult, supervise and monitor community health workers and their performance of healthcare activities. But due to lack of health personnel and adequate resources he had to work as a general practitioner in a health centre. When I raised these issues in an interview with another community doctor, he said:

> "*But when there is no funding to the LG's, the PHC will not work. There is no vehicle to take doctors around to the clinics, no funding for community mobilisations. As the HOD of Community Health is supposed to visit the PHCC at [x] and [xx], but due to lack of resources, I come to work and stay in my office. Corruption has not allowed things to work well"* (CT5 formal).

Based on these statements, it seems as both formal caregivers and local government health representatives shared some frustration which they attached to health political mismanagement and inadequate allocation of resources, impacting on their abilities to perform their work and to implement strategies according to intentions as outlined in

current policies. When I pursued these issues in later conversations with a governmental representative at the state level, he linked the successful implementation of health services at the grass-root level to the work of Ward Development Committees and moreover the capacities and capabilities of its members, which according to him depended on their abilities to:

> *"(...) plan for their own budget for their own self; sustainable and deliverable"* (G2).

He continued elaborating on the role and responsibilities of the Ward Development Committee which he explained mainly were to secure health services to fit into LG- and State PHC programs. So far he believed the main constraint to its success to be lack of sufficient funding and no proper organisation set up. However, in order to improve the situation, he explained that the SMoH had been working to establish a State PHC Development Agency equal to the one at the Federal level, where a memo already had been approved by the Governor. A draft copy was sent to the Ministry of Justice, where it subsequently after drafting would be passed over to the Parliament for final approval. He expected the State PHC Development Agency to considerably contribute in reforming budgetary processes and through such improvements ensuring funds to reach the health sector at the primary level whereby strategies could be implemented according to the intentions of current health policies. He explained:

> *"(…) make it easier to have health funds from the state government, from the LG, from our development partners, enter into this pool or basket of funds. It will now be easier for health managers to know how to use this fund available to reach every level. Unlike the system we have now where the fund simply comes from either State government budget for the year, or LG budget for the year. But all the departments of government are contesting for these funds and in some cases they may not see health as a priority in the sense that the availability and the impact of health, unlike when you build roads, is not the same"* (G2).

When I continued exploring the issue of community participation in health, I was informed by a community doctor that PHC, as the preferred strategy to improved health among populations, only was introduced in Nigeria in 2006 parallel with the introduction of the Ward Health System. In the process of rapidly transforming the previous health system to coincide with the aims of current health policies, he blamed health politicians for not

allowing new primary health strategies to evolve gradually and to build on capacities and structures already at the ground. He shared his thoughts on the matter by saying:

> *"(…) somebody who having lived long, maybe in USA or Britain or these places, you see, will see what is obtainable there. You come home, and you have it in mind, but when once you want to implement it, you will not devise a gradual process from which can evolve to reach that level he saw over there. He just wants to implement(...) and by the time you want to implement such a thing, maybe the little one that was on ground before, you will just overlook it, you shift it"* (CT2 formal).

His statements may indicate concerns about the foreign influence on health policy formulation and the selection of priority health programmes, where implementation strategies fails to adequately assess structures and support systems on the ground necessary to be in place in order to secure new health strategies to work according to intentions. This may involve lacks of proper contextual understanding among those appointed to transform the health system to result in substantial health gains for populations, neglecting systems already existing on the ground that takes local traditions, systems and cultures into account.

He was particularly concerned about leaving community leaders out as counterparts in local health system development which according to him consequently affected community mobilisation and participation, constraining initiations of Community Based Healthcare services. Moreover, he experienced secondary- and tertiary level health facilities to be prioritised by the State Government through systems ensuring salaries, equipment and drugs, attracting community health-workers to come and work in urban areas, draining qualified human resources from rural areas. These views were also supported by two other formal caregivers, whereby they concluded that the current health system had failed to include the primary level. They experienced the PHC system, among other factors, to lack key personnel at the LG level that could ensure the implementation of priority programs and the formation of Community Development Committees. Essential staff expected to be in place was Chief Medical Officers of Health whose duties would be to facilitate and support the work of Committee members, and to monitor, evaluate and report the results of community health activities and health workers performances. Lacks of substantial budgets accompanying health strategies along with political unaccountability was seen as a major part of the problem, perceived to constrain community health programmes from being

implemented and carried out according to intentions. In spite of intentions emphasised by the Nigerian National Primary Health Care Development Agency (2006), reflected through objectives guiding the Ward Health System Policy, the encouragement of bottom up approaches seems unfortunately to have failed in its attempts inviting community members at the grass-root level to involve in health through the establishing of suitable community structures where they could join forces with government health representatives improving people's access to local health services at the study site.

Figur 24: Orlu University Teaching Hospital. Photo: Heidi Olsen

The potential of Community Based Healthcare services supporting old people

Findings so far have pointed to the various constraints presently threatening health system development in the area of the study site, and looked into how these are impacting on health service deliveries, and community involvement and participation. In spite of these constraints, I wanted to find out how participants understood the concept Community Based Healthcare, and how they assessed its potential improving the delivery of healthcare services at the grass-root level. Moreover, I was curious to explore whether it was likely that such initiatives also could address the health needs of elderly people equally with other groups.

Interestingly, all formal caregivers and government representatives participating in this study were well aware of the potential of Community Based Healthcare (CBHC) which they assessed as an important strategy under the concept of PHC. There seemed to be knowledge among them on its appropriateness giving opportunities to implement goal-oriented health services at low cost, making real impact on the health situation of people in rural areas. CBHC was understood to comprise several plans and interventions, where its main goal was to secure care and services to be provided to clients in their own environment and at home that could be of physical-, spiritual-, social-, emotional- and psychological nature. As reflected by a senior nurse working as a tutor:

> *"(...) through this system, care and support can either be rendered by family members or volunteers such as secondary school students, women and youths that are trained for the job by formal caregivers"* (CT 7, formal).

A governmental representative added that CBHC is about solving the health problems existing in a community by utilising resources in communities jointly with those of LG.

According to formal caregivers, CBHC services should preferably be provided under the umbrella of a PHCC of which personnel could assist the work of Ward Development Committees by helping defining community member's need for healthcare, and thereafter supervise them in the planning, implementation and performance of community health activities. They emphasised on the importance of increasing the numbers of CHEWs as they traditionally were trained to work in the community and at the familial level. The main tasks

of CHEWs were understood to involve the detection of diseases and environmental- and social threats impacting on people's health; taking medical records; issue health cards; give health education; take note of the sick ones; and to refer them to the PHCC level of the PHC system whenever necessary. The advantages of including CHEWs in healthcare provision was linked to their attachment to local communities, that they usually were locally trained people and as such recognised and trusted by community members. A community nurse stated:

> *"If CBHC would be integrated and executed within the health system the same way HIV/AIDS is being campaigned and services initiated targeting those living with HIV, it would be marvellous as it is particularly suited to take care of the aged"* (CT1 formal).

The majority of formal caregivers participating in this study recognised the need of increased attention towards the care of old people particularly due to changes in society where rural-urban migration constitute one of several threats to their well-being and health. Such views were largely based on their own private experiences but also observations acquired through their professional work in the communities. Several believed that if the government was carried along providing the necessary materials needed to assist old people, the willingness and skills among them to mobilise was there. According to their opinions, elderly people would largely benefit from a general extension of health infrastructures to also reach villages, as health services would become accessible in closer range to their homes.

Outreach was assessed by formal caregivers to be the most suitable method rendering services to old people. However, they all said that any approach should be brought forward to the Eze and explained properly before initiated. His acknowledgement and approval of any project was seen as crucial for its successful implementation as it constituted a prerequisite for reaching consensus among other community leaders, securing the involvement of community members. Among key persons, only one participant representing the youths was found to have reflected properly on the increasingly troubled situation many elders were facing at the study site. His reflection was based upon recognition of the ongoing societal transition affecting rural communities. During a conversation, we talked about elderly people's current situation and I asked him how he saw social transition to ultimately affect old people health wise- and practically, and the possibilities for strategies to be initiated in order to improve their situation. Generally, he would welcome any initiative

aiming at improving the living conditions of old people. However, he saw a potential to mobilise fellow Youth Group members to go around visiting elders, as one of his particular concerns was related to their feeling of loneliness in the absence of close family members. He said:

> *"Loneliness is another disease too which can cause a disease that is incurable"* (K3V1).

Based on his experience with elders, visiting services was seen as one of the most important interventions if any actions should be initiated. According to him, this would bring happiness into an old person's life, supporting prospects of living a long life. Happiness as a positive state of mind was by him attached to emotional care which could be accommodated through visits, perceived necessary in order to strengthen old people's perceptions of being recognised and thereby loved. However, he was a bit concerned about fostering expectations among elders for more good things to come, such as food. After thinking for a while, he concluded that clarifications should be made between those carrying out services and recipients in need of support before interventions were decided upon and implemented. Next to visiting, he emphasised the role younger people could play in rendering practical help to old people. But he underlined that services in general preferably should be planned in cooperation with representatives from the formal health system securing support from formal health workers. He explicitly mentioned Medical Health Officers to be one of these, as he also believed the provision of drugs and assessment of old people's physical condition to be essential if services should constitute any substantial aid. These services were perceived to be particularly suited for women to perform, but there seemed to be an obvious need for training before women could be involved in performing community health activities to this group. As he said:

> *"(...) because those women do not know anything about health and they will know that through Health Officers. So they need orientation. That is to enlighten them, to highlight what is proper work. But if they are given adequate training, there must be a difference"* (K3V1).

As findings have been uncovered, old people, formal caregivers and governmental representatives recognised elders to be in need for improved care and support, and they were also aware about their vulnerability in times of ill-health. However, while elders expressed the un-likeliness of being supported by the formal health system, and government

representatives claiming their care and wellbeing to be the responsibility of family members, formal caregivers had identified old people's need for formal health interventions and were willing to carry out especially outreach services if supported by local health authorities. They looked at themselves as a resource that easily could be mobilised and moreover to be in possession of skills that could be utilised in the training of community volunteers, securing participation in community health activities targeting elderly people. The majority of key persons residing in the villages seemed only to reflect on the situation of old people when responding to direct questions, whereas one was found to have been thinking about their increasingly troubled situation in the perspectives of having migrating family members. Informal caregivers were found to be reluctant about talking about inadequate family care, but positive to be assisted by formal caregivers if introduced in a proper manner. There seem to be knowledge among formal caregivers on the diversity of services needed to support elders health-wise and moreover strategies suitable to carry them out. All expressed care-giving activities to preferably be performed within the environment- and home of an old person and services to be rendered in collaboration with family members. Their perspectives are interesting in the sense that they are consistent with the needs for healthcare services and support communicated by elders themselves in terms of being sensitive- and accommodating to culture, norms and values cherished by old people. Approaches to health through CBHC strategies are therefore likely to be welcomed and accepted and its potential making a difference as regards to the well-being and health conditions of older people indisputable. Interestingly, none of the participants who recognised old people's need of improved care and support suggested building Old People's Homes, where elderly family members could be admitted and receive institutional care and services at their later part of life.

Unfortunately there exist several constraints to the above initiatives. Many of them are thoroughly presented through findings in this paper pointing to insufficient development of rural societies, inadequate government efforts towards the improvement of rural infrastructures, lacks of proper policies and plans targeting decentralisation of investments and services, and health decision-makers inadequate focus towards the identification of vulnerable groups in need of improved health care and support beyond those identified in current health plans. Within these contexts, corruption is seen as contributing hugely to the

rather pessimistic structural scenario manifested at the study site. In regards to attention towards the difficult situation of elders, and services anticipating their health and wellbeing, a governmental health representative said:

"Accidentally geriatric services are not yet a component within the PHC" (G2).

This statement can be understood to constitute the most crucial constraint to improved health service provision where elderly people are included. It ultimately limits the potential of initiating CBHC strategies in communities where leaders of community groups are sensitised on the difficult situation that many old people experiences, and consequently the potential of utilising the capacities of community members in providing community based health services that anticipates the health needs of this group.

Apart from the above aspects, this study has moreover uncovered organisational constraints to sound health system development and availability of affordable health services at the grass-root level in general. There seems to be huge gaps between formal bodies and community groups in terms of mind-sets which could support collaborative strategies. Such were found to largely prohibit joint utilisation of resources and investment in social capital at the grass-root level, consequently affecting initiations of projects beneficial to people living in these communities. The latter aspects can therefore, at least to some extent, help explaining the inadequate implementation of the Ward Health System where joint efforts in health preferably should be carried out under the auspice of Ward Development Committees securing community members' participation in the detection and delivery of community based healthcare services that also could benefit the older population.

Consequently, there is a need for reorientation of the philosophy behind current health plans in Nigeria, and among those making decisions on primary health components, designing of health programmes, priorities of services, and preferred target groups. This is necessary in order to ensure the inclusion of vulnerable groups entitled to receive primary health services, groups that currently perceive themselves unnoticed and counted out as recipients to healthcare, such as elderly people.

7. PLACING DATA INTO ITS WIDER CONTEXTS AND DISCUSSING FINDINGS WITHIN PERSPECTIVES OF RELEVANT LITERATURE, THEORIES AND PLANS

Introduction

The previous part of this thesis has thoroughly presented findings as they evolved from FGDs, interviews and informal conversations with participants participating in this study, also taking account of observations acquired by the researcher during the fieldwork. This journey has hopefully brought the situational realities of old Igbo people, and the different contexts in which they appear closer to the reader. Emphasis has been directed towards presenting and explaining how elderly people perceive their present situation to affect their wellbeing which ultimately impacts on their perception of having health or not. At the same time, participants representing other groups have been given the opportunity to voice their opinions and understanding of the topics under study, contributing to widening one's knowledge on aspects influential on the reality and life conditions old Igbo people currently are facing, affecting them health-wise. Participants' contributions to this study has consequently provided one with in depth information on contextual constructs, social-, normative- and cultural, that over the years has been perceived as safeguarding the wellbeing of elders, still expected to be accommodated. These are, however, now seen threatened by an ongoing societal transition and an increasing rural-urban migration, weakening the ties of the extended family system, where old Igbo people no longer can count on receiving adequate care and support from family members.

Extensive analyses of findings have been undertaken, where its meanings have been contextually discussed and placed within perspectives taking account of the structural-, health- and socio-political environment existing at the study site. Based on these analyses, answers to the research questions has gradually evolved, providing necessary knowledge and understanding on how it is to become old in an Igbo community, and circumstances impacting on values, norms and traditions guiding customary care to elderly people that gradually are weakening familial support mechanisms in contemporary time. Gaining such knowledge has been essential in order to fully consider and assess the potential of Community Based Healthcare services to elderly Igbo people, and how services could be

complementary to that of family care, welcomed by old people themselves: and importantly; being culturally acceptable for family members caring for elderly to receive.

This part brings findings into its wider contexts, where it will be discussed within the perspectives of other studies addressing issues of ageing in SSA countries, relevant to this study's aim and objectives. I will moreover discuss the relevancy of findings to the aims and necessary actions proposed in international plans on ageing, with special emphasis on the AU Policy Framework and Plan of Action (AU/HAI 2003) that particularly calls for increased attention towards elderly people living in developing countries. It is based on the recognition of an ongoing demographical- and epidemiological transition and decline in family care. Focus is therefore directed towards familial, societal-, structural and health political issues affecting their wellbeing and health conditions, and how access to health services was perceived sensitive and accommodating to their health needs.

Reciprocity and family-care to old Igbo people; findings assessed in the perspectives of earlier scientific research undertaken in similar SSA contexts

Introduction

While conducting this study among the Igbo people in Imo State Nigeria, I particularly emphasised reaching mutual understanding between us on central concepts such as old, family care, health, ill-health, health system, and healthcare. This has been important as it increases the validity of findings of which analyses is based upon, and thereby strengthen the conclusions of the study results. It has been particularly important to highlight the voice of elderly Igbo people.

The focus of this chapter is to present findings related to reciprocity and family-care to old Igbo people, and to assess these with the findings of earlier scientific research conducted in SSA contexts as presented in the literature review. Such focus consequently involves assessing how other researchers through their findings have considered reciprocity and family care-giving to this group not only to impact on their wellbeing and living conditions,

but also their perception to have health. It further discusses whether activities reflecting reciprocity appears to exist outside of their household environment.

The role of reciprocity in family care to old Africans and whether such exceeds beyond the borders of a family household

Elderly Igbo people explained the concept *"old"* to be attached to characteristics involving age (chronological), to have an advisory role to play by being a senior person in the family and to have gained extensive experience in life. But they also related *"old"* to lack of energy, failing health, inability to do things one could do in the past, and to not move fast. This is similar to how Unanka (2002) described how it is to be old based on the subjective perceptions of elderly participating in his study. However, elderly Igbo people were in addition found to particularly distinguish those being only old from those being both old and sick, a perception which only limited is reflected in other studies referred to in the literature review. However, van der Geest (2002) indicated something similar to exist among elderly Ghanaians where he suggested those restricted to walk around due to sickness to lose their social importance and become less interesting to visit, whereby they experienced social death before they died in the physical sense. Such finding captures also the perception of elderly Igbo people, where they extensively emphasised on the importance of retaining physical strength in order to continue executing their social role and stay active within their family, aspects of old age life that considerably fostered health, *"ahu ike".*

Despite the above, studies conducted in SSA contexts have mainly chosen to present *"old"* by the telling of stories (Apt, 1993; van der Geest, 2002), by describing their situational realities within a family based on elderly family members self-perception (Peil et al. 1989; van der Geest, 2002), *"old"* based on young people and family caregivers perspectives (Okoye and Obikeze, 2010; Shaibu and Wallhagen, 2002), or simply referring to elderly people by the use of chronological age (Gureje, 2008; Uwakwe et al. 2009). The latter may however have implications on their study results. Elderly Igbo people, as earlier stated, perceived themselves differently where also economic- and social status, ability to contribute and participate in family- and community activities, and gender mattered. However, it is reasons to believe that their self-perceptions on how it is to become *"old"* within the contexts of their families and communities are not so different from the

perceptions of other elderly people living within similar SSA contexts, based on the results of earlier studies.

Family care to old people within SSA contexts are all found to build on reciprocal norms and obligations between parents and their children, and care normally carried out within a household environment. However, while the reciprocal obligations between an old man and his wife was perceived to always be counted on, the support and care from sons, daughters and daughters-in law could vary over time, largely depending on their opportunity, ability and willingness. Many were also supported by hired helpers and younger relatives (Peil et al. 1989; Apt, 1993; van der Geest, 2002; Shaibu and Wallhagen, 2002; Unanka, 2002; and Uwakwe et al. 2009). Caregivers found to be involved in the support and care of old Africans referred to in these studies are therefore similar to the ones found to assist old Igbo people practically and in difficult situations.

However, the patri-lineal continuation of family line, found to exist within several SSA communities, and its attachment with aspects guiding norms of reciprocity between generations are very limited discussed, though mentioned by Unanka (2002) and Apt (1993). Knowledge on the influence of lineal systems on family care seems to matter as it can be understood to be determinative for the intergenerational exchange of activities one can expect to receive, where the gender of an old person seem to matter. Findings related to reciprocal activities among the Igbo people was found to particularly give importance to the relationship between a father and his son based on the strong patri-lineal system existing at the study site. There seem to be mutual agreements between fathers and sons fostering expectations of reciprocity expressed through care which in return secured the oldest son a right to inheritance including the right to overtake and make decisions on family compound and land. Next to the father of a family, reciprocal duties of the oldest son were related to his obligations and responsibilities towards family welfare, development, involving progress and access to money. An Igbo man should therefore secure the patri-lineal continuation of his family line through marriage, and place importance to his (usually) younger wife's ability to give birth to sons. The strong attachment to patri-lineal systems may indicate especially old Igbo women to become more vulnerable in their old age than old men, by over living their husbands. In this study, all the older women were widows and several were found to live in single-households depending on infrequent support mainly provided by their

daughters. Old men's better positions has to some extent also been confirmed by findings in other studies where they were found to be better off due to the fact that they usually owned houses and land, married younger wives and more often than old women shared their households with junior relatives (Peil et al., 1989; van der Geest, 2002). Despite the practices, van der Geest (2002) pointed to an interesting situation occurring within the Akan society in Ghana where several old men were found to be lonely and poor. Old men referred to situations where their wives would leave them if no longer provided for economically or if they become sick, disabled and dependent. Such situations were usually linked to children's ability to support them financially which again would secure support to their wives. However, gender differences are not extensively discussed within the perspectives of patri-lineal systems, where the situation of elderly African women, due to their rights, status and function within a family, usually are different from that of old men. This could have provided a better understanding on the effect of patri-lineal systems on reciprocity, and helped explaining why the majority of elderly women > 85 years commonly were found to live their life alone (Peil et al., 1989; Apt, 1993) which is similar to what is indicated in this study.

Prevailing philosophies on reciprocity often understand such as a magnitude of acts carried out between generations, expected to be performed. Obligations and duties are understood to be anchored in traditional norms, commonly presented by a life-time intergenerational exchange/wealth flow model where the exchange of wealth between generations appears as exchange for care at old age (Unanka, 2002). Within such philosophy, old people are being cared for not as an act of charity but duty, and ageing is perceived as a blessing. It builds on respect and honour fostering care, which according to Unanka (2002) support theories on *"Old age security"*, that emphasises on the importance of having children in order to secure dignity and good life at old age. However, it is uncertain to what extent these theories consider patri-lineal systems and its implication and influence on old women compared to old men as findings in this study indicates lineal systems to guide not only the nature, but also the extent of support one can expect to receive in old age.

However, both old Igbo men and women expected reciprocal acts to be performed by their children as they saw this as something they were entitled to receive. Interestingly, van der Geest (2002) pointed to a trend describing a growing ambiguity around family solidarity where family members wanted to maintain ties to their matri-lineage whenever this was

perceived beneficial. Unanka (2002) referred furthermore to the emerging of new asymmetrical systems in Nigeria introduced though the establishment of *"Old People's Homes"* which sometimes was found to replace care for elders. Apt (1993) described similar structures to have been introduced in Ghana since the early 1950s, starting with the establishment of the National Destitute Infirmary at Bekwai in the Ashanti region, and Shaibu and Wallhagen (2002) pointed to the expansion of destitute programs in Botswana. However, its intentions were perceived to largely have failed. This was explained mainly to be due to asymmetrical systems' insensitivity to the cultural, normative and social traditions that over the years have guided children's duties to care for their old parents. Such views are consistent with the findings of this study where especially elderly Igbo people and interestingly also informal caregivers perceived institutional care to be highly inacceptable and inappropriate.

Apart from referring to asymmetrical systems in the care for old people, previous studies only limited report and discuss reciprocity beyond the boundaries of a household, and whether such appear within the community or among members of community groups. This is interesting as this study found these structures not only to support collective community efforts but also involve reciprocal activities between members belonging to the same community group. Such is not outstanding as these mechanisms are commonly recognised also within other SSA communities (Okali et al. 2001; Ibem, 2009). Previous research addressing family care and support to elderly Africans leave the readers with an understanding that such mainly seem to occur within the well defined boundaries of a family and a household, not considering that elderly people also are part of their local community. However, Unanka (2002) have in his study mentioned the role of community in the care of elderly, but have failed to elaborate further on this important aspect. When conducting this study, I decided to look closer into the mechanisms of community groups in order to identify activities of reciprocal nature and its influence on older group members. Such investigation uncovered that elderly people contributed by their advisory role, and that their role and function in return was recognised by younger group members, confirming their social status. They helped each other out practically, and had established reciprocal financial support systems within their group, entitling them not only to receive help in times of trouble, but also when doing collective activities and hosting traditional marriages and funerals. However

reciprocity largely depended on whether they were up to date paying their dues, which often was found to be difficult and cause distress. Financial support mechanisms within community groups are to some extent also referred to in the studies by Unanka (2002) and Shaibu and Wallhagen (2002) where the payment of dues was linked to old people's right to receive services, though not discussed further.

When old people no longer could participate and contribute actively within their group, they still received occasional visits from friends and particularly fellow church members, something that was highly appreciated, also mentioned in the study by Ajomale (2007a), Uwakwe et al. (2009), van der Geest (2002) and Apt (1993). They have moreover briefly described how the poorer off sometimes could receive charity from their church congregation during festive seasons, similar to what was found in this study. However, among the Igbo people another important reciprocal act became visible. Old men that through his life had belonged to an age-grade secured him, his wife and sons the right to be buried in the land of the village with the support and attendance of all village people. This can be assessed as an essential reciprocal act of love of both individual- and collective nature, given to a person at the last stage of life, related to rite de passage, and grounded in the strong patri-lineal system existing at the study site. Funerals as an ultimate act of love reflecting family members extent of care for the old ones is also underlined in the study by van der Geest (2002). However he fails to describe the structural and cultural implications involved in the conduct of burials as he solely interprets it as an emerging etiquette aiming to compensate for inadequate care, without considering the deep rooted traditions and meanings behind- and rights attached to such ceremony, which also involves inheritance and land ownership.

Apart from the above, care and support to the old members of communities was mostly seen as a family responsibility. Among the previous studies addressing family care to elderly Africans, especially Peil et al. (1989) and van der Geest (2002) found practises to be guided by community expectations and relatively few old people to depend on- and expect help from friends and neighbours. This information supports the findings of this study and can also help explaining why the increasing hardships of old age life scarcely were discussed outside of a family setting, or raised at community group meetings. It most probably reflects values derived from traditional norms guiding family care-giving to elderly people,

motivationally constructed as to confirm and uphold a family's reputation and pride within a community, and where lack of conformity to such norms could be assessed as shameful and cause embarrassment to fellow villagers.

"Peace" and *"love"* as important properties to the concept family care

Knowledge on how elderly people describes how it is to be old within rural African societies matters in order to fully understand how they assess family care to meet with expectations of care that also upholds their identity and self-esteem, confirming their role within families to be valuable and appreciated. Moreover, how family care through its diversity of activities are perceived by elders to prevent a feeling of ill-health *"oria".* Findings based on the opinions, self-experiences and perceptions of elderly Igbo people gradually made visible a pattern of components attached to the concept family care which consequently supported their sense of psychological wellbeing and an experience to have health. The upholding of *"peace"* seemed to be crucial in order to strengthen the ties between family members and secure elders the availability of someone that could assist them physically and practically in times of need. *"Peace"* was also repeatedly occurring in the data material acquired from FGDs and its importance frequently related to situations involving security and rest of mind, where access to food and other necessities would be made available to them through family member's sharing of wealth, commodities and assets, important in order to uphold life and feel dignified. Similar mechanisms were described in the study among the Yoruba people in Nigeria where Peil et al. already in 1989 found those considered as kind, understanding, generous and peaceful to be more likely to receive sympathy and help from family members than those hard to get along with or those assessed to have personality problems. The behaviour of elderly Ghanaians and how they were perceived by others was in van der Geest (2002) found to influence on the extent of care and support elderly people could expect from their children. Self-control, kindness and patience to others were essential qualities along with being perceived as hardworking in their youthful age. As such, the foundation laid earlier in life would serve as a guarantee securing reciprocal acts from children later in life which dynamics also were found among the Igbo people. Several of the researchers (Peil et al., 1989; Apt, 1993; Ajomale, 2007a) have also pointed to situations where elderly people, and especially old women, suffered from the exclusion of their family due to characterisations and accusations rooted in cultural traditions and norms similar to those

found among the Igbo people and presented in the chapter describing those likely to fall out. The findings of earlier research can therefore be considered helpful by expanding the understanding of properties attached to the concept family care, as it provides additional insights into why elderly Igbo people placed so much emphasis on the upholding of "*peace"* within a family and between themselves and their children.

The efforts made by old Igbo people to allow *"peace"* to reign can consequently be understood within perspectives attached to their behaviour and contributions to their family, which responses in return reaffirmed the extent of which they perceived themselves *"loved"* by family members, confirmed through emotional acts. Emotional acts were frequently related to social inclusion and to be paid attention to through visits and greetings. Several researchers such as Gureje (2008), van der Geest (2002) and Shaibu and Wallhagen (2002) found similar dynamics to exist among the Yoruba people in Nigeria, and among elderly people in Ghana and Botswana. Shaibu and Wallhagen (2002) found in addition to visits the sharing of food to highly be regarded at as expression of care and love. Similar to that of the Batswana people, old Igbo people were also often found to measure love through availability to food, which they saw as a value laden gesture performed by their children. The extent of which old people perceived themselves loved can therefore be understood to also involve how they perceived themselves noticed, socially recognised and included, supporting their sense of being useful and respected, ultimately strengthening their identity and self-esteem. In the study among the Igbo people, emotional care and attention were found to considerably foster happiness in life. Happiness was moreover perceived to alleviate the feeling of ill-health and the burden of an illness, as it fostered a sense of psychological wellbeing. *"Peace"* and *"love"* can therefore be understood as interdependent properties to the concept family care, where its contribution to improved existential state of life secured the wellbeing of old people and their experience to have health.

What is discussed so far can be seen as a dynamic system made visible through the various components attached to familial care. Components can be understood as rooted in values usually cherished by elderly people, seen to guide many of their perspectives on family care and children's acts leading to improved health and wellbeing. Several other researchers (Apt, 1993; Ajomale, 2007a,b; Okoye and Obikeze, 2010) do also mention values among caregivers to influence on the extent and nature of care that can be expected rendered to old Africans,

but only limited elaborate on this aspect, as values commonly are referred to only as *"social values",* except from Aboderin (2004;2009). It is therefore worthwhile to discuss what it is about values that possibly may predict and influence family care-giving, and thereby the wellbeing and health of elderly people.

Values as influential on family care-giving to old people

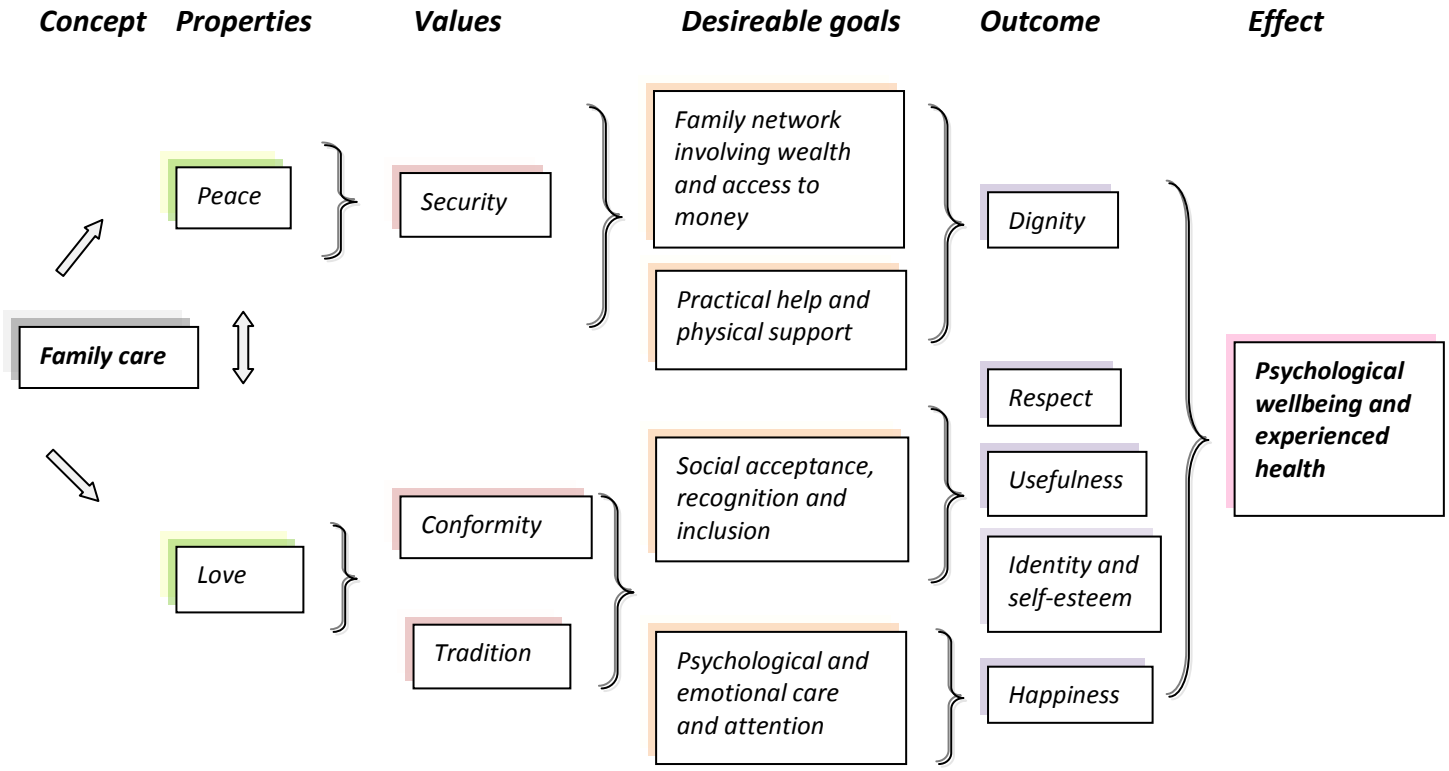
Values can be understood as being motivationally constructed and, according to Schwartz (2011), to have its origin in requirements representing three human conditions; *the needs of individuals as biological organisms; the requisites of coordinated social interaction, and the survival and welfare needs of groups.* From this, he has identified ten basic values of which each can be assessed to motivate one's actions achieving personal goals in life. These are; *self-direction; stimulation; hedonism; achievement; power; security; conformity; tradition; benevolence; and universalism* (Schwartz 2011; pp 2-3).

Following Schwartz (2011), old people are most likely to cherish values representing tradition, conformity and security. This can be explained by having reached to an age where common challenges to life presents itself through economic insecurity and the physical degeneration of the body, where the experience of physical weakness constraints participation in social life, and in activities generating income to themselves or their family. Such worries are well recognised in this study, presented particularly through the statements and perspectives of the older participants. Old Igbo people were found to appreciate environments and social situations consistent with their tradition and conformity with the past. This is not unexpected as it builds on values rooted in customs motivationally constructed as to guide reciprocity and consequently children's duties as carers for their old parents. These findings are in line with aspects of family care presented in several other studies (Peil et al., 1989; Apt, 1993) and also in the study by Shaibu and Wallhagen (2002) where they found elderly people in the Batswana culture to resist change, wanting to live a traditional life affirming continuity with the past. Values representing security, tradition and conformity can consequently be understood to accommodate safety and a predictable environment, considered to protect elderly from adapting to new resiliency strategies in order to manage everyday life. Caregivers complying with these values would consequently allow old people to perform duties and take on responsibilities in ways perceived to be

acceptable and less demanding, but still accommodate their sense of being respected and socially recognised. It is however uncertain how patri-lineal systems influences on values guiding intergenerational support and care to respectively old women and old men, due to being motivationally driven which involves prospects of inheritance and land ownership as incentives in exchange for care.

What is discussed in these chapters can be summoned up and presented through an illustration that highlights two, preferably interdependent, directions of care where one is governed by *"peace"* securing rest of mind making material and technical assistance available in times of need, and where *"love"* governs emotional aspects of family care. This illustration takes account of values as discussed above, as requirements regarded to support the human conditions, and thereby the psychological wellbeing and health of elderly people.

Family care; pathways leading to psychological wellbeing and experienced health



Several of the components presented in the illustration above were equally found by other researchers to be respectively important in the care for old people, though they have not attempted to integrate these into a more holistic system where its effect becomes clearer. As earlier discussed, to be attended to emotionally and recognised socially was considerably perceived essential among old Igbo people as they saw this as a foundation where other necessities of more practical nature would be made available to them, including access to money. Such dynamics were however, experienced to deteriorate influenced by a society in rapid transition fostering increasingly competitive environments. Social- and structural limitations and change caused many of the younger adults to move to urban areas in search for employment improving their financial situation, or to go for higher education, leaving the old ones behind in the villages to more or less cater for themselves. The absence of children was by old Igbo people considered crucial as their unavailability in times of problems not only challenged everyday life but also influenced on how they regarded themselves loved. The younger generations' adaption to values representing self-direction and individual achievement was also seen conflicting with values that traditionally had guided customary care for elderly people, impacting on their identity and how they felt being useful and respected. Similar structural aspects and the effect of societal transitions on elderly Africans are considerably reflected and discussed in several other studies such as Apt (1993), van der Geest (2002), Unanka (2002), Gureje (2008), Ajomale (2007a,b) Uwakwe (2009) and Aboderin (2004;2009).

Absence or distance to caregivers, challenging the support and care to elderly Africans have been observed already since early 1980's where its effect has been described to impact severely on their life conditions**.** Among several others, Peil et al. (1989), Apt (1993), Gureje (2008), and Uwakwe et al. (2009) pointed to the alarming tendency where old Africans now become lonely and increasingly socially isolated. Ajomale (2007a) referred to situations where elderly people was being socially excluded and not visited, and the social networks of communities gradually changed focus and no longer cushioned the effect of neglected elderly people. Moreover, Gureje (2008) uncovered in his study where he investigated factors impacting on the quality of life (QoL) of elderly Yoruba people in Nigeria, that social factors overrode those of direct health-related factors in terms of being health-bringing. He found depression to represent the single most important determinant of ill-health, caused

by social isolation and negligence, lacks of visits and elderly people's exclusion from participation in social activities. Depression was therefore recognised as an indicator expected to increase elderly Yoruba's dependency on caregivers.

The ongoing social transition do not only to influence on value priorities among caregivers, as discussed above, but seems also to change family constellations and caregivers place of residence, introducing caring from a distance. Children's financial status become increasingly important and rather than being present, their abilities to send money found to be crucial, replacing emotions and direct attentions with practicalities as an expression of love. This aspect can explain why old Igbo people extensively linked their experience of health and well-being to access to money, which response interestingly was linked to how they perceived their children to progress. However, similar to the findings of this study, several researchers such as Apt (1993), Shaibu and Wallhagen (2002) and Unanka (2002) found that children unfortunately did not become what their parents regarded as good providers, and several received no help and company, and meagre and infrequent financial support. Peil et al. described already in 1989 how those few who remained home mainly assisted with practical services while those migrating out were expected to send money. However the presence of a helper was found to decline and those being wealthy found to hire nurse-girls to come and look after their aging parents at home. This tendency was also apparent in the villages where this study was conducted where the absence of close family members was bearable when it secured opportunities of financial aid, which also involved children's efforts to accommodate for a hired helper, assisting practically in times of need. However, such practices was rarely discussed nor talked about within the community. Unanka (2002) referred to similar strategies in his study, where elderly people's acceptance of a hired helper interestingly was related to the empathy it represented, and the effort involved interpreted as an emotional act carried out by a child towards an aged parent. However, elderly Igbo people participating in this study still wished for the presence of their children, and care to be performed through direct assistance, accompanied by attention and emotions, confirming love for the old ones. This reflects the findings of Gureje (2008) who pointed to emotional care as more crucial than instrumental support.

In the process of *"developing"* countries such as Nigeria, societies in transition come to reflect structural challenges both at the micro- and macro level driven by forces, largely

uncontrollable, fostering adverse effects on the cultural, normative and social components tied to traditional living and as such come to affect family care, expected reciprocity and old age security. Societal transitions may therefore foster an unintended effect where the younger generation, in order to cope, adapt values conflicting with those representing tradition and conformity, as societies become increasingly money oriented and the possession of material goods become an indicator of success. In order to appear as modern and contemporary, young people may feel obliged to change their motivations, actions and priorities. The effect of societal transitions may therefore extensively come to challenge intergenerational ties and support mechanisms between generations and thereby the foundation of the extended family system making old people increasingly vulnerable to psychological- and physical ill-health, which findings of this study largely indicates.

Looking at care-giving to elderly Igbo people within the perspectives of social modernisation- and material constraint theories

As earlier discussed, old Igbo people experienced a decline in the care and support normally provided for by their children and other close relations. When they were asked to define family care, several compared the past with the present, whereby they experienced less help to be rendered now compared to the last decades. Beyond what is discussed in the previous chapters, they had taken notice of an ongoing change of gender roles, where women due to improved education wanted to pursue their own carriers, achieve self-fulfilment and also economic independence from their husbands, also reflected in the studies by Shaibu and Wallhagen (2002); Ajomale (2007b); Uwakwe et al. (2009) and Aboderin (2009). Increasing living expenses, unemployment and poverty were also experienced to drive children out of their villages with its perceived lack of opportunities and to search for employment and improved living in the cities. Elderly Igbo people connected the ongoing social transition to politicians' inadequate attentions towards decentralisation strategies reflected by poor infrastructures in rural areas and lack of employment opportunities. In addition, elderly Igbo people claimed that the government never showed any concerns on the plight of the elderly and paid attentions to their need for public services. Its crucial effect was experienced on daily basis where they struggled financially, which apart from children's inability to adequately provide for them economically also was reflected by inadequate pension

schemes, lack of social security systems and limited access to healthcare services. Their contributions in understanding the effect of societies in transition is therefore considerable, but not outstanding as similar aspects constraining the wellbeing of elderly Africans extensively are reflected in previous studies by Peil et al. (1989); Apt (1993); Unanka (2002); Ajomale (2007b); Gureje (2008); Uwakwe et al. (2009); Aboderin (2009), Okoye and Obikeze (2010), and Powell (2010).

Major fears related to old age life as they appeared in this study can therefore be considered structural, normative, social, physical, psychological and financial, and its effect devastating for those without family members to help them. However, an understanding of their fears is only to some extent provided by modernisation- and material constraints theories as this research has brought attention towards the more complex dynamics guiding family care, and factors perceived by elderly Igbo people to constrain the fulfilment of being cared for financially, practically, emotionally and socially. Such view is supported by Aboderin (2004; 2009) where she criticise these theories to provide any meaningful explanations for the diminishing care of old Africans. However, the following discussion aims not to present alternative theories on the decline in family care but rather to assess the consistency of findings in this study with notions on ageing represented through these theories where the decline in family care is understood to be driven by either modernity- or material constraints, or a combination of the two.

Factors likely to be explained by modernisation theories

Old people and also informal caregivers residing in the villages perceived improved opportunities to education and knowledge to cause young people to distance themselves from old traditions, norms and values which through the years had guided a person's duties and responsibilities towards his or her family. They experienced changes in behaviour and attitudes among young adults to particularly reflect decline in respect for elders and their role as advisers. They connected inadequate family care and support to their experiences of being less valued when executing roles that traditionally had been within their domain. Based on how they perceived their status, function and role to have changed, several were quite concerned about not controlling their children again, whereby some experienced to not have the right to talk or ask questions about children's whereabouts and even state of

life. Some also explicitly expressed fear of psychological and/or physical abuse. They believed changed attitudes among the younger generation to be influenced by values guiding urban life, reinforced by interaction with urban people and impacted by Western lifestyles.

Several participants participating in this study saw the impact of rural-urban migration to accelerate an adverse effect on family care, and to separate them from their children. Absence of children and to only receive infrequent visits was found to cause mental distress, often presented as high blood pressure and headaches. Access to children in times of need, their ability and willingness to support them, combined with time for help to arrive influenced considerably on their state of mind which increased their psychological and physical vulnerability to ill-health.

The findings presented above are to some extent consistent with prevailing explanations as they appear in theories supported by the modernisation model. Following Aboderin (2004; 2009), the decline in family support to old people is based on the assumption that their social role and status are less appreciated and they as such become less respected and valued by the younger generation. The shift from agricultural to industrialised societies, and the emerge of cash and marked economy as driving forces fostering urbanisation and modernity has impoverished older people and created both physical and social distance between family members impacting on care (Aboderin, 2004; Ajomale, 2007b).

Structural- and social changes are often used as explanations for changed mind-sets among the youth which along with improved opportunities for education also contributes to value change. According the modernisation theory, younger people are therefore no longer willing to provide for their older kin, and the extended family system have to recede from that of nuclear family settings, where married couples prioritise to care for- and support only immediate family members. As a consequence, old people find themselves trapped in a role-less-role, which makes several lonely without the attention of their children (Aboderin 2004;2009).

The effect of modernity as presented above can therefore be assessed to negatively influence aspects of family caregiving as they appear in the illustration presented in the previous chapter, unsupportive to the pathway where family care are driven by components

reflecting love, attention and emotional acts. By breaching with values and the philosophy guiding this pathway, elderly in return feel socially excluded, disrespected and unrecognised. The effect would as a result contribute to subjective existential feelings of ill-health and psychological discomfort, reflecting how they experience to be cared for.

However there are also findings that conflicts both with the theory, and the opinions and perceptions of elderly Igbo people. For instance, Okoye and Obikeze (2010) found educated young people to be less likely to hold negative perceptions about the old which is contrary to the opinions of old people participating in this study. Another important finding is the one where educated women consult a doctor in order to get a certificate justifying absence from formal work when a parent is in need for increased care and attention due to ill- health or disease. Such finding seems to represent a new strategy that I been unable to detect in the other literature presented here. Several studies refer also to women, where many are unable to marry due to caring responsibilities for elderly family members (Peil. et al. 1989), and moreover how daughters in law become the escape goat, where they have to share responsibilities as a wife and as a mother to their children with the caring for and aged parent (Unanka, 2002; Ajomale, 2007a). Uwakwe (2009) reported almost 40% of female caregivers to cut back on work in order to provide care. Similar tendencies were reflected by several of the caregivers participating in this study, where women, especially those residing in rural areas, were found to postpone or stop education due to caring responsibilities.

The perception of the elderly Igbo people should nevertheless be taken seriously as their feelings reflects how they perceive themselves to be seen and considered. Old age life brings about several challenges to life, where one aspect represents their ability to change along with the changes of society and to adapt to new life situations and realities. This is not always easily done, as old people often prefers to clung to what already is known to them, as this would make them to feel confident and secure. Some of their perceptions were they felt less appreciated and their pervious social role to be degraded may therefore be explained due to being old, and the less emotions and attentions received being due to the increasing hardships of life, challenging their caregivers ability to cope meeting up with the basic necessities of life rather than deliberately neglecting the old family members. Findings in this- and other studies has clearly shown that reciprocity, care and responsibility towards the elders still prevails and that caregivers, though mainly female, are willing to stretch

themselves to accommodate care for their parents. As such the increasing loneliness of old people cannot be explained solely by applying the modernisation theory, as the decline in family care also can be explained by material constraints.

Material constraint theories, complementary to- or instead of the modernisation theory

Older Igbo people were found to encourage younger people to migrate in order to progress. However, as this was seen to increase their chance being support financially, it also brought about an adverse effect fostering social isolation and disappointments where children failed to become what the elderly people expected, also reflected in Okali et al. (2001), Apt (1993), Shaibu and Wallhagen (2002) and Unanka (2002). As a result, all the elderly people participating in this study continued to engage in various income generating activities. Its importance was related to their ability to sustain life at a minimum, as most elderly Igbo people experienced to receive inadequate financial aid from their children. They perceived themselves to be poor people, whereby they consequently also feared the onset of physical illnesses as it would represent a double threat to life itself.

With the increased focus on development issues in SSA countries and awareness on how such influenced on the life of old Africans, current international debate on ageing presents a picture that largely offers counter based explanations to the modernisation theory. Such is presented through a material constraint theory which concern is directed towards the severity of interacting factors that impacts- and foster increased vulnerability to the life of elderly Africans (Ajomale, 2007b; Aboderin, 2009; Powell, 2010). It focuses on several areas of concern involving productivity and elderly Africans inabilities to cope when they no longer can engage sufficiently in paid work due to reduced physical capacities. Such concern takes account of the impact of rapid social and structural change, rural-urban migration and the effect of the HIV/AIDS epidemic on elders, though the latter is not discussed in this thesis. The decline in family care and support to elderly are, based on this theory, related to- and explained by material constraints rather than the breakdown of the traditional extended family system. It is understood to be driven by a growing incapacity for the young to cater for their old family members due to financial difficulties making old people extremely

exposed to economical suffering and poverty in societies without any pension or social security systems to support them financially (Aboderin, 2004; 2009; Powell, 2010).

Relevance to the material constraints theory is presented though many of the findings of this study, uncovering how migrating people faced double burdens of responsibilities where their obligations towards older family members need for financial support seemed to overwhelm them and as a result often caused conflicts among family members, considerably influencing on the state of "*peace"* within a family. The importance of upholding "*peace"* in a family has in the previous chapter extensively been discussed and presented as a condition making other necessities and commodities to become available in times of need. The illustration presented in the previous chapter, through its pathway governed by *"peace"*, may therefore come to reflect interacting factors which by material constraints theorists are perceived as critical in order for old people to feel dignified and to receive the physical and practical support they deserve throughout their old age. As a conclusion, the change of human ideas and values cannot solely be explained driven by social or cultural change but rather by poverty caused by economic stagnation and increased hardships of life.

However, and based on the complex dynamics found to guide family care to old Igbo people, both theories seem to a certain extent to provide an insight into why family care to old people continue to decline in contemporary time. But rather than being applied separately, both theories could profit from integrating their respective priority areas and focuses, and thereby come to reflect more holistic perspectives on the interrelation of components found to explain the continued decline in family care, considerably impacting on the health and psychological wellbeing of elderly Africans. These should preferably also include the effect of inadequate political efforts directed towards the decentralisation of investments into rural areas along with insufficient strategies on the improvement of infrastructures.

In the wave of the incapacities of families to provide sufficiently for the elders, the need for formal interventions arises, where access to health services and support from formal caregivers represent alternatives complementary to that of family care. The focus of the next chapter is directed towards discussing access and availability to healthcare, and components of community healthcare found feasible, and culturally acceptable as to support the health needs of elderly Igbo people. The discussion is extensively based on their own

perspectives. I will finally relate the conclusion of the discussion to the framework guiding international principles and practicalities on Community Based Healthcare as presented in the literature review, and how these are reflected through PHC strategies at the study site.

Status quo on the health-situational realities of old Igbo people discussed within the perspectives of Nigerian PHC system and plans on ageing

Introduction

In the wave of the incapacities of families to provide sufficiently for the elders, this study has clearly pointed to old Igbo people and how they wanted to be noticed by health authorities making health services to become available and suited to accommodate the plight of elderly people. Being a group that never have been favoured in terms of formal healthcare interventions nor social security programs, old Igbo people drew parallels between healthcare and family care. Healthcare came therefore to represent aspects similar to that of family care, reflecting practical and emotional components of care. Apart from being skilled, health workers should be compassionate and take notice of the illnesses and ill-health of the elderly people. They should preferably aid their abilities and potential to self-care through supportive services by securing availability of water and food, to keep an old person warm, and to provide medical care in times of illness. The need was perceived as increasingly urgent due to old age reduced capacities, feeling of ill-health and the absence of children and close relatives. When discussing the many issues of healthcare with old Igbo people, they presented strong opinions on the matter, which apart from describing how they understood healthcare, also included how they wished for healthcare to become accessible within their communities and importantly; within their homes.

In the last chapters of this thesis, prevailing opinions on the potential of community based healthcare (CBHC) will be discussed and whether such could transcend into community healthcare services that would make a difference to the health of old Igbo people, and old age worthwhile to live. Integrated into such discussion is of course to present structural and health-political implications affecting access to- and availability of PHC services, and how Community Based Healthcare principally and practically was found to be in line with strategies under the umbrella of PHC, as a method viable, feasible, and culturally acceptable

to support the health needs of elderly Igbo people and their caregivers in their own environments.

These findings will be attached to the broader health political perspectives on health system development within Nigeria, whereas the following discussion also will include how international strategies to improved PHC is reflected through initiatives at the study site that accommodates community participation, anticipates the burden of OOPE and the decentralisation of healthcare deliveries to also reach the grass-root level.

The potential of community health care as supportive, viable and feasible options to care

While studies exploring determinants of health among old Africans, based on their subjective perceptions and experiences, was somehow troublesome to find, I have not been able to access studies where researchers explicitly attempted to explore old Africans self-perception, understanding of- and preferences to healthcare and there exist little knowledge on old African people and their need and use of healthcare providers (Aboderin, 2009). By representing a group that over the years have been neglected by their governments in terms of services, and as a group largely ignored when PHC programmes have been designed and implemented (Ferreira, 2006), healthcare services anticipating the plight of elderly people seems to be largely unavailable within African contexts, which also was found to be the case at the study site.

The following discussion does therefore not only provide answers to the main scientific question of this study. It answers also to issues presented in the Strategic Framework and Plan for Research; Understanding and Responding to Ageing, Health, Poverty and Social change in Sub-Saharan Africa (2005), where one of the priority issues is to gain knowledge on the current state of- and factors influential on the initiation of home- and community based care for old people.

The CCHBHC model in India (WHO, 2004) was developed basically due to the recognition of changes in epidemiology and demography, increased life expectancy and an ageing population. However, in spite of being signatory to the AU Policy Framework and Plan of Action on Ageing (2003), this study has uncovered that PHC services and interventional

health strategies in Nigeria is far from acknowledging, anticipating nor reflecting the urgent health needs of its ageing population. Awareness of old people's increasingly difficult situations at the study site seemed only limited to have attracted the attention of government representatives in charge of healthcare provision at the State level, and a prevailing notion especially among LG representatives was related to their persistent opinions that the care of the old was the responsibility of the family and that the community had arrangements that took care of the elderly ones, where the latter is quite contrary to the findings of this study.

Old Igbo related a well-functioning health system to a strong and healthy population, where health was acquired through the provision of services to all groups of people, and where people were allowed to choose services according to their conditions and needs. In regards to old people, they required the health system to be responsive to their particular needs which could be accommodated through home visits and assistance, provided, preferably, by health workers with attachment to the area in which they lived. The upholding of good health was related to their ability to work, their capacities to earn a living, contributing economically to themselves and their families, and to continued social participation and engagement. This is similar to how the African Union Policy Framework and Plan of Action on ageing (2003) recognises financial and social factors as important determinants to old age health which can be achieved through improved access to- and availability of healthcare services susceptive to the needs of elderly Africans. UN- and AU Plans on Ageing considerably links old age ill-health to poverty, extensively addressed and discussed also by Ogwumike and Aboderin (2005) and in the studies by van der Geest (2002) and Gureje (2008), where they link old age physical disabilities to social death, loneliness and depression.

While the direction of PHC increase its focus on preventive strategies to health that includes all population groups, health plans in Nigeria has come to reflect primary prevention programs that mainly direct its attentions towards CDs, and children and women care. By doing so, it neglects the importance of secondary prevention programmes that also would include curative care, rehabilitation and habilitation beneficial to other population groups, including the disabled and elderly people. The intentions of the Nigerian NSHDP (2010-2015) apart therefore from the recommendations of the African Union Policy Framework and Plan

of Action on ageing (2003) where Nigeria commits to develop health policies and plans that respond to the specific need of old people. The effect of inadequate political commitment to the health needs of old people was particularly apparent at the study site where such where considered non-existent, and where the old people claimed that they never had received any attention nor support from the government. Old Igbo people demanded for services that could accommodate the particular needs of old people, and where nurses and doctors were specially trained to alleviate and help with their age specific health problems. They saw a need for geriatric care to be integrated into health programs at the different levels of the health system, as many suffered from chronic illnesses and ill-health, manifested through body aches and joint pains, physical limitations as a result of stroke, headaches and high blood pressure, and Malaria and Typhoid fever. Pain was a condition considerably linked to old age and the physical degeneration of the body, and was seen particularly threatening to their abilities to continue working, sustain life and prevent the overwhelming effect of poverty.

Both Madrid International Plan of Action on Ageing (UN, 2002) and the African Union Policy Framework and Plan of Action on ageing (2003) stresses the importance of securing old people access to PHC services on equal basis as for other groups, such as children and the young, and to develop exemption schemes that protect those unable to meet the cost of healthcare. Cost of health care services and OOPE was also extensively discussed in the FGDs with old Igbo people as they considered this to be one of the most constraining determinants to improved health. In the perspectives of the African Research on Ageing Network (AFRAN) Policy-Research Dialogue (2008), where the final report informs that Nigeria, along with South-Africa and Kenya, have developed policies on specific health care provision for old people's age related NCDs and moreover subsidised PHC with free access to EDL /EML[23], this was not found to be the case in the area where this study was conducted. Old people complained not only on the inaccessibility of health services that could support them in times of need and the expenses related to healthcare provision in general, but also the cost of medicines. These were found incompatible with their financial capacities, often perceived to be faked and consequently neither improving nor alleviating their health

[23] Essential medicines are medicines that satisfy the priority health care needs of a population. They are selected with regard to disease prevalence, safety, efficacy, and comparative cost-effectiveness. (Source: WHO Fact sheet N°325, Revised June 2010).

conditions. Based on their descriptions and experiences of a non-functioning PHC system, perceived to exclude the needs of the elderly, it is tempting to draw parallels to The Bamako Initiative, sponsored by UNICEF and WHO and adopted by African ministers of health in 1987. Within this period, PHC was adopted as the cornerstone of the health system in Nigeria, and the Bamako Initiative was adapted for the provision of essential drugs in all Local Government Areas (LGAs) as an effort to strengthen the PHC concept. However, as the delegation of PHC to the LG level was intended to bring decision-making processes and services closer to where people lived and work, responsibilities were at the same time allocated to the weakest and poorest tier of the Government (WHO/Ouagadougou Declaration, 2008/Summary of Country Experiences on Primary Health Care Revitalisation AFR/PHC/08/2; WMHCP, 2007-2012; NSHDP, 2010-2015). The obstacles involved was considerably elaborated in a paper by Adeyemo already in 2005 and later by Iyayi (2009) where they addressed the limitations of LG to carry out health services as intended. They pointed to the shortage of qualified personnel, lack of resources including inadequate financial allocations, inadequate infrastructures, inaccessibility to communities, and political instability reflected through the un-sustainability of health programs over time. These are all factors that still reflect the current state of the PHC system in Nigeria, escalating in its intensity down to the LG level affecting the health situational realities of especially rural people, highly experienced and visible in the area where this study was conducted.

However and according to governmental representatives participating in this study, Imo SMoH was currently on its way implementing a Health Insurance Scheme in order to fund and further develop the health system at the grass-root level, where vulnerable people would, one way or the other, be exempted from paying the 500 NGN per month, a figure that currently was set as a target. The initiative is in accordance with what was presented at the International Conference on Primary Healthcare and health systems in Africa, hosted by Burkina Faso in 2008, and represent a major strategy in order for Nigeria to meet with the MDGs, as reflected in the Ouagadougou declaration (2008). However, this study uncovered that the community were quite unaware of these plans. One may therefore question their interest and willingness to comply with the Health Insurance Scheme. This was also reflected by the governmental representatives participating in this study, where they stated their tendency to proclaim policy changes without adequate consultation with the communities.

The above should also be considered in the perspectives of Iyayi (2009) where he, among many others, points to the impact of corruption on health system development in Nigeria, reflected through the self-interests of health officials, civil servants and politicians. The negative culture has over the years transcended down to the primary level of societies, threatening to accountability-, responsibility and transparency principles, leaving the management and operational capacity of the PHC system weak, insufficient and ineffective. His views becomes therefore interesting in the perspectives of the Health Insurance Scheme, and also the Abuja Declaration (2001), that ten years on has measured the African Union Countries Health MDG Status Indicators based on the 2009 compared to 2000 health share of total spending of governments per capita. Nigeria was found not to be on track, and it is questionable whether the FMoH intentions of increasing the health budget to at least 15% of BNP (Nigerian NSHDP 2010-2015) in line with the Abuja targets, actually will transcend into improved health care for populations at the grass-roots level, including those of old people, or rather be siphoned off along the road.

Within these contexts, the chemists constituted old Igbo people's main option to healthcare and medical treatment in times of need at a cost they could manage. Only a few admitted to turn to traditional practitioners in times of ill-health except from in the treatment of Malaria and stroke, where also informal caregivers found them useful. Seeking medical care in the district hospital usually brought along overwhelming problems. These comprised distance and cost of services, where a stay of 2-3 days could involve a half month salary. Inadequate infrastructures represented by lack of transport and security at night was only adding on to already identified problems such as time as in waiting time, dependence on children, and uncertainty regarding their ability to help out financially and practically. Due to these constraints several had no other option than turning to God and prayers in times of suffering and ill-health.

Most formal caregivers, but only one of the key persons leading the Youth group recognised the need for health structures to be established within communities to anticipate the care for the elderly. They linked their need for increased attention to the ongoing societal transition where rural-urban migration was seen to constitute the most threat to their wellbeing and health. Though their work in communities, several had come across old people suffering from loneliness, inadequate access to food and water, and poor physical

status. Their views were compatible with many of the issues identified to impact and threat the health and wellbeing of old Africans, reflected both in the Madrid International Plan of Action on Ageing (UN, 2002) and the African Union Policy Framework and Plan of Action on ageing (2003). These suggest that early interventions should be initiated as elderly people are entitled to have access to preventive and curative care, that should be carried out through socially and culturally acceptable methods within their communities that moreover include the participation of community members. The research Agenda on Ageing for the 21st Century (2007 Update) states moreover that emphasis should be directed towards the integration of informal and formal care systems where improved care and the assistance of elderly people could be achieved through the establishment of CBHC interventions. Central into this concept is the training of community health workers and the participation of communities, where focus is directed towards the plights of old people, including counselling on healthy lifestyles and potential to self-care.

Formal care givers, and also governmental representatives, were quite familiar with the concept of CBHC, which was explained as an important component under PHC, securing the health needs of the rural population. Despite their knowledge, CBHC was not recognised by LG representatives as a strategy necessary to implement in order to meet elderly people's need the care. Formal caregivers on the other hand, had apart from recognising old people's need for assistance and improved access to health services, also acknowledged CBCH as a method suited to assist old people in their own environments and homes, and its variety of programs accommodating to people's physical, social, spiritual and emotional needs.

Outreach services were regarded as a viable strategy particular suitable in the care for elders as it could be initiated at the grass-roots level, with involvement of family members and community groups. It could easily be carried out by volunteers, such as secondary school students, women and youths, trained for the job under the umbrella of a PHCC and the auspice of formal health-workers. It would consequently increase the number of available CHEWs, which was in line with health strategies building on traditions that had existed within local communities long before the introduction of PHC in Nigeria in 2006. Despite the willingness of formal caregivers to mobilise, they clearly stated the need for involvement by LG health authorities, being the responsible body providing the necessary material and resources needed to assist old people, and moreover the interest of community group

leaders to engage in community health projects. Several obstacles to the initiations of CBHC became however apparent during the conduct of this study, threatening to the principles guiding Community Based healthcare and the practicalities securing its implementation.

The principles and practicalities of Community Based Healthcare reflected through PHC strategies at the study site

One of the aims reflected in the current Nigerian NSHDP (2010-2015) taking the intentions of the previous WMHCP (2007-2012) a step further, is the focus on community participation and ownership which according to Egboh (2009) should be promoted as a basic approach to health development. Such attempt includes acknowledging the rights of community members to play an active and direct role in identifying health determinants and to implement health services that accommodate local health needs through active participation and empowerment processes (Egboh, 2009; NSHDP 2010-2015; WMHCP, 2007-2012). Such philosophy is in line with the principles of CBHC as presented in the study by Mullan and Epstein (2002), by the WHO Office for South-East Asia (2004), reaffirmed later in the Ouagadougou Declaration on PHC and Health Systems in Africa: Achieving Better Health for Africa in the new Millennium (2008) and finally through the World Health Report (2008): Primary Health Care – Now More Than Ever (WHO, 2008). As the evolvement of *Community-Oriented Primary Care* (COPC) in South Africa in the early days of 1960s was developed to fit into Public Health strategies, the *Comprehensive Community- and Home-Based Health Care Model* (CCHBHC) from India have later come to represent strategies in health anticipating the PHC initiative, now revitalised by the recognition of new emerging challenges to global health represented, among other factors, by an ageing world. Strategies that anticipates health equity, social inclusion, people-centred care and solidarity are emphasised and encouraged (WHO, 2008). Within these perspectives, CBHC as a concept come to represent methods viewed as viable, feasible and suitable in order for people, especially in rural areas to gain improved access to quality healthcare, and to extend approaches to health beyond healthcare facilities alone. This should preferably be achieved through the motivation and mobilisation of community efforts in health, involving all stakeholders, where services can be carried out jointly with LG health authorities, health workers working in public and private health facilities and/or NGOs.

Community participation, representing the main pillar principle of CBHC, is rooted in quality, partnership, equity, effectiveness, and efficiency (Mullan and Epstein, 2002; World Health Organisation Office for South-East Asia, 2004). Similar principles were also found to guide the implementation of the Ward Health System Policy introduced in Nigeria in 2006. However, while conducting this study, I found SMoH to lack focus on participatory processes in health which reflected down to the LG level where health officials struggled to implement PHC at the primary level and at the same time adhere to the intentions of the Ward Health System Policy (2006) and the PHC initiative as presented in the WMHCP (2007-2012).

It became particular visible through the non-establishment of Community Health Development Committees in the Wards, the smallest but also the main political structure ensuring collaboration between the 4th and 1st level of governance, where community group leaders, traditional chiefs, LG health officials and community workers could meet and discuss local development issues, including those of health. The importance of these structures has also been extensively discussed in the papers by Okali et al. (2001) and Ibem (2009), where especially the latter described the increased likeliness of community projects, including those of health, to be carried out successfully through joint efforts. In the absence of a Ward Community Health Development Committee at the study site, most community leaders were highly unaware of their rights to participate and influence on decision-making processes concerning issues related to health development and demand for healthcare services. Apart from unawareness, several other obstacles to joint action in health were identified which from a community perspective included scepticism towards the trustworthiness of government officials. This influenced on their motivation to participate jointly in community health projects where community involvement in health projects for the time being was restricted to the provision of land only. Governmental officials on their side, perceived community group members and their leaders to only be concerned by internal matters, reflected by misunderstandings, collaborative difficulties and jealousy and competition, factors that consequently would affect joint involvement in projects, also found in Ibem (2009). The negative effect became, however, evidently apparent and visible through community group leaders lack of engagement in health issues, and missed consequently opportunities to be sensitised on the health disparities of rural people and challenges to their health, and moreover opportunities to influence the health situation of villagers.

Despite pointing to the positive effect of community participation and involvement of community groups in projects (Adeyemo, 2005; Chukwuani et al., 2006; Kasaje, 2006; Iyayi, 2009; Egboh, 2009;), Ibem (2009) pointed in addition to the risk of communities to operate as *"shadow governments,"* taxing themselves to provide many of the facilities that government had failed or neglected to provide for in their local communities. In the aftermath of participatory processes in projects, he moreover often found communities to be left with the financial responsibility of continued maintenance and running of projects due to the un-sustainability of political strategies and poor political leadership. This may also be the result where Adinma and Adinma (2010), in spite of recognising some of the challenges attached to community-LG collaboration, suggest Community Based Healthcare Financing to represent a plausible option improving the provision of healthcare services to people at the grass-root level through joint private-public efforts. Iyayi (2009) on his side, based on the international centrality of community participation, questions whether such actually would transcend into improved PHC provision for populations, a timely question to be asked in the perspectives of this study.

One explanation can definitely be related to the practicalities needed to be in place in order to implement CBHC through participatory processes. According to the CCHBHC model that derived from India, practical strategies involved to mobilise and manage resources, building on the existing system, and finally to develop and implement appropriate health information systems (WHO, 2004). However, in a place where the PHC continues to be in deep crises, having problems with re-orientation, still struggling with the implementation of health strategies introduced by the Ward Health System Policy in 2006, and associated priority health programmes reflected in the WMHCP (2007-2012), CBCH was not an issue discussed at the LG level where this study was conducted, and least of all that of community health services to old people.

Complaints were related to insufficient and unsustainable funding of PHC, impacted by weak budgetary approval processes, reinforced by the uncertainty and instability of resource allocation to the health sectors at the grass-root level. In this process, funds were not channelled to the right recipients and corruption was seen as one of the main challenges to the further development of the PHC system. Corruption as a phenomenon was also well

recognised among the study participants in the villagers, perceived to have become the normative and accepted, integrated and interwoven with aspects of society at all levels.

Formal caregivers and government representatives described moreover a situation marked by irregular and insufficient payment of salaries, provision of equipment and medicines to community health facilities, whereby most community health workers as a result charged money for treatment and drugs as they frequently had to purchase such themselves. The poor working conditions in rural communities made many to move to urban cities, as the priorities of the SMoH seemed to favour allocation of resources towards urban health centres and hospitals instead of rural areas. Factors contributing to lack of community health workers in rural areas were extensively addressed in a study by Adeyemo, (2005) and to some extent also in Amaghionyendiwe (2007). Their assessments and concerns is still relevant as it describes many of the factors still impacting on sound health system development at the primary level, which at the study site became noticeable through the limited numbers of health officials that could supervise and build capacities within communities. The implementation of PHC services were further constrained by logistical and infrastructural difficulties and PHC seems so far to have failed in its intentions since its introduction in Nigeria in 2006. Progress seemed to be trapped in unsolved problems represented by political- financial, human resource and environmental limitations to sound PHC development, similar to those identified by Chukwuani et al. (2006), whom through their analysis on the condition of the PHC system in south-eastern Nigeria uncovered alarming cross-cutting issues in need of urgent attention. The findings of Chukwuani et al. are later reaffirmed by Meremikwu et al. (2011) where they where they addressed the priority setting for systematic review of healthcare interventions in Nigeria.

Based on the acknowledgment of the poor status of PHC system at the study site, and old people's inaccessibility to community health services, it is valuable to take note of the suggestions made by formal caregivers participating in this study. They called for a re-orientation of community groups' aims and focus where they preferably should expand their focus to also include engagement in community health projects. On the other side, they demanded increased focus, engagement and commitment from local politicians and LG health officials in order to anticipate the aims and intentions of the Ward system by encouraging and facilitating the set-up of Ward Health Development Committees. Health

workers, members of communities and leaders of the two political tires would then have an arena to meet, discuss, and jointly solve some if the challenges to rural villages, including those that particularly affect the older inhabitants, by drawing on- and include resources in communities.

However, the way forward seem instead to focus the implementation of Health Insurance Schemes, which excludes rather than combines community involvement and participatory processes in primary health system development, inconsiderate political acts that may jeopardise the good intentions and the sustainability of the program right from the start. Based on the results of this study, it therefore seem as the future social- and health situational realities of old Igbo people will continue being highly unpredictable and uncertain.

8. THE STRENGTHS AND WEAKNESSES OF THE STUDY

One of the strengths of this study is related to the research protocol and adhering to- and carrying out the research as intended. This process have extensively been presented and discussed in the Methodology chapter, and will not be repeated here. However, some of the key factors that considerably contributed to strengthen the validity and reliability of the study results can be attached to the different methods applied, the participation of different groups of participants, and the ethical considerations made along the way. The nature of this study gave opportunities to explore issues in–depth which contributed to the uncovering of unexpected findings in need of further research. But the study results contributed also to improve the understanding of old people's health perspectives, attitudes and behaviour and their social and environmental determinants. As such, this study meets information needs as required in the Research Agenda on Ageing for the 21st Century (2007 Update) and requirements by the African Research on Ageing Network (AFRAN) Policy-Research Dialogue (2008). This study can therefore be considered to support some of the gaps that currently exists within the area of old age research that focuses on the social and health situational realities of old Africans.

It is difficult to assess if the results of this study also is applicable to other African contexts. Analysis and the discussion have mainly have focused on Nigerian-, or rather the PHC health system issues of Imo State, and within this context assessed the potential of Community Based Healthcare services to old Igbo people. However, by assessing priority areas as outlined in international plans on ageing, and especially the AU Policy Framework and Plan of Action on Ageing, it seems as the health situation of old Igbo people are not so different from other old African men and women. However, many of the findings describing old Igbo people in the context of their family and community, and the social implications of out-migration and societal transitions are similar to the findings of other researchers' conducting research on family care within other SSA contexts.

My attachment to the study site is extensively elaborated earlier in a separate chapter presented in the Methodology part of the thesis. This may have had an adverse effect on the study results, but hopefully impacted positively, as I continuously reflected on the possible bias. A likely weakness of this study is related to time constraints that prevented me from

returning to participants in order confirm, or follow up many of the issues that evolved along the road. Lastly, I was unable to closely monitor FGDs conducted in Igbo language. This prevented me from engaging actively in what was discussed and to follow up on issues that emerged during discussions. I depended therefore fully on the skills of my research assistant.

9. CONCLUSION

While conducting this study, I have become increasingly aware that old Igbo people are not so different from old people in other countries, including those living in Norway. From my experiences as a nurse over the past 34 years, providing care and assistance to old people in nursing homes, with a particular focus on rehabilitation, I have seen how they long for emotional care expressed through assistance, attention and visits from their children and close family relations, and how they rather would have preferred to stay in their own homes than spending their late lives in nursing homes. As nurses strive to provide holistic care to the old ones, they rarely have the capacity to fully meet their social, psychological and spiritual needs, which seems only to be fully accommodated by contact with close age-mates or relations, achieved through the sharing of history and mutual references to lived life. Old Norwegians preferences to old age care and life seems therefore to be quite similar to those of old Igbo people. However, while old Norwegians in times of ill-health, absence of children and social insecurity look to the government for support assistance and help, and expect the well established health- and social security system to provide for their needs, old Igbo people have no other option than to look to their children and close relations. They therefore become increasingly vulnerable in societies undergoing rapid transitions, and where out-migration of children deprives them from the social security network of a caring family, left to cater for themselves and where old Igbo women seems to be more vulnerable than old men.

Elderly Igbo people's participation in this study have contributed to widen perspectives on determinants influential on old age health, also in a time perspective as they usually compared life situations relevant to their past with their present experiences. This study have, by its scope provided information that responds to research questions, and the aim of the study, as well as to the requirements for research, where one of several cross-cutting issues is related to improved understanding of old people's health perspectives, attitudes and behaviour and their social and environmental determinants. It has moreover identified Community Based Healthcare to be a viable and culturally acceptable option to care and assistance in the absence of children. While informal care is regarded complementary to professional care in many of the Western countries, formal healthcare providers can make a difference to the lives and health of old Igbo people, complementary to the care they receive

from their children and close family members. This can best be acquired by involving the communities in healthcare provision through participatory processes, and the potential of CBHC as a concept seems well suited to secure old Igbo people access to health services within their communities and homes that accommodate culture and tradition, making interventions acceptable for informal caregivers as well. However, several obstacles were identified along the way that needs urgent attention. One is related to the recognition and awareness of communities on the increasingly troubled situation of elderly Igbo people, whereas they at the health system level still seem to constitute an unnoticed group, neither reflected- nor included as recipients entitled to PHC services. As such there seems to be several challenges ahead before elderly people are considered a group with equal rights to healthcare as for instance youths, women, and children.

It difficult to make any specific recommendations on actions that will make any considerable improvement on old Igbo people's social life and health conditions in a short time perspective, but at the micro level it would be helpful to establish Ward Development Health Committees where elderly Igbo people could engage socially by having a seat and a saying. It will give them an opportunity to voice their opinions, demands, interests and concerns.

At the macro level, it seems wise to mainstream the social and health needs of old Nigerians into all national policies and plans in order to ensure that their needs are reflected, considered and included when programmes are designed and services implemented. As for now, they mainly appear as an "add on" group.

The conduct of this study has identified other groups of old Igbo people in need of urgent attention. This can be achieved through further qualitative research where the focus should be directed towards:

- *Old Igbo people who are not able to come out from their houses*
- *Old Igbo women living in single households*
- *Old Igbo people labelled Omu and Osu, and old Igbo women stigmatised Amosu.*

Figure 25: Blooming Okra. Photo: Heidi Olsen

ACKNOWLEDGEMENTS

Most of all I want to show my appreciation to the participants that took time to come meet with me and my little research team. A special thank goes to all the old Igbo people that in spite of their busy days, and for some of them also their aches and physical limitations, came to the Village Hall to participate in the FGDs. This has really confirmed that old people want to engage in matters of interest to them. Without them, this thesis could not have been written. Thanks also to the welcoming societies of the villages, and to the two Eze that approved this research to be conducted within their areas.

I want to give my regards to Sam, who right from the start of this study showed his support. He engaged as an interested discussion partner and was always there to listen when the writing process was problematic. Thank you. And to you Amo for involving in the project, great help, thanks! Hyginus Eze, I'm finally there! Thanks also to all family and friends in Nigeria that cared and supported me throughout my stay.

Professor Gunhild (Hagestad); thanks for ideas and help with the initial part of the thesis, and Dr. Arnfinn (Helleve) for supervision, comments and suggestions along the road. Dr. Diwe, I really appreciated our meetings every second Friday at Orlu University Teaching Hospital. Great advises and support!

And to Kate and Geir, and all my friends here in Norway that bear with me during the writing process, you must many times have been tired listening to me, but despite the headaches, you were there for me. Big hugs to you all!

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Heidi Olsen

May 13. 2013

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ANNEX 1 ETICAL CLEARENCE, REK- NORWAY

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REC sør-øst A	Jørgen Hardang	22845516	08.06.2011	2011/901
			Deres dato:	Deres referanse:

Arnfinn Helleve Blindern
University of Oslo

2011/901a "The role of Community Based Healthcare in changing societal environment: the case of old Igbo's in rural Imo state, Nigeria".

Project manager: University lecturer Arnfinn Helleve Blindern, University of Oslo

The application was received 29 July 2010 with the following enclosures: protocol, prototype consent form; enquiry on participation in research project, consent form; CV for Heidi Olsen and CV for AH.

The Regional Ethics Committee reviewed the project application during their meeting on 5 May 2011.

The project was assessed by the Committee in accordance with the Norwegian Research Ethics Act of 30 June 2006 and Act on Medical and Health Research (the Health Research Act) of 20 June 2008.

The project is described by the project manager in the following way: "The aim of the study is to explore how and to what extent the recent National Strategic Health Development Plan facilitates for the development of Community Based Healthcare programs directed towards older Igbo people in rural Imo State, Nigeria. The study design is qualitative. The methods comprise semi-structured in-depth interviews with key informants and stakeholders, and focus-group discussion with older people in addition to general observations and informal conversations."

The Committee considers that the aim of the project is not to gain knowledge about diagnosis or treatment, but to study how the Health Service functions. The project does not collect any medical information about the individual persons.

Decision

The Committee concluded that they consider the research project to be outside the remit of the Act on Medical and Health Research and therefore can be implemented without the approval from the Regional Committee for Medical Research Ethics.

Yours sincerely

Gunnar Nicolaysen
Chairperson, Section A
Regional Committee for
Medical Research Ethics, South-East Norway
(P.P.)

Jørgen Hardang
Committee Secretary

Besøksadresse:
Gullhaug torg 4A
0484 Oslo

Telefon: 22845511
E-post: post@helseforskning.etikkom.no
Web: http://helseforskning.etikkom.no

Vi ber om at alle henvendelser sendes inn via vår saksportal eller på e-post. Vennligst oppgi vårt referansenummer i korrespondansen.

ANNEX 2 ETICAL CLEARENCE NHREC-NIGERIA

National Health Research Ethics Committee of Nigeria (NHREC)

Promoting Highest Ethical and Scientific Standards for Health Research in Nigeria

Federal Ministry of Health

NHREC Protocol Number NHREC/01/01/2007-07/12/2011
NHREC Approval Number NHREC/01/01/2007-16/01/2012
Date: January 16, 2012

Re: "The role of Community Based Healthcare in Changing Societal Environment: the case of old Igbo's in Rural Imo State, Nigeria"

Health Research Ethics Committee (HREC) assigned number: NHREC/01/01/2007

Name of Co- Investigator: Dr. Diwe Chiekulie Kevin
Address of Co-Investigator: Imo State Univeristy
Phone: 08037092284
E-mail: drdiwe2003@yahoo.com

Date of receipt of valid application: 07-12-2011
Date when final determination of research was made: 16-01-2012

Notice of Full Committee Review and Approval

This is to inform you that the research described in the submitted protocol, the consent forms, advertisements and other participant information materials have been reviewed and given full committee approval by the National Health Research Ethics Committee in relation to your research with **Ms. Heidi Olsen**, a Masters Student with the University of Oslo, Norway.

This approval dates from 16/01/2012 to 15/01/2013. If there is delay in starting the research, please inform the HREC so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the HREC assigned number and duration of HREC approval of the study.* In multiyear research, endeavour to submit your annual report to the HREC early in order to obtain renewal of your approval and avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the HREC. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the Code. The HREC reserves the right to conduct compliance visit your research site without previous notification.

Signed

Clement Adebamowo BMChB Hons (Jos), FWACS, FACS, DSc (Harvard)
Honorary Consultant Surgeon, Director, West African Center for Bioethics and
Chairman, National Health Research Ethics Committee of Nigeria (NHREC)

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ANNEX 3 FINANCIAL STATEMENT, FIELD WORK

Financial Statement, Field Work Aug-Dec 2011, Imo State, Nigeria

Period Sep-Dec 2011 (Field Work)		
Travel Expenses	NOK	NGN
Oslo-Lagos-Oslo	6000.00	
Lagos-Owerri, bus	186.00	5000.00
Lagos Guest House, 1 night	186.00	5000.00
Owerri-Lagos flight	745.00	20000.00
Multiple visa, Nigeria	1756.00	
Vaccines	3000.00	
Travel Insurance/Life Insurance	1000.00	
Total travel Expenses NOK	12873.00	

Living Expenses		
Accommodation , renovation, purchase of commodities	9312.00	250000.00
Food and beverages, household (5000 NGN per day x 90 days)	16800.00	450000.00
Medication (Malaria prophylaxis - Malarone, etc)	5000.00	
Unexpected costs	4084.00	100000.00
Total Living Expenses SEK	35196.00	

Field Costs		
Public Transport, Owerri, Imo State x 2 pers	3350.00	90000.00
Food and Incentives field work/communities/FGDs	3600.00	90000.00
Send off meal after completing field work	816.00	20000.00
Internet and Phone cards	5600.00	150000.00
Digital recorder	2500.00	
Research assistant and interpreter	7500.00	200000.00
Floppy disk (back up)	500.00	
Total Field Costs SEK	59062.00	
Total Cost Field Work Sep-Dec 2011	**107131.00**	

Assets		
Statens Lånekasse	54000.00	
Norwegian Nursing Association	12000.00	
Personal savings	41131.00	
Total Assets	**107131.00**	

ANNEX 4 SEMI-STRUCTURED QUESTION GUIDE, OLD PEOPLE

LGA:... District/town:_____ Village:_____ **Code:**_____

Question Guide for Qualitative Research Project – Participants in Focus Group Discussion, older people – female/male/mixed

Date:_____ Time:_____

Researcher's name:_____ Role:_____

Research assistant's name:_____ Role:_____

Interpreter's name (if any):_____ Role:_____

Language used in conducting the FGD:_____ Kindred:_____

Biographical data of participant – **Code** _____ **-FGD**

You are selected as a participant in this study due to your role as an older person. As such, you are considered to hold key information about what should be involved in regards to caring for and supporting older people in times of ill-health. We are interested in learning about this through your opinions, views and experiences. During our group discussion, we would like only one person to speak at a time. This is because we would like to clearly hear and understand your opinions about the topic under discussion. Please note that there are no "right" and "wrong" answers to any of the questions. All contributions are equally valuable. In order to remember correctly what is being said, we would like to use a voice recorder during the discussion. I hope this is acceptable. Yes/no. Another point of importance is that what is discussed here, should remain as shared knowledge within the group, and not be shared with people not participating in the group discussion. We call this confidentiality, and it matters for us all when speaking from our heart in a free and open manner, not fearing what is being said to be spread outside of the group. Thank you.

Family name:_____ First name:_____

Family name at birth:_____

Sex:_____ Age:_____

Marital status:_____ Remarried:_____ Husband/wife from:_____

Nb of spouses:_____ of which I am nb _____

Number of children:_____ of which_____is living

Gender (M/F/D): 1st_____2nd_____ 3rd_____ 4th_____5th_____ 6th_____ 7th_____ 8th_____9th_____

Education, highest level:_____ Speciality/profession:_____

Occupation, present or/and before retirement: _____

Sources of income/economical support:_____

Religion(s):_____ How religious: strong/moderate/inactive/indifferent

Worships: daily/weekly/monthly/several times a year/ yearly/once every several years

Residence pattern (mobility):

Place of birth:_____ Birth order:_____

Present residence:_____ Compound of _____family

Past/earlier residence:_____ Nb of years:_____ city/town/village/rural

Past/earlier residence:_____ Nb of years:_____city/town/village/rural

Present family composition:

How many families live in the same compound?_____

How many people from the same family live permanently in the household you are living?_____

Who (relationship):_____

_____

How many people live permanently under the same roof as you:_____ and are they family member(s): yes/no

If yes, who:_____ if no, who:_____

Family loss same age-group:

Family loss:_____ Who:_____

Family loss:_____ Who:_____

Family loss:_____ Who:_____

Family loss:_____ Who:_____

Family loss:_____ Who:_____

Family loss:_____ Who:_____

Family loss:_____ Who:_____

Others:_____

_____

_____

_____

Family migration, who:_____ Where to:_____

Family migration, who:_____ Where to:_____

Family migration, who:_____ Where to:_____

Family migration, who:_____ Where to:_____

Family migration, who:_____ Where to:_____

Family migration, who:_____ Where to:_____

Social Structures, association ties and participation at old age

In what social organisation/association tie do you participate?_____

Role:_____

Age-grades, still intact/functional:_____

What role does it play in times of old age?_____

Is there an alternative social network/system of support existing at old age for men/women?_____

_____

_____

Role:_____

Support in Activities of Daily Living (ADL)

Are you in need of daily support from a caregiver in order to manage ADL? Yes/No

What activities require assistance?_____

Who does normally render such support?_____

Is this the person you would prefer to render such support? Yes/no.

If no: who would you preferably like to render such support?_____

Support and care in times of ill-health

Main provider of support in times of ill-health, if any, informal:_____

Main provider of support in times of ill-health, if any, formal:_____

Main provider of support in times of ill-health, if any, traditional:_____

Main provider of support in times of ill-health, if any, religious:_____

Which (from the above) do you consider to be most important in times of ill-health?

Informal_____ formal_____ traditional_____ religious_____

Other: _____

_____

Comments/observations:

Inter-subjectivity should be ensured on the following concepts:

Being "an old person"

What does being "an old person" mean in your community? Based on this understanding; who can be considered to be "an old person"? Has the role of being "an old person" changed during the years/time? What is the role of "an old person" in times of today? Are there any expectations from family or community towards "an old person"? Are there any expectations from "an old person" towards his/her family or the community?

Health

What comes to your mind if we talk about "health"? Do you have local word for it?

Ill-health

What comes to your mind of we talk about "ill-health"? Do you have a local word for it?

Healthcare

What comes to your mind if we talk about "healthcare"?

Family support

What comes to your mind if we talk about "family-support"?

Health system

What comes to your mind if we talk about "health-system"?

Discussion guide:

We will start to discuss about ill-health at old age, and the different kind of support or healthcare that are available to you in times of ill-health.

What are your opinions on this matter?

In your opinion; what role do cultural tradition, norms and values play?

- When receiving family support to an older person?
- When healthcare services are received from a clinic, hospital, traditional, church?

Following the previous questions; what role may gender play when receiving such support or healthcare services?

In your opinion, what do you think impacts on the availability **(strengths, weaknesses and threats)** of the support or healthcare you receive in times of ill-health?

Has this changed during times let's say compared to the previous generation?

What, in your opinion, contributes to this change?

How may it impact on the provision of support and care you receive?

In your opinion, what may be the possible consequences for you as an older person? **(Alternative arrangements for care and support in times of ill'health of an older person)**

(Remember that we have to include views/opinions on the role of:

- **Social structures and organisations in the community – role to play at old age for women and men**
- **Religion and spirituality, for women and men**
- **Societal change (change of the role of extended family system)**
- **Migration**
- **Economy/cost**
- **Availability of healthcare services (including; number of health facilities in village or district, trained personnel, equipment, medicines, support devices, distance/transport, waiting time)**
- **Attitudes (abuse) from family and professional health workers)**

Based on what we have discussed so far and in your opinion: How can a healthcare system provide services of assistance to you in times of ill-health that are acceptable to you?

Do you have some opinions on whether this can be done in collaboration with existing social organisations/associations (informal) in your community?

If you had the power to improve support and healthcare services to older people in times of ill-health, what would you do?

Who would you involve?

Thank you for participating in the group discussion. You have given valuable insights and knowledge about the topic we have discussed. In addition you have proposed strategies for improvement that you find acceptable to you. Your views will be reflected in the final report.

ANNEX 5 INVITATION AND CONSENT FORM

Invitation to participate in the research project;

The potential of Community Based Healthcare in a community undergoing societal transitions: the case of old Igbo people in rural Imo state of Nigeria

This research project is integrated in the graduation year of the Masters Programme in International Community Health at the University of Oslo – Norway, qualifying to the degree Masters of Philosophy. The research will be conducted in period September- December 2011.

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The results of the study (report) will be published through the final Master's Thesis in May 2013

1. Background information: Nigeria is influenced by an ongoing demographic and epidemiologic transition that impacts the health-needs and the provision of healthcare to members of households and the community as a whole. An ongoing rural-urban migration may challenge the extended family systems traditional role as healthcare provider for older family members. Societies undergoing transitions impacts the vulnerability of old Igbo people and increases their need of community health services.

Nigerian Health authorities encourage members of the communities to express demands for health care services according to their needs through community participation. This opens for exploring to what extent Community Based Health Care (programs) activities are viewed essential playing a complementary role in healthcare provision to old people in times of ill-health.

The overall study aim is;

> *To explore the potential of Community Based Healthcare services to elderly Igbo people, complementary to that of family care, in a rural area undergoing societal transitions.*

2. Invitation to participate in the research project.

In order to obtain improved knowledge on what role Community Based Healthcare as a concept may play in achieving improved health for older Igbo people, I would like to invite health authorities and stakeholders to express their views, opinions and perceptions freely on this issue by participating in interviews, and older people by participating in focus group discussions.

Participants are invited to participate in this study based on their key role; as health planners and decision-makers; healthcare providers and implementers; and older people as recipients of healthcare services.

This study will be conducted in one Local Government Area in Imo State. Focus-group discussions will be conducted in three villages within this Local Government Area – one in each village.

3. Participation in this study involves participating in interviews and focus-group discussions.

- ✓ Each interview will take at minimum 1 (one) hour and at maximum 1.5 (one and a half) hour. There may be a need of follow up questions/clarifications. Conducting a follow up interview will be done in agreement with you (the participant).
- ✓ Each focus-group discussion will take at minimum 2 (two) hours and at maximum 2.5 (two and a half) hours.
- ✓ You will be provided with a summary of the interview/discussion if wished.
- ✓ Interviews and focus-group discussions will be conducted at a time and venue of convenience of you (the participant).

4. Benefits

For participants:

- ✓ This study may benefit the future health and social security of older Igbo people in one rural Local Government Area in Imo State, Nigeria.
- ✓ This study may increase the awareness among the participants in this study on ongoing societal, demographic and epidemiological changes, impacting on the health of older people.
- ✓ Knowledge about the recent national strategic health development plan (NSHDP), where one priority area is to strengthen Community Participation, may contribute to the empowerment of older people and encourage demand for healthcare services according to their health-needs.

Public Transport costs in relation to the participation in the study will be reimbursed. Refreshments will be provided during the interviews and focus-group discussions.

For society:

- ✓ This study may lead to increased awareness, motivating health authorities and policy makers to consider the health status and social security of older people when implementing strategies for

improved primary healthcare services, where accessibility and availability is one of the main goals of NSHDP.

- ✓ The study may increase motivation among health authorities and health providers in developing a Community Based Healthcare approach, where Community Participation is an integral part and where community members and providers from the formal health system share mutual responsibilities in the provision of healthcare services, including health provision to older people.

For science:

- ✓ This study will contribute to increased knowledge on how Community Based Health Care (programs) activities are viewed to be essential and play a complementary role in healthcare provision to older Igbo people in times of ill-health.
- ✓ This study may contribute to interest in including the field of gerontology and geriatrics in a); professional medical and nursing programmes and b); to contribute to educational programmes on informal care for older people targeting the caretakers

5. Possible harm

When conducting the interviews and focus-group discussions I will anticipate;

- ✓ To prevent offending any of you (the participants), I will behave in a respectful manner, act trustworthy and adhere to cultural and social codes of conduct.
- ✓ I will not interrupt in daily activities and responsibilities or impose initiatives that to my knowledge are inconsistent with your norms and cultural values.

There will be no risk of physical harm of the participants participating in this study.

Participation in this study should not involve additional costs for you.

6. Ensuring confidentiality and anonymity and protecting the privacy of the participants.

- ✓ The private data identifying the participants in the study will not be disclosed during the research process and in the final research report.
- ✓ The location of the study site (Local Government Area including villages) will not be disclosed in the final report.
- ✓ I, the researcher, will adhere to protect your confidentiality and anonymity throughout the research period and later.
- ✓ The research assistant and interpreter will sign a declaration of confidentiality before being assigned to the research project.
- ✓ Data from interviews and discussions will be transferred in to a computer and thereafter depersonalised.
- ✓ The computer is protected with a password only known to the researcher

- ✓ All material will be stored in a locked metal cupboard inside a locked room where I, the researcher, is the only person having access.
- ✓ I will ensure that all audio-recordings and transcribed material is deleted after the end of the research project.

7. Participation in this study is voluntary. Abstaining from participating in the study will have no negative consequences for you as an individual person.

- ✓ You as a participant have the right to abstain from participating in the study at any time; before, at the beginning or during the study. This includes your right to withdraw any previous or present information given through interviews or group-discussions.
- ✓ Withdrawal from participating in the study at any time will have no consequences for you.

8. Voluntarily given informed consent

- ✓ You have the right to be provided with the above information in Igbo language.
- ✓ In addition, an oral explanation of the research project will be provided to you in English or in Igbo, to ensure that all information is adequately understood before you decide to participate in the study, or to abstain in participating.
- ✓ You can at any time ask for the information to be repeated or ask additional questions.
- ✓ If you decide to participate, the attached informed consent form has to be signed.
- ✓ If you wish, you can give an oral consent. A person you trust will witness that your consent is voluntarily given and sign a declaration proving that you have consented to participate in the research study.

Statement of person obtaining informed consent:

I have fully explained this research project to _____ and have given sufficient and adequate information, congruent with information in the invitation letter, in order to ensure an informed decision.

DATE: _____ SIGNATURE: _____

NAME: _____

Statement of person giving consent:

I have read the description of the research or have had it translated into language I understand. I have also talked it over with someone I trust. I understand that my participation is voluntary. I know enough about the purpose, methods, risks and benefits of the research study to judge that I want to take part in it. I understand that I may freely stop being part of this study at any time. I have received a copy of this consent form and additional information sheet to keep for myself.

DATE: _____ SIGNATURE: _____

NAME: _____

WITNESS' SIGNATURE (if applicable): _____

WITNESS' NAME (if applicable): _____

This research has been approved by the Health Research Ethics Committee in Norway - South-East region. Document number: 2011/901a

Enquiries can be forwarded to:

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And

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University of Nigeria Teaching Hospital; Health Research Ethics Committee in Enugu State.

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