

**MODELS OF INSTITUTIONAL CARE  
FOR THE ELDERLY IN NAMIBIA**

With A Case Study of Sweden

**A THESIS SUBMITTED IN PARTIAL FULFILMENT  
OF THE REQUIREMENTS FOR THE DEGREE OF**

**MASTER OF ARTS  
IN SOCIOLOGY**

**OF**

**THE UNIVERSITY OF NAMIBIA**

**BY**

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**DECEMBER 2003**

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## DECLARATION

I, DIMA EDITH MARY, hereby declare that this thesis is my original work and that to the best of my knowledge, it has never been submitted for any degree to this University and / or any other University before.

Signed .....

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## **CONFIRMATION**

This is to confirm that this thesis has been supervised by me, and was presented for the award of Master of Arts (Sociology).

DR. DEBIE LEBEAU

University of Namibia

## **DEDICATION**

To: My late father Simon Tibaijuka (RIP),  
who launched me on the education path.

My loving and encouraging mother  
Tilifosa Kamazooba Tibeijuka.

My husband Scopas, for the support, encouragement  
and friendship through it all

## Acknowledgements

I acknowledge with gratitude, a number of people who made it possible for me to undertake and complete my studies.

First, I thank my supervisor, Dr. Debie LeBeau, for her critical guidance of work, and her commitment to see me through the study programme.

I am very grateful to Mr. Tom Fox for the assistance with the case study of the Swedish elderly care system while we were in Sweden, for guidance in drafting the outline and theoretical parts of the thesis, and for reading the entire draft.

I would like to thank the Department of Sociology, University of Namibia, for giving me a chance to engage in an academic activity at University of Trollhattan/Uddevalla, Sweden, that enabled me to undertake a Case Study of Sweden's elderly care system.

I am grateful to Dr. Elsebeth Fog and Prof. Magnus Berg of the University of Trollhattan/Uddevalla (HTU) Sweden, for all the assistance they accorded to me while I was in Sweden during the Spring Semester of 2003. I also appreciate the insightful information I received from Thomas Winman and Las Svensson at HTU. Among the Swedish team, I am deeply indebted to Mrs Permis Arjomand, then a student at HTU, for the assistance in visitation to elderly Service Centres accommodating elderly immigrants.

I am grateful to all elderly people who completed the Questionnaire and answered my questions.

To all my sisters, for encouragement, moral support and a shared ambition to continue studying. To my dear friend, Annette Maitwe Namaganda, for her encouragement and shared pact to forge ahead.

Last but most important, I am grateful to my family, my daughters Patience and Penelope, my husband Scopas, for the financial and moral support of my studies. Together as a family, we finished the work.

However, all the above people only share in the merits of this work, but I remain personally responsible for the views, ideas and context of the work.

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# **MODELS OF INSTITUTIONAL CARE FOR THE ELDERLY IN NAMIBIA**

## **With a Case Study of Sweden**

**By**

**Edith Mary Dima**

### **Abstract**

The Namibian family has always cared for elderly people, but it is beginning to fail due to modernisation factors. Institutionalisation of elderly people is becoming another form of elderly care in Namibia. The question arises as to what model of institutional care is appropriate for the majority of elderly Namibians.

Modernisation factors such as urbanisation and changing family structures, for example nuclearisation of families, weaken the extended family; contribute to changing attitudes and adoption of new ideas in society. Thus modernisation theory of ageing is used to explain what model of OAH would be appropriate for the majority of elderly Namibians.

This thesis investigates institutional care for the elderly in Khomas, Erongo, Kunene and Otjozondjupa regions of Namibia; determines what socio-economic factors influence levels and types of care given to the elderly, and assesses areas for improvement. Objectives of the study are: to assess attitudes of the elderly towards institutionalisation; to determine an appropriate model of OAH; and to assess the welfare policy vis-à-vis operation of OAHs. The hypothesis is that 'socio-economic factors in the Namibian society determine levels and types of care given to the elderly and necessitate a model of institutional care that is adapted to local conditions'. The methodology involved administering a questionnaire to 238 elderly respondents, conducting thirty-one key informant interviews and collecting four elderly case studies. A case study of elderly care in Sweden forms part of the literature study.

Major findings indicate five models of OAHs operating in the study areas. Economic factors determine how the models have evolved and how they operate. Attitudes are changing towards acceptance of OAHs but to target the elderly without families. Model III OAH supported by the municipality presents the most appropriate attributes as an alternative to family care. Other possibilities exist, such as assisted living, but are not operated in Namibia.

Factors determining levels and types of care include family care; the elderly's financial status, the model of OAH; caregiver training and support; information dissemination; gender-related care; social policy and government support. Main conclusions include a need to support the family to continue its eldercare role; caregiver support and training; improvement of the elderly's financial status; and information dissemination. Recommendations include promotion of family elderly care, municipal involvement in the operation of OAHs and periodic studies to update information on conditions of the elderly so as to aid policy and programme formulation.

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## **LIST OF ACRONYMS**

|          |   |
|----------|---|
| ABB      | Christlike Vrou Hulpdiens and Aksie Bediening vir Bejaardes (Ministry to the elderly) |
| ADL      | Activities of Daily Living  |
| ASC      | Association of Senior Citizens Club   |
| DHSS     | Department of Health and Social Services  |
| ELCIN    | Evangelical Lutheran Church in Namibia  |
| HAI      | HelpAge International   |
| HDR      | Human Development Report  |
| FHH      | Female Headed Household   |
| GRN      | Government of the Republic of Namibia   |
| HIV/AIDS | Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome                     |
| HPI      | Human Poverty Index   |
| HTU      | University of Trollhattan/Uddevalla<br><i>(Hogskolan Trollhattan-Uddevalla)</i>       |
| ICSW     | International Conference on Social Welfare  |
| ILO      | International Labour Organisation   |
| IMF      | International Monetary Fund   |
| MHH      | Male Headed Household   |
| MoHSS    | Ministry of Health and Social Services  |
| MoL      | Ministry of Labour  |
| NCOPN    | National Council for Older Persons in Namibia   |
| NGOs     | Non-Governmental Organisations  |
| NPC      | National Planning Commission  |
| OAHs     | Old Age Home(s)   |
| OECD     | Organisation for Economic Cooperation and Development                                 |

|       |   |
|-------|---|
| SADC  | Southern Africa Development Community         |
| SANC  | South African National Council for the Aged   |
| SAPs  | Structural Adjustment Programmes              |
| SPSS  | Statistical Package for Social Sciences       |
| SWA   | South West Africa                             |
| SWAPO | South West Africa Peoples Organisation        |
| UN    | United Nations                                |
| UNAM  | University of Namibia                         |
| UNDP  | United Nations Development Programme          |
| UNFPA | United Nations Fund for Population Activities |
| USA   | United States of America                      |
| WHO   | World Health Organisation                     |

## **Definitions of Terms and Concepts**

In this thesis, the following terms and concepts are defined as stated.

‘Active Ageing’ means remaining active as one grows older.

‘Activities of Daily Living’ include bathing, dressing, cooking, eating, cleaning and walking.

‘Ageing-in-Place’ specifically refers to having adequate housing, a safe and enabling environment in elderly people’s own homes as well as institutions.

‘Ageing’ means the increase in the proportion of elderly people in a country’s total population. It is also used synonymously with advancing in chronological age.

‘Aged’ means an elderly person who is 60 years and older. It is synonymous with an elderly person or pensioner.

‘Changing Society’ refers to a modernising society characterised by value judgement changes in indigenous values and norms. In most cases, there is an inclination towards westernised values and norms.

‘Class’ is defined as a “group of people who share common life chances” (Max Weber 1968:927).

‘Community’ means a group of people with commonalities of interests, activities, practices and history.

‘Dependency Ratio’ refers to a ratio of children aged between 0 to 14 years and elderly people aged 60 years and older, to the working population aged 15 to 59 years.

‘Elderly’ refers to people who have attained the age of 60 years and above. In Namibia, an elderly person qualifies to receive a state social pension, and is commonly referred to as pensioner.

‘Elderly Friendly Environment’ in relation to an OAH refers to the architectural design and fittings of the building that eases difficulties of the elderly person in movement and accomplishment of activities of daily living. For example, adequate space for wheel chairs and access to facilities, appropriate furniture and walk supports.

‘Ethnic Group’ is a reference group made up of people who may share common values, beliefs, history and many times biology due to preferential spouse selection.

‘Housewife Competence’ refers to knowledge and skills for care-giving for vulnerable members of the family including elderly people. It is learnt through experience, without undergoing any formal training.

‘Institution’ is a formal long-term care facility that can be an elderly person’s last home.

‘Institutionalisation’ refers to the care of elderly people in institutions.

‘Old Age Homes’ are institutions where elderly people live and receive formal care.

‘Racial Group’ is a reference group which is socially and not biologically defined. Racial categorisation is based on physical characteristics and has been used to promote negative interaction between socially defined ‘separate groups’ in southern Africa.

‘Racism’ refers to the belief in the biological superiority of one racial group and inferiority of others.

‘Sandwich Generation’ is a term used to refer to a generation of people between three generations. That is adults sandwiched between caring roles of their elderly parents as well as their own younger children.



‘Skip-generation parenting’ refers to a situation where grandparents have to raise orphaned grandchildren due to increasing deaths of the children’s parents from AIDS. Households consist of grandparents and grandchildren and perhaps other relatives.

‘Social Conditions’ in respect of elderly people refer to relationships with their families regarding care.

‘Social Distance’ is a measure of the degree of intimacy and equality in relationships between two groups.

‘Social Networks’ refer to an individual’s total set of relationships.

‘Social Integration’ refers to a state in which elderly people are strongly integrated into the larger social structure that embodies networks of family, friends and community.

‘Ubuntu’ is an African value orientation that stands for human respect, dignity, trust, equality, togetherness, mutual responsibilities and mutual assistance. An Ubuntu community is built on strong and caring families in a neighbourhood. ‘Ubuntu’ is also termed ‘the essence of being human’.

‘Urban Areas’ refer to areas which have been designated as ‘urban’ by government, based upon given criteria, which can be population, size, development or other criteria.

‘Welfare’ means a range of services and benefits provided for the protection of people in different conditions according to their needs, for example childhood, sickness, disability or old age.

‘Welfare State’ refers to a state that bears a major responsibility for welfare provision to citizens through social security systems.

‘Welfarism’ is an ideology committed to providing and caring for citizens and groups with particular needs, such as elderly people.

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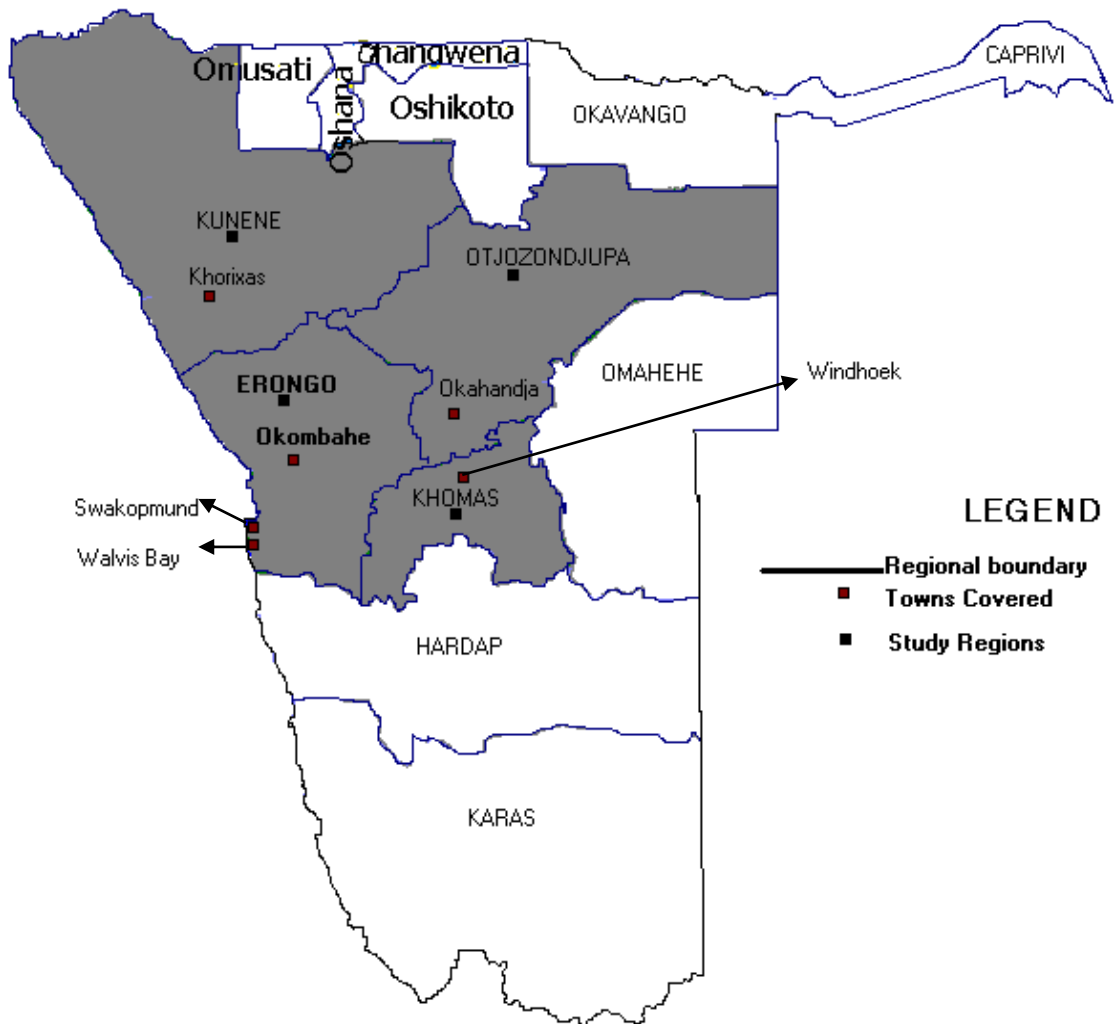
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Map of Namibia – Research Areas

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**Map 1: Namibia - Research Areas (Four Regions)**



## CHAPTER 1

### INTRODUCTION AND BACKGROUND TO THE STUDY

#### 1. Introduction

This Chapter presents an introduction to the study, a profile of the Republic of Namibia, the conceptualisation of Ageing and statement of the research problem, followed by the definition of terms and concepts used. The structure of this thesis is presented at the end of this chapter.

In Namibia, as with elsewhere in world, the traditional social institution of the family has always cared for the elderly (and other frail or vulnerable members of society).<sup>1</sup> Due to modernisation, urbanisation and changing family structures, the family is failing to meet this function. This failure threatens elderly social security in society. Other forms of elderly care operating in the Namibian society currently include institutionalisation or Old Age Homes (OAHs), whereby the family responsibility for elderly care is outsourced, commercialised and transferred to these specialised service institutions. OAHs are privately operated in most urban areas of Namibia, but two are in rural areas, except in the extreme north and north-eastern parts of the country (among the Owambo, Kavango and Caprivian people). The majority of Namibian elderly are cared for through informal family care, but

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<sup>1</sup> The elderly are defined as people who have attained the age of 60 years and older.

in the formal care, the OAHs are run along different lines, with different operational philosophies on the part of management. However, a question arises: ‘what model of elderly institutional care is appropriate for Namibia, in view of significant social changes in society, both prior to and after independence? In this research, ‘model’ is defined as the approach to institutional care that Namibia has adopted – that is, the different types of OAHs that operate in the country. Answers to the question require consideration of Namibia’s unique circumstances, considering that modernisation significantly impacts on functions of the family and community.

Namibia’s political history characterised by social stratification along racial/ethnic lines has contributed to extreme inequalities in Namibian society. Poverty is rampant in almost all communities. Inequality and poverty in society have a significant impact on care levels extended to elderly people both within families and formal elderly care institutions. Labour migration especially through the contract labour system, contributed to groups of retired former labourers remaining in urban areas. Some of these have no close family members to rely on for care in old age, and thus turn to OAHs. In addition, many Namibians lived outside the country during the war for independence and lost close ties with extended family. This lack of close family ties has an implication on future elderly care in Namibia.

Since independence in 1990, elderly care in Namibia has continued to be guided by provisions from a colonial Act that is inappropriate in contemporary Namibia. A new bill for the protection and care of elderly persons has been drafted and is expected to be tabled in Parliament during 2003. The new bill reflects philosophy change from a predominantly institutional approach for elderly care, to a strategy for the family and community to be the core of support systems for elderly people.

## **1.1 Background**

### **1.1.1 Namibia: A Country Profile**

Namibia, formerly known as South West Africa, is located in the southwestern part of Africa, on geographic coordinates 22 00S, 17 00E; bordering the South Atlantic Ocean, South Africa, Angola, Zambia and Botswana. Namibia has a landmass of 824 116 square kilometers.

Namibia gained independence from South Africa on 21 March 1990. The country was under German colonial rule from 1884 to 1915. At the end of the first World War, the League of Nations mandated South Africa to administer Namibia, then South West Africa, but South Africa proclaimed the mandate invalid after the second World War in 1945, and annexed Namibia to South Africa. South Africa then imposed the apartheid system in Namibia. As in South Africa, indigenous African land was appropriated for white settlers, and local people were confined to small reserves. A contract labour system was introduced to support the economy through provision of

cheap labour from the indigenous population. Starvation wages and subsistence agriculture was to support families of indigenous communities, during sickness and old age. These conditions sparked off resistance from many communities. South West Africa Peoples Organisation (SWAPO) was formed in 1960, initially concerned with labour issues but transformed into a nationalist liberation organisation. In 1966, SWAPO launched an armed struggle for Namibian independence from South Africa, with the war concentrated in northern Namibia.

Namibia was politically and economically isolated from the rest of the world through an international embargo. Many indigenous Namibians left the country during the liberation war and returned when fighting ceased, before independence. Supported by the United Nations Security Council Resolution 435, the first free and fair elections were held in 1989, and Sam Nujoma, the leader of SWAPO became the first president of the Republic of Namibia at independence in 1990. About 85,000 Namibians returned to the country from exile, who included children who had been taken to Germany (former German Democratic Republic) commonly known as GDR kids (Iiping and Le Beau 1997:13; Katjavivi 1988:59-64).

Namibia is democratically governed by a constitution which guarantees equality of all people. To ensure checks and balances in the decision-making process, the government of Namibia has a three-tiered structure: the Executive with the power vested in the president who is head of state, the



Legislature consisting of the National Assembly and the National Council, and the Judiciary with powers vested in the courts (GRN.1998:2).

Namibia's ethnic heritage is composed of indigenous ethnic groups of Owambo, Herero, Damara, Nama, Kavango, Caprivi, San, Tswana, and mixed people commonly referred to as 'Coloureds' or 'Basters', spread over the 13 administrative regions. Indigenous groups are commonly referred to as 'blacks', communities of European descent are primarily made up of Germans, English, and Afrikaners. People of European descent are commonly referred to as 'whites'. This small but economically significant European population of 6.4% controls the economy, even though the Owambo constitute about 51% of Namibia's population (UN 1999:9; Malan 1995:131, Yamakawa 2001:81). Among the indigenous groups the Owambo and Kavango have a matrilineal descent system, the Nama are patrilineal, the Herero follow a double descent system while the Damara have bilateral descent but patrilocal extended family (Malan 1995:7, 18-19; Yamakawa 2001:79). Most other groups have a patrilineal descent system.

Namibia has a population of 1.8 million people, with a growth rate of 2.6 and a density of 2.2 per square kilometres. Women comprise 51.5% and men 48.5% of the population. The total fertility rate is 4.1. The population of Namibia is youthful, with the elderly population comprising of 7% of the population (up from 4.8% in 1991). There are 346 455 households with an average size of 5.1 persons per household. The population is predominantly

rural at 67% with an urban population of 33% (NPC 2003:4)<sup>2</sup>. Urbanisation has significantly increased since independence in 1990.

Namibia's per capital income for the year 2000 was N\$ 3 608, with a potential labour force of 56%, but only 54.1% of this number are economically active<sup>3</sup>. Labour dependency ratio<sup>4</sup> for 2000 is 81.8 % (MoL 2002:30). Relatively high dependency rates<sup>5</sup> are found in rural areas, and the northern parts of the country, with most central and southern regions having relatively low dependency rates. The Namibian society is extremely unequal, with high levels of poverty for most sectors. The Human Poverty Index (HPI)<sup>6</sup> varies between 8% for whites but ranges between 17-58% among indigenous communities. The percentage of households whose main source of income is a social pension for elderly members is 11% countrywide (NPC 2003:4; UNDP 2000:155).

Life expectancy has fallen from 63 years of age for women in 1991 to 50 years in 2001, and from 59 to 48 for men due to the impact of HIV/AIDS (NPC 2003:4). The country has an overall HIV/AIDS prevalence rate of about 22% among sexually active adults (UNAIDS 2002: ). However, life

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<sup>2</sup> According to the 2001 Census there are 1 830 330 people, females are 942 572 and males are 887 721.

<sup>3</sup> The 2000 labour force survey by Ministry of Labour reports that 61% of the population is economically active.

<sup>4</sup> The ratio of children below 15 years and the elderly above 60 years.

<sup>5</sup> Dependency rate is the ratio of the total of dependent children below 15 years and elderly people above 60 years, to the employed population in a given area (NPC 2003:41).

<sup>6</sup> The HPI is a measure of deprivation, and is measured on dimensions of longevity, knowledge and a decent standard of living (UNDP 1999:9).

expectancy among the European communities is much higher than that of indigenous groups: Afrikaner 67.2 years, English 66.9, German 75.0, while indigenous ethnic groups range between 48.1- 61.7 years (UNDP 2000:156). Although Europeans have longer life expectancy than people from other ethnic groups, ageing is experienced in all communities of Namibia's multi-ethnic society. Hence it is necessary to expound on the concept of ageing in general.

## **1.2 Conceptualisation of Ageing**

The concept of Ageing can be defined as the increase in the number of old people in a population. Population ageing is a global phenomenon and has come about due to modernity - as a product of reduced mortality rates, increasing births and longer life. In biological terms, ageing may be referred to as the increasing inability of a person's body to maintain itself and to perform operations as it once did (Apt 1997:1). However, ageing is commonly used synonymously with advancement in chronological age, and researchers use chronological age to provide an operational definition of old age. In many countries, old age is closely linked to chronological age, and attainment of that age qualifies an individual to receive social security benefits. For example eligibility to a social pension is attainment of 60 years of age in Namibia. Hence the statistical definition of old age has come to be recognised as the official retirement age in a given country, which in Africa ranges from 55 to 65 years. In many developed countries, retirement is from 65 years of age but 70 years in the USA.

This defined category for retirement is incongruent with the African experience because only a small percentage of African people are engaged in the formal sector with appropriate retirement provisions. The majority of ageing Africans work in the informal sector until age or ill health makes it impossible to be active (Apt 1997:1). At this stage in life, the extended family has always given informal care to their elderly members, but social change and modernisation have eroded structures and patterns of care. However, global ageing has now led to a redefinition of old age.

### **1.2.1 The Changing Definitions of 'Old' Category**

The older population itself is ageing such that the fastest growing age group in the world is the 'oldest old'. According to the UN (2002:2), those aged 80 years or older are increasing at the rate of 3.8 per cent per year, and constitute 12% of the total number of the elderly globally. People are increasingly living up to 80 years and older, hence there is a tendency by demographers to divide the population over 65 years into two or three categories (Brinkerhoff et al 1997:358):

- Young old ( or old age)                      65-74 years
- Old old (or late old age)                      75 years and older

Developmentalists however, distinguish a third category of the oldest elderly being from 85 years and older as 'the oldest old' (Weeks 1996:387; Santrock 1997:530). The majority in the 'young old' category tend to be in good health, but advancing age towards 'oldest old' is characterised by

chronic health problems and disability. This health situation exacerbates problems of ageing in all countries, including Namibia.

### **1.3 The Problem of Elder Care in Namibia**

Namibia's political history and colonialism led to displacement of indigenous people, disparities in income and unequal access to basic social services (for example education and health). This situation, compounded by modernising forces (such as urbanisation and labour migration) resulted in the breakdown of traditional communities and family support structures that hitherto had supported vulnerable members of society, including the elderly. Institutionalisation of the elderly in OAHs was introduced into Namibia through people of European descent during the colonial era early in the twentieth century, but was adopted by some sections of indigenous communities. The question that arises is: 'what model of elderly institutional care is appropriate for Namibia, in view of significant social changes in society, both prior to and after independence? The aim of the research upon which this thesis is based was to collect relevant data to determine what socio-economic factors influence the level and types of care given to the elderly, so as to assess the appropriateness of the current model of elderly institutional care in Namibia.

#### **1.4 Objectives of the Study**

The objectives of this study are to:

- (i) Assess attitudes of the elderly towards institutionalisation, that is, elderly residing in formal care institutions.
- (ii) Determine which model of OAH offers an alternative option to family care for the elderly in Namibia.
- (iii) Assess Namibia's Social Welfare Policy vis-à-vis operation of OAHs.

#### **1.5 Research Hypothesis**

The hypothesis for this study is: “ Socio-economic factors in Namibian society determine the level and types of care given to the elderly and necessitate a model of institutional care that is adapted to local conditions”.

#### **1.6 Rationale for the Study**

In Namibia the traditional social institution that cared for elderly people (and other frail members of society such as the young, sick and disabled) has been the family. The impact of social change, modernisation, urbanisation and changing family structures, and poverty make it difficult for the family to fulfill this function. In addition, many urbanised elderly people, particularly former contract labour migrants and some liberation war returnees have lost close touch with their extended families which would have cared for them in old age. Hence, some of these people seek for care in OAHs. The different ethnic groups in the Namibian society share common values but differ in

others. Many white elderly live and are cared for in formal institutions. While such practice is new in most of the indigenous cultures, it needs to be ascertained whether attitudes towards living in OAHs may be changing.

In Namibia, all OAHs are privately operated, and largely operate on different lines from those in western countries where the concept originated. Questions arise as to how these service institutions have evolved in the Namibian situation. Factors that play a major role in the evolution of the institutions that include political history need to be examined; and the appropriateness of the models of institutional care in the face of extreme inequalities in the country. Poverty and extreme inequalities within the Namibian society continue to hamper families' abilities to extend equal services to the elderly, both within society and in OAHs. An assessment on the way forward needs to be made in light of the global phenomenon of increasing numbers of elderly; and Namibian government philosophy change to focus elderly care systems on the family and community. To what extent can government support the family to empower this institution to continue undertaking the role of elderly care? What model of formal elderly care can be adopted in the absence of family and community support? Studies are required to enable the Namibian government to develop realistic policies and formulate relevant programmes that will support the family and community in their effort to meet the needs of elderly Namibians as their numbers increase in the years ahead.

## 1.7 **Structure of the Thesis**

This thesis is divided into eight chapters. Chapter one introduces the subject of the study, presents a background covering a country profile of Namibia; conceptualisation of ageing; a statement of the problem of eldercare in Namibia; the objectives of the study; the research hypothesis; and the rationale for the study. Chapter two presents some theoretical perspectives on ageing. A critical literature study on social research and the study of old age, followed by a case study of Sweden and the situation in Namibia, are presented in Chapter three. Chapter four describes the methodology for this empirical study. Chapters five and six present the findings of the study. Chapter seven discusses the implications of the study findings for elderly care in Namibia. The thesis ends with chapter eight that draws conclusions from the study, and then makes recommendations. Chapter eight ends with re-evaluation of the thesis rationale. References and appendices are presented after the last chapter.



## CHAPTER 2

### **THEORETICAL PERSPECTIVES ON AGEING AND SOME CONCEPTS IN SOCIAL POLICY STRATEGIES**

#### **2. Introduction**

This chapter examines the concept of ‘old age’ as a cultural norm and social construct in different cultures and then presents some theoretical perspectives on ageing.

#### **2.1 Old Age: A Cultural Norm and Social Construct Across Time and Space**

Old age may be defined in several ways, such as social, physical, and psychological changes associated with ageing, or simply by chronological age. Old age is a flexible concept, socially constructed, perceived differently and accorded status in different societies according to social values and norms. Hence the ‘old age’ concept becomes a cultural norm and social construct across different cultures. Since culture is a dynamic concept, perceptions of old age and relations between generations are bound to change over time, simultaneously changing societal responses to elderly people. Responses to elderly people also differ within and between developed societies such as Europe and Japan, and between developing countries in Asia and Africa. Perceptions of old people and the status accorded to the elderly in traditional African societies are changing, and the Namibian society is no exception.

All societies stratify their members by age (young, adult and elderly), and each strata is accorded different roles, rights and privileges as constructed according to societal norms. One of sociology's interests is on social norms and roles that structure people's behaviour at different age strata; and whether the rights and privileges associated with the age roles are embedded within structural inequalities (Brinkerhoff et al 1997:347). Age stratification can be a basis for unequal distribution of resources, which can either be economic goods or crucial intangibles such as social approval, status and respect (Weeks 1996:274). Age stratification in modern bureaucracies within states affects the daily lives of people.

#### 2.1.1 **Age and Social Structure in Modern States**

Modern bureaucracies in different societies are giving the ageing experience more formal structures by setting critical points, such as age to start school, when to vote or when to draw pension benefits. For example in Namibia, children start school at six years of age, people vote from 18 years and eligibility to draw a social pension is 60 years. Formal structures have led to age norms being institutionalised, thus institutionalised structures affecting pension benefits create age norms about retirement (Brinkerhoff et al 1997:348). Therefore the elderly's continued participation in state and social activities does not only depend on physical and mental vigour, but also on social structures in which the individual participates. Such participation differs between societies in developed and developing countries.

Western Developed Countries: Most old populations in industrialised and developed countries reach old age in reasonably good health and thus delaying their retirement. For example retirement age in the USA is now 70 years, and 65 years in other western countries but with options to remain in full pensionable employment if desired. In these countries, responsibility for eldercare has been transferred from the family and community to the state, although prospects for elderly people in developed countries differ according to levels of development of a society. Compared to developing countries however, elderly people have several options and opportunities (such as social security benefits or lifelong learning), though this is not homogenous.

Some ideologies and changes in customs in developed countries negatively affect old people, for example the American dream in USA (Brinkerhoff et al 1997:235)<sup>7</sup>. Tonstol (2002:4) argues that America's glorification of the youthful, competitively self-reliant and action-oriented 'pepsi' generation present values contradictory and harmful to the self-esteem of the older person. Therefore growing old in this environment might be considered a threat, counterproductive and inefficient. Further, family norms in the USA are said to carry a general belief that parents have an obligation to support children but children are not obliged to support their parents. The government is entrusted with the responsibility to allocate resources to

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<sup>7</sup> The **American Dream** is an ideology suggesting that equality of opportunity exists in America and a person's position in a class structure reflects what is deserved. That is, if a person is worthy and works hard, he/she can succeed. Position comes entirely from their own efforts and take blame for own failure (Brinkerhoff et al 1997:235).

elderly people and public belief is that this is fulfilled relatively “evenhandedly” (Brinkerhoff et al 1997:366). Further, Tonstol (2002:4) argues that age stratification implies isolating the youth which leads to development of youth culture. Focus on production and outcome and promotion of youth culture denies social power to the majority of elderly people.

Elderly in America, Canada and European societies are much more separate from their children than in Asian and African societies (Weeks 1996:386). Co-residence of the elderly and their children has drastically reduced, for example, in Sweden only 4% of elderly people reside with their adult children while in Japan it is 50% (Johansson 2000:12; Catholic Medical Quarterly 2000). Living arrangements among the elderly are diverse, compounded by patterns of marriage, divorce and remarriage, in addition to women’s longevity (Weeks 1996:385). According to Korpi (1995:248) this situation creates complicated family structures with children of mixed parentage that continue to negate future patterns of informal elderly care.

Economic change also creates other problems in eldercare. In the study of western Ireland, details how the collapse of community economic cooperation and forced retirement practices have led to radical transformations in customs regarding ageing. The previously dignified

movement of the elderly to the sacred “west room”<sup>8</sup> of the house has been replaced by unceremonious “warehousing”<sup>9</sup> of the elderly in institutions (Tonstol 2002:4). Welfare state systems are facing economic difficulties, compounded by globalisation, and are shedding off some elderly services so that these be performed by the family and the market. Such changes are also occurring in Asian countries, although the rate of change is slower than in western developed countries.

**Asia:** A cultural value of filial piety has governed intergenerational transfers in Asian countries for generations, especially in Japan, China and Malaysia. The system upheld children’s, especially boys, obligations to their parents. The children are expected to provide their parents with devotion, reverence, economic aid, affection and companionship throughout the parents’ lives. Co-residence of generations has been the norm (Brinkerhoff et al 1997:366). However, there is evidence of this value system being eroded as families are increasingly failing to care for elderly members. For example, a government survey in China has shown higher proportions of elderly people among the homeless in some cities (Brinkerhoff et al 1997:367). Percentages of co-residence of parents with children is decreasing in Japan and Malaysia, especially in urban areas and among the educated children. The 1985 Japanese census indicated that 65% of people 65 years and older co-resided with children (Weeks 1996:386-7). However, the Catholic Medical

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<sup>8</sup> A room in a multigenerational home which an elderly person moves into and leaves the main room, usually bigger, for younger family members.

<sup>9</sup> A term used in a derogatory way to describe institutionalisation of the elderly.

Quarterly (2000) reported that statistics for 2000 reflected a decrease to 50% of the elderly in co-residence with their children. Remedial strategies include support of families. As in Asia, the African family has always undertaken the elder care role but the situation is also changing.

**Africa:** Change in tradition within the African socio-cultural context has steadily become apparent. Traditionally, the aged were well integrated into the social and economic life of their communities. The traditional society is organised on the basis of 'gerontocracy', where authority and respect of the elderly is never challenged; with norms incorporated in the daily lives of the family and community as a whole. The elderly are respected and honoured, and are held in high esteem as heads of their families, with wisdom and knowledge; and as guardians of culture (Apt 2000:6; Apt 1997:7-8; Apt 1996:32; Adamchak 1989:172). Intergenerational co-residence in the extended family has been an acknowledged pattern, with the elderly having their share of economic input. Substantial intergenerational economic and domestic service exchanges take place. The elderly take on less strenuous chores in the home and childcare, while young people undertake physically strenuous chores that old age and infirmity render difficult. Under this system, the elderly have access to social stimulation from the young, and the young receive substantial wisdom and knowledge from the elderly. This intergenerational exchange of services forms the core of the traditional African informal welfare system (Apt 1996:33).

However, modernisation has eroded the extended family, rendering its continued support of elderly members questionable. Urbanisation and modernisation of economies have drastically affected family structures and intergenerational supports (Apt 1997:7; Hampson 1985:85, 173). Assets and domestic support and services can be purchased in the market, technologised education renders elderly knowledge obsolete, and extended family linkages are being shed off. For example, studies in Ghana show that conflict of royalties is evident in newer conjugal families and extended families – 8% of younger people consider the extended family as not being feasible in current times (Apt 1998b:3; Chinkanda 1989:152). In addition, urban housing and living, especially sizes of house structures, do not encourage intergenerational co-residence.

The elderly have also lost ability to dictate inheritance as an insurance for their welfare. New legal systems through modern legislative reform which are designed to produce social equity, contribute to weakening the elderly's ability to use inheritance options while alive, to ensure children's support (Apt 1997:8, Adamchak 1989:172). Thus these new threats require new strategies for continued support of African elderly people. However, African countries are unlikely to have resources to build comprehensive welfare systems to meet the needs of elder care and support. In contexts that do not have public social welfare arrangements, African elderly support can only be offered by the extended family (op cit). Theoretical perspectives are used

in attempts to explain why and how ageing has come about; and social changes and norms associated with ageing.

## **2.2 Theoretical Perspectives on Ageing**

With reference to Cowgill and Holmes (1972:1), Ferreira et al (1989:84) states that there is a lack of a coherent and meaningful sociological theory on ageing. Bearing this in mind, five theoretical approaches are considered relevant to the study. These are modernisation theory, disengagement theory, activity theory, race and ethnicity, and class theories. However, focus of this study is modernisation theory. This theory allows for universal experiences shared by old people, regardless of culture or ethnicity, though some experiences of old age differ according to culture, ethnicity and history of communities.

### **2.2.1 Modernisation Theory of Ageing**

As a macro theory, Modernisation Theory presented by Cowgill and Holmes (1972) gives a foundation for assessing how continuous changes in society, culture and popular values affect certain groups within the population (Tonstol 2002:4). Basic tenets of the theory are that with increasing modernisation, the status of the elderly declines (Baker 1997:1). A major assumption is that social and economic changes that usually accompany modernisation of traditional institutions and structure erode the status of the elderly (Apt 1996:16). This is one of the questions that is tested through this research. The Cowgill model presents four factors that



combine to lower the status of the elderly. These four factors are: health technologies, economic technologies, urbanisation and education.

Health technologies increase longevity, leading to an ageing population, and creating intergenerational competition for jobs and resources. Economic technologies create new high status jobs occupied by young people and make the knowledge of elderly people obsolete. Rural - urban migration in search of new lifestyles and new economic relationships increases with modernity and creates new social structures in rural and urban areas.

Increased urbanisation is characterised by segregated housing, nuclearisation of families and weakening of values towards extended family and kin (Apt 1996:2,6; Viljoen 1983:30). Furthermore, labour migration for development purposes characterises modern society. Circulatory labour migration has been characteristic in southern African societies. Circulatory migrants can be defined as those who alternate between first and third world economies. Typically, circulatory migrants tend to work in urban-industrial centres, or on commercial farms, away from their rural-based families most of their working lives; and are reunited with the families only after retirement. Thus working life and retirement is spatially and occupationally defined, which may be seen to coincide with return migration (Weeks 1996: 216-217, 369; Moller 1989:48).

According to Ferreira (1989:48) return migration theorists distinguish between 'the return of success' and a 'the return of failure'. It is claimed that achievements of working life have a positive influence on retirement, where success is denoted by material and psychological well-being as well as benefits to their families and communities through accumulated wealth. Failure implies returning as a burden to their families and communities of origin. Examples of failure are, cases of former contract labour workers and other labour migrants from neighbouring countries into Namibia. Some of the migrants who remained in urban areas lost close touch with their families, had not accumulated wealth, and hence in old age had to seek care in OAHs. Thus in Africa, migration is connected to breakdown of the extended family that represents a traditional welfare system with its accompanying traditional support network for the aged. Several studies confirm erosion of the extended family in many African societies<sup>10</sup> (The UN 2000:6; Adamchak 1989:169-170).

Modern technology-driven mass education targets young people, segregates the elderly from the mainstream and renders their knowledge and skills obsolete. The elderly lose respect, power and independence. Subtle changes associated with education, urban living and access to world media further increase social distance between generations (Apt 1996:5; Weeks 1996:372; Adamchak 1989:175). Thus traditional social order is broken down by

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<sup>10</sup> See for example, studies in Ghana by Apt (1996; 2000:6); South Africa by Chinkanda 1989; the Samia of Kenya by Cattell (in Apt 1998b :2; Zimbabwe by Hampson (1985); Adamchak 1989:169-170).

modernisation and the traditional ability of families and communities to support, integrate and care for the elderly is greatly reduced. The scope of changes and their impact on the elderly has gains and losses to both the elderly and other groups in society, reflected in modern economic and social trends in the respective countries (Apt 1996:4).

To account for critiques on the rising status of the elderly in developed countries, Apt (1996:14) cites Cowgill's assertion that the status of the elderly initially declines with modernisation but rises again with the development of the post-industrial welfare state. Significant and far-reaching structural changes, such as urbanisation, industrialisation, labour migration and changing family structures, occurring in developing countries such as Namibia, affect the family and its ability for continued eldercare.

### **2.2.2 Disengagement Theory of Ageing**

Two general view points on ageing – Disengagement and Activity theories are based on observations that as people grow older, their behaviour changes, their activities are curtailed and the level of their social interactions decrease. Disengagement theory of ageing is a functionalist theory, advanced by Cumming and Henry (1961) which assumes 'consensus' through cooperation of all age groups for common good of self and society (Brinkerhoff et al 1997:227,367; Apt 1997:1). For example, a lack of or inappropriate care of the elderly group would lead to dis-equilibrium in society as a whole. The theory postulates that ageing is natural, inevitable and universal, and

involves mutual disengagement between the older person and society to enable optimal functioning of society (Brailier 2002; Chinkanda 1989:146). That is to say, old people disengage themselves from active social participation and gradually drop from social roles, production, family, church or community even before the onset of their inabilities due to old age.

This disengagement becomes functional for society because it allows younger people, with new ideas and skills for a fast changing society, to replace older people with set ideals. An orderly transition from one generation to the next is attained, with provision of individuals to rest as well as the reduction of shame from declining abilities. However, Ferreira (1989:146) draws on Cumming and Henry and concedes that re-engagement to cultivate a new set of values is possible. It is asserted that the elderly's diminished valued contribution to society becomes a social problem (Sullivan 1980:341, 366).

Criticisms of the theory point to its simplicity, lack of empirical verification, and questionable claim of universality because not all elderly disengage from society (Ferreira et al 89:32; Scogings 1992:9). Furthermore, the theory disregards power, although power can be manipulated to advantage or disadvantage some groups in society. For example, historical political power structures contributed to current inequalities in levels of care extended to the elderly in Namibia.

### **2.2.3 Activity Theory and Ageing**

Activity Theory challenges assumptions of disengagement theory and views the welfare of the elderly as meaningful involvement, not withdrawal. This theory suggests that individuals should continue their middle adulthood roles and activities through late adulthood, to remain active and involved in societal activities. If roles are taken away (e.g. in forced retirement), it is important to find substitutes or make new relationships. Several studies reveal higher levels of health and satisfaction associated with active elderly people who have networks of close friends and relatives, even though levels of activity may shift to a certain degree. (Brailier 2002:1; Santrock 1997:573). The theory thus advocates active ageing.

Instead of being explanatory, Disengagement and Activity theories aim to establish a norm, but such a norm may fail to apply to multiracial and multi-ethnic societies, such as in Namibia. Furthermore, elderly in Africa do not retire in the modern bureaucratic sense but work until they are unable to. Besides, many people work in the informal sector and retirement does not apply. Hence, Viljoen (1989:85) argues that to see activity as universally synonymous with contentment in old age would be wrong.

### **2.2.4 Race and Ethnicity Theories and Ageing**

Race and ethnicity can be the bases of social stratification with negative consequences. Race and ethnicity can be exploited to foster social inequality

in many societies if supported by economic dominance of one group (Brinkerhoff et al 1997:286).

Race is socially defined as a category based on physical characteristics, such as colour of skin. Beliefs in the superiority of one racial group over another results in racism. Prejudice and discrimination augment racism and create social distance between racial groups in society (Giddens 1993:255, 263). According to Brinkerhoff et al (1997:288), through processes that promote social distance, racial groups tend to remain separate and often unequal even after many generations of living together in the same society. Hence elderly people may have an added disadvantage of inability to access services, where such access may be racially or ethnically determined or extended to segregated neighbourhoods. Racism and discrimination become institutionalised, as in the case of Namibia and South Africa, when rules, practices, laws and policies are applied to different groups at national level. Such policies affect social services to elderly people (and other groups in need) and deprive them on a racial basis, of equal entitlements and benefits. In unequal societies such as Namibia, the economically better-off racial groups can better support elderly members of their communities.

**Ethnicity:** An ethnic group is also socially defined on the basis of cultural characteristics such as language or history, and is distinguished by group members themselves and others (Yetman 1993:288). The most common basis of ethnic group formation is belief in common ancestry, real or

fictitious. Through the process of interaction, people may identify themselves to be members of one ethnic group, even though they do not share the attributes mentioned (LeBeau 1991:3). According to LeBeau (1991:4), ethnic identity formation is affected by three large contexts of colonialism, nationalism and immigration. Ethnicity has many times enhanced or hampered opportunities open to individuals and groups. For example, Steinitz (1998:3) observes that in Namibia, occupancy in better-managed OAHs is partly financially, ethnically and racially determined. Furthermore, ethnic groups, especially minorities in developed countries and the formerly colonised majority in Africa, earned substantially less during their peak years of activity. Therefore, these people are unlikely to be able to save or accumulate assets (such as house ownership or investments) to cushion income loss during retirement. In addition, studies show that the economic status of people in racial or ethnic economically minority groups become worse, relative to economically dominant races in a given society. For example, the majority of indigenous groups in South Africa and Namibia are financially worse off, compared to the groups of European-descent in these countries; or many international immigrants from developing countries to USA and Europe.

Immigrant elderly people from developing countries to developed countries find it difficult to assimilate new cultural values that place a high value on activity, productivity and individual achievements (Brinkerhoff et al 1997:373). Thus some elderly miss opportunities presented to those who

embrace dominant values in the society. LeBeau (1991:5) points out that urban migrants use cultural or ethnic identities to interact with other people. Thus urbanised elderly's social networks are likely to be confined to and within ethnic groups.

### **2.2.5 Class Theory and Ageing**

Society is stratified along several bases including 'class'. Two classical views on the concept of 'class' are presented by Karl Marx and Max Weber. Karl Marx (in Giddens 1993:216) views class in economic terms and defines the concept as "a group of people who stand in common relationship to means of production". To Marx, class is directed towards objectively structured economic inequalities in society. Class therefore refers to objective conditions which allow some people to have greater access and control of material resources than others (Giddens 1993:215-217; Brinkerhoff et al 1997:219). Class is identified with divisions of the 'upper class', the 'middle class' and the 'lower class.' However, Marx views society to be polarised into two classes, the bourgeoisie and the proletariat.

Max Weber defines 'class' in a pluralistic way to cover status and power, referring to a group of people who share common life chances. Weber used status as a synonym of social honour or prestige (Giddens and Held 1982:521). Classes are not homogenous but are highly differentiated internally and embrace different interests. Hence this multi-dimensional



concept forms 'social class'.<sup>11</sup> A social class is a category of people who share the same class, status and power, and who identify with each other (Giddens and Held, 1982:183; Brinkerhoff et al 1997:220). In Africa, class is not necessarily based on the same criteria as that in developed countries, but class divisions do exist. For example, the new political and educated elite or upcoming farmers and business people in Namibia would constitute a middle class.

Social class affects elderly people both directly and indirectly. Class directly arises out of structures of inequality; and social class is directly related to income and social networks. The low financial status of elderly people from lower social classes emanates from low earnings in earlier life. Such earnings have no pension provisions for retirement and the situation is exacerbated by reduced income in old age. Furthermore, elderly people from higher social classes have larger social networks and are therefore more likely to get help or support from these social networks when in need of assistance.

**Summary:** Old age is a cultural concept and social construct, perceived differently and accorded different statuses according to changing social values and norms in both developed and developing societies. Physiological explanations of age stratification fail to explain cross-cultural or social

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<sup>11</sup> Social class can be measured subjectively by self-identification (asking 'what is your class') or objectively by socio-Economic Status (SES) through ranking individuals on income, education and occupation or a combination of these (Giddens and Held 1982:175).

changes that impact on perceptions of the elderly. It is acknowledged that not any one theory can alone explain the ageing process or its consequences. Different theories explain discrete aspects of the process, and an integration of the aspects will provide some insightful explanations about ageing. The assumption is that social-cultural settings are not static conditions within which ageing occurs, but are susceptible to change. Consequently, levels and types of care extended to the elderly are subject to change, leaving affected elderly people vulnerable. Based on the discussion of the various theories, modernisation theory of ageing explores the negative effects of social-cultural change on the status of the elderly. Therefore it is within this framework of modernisation theory that this study is directed.

## **CHAPTER 3**

### **SOCIAL RESEARCH AND THE STUDY OF OLD AGE**

#### **3.1 Introduction**

The purpose of this literature study is fivefold. Firstly, to explain how an increased proportion of elderly people in the population has come about. Secondly, to highlight factors that impact on the elderly as a social category and hence require consideration in elder care discourse. Thirdly, to review studies undertaken in different societies on a range of approaches to elderly care. Fourthly, to examine some concepts in elder care strategies, and lastly, to highlight the Namibian situation so as to achieve the objectives of this study. This chapter presents an overview on issues of global ageing in general and elder care in developed and developing countries; as well as factors that affect elderly people in general and how these affect elder care systems. A case study of a developed country, Sweden, is presented and finally this chapter ends with a focus on the contemporary Namibian situation regarding ageing and elder care.

#### **3.2 Overview of Global Ageing**

The world population is ageing, with an increasing proportion of elderly people (60 years and older) at a rate of 2% per annum, a faster rate than the world population as a whole (The UN 2002:2). In 2002, the worldwide number of the elderly was estimated to be 629 million and was projected to

reach 2 billion by 2050 when, for the first time in history, the population of older persons worldwide will exceed that of the young (less than 15 years). According to the UN (2002:2) 54% of the world's elderly live in Asia and 24% live in Europe. By 2030 more than 75% of the world's elderly population will live in developing countries (op cit :18). In Africa, the number of elderly people is expected to increase to 50 million by 2025, with rural numbers doubling by that year. Women form the majority of elderly people because of longer life expectancies. Women are more likely to be single or widowed and tend to be poorer than men (op cit :2,11). Increasing elderly populations means that the dependency burden on workers will increase, implying that the Potential Support Ratio (PSR)<sup>12</sup> will continue to fall. The Parent Support Ratio (PSR) - the ratio of the population 85 years or older to those aged 50 to 64 years has increased and provides an indication of the support families need to provide for their oldest members.<sup>13</sup>

Proportions of elderly vary between developed and developing regions of the world. According to the UN (2002:5), one fifth of the population was aged 60 years in 2000, while 8% of the population in developing countries is 60 years and older. This rate of growth requires economic and social adjustments in most countries, but challenges in developed and developing

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<sup>12</sup> PSR has been defined as the number of children or persons aged 15 to 64 years available to care for one old person, aged parents or those 65 years and older (Brinkerhoff et al 1997:366). Between 1950 and 2000, PSR rate fell from 12 people in working ages per each person 65 years and older, to 9 people in working age (The UN 2002:3)

<sup>13</sup> Globally, PSR increased from less than 2 persons aged 85 or older for every 100 persons aged 50-64 who would provide support in 1950, to 4 persons aged 85 years per 100 of those aged 50-64 in 2000, and is projected to reach 11 per 100 by 2050 (The UN 2002:3).

countries<sup>14</sup> differ. Challenges relate to differences in economic conditions, traditions, family structure, the HIV/AIDS pandemic, armed conflicts, refugee populations and natural disasters (The UN 2002:5). State welfare support in developed countries has declined under economic pressures leading to increased family and individual elder care support. The majority of elderly in developing countries live in rural areas and ageing in rural areas will, among other things, affect social organisation and production patterns. It is predicted that the family will experience rapid and demographic change leading to reduced family support for elderly people, without having alternative formal support that developed countries enjoy.

### 3.2.1 **Eldercare in Developed and Developing Countries**

Although longevity adds more years to life, potentially more years of dependency are also added because of the increased risk of illness, disability and frailty. The economic and social situation of the elderly differ greatly in both developed and developing countries; and these differences affect conditions and possibilities for policies on care of the elderly in individual countries. The social support burden of supporting the elderly has greatly increased on younger people. While state welfarism provides a safety net for eldercare services in developed countries such as Sweden, Germany, Canada,

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<sup>14</sup> 'Developed countries' refer to industrialised countries, with well developed socio-economic infrastructure, including that for elderly care. Many services to the elderly are formal and fall under state welfare.

'Developing countries' are non-industrialised, and are generally poor, without well developed infrastructure. Elderly care structures are not fully developed and elderly services remain largely informal.

Britain, eldercare remains the responsibility of the family in developing countries (The UN 2002:2).

Eldercare in developed countries has tended to follow levels of wealth and development as proportions of elderly populations increase. In western countries, public assistance through welfare state systems using various formal institutions have developed to provide care-giving functions that the family is unable to perform. However, experience over time shows that these formal institutions have been unsatisfactory, and the global trend has turned to de-institutionalisation (Apt 1998b:4). Challenges to welfare state systems regarding public assistance to the elderly involve pension schemes and public financed medical provision. Co-residence of elderly people with their adult children in some developed Asian countries is also decreasing.

In developing countries, mostly in sub-Saharan Africa, the family continues to be a dominant source of care and support for the elderly due to the lack of a comprehensive social security system for all (Apt 2000:6; Apt 1998a:4). Co-residence with children continuously or when parents grow older has been customary in Sub-Saharan Africa and developing countries in general (Hermalin 2000:13). A combination of increasing numbers of elderly people, economic and social change, and modernisation with rural-urban migration continue to undermine the viability of traditional elder care systems. With competing demands on scarce resources, policy makers have not had sufficient awareness to put new caring arrangements in place

(Kinsella 2000:541; Apt 2000:2). Lack of recognition of informal African caring systems by colonial administration; and neglect by post-independence governments have disguised the proportion of the crisis of caring for the elderly. In addition, widespread poverty, inequalities in some societies and the effects of the AIDS pandemic hinder family caring efforts.

The proportions in populations of developing countries is not only rapid but is taking place at a much lower socio-economic level than it has done in developed countries (The UN 2002:2). Growth of elderly populations challenge social institutions to adapt to changing age structures and find solutions to new problems as they unfold. Scogings (1992:171) cites Tout (1989:258) that “a criterion for assessing the appropriateness of services, methods, technologies and treatment is whether or not they facilitate self-help, self or family care”. It is questionable whether developing countries, and African countries in particular, will remain economically strong enough for families to maintain ties to older members as the dependency burden increases (Kinsella 2000:541; Lekgetta and Robertson 1978:11). Intertwined in the eldercare discourse in all countries is a growing awareness of incidences of elder abuse that bears considerable financial and human costs.

### 3.2.2 **Elderly Abuse**

The phenomenon of elder abuse has only recently been recognised as a global problem. Elder abuse is described as a gross violation of elderly people’s human rights (The UN 2002; WHO 2002:1). Abuse may be a

single or repeated act and takes place within the family, community or institutional settings. Abuse takes various forms: physical, emotional or psychological, sexual, financial, intentional or unintentional neglect and discrimination (The UN 2002:21-22; Voelker 2002; Glendenning 1999:1; HAI 2000:10; Ingstad 1994:38).

Physical abuse involves causing pain or bodily harm, and in the extreme, murder. Emotional or psychological abuse can be abusive language, humiliation or intimidation. Such abuse includes disrespect and contemptuous behaviour within family settings. Financial abuse may involve a trusted caregiver who illegally uses or misappropriates an elderly person's financial assets or property. Sexual abuse ranges from rape, indecent assault or sexual harassment. Intentional or unintentional neglect, both in family or institutional settings includes inadequate attention to hygiene, denial of appropriate or clean clothing, inadequate food, isolation and deprivation of social contacts. The elderly may also be socially discriminated against because of their age – ageism (The UN 2002:21-22). The UN also identifies political as well as HIV/AIDS related abuse against elderly people. During forced displacements due to political violence, special needs of the elderly are neglected by humanitarian relief plans. Older women in countries affected by HIV/AIDS pandemic get burdened with care-giving to dying relatives as well as orphaned children (CBS News.com 2002:1; The UN 2002:22).



Causes of elderly abuse vary in different cultures, and both inside and outside formal institutions. Perpetrators could be dependent on the victim in some way, stressed institutional caregivers, or deliberate negligence through cost-cuts and the quest for maximisation of profits by private caregiver companies that ultimately erodes service quality (Ueno 1998:1). However, a broader landscape of poverty and structural inequalities in society lays fertile ground for elder abuse (The UN 2002:22; Brenda 2002:16-17, Bergeron and Gray 2003:96).

#### **Spread of Elder Abuse:**

Although elder abuse has been researched mostly in developed countries, available information from various records indicate widespread incidences in developing countries. In Africa, elderly women get ostracised on accusations ranging from witchcraft to cause of drought or too much rain. For example, abandonment of elderly people in hospitals has been reported in Kenya and Zimbabwe; and witchcraft accusations in Tanzania (Cook-Daniels 2003:3; Voelker 2002:6-7; The UN 2002:21; HAI 2000:9; UNFPA 1998:16).

#### **Intervention**

Financial and human costs of elder abuse are considerable but many cases remain unreported for numerous reasons. Victims may not know what is happening to them, or fear retribution; feel embarrassed or retain loyalty to the perpetrator. However, elderly abuse cases can also be linked to lack of

uniform reporting laws. Effective preventive measures require mandatory understanding of a cultural perspective or context of the community in which elder abuse occurs. A multi-sectoral intervention approach to causes of abuse should include strategies to improve broader social, economic and political conditions in the society (The UN 2002:22-23; Brenda 202:16-17; Bergeron and Gray 2003:96,102; Wilson and Parsons 1991:110-114).

Apart from elder abuse, various other factors affect elderly people in general, and these factors have an impact on elder care systems, depending on situations in individual countries.

### **3.3 Diversity and Convergence of Factors Affecting Elderly People**

Various factors of a biological and social nature largely determine the welfare of the elderly, or create problems for elderly people across societies. However, in both developed and developing regions, some factors may be specific to or may differ in intensity to a particular society or country. Biological factors refer to senescence resulting from decline in physical viability, accompanied by a rise in vulnerability to disease and disability (Weeks 1996:369). Most problems however, arise from socio-cultural aspects of ageing within societies. Coping with old age is seen as not only being a personal task, but also a measure of the quality of societal conditions (Lauer 1995:234; Adamchak 1989:168; Baltes and Reichard in Datan and Lohmann, 1980:252). Therefore some factors covering social-cultural aspects of ageing in societies are examined below, with an emphasis on the

African situation. These factors include social institutions of family and intergenerational transfers, institutionalisation of elderly people; reduced income and poverty; food and nutrition; health; housing and living environments; education and media; migration and emergency situations and social welfare policies.

### 3.3.1 **The Social Institution of Family and Intergenerational Transfers**

The family is a basic unit of society and a major socialising agent. A traditional family forms a unit of production in rural areas, but in urban areas, it becomes more reproductive based on market exchange. One of the functions of the family is caring for its members at all stages of life. Whereas the family forms the ultimate safety net for elderly care in developing countries, this role has been replaced by formal arrangements through the state in developed countries. In African societies, elderly care was previously guaranteed through the extended family system that has been a traditional welfare system. However, this norm has been eroded by social change enhanced by colonial rule, industrialisation, modernisation and urbanisation (The UN 1999:34; HAI 2000:7; Apt 1996; Apt 2000:4-6; Adamchak 1989:169-170). Weakening and breakdown of extended family structures, compounded by family incapacity to extend care due to poverty, leave vulnerable members of African societies (young and old) unprotected.

Structural change of the family has created problems in traditional elderly care structures. In developed countries, increased divorce and remarriages

lead to formation of a range of household and family compositions that do not guarantee elderly caregivers. For example, families with children of multiple parentage may not want to undertake responsibility over the elderly who are not their biological parents. Even the filial piety<sup>15</sup> value, particularly strong in Asian countries, is also being eroded. In developing countries, rural-urban migration, urbanisation, education and wage labour are the main factors within the broader socio-economic changes that affect living arrangements and the elderly support system of the family. Increasing nuclearisation of families (84% of households in Egypt are nuclear families) not only reduces potential elderly caregivers, but it also leads to conflict of loyalties between newer conjugal families and the extended family as adult responsibility focuses on the nuclear family. Studies in Zimbabwe and South Africa report a conflict of loyalties in the family institution (Apt 2000:3; UNFPA 1999:2; Chikanda 1989:144; Adamchak 1989:172. Apt 1996; Wilson and Parsons 1991:111).

Rural-urban migration and urbanisation result in a breakdown of traditional care structures, such that the elderly are left alone, deprived of agricultural human power and domestic support from able-bodied young people. Social distance is created between rural and urban families and households, weakening norms of individual responsibility towards rural elderly kin. Urban segregated housing also negates intergenerational co-residence among

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<sup>15</sup> **Filial Piety** is a cultural value involving a system of children's obligations to their parents in devotion, reverence, economic aid, affection and companionship throughout the parents' lifetime (Brinkerhoff et al 1997:366; Weeks 1996:385).

urbanised families. Further, unemployment and underemployment of adult caregivers on low wages without pension schemes and social security results in a failure to provide for elderly family members. Such people fail to make financial provisions for their own old age (Apt 1996:45).

In many African countries, no structural intervention has evolved to effectively replace the loss of family support for the elderly. For example the Namibian government recognises that no alternative support structures are yet in place (NPC 1995), while Wilson and Parsons (1991:111) lament on a lack of new structures in Zimbabwe. Although the family can no longer cater for all needs of elderly people, it still provides a central structure for social welfare in developing societies. Several studies therefore recommend support and empowerment of the family, without seeking to replace its function, even when forms of support differ in societies. This recommendation has deep implications for elderly care especially in poor developing countries with no formal arrangements. (Apt 2000:4; UNFPA 1998:5; Nair 1989:184; Bergeron and Gray 2003:96).

### 3.3.2 **Elderly Institutional Care**

Elder care institutions are long term care facilities for elderly people and institutionalisation refers to caring for the elderly in institutions. These institutions characterise social division of labour by taking over eldercare responsibilities previously integrated in the practices of the family. Institutions for eldercare differ significantly in ideology and operational

philosophies in different countries; and differences have an impact on, but also depend on policy (Lawton 1989:13). Examples of institutions include, OAHs, nursing homes, geriatric wards and group living arrangements, but OAHs are more common in Africa.

Institutionalisation of elderly people is more common in the western and other developed countries through public funding, but is new in many developing countries, especially in Africa. A combination of circumstances lead elderly to move to institutions, ranging from a personal choice to rest, to having no choice because of frailty and disability, poverty, or no family to care (Lawson 1989:15). However, it has been argued that institutionalisation of elderly people presents a failure of the family, local community, statutory and voluntary authorities to keep them in their own homes (Madzingira 1997:15). From a study in South Africa, Ferreira (1984:5) argues that elderly people who are socially integrated in communities may be less desirous of moving to an institution. This is closely related to the theory of social integration postulated by Rosow. Another study in Botswana indicates that elderly people hate institutionalisation, and prefer to live with their families (Ngome 1994:107). Ngome found that the elderly prefer to live with their own children, even if the children mistreat them. These elderly state that they would rather be mistreated by their own children rather than a stranger.

In Eastern and Southern Africa, OAHs are mostly found in the urban centres, particularly in countries with European settler communities, such as Kenya, South Africa, Namibia and other SADC countries. Most of the OAHs are operated by private organisations and Churches (Nyanguru 1991:73; Gunzel 1997:1; Lawton 1989:15; Steintz 1998:4; Dima 2001:75, 79; Van Zyl 1980:2). In other countries such as Uganda, advocacy on the plight of the elderly, especially in cities has recently been spearheaded by church leaders who, aided by the UN and HelpAge International (HAI), introduced the idea of OAHs for urban elderly destitutes (URAA 1997:1).

Several problems are associated with elder institutionalisation: institutions are expensive to run, implying that occupancy is mostly financially determined. Hence in Africa, the homes are mostly occupied by economically better-off elderly, most often those of European origin (Madzingira 1997:8, Wilson and Parsons 1991:111). Institutions also have a negative impact on psychosocial well-being of elderly people. OAHs have a restrictive rigid regime that compels change of lifestyle; for example, lack of privacy and autonomy, perceived uncontrollable environment and isolation from family and friends (Chinkanda 1989:151). Feelings of rejection by family, anxiety, stress, hopelessness and depression have been observed among residents (Datan and Lohmann 1980:198; Ngome 1994:103, Van Zyl 1980:1). Institutionalisation carries negative stereotypes of being likened to a 'jail', or 'warehousing' (Tonstol 2002:4).

Furthermore, inadequate services in some OAHs, such as limited mobility and lack of exercise, can lead to the inability to perform Activities of Daily Living (ADL) (op cit). Adoption of western models of institutional care by developing countries, particularly in Africa has received a lot of criticism. Based on a case study in Zimbabwe<sup>16</sup>, Wilson and Parsons (1991:111) point out that current OAHs in Africa are replica of outdated and static European models of continuing care, and are thus inappropriate for most African situations. Therefore, African gerontologists argue for building an intergenerational society that would harness support structures already present in Africa, such as kinship systems, instead of adopting inappropriate and expensive western models (Apt 1996:144; Moller 1998:1-2).

### 3.3.3 **Income and Poverty in Retirement and Old Age**

The economic situation of elderly people differs by country and differences affect conditions and possibilities for policies on care for the aged in each country. Income of elderly people is drastically reduced upon retirement from active service, mostly at the age of 60 or 65 years in most countries, but 70 years in USA (Weeks 1996:381). Post retirement jobs are limited, and when secured, remuneration is substantially reduced. The economic position of the aged to a large extent is determined by pension systems. For the majority of elderly, social security and pensions provide the only income and

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<sup>16</sup> Zimbabwe had 81 OAHs in 1991 (Nyanguru 1991:73); Namibia currently has 24 OAHs (MoHSS 2001).



many live below the poverty line<sup>17</sup> (HAI 2000:9). In some rich developed countries such as Sweden, however, provisions and pension systems eliminated poverty in old age (Palme et al 2002:76). In developing countries, Africa in particular, the majority of economically active people are dependent on subsistence agriculture in rural areas, or work in the informal sector without pension provisions. According to Brinkerhoff et al (1997:359) 12% of those over 65 years have incomes below the poverty level. Studies show that fewer elderly people in many African countries receive pension from previous wage employment; for example although 15% of wage earners in Zimbabwe are in pensionable employment, a study found that only 4% of the elderly actually receive pensions (Adamchak 1989:171; Wilson and Parsons 1991:111).

Only five countries in sub-Saharan Africa pay universal non-contributory social pensions to their elderly citizens, although in most cases these are too low for prevailing economic conditions. South Africa started paying pensions in 1928 for people of European descent and currently pays R 600 per month to 1.6 million social pensioners; Botswana started in 1997 and currently pays 110 Pula per month to 80 000 social pensioners; the other countries are Namibia, Mauritius and Seychelles (Duveraux 2003:1; Adamchak 1989:171). South Africa and Namibia extended and equalised

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<sup>17</sup> Poverty can be absolute or relative. **Absolute poverty** refers to inability to attain a minimum standard of living, based on the notion of basic needs for individual sustenance. **Poverty Datum Line (PDL)** is a cutoff measure or line below which people are considered poor, and is used to calculate the size of the poverty problem. **Relative poverty** relates to relative deprivation in society, relating to needs and demands of a changing society (Duveraux et al 1995:2; Townsend 1979:129).

social pension payments to blacks after transition to democracy in the 1990s (Duverieux 2003:2). In all of these countries, the social pensions, however small, are in most cases the only source of income supporting intergenerational households (Duverieux 2003:2; Duverieux et al 1995; Lekgetha and Robertson 1978:11). Lawson (in Ferreira et al 1989:195) recommends research to determine how receipt of pensions affects desirability of elderly members in younger but poor families, its interaction with costs of care and living space available. However, increasing elderly populations coupled with the rising costs of the programme make the future of social pensions uncertain.

It has been pointed out that financial problems in old age are partly rooted in political programmes and discriminatory practices in the economy (Lauer 1995:258; Sullivan 1980:347; NDP 1). Weeks (1996:384) further points out that economic advantages and education in younger years are closely related to income in old age. For example, apartheid legislation in Namibia and South Africa denied equal opportunities and services for education and employment between whites and blacks. Hence many elderly black people are poor.

In addition, early or forced retirement without appropriate pension plans or other retirement arrangements curtails an individual's ability to support elderly relatives, or save for himself/herself in old age. For example, employee retrenchments through Structural Adjustment Programmes dictated

by the International Monetary Fund (IMF) in African countries lead to early retirement without appropriate pension arrangements (Meiring and Blake 1984:659). Further, in Africa, families remain the main source of social and economic support for the needs of the elderly, but modernisation and monetisation of the African family continue to erode norms of intergenerational transfers. For example, a survey in Zimbabwe indicated that 63% of rural households reported that urban relatives' had failed to remit financial aid to them (Adamchak 1989:173); while the elderly in Namibia and Botswana complain of a lack of financial support from children (Guillette 1994:114).

#### 3.3.4 **Food and Nutritional Needs of Elderly People**

Elderly people require an appropriate diet in quantity and quality for their ageing bodies (The UN 1998:29). Malnutrition is common among elderly people due to several causes including: poverty, ignorance, isolation, poor eating habits, including those due to dental and medical problems or alcoholism, as well as mal-distribution of food in families and institutions (Bennett and Ebrahim 1995). Poverty prevalence in developing countries leads to the inability of many families to access adequate food. In addition, caregiver's lack of knowledge of nourishing food for elderly people resulting in malnutrition. Poor eating habits resulting from isolation and loneliness, or from untreated dental and medical problems result in inadequate food intake. Another factor is that in emergency situations, the elderly are given low priority in food distribution, both within families and

emergency or refugee situations. In most cases, special diets for health cases such as diabetes are not provided, further exacerbating health problems. Malnourishment increases susceptibility to diseases, and compounds severity of health disorders, particularly those that are deficiency-related (The UN 2002:43; HAI 2000:15; Dubazana 1989:39; Lekgetha and Robertson 1978:10;).

### 3.3.5 **Health of Elderly People**

Healthy elderly people reduce the financial burden on health care systems and family budgets. The the UN defines 'health' as a state of total physical, mental and social well-being (The UN 1998:25). Ageing processes lead to a high susceptibility to disease and disability. Common chronic diseases among elderly people, confirmed by various studies in different countries are: dementia, hypertension, cardiovascular problems, stroke, diabetes, depression, poor eye sight, hearing loss and HIV/AIDS (Kinsella 2000:544; HAI 2000:8; Brinkerhoff et al 1997:358; Weeks 1996:370-1; Nyanguru 1991:78). Healthier elderly people can live in their homes as long as possible and thus reduce financial expenses, cut down hospitalisation needs and long term care facility requirements.

UNFPA (1998:5) asserts that the health of elderly people depends on quality of available health care, income and living conditions, and health status in their earlier years. To reduce disabilities and disease in old age, the UN (1998:26) recommends a primary health care strategy, early diagnosis and

appropriate treatment, and preventive measures. Poverty negates early medical attention - lack of funds to pay for transport, health care and drugs, including low prioritisation of elderly needs in family budgets. A lack of drugs for chronic disorders such as diabetes leads to complications (HAI 2000:8,12). Based on studies in Zimbabwe, Wilson and Parsons (1991:111-113) recommend medical professionals use an interdisciplinary approach in dealing with hospitalised elderly. Such an approach necessitates understanding of the elderly's social context in which health breakdown occurs, communication with the family and liaison with community resources to support elderly people upon discharge.

Different kinds of disability require different responses regarding health care and social service providers. The ageing society therefore challenges state, communities and the family for adequate assessment and modes of care to meet the needs of elderly people, such as housing, transport, respite services and assistance with ADL (The UN 2002:9-10; Amosun and Reddy 1997:18; Weeks 1996:387). The UN advocates for active ageing for the elderly to remain healthy and economically active in communities. This entails developed countries and those in transition making innovative planning and policy reform. Most developing countries have yet to develop comprehensive policies to deal with demographic changes and changes in disease patterns, including HIV/AIDS, which negatively impact on state finance and individual well-being (The UN 2002:9).

The HIV/AIDS pandemic affects the physical, emotional, economic, and social well-being of elderly people. Its effects disrupt intergenerational transfers through reduction of social-economic support mechanisms to the elderly and those directly dependent on the sick (Knodel et al 2000:8). Therefore, the elderly in these countries are disproportionately impacted by the HIV/AIDS pandemic (The UN 2002:31; Knodel et al 2000:8-9,14; Adamchak 1989:174).

Furthermore, increasing deaths of young people due to AIDS deprive elderly people of future potential caregivers. A study in rural Uganda reports lament by the elderly that “we will be alone when we die” (William and Tumwekwase 1998:20). The elderly are not able to retire in old age but are forced into what has been termed “skipped generation parenting”, without basic resources to do so<sup>18</sup> (Ntozi and Zirimenya: 2002:14; Agyarko et. al 2000:1). Observations in Zimbabwe suggest cultural norm change in response to the care for HIV/AIDS orphans as responsibility is increasingly being taken up by the maternal relatives, rather than the paternal side (Knodel et al 2002:20). Repercussions for potential future elder caregivers on the paternal side are bound to change because children will bond and feel responsibility towards maternal foster grandparents. The UN urges Africa to support and address the vulnerability of older people, by developing

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<sup>18</sup> **Skipped generation parenting** refers to grandparents raising orphaned grandchildren when parents die. Households consist of grandparents and grandchildren (perhaps with other relatives) with a missing generation in between (Knodel et al 2002:14).

policies and programmes that will sustain elderly people in the new roles of care for the terminally ill and orphaned children (The UN 2002:31-32).

### 3.3.6 **Reduced and Changed Roles in Old Age**

Societies are stratified among other bases, according to age, and each age stratum is accorded rights and privileges. Roles of older people change upon retirement and for the majority, spheres of socialisation are reduced; new roles, mostly of low status may be taken up. Sometimes this leads younger people in society viewing them as non-participants in productive activity, and by implication deserving low priority in allocation of resources by both the state and the family (Wilson and Parsons 1991:111; Zimbardo et al 1995:160). However, the universality of retirement is challenged because in Africa, elderly people do not retire but continue to work until they are unable due to ill health or old age.

Furthermore, new roles taken up are not necessarily low status but are important and respected in society; and keep elderly people actively involved. Women's care-giving roles to their families continue in old age and keep them close to their families. For example, elderly women take on roles of childcare and domestic work around the home, relieving younger family members to carry out more strenuous work. Elderly men, particularly in rural areas tend domestic animals, or attend to other less strenuous work like shelling maize or beans, while some returned migrants take on informal trading. Lauer (1995:246) argues that the high levels of activity and

meaningful social interaction lead to healthier and happier aged people. It is necessary that planning for eldercare in any society should consider the elderly's new roles and provide for opportunity to participate in meaningful activities.

### **3.3.6.1 Meaningful Activities in Old Age**

Activity involvement has been found to be positively related to well-being. Elderly people need independence and being in control. They can be traumatised by the strain of orientation to new devalued roles, loss and reduced social arena, perceived neglect by society or being institutionalised (Riley and Waring 1976:383,379; Frogatt 1990:98). Most often, elderly people get discriminated against in the job market. However, unplanned or forced retirement with no alternative employment, such as through SAPS pushed by IMF, gives no chance for development of alternative hobbies and interests (Meiring and Blake 1984:659). The UN (2002:33) advocates volunteerism by older persons, not only to offer a meaningful activity but also as a mode of 'productive ageing'. Elderly people have a wealth of knowledge, expertise, skills, wisdom and human warmth of life experience that can be passed on to younger generations through voluntary participation; for example through teaching lessons in cultural heritage in schools. This is not possible because elderly people have no roles in the modern school classroom.



Elderly voluntary activities would keep the elderly engaged with society through the nonprofit sector, boost their sense of self-respect and innate value. Elderly people in developed countries undertake a lot of voluntary and charity work. The UN (2002:33) argues that elderly voluntarism can fill gaps that state and the market are unable to or are unwilling to fill. Depending on opportunity, elderly expertise and networks could be helpful in organisations (boost bridging social capital) especially at local levels (The UN 2002:33). Such involvement would lead to more independence, better health and well-being for the elderly, thereby easing the care burden on families, communities and the state. A concept of 'reciprocity' inherent in voluntary work, aided by elderly's continued involvement, may serve as a form of social security and help shift societal perception of older people being unproductive and dependants (op cit:34).

There are barriers to the elderly's continued participation in societal activities. For example, new office technologies and ageism in formal organisations; lack of information and opportunities to volunteer; and economic difficulties to access such opportunities. It is argued that more can be gained by providing social infrastructure, and some finance for mutual activities would allow the elderly to continue to be involved with other generations; as well as external links (op cit :34).

### 3.3.7 **Gender, Ageing and Elder Care**

According to the UN (2002:17) and the UNFPA (1998:7), there are 328 million women aged 60 years and older, and 265 million men. Longevity of women has had the consequence of feminisation of the old population. Women's particular vulnerabilities derive from their lifetime disadvantages leading them to multiple jeopardy (The UN 2002:17; HAI 2000:13; The UNFPA 1998:5). Women are more likely to be poor in old age, face a higher risk of illness and disability, and face discrimination and marginalisation more than men.

**Women's economic situation:** There are fewer opportunities open to women to earn and make savings and investments; more often than not, women earn less than men leading to less pension (except for universal social pension); social security systems supposed to cover older persons target wage earners but ignore domestic work and family care given by women. In developed countries where elderly derive financial support from formal pension systems, a widow may not receive as much pension or social security as her husband received before death (The UN 2002:18; UNFPA 1999:5; UNFPA 1998:7; HAI 2000:13; Apt 1998b:1, 6). In Africa, traditional gender arrangements dictate women's financial position to be mediated through their male partners (Apt 1998b:5). Many African cultural practices and legal systems discriminate against women, and accord them lower status. Inheritance systems favour sons, and in many cases widowhood means loss of property as control of assets may pass to a male relative. For

example, in the rural areas of northern Namibia, widows are chased back to their families of origin (LeBeau et al 2003). All of these factors perpetuate women's poverty in old age.

**Gender relations:** Stereotyping of women reinforces their disadvantaged position. Tonstol (2002:6) demonstrates the persistence of dismissive, contemptuous and hostile attitudes towards elderly women in contemporary Western setting. For example, derogatory colloquialisms such as 'old bag' are used to describe elderly women. In Africa, older women suffer because of myths held in communities: elderly women are accused of causing natural calamities such as poor weather or crop failure, resulting in abuse (HAI 2000:13; Brinkerhoff et al 1997:371-2). Studies by HelpAge International in Tanzania report on elderly women being ostracised because of accusations of witchcraft (HAI 2000:13).

Gender relations in later life, arising from social expectations of age-appropriate attitudes and roles reduce women's opportunities to live fuller lives in their communities. For example, the double standards of ageing perpetuates a hostile social climate towards elderly women as regards to female body attractiveness. Older women are driven to use creams and surgery to retain the decorum of society (Tonstol 2002:6). Further, experiences of old age between sexes and consequences for quality of life differ. For example, when widowed in older years, men are more likely to remarry or establish informal relationships soon after the loss of a spouse

(commonly with younger women) and receive social approval, whereas women would be scorned for such a decision, hence the tendency to remain single (Brinkerhoff et al 1977:360, 372; Giddens 1993:614; Apt 1998b:5-6).

**Women's Health:** Longevity of women has consequences on health as women tend to suffer more from chronic and disabling illnesses (The UN 2002:18). In addition, care-giving strains and stresses take their toll on female caregivers' health, more so with reduced numbers of female caregivers due to changing family structures and urbanisation with formal employment (The UN 2002:18; UNFPA 1998:5; Apt 1998b:1). It has been recognised that in both developed and developing countries, special health needs of older women have so far been neglected in policy (The UNFPA 1998:5; The UN 2002:19). In the case of Africa, Apt (1998:1) points out that the issue of gender and ageing is not yet fully addressed, even though women outlive men, and experience financial and cultural constraints which affect their quality of life as older persons. To set up an effective support system, the UN urges for the collection of more information to better understand connections between poverty, ageing and gender. This would help formulate proper policy responses to improve living conditions and economic security of women; improve health conditions; promote lifelong learning and well-being of caregivers and challenge stereotypes within communities (The UN 2002:19; Tout 1993:289).

### 3.3.8 **Housing and Living Environments for Old People**

A good living environment for older people becomes important as they age, hence adequate housing and a safe and enabling environment becomes a basic need for older people and their children (The UN 2002: 13; Lawton 1989:12; Viljoen 1989:86; Baltes and Reichart 1996:252). As people age, abilities, health, participation and other types of activities become more diverse. Simultaneously however, as they age from young old to oldest old, disabilities become more common, mobility and consequently access becomes more limited (The UN 2002:13-14). Therefore, the UN (2002:14) urges for the adoption of ‘ageing-in-place’<sup>19</sup> in policies to design elderly-friendly environments, including social integration as a fundamental and necessary element to enable elderly people to continue to participate in the social and economic life of their communities.

Architectural designs of houses should be elderly friendly and meet a variety of needs, and may require structural adaptation (e.g. for wheel chairs) as elderly get frailer. Similarly, when institutional care becomes necessary, designs should be elderly-friendly, adapted to be more domestic than institutional (Viljoen 1989:86). Family homes and institutional housing should have elderly-friendly furniture and fittings, and be spacious for assisted mobility aids (such as wheel chairs and walkers) without

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<sup>19</sup> Two complementary concepts are often used in designing and implementing policies for provision of a safe and enabling environment for older persons: **Active Ageing and Ageing-in-place**. Active ageing means remaining active as one grows older. Ageing-in-place is more specific to adequate housing and a safe and enabling environment (The UN 2002:14).

impediments to movement, such as stairs, small bathroom, toilet space or slippery floors. All of these remain unobtainable ideals in developing countries in their struggle to apportion scarce resources.

Nonetheless, implementation of ageing-in-place policies should keep other options open, for example changing housing for the older person, or co-residence with caregivers. Whereas issues of ageing-in-place cause more worry to adults in the ‘sandwich generation’<sup>20</sup> in developed countries, concerns in developing countries dwell more on the rapid process of ageing, where elderly live in unhealthy and precarious circumstances without basic needs. Rural dwellings mostly lack supportive architectural designs and elderly-friendly furniture and fittings. In addition, many elderly people live in informal ‘squatter’ settlements around urban centers and cities in the developing world. For example, a report on Namibia is that 9% of total households in the country are living in very precarious housing conditions (MoL 2002:8). Homelessness among elderly people is observed in many urban areas of developing countries; for example, homeless elderly living on the streets of Bamako city in Mali, Windhoek in Namibia and some Chinese cities (Brinkerhoff et al 1997:367; Adamchak 1989:169).

Furthermore, elderly needs are excluded from infrastructural designs of town planning in most developing countries (HAI 2000:14; The UN 2002:13).

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<sup>20</sup> A **sandwich generation** refers to three generations, adults sandwiched between caring roles for their elderly parents as well as their own young children.

Some of the elderly live in small structures in poor conditions but lack resources to improve them. Appropriate improvements to housing (such as design change and access to services) contribute to sustained activity levels of the elderly and thereby reduce their dependency (The UN 2002:14-15).

### 3.3.9 **Education, Information, Media and Elderly People**

Elderly people in developed countries are educated, have access to information for continuing education and self development, as well as opportunities to engage in societal activities. However, in developing countries, particularly in contemporary Africa, poor or no access to education in earlier life means many elderly people are illiterate, which is a major hindrance to access to modern knowledge and information. Consequently, many elderly people do not know their rights and get exploited. Furthermore, changes in official languages in some African countries after colonial rule presents a barrier to information and knowledge for the majority of the elderly. For example, Afrikaans was introduced in Namibia and many elderly people learned it. However, introduction of English after independence has been a problem to the elderly. Language barriers deprive the elderly of vital information, such as nutritional requirements, health and opportunities for self development. Older people continue to be excluded from skills development programmes (HAI 2000:5).

Providing elderly with knowledge and their continued involvement with society contributes to support functions for the elderly (Rosemayr 2001:12).

African elderly's generational skills (craft and cultural history) have become worthless because of their exclusion from the modern schoolroom that is tailored to western models. Apt and Grieco (1998:4) argue for the design of appropriate roles for older people into the curricula of Africa's young generation as a policy step that needs investigation. HelpAge Ghana is helping explore benefits and opportunities for integrating older persons into the modern Ghanaian schoolroom. Kenya has started programmes that provide for community influence over the educational syllabus (Apt and Grieco 1998:1,3), while in Mali, the elderly still have a role to play in education (Rosemayr 2001:10). Already, developed countries such as Australia have realised the importance of this need and have began recruitment of older persons back to schoolrooms as part of the educational team (Apt and Grieco 1998:1).

The media reflects and creates society's views. According to modernisation theory, dissemination of ideas and information is a feature of a modern society that heightens and encourages awareness in society (Webster 1990:54). The elderly in developed countries have access and benefit greatly from programmes and information through numerous forms of media. In developing countries, a combination of poverty, illiteracy, lack of radio, television and print media at the individual level, as well as poor infrastructure and services development at the state level exclude the elderly from media and information. For example, special programmes addressing the needs of the elderly, such as health, opportunities for volunteering and



gainful activities, including those that contribute to the support function are lacking (Rosenmayr 2001:10).

In many developing countries, the absence of programmes targeted at the elderly or about elderly issues is very apparent (HAI 2000:5; Hogg and Vaughan 1998:323; Dima 2001:74). Consequently, the elderly and in general, the public remain ignorant not only of the plight and rights of elderly people, but also vital caregiver information on elderly needs. Thus the elderly need information as much as other generations and barriers to information and the media should be broken. Education of elderly people and inclusion of their issues in social planning programmes serves as a support function that is good for elderly people and society as a whole.

#### 3.3.10 **Old People in Migration, Conflict and Emergency Situations.**

There is no safety net for elderly migrants and refugees in developing countries, but in developed countries, general conditions and services for elderly people may be relatively better.

**Conflict and emergency situations:** Many African countries are affected by conflicts, civil wars and natural disasters, resulting in the massive displacement of people. In situations of separation or dispersal of people, social disintegration occurs, decline in formal and informal support systems are eroded, housebound elderly people are left behind or fail to access essential services and food. For example, elderly face hardships in civil wars

in Liberia and Rwanda, floods in Mozambique in 2001 and Rundu in Namibia in 2003. The needs of those who take refuge in camps or safe havens are neglected in programmes. Most often, food provided may be unsuitable for elderly's digestive and dental requirements, harsh environmental conditions and lack of drugs for chronic diseases exacerbate health problems and lead to complications (The UN 2002:36; HAI 2000:12). Although no special services need be created for elderly people in emergency circumstances like those for children, appropriate planning should be made within existing programmes.

**Older migrants:** People usually migrate from rural to urban areas or from one country to another during younger years, mostly seeking employment and better lifestyles. Available data from the UN indicate a figure of 150 million people living permanently or temporarily outside their country of origin (The UN 2002:36). Migration changes family structures, especially the aged are left behind, creating gaps in support structures and production patterns (Apt 1996:37). Circulatory migration for development purposes is characteristic of Southern Africa, but European countries such as Sweden also have many labour migrants. Observations indicate that most migrants earn low wages, receive low or no benefits, and work with minimal safety or health protection (op cit). Such conditions negate savings for old age.

In addition, elderly migrants lack the social support networks of the extended family, with no alternative replacement. The elderly migrant's situation

becomes critical during illness or disability (Geiring and Blake 1984:659; the UN 2002:36). For example, some former contract workers who settled in different regions in Namibia and South Africa find themselves with no support should they become ill or disabled. The situation of international migrants depends on how they are integrated in the new country, those in developed countries are provided for through extension of social protection and pension rights; for example, the Finnish immigrants in Sweden receive pensions and are accorded appropriate state care in OAHs. For migrants in developing countries, Africa in particular, there are no state provisions and the family remains the ultimate safety net. Adamchack (1989:170) reports that in Zimbabwe, perhaps 10% to 20% of elderly people either migrated from Zambia, Malawi or Mozambique, and many do not have the extended family network that native-born Zimbabweans do, nor do they have communal land rights. Hence, the UN (2002:36) urges that efforts to assist older and poor people should cover elderly migrants as well, since the all elderly experience similar problems of the ageing process.

### 3.3.11 **Social Policy and Elderly Welfare and Care**

Social welfare ranges from public assistance to various forms of relief during hardships, and covers pension rights. However, services under most schemes may be covered by pieces of legislation which specify beneficiary groups but exclude elderly people (HAI 2000:16). According to Apt (1998a:2), policy actions on elder care vary and require specificities on regional and national levels. In developed countries, specific policies for elder care form part of

the overall social services in each country. Many developing countries do not have an information generation system to support realistic policy formulation and related programmes. In most cases, the countries lack an integrated social welfare policy covering elderly people regarding elderly services; information dissemination; gerontological health care and caregiver training.

Welfare systems applied in most of Africa have ignored traditional mechanisms that sustained families and communities. In sub-Saharan Africa, only Mauritius, Seychelles, South Africa, Namibia and Botswana provide universal non-contributory social pension (Adamchak 1989:171). In some cases, stringent regulation deny some elderly access to basic needs, for example studies in Botswana indicate how harsh regulations bar some destitute elderly people from getting basic food (Ingstad 1994:38). Further, adoption of SAPS with a cost sharing component forces elderly in many African countries to pay for services originally given free, and are deprived if they fail to pay (Kaseke 2000:16).

In sub-Saharan Africa, rural-urban disparities in elder care services are perpetuated by governments' tendency to concentrate development in urban areas, with resultant wide disparities of social and economic infrastructure (Apt 1998b:3). Furthermore, between urban and rural areas, the elderly are a vulnerable social group who are, to varying degrees, dependent on others for economic and social support. Despite this dependence, the elderly, as a

group takes low priority in allocation of resources in state and family budgeting. Increasing numbers in this group exacerbates its vulnerability (Wilson and Parsons 1991:111). Hence, researchers recommend various policy actions including empowerment of the family and revival and support of traditional support structures. Family empowerment takes various forms including caregiver training and incentives (Adamchak 1989:172; Apt 1998a:3; Madzingira 1997:17). An updated information system on the dynamics of the family and the elderly situations should form a basis for formulation of effective eldercare policies<sup>21</sup> (Ardington 1989:62-64; The UN 2002:43).

Social policy makers formulate strategies based on some concepts to target different groups in society, including the elderly. For example, provision of elderly services through a welfare state system; strategies to mobilise social capital in communities; involvement of NGOs in elderly care and privatisation of eldercare services.

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<sup>21</sup> To provide a valid base for national policies, data should be drawn from all communities within national borders, not particular groups. Information gathered beyond national boundaries may be irrelevant and obscure issues being investigated. Sampling should be based on the total population applicable so as to assess overall effectiveness of the system (Ardington 1989:62).

### 3.3.11.1 Some Concepts in Social Policy Strategies

**‘Welfare state’** is a term that emerged in the 1940s<sup>22</sup> describing situations where the state bears a major responsibility for welfare provision to citizens through social security systems, providing services and benefits to meet people’s needs (Olsson 1993:17; Pierson 1991:102). Welfare may be severally defined, to mean ‘wellbeing’, but also refers to a range of services provided for protection of people in different conditions, e.g. childhood, sickness, disability or old age. Thus welfarism is an ideology committed to caring for the elderly and other groups in need. However, welfare goes beyond meeting needs to embody people’s choices and the scope to achieve personal goals and ambitions. Although social policy in developed countries incorporates state provision of welfare to elderly people, poverty in developing countries impedes comprehensive state welfare provision to elderly people and other groups in the population.

**The concept of Social Capital** derives from an attempt to introduce better social thinking into Economics. The concept describe types of relations that exist between individuals in both families and communities. It also refers to stocks of social trust and reciprocity, norms and networks in communities (Cavaye 2000:2; Van der Linden 2002; Putnam 1993). These stocks may be mobilised to provide better or continuing welfare to elderly people

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<sup>22</sup> The origins of various measures of social insurance date back to 1880s in Europe (Pierson 1991:107).

in society<sup>23</sup>. (Cavaye 2000:2,7). Social capital is identified at two levels: one concerning bonding networks within communities and the other bridging links between different groups. Bonding social capital is referred to as the trust and mutual support of insiders of a group. Bridging social capital makes linkages between different groups to draw resources from other networks; and is important for getting ahead, creating new opportunities and growth. Both levels of social capital are needed, and can be viewed as part of an individual or household stock of resources, for example, asking a friend to complete a pension claim form (Onyx 2001:3-4). Social capital holds potential for informal social networks to substitute for government's failure or inability, that is, promoting welfare in the absence of public services (Rose 2000:1-2; Onyx 2001:5).

It is necessary to know the homogeneous form of social capital based on racial, class and ethnic ties, especially in multi-ethnic/multiracial societies such as Namibia. Such knowledge would enable harnessing of broader linkages across these boundaries, and focus design of policy and institutional partnerships to provide needed support. According to Carmen and Friedland (1995:2) church congregational-based organisations can mobilise stocks of social capital across denominations and sometimes across racial and ethnic lines (Cavaye 2000:3, 13-14, 17; Carmen and Friedland 1995:1; SCIG 2000:585).

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<sup>23</sup> Examples of capital are: Physical such as buildings, equipment; Financial which is money; Human such as abilities, skills and leadership. although education enhances human capital, people with little formal education can have considerable human capital (Cavaye 2000:2).

**Non-Governmental Organisations (NGOs)** is a term which in Europe and North America refers to nonprofit organisations active in Third World development and international politics (Anheier, 2002:1). NGOs play a large role in social welfare services, including elderly welfare. NGOs hold a potential to fill gaps in provision of elderly care services that are left by government (Anheier 2002:2-3; Ueno 1998:2; Gidron, Kramer and Salamon 1992:19, 24). NGOs take on different forms in different national settings, reflecting differences in cultural traditions, legal structures and political histories (Gidron, Kramer and Salamon 1992:2). African experiences show that in many instances, externally funded NGOs often impose their own direction on development programmes which are at times inappropriate to local settings. Effectiveness of locally funded NGOs in many developing countries, including Namibia, is perpetually constrained and curtailed by prevalence of poverty in communities.

**Privatisation of Elder Care Services** refers to strategies that involve the private sector in the provision of services to elderly people. This involves the state contracting private service providers to deliver services to the elderly. Globalisation and economic change have imposed economic strain on developed countries in recent years, leading to policy reforms, such as privatisation and marketisation of a number of elderly care services (Palme et al 2002:71-78; Kenji 2001:2).



In developing countries, provision of elder care is mainly informal, with the state mainly providing health care services. However, in the few countries which pay universal social pensions to elderly people, for example Namibia and South Africa, distribution of pensions has been privatised and contracted to service providers, albeit not so efficient. Privatisation of elderly care services bears inherent potential for abuse, both in the quality of service provided and susceptibility to malpractices by company and government employees (Ueno 1998:1). Examples of elder abuse scandals by private service providers have been reported in both developed and developing countries, for example, in the Lex Sara<sup>24</sup> scandal in Sweden, the elderly's hygiene was neglected so as to cut costs (Fog pers. comm. 2003); and poor administration of social pension distribution in Namibia and South Africa (*The Namibian* 2001);<sup>25</sup> Ardington 1989:70). For these reasons policy controls have to be put in the service system for prevention and early detection of elder abuse by NGOs and private service providers.

A case study of a specific developed and modern country may be used to draw some lessons and comparisons for developing countries such as Namibia.

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<sup>24</sup> Inadequate controls in the system resulted in serious elder abuse reported in the cities of Stockholm and Malmo. Lex was an employee who revealed the abuses and resultant legislation was named after her (Fog pers. comm. 2003).

<sup>25</sup> *The Namibian* Newspaper has reported numerous elderly people's complaints about delays of payments and cancellation of paydays by contracted companies, such as the United Africa Namibia and its predecessor Cash Payment Services (*The Namibian*, 3<sup>rd</sup> March, 10<sup>th</sup> March, 13<sup>th</sup> March, and 15<sup>th</sup> March 2001; and NBC TV News 23<sup>rd</sup> March 2001).

### **3.4 Case Study: The Swedish Experience**

Sweden is a developed country with one of the oldest populations that has built an exemplary welfare state system, comprising various institutional settings for elderly care. The country reviewed its social policies to adjust to a different demographic and economic situation in the 1990s.

Sweden is a country with a diversified economy and an advanced industrial structure, that has for a long time been known as an archetype of welfare system in the developed world. Sweden has a population of 8.8 million people, of which 17.4% is aged 65 years and older. Almost 5% of the aged are 80 years and older (Johansson 2000:1). Longevity at birth is 81.9 years for women and 76.9 years for men. Despite improving health and longevity of the Swedish population, the 80 years and older still constitute a problematic group to care for, even under welfarism. Other developed countries such as Germany and Denmark also report similar experiences (Korpi 1995:269; Palme et al. 2002:76).

#### **3.4.1 Swedish Social Policy on Elderly Welfare**

Sweden's social policy is distributive, it equalises incomes according to family commitments and working capacity between different periods of people's lives (Socialstyrelsen:1997:11) The central tenet of the policy on elderly care is to guarantee that the elderly have financial security, adequate housing, social services and health care according to needs. In principle, policy context provides for equity in the provision of care, regardless of sex,

age, ethnicity, place of residence or purchasing power.<sup>26</sup> (Johansson 2000:1). Official policy has been to enable the elderly live in their own homes for as long as possible. Local government at municipality and council levels<sup>27</sup> are mandated to implement the policy following five steps:

- (i) to improve health and ability to cope with Activities of Daily Living (ADL)<sup>28</sup>,
- (ii) to improve the physical and social environment of the elderly, for example to adapt homes for wheel chair access, subsidised taxi services, to provide meals on wheels, provide and check apartment safety alarms, and perform telephone contacts by social workers,
- (iii) to provide home healthcare through district nurses and physicians, podiatric and hair care services; and social and economic support to informal caregivers by providing day care units, centers for training and leisure activities, relief and respite units, and social insurance payments.

These strategies take into consideration the overall condition of elderly people in Sweden.

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<sup>26</sup> Equalisation between childless and child families, young people with low incomes and middle aged with large incomes, and between economically active and pensioners.

<sup>27</sup> There are 21 County Councils and 289 municipalities in Sweden. County Councils implement health care while municipalities are responsible for social services.

<sup>28</sup> **ADL** include bathing, dressing, cooking, cleaning, and walking (Reich & Mathews 1982:33).

### 3.4.2 Conditions of the Elderly in Sweden

**Social Conditions:** Social conditions refer to relationships to family regarding care. A common feature in developed countries, Sweden inclusive, are high levels of divorce and remarriage. Remarriage creates complicated family structures, with children in a family having mixed parentage. According to Korpi (1995:248) this has relevance for future patterns of informal care for the elderly. Elderly co-residence with children is only 4% but 40-60% of the elderly have regular contact with their adult children. The reserve of informal caregivers is small because the majority of women work in the public sector (Johansson 2000:12; Korpi 1995:249). This creates a need for social ties at the individual level – that is social support and social networks.<sup>29</sup>

**Health Conditions:** Systematic surveys on various health aspects carried out in Sweden indicate that elderly Swedes are healthier than in prior decades, implying that the elderly will have fewer years of severe health problems, although those aged 75 years and older need and use more health care services (Korpi 1995:252).

**Economic Conditions:** The economic position of elderly Swedes to a large extent is determined by the pension system (Olsen 1999:6; Korpi 1995:245).

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<sup>29</sup> **Social support** refers to having close people who can provide help, encouragement and support when necessary. One indicator of social support is having a close friend in whom one can confide freely. **Social networks** refer to the existence and structure of the relationships and ties with other people, also referred to as an aspect of ‘bridging social capital’. Weak social networks relate to limited contact with family and friends outside elderly’s own household (Palme et al 2002:46; Onyx 2001:4).

Sweden pays a basic pension from 65 years. Poverty among the elderly in Sweden has virtually been eliminated, reflecting improvements in the pension system since World War II.<sup>30</sup> Fewer elderly Swedes experience financial difficulties, because those with low incomes get subsidised by the welfare system. Although private pensions remain few, Sweden, like other OECD countries, has restructured its pension system and tied it to the market.

The situation of elderly people affects conditions and possibilities for policies on patterns of care for the aged. As in other developed countries, elderly care in Sweden is provided through two patterns of formal care: Home Help and Institutional Living.

### **3.4.3 Patterns of Elderly Care in Sweden**

(i) **Public home help:** Public home help services cover both health and social care. Social care for elderly people may be either formal through public funding or informal care given by family members or other relatives. Home help care services enable the elderly to remain in their homes as long as possible; and institutional living is provided for those who can no longer live at home (Korpi 1995:246-7, 254; Palme et al 2002:76).<sup>31</sup> Due to

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<sup>30</sup> **Relative poverty** is often defined at 50% median income. Basic pensions have increased since 1948 as well as earnings related to pensions introduced in 1958, these combined to lift all pensioners out of poverty.

<sup>31</sup> Estimates for 75 to 84 year olds was 600 000; and for those 85 years and older it was 200 000 (Palme et al 2000:76).

longevity and the tendency to live alone, more women than men receive public home help services (Korpi 1995:259-260)<sup>32</sup>.

Initially, the bulk of caregiver employees comprised of women with only housewife competence, but the occupation was later professionalised through training in basic care offered at high school level and through adult training programmes (Omvårdnadsprogrammet 2000:65).

Receipt of public home help is means-tested and dependent on the recipient's need, but it is targeted at those who are 80 years and older, who actually utilise the highest number of hours (Korpi 1995:261, Gustavsson pers. comm..2003). Services cover hygiene and ADL. Critiques perceive home help services as being task-oriented with little attention to emotional and social needs of the elderly. In addition, problems of equity have been experienced due to increased user fees coupled with service cutbacks, primarily affecting female and less educated elderly people (Korpi 1995:271; Szebehely 1995:285-6; Leckström pers. comm. 2003; Gustavsson pers. comm. 2003).

**Informal home care by relatives:** As in other countries, informal care for the elderly by relatives (spouse, kin, friends and neighbours) forms the largest part of social care and is estimated to be two to three times that of formal public care. Therefore the state provides caregiver support for

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<sup>32</sup> In 1992 almost two thirds of home help clients were 80 years or older and about 80% of recipients lived alone (Korpi 1995:259-260).

informal care in three ways: economic support, respite care, as well as counselling and personal support (Korpi 1995:262; Johansson 2000:4).

Economic support can be 'tax-free attendance allowance' paid to an elderly to pass on to the caregiver or a 'taxable care allowance' with social security protection paid to caregivers below 65 years. The support can also be 'care-leave' (time off work) for 60 days of care, compensated to a caregiver from national social security insurance. Respite care is both institutional and in-home.<sup>33</sup>, aided by 'Adult day care centres' and extra services from municipalities to enable caregivers to take time off. 'Support groups' commonly provided by NGOs may offer counselling services regularly or occasionally; and mostly target families caring for dementia afflicted elderly. Subsidised taxi service is accessible from 65 years, and is provided on a doctor's certification for inability to use normal public transportation service.

#### **(ii) Institutional Elderly Care**

Elder care institutions in Sweden target those 80 years and older. These include: assisted living in service apartments, group living, nursing homes, OAHs and 'long term hospital care' in geriatric wards. In assisted living, elderly people can rent self-contained service housing apartments, with facilities of a restaurant, activity rooms, a nurse and other personnel. Current trends favour small group living institutions catering for seven to eight

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<sup>33</sup> 6282 beds, almost 5% of institutional beds were reserved for respite care in 1997 (Johansson 2000:4).

persons and situated within residential areas. OAHs are means-tested, offer full board but they present a regimented character, unlike normal family living. OAHs construction in Sweden stopped from 1980s. Nursing homes and geriatric wards have declined in numbers, and on average have 55 beds per home. There are few private nursing homes but these also have to be certified and supervised by municipalities.

Institutional care poses several challenges such as:

- A need for flexibility of institutions to meet high probable ‘needs-change’ among elderly, presents a problem that requires flexibility of institutions.
- The cost of operating elderly care institutions is high,
- Institutions face problems of staff shortage (Korpi 1995:271; Palme et al 2002:78; Gunner pers. comm. 2003).
- Increasing numbers of immigrants who are not fluent in Swedish present particular problems not yet addressed by policy initiative. For example, the phenomena of second language loss among the elderly as they get older complicates the help situation (Winman pers. comm.. 2003; Kranberg pers. comm. 2003). Economic strain in the 1990s compelled Sweden to reform economic and social policies and to formulate new strategies in all patterns of elderly care.



### **3.4.4 Sweden's New Elderly Care Strategies from mid-1990s**

The cost of welfare programmes is influenced not only by legislation but also demographic factors, the economy and changes in ideology. Re-orientation of social policy on elderly care in the 1990s prompted policy makers to devise new strategies in eldercare. The new strategies involved structural changes, involvement of the nonprofit sector and privatisation of elderly welfare services.

#### **(a) New structural changes**

Through the 'Ådel Reform', political, financial and administrative responsibilities were decentralised, with more responsibility delegated to municipalities. The major aim of these strategies was consolidation of caring and efficient use of resources (Palme et al 2002:115; Johansson 2000:5, Olsen 1999:6; Korpi 1995:272).

#### **(b) Involvement of the Nonprofit Sector in Sweden's elder care system**

The difficult economic situation and pressures on state budget have contributed to a shift in articulation of the voluntary sector in new ideological ways. The implication of the shift is that NGOs hold potential capacity for service provision (Wijkstrom 1997:213). Nonprofit sector involvement in elderly care services draws from high associational membership among the Swedes<sup>34</sup> (Grassman and Svedberg 1996:419-420,

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<sup>34</sup> 150 000 membership organizations to 8.8 million people makes an average Swede belong to at least three organisations.

424-5; Red Cross pers. comm. 2003). Further, rural Sweden, in particular northern and western areas, are faced with high levels of economic decline, but manage to maintain services through a tradition of social capital mobilisation (Bertgström and Fog 1996:3). In these areas, municipalities consult community organisations before undertaking social planning (op cit).

Pensioners' organisations such as PRO and Svriges Pensionersförbund (SPF) are active lobbyists and opinion makers and therefore influence policy in favour of their members (SPF Vänersborg pers. comm. 2003; Grassman and Svedberg 1996:419). On the whole, NGOs in Sweden undertake activities and fill elder care roles that lie beyond the reach of the welfare state, and tend to pioneer and pinpoint new problem areas in society or steer awareness of different groups in needy situations.

**(c) Privatisation and marketisation of elder care services**

Involvement of the private sector meant that not only the elderly but also municipalities had to turn to the market to contract service providers for home help services, although some municipalities are more active at privatisation than others (Palme et al 20002:71-78; Gunner pers. comm 2003). However, privatisation or marketisation of eldercare services in Sweden has not totally disengaged the public sector as has happened in other

countries such as the United Kingdom or Australia.<sup>35</sup> (Kenji 2001:2). However, critiques of privatisation, point out the quest of private companies for cost-cuts that hold potential for reduction in service quality (Fog pers. comm. 2003, Gustavsson pers. comm. 2003; Kranberg pers. comm. 2003).

Some dilemmas in the formal care giving discourse include division of responsibility between state and family, targeting services in care amid shrinking resources and how to determine effective caregiver support. However, Sweden is continuously searching for alternative forms of handling problems of elderly care (Korpi 1995:272). Developing countries such as Namibia, can draw lessons from the Swedish experience.

### **3.5 Eldercare in Namibia**

Traditionally, the family in Namibia has always carried out the role of elderly care, and continues to do so especially among indigenous communities, despite erosion by modernisation. Institutional care is more common among white communities but very minimal among indigenous communities and restricted to urban centres.

The Namibian Constitution defines the family as “the natural and fundamental group unit of society” (GRN 1998:12). To understand the family sociologically in contemporary Namibia so as to assess its ability to

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<sup>35</sup> Contract-based activities in total social services reached 10% in 1998 and continued to rise the following year.

provide care for the elderly requires consideration of the changing factors in the society. The Namibian government acknowledges that the extended family has been subjected to erosion. The eroding factors include displacement of communities during the colonial era, social changes due to urbanisation, migration and high levels of poverty. These factors have reduced the ability of the family to care for its elderly people. There are no new social support mechanisms to fill the gap being left by the family (NPC 1995; MoHSS 1998). Winterfeldt ( in Winterfeldt et al 2002:68) observes that rural-urban migration has resulted in the development of new values with the urbanised groups feeling much more western and metropolitan. The impact of change has resulted in the concept of family being used synonymously with 'household' to operationalise it in Namibian research (Winterfeldt and Fox 2002:161-164). Further, the Namibian family is being transformed by a variation in family structures. For example, increasing numbers of Female-Headed Households (FHHs) and single parent families have a high likelihood of being poor (op cit).

It is within the transformed family setting that elderly people in Namibia have to be cared for, hence an analysis of their social and economic conditions becomes necessary.

### **3.5.1 Conditions of the Elderly in Namibia**

Since there have been no specific studies on Namibia's elderly population, conditions of elderly people in Namibia may be grouped into two categories: social and economic conditions.

#### **3.5.1.1 Social Conditions of the Elderly in Namibia**

Social conditions of elderly people refer to relationships to family with regards to care and support. Family relationships are particularly important for policy in Namibia because elder care largely remains a responsibility of the family in both rural and urban areas. Almost all elderly people have children, and tend to live with other extended family members in the household (average of 5.1 people per household) (NPC 2003:v). However, migration and urbanisation have not only restructured the Namibian family, but have also contributed to the transformation of gender relations, with women taking on increased roles in rural households. High proportions of rural-urban migrants are unemployed, with many migrants living in informal squatter settlements and thereby cannot financially support elderly parents. Inequalities in the Namibian society mean that elderly care is not equal among communities, with households of whites having economic advantage and thereby being better equipped to support elderly members than those in most indigenous communities (Steintz 1998:4).

**Health of Elderly Namibians:** Elderly Namibians suffer from health problems common among other elderly people elsewhere in Africa, such as

Zimbabwe and South Africa. Ailments include cardiac problems and stroke, hypertension, sight and hearing problems, diabetes and arthritis, to cite a few (Nyanguru 1991:78; Dima 2001:51). In Namibia, the state provides free medical attention to all elderly people at government health facilities, but elderly pay a minimal fee for medication (currently N\$ 15.00). However, high prevalence of HIV/AIDS-related deaths, especially in the northern rural areas of Namibia, continue to render a heavy burden on elderly people.

Furthermore, the elderly are losing physical and economic support from their dying children, and are increasingly taking on the role of caring for orphaned grandchildren. In most cases the only income to support orphaned children is the elderly person's social pension. At the same time, the ability of families to support their elderly members is being reduced by the high expense involved in caring for HIV/AIDS sufferers (Abate et al 2003:1). HIV/AIDS and its impact specifically on the elderly in Namibia is an area that has so far not been researched on. However, the government recognises an increased pressure on elderly people resulting from the burden of caring for the sick and upbringing of orphaned grandchildren brought about by increased HIV/AIDS deaths.

**Institutionalisation of the Elderly in Namibia:** The concept of elder care institutions is new to indigenous communities and only a minority of elderly people in urban areas reside in them. There are twenty four (24) OAHs in Namibia, all privately operated by associations and churches; and with the

exception of only two, they are all located in urban areas. However, there are no OAHs in the north and north-eastern regions of Namibia (among the Owambo, Kavango and Caprivi), despite hosting the country's highest population density. OAHs occupied by white elderly have specialised facilities, such as frail care units, and provide excellent services justified by high costs. On the other hand, those OAHs occupied by indigenous elderly people lack elderly friendly architectural designs and adequate services. However occupancy fees of these OAHs are very low and payable from social pensions, thus contributing little to service improvement (Dima 2001:37-41).

Churches play a significant role in elderly welfare and care, either through specific programmes or through ministries to elderly people within their congregations. Significantly, whites constitute the majority of residents in Namibia's OAHs, both in absolute terms and percentage basis (Steinitz 1998:3). Contributing factors for the higher numbers of white elderly include:

- The fact that colonial administration favoured whites in service provision for the elderly in white neighbourhoods,
- The general ambiance of OAHs' (language spoken, foods served and cultural atmosphere) may not attract indigenous elderly,
- High costs,

- prohibition of multigenerational households generally preferred by indigenous groups, and
- colonial laws and regulations still in force

All of these factors challenge racial integration in OAHs. In addition, whites live longer perhaps due to access to better healthcare; tend to have fewer children and live alone or in single-generation households; which add to their dependency on institutional services (Steinitz 1998:3).

#### 3.5.1.2 **Economic Conditions of the Elderly in Namibia**

Namibian society is characterised by extreme inequalities within different racial and ethnic groups. A minority group comprising of 5% white communities earn more than five times the average income (Namibia's *per capita* income N\$ 3 608), while half the population survives on approximately 10% of the average income (UNHDR 1999:8). The ratio of *per capita* income between the top 5% and bottom 50% is approximately 50:1 (op cit). These inequalities are reflected in a high prevalence of poverty among indigenous communities. The implication of these inequalities is that the majority of elderly people are poor, and many families and communities can barely extend appropriate and sufficient support to their elderly members.



### **Old Age Social Pensions**

Namibia is one of the five countries in sub-Saharan Africa that provide a non contributory social pension to all persons 60 years and older<sup>36</sup>. Before independence, terms of employment for indigenous Namibians excluded pension provisions and thus disadvantaged current elderly citizens in their active years. Payment of racially-determined social pensions in Namibia dated back to 1948 and was inherited at independence. However, the social pension was restructured and equalised for all elderly people, and currently an amount of N\$ 250 per month<sup>37</sup> is paid to 108 423 social pensioners (MoHSS 2003:7). Although coverage reached 83% of eligible elderly in 1994, the amount remains inadequate and out of line with inflationary rates in Namibia. Distribution of social pensions was privatised in 1996 but is plagued by mismanagement by contracted private service providers (*The Namibian* March 3<sup>rd</sup> ; 15<sup>th</sup> 2001; NPC 1995:343).

To the majority of elderly Namibians, especially women, the social pension is the first formal earning in their lives and greatly enhances their status. As in South Africa, social pensions in Namibia provide the only source of income supporting many intergenerational households (MoL 2002:8; Devereux 2003:3; NPC 1998:348). In the Namibian 2001 census, 11% of 346 455 households reported 'pension' as the main source of income.

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<sup>36</sup> Other countries are South Africa, Seychelles and Mauritius and Botswana (Adamchak 1989; NPC 1995, 1999:385).

<sup>37</sup> In the last week of October 2003, an increase of 20% was approved by Parliament through a Supplementary Budget for 2003, raising the social pension to N\$ 300 per month from January 2004.

However, the proportion is closer to 12% in rural areas where many elderly people reside (NPC 2003:4). Competition over the control of the elderly social pension funds has in some cases resulted in elder abuse (*The Namibian* 2002:1).

### **Elder Abuse in Namibia**

The MoHSS defines elder abuse in relation to an older person as the “maltreatment of such a person or the infliction of any physical, mental or financial power on such a person which adversely affects that person” (MoHSS 2002:3). Elderly abuse exists in Namibian society, and extreme cases have appeared in the press regarding theft of property and assets, but most abuse allegedly involves the elderly person’s pension funds. Reports of assault and murder of some elderly people by relatives and other people intermittently appear in the press (*The Namibian* 20<sup>th</sup> January 2002; 28<sup>th</sup> February/1/2002). In addition, widows in northern Namibian communities lose property to the deceased husband’s relatives due to cultural practices.

### **3.5.2 Social Policy and Elderly Welfare in Namibia**

Since independence, elderly welfare and care has continued to be guided by a colonial Act – The Aged Persons Act No. 81 of 1967, and Regulations R 3 759 of 21<sup>st</sup> November 1967, both as amended. This Act focuses on institutional care as the mode of continuing care for elderly people in Namibia.

Current government support for the elderly in the social assistance system covers social pensions administered through the National Pensions Act (No.10 of 1992), special accommodation for older people at reduced rates (sub-economic housing); a funeral benefit scheme of up to N\$ 2 000 that includes the cost of a coffin for N\$ 700; and foster-parent allowance that can be claimed by elderly people caring for orphans (MoHSS 2003). There are 24 OAHs almost all privately operated and 350 low-rent flats administered by the government countrywide (MoHSS 2002:5). Guidelines for the establishment and operation of OAHs and charitable welfare organisations are stipulated in the Act. Several charitable welfare organisations also provide services to elderly people, although the majority operate in urban areas. However, in many ways the Act is inappropriate and there are gaps that can only be filled by revising the Act.

### **3.5.2.1 Weaknesses of the Current Elder Care Policy**

OAHs that meet the set criteria contained in the Act receive a financial subsidy from the government towards operation costs. The OAHs that actually need such a subsidy are excluded because they do not meet the set standards. This perpetuates inequality in services to elderly people even after thirteen years of independence.

Due to the apartheid system the general situation is that the social welfare policy, and to some extent that of older NGOs, was developed targeting white elderly, excluding specific problems of indigenous elderly people.

The necessity for equality of services between racial groups led to extension of the policy developed for whites to indigenous ethnic groups, but not necessarily with all financial implications. Therefore it was a response to political pressure and not to specific problems. For example, only OAHs that meet standards set under former white administration continue to benefit from government subsidies. Furthermore, payment of subsidies for utilities for elderly people living in special accommodation excludes elderly people living in their own homes. Many of these elderly are still paying mortgages for their houses, some of which lack maintenance due to lack of adequate funds. Support through foster-parent grants to the elderly raising orphans is almost inaccessible due to stringent regulations and outdated bureaucratic procedures involved in processing the grants. Elderly people in other countries have similar experiences, for example in South Africa social policies targeted problems of the white elderly only and excluded black the elderly (Ardington 1989:66; Viljeon 1989:86).

Furthermore, no studies were found to have been undertaken to assess the conditions of the elderly in Namibia. The implication is that little is known about the general situation of elderly people in different parts of the country, especially in rural areas.

### **3.6 Summary of literature**

In summary, social research and the study of old age indicates that ageing is taking place in all societies, including Namibia. There is a convergence of experiences of old age among all elderly people. However, philosophies and approaches to care differ in developed and developing countries but the latter can benefit from the experience of the former. The situation of elderly people and elderly care in Namibia has been presented and placed in perspective for the empirical study.

## **CHAPTER 4**

### **A NEW EMPIRICAL STUDY OF ELDER CARE IN NAMIBIA: METHODOLOGY**

#### **4.1 Introduction**

The research involved a comprehensive literature study on social research and studies on old age, with a case study of the care of the elderly in Sweden; as well as an empirical field research study. This chapter presents a profile of the research area; and describes the methodology used in the empirical research; the type of data; the data admissibility criteria; methods and tools for the research; sampling frame and sampling design; data collection methods and data analysis. Limitations during the study, followed by validity of elderly people's answers are stated at the end of this chapter.

#### **4.2 Analysis of social research**

The extensive literature study undertaken involved a review of the theories on ageing and an analysis of social research and studies of old age. Various approaches to elderly welfare and care were examined, covering both developed and developing countries, with an emphasis on Africa. Diversity and convergence of factors that generally affect old people in all societies were analysed. A case study of the Swedish experience on care of the elderly was compiled while based at University of Trollhattan/Uddevalla (HTU) in Sweden from January to May 2003. For Namibia, a critical review of government reports, documentation on the situation of elderly people and

the Draft Bill for the protection and care of the elderly, were reviewed. The reviewed literature created a basis to place the empirical study in a broad context of research on the care for elderly people in an ageing world, and to select appropriate methods of sampling and data collection for the empirical study.

#### 4.3 **Methodology for Empirical Study**

An empirical research was conducted in four regions of Namibia – Erongo, Khomas, Kunene and Otjozondjupa, between June 2002 and December 2002. Supplementary data were collected during June 2003. The study involved interviews and a Questionnaire survey. The sample was stratified into two, 50% covering the elderly in OAHs and 50% covering the elderly living outside OAHs (either with families, on their own or homeless on the streets). The strata for OAHs covered fourteen OAHs: five OAHs in Khomas, two OAHs in Otjozondjupa, six OAHs in Erongo and one OAH in Kunene region.

According to the 2001 population census, the four regions have a total population of 562 004 people with the population of those 60 years and older ranging between 4% in the Khomas Region, to 7% in the Kunene Region (NPC 2003:4,10-11, 17). A statistical profile of the research regions is presented in Table 1 below.

**Table 1: Statistical Matrix Of the Research Regions**

| Region       | Population | Population<br>60 yrs +<br>% | No of<br>Hseholds | Av.<br>Hsehold | Pension as<br>Main<br>income % | Urban/<br>Rural<br>% |    |
|--------------|------------|-----------------------------|-------------------|----------------|--------------------------------|----------------------|----|
| Khomas       | 250 262    | 4                           | 58 580            | 13.8           | 4.2                            | 93                   | 7  |
| Otjozondjupa | 135 384    | 5                           | 25 338            | 6.6            | 4.6                            | 41                   | 59 |
| Erongo       | 107 663    | 6                           | 27 496            | 5.8            | 3.8                            | 80                   | 20 |
| Kunene       | 68 735     | 7                           | 12 489            | 3.7            | 5.3                            | 25                   | 75 |
| Total        | 562 004    |                             | 123 903           |                |                                |                      |    |

Source: 2001 Population and Housing Census ( NPC 2003:6, 10-11, 17).

#### **4.3.1 Type of Data and Admissibility Criteria**

Qualitative and quantitative data were collected in this study. The criteria for admissibility of data was that a questionnaire was only valid if all the questions were answered correctly. For qualitative data to be valid each informant had to complete the interview.

#### **4.3.2 Research Methods and Tools**

Three research methods were used in this study. Key informant interviews and case studies with elderly people to collect qualitative data; and a Questionnaire to collect quantitative data. Key informant interviews method was selected to collect in-depth data from key informants and elderly people. According to Punch (1999:243) such data has the capacity to explain the complexity of social phenomena. The data thus support and augment quantitative data. Unstructured interviews were conducted using a set of guideline questions relating to problems associated with caring for elderly people in home and institutional environments; social and financial



implications of elderly care; and views on what model of institutional care would be appropriate for Namibia (Appendix I and III). In addition, the researcher made personal observations on the physical environment each elderly person lives in. The behaviour towards the researcher, and additional comments made by some elderly respondents were also noted.

Quantitative method was selected to represent a big number of elderly people from inside and outside OAHs. The sample was drawn from Windhoek, Okahandja, Swakopmund, Walvis Bay, Okombahe and Khorixas, totalling 238 respondents. One type of questionnaire targeted elderly people living inside and outside OAHs. The questionnaire contained 47 pre-coded and close-ended questions, except three which were open-ended. The questions were designed to obtain a profile of respondents and to establish their views on the model of institutional care they would prefer. Thus some questions in Likert-scale aimed to assess the respondents' attitudes towards institutionalisation of elderly people. Nine themes were covered in the questionnaire: health, nutrition, attitudes towards institutional care, race/ethnicity, social class, social economic status, social life and activities, education and media, and gender issues in elderly care (Appendix I and II).

### **4.3.3 Sampling Frame and Sampling**

#### Quantitative Data

The sampling frame for this study was defined as all people 60 years and older in the four regions: Khomas (elderly living in Windhoek),

Otjozondjupa (elderly living in Okahandja); Erongo (elderly living in Swakopmund; Walvis Bay and Okombahe); and Kunene (elderly living in Khorixas). These areas were targeted to get a wider ethnic representation in OAHs.

The research sample comprised of 238 elderly people in two strata: 118 elderly people living in OAHs and 120 elderly people living outside OAHs.

**Table 2: Sample Selected: Respondents' Distribution by Region:**

| Region       | No. of OAH | No. in OAHs | No.Outside OAHs | Sample Size |
|--------------|------------|-------------|-----------------|-------------|
| Khomas       | 5 *        | 40          | 40              | 80          |
| Otjozondjupa | 2          | 20          | 20              | 40          |
| Erongo       | 6          | 48 **       | 50              | 98          |
| Kunene       | 1          | 10          | 10              | 20          |
| <b>Total</b> | <b>14</b>  | <b>118</b>  | <b>120</b>      | <b>238</b>  |

\* One OAH is for the mentally challenged elderly.

\*\* One is a Geriatric Hospital Ward. Some of the elderly in this ward died before the scheduled data collection date.

Due to the fact that some OAHs have small numbers of elderly residents, proportional sampling would have been statistically invalid. Therefore the number of elderly respondents from each home were determined by equal representation. Individual respondents in and outside of OAHs were picked by opportunity sampling from those who were able to answer questions. In addition, some effort was made to attain a gender balance. The opportunity

sampling technique was selected because many elderly people were not in good physical or mental health, ruling out more systematic methods which could have selected disabled elderly. Observations show that a similar health situation applies to the elderly even in developed countries, although the majority of institutionalised elderly in these countries are 80 years and older.

### **Qualitative Data**

**Key informant Interviews:** Key informants were selected on the basis of the nature of their work with or concerning elderly people. A total of 31 key informants were interviewed. These included managers of OAHs and charitable welfare organisations, policy level staff in MoHSS, social workers in the field at regional level and relatives of elderly people who help them most. Four case studies of elderly people were also undertaken.

Managers of OAHs are responsible for operation and maintenance of these institutions and overall care of elderly residents. Charitable welfare organisations and NGOs, including churches, fall under the non-profit sector in the economy, and are highly involved in elderly welfare and care. For example, the Council for Older Persons in Namibia promotes the interests and well-being of the elderly and coordinates the activities of all groups involved in elderly welfare in the country. A policy level official in the MoHSS was interviewed and also provided information on the review of the Older Persons Act. The aim of the interview was to find out the link between policy framework and policy implementations. That is, how realistic is the

policy and how it relates to the programmes of eldercare being implemented. Regionally-based social workers are involved with elderly care down to grassroots level. The social workers can identify some factors that influence the level and types of care given to the elderly in their respective areas of jurisdiction. Relatives of elderly people who help them most were interviewed about their care-giving role and its social and economic impact on them personally, as well as their families. Personal views on institutionalisation of elderly people were also solicited. Finally, four elderly case studies were collected, one from each region, on care for the elderly in their own communities, and their views on elderly care in the Namibian society in general. The ultimate goal of the research design was to enable a description of the whole population.

#### 4.3.4 **Data Collection Methods**

The data were collected with the assistance of enumerators who were trained in translating the questions into local languages and then filling in the questionnaire in English. Debriefing of enumerators was done in the evenings.

##### **Qualitative Data**

Unstructured interviews were conducted using guideline questions covering themes about eldercare and models of institutional care that would be appropriate for Namibia. The interviews were conducted face-to-face with all key informants, managers in their offices and other informants at their homes, using the preferred language of the informant. Translations were

made from English into local languages and vice versa as necessary. Each informant was allowed to answer in as much detail as he or she liked, and then was guided to the next question. Notes were taken during the interviews and in a few cases tape recording was done, although many of the elderly refused to be tape-recorded.

### **Quantitative Data**

All questionnaires were completed face-to-face with the elderly by the researcher and/or enumerators. To facilitate data collection, the questionnaire was translated into Afrikaans, a language that many urbanised elderly understand, but translators also helped with other local languages. No questionnaires were completed at Hephata OAH in the Khomas Region because the elderly residents are recommended from the psychiatric hospital and therefore are not mentally stable enough to understand questions. Only the manager was interviewed.

#### **4.3.5 Data Analysis**

**Qualitative Data:** Interview notes from key informants were summarised, taped interviews were transcribed and integrated with the researcher's observations.

**Quantitative Data:** All Questionnaires were checked for consistency. Open-ended questions' content was analysed manually, then coded. All data were analysed using a Social Science Statistical Package (SPSS) Version 10.0 for Windows. Basic statistics were run first and later more detailed

crosstabulations and correlations were processed and evaluated. The data from both research methods (qualitative and quantitative) were then analysed using triangulation.<sup>38</sup>

#### 4.4 **Limitations in the Field**

There are some limitations to this study. The primary limitations are:

- Financial limitations resulted in limiting the study to the four regions. Additional funding would have enabled inclusion of OAHs in the southern and eastern regions of the country.
- The death of elderly people at the State Hospital Geriatric Ward in Swakopmund reduced the number of respondents originally proposed to be covered in the Erongo Region.
- At Hephata OAH in the Khomas Region, elderly people were incapable of answering the questionnaires due to their poor mental state. Therefore only qualitative data was collected from this OAH through an interview with the manager.
- Suspicion among some managers of OAHs occupied by white elderly people and the elderly themselves, made data collection in these homes difficult. It was also difficult to access white elderly living in their own homes because open hostility was displayed by some of these elderly, while others only consented to answer the questionnaire at the gate while the researcher stood outside the gate.

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<sup>38</sup> **Triangulation** is the use of multiple research methods as a way of producing more reliable data than is available from any single method used in isolation (Giddens 1993:698, 765).

#### **4.5 Validity of Elderly People's Answers**

- (i). Interjections and interference from other family members who insisted on being present during interviews with elderly people could have influenced some answers given by elderly people. For example, an interjection from the granddaughter of an old man that people can be ungrateful, after the old man had stated that he was not well cared for, made the old man become evasive to a later question about the problems he faced. Similar situations have been recorded in research on the elderly in South Africa (Dubazana 1989:42).
  
- (ii) The approach of asking people to name preferences has problems. For example, not all elderly people are equally familiar with each alternative type of OAH, especially the rural elderly. It is possible that some elderly gave options of OAHs just to provide an answer to the question. Lawson (1989:192) points out that "there is an inherent limitation of people's ability to express an opinion of something they have not experienced". Lawson further stresses that there is a degree of limited knowledge that description or hearsay on something may not place an individual in position to state preference regarding their own future behaviour. Therefore it is possible that elderly living outside OAHs could have experienced this difficulty when asked about types of OAH preference or whether or not they would move to an OAH at a future date.

## CHAPTER 5

### DIVERSITY AND CONVERGENCE IN REGIONAL NAMIBIAN ELDERLY CARE

#### 5.1 Introduction

This study covered fourteen OAHs in the four regions, three charitable welfare organisations involved in elderly welfare, and three elderly people's associations or clubs. All charitable welfare organisations involved in elderly care, as well as clubs are all expected to be affiliated to a national council that serves as a coordinating body at the national level. This chapter presents profiles of the OAHs by region, reflecting ownership and registration status;<sup>39</sup> information on elderly residents; funding and staffing; admission criteria and problems experienced at each OAH. The OAH profiles are followed by profiles of welfare organisations, associations and clubs for elderly people. The chapter ends with an outline of the new policy strategies contained in the draft bill on rights, protection and care of older people in Namibia. The findings in this qualitative analysis are further augmented by analysis of quantitative data in chapter six.

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<sup>39</sup> OAHs that meet criteria stipulated in the Older Persons Act No. 81 of 1967 are registered with MoHSS and qualify for a monthly subsidy towards its operations from Government.



## **5.2 Profiles of OAHs by Region**

### **5.2.1 Khomas Region**

The five OAHs in Khomas Region all operate in the national capital, Windhoek: Susanne Grau Heim; T.J. Portgieter Tuiste; Katutura; Tabitha and Hephata Elderly and Disabled OAHs respectively.

#### **(i) Susanne Grau Heim OAH**

Susanne Grau Heim OAH belongs to a German Women's Organisation. The OAH was founded in 1920 and started operating in 1935. The OAH is registered with the MoHSS and presents a high standard of elderly friendly environment and has a frail care unit. This OAH has no affiliation to the National Council for Older Persons in Namibia. There are 96 residents, of whom 95% are German and 5% are Afrikaner and English elderly. There are 10 men and 86 women, with the oldest aged 100 years and the youngest 59 years, with an average age of 85 years. These elderly come from middle to upper social classes in white communities.<sup>40</sup> The OAH is funded through fundraising activities, donations and high resident's fees. Depending on the level of care and size of room or apartment, rental fees range between N\$ 1 500 – 3 000 per month for an unfurnished room, meals, laundry and nursing. In addition, the OAH receives a monthly subsidy of N\$ 1 400.00 from the government and high support from elderly residents' families and communities. A total of 35 staff, including five professional nurses manage

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**40** Social class is reflected here because of its link to financial income. The majority of elderly who can afford to pay the high residential fees are mostly from middle to upper social class. The social classes here refer to social class in the western European context because all elderly residents are of European descent. In addition, due to the history of apartheid in Namibia, white and black people generally do not mix easily.

the OAH. These staff members undergo continuous in-house training in elderly care.

Apart from attainment of the age of 60 years, admission criteria include a doctor's certificate for mental stability and ability to pay fees. Most elderly can afford the high fees because they have pensions and other sources of income. Health problems are characteristic of old age, and many elderly are medically insured but those unable to pay rental fees or medical expenses are supported by their families. Exercises and other activities such as outings and shopping are provided, but the elderly are also involved in their own associational activities. Management concerns include fund raising to maintain high standards at the OAH, and possible staff shortage because young people are not interested in elder care jobs.

(ii) T.J. Portgieter Tuiste OAH

T.J. Portgieter Tuiste OAH is the property of the Dutch Reformed Church in Namibia. The OAH has an elderly-friendly environment and provides high quality service, including frail care. Although registered, the OAH is not yet affiliated to the Council. A total of 135 elderly residents, the majority of whom are Afrikaner, as well as a few English and colourerds, live at this OAH. There are 25 men and 110 women, aged between 40 and 99 years, with the average age range of 75-85 years. The mentally ill are admitted below 60 years. The elderly residents come from the middle class in their

communities and can afford to pay the high rent.<sup>41</sup> The OAH is funded through investments, rental fees, donations, a church fund and fund raising activities. Investments raise a net income ranging from N\$ 3 million per annum and higher, therefore the OAH decided to forego government subsidy in the year 2000. Rental fees range between N\$ 615 – 2 800 per month for an unfurnished room, laundry, meals and nursing. The church fund caters for those who cannot afford, but the OAH also has a lot of family and community support. The OAH employs 23 staff members, excluding office staff, of whom five are professional nurses and four are assistant nurses. The staff receive in-house training. Admission criteria stipulate ability to pay but excluding Moslems.

Health problems are characteristic of age and some of the elderly have medical insurance. Some of the elderly also have other sources of income, although a sizeable number are supported by their families. Elderly residents without family support or savings are assisted through the church fund. Exercises and activities provided include games, library, outings and shopping, but able-bodied elderly also participate in activities of their associations and clubs. Management concerns are directed towards fund raising to maintain high standards and for expansion.

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<sup>41</sup> Social class is reflected here because of its link to financial income. The majority of elderly who can afford to pay the high residential fees are mostly from middle to upper social class.

(iii) Katutura OAH

The Katutura OAH belongs to Katutura Voluntary Family Care Organisation and is managed by a committee. The OAH is not registered with the MoHSS because the premises do not meet government-set criteria. The buildings and fittings are not elderly-friendly. The OAH management plans to have an affiliation with the Council for Older Persons in Namibia. Twenty five elderly people aged between 59 and 94 years reside at the OAH. There are 20 men and five women. The majority are Owambo, but all five women are Damara. Ethnicity here is important because of different cultural values about elderly care. Further, most of the men were migrant workers whose roots with the extended family became weak. Family ties among the Damara are not as strong as among other indigenous ethnic groups.

The OAH is dependent on donations for funding its operations, including payment of staff salaries. The elderly pay N\$ 20 per month towards food from their only income of a social pension. There is no support from the elderly's families or communities, although a few volunteers sometimes provide the elderly with soup. The OAH is staffed by six staff who are not trained in elderly care, with exception of the manager who has basic knowledge of nursing care. Although more staff are needed, there are no funds to hire more or to train the present staff. Admission criteria stipulates ability for self care and no special diet requirements. All of the elderly have no medical insurance and health problems are referred to state health centres. Except for irregular outings to monthly outreach meetings organised by the

regional welfare office, the elderly have no club memberships, and are not provided with exercise or activities at the OAH. Problems experienced at the OAH stem from acute lack of funding for food and other basic necessities and services, such as transport, additional staff and staff training. This OAH is in critical need of support.

(iv) Tabitha OAH

Tabitha OAH is operated by the Evangelical Lutheran Church of Namibia (ELCIN) and is registered with MoHSS. Although the location and premises are good, only part of the building is utilised for the OAH. They lack an elderly-friendly architectural design. Some fixtures and fittings are elderly-friendly but are inadequate, although the facility is much better than the Katutura OAH. Twenty elderly people, nine men and eleven women aged between 76 and 95 years reside at the OAH. Most of the elderly are from the Damara ethnic group, but there are a few Owanbo and South Africans. Compared with other ethnic groups, extended family ties among the Damara are weaker. The OAH is funded by the ELCIN church, donations from overseas (especially Germany and Holland) and residents' fees. The elderly pay N\$ 100 from their social pensions, for a furnished room and meals. There is no support for the OAH from families of residents or their communities because of poverty. The OAH has nine staff members, four administrative staff and five caregivers all of whom are not trained in elder care. The manager has to be an ELCIN church-appointed pastor.

Admission criteria entails attainment of 60 years of age, ability for self care and receipt of a social pension. The OAH provides special diet to diabetics, but the elderly are not medically insured and receive care at state health centres. No exercise is given at the home, and activities are limited to church services, choir and a few craft activities. The elderly at this OAH do not belong to any social clubs but attend monthly outreach gatherings organised by the MoHSS regional welfare office. Major problems at the home are shortage of funds to enable utilisation of the facility's full capacity, restructuring for elderly friendly structures and fittings; and staff training.

(v) Hephata Elderly and Disabled OAH

Hephata OAH belongs to the German Lutheran Church and also functions as a day-care centre. There is an acute shortage of space at this OAH, including a lack of an elderly-friendly environment, hence it is not registered. The OAH is affiliated to the Council for Older Persons in Namibia, with the manager being a member of the Council's executive committee. A total of 12 mentally challenged elderly from all Namibia's indigenous ethnic groups reside at the OAH. There are six men and six women aged between 61 and 81 years. In addition, daytime elderly numbers rise to between 15 and 20 because of elderly who seek day care.

Hephata Elderly and Disabled OAH is funded through a grant of N\$ 1 000 per month from the church and other donations. Residents and day-care elderly do not pay but some relatives contribute some funds to the church.

The manager has no other staff, and there is no contribution to the OAH from the community. Admission criteria is dependent on a psychiatric hospital's recommendation. The main health problem is mental disturbance and medical attention is sought at the psychiatric state hospital. All the elderly residents are not medically insured. Further, no exercises or activities are provided at the OAH. Major problems at the OAH are inadequate funds, inadequate space, food shortage and lack of staff.

### 5.2.2 **Otjozondjupa Region**

There are four OAHs in the Otjozondjupa Region, two in Okahandja, one in Otjwarongo and one in a rural area in Okakarara. The study covered only the two OAHs in Okahandja: Nau Aib and Sonder Sorge.

#### (i) **Nau Aib OAH**

Nau Aib OAH was built by the Municipality of Okahandja and Ministry of Local Government in 1999, to replace an OAH in disrepair located in the area formerly known as the black location.<sup>42</sup> The structures bear an elderly-friendly architectural design, but there is no frail care facility and construction of the buildings is yet to be completed. Hence the OAH is not yet registered and management is under a committee that reports to the department of social services. The OAH is not affiliated to the Council for Older Persons in Namibia. The OAH houses twenty-four elderly people

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<sup>42</sup> Areas where indigenous people were confined to live during the colonial dispensation imposed on Namibia by South Africa.

from Damara, Herero, Coloureds and migrants from Angola and Mozambique. The migrants are former contract workers who remained in urban centers and therefore have weak ties with their families. The residents at the OAH comprise of 20 men and four women, with the majority in their 70s.

This OAH is funded by donations and resident's fees. The elderly pay N\$ 125 per month from their social pensions for a room, meals and laundry. The migrant residents without pensions undertake some work at the OAH if they are still able to do so. The OAH does not receive any support from the elderly's families or communities from which they come. Five staff members who are not trained in elderly care work at the OAH but this number is not enough. The criteria for admission are attainment of 60 years, ability for self care and receiving a pension, as well as no alcohol problem. Health problems are similar to those of people living in OAHs in the Khomas Region. The elderly are not medically insured and health care is given at state health centres. No exercise or activities are offered at the OAH but individuals take walks and do gardening. Problems experienced at the OAH are shortages of funds and staff, lack of transport for the elderly, lack of furniture and beddings, a lack of wheel chairs and walk supports, and constant telephone breakdown. The elderly also complain of staff mistreatment, they dislike the gate being locked at all times, and men demand for the freedom to bring their female friends into their rooms.



(ii) Sonder Sorge OAH

Sonder Sorge was started in 1989 and is a privately owned and registered OAH with frail care facilities. The OAH has no affiliation with the Council for older persons in Namibia. There is a total of 96 elderly comprising of German, Afrikaner and a few English residents at the OAH. Men are only eight while women are 88, aged between 69 and 98 years, with an average age of 78 years. The elderly residents are from middle to upper social classes, but with a few from lower social class. Funding is raised through donations, fundraising activities and residents' fees. Rental fees range from N\$ 390 – 1 125 per month for a room or flat, meals, laundry and nursing care. Families and communities of residents support the OAH. All 35 staff members at the OAH are trained in elder care, of whom two are professional nurses. Admission criteria are self care and capacity to pay fees.

Health problems are similar to those found in OAHs in the Khomas Region, but with an increase in elderly falls. Some of the elderly have medical insurance coverage and special diets are provided. Exercise and various activities are provided, such as regular organised outings, holidays with family but the elderly also have associational membership activities. Problems at the OAH involve employee management and a disregard of advice against smoking by the elderly.

### 5.2.3 Erongo Region

Five OAHs are operated in the Erongo Region, the two OAHs in Swakopmund are Lions and Prinses Ruprechtheim; two other OAHs in Walvis Bay are Huis Palms and Kuisebmond; and one in a rural area in Okombahe (about 200 Kilometres from Swakopmund). In addition there is a geriatric ward at Swakopmund state hospital. This study covered all of the above mentioned facilities.

#### (i) Lions OAH - Swakopmund

Lions OAH is a registered property of Swakopmund Lions Club that was established in 1972, and includes a private Lions village, some single rooms and frail care facilities. The OAH has no affiliation to the Council for Older Persons in Namibia. There are 97 elderly people at this OAH, the majority of whom are Germans. There are 17 men and 80 women. Twenty-five elderly live in the Lions village, of whom 11 are men and 14 are women. The residents are aged between 63 to 96 years of age, with the average age being 80 years. These elderly are from the middle class and can afford to pay the high fees. This OAH is funded through rental fees, ranging between N\$ 550 and N\$ 2 500 per month. The elderly living there can afford to pay and there is some support from elderly's families and the community they come from. Twenty-eight staff members work at the establishment, 20 of whom are trained in elder care, while 8 are kitchen and garden staff.

Although admission criteria state that only old age is required to qualify for admission to in this OAH, priority is given to Lions Club members. Health problems are similar to those of elderly from the other two regions, with an addition of asthma and osteoporosis. Elderly are medically insured and pay their own bills. Special diets are provided at no extra cost and exercise is provided, including passive or geriatric gymnastics. Social life at the OAH involves various activities including civic activities such as municipal meetings and voting in elections, organised outings and holidays, but the elderly are also involved in associational activities in their own clubs. Concerns at this OAH are need for additional funding to maintain standards, and a future need for trained professional staff, especially nurses.

(ii) Prinses Ruprechtheim OAH – Swakopmund.

Prinses Ruprechtheim is a registered OAH that started in 1989 for frail care with a link to a hotel and belongs to the German Red Cross. There are 18 elderly residents, most of whom are German, a few Afrikaner and English. The residents are all women aged between 49 and 96 years old. Choice to live at the OAH is primarily based on economic reasons because of the high fees. The elderly at this OAH come from middle and upper social class. The OAH is funded through rental fees of N\$ 4 500 for a single room and N\$ 3 700 to 4 000 for a double or shared room per month. Most of the elderly can afford to pay this fee themselves while others are supported by their families. However, the home receives a lot of support from elderly's

families and communities. The OAH has 17 trained staff, including professional and registered nurses but this number is inadequate.

Admission criteria stipulate a need for frail care and ability to pay. Health problems are mainly degeneration due to old age, all residents require full time care and are on a soft diet. Elderly activities are limited to reading and watching television, with outings and holidays organised by their own families. The OAH experiences only minor financial problems and elderly at times complain of inadequate care due to shortage of staff.

(iii) Geriatric Ward 6 – State Hospital Swakopmund

Frail elder care at Swakopmund State Hospital Geriatric Ward 6 was started before independence but is being phased out. Only two elderly women in their 70s remain in the ward under state funding. A nurse and two cleaners care for the two elderly women, who are on soft diet but are too frail for any activities.

(iv) Huis Palms OAH – Walvis Bay

Huis Palms is a registered OAH with frail care facilities that started operating in 1991 and belongs to the Walvis Bay Society Care for the Aged. It is affiliated to the National Council for Older Persons in Namibia. There are 36 German and English speaking elderly residents at the OAH. These elderly comprise of seven men and 29 women aged between 72 and 97 years of age, with the average age of 85 years. The OAH is funded through

donations, fundraising activities and resident's fees. Rental fees for an ordinary normal room is N\$ 2 139 while frail care is N\$ 2 553 per month. The elderly or their families can afford to pay and the OAH receives fair support from the elderly's families and communities. The OAH has 28 staff members who receive in-house training in eldercare and the number is adequate for the home.

Admission criteria is 65 years old but those who suffer from Alzheimer's disease can be admitted from 55 years. Health problems at the OAH are similar to other elder from other OAHs although none require a special diet. Some elderly are medically insured but all have access to state services. The elderly exercise through walking and are involved in various activities, organised outings, holidays with their families and other civic or associational activities with their clubs. Concerns at the OAH are additional funding to maintain standards and a slight lack of trained staff.

(v) Kuisebmond OAH - Walvis Bay

Kuisebmond OAH was started in 1982 by the then colonial administration, but the Walvis Bay Municipality took it over, renovated and expanded the structures. Twelve elderly people, most of whom are Owambo and some Coloureds reside at the OAH. There are ten men and two women aged between 62 and 75 years, with the average age is 65 years. The elderly are former contract and factory workers.

The OAH is funded through the municipal budget, donations from the church, the Lottery Club, private companies and low rental fees, elderly pay only N\$ 20 from their social pensions. There is no support from the elderly's families and communities. No staff have been recruited to manage the OAH but one volunteer helps out, under the direction of the municipal social worker and a nurse. Health problems are diabetes and blood pressure. These elderly are not medically insured and receive medical attention from state health care centres. The elderly do self-care but are given exercises once a week on Tuesdays. No activities are offered, but two volunteers take them out for outings. The elderly have joined a newly formed club, initiated by the municipal social worker. Problems faced by the OAH include the lack of a central kitchen, alcohol abuse and fights among the residents.

(vi) Okombahe OAH

Okombahe OAH is located in a rural area, 200 kilometres from Swakopmund and is a legacy of the apartheid dispensation, set up under separate administration of the former Damara Administration, and falls under MoHSS. The structures were good in the past, with several self-contained housing units for two people each, a kitchen and dining hall block and office facilities. However, the dining hall and offices do not function any more and all structures are now in deplorable condition due to the lack of maintenance. Most of the housing units are occupied by other younger people including school teachers, and only eight elderly people are accommodated in four units, six men and two women. The OAH is located in the Damara rural area

and therefore seven of the residents are Damara. The MoHSS pays the wages of two staff members both of whom are not trained in elderly care. Funding is mainly through residents' fees, the residents pay N\$ 250 per month. Other support is given by the Red Cross by providing an occasional meal and get-together at the church house; but families and the community are too poor to support the OAH.

Admission criteria include receipt of pension which has to be surrendered in full, leaving the elderly with no money for other expenses. Health problems are similar to those found at other OAHs in the region, except for an additional problem of epilepsy. The elderly are not medically insured and depend on the local state clinic, although there is no doctor. There are no exercises or activities provided at this OAH but some elderly keep chickens and ducks as a pastime activity. The elderly do not belong to any club. The OAH faces many problems such as maintenance and renovation of housing units to be more elderly-friendly; inadequate staff, a lack of furniture especially beds; a lack of care aids such as wheel chairs; an acute shortage of money for food; the lack of a doctor at the health clinic, transportation means for the sick and long distances to pension pay points in Omaruru or Otavi.

#### **5.2.4 Kunene Region**

There are two OAHs in the Kunene Region, one occupied by white elderly in Outjo and another occupied by indigenous elderly in Khorixas. The study covered the Khorixas OAH.

### Khorixas OAH

The Khorixas OAH is not a single building but consists of 51 individual units owned by the Town Council and allocated for exclusive use by the elderly. However, the Town Council has not carried out any maintenance on the units for many years. The OAH has no centralised management structure and is under the charge of a social worker. This OAH is not yet affiliated to the National Council for Older Persons in Namibia, but intends to become affiliated in the future. Fifty-five elderly people, 20 men and 35 women live in the units with their families. The elderly's age ranges between 60 and 75 years old. The OAH is located in the Damara area and therefore the majority of the elderly are Damara, with a few other ethnic groups. The elderly chose to live in this OAH because the housing units are free of charge. These elderly live with and are cared for by family members but the family members are not formally trained in eldercare.

Health problems at this OAH are similar to those found in other OAHs but all elderly are not medically insured and are state patients when ill. Activities are carried out according to individual needs in the homes. Major problems at the OAH include a lack of funds to repair and maintain the housing units and subsequently many of them are in deplorable condition. The housing units lack proper toilets with appropriate sanitation. Structures are unsuitable for elderly needs but the elderly cannot afford to undertake any repairs themselves. Lack of a centralised management structure negates



provision of better services to elderly residents because of a lack of coordination.

### **5.3 NGOs and Charitable Welfare Organisations**

Several charitable welfare organisations fall under the category of Non-Governmental Organisations (NGOs) and are involved in elderly welfare, while elderly people also have their own associations. The National Council for Older Persons in Namibia (the Council) is an umbrella body to which such organisations are expected to be affiliated. This study examined profiles of the Council and two welfare organisations that operate on membership basis outside OAHs. These are: Namibia Christlike Vroue Hulpdiens and Aksie Bediening vir Bejaardes (ABB). The two elderly people's associations are: Association of Senior Citizens Club (ASC) in Windhoek and Senior Citizens Clubs in Walvis Bay in Khomas and Erongo regions respectively.

#### **5.3.1 Charitable Organisations**

##### **(i) The National Council for Older Persons in Namibia**

The National Council for Older Persons in Namibia (the Council) was initiated by social workers in MoHSS and established in 1999 but started its operations in 2000. The Council is headed by a president and managed by an executive committee based in Windhoek, and represented in all 13 regions of the country through regional boards. The main objective of the Council is to promote the interests and well-being of elderly people. In addition, the Council coordinates activities of all interested parties in elderly welfare and

care, and encourages improvement of services through research, education and training programmes on elderly issues in the country. However, the activities of the Council are currently constrained by lack of funding for capacity building, establishment of an independent office and lack of recruitment of fulltime staff. The Council's executive committee members currently work on a voluntary basis, temporarily using the office of the Council president at the church. These constraints have delayed planned programmes including the affiliation process of OAHs and other organisations. If all planned activities get implemented, the Council will play an instrumental role in elder care activities in the country.

(ii) Namibia Christlike Vroue Hulpdiens – Windhoek

Namibia Christlike Vroue Hulpdiens was started in 1979 and in 1982 branches were opened in Gobabis, Okahandja, Mariental, Keetmanshoop and Luderitz. The branches operate independently in the respective towns but occasionally organise general meetings. The Windhoek branch has a membership of 100 elderly and is managed by a committee of ten people. Each committee member undertakes responsibility over ten elderly people. This organisation caters for the elderly from the coloured communities. The objective of this organisation is to extend assistance to its members; promote interaction among the elderly and thereby reduce elderly people's isolation and loneliness. A major concern of the organisation is a lack of trained caregivers in communities, especially frail care.

The organisation is funded through donations but the branch is currently facing financial difficulties and cannot expand its activities. Churches had been major donors to the Windhoek branch of the organisation, but many churches have set up programmes within their congregations and no longer assist. Transport is a problem because the organisation's vehicle is too old and committee members have also grown old.

(iii) Aksie Bediening Vir Bejaardes (ABB) (Ministry to the Elderly)

Aksie Bediening Vir Bejaardes (ABB) was instituted in 1998 within the United Reformed Church as a ministry to the elderly, operating in Windhoek. The ABB has a membership of over 200 elderly from lower and middle social class in the coloured community, of whom 5% live in OAHs. An executive committee of five to eight members, aided by some church congregation members run the organisation. An annual programme of activities is drawn up, and entrusted to four committees: project fundraising, elderly education, sickness and death assistance, and bridging to other groups. Concerns of the organisation are: the high expense of OAHs that provide good eldercare services, a shortage of trained caregivers in both institutions and community, the lack of support for families caring for the elderly, especially the frail. Furthermore, ABB is concerned about inadequate information dissemination on elderly welfare and other elderly issues in Namibia.

The organisation is funded through church support and fundraising activities. Fundraising is a major challenge for an increasing number of elderly people. ABB believes that the elderly are better cared for in OAHs and plans to set up an OAH using one of the church-owned buildings. Members of ABB do not have medical insurance coverage and a special funeral project fund was set up to assist members. The elderly invest N\$ 10 per month to the fund, and the organisation pays an amount of N\$ 500 for an elderly who stays on the scheme for a period of six months, the amount increases to N\$ 2 000 for a two-years' stay. Observations reveal that this organisation is supported by educated and middle to high income earners in the church, whose programmes include imparting knowledge (such as nutrition, exercise and care for the bedridden) to the elderly members of ABB to improve their health and quality of life.

### 5.3.2 **Elderly's Associations**

#### (i) Association of Senior Citizens club (ASC) - Windhoek

The association of Senior Citizens Club (ASC) is a self-supporting organisation that has been operating for about 20 years. In Windhoek, the association has a membership of over 200 elderly people. Most of the members live in retirement homes at Senior Park, Eastern Court, as well as those living in their own homes. Membership is however subject to application and acceptance.

ASC is funded through membership fees and fundraising activities but is strongly supported by the white communities. Activities of the organisation cover promotion of members' welfare and care, elimination of isolation and provision of opportunities to be active. Transport is provided for organised tour trips, visits and shopping trips. Monthly market days are organised at Senior Park for the elderly to sell their wares, such as knitting, needlework and cookery.

(ii) Association of Senior Citizens Clubs – Walvis Bay

Two clubs are newly formed under the direction of the municipal social worker in Walvis Bay. The formation and management differs from that of the ASC in Windhoek. These clubs cater for the elderly among indigenous and coloured communities in Walvis Bay. 'God Help Us Senior Citizens Club' in Kuisebmond has 92 members; and 'Alive Citizens Club' in Narraville has 64 members.

The objectives of the clubs involve eldercare in general and social life of elderly people. The elderly are kept active through visitation and encouragement of mutual support. A list of bedridden elderly is compiled and updated for visitation to eliminate isolation and loneliness. Meetings of the elderly are also organised at the new hall at Kuisebmond OAH. The clubs are currently supported through a municipal budget and may remain so for a long time because most members' only source of income is social

pensions, from which adequate subscriptions cannot be raised to sustain the clubs.

#### **5.4 Regional Diversity and Convergence in Elder Care**

The profiles of OAHs in the four regions present diverse levels and types of care extended to elderly people, although there are also several areas of convergence. Thus, in addition to the traditional informal care for elderly people, several models of formal care in OAHs are presented.

##### **5.4.1 Models of OAHs in the Study Areas**

The type of OAH as it operates in developed countries has been remodeled in the Namibian context, such that five models are identified in the study areas as:

- Model I: Private or association-owned, high cost, varied and high standard service providing OAHs
- Model II: Community welfare organisation OAHs
- Model III: Church or municipality-supported OAHs
- Model IV: Town Council or MoHSS-supported OAHs
- Model V: MoHSS Geriatric Wards

##### **5.4.2 Regional Comparisons of OAH Models**

Out of the five OAHs in the Khomas Region, two are Model I (Susanne Grau Heim and T.J. Portgieter), one is Model II (Katutura OAH), two OAHs are Model III (Thabitha and Hephata) respectively. In the Otjozondjupa Region, only a Model I (Sonder Sorge) and a Model III (Nau Aib) OAHs are covered

in the study, although there are two other OAHs of similar models in the region. The Erongo Region has three Model I OAHs (Lions, Prinses Ruprechtheim and Huis Palms), one Model III OAH (Kuissebmond), one Model IV OAH (Okombahe) and one Model V (Geriatric ward 6 State Hospital). The study covered only one Model IV OAH in Kunene region (Khorixas).

Model I OAHs are occupied by whites and some coloured elderly while indigenous and coloured elderly mainly reside in the rest of the models. The communities from which Model I elderly residents come, support the OAHs through fund raising and other services. The OAHs where indigenous elderly live get little support from the elderly residents' communities partly because these communities are poor and cannot afford to help. OAHs are new to these communities and perhaps people are not sure of the responsibility towards OAHs. For example, a case study conducted in the Khorixas Region reveals that the: *"...Public needs education on new changes [in society and ways of care]. OAHs are new and people should be educated on advantages and disadvantages [of such OAHs]"* (Elderly case study, Kunene Region). Lack of information has led to stereotypes about living conditions in OAHs and a need for community support of OAHs. A relative of an elderly person living in the family states: *"...People can help if educated about it [OAHs]. ...Now people [the public] think that people [elderly] go there to be mistreated"* (Relative of elderly person living in the community, Khomas Region).

Although problems at all OAHs involve finance, white-occupied Model I OAHs need finance to maintain high standards, while those where indigenous elderly live need to meet elderly's basic needs, recruit and train staff. Staff training is a necessity at all OAHs although at Model I OAHs it is a future concern, while for the other OAH models, there is immediate need. General differences in service levels to the elderly between urban and rural areas are highlighted by better service levels and opportunities for support as well as meaningful activities for urban OAHs, which are lacking at the OAH in a rural setting.

It is expected that problems facing different models of OAHs and the elder care system in general will be reduced or eliminated after implementation of the new policy strategies contained in the draft bill. An outline of the draft bill is presented below.

#### **5.5 Rights, Protection And Care of Older People in Namibia Bill, Draft XIII(b) of September 2002**

The new bill reflects a philosophy change regarding care needs of older people, from a predominantly institutionalised approach that mainly suited one racial group, to an endeavour to strengthen and promote older peoples' position in society for as long as possible. New strategies in the bill aim to meet the challenges of ageing and elderly care in an independent and modern Namibia (MoHSS 2002).



The essence of the new strategies is for the family and community to be the core of support for older people. The main provisions of the new bill entail that:

- All persons bear the responsibility to provide for their social and financial independence in ageing (MoHSS 2002:7).
- Family, friends, community, and government share responsibility to provide assistance where independence is unattainable. Basic needs will be provided only to the elderly who are desperate, especially the destitute, poor and frail elderly, as well as empowering their families to obtain basic necessities for the elderly under their care (op cit :43)
- State provision of health care services at state health centres.
- Establishment of Namibia Council for Older Persons to promote ageing and elderly welfare and care in Namibia (op cit :7). One of the council's functions will include liaising and negotiating with educational and training institutions to introduce courses and syllabi relating to elder care so as to train different people involved in the process. The council is also to undertake research activities related to elderly people.
- Protection and care of older people and prohibition of elder abuse (op cit :13).

- Provision of appropriate and affordable housing for the elderly, establishment of homes and shelters for the elderly, and frail care units. The provision of these accommodations is to involve individuals and families, private developers, NGOs, religious organisations and local authorities (MoHSS 2002:11, 21).
- Fees of private OAHs will be regulated.
- Establishment of an integrated community care and support system involving personal, recreational, social or cultural activities in order to promote and maintain independent functioning and well-being of older people in the community (op cit :37).

These policy strategies hold potential to improve the elderly people's situation but there are several gaps that cannot be ignored. For example, the lack of research data on the condition of the elderly in all regions of the country that would aid policy formulation.

In summary, although more than one model of OAH is represented in all regions, occupancy is consistently race-based, reflecting inequalities in income. Income is linked to the type of OAH an individual elderly person can afford to pay for. The services given at the different models of OAHs also depend on the financial strength of the OAH, and the amount of fees elderly residents pay. Thus the OAHs reflect and perpetuate income inequalities in the Namibian society. Gender differences in OAH occupancy

reveals more men than women in OAHs occupied by indigenous elderly but the opposite is true for white-occupied OAHs. Most of the indigenous elderly men are former contract workers and labour migrants who lost close contact with the extended family who would care for them in old age. Hence they seek care in OAHs. However, it could be that indigenous communities tend to care for the elderly women because of care giving roles they continue to render to their families in their old age, such as childcare.

Given the economic inequalities within Namibian society, the levels and types of care extended to the elderly in the different models of OAHs, are by implication economically determined. Thus inequalities of the wider picture in society are perpetuated in care for the elderly. Although not yet implemented, the new government policy strategies for elderly care lack support of research data on the actual situation and conditions of the elderly in the whole country. A detailed discussion on the models of OAHs is given in chapter seven.

## CHAPTER 6

### SOCIO-ECONOMIC FACTORS INFLUENCING LEVELS AND TYPES OF ELDERLY CARE IN NAMIBIA

#### 6.1. Introduction

This chapter analyses data from the four regions derived from questionnaires and integrated with data from interviews with key informants, as well as researcher's observations. A description of the sample population is presented first. In order to gain an impression of the levels and types of care extended to elderly people in the four regions, the questionnaire data are analysed under the themes:

- The elderly's health
- Nutritional status and nourishment needs
- Attitudes towards institutionalisation
- Socio-economic status and elderly needs
- The family, community and government elderly support
- Education and information sources
- Current problems the elderly face

The chapter ends with the elderly's perceptions of the future of elderly care in Namibia.

Most of the basic statistics such as cross tabulations and correlation analysis were done but they showed no important statistical significance.

## 6.2 **Description of the Study Sample**

A total of 238 elderly people completed the questionnaire, of whom 42% (n = 101) are men and 58% (n = 137) are women (Table 3). These data confirm the longevity of women over men (The UN 2002:17). Among the elderly surveyed, most of them (44%, n = 104) are aged between 70 and 80 years, the 'young old' aged between 60 to 69 years of age comprise 40% (n = 93), while 17% (n = 36) are between 81 and older (Table 4). The higher percentage of those aged between 70 and 80 years indicates the increasing number of people living into their 80s in the Namibian society. This increased number also confirms the literature on a rapid increase of this age category (The UN 2002:2). There is likely to be a problem in the future because there will be more people in their 80s who will require higher levels of care.

Marital status in old age poses particular constraints that require adjustment in care provision, especially for the elderly who live alone. Most of the elderly are widowed (44%, n = 105) while 31% (n = 73) are married or co-habiting, 5% (n = 11) are divorced or separated, and 20% (n = 49) are single (Table 5). Out of the 44% (n = 105) widowed elderly, women make up 34% (n = 81) while widowed men are only 24% (n = 24) (Table 6). The high number of widows agrees with the literature on the feminisation of old age (The UN 2002:17). The higher percentage of elderly women, coupled with that of widowhood implies differences in the old age experience between sexes in the Namibian population.

Eldercare patterns and levels of care extended to the elderly differ between ethnic groups. The elderly were asked to indicate their mother tongue. Among the white elderly sampled, 40% (n = 95) speak Afrikaans; 9% (n = 22) speak German while English speakers make of 5% (n = 11). Among the indigenous groups, 30% (n = 72) are Damara>Nama speakers; 9% (n = 22) speak Oshiwambo; 3% (n = 7) speak Otjiherero, while other language speakers make up 4% (n = 9) (Table 7). Key informants confirm that the majority of elderly people who seek care in OAH are white. Furthermore, the study area covers Damara>Nama areas, which may explain the higher percentage of Damara>Nama speakers.

Churches and religious groups play a significant role in elderly welfare and care, while different church congregations undertake particular programmes for elderly members. The elderly belong to different Christian denominations. The Lutheran church has the highest number of followers among the elderly (39%, n = 92); 14% (n = 34) are from Dutch Reformed Church; 32% (n = 76) belong to other Christian churches, with other religions making up 13% (n = 32) (Table 8). In addition to their religious beliefs and about God, the elderly' high involvement with churches present them with a chance of getting assistance from church-sponsored support. This contention is supported by key informants who report strong church support and congregational-based organisations for elderly welfare, such as Aksie Bediening vir Bejaardes (ABB). Furthermore, literature indicates that the elderly become depressed if they perceive that they have no control over

the OAH environment. For example, regulated meal times or movement in and out of the OAH premises. There is a correlation between religion and personal adjustment in old age, therefore religious beliefs can be a source of control for elderly people.

### **6.3 Elderly People's Health**

The ageing process leads to high susceptibility to disease and disability that can shorten lives. The elderly were asked to indicate health problems they experience. While 12% (n = 29) of the elderly do not have any health problems at all, 44% (n = 104) suffer from joint pains and backache; 42% (n = 101) have blood pressure problems; 31% (n = 73) have poor eye sight, 16% (n = 38) suffer from heart/stroke problems, 11% (n=26) are diabetic; and 27% (n=64) suffer from other ailments (Table 9). Key informants confirm high incidences of these health problems in and outside of OAHs. These findings agree with the literature that these health problems are similar to those found among these age group elsewhere in other countries, such as in Zimbabwe (Nyanguru 1991:78). Hence increased health problems reflect resultant health care demands on the OAHs, the family and state resources.

Medical costs increase with increased health problems in old age, but healthy elderly people reduce the financial burden on care systems and family budgets. Access to specialised health care is often difficult, but medical insurance reduces the burden of medical costs. The elderly were asked to indicate if they are medically insured. The majority of the elderly in the

study areas (90%, n = 213) do not have any medical insurance coverage as indicated in Table 10 below.

Table 10: The Elderly Who Have Medical Insurance Coverage

| Medically Insured | Number | %   |
|-------------------|--------|-----|
| Yes               | 24     | 10  |
| No                | 213    | 90  |
| Total             | 237    | 100 |

Note: Total number is not 238 due to non-response.

Key informants confirm this lack of medical coverage among the elderly in all regions. A lack of medical coverage among the majority of the elderly respondents means that they are dependent on state healthcare services. Key informants express concern about the elderly's failure to access specialised but expensive health care services that government health care facilities cannot provide.

**Special Diets:** An inadequate and inappropriate diet can lead to the deterioration of health conditions, such as diabetes and high blood pressure. Of the 237 elderly who answered the question on whether or not they receive a special diet, 32% (n = 76) say they do not need it, but 46% (n = 109) do not receive a special diet even though they need it as Table 11 below indicates.



Table 11: Elderly who Receive Special Diet

| Receive S/Diet | Number | %   |
|----------------|--------|-----|
| Yes            | 52     | 22  |
| No             | 109    | 46  |
| Do not Need it | 76     | 32  |
| Total          | 237    | 100 |

Note: Total number is not 238 due to non-response.

Key informants at OAHs confirm that special diets are provided to elderly residents, except at Katutura and Hephata, Nau Aib and Okombahe OAHs. There is no central kitchen at Kuisebmond and Khorixas OAHs to provide meals. The provision of special diets indicates that some OAHs are making efforts to prevent deterioration of the elderly's health conditions.

#### **6.4 Elderly's Nutritional Status and Nourishment Needs**

Elderly people need to nourish the ageing body with a diet of appropriate quantity and quality. Malnutrition, resulting from inadequate diet is common among the elderly and contributes to poor health. The elderly were asked to indicate the number and quantity of meals they eat in a day. Of the 238 elderly 68% (n = 162) eat three meals a day; 23% (n = 54) eat two meals per day (Table 12). The quantity of food is often enough for 66% (n = 156) but never enough for 17% (n = 41) of the elderly (Table 13). Key informants confirm that in some OAHs and within communities, elderly people find it difficult to access nutritious food.

These results indicate that a sizeable number of elderly people get inadequate nourishment with implications on their health. This could partly explain why some welfare organisations solicit for food donations and distribute food parcels to their elderly members who live within the community.

## **6.5 Elderly's Attitude Towards Institutionalisation**

Societal values determine care norms. New values are either adopted, accommodated or assimilated. Institutionalisation is a new concept among indigenous communities in Namibia, and positive attitudes towards this concept may indicate a value change, which may determine elderly people's choice to live in institutions. Several questions were posed to the elderly to indicate the positive and negative aspects of their living environments as indicated in six aspects below.

### **6.5.1 Where The Elderly Live**

Based on the previously mentioned sampling methods, the elderly in one strata of the sample live in OAHs while the other half live outside OAHs. Among the elderly living outside OAHs, just over half (51%, n = 61) live in their own houses; while 24% (n = 29) of the elderly live in rented accommodation; 13% (n = 15) live with their own children, and the rest live with extended family members, friends or are homeless (Table 14). For those elderly who live in OAHs, 95% (n = 112) like living in these homes very much (Table 15). For those who like living in an OAH, the majority (71%, n = 84) cite company of other elderly as the primary reason they like

the OAH; 63% (n = 74), say that they get needed help fast; 39% (n = 46) say there is enough time to rest, 36% (n = 42) like having friends nearby (Table 16). Almost all (95%, n = 112) of the elderly say they are satisfied with the care given at the OAHs where they reside (Table 17). However, researcher's observations reveal religious morals among respondents who assert that as Christians, they should be satisfied with what was being given to them. These results indicate that the elderly are satisfied with the care given to them in OAHs even though individual elderly base the satisfaction on different aspects.

Failure to adjust to the OAH environment negatively affects health and well-being of elderly people. When asked to indicate the positive aspects they liked while living outside the OAH, slightly over half of the elderly in OAHs (56%, n = 66) indicate they liked working outdoors and an active social life; 22% (n = 26) indicate they liked living with, caring and being cared for by family and kin; 25% (n = 30) indicate they miss security, peace, privacy and freedom in their own homes; while 16% (n = 19) indicate they miss the financial security while they were working ( Table 18).

However, when asked to state the negative aspects they had experienced as elderly people living outside OAHs, 28% (n = 33) could not state any negative aspect while 33% (n = 39) state that they disliked the poor security, inadequate care and abuse by children; 21% (n = 25) state they had financial

problems and inadequate access to basic needs; and 18% (n = 21) state loneliness while living outside the OAH was a problem (Table 19).

These results indicate that although some elderly have things that they miss about living outside OAHs, most elderly who live in OAHs are satisfied with their living situation. It appears that these elderly people have adapted to the concept of institutional living.

#### 6.5.2 **Elderly's Attitudes Towards Moving to an OAH**

Studies indicate that elderly people who are socially integrated into their communities are less desirous of moving to OAHs (Ferreira 1984:5). Furthermore, the likelihood of an elderly person moving to an OAH is determined by different circumstances, including the individual's attitude towards such institutions. The elderly living outside OAHs were asked to state whether or not they would move to an OAH at a future date. Of the 120 sampled elderly living outside the OAH, the majority (73%, n = 87) state that they will not move to an OAH (Table 20).

**Table 20: Attitudes Towards Moving to an OAH**

| Like to Move to OAH | Number | %   |
|---------------------|--------|-----|
| Yes                 | 33     | 27  |
| No                  | 87     | 73  |
| Total               | 120    | 100 |

Note: Totals for elderly living outside OAHs.

However, when all the elderly were asked whether or not they think more OAHs should be built, the majority support the idea (69%, n = 160)

(Table 21). These results show that even though the majority of the elderly living outside the OAH do not intend to move to one, they recognise a need for OAHs in some circumstances. Key informants from OAHs confirm that they have long waiting lists of applicants. Most of the elderly living in OAHs like it and therefore support the idea of building more OAHs.

### 6.5.3 Decision-Making on Institutional Care

It is argued that the institutionalisation of elderly people represents a failure of family, community, statutory bodies and others concerned, to keep these elderly people in their own homes (Madzingira 1997:15). Decision and choice to move to an OAH can either be made by the elderly person or the caregivers. The elderly living in OAHs were asked to state who made the decision for them to move to the OAH. Table 22 shows that the majority (64%, n = 75) state that they made the decision themselves; but for 22% (n = 26) of the elderly, the decision was made by relatives.

Table 22: Decision-Making on Institutional Care

| Decision Maker | Number | %   |
|----------------|--------|-----|
| Myself         | 75     | 64  |
| Relatives      | 26     | 22  |
| Church         | 9      | 7   |
| Government     | 8      | 7   |
| Total          | 118    | 100 |

Note: Only elderly living in OAHs with a total of 118.

Among the 22% of the elderly whose relatives made the decision for them to move to an OAH, there are some elderly who were forced to move. For example, one relative admits:

*“... I made the decision and choice [of the OAH]. I forced her [my mother] to go... she did not want to go. She is unhappy and complains daily, but I am satisfied. The attention given [by the OAH to my mother] is good. (Daughter of OAH resident, Khomas Region).*

Despite financial problems and inadequate living space in housing units, some families are prepared to care for their elderly members at home and only request for financial support from the government. Some family members feel strongly that it is their responsibility to care for elderly parents and would not take them to an OAH under any circumstances, one woman asserts:

*“... I will never do that [take my mother to an OAH] ...as long as I am alive. I am stretched.... She [my mother] raised me. It is my responsibility to care for her. The culture [I am raised in] demands of me to care for her [my mother] (Daughter of elderly, Khomas Region). “... even if I am still a young unmarried boy, I can still care for my old mother and father (Son of elderly, Kunene Region).*

These results indicate that although the decision to move to an OAH largely lies with the individual, a few family members choose to take elderly members to OAHs but not always with the elderly person's consent. Furthermore, despite financial costs involved in elderly care or pressure from modernisation forces, some families are still committed to care for their elderly members within the family. This commitment provides a basis to encourage and support the family to continue its elderly care role.

#### 6.5.4 How Families Value Their Institutionalised Elderly Members

Societal values and respect for the elderly continue to change with the modernising process. Feelings of rejection by family, as well as other negative effects, have been observed among institutionalised elderly people. The elderly's views were solicited on whether or not families who move elderly relatives to OAHs value these elderly less. Just over half, (54%, n = 127) of all elderly respondents do not think such families value these elderly members less (Table 23). Case studies and key informants confirm that most OAH residents are regularly visited by family members. Furthermore, many families of the elderly who live in expensive OAHs pay the fees. Table 24 indicates personal views on elderly institutionalisation. Slightly over half of the elderly (54%, n = 128) personally feel that the family has failed to care for the elderly at home. In addition, 27% (n = 63) feel the community has also failed, while another 28% (n = 67) feel the community has not failed but is simply not bothered about old people.

Table 24: The Elderly's Personal Views on Elderly Institutionalisation

| Personal View          | Yes |    | No  |    | Total |     |
|------------------------|-----|----|-----|----|-------|-----|
|                        | No  | %  | No  | %  | No    | %   |
| Failure of Family      | 128 | 54 | 110 | 46 | 238   | 100 |
| Failure of Community   | 63  | 27 | 175 | 73 | 238   | 100 |
| Community not Bothered | 67  | 28 | 171 | 72 | 238   | 100 |
| Other Reasons          | 48  | 20 | 190 | 80 | 238   | 100 |

From these results the elderly feel that families still value and respect their elderly members even if institutional residence is preferred. Even if the percentage of elderly people in OAHs is small compared to the country's population, these results indicate a positive change towards acceptance of OAHs as an alternative method of caring for the elderly when circumstances necessitate.

#### **6.5.5 Elderly's Preferences on Where to Live**

Options of where to live largely depends on where an individual believes he or she would receive better care. When asked to state their preferences on where to live, half of the elderly (51%, n = 121) say that they would prefer to live in an OAH; 30% (N = 70) prefer to live on their own, and 19% (n = 44) of the elderly prefer to live with family and friends (Table 25). The majority of the elderly who prefer OAHs (75%, n = 88) cite better care as the main reason for their preference; but 40% (n = 47) say that children are too busy (Table 26).

From these results, the number of the elderly who prefer to live with their families is reducing, an indication of changing attitudes among the elderly who wish to retain their independence. Modern aspects such as urban living and lifestyle leads to change in attitudes and people's perception of things. Hence, the elderly's perception that children are too busy to give appropriate care to elderly parents.



### 6.5.6 Elderly's Attitudes Towards Culturally-mixed OAHs

The Namibian government policy of reconciliation is expected to contribute to racial integration, reduce inequalities in society and enhance equitable provision of services and sharing of resources among citizens. The elderly were asked to state whether or not they would live in a culturally-mixed OAH. The majority, (74%, n = 166) state that they would live in such an OAH, while 26% (n = 58) would not (Table 27). The reasons given by the majority of the elderly who would not live in such an OAH include preference to live with people of similar ethnic group (48%, n = 25), and not being able to understand elderly from other cultures (44%, n = 23) (Table 28).

The reflection of the majority being positive about living in a culturally-mixed OAH contradicts observed behaviour by the researcher whereby some white elderly allowed the white research assistant into their houses but not the black researcher or the indigenous (Damara) research assistant. The latter had to complete the questionnaires while standing outside the gate. It is unlikely that such an attitude would change to enable an elderly person live with others from different cultures in the same OAH. Key informants assert that “...at that age, they [elderly people] need to be with their own people, so racial segregation cannot be taken out of institutions [OAHs]. Change of attitudes is not easy in old age (Relative of OAH resident, Khomas Region.

Key informants point out that there is an ethnic tendency in occupancy of OAHs by white elderly, as one points out that “...Germans have their

*expensive one [OAH] while Afrikaner are also alone. Blacks [indigenous groups] cannot afford to live in these homes [OAHs] in any case... (Relative of OAH resident, Erongo Region).*

These results indicate that operating a culturally-mixed OAH is difficult at the present time because of the history of apartheid. All current categories of elderly people are products of racial segregation for whom change of attitudes is difficult. Such attitude change will occur with time, considering that younger people currently mix more than in the past.

## **6.6 Social Economic Status and Needs of the Elderly**

### **6.6.1 Elderly's Previous Occupations**

Low and inferior earnings in earlier life without pension provisions result in lack of savings with implications for financial hardships in old age. The elderly were asked to indicate their previous occupations. Most of the elderly (31%, n = 74) are former farm or domestic workers, and only 26% (n = 62) were government or company employees. The rest of the elderly are former farmers, housewives or held other poorly paid occupations (Table 29).

These findings imply that the majority of the elderly earned wages that had no pension provisions or opportunities to save or invest for financial security in old age. The literature confirms how inferior earnings in earlier life contribute to poverty in old age (Weeks 1996:384, Lauer 1995:258).

### **6.6.2 Social Pensions and Elderly's Other Sources of Income**

Elderly's economic position to a large extent is determined by pension rights. Asked to confirm whether or not they receive a social pension and the pension adequacy, the majority of the elderly (79%, n = 188) confirm that they receive social pensions from government, but 21% (n = 50) do not receive it (Table 30). Of the elderly who receive a social pension, the majority (91%, n = 171) find it inadequate for the needs of (Table 31). Almost half of the elderly (46%, n = 79) top up their inadequate pension with additional funds from families and friends; 16 % (n = 28) have investments and OAHs pay for 14% (n = 23) (Table 32). For the elderly who do not receive social pensions, 24% (n = 12) are financially supported by their families and the rest of the elderly raise funds from different sources including the church (Table 33).

These results indicate that the social pension is inadequate and cannot meet financial requirements of most of the elderly, including payment of high fees of OAHs which provide good services. The family remains a source of financial support to supplement the elderly's social pensions.

Other sources of income augment the elderly's financial resources to access services and other health care needs. As indicated in Table 34 below, the majority of the elderly (61%, n = 145) do not have any other source of income other than the social pension. Furthermore, most indigenous elderly failed to prepare for retirement and old age due to the political situation

during their working life. One former manual employee of MEATCO laments: “...I did not prepare [save or invest money] for old age. Many people of low income do not prepare [save], the money is not enough...”

Table 34: Elderly’s Other Sources of Income

| Other Income Sources | A Source |    | Not A Source |    | Total |     |
|----------------------|----------|----|--------------|----|-------|-----|
|                      | No       | %  | No           | %  | No    | %   |
| None                 | 145      | 61 | 93           | 39 | 238   | 100 |
| Family               | 41       | 17 | 197          | 83 | 238   | 100 |
| Savings and Interest | 26       | 11 | 212          | 89 | 238   | 100 |
| Private Pension      | 22       | 9  | 216          | 91 | 238   | 100 |
| Investments          | 16       | 7  | 222          | 93 | 238   | 100 |
| Rent of Property     | 8        | 3  | 230          | 97 | 238   | 100 |

These results, together with information from key informants, indicate that the elderly are poor and are dependent on the small social pensions. Low or no earnings during working life and the political situation contributed to failure to save for old age. The few respondents with savings and investments are white. The family, whether poor or not, remains a consistent source of support for elderly people.

### **6.6.3 The Elderly’s Associational and Club Memberships**

Associational networks increase an individual’s sources of help. Only 35% (n = 82) have club and associational memberships, while the majority,

65% (n = 154) are not members of any association or club (Table 35). Key informants confirm that elderly associations and clubs offer their members services not accessed by non-members. These results indicate that the majority of the elderly do not benefit from opportunities and support prospects offered by such organisations, regardless of whether they live in or outside of OAHs.

## **6.7 Family, Community and Government Elderly Support**

### **6.7.1 Family and Community Elderly Support**

Modernisation erodes traditional values, family roles and community support structures for care of older people (Apt 1996:16). Of all the elderly sampled 87% (n = 207) have children but only half of these elderly (52%, n = 108) receive support from the children (Tables 36 & 37). In evaluating adequacy of children's support to elderly parents in their communities, 56% (n = 130) of the elderly rate the support as inadequate; with only a minority of 12% (n = 30) rating the support as adequate (Table 38). The rest of the elderly rate the support to be moderate or none at all. Some elderly people are confident of their children's dedication to continue caring for them and therefore would not need to move to an OAH. One elderly person states:

*“... no [I will not move to an OAH]. My children will care for me. I only expect government to assist [elderly person] with transport to health centres” (Kunene Region).*

However, when asked for views on an extended family's propensity to give better eldercare than a nucleus family, only 28% (n = 64) state that an

extended family would offer better care, but the majority of the elderly (72%, n = 169) do not think so. Key informants concur that extended families have a potential to share the care responsibility, but it does not always happen (Table 39).

These results confirm that although the level of support is being eroded, many elderly still get support from their children. However, the elderly's views are that small families can still offer quality care to elderly members compared to some extended families.

#### **6.7.2 Impact of Elderly Institutionalisation on Family Economics**

Institutionalisation of elderly people is one of the results of a changing society. Institutional elderly care has an impact on the economics of the family with respect to finances and time benefits, but also bears problems. Models of OAHs offering high quality care services are expensive and require advance planning by the elderly or their families. For example to make investments so as to afford increasing costs of the OAHs. Operating OAHs at state level on a comprehensive welfare state system is too expensive for a developing state such as Namibia.

However, the families of the elderly in Model III OAHs supported by the church or municipality, such as Nau Aib and Kuisebmond, report financial benefits. These benefits include relief from additional payment to cover room fees; savings on food; clothing and daily care costs. Where the

municipality supports the OAH, the financial burden is distributed to all taxable municipal residents. In addition, a time benefit of institutionalising the elderly is that younger family members are free to concentrate on productive work.

However, families also report a financial loss in terms of security around the home when a strong elderly member moves to an OAH. In Model IV OAHs supported by either the Town Council or MoHSS, a house unit is allocated to an elderly person, but other family members live in the house free of charge, such as Khorixas OAH. In addition, the social pension forms part of the budget for the household. Although family members provide care to the elderly member, the elderly person's financial needs remain unfulfilled.

In contrast to families of the elderly who live in OAHs, families who care for the elderly at home derive financial benefits in terms of services rendered by the elderly person. For example, sharing social pensions in the family budget; child care; house chore services and house security provision when the elderly person stays at home. Younger family members are therefore free to work or socialise because of the elderly's assistance and input to the family activities. Problems faced by families involve disabled and frail care demands on time; inadequate frail care knowledge; lack of transportation services; inadequate space in family houses and curtailed social life of caregivers. Relatives of the elderly indicate that the solution to negative

impacts of elder care on the family is financial support from government to enable it continue with the responsibility.

These results show that although there are benefits to the family in caring for elderly members, the problems are many. OAHs provide an alternative to family elderly care but are expensive to run. Therefore spreading the cost to the public, such as that of Model III OAHs supported by the municipality provides relief to families or individuals who pay the fees.

### **6.7.3 Elderly's Views on Government Elderly Support**

Modern institutions and national social welfare policies at times fail to target support to specific needs of elderly people or fall short of target expectations and require redirection. The elderly's views on government support in aspects of finance, housing and health care for elderly people are indicated in Table 40 below.

Table 40: The Elderly's Perceived Government Support

| Type of Support | Enough |    | Not Enough |    | Total |     |
|-----------------|--------|----|------------|----|-------|-----|
|                 | No     | %  | No         | %  | No    | %   |
| Financial       | 23     | 10 | 210        | 90 | 233   | 100 |
| Housing         | 40     | 18 | 185        | 82 | 225   | 100 |
| Health          | 53     | 23 | 178        | 77 | 231   | 100 |

Note: Totals do not add to 238 due to non-responses.



The table shows that the majority of the elderly perceive support from the government to be inadequate in all three aspects. Key informants and elderly case studies confirm the contention that government support for the elderly is inadequate and that poor families are worse off.

These results indicate that government eldercare support and services fall short of elderly expectations. Examples in the three aspects are clear. Even if the social pension is increased to N\$ 300 per month from January 2004 as Parliament has passed, the amount is still too low for prevailing economic conditions. The increase cannot cover a significant increase of OAH fees so as to improve services. The high cost of utilities, with subsidy being paid only to a few elderly living in subsidised housing units excludes the majority of elderly people living in their own homes; and specialised health care is not provided at government health centres.

#### 6.7.4 **Activities of Elderly People**

Activity provision to elderly people is a support function. Activity involvement is positively related to well-being of elderly people, because activities help structure time, improve mental alertness and help avert feelings of loneliness. Hence the elderly need opportunities for meaningful activities. When asked to indicate free time activities, 77% (n = 183) of the elderly listen to radio or watch television; 68% (n = 162) take walks or talk to friends and 58% (n = 137) read books or the bible. Other free time activities include handicraft making (Table 41).

While Model I OAHs provide elderly residents with a range of activities, other models of OAHs provide only a few or none at all. Of the 118 elderly living in OAHs, 36% (n = 42) say no activities are provided at the OAHs they reside in. However, the main activities provided by OAHs include bible study (48%, n = 56) and library (43%, n = 51). Other activities are choir and music, as well as indoor games (Table 42). Key informants confirm disparities in activity provision at OAHs, as well as among the elderly living within communities. Some elderly report that:

*... they [elderly residents] are too busy. Women from German Organisation conduct weekly activities (Manager OAH in Khomas Region). None [activities] are organised but some elderly moved [to the OAH] with their chickens to rear (Manager rural OAH in Erongo Region). We create opportunities to keep elderly active... (Chairman, Elderly Association in Khomas Region). ...all encompassing activities [including education on health] to registered members (Chairman, church-congregational Welfare organization in Khomas Region).*

These results show that activity provision at different models of OAHs depend on financial status of the home; and to an extent education levels of community members that support the OAH. Therefore access to activity provision as a support function depends on the model of OAH an elderly person resides in. Furthermore, the results reveal that popular activities include bible study and choir; listening to radio or watching television. Therefore, these media can be effectively used for information dissemination on elderly issues.

### **6.7.5 Elderly's Perception of Gender Balance in Elderly Care**

Women's longevity and their continued care-giving roles in families tends to keep them closer to families, raising expectation of reciprocal care. The elderly's views on gender balance<sup>42</sup> in elder care indicate that the majority view (81%, n = 191) is that equal care is given to both elderly men and elderly women, but 14% (n = 34) indicate that females are favoured (Table 43).

Even though the results indicate a low percentage of females being favoured in eldercare, low female numbers in OAHs occupied by indigenous elderly indicate a higher likelihood of women being cared for within families. One key informant states:

*"... there are more men [in Katutura OAH]. Women are taken by families. It could be that the community is willing to care for females [elderly women] more than men".*  
(Chairperson, Management Committee, OAH in Khomas Region).

### **6.8 Education and Information Sources for Elderly People**

Extensive information dissemination is a characteristic of a modern society. Providing elderly people with knowledge and information, such as information on health and nutrition, empowers such elderly to keep healthy. Information provision also serves as a support function to maintain the elderly involved with society. The majority of respondents (82%, n = 195) indicate radio as a source of news and information, 57% (n = 135) indicate

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<sup>42</sup> Gender balance in care here is if the level of care given to elderly men is the same as that given to elderly women.

television, 45% (n = 106) indicate newspapers. OAH also provide news and information to the elderly (Table 44). Furthermore access to information empowers the elderly to know and claim their rights. The majority of respondents, 71% (n = 170) state that they do not know about elderly rights passed by United Nations (UN) (Table 45).

These results collaborate free time activities of the elderly and confirm that radio and television are accessible media through which information and programmes on elderly issues can be channeled. However, programmes on elderly issues in the Namibian media are lacking. This assertion is supported by a question posed by an elderly person living in an OAH in Erongo Region that, “ ....we [elderly people] like to get news about our [elderly people's] issues. Why isn't it [elderly news] there [in the media]?....”

From these results it is clear that information dissemination as a support function for elderly people is generally lacking, and therefore presents a gap in the elder care system.

#### 6.9 **Current Problems Faced by Elderly People**

Older people face various psychosocial and socio-economic problems that negatively impact on quality of life. While only 13% (n = 31) of the elderly say they have no problems at all, 63% (n = 149) have financial problems, and 62% (n = 148) say they do not have adequate food or clothing (Table 46). Key informants confirm these problems and stress that lack of trained

caregivers hampers delivery of appropriate care to frail and bedridden elderly people. These results show that most of the elderly cannot access the services they need because of financial problems and lack of adequate care.

#### **6.10 Elderly's Perception of the Future of Eldercare in Namibia**

Based on community and personal experience, elderly people can provide insightful advice and information on eldercare needs, and identify gaps in the care system that would assist policy and programme formulation to target those particular needs.

The elderly, supported by key informants, identified gaps in the current eldercare system as:

- Expensive and inappropriate models of institutional care for the majority of elderly people
- Inadequate financial support for families and the elderly
- Inadequate recreational facilities and activities
- Lack of caregiver training
- Poor information dissemination
- Lack of research-based information to formulate realistic programmes to meet elder care needs, and
- An inequitable government system of elderly support.

Furthermore, the elderly discussed the future of eldercare in Namibia in the next decade and beyond. To reduce the elderly's financial problems, most of

the elderly (44%, n = 104) recommend an increase of social pensions and improvement in the processing and payment procedures. Another 32% (n = 76) advise government support for housing and a subsidy in utility costs, recreational facilities and increase of social workers; 26% (n = 62) advise government to promote eldercare in families but build OAHs only for the destitute and frail care needs; 23% (n = 55) advise government support to caregivers through incentives, both financial and in-kind. Other suggestions include teaching eldercare in formal schools, building more OAHs and improvement of health care services (Table 47).

Key informants strongly support the elderly's views, but lay emphasise a need for:

- Increased government support at community level, and decentralisation of responsibility to municipal councils
- Family and caregiver support through payment of incentives
- Caregiver training for home-based care, and
- Public information dissemination on elderly issues.

Additional areas of concern include elderly participation in voluntary activities; formation of associations at local levels; revival and support of traditional care structures by government; and reduction of disparities in services between urban and rural areas. A need for systematic studies is also emphasised so as to keep abreast of changing elderly needs in communities to support policy and programme review. These results reflect gaps in the current elderly care system that need to be filled.

A Bill on 'Rights, Protection and Care of Older People' has been drafted ahead of a national survey on the status and living conditions of older people in Namibia. The survey aims to assess the quality of service provision so as to recommend future strategy and policy.

In summary of the survey data, several factors that have an impact on the levels and types of care offered to the elderly emerge from the results of the study. The study population comprises of more elderly women than men. The higher numbers of elderly aged between 70 to 80 years indicates that there will be more people over 80 years who will require higher levels of care in the future. Elderly care has an impact on family economics in respect of finance and time requirements. However, the family lacks adequate government support. In addition, the elderly's financial status is poor. Furthermore, most of the elderly caregivers need to be trained to acquire adequate basic knowledge to fulfill their roles. Information dissemination on elderly issues is mostly lacking.

As indicated in Chapter five, five models of OAHs are identified in the study areas. Occupancy of the OAHs shows that numbers of elderly women in OAHs occupied by indigenous elderly are much lower than those of men, while it is the opposite in OAHs occupied by the white elderly. Analysed from an ethnic perspective, most of the men in OAHs occupied by indigenous elderly are Owambo, mostly products of the contract labour system. Most of the women are Damara. Unlike the Herero or Owambo

ethnic groups, the Damara do not have strong extended family ties. Therefore the tendency of families to care for elderly members at home is reduced. On the other hand, the majority of white women in Model I OAHs are German. The Germans as an ethnic group have longer life expectancy, but longevity of women over men in general places their numbers higher than that of men.

Levels of care in the different models of OAHs also differ greatly and reflect income inequalities in the Namibian society. On the whole, government support to the elderly is perceived to be inadequate. The Act on elderly care is under review and a national survey on the situation of the elderly in the country was launched on 1<sup>st</sup> October 2003. The implications of the results of this study are discussed in details in the next chapter.



## **CHAPTER 7**

### **IMPLICATIONS OF RESEARCH FINDINGS FOR ELDERLY CARE IN NAMIBIA**

#### **7.1 Introduction**

This chapter discusses the implications of the study findings for eldercare in Namibia, by examining various factors that determine levels and types of care given to elderly people. Attitudes towards institutionalisation are assessed and models of institutional care in the study areas are discussed. Namibia's new policy strategies are evaluated against operation of OAHs, and the chapter ends with a discussion on elderly people's vision for elderly care in Namibia in the future. The discussion takes into consideration information from case studies and key informants contained in Appendix III.

#### **7.2 The Study Population**

Similar to other countries, the study population comprises of predominantly widowed elderly women, this fact confirms literature on the longevity of women over men (HAI 2000:3; UN 2000:17). Given the higher percentage of the category aged between 70 to 80 years (44%), there will be increased pressure on the family and government resources for care. Furthermore, the higher percentage of elderly women (58%) calls for an examination of the issues of gender in elderly care, so as to develop policy strategies that target women because of women's vulnerabilities (Apt 1998:1; UNFPA 1998:5; The UN 2002:19).

Elderly people in the study areas have similar experience of increased health problems as in other countries such as Zimbabwe (Nyanguru 1991:78). The impact of increased number of deaths due to AIDS on elderly people is not directly addressed in this study, but data from key informants imply that AIDS has become a major concern to the elderly, as well as to government. Considering negative effects of the HIV/AIDS on the general well being of the elderly in other countries affected by the pandemic, Namibia cannot be an exception. Literature indicates that in Uganda and Zimbabwe the elderly are physically, emotionally and economically drained while caring for their sick adult children and later raising orphaned grandchildren (Ntozi and Zirimenya 2002:14; Foster et al 2000:20).

### **7.3 Factors Determining Levels and Types of Care**

Factors that have an impact on the levels and types of care given to the elderly in the study areas include:

- Informal family care
- Elderly's financial status
- Caregiver training and support
- Information dissemination on elderly issues
- Gender and elderly care,
- Government support and rural/urban services
- NGOs and elderly care services, and
- The model of OAH where the elderly live.

### **7.3.1 Informal Family Elderly Care and Family Economics**

The traditional family in Namibia has always cared for elderly people although it is increasingly failing to fulfill this role due to poverty and forces of modernisation. Given that 87% (Table 36) of the elderly have children but only 52% (Table 37) support their elderly parents; the implication here is that the role of the family in providing elderly care is being eroded. Furthermore, over half of all the elderly sampled state that institutionalisation shows the family's failure to give care. Literature shows this erosion of the family's role in other African countries (c.f Apt 1996; Cattel 1989; and Hampson 1985; Wilson and Parsons 1991:111).

#### **7.3.1.1 Impact of Elderly Care on Family Economics**

Informal elderly care has both positive and negative impacts on family finances and time costs. Financial costs for elderly care are high and cover basic needs of food, clothing, housing, as well as medical and transportation costs. Many of the children of the elderly living in expensive OAHs pay or contribute towards the high fees even though some of them complain about the cost.

Furthermore, the results show increased health problems among the elderly, but 90% (Table 10) of the elderly having no medical insurance coverage. In addition, specialised treatment costs are not covered by government health care services. The implication here is that in most cases the family has to bear these medical costs, hence caregivers complain of being financially

stretched. Given the poverty levels in communities, access to specialised medical care will be accessible only to elderly who are financially better off. Observations show that high poverty levels and historical inequalities in the Namibian society render many families incapable of extending adequate care to their elderly members. This poverty has contributed to the social pension being the main source of income supporting 11% of intergenerational households (NPC 2003:4). The implication here is that the elderly cannot satisfy their own financial needs. Similar experiences of social pensions supporting intergenerational households are reported in South Africa (c.f. Lekgetta and Robertson 1978:11; Duveraux 2003:1). Considering high levels of poverty within communities, it remains to be determined by future research whether or not a social pension is a prime consideration as a source of financial support when young families decide to care for elderly members at home.

Emotional costs to the family and informal caregivers for the elderly are high. Assessed from a practical point of view, the results indicate that caring for elderly people is time consuming and curtails social life of family caregivers, more so when caring for frail and disabled elderly people. Nair's study (1989:105) reports of similar experiences of reduced social life among family caregivers in Durban, South Africa. However, informal elderly care also has benefits derived through mutual support and exchange of services between generations in the family. The implication here is that the elderly are not only recipients of care but are also caregivers. The elderly contribute to

the family when they undertake house chores, childcare or security of the home by staying around the home. Another implication here is that younger family members get time to socialise or undertake other more strenuous work.

Nevertheless, despite poverty and erosion through nuclearisation of the family, urbanisation, and segregated housing, the study findings indicate that the Namibian family has remained consistent in supporting elderly members (Table 32 and Table 33).

### **7.3.2 Elderly People's Financial Status**

Elderly people's financial status contributes greatly to services they can procure, such as specialised medical care, food, clothing or transportation costs. The results show that financial problems rank the highest among current problems faced by the elderly (Table 46). The majority of the elderly had low occupations and earned low wages during working life, while others were unemployed (Table 29). In addition, pre-independence government policies excluded many indigenous government and company employees from contributing towards pensions. The implication here is that most of the elderly did not save funds or make investments to cover retirement and old age. Studies in South Africa and Zimbabwe show similar financial problems facing the elderly (Madzingira 1997:8; Wilson and Parsons 1991:111).

Even if the social pension is to be increased to N\$ 300 per month from January 2004, the amount is still low and will remain below prevailing inflationary levels. The government of Namibia states that it is unable to substantially increase the social pension due to economic pressure on the government budget. Experiences of developed countries indicate that pension improvements eliminated poverty among elderly people (c.f. Palme at al 2002:76). The implication here is that the elderly's financial problems will persist as long as their pensions remain low.

### **7.3.3 Caregiver Support and Training**

The study identifies a lack of trained caregivers, and a lack of motivational support for caregivers as major gaps in the eldercare system. Caring for the elderly, especially for the frail and invalids, is a difficult and emotionally draining job that requires motivational support. Given the poverty within communities and the high levels of unemployment, individuals who care for the elderly need to be motivated and supported in various ways so as to meet their own personal needs. The implication here is that when caregivers' own needs are met, they will continue to be responsible for their elderly relatives.

Informal caregivers and employees of OAHs occupied by the indigenous elderly lack basic knowledge in physiotherapy, elderly nutritional needs and frail care. The implication here is that these elderly cannot be given the quality of care they need. However, this does not mean that caregivers lack traditional ways of caring for elderly people, but due to social changes and

lifestyles, this knowledge needs to be augmented. Furthermore, without putting a training programme in place, a lack of trained elderly caregivers will continue to hamper effective and quality care services given to the elderly in the future.

Elderly case studies propose an introduction of elder care training through formal schools and adult training programmes. The implication here is that a pool of elderly caregivers will be built systematically to meet future elderly care needs. Furthermore, formal education and training in elderly care bears an inherent advantage of strengthening a sense of responsibility towards the elderly into young children as potential future elderly caregivers. This sense of responsibility towards the elderly is being eroded by, among others, nuclearisation of families and the segregated housing which are characteristics of a modern society. In addition, introducing elder care in formal education presents an opportunity to involve the elderly in the modern schoolroom education for children to benefit from the elderly's cultural knowledge, and keep the elderly involved with society. Literature indicates the benefits of integrating the elderly in the modern schoolroom in Ghana, Kenya and Australia (Apt and Grieco 1998:1, 3).

#### **7.3.4 Information Dissemination on Elderly Issues**

Effective information dissemination on elderly issues is lacking in the elderly care system. The majority of the elderly have access to a radio and a television. Most of the elderly also listen to and view these media as a free

time activity but 71% (n = 170) do not know about the elderly rights proclaimed by the UN (Table 41, Table 44 and Table 45). The implication of these findings are that the elderly are deprived of information on issues that concern them because topical programmes on elderly issues are lacking in the media.

Furthermore, the general public is also deprived of knowledge that would enable them to improve the quality of care extended to the elderly; initiate and support elderly care programmes in communities; and enlighten individuals on how to better prepare for old age. For example in Ghana, literature reports on how improvements in elderly care and support services have been achieved with the aid of information dissemination through the media (Apt 1996; Rosemeyr 2001:10). Media programmes and opportunities for the elderly to air their views about issues that affect them are also lacking. The involvement of the elderly in media programmes would also help to keep the elderly involved with society.

### **7.3.5 Gender and Elderly Care**

Longevity of women over men is confirmed by the study (58%) most of whom are widowed (34%). Conditions of women in Namibia indicate some cultural practices that involve widows' loss of property to their deceased husband's relatives. Widowhood and cultural practices contribute to poverty among women during their old age. Although 81% of the elderly perceive eldercare levels to be balanced between men and women, there is an ethnic



dimension to gender in formal institutions. The number of indigenous elderly women in OAHs compared to men is very small; but the opposite applies to white elderly. There are more white elderly women than elderly men in OAHs. This may be partly explained by cultural preferences of families in indigenous communities to care for the elderly at home.

Women's lifelong caring role continues in old age, and these results indicate that elderly women who live with families continue to undertake household chores and childcare roles. The desire to give care to their families or the preference of families to care for elderly female members within the family may negatively influence elderly women's attitude towards institutional care. Thus this partly supports objective one of the study which is 'to assess attitudes of the elderly towards institutionalisation'. Experiences of elderly women as receivers and providers of care are supported by literature (Apt 1998a:1-5; The UN 2002:19).

Furthermore, the social pension is often the first formal income for many elderly women and in most cases it is shared by the family. Some elderly women have been abused and others murdered by family and community members because of competition over the social pension (*The Namibian* 30<sup>th</sup> January 2002; 1<sup>st</sup> March 2002). The conditions of women in Namibia, as in other countries, indicate that women face multiple jeopardy of poverty, widowhood, negative cultural practices, poor health and the stress of care giving roles in old age. The implication here is that this multiple jeopardy

impacts on the quality of life of elderly women, and on the levels and types of care they receive.

### **7.3.6 Government Support and Urban Versus Rural Elderly Services**

The government welfare support system for elderly people has a major impact on the levels and types of care extended to the elderly. The elderly perceive government support in financial (90%), housing (82%) and healthcare (77%) aspects as inadequate (Table 40). Given the poor financial status of the elderly, dependency on the low social pension as the only source of income, government support services fall short of the elderly's expectations. Access to low-rent accommodation provided by government; payment of subsidised utility costs by the elderly; and subsidies to OAHs remain unequal. These services continue to benefit mainly white elderly but key informants confirm that a few coloured elderly have been admitted in low rent accommodation. Furthermore, the majority of the elderly cannot afford to pay for specialised medical health care. The government strategies for elderly care and support should aim to equalise services to all the elderly.

The study reveals that there is an urban bias in provision of services to the elderly. Government statistics reflect that Khomas Region is 93% urban while Erongo Region is 80% urban (NPC 2003). Services to the elderly are comparatively better in the urban centres than rural areas. For example, proximity to healthcare centres and pension pay points, access to social workers, potential donors for OAHs as well as outreach programmes for the

elderly are comparatively more convenient for the elderly living in urban areas. In addition, elderly associations in the study areas are urban-based, and supported by educated young people whose earnings are much better than their rural counterparts. Although transport is a problem for some of the residents of OAHs located in urban areas, the problem is more acute in the rural area. For example, the elderly in Okombahe lack transportation not only to a pension pay point which is over 65 kilometres away in Omaruru, but also to hospitals when referred from the local clinic. These elderly people also lack assistance to complete pension claim forms, and are unable to follow up on delays in processing the forms at the regional office in Swakopmund, which is over 100 kilometres away. The implication here is that if the disparities between urban and rural services to the elderly are not addressed, the rural elderly will continue to benefit less than their urban counterparts. Perhaps this will compel more elderly to move to urban areas to seek better services.

Furthermore, professional social workers in the field and case studies reveal difficulties experienced by rural families in accessing funds under the funeral scheme when an elderly person dies. Long distances from government offices prompt family members to bury the body before processing funds under government funeral scheme. However, MoHSS does not pay the funds to the family members after the body has been buried. The implication here is that some strategies of government services do not target specific problems and circumstances of the rural elderly. Literature indicates similar

experiences of the rural versus urban disparities in elder care services in South Africa as reflected in the work of Dubazana (1989:40). Apt (1998:3) points out perpetuation of rural versus urban disparities in elderly care services in Sub-Saharan Africa through government concentration of development in urban areas. The general implication of these findings are that there is a growing trend for people to move to urban areas where care services are better. This urbanisation trend is a characteristic of modernisation.

### **7.3.7 NGOs and Services to the Elderly**

Pressures on national welfare budgets have led to the articulation of the voluntary sector in new ideological ways, as well as the sector's potential for elderly care services (Wijkstrom 1997:213; Svdberg 1996:416). The voluntary sector is composed of NGOs involved in elderly welfare, but in the Namibian situation, the church is also included. Churches shoulder a major role of the elderly welfare services, including the operation of OAHs. The findings here are similar to the experiences in Zimbabwe as reflected in the work of Madzingira (1997). Given the strong Christian affiliations in the study population (85% n = 202, Table 8). The implication here is that the high involvement of churches in elderly welfare presents a chance to mobilise church-sponsored financial and moral support through church congregations. This view is supported in literature Carmen and Friedland (1995:2) report on the potential for congregational-based organisation of

communities to provide effective services for the elderly across racial and ethnic lines.

Associational organising is a characteristic of modern society. Some elderly people also benefit from services provided through associational membership and clubs, which are not accessible to non-members. However, with the exception of ASC in Walvis Bay, current elderly welfare organisational activities in the associations and clubs are ethnic-based, based on financial resources of the elderly. For example paid-up membership of ASC in Windhoek is drawn from white communities, while that of ABB in Khomasdal in Windhoek is drawn from the coloured community. The implication here is that the elderly associate with other elderly who are mainly from their own ethnic groups who can afford to join the clubs. This limitation in association means the elderly miss out on chances to benefit from new ideas and knowledge that could be drawn from other ethnic groups.

However, NGOs can be used to mobilise stocks of 'bridging social capital' within communities to support elderly programmes across ethnic lines. This support can be for elderly living within families, as well as OAHs. Considering high poverty levels in the communities, and the fact that OAHs are a new concept in indigenous communities, NGOs can help enhance and promote the concept of voluntarism to assist the elderly. Literature indicates

success of such efforts in other countries, for example, elderly care cooperatives in Japan reported by Ueno (1998:2).

Furthermore, experiences in other countries show that NGOs also fill gaps left by government and identify new areas of need. For example, the work of the South African National Council for the Aged (SANC) ; and the Swedish experience of NGOs undertaking programmes for the elderly in western and northern areas affected by high levels of economic decline (Bertstrom and Fog 1996:3). However, NGO involvement in elderly care does not present an alternative or substitute to state or family roles but supplements them. Financial constraints hamper activities of local NGOs because local financial support is difficult due to poverty in the society and therefore external funding has to be solicited. The Council for Older Persons in Namibia, registered as a welfare organisation by the MoHSS, has not been able to undertake any activities due to a lack of finance. In most cases, local NGOs close within a year or two of termination of external finance. Therefore, donor dependency makes it difficult for local NGOs to remain in operation. The implication is that local NGOs should have strong community based support if they are to sustain services to the elderly.

All these factors impact upon the support an elderly person may naturally expect to receive from his or her family, community and government. Ardington (1989:66) asserts that these factors also determine the effect of welfare policies on elderly care.

#### **7.4 Attitudes Towards Institutionalisation**

Similar to other SADC countries such as Zimbabwe, Zambia and South Africa, (c.f. Madzingira 1997:8; Gunzel 1997:1; Lawton 1989:8), whites form the majority of OAH residents in Namibia. Elderly people choose institutional care for various reasons, ranging from desire to rest, frailty and disability, poverty or lack of family to give care. The results show that the majority of elderly people living outside OAHs do not want to move to OAHs (73%, n = 87, Table 20). However, the elderly recognise a need for some OAHs in both rural and urban areas to cater for the poor, destitute and those without families (69%, n = 160, Table 21). Such OAHs would have to be supported by the government and voluntarism because OAHs are expensive to run. This need for OAHs to cater for poor elderly is acknowledged even in other African countries which currently have no white elderly people and elderly care remains a family responsibility. For example, in Uganda the Catholic Church supported construction and operation of an OAH (URRA 1997:1).

The observation is that there is a gradual change in attitudes especially among indigenous communities, towards the acceptance of institutionalisation of elderly people in special circumstances. This change can be explained by modernisation theory. Modernisation changes people's outlook from a traditional way of doing things to new ways, such as outsourcing elderly care services.

Furthermore, attitude change can be substantiated by the fact that the majority of OAH residents themselves made the decision to move to the OAH (64%, n =75, Table 22) and almost all (95%, n = 112, Table 17) are satisfied with the care given; and the majority enjoy the company of other elderly people (71%, n = 84, Table 16). However, observed behaviour indicates that currently, due to the history of apartheid and attitudes of discrimination between racial groups, culturally-mixed OAHs would be difficult to operate in the Namibian society at the present time. It is a generational issue that is bound to ease in time because it will be easier for younger generations of people who currently mix more than their parents did, to live together during their old age. In addition, the elderly do not support a view that families value elderly members any less when care services are outsourced in OAHs (Table 23). Literature shows similar attitude changes towards acceptance of institutionalisation of the elderly when necessary is indicated in other countries as elucidated in studies in Botswana (Ngome 1994:107) and South Africa (Ferreira 1984:5). Chinkanda (1989:152,155) reports of the changing views in South Africa that elderly care should not be regarded as a responsibility of the family alone.

These findings, supported by the fact that consideration of the poverty levels in society and resultant hardships faced by some families in caring for elderly members; individual community members' willingness to help out at OAHs if called upon; the elderly's suggestion for public education on new ideas introduced in the society, the elderly's acknowledgement of a need for



some OAHs in some circumstances, all confirm a gradual change of attitudes towards acceptance of insitutionalisation of the elderly. Hence the findings meet objective one of this study 'to assess the attitudes of the elderly towards institutionalisation'. The implication of this change in attitudes presents an alternative for the family to outsource the elderly care responsibility when circumstances necessitate it. Therefore, the model of such an institution should be appropriate to meet the needs and expectations of the elderly.

#### **7.5 Models of OAHs in Formal Care**

One of the objectives of this study is to determine which model of OAH offers an alternative option to family care for the elderly in Namibia. The study identifies five models of OAHs in formal care in the study areas, which mirror formal elderly care facilities in the country.

Model I OAHs, staffed by professional staff and other trained caregivers, provide good elderly care and services to residents but are inaccessible to the majority of the elderly because of the high costs involved. Model I OAHs have strong support from the white community who hold economic power. The implication is that the model will remain exclusively open to elderly from white communities who can afford to pay. However, it is possible that the upcoming black elite who will not be cared for within the family, and yet will be unable to get into white-run OAHs, may set up their own Model I OAHs. Persistent economic inequalities between racial groups in the

Namibian society tend to perpetuate the status quo. For this reason, model I OAHs do not offer an option to family care for the majority of Namibia's elderly. Hence the implication is that alternative models for caring for the majority of elderly need to be examined. These findings are supported by similar experiences in other SADC countries as reflected in the work of Nyanguru (1991:73) in Zimbabwe and Gunzel (1997:1) in Zambia.

Model II OAHs are operated by community welfare organisations, such as the Katutura OAH in the Khomas Region operated by Katutura Voluntary Family Care Organisation. There is a lack of community support for this OAH partly because of poverty among indigenous communities. However, OAHs are a new concept to these communities so people are not sure of what their responsibilities are regarding support of the OAHs. The dependency on unreliable donor funding and the residential fees charged by this OAH result in failure to deliver appropriate services to the elderly. Furthermore, structures of the OAHs are not elderly-friendly but inadequate funding of the OAH hinders renovations. Until such time that reliable financial support is secured, Model II OAHs also do not present an option to family care for the majority of elderly Namibians. Therefore other models have to be examined.

Model III OAHs are of two types according to the source of financial support. The first type is operated and financially supported by churches, and the second type is supported by local authorities through municipalities. In both types, this model presents a reasonable elderly-friendly environment

and provides better services than Model II OAHs. However, the level of services cannot be compared with that of Model I OAHs. For example, comparison of services at church-supported Tabitha and Susanne Grau Heim OAHs in the Khomas Region; or municipal-supported Kuisebmond OAH compared to Huis Palms OAH in the Erongo Region show that Model I OAHs are superior in quality service delivery. Apart from donations, Model III OAHs receive financial allocations from the church or municipality on a monthly basis. Although the amount is not adequate for all requirements, it is reliable and enables OAHs to charge elderly residents affordable fees.

The main difference between church-supported and municipality-supported OAHs is that the municipality-supported OAHs are indirect publicly financed through taxation. Sustainability of Model III OAHs is assured by taxing the public, augmented by donations and affordable residents' fees. This implies that care for the elderly in the OAH would be a shared responsibility with the general public, thus reducing the burden on the family and the elderly person. Therefore Model III OAHs supported by municipalities currently present attributes for the most appropriate option to family care at manageable costs. Should the OAH be in the rural area, local authorities have to take responsibility for financial support. A lesson may also be taken from the case study of Sweden where operation of elderly institutions is decentralised to municipalities (Palme et al 2002:115).

Therefore Model III OAHs supported by municipalities presents one option to the second objective of the study ‘to determine which model of OAH offers an alternative option to family care for the elderly in Namibia’. The current Model III OAH may be appropriate but it still has some problems, such as:

- (i) How municipalities will raise funds for OAHs. Funding has to be raised either through direct government grants or local taxes but small municipalities may find it difficult. Business enterprises may be few or absent, and utility costs for water and electricity are high. Perhaps small municipalities can institute forced volunteerism, for example, payment of a given amount of money or work for a specified number of hours at the OAH. Painting of premises or maintenance of grounds could be done by volunteers. Hence the question that arises and is not within the scope of this study is: what will be taxed to raise funds for operating OAHs?
- (ii) The structure of the OAH and how much care the municipality can provide, for example meals and transport.

On the other hand, municipalities may be in a better position to provide infrastructure, such as planning a clinic based on the location of OAHs.

Model IV OAHs are a weak collaboration between elderly people and the Town Council or MoHSS. These OAHs are Okombahe OAH in the Erongo Region supported by the MoHSS in terms of buildings and wages for the caregiver; and Khorixas OAH in the Kunene Region supported by the Town Council in terms of providing housing units. In both cases, no maintenance of housing structures has been carried out for many years and the elderly live in deplorable conditions. Services at both OAHs are very poor, but at Khorixas OAH, the situation is worsened by the lack of a centralised structure of administration. Although Model IV OAHs are closer to Model III, there is no open channel for future sustainability of the OAHs even if structures are renovated. For this reason, this model does not offer an option to family care for the majority of the elderly.

Model V elderly care facility is provided by a hospital geriatric ward at Swakopmund State Hospital, funded by the MoHSS. Government cannot financially sustain geriatric wards on a large scale but the wards can only remain for short-term health care for the sick. Hence the model cannot be an alternative to family care. Literature supports the view that geriatric wards are financially unsustainable as reported in the work of Wilson and Parsons (1991:111-113) in Zimbabwe.

#### **7.5.1 Summary of the OAH Models**

In summary, the different models of OAHs have evolved into the forms presented due to a history of apartheid, disenfranchisement of local

communities and poverty. In evaluating the appropriateness of the models of OAHs, caution needs to be taken for Model III to be perceived of as having met the needs of a particular area in the region which could be copied elsewhere. Socio-economic factors in each municipality have an impact on the choice of OAH model. In addition to the problems of what to tax and the structure of the OAHs discussed earlier, it is critical to identify types of services required and what needs are not met in each municipality. This would aid proper planning for OAHs in each area. This view is supported by the recommendations of Lawson (1989:196) on ageing research to support policy formulation. Therefore Model III OAHs, even though supported by municipalities, will differ in services and care provision according to specific needs in different regions, and the level of community support that can be generated within a particular municipality.

Similar experiences of differences in elderly care services between municipalities are reflected in the case study of Sweden (Johansson 2000:11). Thus the hypothesis that 'socio-economic factors in the Namibian society determine the model of institutional care that is adapted to local conditions' is supported. The overall evaluation of the five models of OAHs presented in the study indicates that Model III OAH has the closest attributes to serve the majority of elderly Namibians. This model can be adopted by all municipalities across the country, and then reworked to meet local conditions. However, Model III is not the only option that could be introduced in Namibia.

### **7.5.2 Other Possibilities of Institutional Elderly Care**

There are other types of institutions of elderly care that could be introduced, or a combination of models, even though such institutions are currently not available in Namibia. These institutions are dictated by the cost and amount of care needed. The apartheid circumstances led to Namibia's isolation from the rest of the world and therefore there was no access to information on new ideas of other models. Hence only the current outdated European models evolved as literature indicates (Wilson and Parsons 1991:111). However, with new information coming into the country and free movement of Namibians, models are likely to change.

Model III OAH may fit the current situation, but in the future the composition of the elderly in Namibia will change. For example, Namibians are earning higher income with more pension options than before; the number of indigenous elite or middle class is growing and there are liberation war returnees and children who lived in foreign countries, such as the so called German Democratic Republic Kids (GDR Kids).<sup>43</sup> Not all returnees were integrated into the extended family system and others have no families. In addition, nowadays people travel more and bring back new ideas. Modernisation and Namibia's integration into the world economy after independence bring possibilities and problems in elderly care. The weakening of the extended family system requires other options to be put in

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<sup>43</sup> GDR Kids were children of SWAPO combatants who were taken to GDR during the liberation war. The children were housed, put into schools and were returned to Namibia after independence. Some reunited with their families but others lost parents in the war.

place. Therefore, all these new strata in society will need new forms of care.

Literature indicates several examples, some of which are:

- **Assisted Living in Service Apartments.** These apartments are common in developed countries. The apartments are self-contained but have a communal area for meals and recreational areas. Other services such as transportation facilities are also provided. The level of care goes up as the need increases. The apartments provide an option to individuals to sell their own houses and move into assisted living apartments. Another advantage of assisted living is alleviation of isolation among the elderly who live on their own (Korpi 1995:271; Palme et al 2002:78).
- **Group Living institutions** cater for small groups of seven to eight elderly and are located within residential areas. Group living allows for independent living but can also be used to care for those affected by dementia. In the case study of Sweden, Palme et al (2002:78) reports that current trends favour Group Living institutions. Members of the group share household chores as well as costs for their requirements.
- **Retirement villages** present another option. The areas are provided with services such as shops, clinics with specialised medical care, pharmacies and churches.



Other than Model III OAHs, these possibilities provide new elderly care options that could be used alone or in combination with others, depending on local circumstances.

#### 7.6 **Elderly's Perceptions of the future of elderly care in Namibia**

Based on personal and community experience of the elderly, the elderly's perceptions for the future and advice on improvements in care systems focuses on five main aspects: financial security; housing; promotion of family care; caregiver support and OAHs for destitute elderly.

The elderly's financial security is perceived of as a major aspect in the support system as indicated in demands for increased social pension by 44% of the elderly interviewed. The new policy strategies do not provide for an annual social pension review based on inflation rates. Given the fact that the social pension is the only source of income for the majority of the elderly and many of their family members, this implies that financial problems will persist.

The elderly perceive housing problems as a second aspect that future elderly care programmes should address. Conditions of the elderly indicate that many of the elderly live in poor housing units, especially in rural areas. Housing for the elderly covers the provision of affordable and appropriate housing units; maintenance of existing units; subsidised utility costs; recreational facilities and appropriate OAHs for the most needy, perceived to

be the destitute. The new policy strategies provide for the provision of appropriate and affordable housing for elderly people by private developers, NGOs, religious organisations and local authorities (MoHSS Policy Guidelines V (1.16)). Given the elderly's financial status and general poverty levels, only a few elderly can afford to pay for new housing units, or afford unsubsidised utility costs. This implies that elderly's housing problems are likely to persist, unless there are improvements in their financial status. The literature reveals similar housing problems facing the elderly in other countries, for example South Africa (Viljoen 1989:91).

The third aspect to be in the future eldercare system is the promotion of elderly care to remain in the family. The traditional welfare system through the extended family continues to be eroded by modernising forces. For example nuclearisation of families, urban living and work in formal employment that reduce the number of potential elderly caregivers. The implication here is that traditional elderly care structures are being lost, and therefore further eroding the family's ability to continue caring for the elderly.

The fourth aspect linked to the promotion of family care is a need for elderly caregiver support. The elderly rank caregiver incentive as the fourth aspect that should be included in any future elderly care system. The new strategies do not provide for any incentives to caregivers, except for provision of basic needs for the elderly person. Again, given the economic

status of most families, younger elderly caregivers have to seek other sources of income to meet their personal needs. The implication is that the number of caregivers will continue to decline and negate the promotion of family care in the future.

A need to build OAHs for the poor and destitute elderly is the fifth aspect that the elderly propose for future elderly care in Namibia. Although promotion of family care is the preferred option, the elderly acknowledge a need for OAHs to cater for the elderly who cannot be cared for within families. However, the model of an appropriate OAH to meet this need has not been determined. Other aspects advised by the elderly include better medical services that cover specialised treatment; increased government support and services at community level, and inclusion of elder care on the school curriculum. These aspects would contribute to keeping the elderly actively involved with society for as long as possible.

The overall implication of the perceptions of the elderly identify gaps in the present elderly care system and needs that are currently not being met. The review of the elderly care policy strategies need to target these gaps so as to improve the future elderly care in Namibia.

### **7.7 Evaluation of New Policy Strategies in Elder Care**

The Namibian policy on the care of elderly people is examined with a hindsight that current legislation was developed targeting white elderly, excluding specific problems of indigenous elderly people. In line with the

global trend to deinstitutionalise elderly care, the new strategies contained in the bill present a philosophical change from an institutional approach to family care of elderly people. The aim is for the family and community to remain the core of support services to elderly people, while OAH care is to be given only to needy elderly, such as the poor and destitute, or those without families. This strategy therefore supports the perception of the elderly regarding the promotion of family elderly care in Namibia.

The new strategies include procedures, methods and modalities for implementation, although some weaknesses can still be discerned. Criticisms of the new strategies include a lack of supportive research data; a lack of an identified appropriate model of OAH; a lack of clarity on activities of the new Council for Older Persons; inadequate family and caregiver support; and disparities in rural versus urban services.

#### **7.7.1 Lack of supportive research data**

The review of the Older Person's Act reflected in Draft XIII (b) of September 2002 has preceded a national survey on the status and living conditions of the elderly in the country, therefore it lacks supportive research data. It is hoped that this will be rectified before the bill is presented to parliament. The implication is that the strategies may not fully target specific problems of the elderly in different regions. Effective policies, especially those relating to rural elderly, should be based on a foundation of information gleaned from data collected from the population to be affected

by such policies. Such data should be broad-based, with in-depth information to reveal relevant issues. Tout (1989:258 in Scogings 1992:171) makes a valid point when stating that “criterion for assessing the appropriateness of services, methods, technologies and treatment is whether or not they facilitate self-help, self or family care”. Thus supported by a study in South Africa, Dubazana (1989:40-41) argues for the need to formulate research-based strategies in elderly care.

#### **7.7.2 Legislation against elderly abuse**

Legislation against elderly abuse is in line with the global efforts to curb the malpractice, both in formal institutions and within the community. However, it is not backed by data on the types, extent, prevalence and perpetrators of abuse so as to target preventive strategies. Private service providers and NGOs can also perpetuate elderly abuse in service provision, for example the problems of social pension distribution in the Namibian situation and what has been revealed by the case study of Sweden (c.f. *The Namibian*, 3<sup>rd</sup> March 2001; Fog pers. comm. 2003). No specific control measures to guard against such occurrence are indicated in the strategies, except steps to be undertaken when detected. A lack of support from research data renders some strategies irrelevant in some places. Therefore municipalities have to put tighter controls in place to supervise private service providers and NGOs, for example in the supervision of construction and maintenance of houses for the elderly.

### **7.7.3 State-run OAHs and Frail Care Units**

Plans to set up state-run OAHs and frail care units for the poor and destitute elderly meet with the elderly's advice on a need to build OAHs for the elderly in special circumstances. However, an appropriate model of OAHs that would provide quality care but be financially affordable and sustainable has not been identified. The low-cost housing units for independent living provided by the government in some towns are inadequate. Government is no longer undertaking construction of low-cost housing for the elderly. In addition, the majority of the elderly cannot meet the minimum financial income requirement. The model identified in this study, Model III OAH supported by municipalities, presents the most appropriate attributes for the majority of elderly Namibians and can be adopted. However, introduction of other models that are currently not operating in the country remains an option.

### **7.7.4 Establishment of a Council for Older Persons**

Establishment and activities of a new council for older persons within government departments is likely to be constrained in its operations by government bureaucracy. This implies that the council may fail to respond timeously to the problems and needs of OAHs and elderly caregivers. This failure is exemplified in current difficulties in accessing foster-parent grants. Furthermore, some of the council functions duplicate those of the welfare organisation with the same title and is registered with MoHSS. This duplication can lead to a clash or delay in service provision to the elderly.

Further, one of the functions of the council is to liaise and negotiate with educational and training institutions to introduce courses and syllabi in elder care. Caregiver training would meet the needs of OAHs as well as for homecare. Training of elderly caregivers should not be a subject of negotiation, but a firm government policy directive based on policy provisions responding to the needs in the communities. Negotiation for training courses leaves room for bias in training course provision that can lead to disparities in capacity building for elderly caregivers.

#### **7.7.5 Government support to the Family and Caregivers**

Supporting the family should ideally make it easier for the family to cope with demands of elder care. Poverty limits families in providing appropriate care to the elderly and limits government to provision of basic needs only for the elderly person. The demand for caregiver support has been highlighted in this study as emphasized in the elderly's perceptions for future elderly care in Namibia. However, the provisions of the new policy strategies fall short in scope to meet this demand. Given poverty levels in communities, especially among indigenous communities, this aspect of family and caregiver support needs to be re-examined. Apt (2000:5) advises that African policy responses should support traditional social welfare institutions so as to meet new challenges of modernisation and be able to attain what they accomplished so effectively in the past. Caregivers in institutional settings of OAHs and within families need to be supported and motivated if they are to provide effective care to the elderly. Experiences from other

countries show that the provision of financial, professional and respite services motivates caregivers to continue with the elder care role and contributes to quality care delivery (Johansson 2000:4).

In summary, findings of this study examine factors that impact on levels and types of care given to the elderly in the study areas. These factors reveal aspects that shape models of institutional care in Namibia. Historical and economic factors underpin the evolution and operation of the models of OAHs identified in the study areas. Perceptions of the elderly on the future of elderly care in Namibia reveal gaps in the elderly care system, as well as needs that are not met. Although the new policy strategies target many of these gaps in the current elderly care system, its scope is limited by a lack of research needed to formulate targeted and relevant programmes to specific problems of the elderly in all communities. The new strategies also do not identify an appropriate model of an OAH that would meet needs and cater for the majority of the elderly in Namibia.



## CHAPTER 8

### CONCLUSIONS AND RECOMMENDATIONS

#### 8.1 Introduction

This thesis examines models of institutional care for elderly people in Namibia. Socio-economic factors that impact on the levels and types of care given to the elderly are stated. In this final chapter conclusions are drawn from the major findings, with discussions thereafter. The recommendations are generated from the conclusions with suggestions for further research. Finally, re-examination of the thesis rationale is made regarding objectives of the study, the hypothesis and modernisation theory of ageing.

#### 8.2. Conclusions on major findings of the study

The 'old old' category of 70 to 80 years of age constitutes the largest proportion of the elderly in the study areas. This category is the most problematic in care requirements and it has implications for financial and social costs to the family and the government.

Six factors primarily determine the levels and types of care given to the elderly:

- the status of the family
- the economic status of the elderly
- caregiver training and support

- information dissemination on elderly issues
- gender related care
- social policy on elderly welfare and care, and
- government support to the elderly.

The traditional social institution of the family has always cared for the elderly in Namibia, but in some cases it is failing to perform this role due to poverty and forces of modernisation such as urbanisation. Elderly care has positive and negative impacts on family economics. Economic and social benefits in caring for elderly family members include financial income from social pensions, childcare, household chores and home security provision by elderly members. Difficulties faced in elderly care involve emotional, financial and social costs. Despite these difficulties, the Namibian family still continues to support its elderly members. The family effort can be sustained with appropriate support.

Attitudes towards care of the elderly in OAHs are changing, especially among indigenous elderly people. This attitude change can be attributed to modernisation. However, the general view remains that OAHs should cater for the poor and destitute who have no families to care for them.

Economic factors determine how models of OAHs have evolved and how they operate. As stated in the previous chapter, five models of OAHs operate in the four regions, with at least two models in each region. Each model

exhibits positive and negative attributes that credit or discredit it as an appropriate option to family care for the majority of the elderly in Namibia. The attributes of these models are: high quality care and high fees in Model I OAHs which are not affordable by the majority of the elderly; low-fees in Models II and IV OAHs that lack the capacity to provide good care and services to the elderly; and geriatric hospital wards in Model V that government cannot sustain on a long-term basis. Model III OAHs fall into two categories according to supporters: those supported by the church and others supported by municipalities. Model III OAHs supported by municipalities present the most appropriate attributes as an option to family care. Reasonably good services are sustained at affordable fees, donations and municipality contributions raised through public taxation. The question of what will be taxed by municipalities, especially small ones, to raise funds for operating OAHs remains unanswered. However, there are other possibilities for elderly care that could be adopted, even though they are currently not operated in Namibia; for example assisted living.

This study confirms the longevity of women over men in the study area. Despite changing attitudes towards OAHs, the findings reveal differences in the numbers between men and women in OAHs occupied by the indigenous elderly. A significantly smaller number of indigenous elderly women reside in OAHs, compared to elderly men, while the opposite is true for OAHs occupied by white elderly.

Access to OAHs with good eldercare services depends on the financial status of the elderly person and that of his or her family. Financial problems rank the highest among the elderly's problems. The social pension, which is the only source of income for the majority of the elderly, is too low to meet their needs. Budgetary pressures hinder government from substantially increasing social pensions. The elderly currently receive N\$ 250 per month but there will be a small increase to N\$ 300 from January 2004. As a developing country, Namibia is unable to develop comprehensive welfare policies that would alleviate poverty in old age. Hence, the elderly's financial problems are bound to persist.

This study further reveals other factors that exacerbate the elderly's financial problems such as: access to appropriate and affordable housing; the cost of utilities; and inaccessibility or high cost of transportation. Many elderly people live in poor housing environments. Elderly people require assistance in the construction of affordable and appropriate housing, as well maintenance of existing units. The government's provision of low-rent accommodation and subsidy on utilities remains unequal and currently favours white elderly. Subsidies on utilities also exclude the elderly who live in their own homes. Transportation is a problem at OAHs with the exception of those occupied by white elderly, but the problem is more serious for elderly people living in rural areas.

Government support to the elderly is perceived of as inadequate and falls short of the elderly's expectations. In addition, there is an urban bias in service provision to the elderly by government, as well as by elderly associations and clubs. The elderly residing in urban areas have an advantage over rural elderly because of proximity to government machinery; and concentration of development programmes in urban areas. This urban advantage perpetuates rural versus urban disparities in the eldercare system (c.f. Apt 1998:3).

The lack of caregiver support and training is a major gap in the eldercare system, and covers both short term and long term needs. Traditional elderly care knowledge and support networks are being eroded by forces of modernisation such as urbanisation and nuclearisation of families. The study shows that most caregivers lack basic knowledge in physiotherapy, elderly nutritional needs and frail care. It is necessary to institute short term and long term training programmes for elderly caregivers to attain effective eldercare delivery. Furthermore, elderly care is a difficult, emotionally and socially draining job, therefore caregivers require incentives to keep them motivated for the role.

The study reveals another gap in the eldercare system as poor information dissemination on elderly issues. The lack of information dissemination programmes on elderly issues deprives those involved in elderly welfare of an opportunity to pass on vital information to the elderly; and the general

public. Such information covers health; nutritional needs; community responsibilities towards OAHs; removal of stereotypes about the elderly or OAHs; and elderly rights. Furthermore, reciprocal involvement of the elderly in media programmes would keep them involved with society as a support function and by implication, contribute to the improvement of their quality of life.

NGOs, welfare organisations and church groups, to an increasing extent, provide services to the elderly in urban and rural areas. The NGOs have the potential to fill gaps in elderly care left by government, and therefore the new policy strategies encourage communities to form local NGOs. However, local NGOs are donor-dependent on external support and therefore their activities are constrained by a persistent lack of finance. The concept of voluntarism to support OAHs is very weak, and non-existent in most places. Furthermore, some of the elderly benefit from services provided by their associational membership clubs. These associations and clubs are mostly ethnic-based and located in urban areas. The relevance of clubs in elderly institutional care settings is that some of them operate OAHs. For example, this study reveals that the Lions Club operates Model I OAHs and gives preferential admissions to registered members. Furthermore, de facto ethnic-based associations that limit access do not benefit from new ideas and knowledge of potential members; and hinder cross-ethnic fertilisation of ideas.

The elderly identify five major gaps that should be filled in the future of eldercare in Namibia. These gaps include:

- improvement of the elderly's financial status through the increase of social pensions;
- provision of affordable housing that covers house maintenance and subsidised utility costs;
- promotion of elderly family care;
- payment of financial incentives to caregivers; and
- building OAHs for needy elderly who cannot be supported in families.

These gaps are targeted in the various provisions of the new policy strategies except for the social pension increase and payment of caregiver incentives.

The new policy strategies present strengths over the existing policy, but several weaknesses are identified. A major criticism is that the strategies are not backed by research data. Therefore, some of the strategies are bound to be inappropriate and may not be relevant in different areas. In addition, the strategy to build OAHs and frail care units does not identify an appropriate model of these institutions. Furthermore, government support to families is limited to the provision of basic needs for the elderly person. Considering poverty levels in communities, this level of support is inadequate and will not empower families to continue the elderly care role. Payment of financial incentives to caregivers would motivate them to continue caring for the elderly.

### 8.3 **Recommendations**

The following recommendations are made on the basis of the study findings:

- (i) In the absence of an appropriate model of institutional care presented by the government, Model III OAH identified in this study should be adopted. Sustainability of the model derives from affordable fees, donations and municipal funding raised through taxation.
- (ii) The concept of voluntarism to assist OAHs, especially among indigenous groups who cannot give monetary support, should be promoted and increased.
- (iii) Most of the elderly are cared for by families. Therefore, the family requires support in various forms to enable it continue its eldercare role. In its planning for the future, the government of Namibia should encourage and support the revival of traditional care institutions and support networks, such as the extended family system, that has sustained elderly care in communities. The problem of elder care is likely to worsen when numbers of elderly people increase, especially the 'old old' category aged 80 years and older.
- (iv) Caregiver training should be effected at two levels. To meet immediate training needs of caregivers, training workshops augmented by media programmes, should be provided to OAH employees and home-based caregivers of the elderly. In-service training workshops should also be given to update the knowledge and skills of caregivers. NGOs or the



National Council for Older Persons in Namibia could conduct this training in collaboration with the MoHSS. A pool of caregivers should systematically be built to meet long-term eldercare needs by introducing eldercare in the syllabi of formal schools and training institutions. Teaching school children about elderly care would inherently instill a sense of responsibility into potential future elderly caregivers.

- (v) Financial incentives should be paid to caregivers to support and motivate them to continue their elderly care role.
- (vi) Dissemination of information to the elderly and the general public should be enhanced to support the eldercare and service support system. Media education programmes should target information on health and nutrition, frail care, active ageing, stereotypes and elderly abuse, and other issues concerning elderly people. The programmes should aim to inform, educate and clarify elderly issues so as to cultivate a responsible attitude in communities towards the continued support of the elderly and OAHs.
- (vii) Local authorities and municipalities should devise and put in place tight controls for prevention and fast-detection of elderly abuse by private service providers and NGOs.
- (viii) Government should aim to reduce rural versus urban disparities in elderly care services. Research-based data should be used to formulate strategies and programmes that target specific problems of the rural elderly. More

community-based programmes should be devised and NGOs should be encouraged to provide elderly services in rural areas.

- (ix) The social pension should be substantially increased to improve the elderly's financial status.
- (x) The elderly should be assisted in transportation to and from health centres and pension pay-points. For example, the elderly could be given tokens that can only be used for that purpose although the tokens could also be stolen. An alternative would be to pay the elderly a transportation allowance proportionate to estimated distances to be covered to and from health centres and pension pay-points.
- (xi) Assistance should be given in the provision of affordable housing units and maintenance of existing ones. Government subsidies for utilities should be equalised for all the elderly, regardless of their housing type.
- (xii) Formation of NGOs across ethnic lines should be promoted to encourage cross-ethnic fertilisation of ideas and information across ethnic lines so as to enrich elderly care services in communities.
- (xiii) Gender-sensitive eldercare programmes should be formulated to target elderly women's vulnerabilities within and outside families.
- (xiv) The objectives and functions of the National Council for Older Persons in Namibia welfare organisation, and those of the proposed new council

(whose membership is to be drawn from government departments) should be distinct to avoid duplication and conflicts of interest.

- (xv) The results of the national survey on the status and conditions of elderly people in the country, launched on October 1<sup>st</sup>, 2003, should be incorporated into the draft bill before presentation to Parliament, so that the new Act is made more appropriate and relevant.
- (xvi) Periodic research should be undertaken to update information on the status and conditions of the elderly in the country so as to formulate new or review the existing policies on elderly care, backed by a research database.

### **8.3.1 Areas for Further Research**

- (i) Based on the findings of this study, it is established that the family is the primary caregiver to the elderly. Hence, it is recommended that a study be undertaken to determine the changing structure, functions and dynamics of the Namibian family as an institution.
- (ii) A study of municipalities should be undertaken to determine possible taxable items to raise funds for supporting OAHs that fall under municipal support.

- (iii) A study should be undertaken to ascertain types, extent, prevalence and perpetrators of elderly abuse in communities, to aid in the formulation of appropriate and relevant preventive measures, and
- (iv) Finally, considering the poverty levels in communities, studies should be done to ascertain if the desire of young families to care for elderly women within the family is influenced by economic gain from the social pension of the elderly person, or the services elderly women render to the family.

These are not the only important issues to be addressed for the future of elderly care in Namibia. However, they have a strong impact on the future of the family's ability to continue the elderly care role, and thereby reduce the number of elderly people in OAHs.

#### **8.4 Re-examination of Thesis Rationale**

The integration of Namibia into the world economic system removed the country's social, political and economic isolation. Economic factors have determined the conditions under which the different models of OAHs have evolved. This has been dictated by the history of apartheid, disenfranchisement of indigenous communities and poverty. Although the majority of the elderly are still cared for by families, many of these families face difficulties in adequately fulfilling this role due to poverty and changing attitudes.

#### **8.4.1 The Objectives of the Study**

This study had three objectives, all of which have been met. The first objective was to assess attitudes of the elderly towards institutionalisation. It has been ascertained that attitudes towards elderly living in OAHs, particularly among indigenous elderly, are changing towards acceptance of the concept in certain circumstances. It is suggested that OAHs should be provided for poor and destitute elderly, and those without families.

The second objective was to determine which model of institutional care offers an alternative option to family care for the elderly in Namibia. Of the five models of OAHs identified in this study, Model III OAH supported by the municipality presents the best attributes as an alternative to family care for the majority of elderly Namibians. However, other possibilities exist, even if they are not currently operated in Namibia.

The third objective was to assess Namibia's social welfare policy vis-à-vis operation of OAHs. The current Act on elder care is inadequate and a new one has been drafted. Although new policy strategies present strengths over the existing policy, there are some weaknesses. For example, an appropriate model of OAHs and Frail Care Units has not been identified. There is also lack of supportive research data on elderly and OAH needs in different areas of the country.

On the basis of the findings of this study; identification of Model III OAH to have appropriate attributes for the majority of the elderly in Namibia; and the

discussions, it is concluded that the results of this thesis can be generalised to the rest of Namibia.

#### **8.4.2 Research Hypothesis**

The hypothesis of this study states that socio-economic factors in the Namibian society determine the level and types of care given to the elderly, and necessitate a model of institutional care that is adapted to local conditions. Economic factors in the country and levels of income in different groups of the Namibian society have determined how different models of OAHs have evolved in the country. Needs of the elderly in each locality need to be identified so as to design and target care programmes. These needs include the model of OAH that would be affordable by the majority, and serve the elderly well. Therefore, the hypothesis of this study is accepted.

#### **8.4.3 Modernisation Theory**

Modernisation theory of ageing explains many of the findings of this study. Increasing numbers of the elderly living to their 80s in the study areas is explained by modernisation as longevity is one of the features of modernisation. Urban living separates families, weakens bonds between members and contributes to changing attitudes towards elderly care responsibilities. Hence the erosion of the family's ability to care for elderly members. Changing attitudes towards acceptance of OAHs for needy

elderly indicates acceptance of new ideas in the society. Other findings indicate elderly's perception of children as being too busy to give elderly parents appropriate care; and the elderly's demand for information and education on new ideas. Information dissemination is vital to inform the community on new ideas, such as responsibilities towards OAHs. Therefore, with support from the municipality, needy elderly can be provided with an affordable OAH with good services that would be supported by an informed community. Hence from the models of OAHs currently being operated in the country, modernisation theory explains the model of institutional care appropriate for Namibia.

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## **APPENDIX I: RESEARCH TOOLS**

1. Questionnaire
2. Key Informant Guideline Questions
3. Elderly Case Studies

## QUESTIONNAIRE

Hullo, my name is ..... I am from UNAM Sociology Dept. I am conducting a study on the care for elderly people. This Questionnaire seeks information on the care for elderly people who are 60 years and above, living in and outside Old Age Homes. The information filled on the Questionnaire will be kept confidential.

**Please circle the answer selected.**

### DEMOGRAPHIC INFORMATION

Q.1. Sex

|      |   |        |   |
|------|---|--------|---|
| Male | 1 | Female | 2 |
|------|---|--------|---|

Q.2. Age Group

|         |   |         |   |
|---------|---|---------|---|
| 60 – 64 | 1 | 76 - 80 | 4 |
| 65 – 69 | 2 | 81 - 90 | 5 |
| 70 – 75 | 3 | 91 +    | 6 |

Q.3 Marital Status

|                        |   |                 |   |
|------------------------|---|-----------------|---|
| Single (Never married) | 1 | Separated       | 4 |
| Married                | 2 | Widow/Widower   | 5 |
| Divorced (Legally)     | 3 | Living together | 6 |

## Q. 4. Mother Tongue

|             |   |                      |    |
|-------------|---|----------------------|----|
| Afrikaans   | 1 | Oshiwambo            | 6  |
| English     | 2 | Otjiherero           | 7  |
| German      | 3 | Rukavango            | 8  |
| Damara>Nama | 4 | Tswana               | 9  |
| Silozi      | 5 | Other (Specify)..... | 10 |

## Q.5 Religion.

|                 |   |
|-----------------|---|
| Lutheran        | 1 |
| Dutch Reform    | 2 |
| Other Christian | 3 |
| Other Religion  | 4 |
| Non-Believer    | 5 |

**HEALTH**

## Q.6. Which of these health problems trouble you?

|                           |   |                       |    |
|---------------------------|---|-----------------------|----|
| Heart                     | 1 | Joints Pains          | 7  |
| Stroke                    | 2 | Poor Eye Sight        | 8  |
| Blood pressure (high/low) | 3 | Poor Hearing          | 9  |
| Persistent Cough          | 4 | Backache              | 10 |
| Diabetes                  | 5 | Other (Specify) ..... | 11 |
| Stomach ulcers            | 6 | None                  | 12 |

## Q.7. Do you receive a doctor's prescribed diet because of your medical condition?

|                |   |
|----------------|---|
| YES            | 1 |
| NO             | 2 |
| Do not need it | 3 |

Q.8. Do you have a Health Insurance Policy?

|     |   |    |   |
|-----|---|----|---|
| YES | 1 | NO | 2 |
|-----|---|----|---|

### FOOD AND NUTRITION

Q.9. How many meals do you normally eat in a day?

|       |   |
|-------|---|
| Three | 1 |
| Two   | 2 |
| One   | 3 |

Q.10. How often is the quantity of food enough for you?

|            |   |              |   |
|------------|---|--------------|---|
| Most often | 1 | Sometimes    | 3 |
| Often      | 2 | Never enough | 4 |

### ATTITUDE TOWARDS INSTITUTIONALISATION

Q. 11. Where do you live?

|                               |   |                      |   |
|-------------------------------|---|----------------------|---|
| OAH                           | 1 | Own house            | 4 |
| With Own Children             | 2 | Rented House         | 5 |
| With Extended Family /Friends | 3 | Other (Specify)..... | 6 |

Q.12. If living in OAH, how much do you like living in this OAH?

|                       |   |
|-----------------------|---|
| Very much             | 1 |
| Much                  | 2 |
| Not much              | 3 |
| Do not like it at all | 4 |

Q.13. If living in OAH and like living there, what things do you like about this OAH?

|                                 |   |
|---------------------------------|---|
| Being with other old people     | 1 |
| Having Friends nearby           | 2 |
| Getting help any time I need it | 3 |
| Having enough time to rest      | 4 |
| Safe                            | 5 |

Q.14. If living in OAH but **do not** like living there, what things don't you like in the OAH?

|                                |   |                    |   |
|--------------------------------|---|--------------------|---|
| Not Happy with Other residents | 1 | Workers Not Kind   | 5 |
| No Friends in the OAH          | 2 | Strictness of Time | 6 |
| Space not enough               | 3 | Furniture Not Good | 7 |
| No Privacy                     | 4 | Food Not Enough    | 8 |

Q. 15. If living in OAH, how satisfied are you about care you get at the OAH?

|                    |   |
|--------------------|---|
| Very Satisfied     | 1 |
| Satisfied          | 2 |
| Somewhat Satisfied | 3 |
| Dissatisfied       | 4 |
| Very Dissatisfied  | 5 |

Q.16. What things did you like where you were living before moving to the OAH?

.....

.....

.....

.....

.....

.....

Q.17. What things didn't you like where you were living before moving to the OAH?

.....  
 .....  
 .....  
 .....

Q.18. If you were to advise, how would you want to see elderly people in Namibia being cared for?

.....  
 .....  
 .....  
 .....

Q.19. If living outside OAH, would you like to move to one?

|     |   |    |   |
|-----|---|----|---|
| YES | 1 | NO | 2 |
|-----|---|----|---|

Q. 20. Do you think more OAHs should be built for all elderly in towns and rural areas?

|     |   |    |   |
|-----|---|----|---|
| YES | 1 | NO | 2 |
|-----|---|----|---|

**DECISION-MAKING ON INSTITUTIONAL CARE**

Q.21. If in OAH, how did you come to live here?

|                     |   |                                 |   |
|---------------------|---|---------------------------------|---|
| Brought myself      | 1 | Brought by Church               | 4 |
| Brought by relative | 2 | Brought by Government/ Doctor   | 5 |
| Brought by friends  | 3 | Brought by Welfare Organisation | 6 |

Q.22. Would you say families that take elderly relatives to OAHs value these elderly less?

|     |   |    |   |
|-----|---|----|---|
| YES | 1 | NO | 2 |
|-----|---|----|---|

Q.23. Given a choice, where would you prefer to live?

|                       |   |
|-----------------------|---|
| By myself             | 1 |
| In OAH                | 2 |
| To family/Friends     | 3 |
| Other (Specify) ..... | 4 |

Q. 24. If you prefer OAH, why?

|   |   |
|---|---|
| OAHs have better care                     | 1 |
| Children have no time                     | 2 |
| I do not like bothering others            | 3 |
| Family members do not like to be bothered | 4 |
| Family too poor to afford care            | 5 |

Q.25. What does it mean to you personally if families take elderly people to live in OAHs?

|  |   |
|--|---|
| Failure of family/Extended family to give care | 1 |
| Failure of community to give support           | 2 |
| Community not bothered about old people        | 3 |
| Other (Specify) .....                          | 4 |

### **RACE / ETHNICITY**

Q. 26. Would you like to stay in a culturally mixed OAH?

|     |   |    |   |
|-----|---|----|---|
| YES | 1 | NO | 2 |
|-----|---|----|---|



Q.27. If No, why?

|                                     |   |
|-------------------------------------|---|
| Prefer to live with own people      | 1 |
| Would not understand other cultures | 2 |
| Other (Specify).....                | 3 |

### SOCIAL ECONOMIC STATUS

Q.28. What was your previous Occupation?

|                     |   |                       |    |
|---------------------|---|-----------------------|----|
| Government Employee | 1 | Farmer's Wife         | 6  |
| Company Employee    | 2 | Domestic Worker       | 7  |
| Farmer              | 3 | Farm Worker           | 8  |
| Business Person     | 4 | House wife            | 9  |
| Miner               | 5 | Other (Specify) ..... | 10 |

Q.29. Do you receive a Pension from Namibian Government?

|     |   |    |   |
|-----|---|----|---|
| YES | 1 | NO | 2 |
|-----|---|----|---|

Q.30. If YES, is Pension of N\$ 250.00 per month adequate for your needs?

|     |   |    |   |
|-----|---|----|---|
| YES | 1 | NO | 2 |
|-----|---|----|---|

Q.31. If not enough, how do you raise additional money?

|              |   |                      |   |
|--------------|---|----------------------|---|
| OAH Pays     | 1 | My Investments       | 5 |
| From Family  | 2 | From Savings         | 6 |
| From Friends | 3 | Do some work         | 7 |
| From Church  | 4 | I have other Sources | 8 |

Q.32. If not getting Pension, who pays for your Stay/living expenses?

|                              |   |              |   |
|------------------------------|---|--------------|---|
| Have other sources of income | 1 | Church       | 4 |
| Children/Family              | 2 | Do some work | 5 |
| Friends                      | 3 | OAH          | 6 |

Q.33. What other sources of income do you have?

|                      |   |                 |   |
|----------------------|---|-----------------|---|
| Savings and Interest | 1 | Family          | 4 |
| Investments          | 2 | Private pension | 5 |
| Rent of property     | 3 | None            | 6 |

### **SOCIAL CLASS**

Q.34. Within your community do you think elderly living in OAHs come from a special class?

|     |   |    |   |
|-----|---|----|---|
| YES | 1 | NO | 2 |
|-----|---|----|---|

Q.35. Were you /are you a Member of any Association or Club?

|     |   |    |   |
|-----|---|----|---|
| YES | 1 | NO | 2 |
|-----|---|----|---|

Q.36. Did you ever /Do you go on holidays?

|     |   |    |   |
|-----|---|----|---|
| YES | 1 | NO | 2 |
|-----|---|----|---|

### **FAMILY, COMMUNITY AND GOVERNMENT SUPPORT**

Q.37. Do you have children?

|     |   |    |   |
|-----|---|----|---|
| YES | 1 | NO | 2 |
|-----|---|----|---|

Q.38. If YES, do they support you?

|     |   |    |   |
|-----|---|----|---|
| YES | 1 | NO | 2 |
|-----|---|----|---|

Q.39. How would you rate support of children in your community to elderly parents?

|                     |   |            |   |
|---------------------|---|------------|---|
| Adequate            | 1 | Inadequate | 3 |
| Moderately Adequate | 2 | No support | 4 |

Q.40. Would you say an extended (big) family cares for elderly better than a small one?

|     |   |    |   |
|-----|---|----|---|
| YES | 1 | NO | 2 |
|-----|---|----|---|

Q.41. Would you say the government is giving enough support to the elderly?

|         |     |    |
|---------|-----|----|
|         | YES | NO |
| Money   | 1   | 2  |
| Housing | 1   | 2  |
| Health  | 1   | 2  |

### **SOCIAL LIFE, ACTIVITIES AND LEISURE**

Q.42. What do you do in your free time?

|                              |   |                       |    |
|------------------------------|---|-----------------------|----|
| Sit Around                   | 1 | Knitting & Crocheting | 7  |
| Sleep                        | 2 | Watch TV              | 8  |
| Do an activity provided here | 3 | Listen to Radio       | 9  |
| Take a walk                  | 4 | Read Bible            | 10 |
| Talk to friends              | 5 | Read books            | 11 |
| Handicrafts                  | 6 | Other (Specify) ..... | 12 |

Q.43. If in OAH, what activities are offered by this OAH?

|                 |   |                       |   |
|-----------------|---|-----------------------|---|
| Library         | 1 | Bible study           | 4 |
| Choir and Music | 2 | Other (Specify) ..... | 5 |
| Indoor Games    | 3 | None                  | 6 |

### EDUCATION AND MEDIA

Q.44. How do you get news and information on what is going on around the country or outside?

|                  |   |                              |   |
|------------------|---|------------------------------|---|
| Listen to Radio  | 1 | From OAH staff and residents | 4 |
| Watch Television | 2 | Other (Specify) .....        | 5 |
| Read Newspapers  | 3 | Do not care about news       | 6 |

Q.45. Do you know about Rights of Elderly People passed by United Nations?

|     |   |    |   |
|-----|---|----|---|
| YES | 1 | NO | 2 |
|-----|---|----|---|

### GENDER ISSUES IN ELDERLY CARE

Q.46. Do you think any gender is favoured in elderly care?

|                               |   |
|-------------------------------|---|
| Males are favoured            | 1 |
| Females are favoured          | 2 |
| Everyone is cared for equally | 3 |

### CURRENT PROBLEMS

Q.47. What do you consider to be major problems where you live?

|                  |   |                       |   |
|------------------|---|-----------------------|---|
| Medical Care     | 1 | Lack of Clothing      | 4 |
| Food             | 2 | Other (Specify) ..... | 5 |
| Inadequate money | 3 | None                  | 6 |

## **KEY INFORMANT INTERVIEW for:**

### **(a) OLD AGE HOME MANAGERS**

Hullo, my name is ..... I am a student at the University of Namibia. I am carrying out a study in care for elderly people. I would like to interview you on management aspects of this home. Whatever you tell me will be kept confidential.  
 Name of Home ..... Name of Manager ..... Duration ....

#### **General**

1. Who owns this home? When was it started? Is it registered? If not, why?
2. How many elderly residents are in this home? Male ..... Female .....
3. What is the age of residents? Highest ---- Lowest ----- Average ----
4. From which ethnic groups/communities? Do you think they specifically chose this home because of this?
5. How would you rank the social status of the residents?
6. Does the Manager have to be a social worker or be trained in elderly care?
7. Is the OAH affiliated to the National Council for Older Persons in Namibia?
8. Are you familiar with Older Person's Act? Please explain what you know about it.

#### **Staff:**

1. How many staff work here? Are they trained in elderly care? Is number enough?

#### **Finance:**

1. How is this OAH funded?
2. How much is the monthly fee paid by residents? Can they afford?
3. Are there preconditions for entry to the home?
4. How much support does the home get from residents' families/ Community?

#### **Health**

1. What are typical health problems at the home? Who pays their medical bills?
2. How many need continuous full time care? Do you have a separate sick /frail care unit?
3. Are there many who need doctors prescribed diet? Do they have to pay for it separately?
4. What exercises are offered by this home?

**Social Life & Lifestyle**

1. What leisure activities are the elderly provided with at the home? List
2. How regularly do they leave the home? Are there organised Outings?
3. Do they go on holidays?
4. Do they participate in civic activities/Associations/Clubs?
5. What complaints do they take up with you?

**Problems**

1. What problems does the OAH face? Finance/Staff/Management.

**Personal Views:**

1. Do you think this model of OAH is appropriate for all Namibian elderly?  
Why?
2. Do you think government should enact a law for families to care for their parents?
3. How would you like to see elderly care in Namibia being undertaken in 10 + years?

## **KEY INFORMANT INTERVIEW for:**

### **(b) WELFARE ORGANISATIONS and CHAIRMAN, THE NATIONAL COUNCIL FOR OLDER PERSONS IN NAMIBIA**

Hullo, my name is..... I am a student at the University of Namibia. I am conducting a study on the care of the elderly. I would like to interview you on the activities of your organisation in the care for elderly people. Whatever you tell me will be kept confidential.

.....

1. When did the organisation start operating? What areas of the country are covered?
2. Tell me about activities of the organisation.
3. How many elderly people are you covering?
4. Do the elderly you cover fall under any social class in the community?
5. What changes do you think have taken place within the community regarding elderly care?
6. Do you think extended families are more likely to care for their elderly members at home?
7. How much care would you say families/community supports the elderly in Areas you cover?
8. Funding: How/who funds this organisation?
9. Do you get any financial aid from NGOs/Government?
10. Are the elderly you cater for covered by Medical Aid?
11. Have you considered building an Old Age Home?
12. Would you say the current model of OAHs is appropriate for Namibia? Why?
13. What major gaps do you see in current levels of elderly care that the revised Older Persons Act should address in : Formal institutional care and Informal Family /community care?
14. Do you think government should enact a law for families to care for elderly members?- How can families be persuaded/empowered to care for their elderly members?
15. How would you like to see elderly care in Namibia being undertaken in 10 + Years?
16. What challenges or problems do you face in your work?

## **KEY INFORMANT INTERVIEW for:**

### **(c) POLICY LEVEL STAFF - MINISTRY OF HEALTH AND SOCIAL SERVICES**

Hullo, my name is ..... I am a student at the University of Namibia. I am conducting a study on care for elderly people in institutions. I would like to interview you on Policy issues regarding the care for elderly people in the country. Whatever you tell me will be kept confidential.

.....

1. a) How does the government currently support elderly people?
  - b) What changes do you think have taken place within the Namibian society regarding elderly care?
2. Do you think extended families are more likely to care for their elderly members at home?
3. The social welfare policy discourages institutionalisation of the elderly, how would elderly without families be cared for?
4. Considering poverty situation and deaths of young people from HIV/AIDS, wouldn't there be need for institutional care to be extended to Namibian elderly?
5. Would you say the current model of OAHs is appropriate for Namibia? Why?
6. What community support is there for OAHs?
7. Do you think government should enact a law for families to care for their elderly members?  
How can families be persuaded/empowered to care for their elderly members?
8. When is a revised Older Persons' Act expected to be operational?
9. What major gaps do you see in current levels of elderly care that the revised Older Persons Act should address in : Formal institutional care and Informal family/community care ?
10. How would you like to see elderly care in Namibia being undertaken in 10 + years?



## **KEY INFORMANT INTERVIEW for:**

### **(d) REGIONAL-BASED SOCIAL WORKERS**

Hullo, my name is ..... I am a student at the University of Namibia. I am conducting a study in care for elderly people. I would like to interview you on your work with elderly in the region. Whatever you tell me will be kept confidential.

.....

1. Tell me about family care and community support for the elderly in the region.
2. What changes do you find in the communities that might have negative implications for elderly care?
3. Do you think extended families are more likely to care for their elderly members at home in this region?
4. What do you think about a maintenance law for children to care for elderly family members?
5. Is there desire for OAHs in the region?
6. Would you say the current model of OAHs is appropriate for Namibia? Why?
7. How can families be persuaded/empowered to care for the elderly?
8. What gaps do you find in levels of elderly care in: Formal Institutional care and Informal family care?
9. How would you like to see elderly care in Namibia being undertaken in 10 + years?

## **KEY INFORMANT INTERVIEW for:**

### **(e) RELATIVES OF ELDERLY PEOPLE (who help most)**

Hullo, my name is ..... I am a student at the University of Namibia. I would like to interview you on care of your Elderly relative living with you/at Old Age Home. Whatever you say will be kept confidential.

Name of Home / Area..... Relationship to Elderly Person .....

.....

#### **A) ELDERLY LIVING IN OAHs**

1. When did your relative move to an OAH? Was s/he living with you before moving?
2. Who made the choice for the move? You/Elderly?
3. Why was this particular OAH chosen? Would you consider taking her to a culturally mixed OAH? Do you think s/he misses home?
4. Have you ever felt you should return him/her to your family?

#### **6. IMPACT ON FAMILY ECONOMICS:**

##### **a) Economic Benefit:**

In terms of financial obligations to your family, tell me about the benefits of having the elderly family member cared for by the OAH. (e.g. savings on medical/clothing/food/house help, house chores).

##### **b) Time Benefit:**

How would you assess time benefits to the family (for other obligations) by having the elderly family member being cared for by the OAH?

##### **c) Problems:** What problems does the family face by having the elderly cared for at the OAH?

7. What do you think about institutionalisation of elderly people in general?
8. Would you say the current model of OAHs is appropriate for all Namibian elderly? Why?
9. Do you think extended families are more likely to care for their elderly members at home?
10. How much care would you say families/community support OAHs?
11. Would you say elderly who live in OAHs are of a different social class than those who do not?
12. Do you think Government benefits in any way if elderly are cared for in OAHs?
13. What do you think about government enacting a maintenance law for children to care for elderly family members?
14. How would you like to see elderly care in Namibia being undertaken in 10 + years?

**B. ELDERLY LIVING IN THE COMMUNITY**

1. Have you always lived with your elderly family member?
2. **IMPACT ON FAMILY ECONOMICS:**
  - a) **Economic Benefit:**  
What financial benefits are there in caring for your elderly family member at home? (e.g. house chores help, financial contributions)
  - b) **Time Benefit:**  
In what ways does caring for your elderly family member at home affect time you require for any other activities?
  - c) **Problems:** (i) What problems are faced in caring for an elderly person in the family?  
(ii) What support could be provided to such families? By who?
2. Do you think extended families are more likely to care for their elderly members at home?
4. What do you think about government enacting maintenance law for children to care of elderly family members?
5. Do you think Government benefits in any way if elderly are cared for in OAHs?
6. Have you considered moving him/her to an OAH?
7. What do you think about institutionalisation of elderly people in general? What about culturally mixed OAHs?
8. Do you think families, which send their members to OAHs, are different in social class?
9. Would you say the current model of OAHs is appropriate for Namibia? Why?
10. Would you voluntarily support OAHs in any way even if your elderly family member is not living there?
11. What changes do you think have taken place within the community regarding elderly care?
12. How would you like to see elderly care in Namibia being undertaken in 10 + years?

**(f) ELDERLY CASE STUDIES  
(BY REGION)**

1. Demographics: Sex ..... Age .... Marital Status .... Former Occupation .....
2. How do you view elderly care in the community? What has changed?
3. Tell me about how you prepared for retirement and old age?
4. What did you expect from your government as a retiree?
5. What do you think you can still contribute to society while in retirement and old age?
6. What do you think about institutionalisation of elderly people?
7. Tell me whether you intend to move to an OAH, and what sort of OAH you would like to move to.
8. Do you think the current types of OAHs are appropriate for all Namibian elderly?
9. Do you think extended or big families are more likely to look after their elderly at home rather than send them to OAHs?
10. How do you think community can contribute to operation of OAHs?
11. What do you think about government enacting a maintenance law for children to care for their elderly family members?
12. What can be done to ensure good care for the elderly in Namibia in 10 + years?
13. What else would you like to talk about regarding care of old people?

APPENDIX II: QUANTITATIVE DATA

TABLES

**Table 3: Sex of the Elderly**

| Sex    | Number | %   |
|--------|--------|-----|
| Male   | 101    | 42  |
| Female | 137    | 58  |
| Total  | 238    | 100 |

**Table 4: Age Groups Of The Elderly**

| Age Group | Number | %   |
|-----------|--------|-----|
| 60 - 69   | 93     | 39  |
| 70 – 80   | 104    | 44  |
| 81 - 90   | 36     | 15  |
| 91 +      | 5      | 2   |
| Total     | 238    | 100 |

**Table 5: Marital Status Of The Elderly**

| Marital Status     | Number | Percentage |
|--------------------|--------|------------|
| Single             | 49     | 20         |
| Married/Cohabiting | 73     | 31         |
| Divorced/Separated | 11     | 5          |
| Widowed            | 105    | 44         |
| Total              | 238    | 100        |

**Table 6: Elderly's Marital Status By Sex**

| Marital Status     | SEX  |    |        |    | Total |     |
|--------------------|------|----|--------|----|-------|-----|
|                    | Male | %  | Female | %  | No    | %   |
| Single             | 25   | 10 | 24     | 10 | 49    | 20  |
| Married/Cohabiting | 45   | 19 | 28     | 12 | 73    | 31  |
| Divorced/Separated | 7    | 3  | 4      | 2  | 11    | 5   |
| Widowed            | 24   | 10 | 81     | 34 | 105   | 44  |
| Total              | 101  | 42 | 137    | 58 | 238   | 100 |

**Table 7: Elderly's Mother Tongue**

| Language    | Number | %   |
|-------------|--------|-----|
| Afrikaans   | 95     | 40  |
| English     | 11     | 5   |
| German      | 22     | 9   |
| Damara>Nama | 72     | 30  |
| Oshiwambo   | 22     | 9   |
| Otjiherero  | 7      | 3   |
| Other       | 9      | 4   |
| Total       | 238    | 100 |

**Table 8: Elderly's Religious Beliefs**

| Religion        | Number | %   |
|-----------------|--------|-----|
| Lutheran        | 92     | 39  |
| Dutch Reform    | 34     | 14  |
| Other Christian | 76     | 32  |
| Other Religion  | 32     | 13  |
| Non-Believer    | 4      | 2   |
| Total           | 238    | 100 |

**Table 9: Elderly's Health Problems**

| Health Problem    | A Problem |    | Not Problem |    | Total |     |
|-------------------|-----------|----|-------------|----|-------|-----|
|                   | No        | %  | No          | %  | No    | %   |
| Heart/Stroke      | 38        | 16 | 200         | 84 | 238   | 100 |
| Blood Pressure    | 101       | 42 | 137         | 58 | 238   | 100 |
| Diabetes          | 26        | 11 | 212         | 89 | 238   | 100 |
| Joints / Backache | 104       | 44 | 134         | 56 | 238   | 100 |
| Poor Sight        | 73        | 31 | 165         | 69 | 238   | 100 |
| Others            | 64        | 27 | 174         | 73 | 238   | 100 |
| None              | 29        | 12 | 209         | 88 | 238   | 100 |



**Table 12: Elderly's Daily Meals**

| Daily Meals | Number | %   |
|-------------|--------|-----|
| Three       | 162    | 68  |
| Two         | 54     | 23  |
| One         | 22     | 9   |
| Total       | 238    | 100 |

**Table 13: Whether Quantity of Food Is Enough For The Elderly**

|                  | Number | %   |
|------------------|--------|-----|
| Most Often/Often | 156    | 66  |
| Sometimes        | 41     | 17  |
| Never Enough     | 41     | 17  |
| Total            | 238    | 100 |

**Table 14: Where The Elderly Outside OAHs Live**

| Place                     | Number | %   |
|---------------------------|--------|-----|
| With Own Children         | 15     | 13  |
| Extended Family / Friends | 10     | 8   |
| Own House                 | 61     | 51  |
| Rented House              | 29     | 24  |
| Other                     | 5      | 4   |
| Total                     | 120    | 100 |

Note: Only elderly living in outside OAHs with a total of 120

**Table 15: How The Elderly Like Living in OAHs**

| Like OAH              | Number | %   |
|-----------------------|--------|-----|
| Very much/Much        | 112    | 95  |
| Not Much              | 5      | 4   |
| Do not Like it at all | 1      | 1   |
| Total                 | 118    | 100 |

Note: Only elderly living in OAHs with a total of 118.

**Table 16: What The Elderly Like About OAHs**

| Reason                   | Liked |    | Not Liked |    | Total |     |
|--------------------------|-------|----|-----------|----|-------|-----|
|                          | No.   | %  | No.       | %  | No    | %   |
| Being with Other Elderly | 84    | 71 | 34        | 29 | 118   | 100 |
| Having Friends Nearby    | 42    | 36 | 76        | 64 | 118   | 100 |
| Getting Needed Help      | 74    | 63 | 44        | 37 | 118   | 100 |
| Enough Rest Time         | 46    | 39 | 72        | 61 | 118   | 100 |
| Safety                   | 8     | 7  | 110       | 93 | 118   | 100 |

Note: Only elderly living in OAHs with a total of 118

**Table 17: Elderly's Satisfaction With OAH Care**

|                   | Number | %   |
|-------------------|--------|-----|
| Satisfied         | 112    | 95  |
| Very Dissatisfied | 6      | 5   |
| Total             | 118    | 100 |

Note: Only elderly living in OAHs with a total of 118

**Table 18: What OAH Residents Liked Outside OAHs**

| Interests          | Liked |    | Not Apply |    | Total |     |
|--------------------|-------|----|-----------|----|-------|-----|
|                    | No    | %  | No        | %  | No    | %   |
| Social Life        | 66    | 56 | 52        | 44 | 118   | 100 |
| Living with Family | 26    | 22 | 92        | 78 | 118   | 100 |
| Security           | 30    | 25 | 88        | 75 | 118   | 100 |
| Financial Security | 19    | 16 | 99        | 84 | 118   | 100 |

Note: Only elderly living in OAHs with a total of 118.

**Table 19: What OAH Residents Disliked Outside OAHs**

| Dislikes           | Disliked |    | Not Apply |    | Total |     |
|--------------------|----------|----|-----------|----|-------|-----|
|                    | No       | %  | No        | %  | No    | %   |
| Loneliness         | 21       | 18 | 97        | 82 | 118   | 100 |
| Poor Security      | 39       | 33 | 79        | 67 | 118   | 100 |
| Financial Problems | 25       | 21 | 93        | 79 | 118   | 100 |
| None               | 33       | 28 | 85        | 72 | 118   | 100 |

Note: Only elderly living in OAHs with a total of 118.

**Table 21: Views On Building More OAHs**

| Build more OAHs | Number | %   |
|-----------------|--------|-----|
| Yes             | 160    | 69  |
| No              | 73     | 31  |
| Total           | 233    | 100 |

Note: Total number is not 238 due to non-responses.

**Table 23: How Institutionalised Elderly are Valued by Family**

| Valued Less | Number | %   |
|-------------|--------|-----|
| Yes         | 108    | 46  |
| No          | 127    | 54  |
| Total       | 235    | 100 |

Note: Total number is not 238 due to non-responses.

**Table 25: Elderly's Preferences Of Where To Live**

| Preference          | Number | %   |
|---------------------|--------|-----|
| By Myself           | 70     | 30  |
| In OAH              | 121    | 51  |
| With Family/Friends | 44     | 19  |
| Other               | 1      | -   |
| Total               | 236    | 100 |

Note: Total number is not 238 due to non-responses.

**Table 26: Reasons For Preference of OAHs**

| Reason for Preference               | Reason |    | Not Reason |    | Total |     |
|-------------------------------------|--------|----|------------|----|-------|-----|
|                                     | No     | %  | No         | %  | No    | %   |
| Better Care                         | 88     | 75 | 30         | 25 | 118   | 100 |
| Children too Busy                   | 47     | 40 | 71         | 60 | 118   | 100 |
| I do not like to Bother Others      | 26     | 22 | 92         | 78 | 118   | 100 |
| Family Does not like to be Bothered | 52     | 27 | 86         | 73 | 118   | 100 |
| Family Too Poor                     | 20     | 17 | 98         | 83 | 118   | 100 |

Note: Only elderly living in OAHs with a total of 118.

**Table 27: Elderly's Attitudes Towards Living in Culturally-Mixed OAHs**

| Can Live in Culturally-Mixed OAH | Number | %   |
|----------------------------------|--------|-----|
| Yes                              | 166    | 74  |
| No                               | 58     | 26  |
| Total                            | 224    | 100 |

Note: Total number is not 238 due to non-responses.

**Table 28: Reasons For Rejection of Culturally-Mixed OAHs**

| Reason for Rejection of Mixed OAH | Number | %   |
|-----------------------------------|--------|-----|
| Prefer Own Ethnic Group           | 25     | 48  |
| Do Not Understand Other Cultures  | 23     | 44  |
| Other Reasons                     | 4      | 8   |
| Total                             | 52     | 100 |

Note: Only answered by those who said No in table 27. Totals not 58 due to non-responses.

**Table 29: Elderly's Previous Occupations**

| Previous Occupation   | Number | %   |
|-----------------------|--------|-----|
| Govt/Company Employee | 62     | 26  |
| Business              | 8      | 3   |
| Farming               | 26     | 11  |
| Farm/Domestic Worker  | 74     | 31  |
| Housewife             | 33     | 14  |
| Other                 | 35     | 15  |
| Total                 | 238    | 100 |

**Table 30: Elderly Who Receive Social Pension**

| Receive S/Pension | Number | %   |
|-------------------|--------|-----|
| Yes               | 188    | 79  |
| No                | 50     | 21  |
| Total             | 238    | 100 |

**Table 31: Social Pension Adequacy**

| Pension Adequacy | Number | %   |
|------------------|--------|-----|
| Adequate         | 17     | 9   |
| Inadequate       | 171    | 91  |
| Total            | 188    | 100 |

Note: Total only for those who answered Yes in Table 30.

**Table 32: Source of Additional Funds To Top Up Social Pensions**

| Sources of Add. Funds | A Source |    | Not A Source |    | Total |     |
|-----------------------|----------|----|--------------|----|-------|-----|
|                       | No       | %  | No           | %  | No    | %   |
| Paid by OAH           | 23       | 14 | 148          | 86 | 171   | 100 |
| From Family & Friends | 79       | 46 | 92           | 54 | 171   | 100 |
| From Church           | 11       | 6  | 160          | 94 | 171   | 100 |
| My Investments        | 28       | 16 | 143          | 84 | 171   | 100 |
| Have Other Sources    | 9        | 5  | 162          | 95 | 171   | 100 |
| Do Some Work          | 13       | 8  | 158          | 92 | 171   | 100 |

Note: Totals for those who answered Inadequate in Table 31.

**Table 33: Sources Of Financial Support For Elderly Without Social Pensions**

| Sources of Additional Funds | A Source |    | Not A Source |    | Total |     |
|-----------------------------|----------|----|--------------|----|-------|-----|
|                             | No       | %  | No           | %  | No    | %   |
| Have Other Sources          | 8        | 16 | 42           | 84 | 50    | 100 |
| Children / Family           | 12       | 24 | 38           | 76 | 50    | 100 |
| Friends                     | 1        | 2  | 49           | 98 | 50    | 100 |
| Church                      | 4        | 8  | 46           | 92 | 50    | 100 |
| Do Some Work                | 8        | 16 | 42           | 84 | 50    | 100 |
| OAH Pay                     | 7        | 14 | 43           | 86 | 50    | 100 |

Note: Totals for elderly who answered No in Table 30.

**Table 35: Elderly's Associational and Club Memberships**

| Membership | Number | %   |
|------------|--------|-----|
| Yes        | 82     | 35  |
| No         | 154    | 65  |
| Total      | 238    | 100 |

**Table 36: Elderly Who Have Children**

| Have Children | Number | %   |
|---------------|--------|-----|
| Yes           | 207    | 87  |
| No            | 31     | 13  |
| Total         | 238    | 100 |

**Table 37: Elderly Who Get Support From Children**

| Children Support | Number | %   |
|------------------|--------|-----|
| Yes              | 108    | 52  |
| No               | 98     | 48  |
| Total            | 206    | 100 |

Note: Answered by those who answered Yes in Table 36. Total is not 207 due to non-response.

**Table 38: Evaluation of Children's Parental Support In Community**

| Evaluation of Support  | Number | %   |
|------------------------|--------|-----|
| Adequate               | 30     | 12  |
| Moderately Adequate    | 74     | 32  |
| Inadequate/ No Support | 130    | 56  |
| Total                  | 234    | 100 |

Note: Total number is not 238 due to non-responses.

**Table 39: Elderly's Perception of Eldercare Between Extended Family and Nucleus Family**

| Extended Family Gives Better Care | Number | %   |
|-----------------------------------|--------|-----|
| Yes                               | 64     | 28  |
| No                                | 169    | 72  |
| Total                             | 233    | 100 |

Note: Total number is not 238 due to non-responses.



**Table 41: Elderly's Free Time Activities**

| Free Time Activity   | Undertake |    | Do not Undertake |    | Total |     |
|----------------------|-----------|----|------------------|----|-------|-----|
|                      | No        | %  | No               | %  | No    | %   |
| Sit Around / Sleep   | 117       | 49 | 121              | 51 | 238   | 100 |
| Activity/Handicraft  | 95        | 40 | 143              | 60 | 238   | 100 |
| Walk/Talk to Friends | 162       | 68 | 76               | 32 | 238   | 100 |
| TV / Radio           | 183       | 77 | 55               | 23 | 238   | 100 |
| Read Bible / Books   | 137       | 58 | 101              | 42 | 238   | 100 |
| Other                | 38        | 16 | 200              | 84 | 238   | 100 |

**Table 42: Elderly' Report on Activities Provided By OAHs**

| Activity Provided | Provided |    | Not Provided |    | Total |     |
|-------------------|----------|----|--------------|----|-------|-----|
|                   | No       | %  | No           | %  | No    | %   |
| Library           | 51       | 43 | 67           | 57 | 118   | 100 |
| Choir / Music     | 33       | 28 | 85           | 72 | 118   | 100 |
| Indoor Games      | 27       | 23 | 91           | 77 | 118   | 100 |
| Bible Study       | 56       | 48 | 62           | 52 | 118   | 100 |
| Other Activity    | 16       | 14 | 102          | 86 | 118   | 100 |
| None              | 42       | 36 | 76           | 64 | 118   | 100 |

Note: Only elderly living in OAHs with a total of 118.

**Table 43: Elderly's Views On Gender Balance In Elderly Care**

| Gender           | Number | %   |
|------------------|--------|-----|
| Males Favoured   | 12     | 5   |
| Females Favoured | 34     | 14  |
| Equal Care       | 191    | 81  |
| Total            | 237    | 100 |

Note: Total number is not 238 due to non-response.

**Table 44: Elderly's Source of News and Information**

| Source                | Source |    | Not Source |    | Total |     |
|-----------------------|--------|----|------------|----|-------|-----|
|                       | No     | %  | No         | %  | No    | %   |
| Radio                 | 195    | 82 | 43         | 18 | 238   | 100 |
| Television            | 135    | 57 | 103        | 43 | 238   | 100 |
| Newspapers            | 106    | 45 | 132        | 55 | 238   | 100 |
| OAH Staff & Residents | 21     | 9  | 217        | 91 | 238   | 100 |
| Other Sources         | 31     | 13 | 207        | 87 | 238   | 100 |
| Not Interested        | 6      | 3  | 232        | 97 | 238   | 100 |

**Table 45: Elderly's Knowledge About UN Rights Of Older People**

| Know UN Rights | Number | %   |
|----------------|--------|-----|
| Yes            | 68     | 29  |
| No             | 170    | 71  |
| Total          | 238    | 100 |

**Table 46: Elderly's Current Problems**

| Type of Problem          | Problem |    | Not Problem |    | Total |     |
|--------------------------|---------|----|-------------|----|-------|-----|
|                          | No      | %  | No          | %  | No    | %   |
| Financial                | 149     | 63 | 89          | 37 | 238   | 100 |
| Inadequate Food/Clothing | 148     | 62 | 90          | 38 | 238   | 100 |
| Medical Care             | 117     | 49 | 121         | 51 | 238   | 100 |
| Other                    | 53      | 22 | 185         | 78 | 238   | 100 |
| None                     | 31      | 13 | 207         | 87 | 238   | 100 |

**Table 47: Elderly's Advice on Future Elderly Care in Namibia**

| Advice                    | Advised |    | Not Advised |    | Total |     |
|---------------------------|---------|----|-------------|----|-------|-----|
|                           | No      | %  | No          | %  | No    | %   |
| Increase Pension          | 104     | 44 | 134         | 56 | 238   | 100 |
| Better Medical Services   | 36      | 15 | 202         | 85 | 238   | 100 |
| Promote Family Care       | 62      | 26 | 176         | 74 | 238   | 100 |
| Teach Eldercare in School | 34      | 14 | 204         | 86 | 238   | 100 |
| Housing Assistance        | 76      | 32 | 162         | 68 | 238   | 100 |
| Govt. Community Support   | 34      | 14 | 204         | 86 | 238   | 100 |
| Maintenance Law           | 22      | 9  | 216         | 91 | 238   | 100 |
| Caregiver Incentive       | 55      | 23 | 183         | 77 | 238   | 100 |
| Build More OAHs           | 45      | 19 | 193         | 81 | 238   | 100 |
| Family Help in OAH        | 5       | 2  | 233         | 98 | 238   | 100 |
| Others                    | 10      | 4  | 228         | 96 | 238   | 100 |

## **APPENDIX III: QUALITATIVE DATA**

### **KEY INFORMANT INTERVIEWS**

- (a) OLD AGE HOME MANAGERS
- (b) WELFARE ORGANISATIONS AND NGOs
- (c) POLICY LEVEL STAFF – MINISTRY OF HEALTH AND SOCIAL SERVICES
- (d) REGIONAL-BASED SOCIAL WORKERS
- (e) RELATIVES OF ELDERLY PEOPLE (Who Help Most)
- (f) ELDERLY CASE STUDIES

### a) OLD AGE HOME MANAGERS

Q. From which ethnic group are elderly in OAHs?

A. European occupied OAHs - The majority are European, the majority are women

Indigenous occupied OAHs - From indigenous ethnic communities. The majority are men. *“There are more men. Women are taken by families. It could be the community is willing to care for females more than men”*. (Chairperson, Management Committee, OAH Khomas Region)

Q. What leisure activities are the elderly provided with at the home?

A. Some OAHs provide activities and others do not. *“They are too busy. Women from German Organisation conduct weekly activities* (Manager OAH Khomas Region). *“None are organised but some elderly moved to the OAH with their chickens and rear these chickens there”* (Manager, rural OAH Erongo Region).

#### Staff

Q. Are the staff trained and is the number adequate?

A. European occupied OAHs - They are trained and some are professionals. In-house training is also given. The Numbers are adequate.  
Indigenous occupied OAHs – They are not trained, and numbers are not enough.

#### Finance

Q. How are the OAHs funded?

A. European occupied OAHs - Funding is from high fees, donations, investments, and community support through fund-raising. The main problem is finance to maintain high standards and for expansion.

Indigenous occupied OAHs – The fees are low. Elderly residents are poor and depend only on social pensions. OAHs are mostly donor- dependent and therefore funding is unreliable. Problems involve finance to provide basic needs, hire more staff and train them. There is lack of transportation means, worse in rural areas. Structures lack an elderly-friendly environment and fittings. Government support is required to upgrade structures.

Personal Views

- Q. Do you think the model of OAH is appropriate for all Namibians? Why?
- A. No one model is appropriate at the moment. You have to consider culture. Each area should get what works for them. Families and government should both get involved. Smaller houses are better. Government should also provide allowances and support eldercare services for places in need. OAHs occupied by European elderly are too expensive and can only be afforded by a few who have money. The pensions are also too low.
- Q. How would you like to see elderly care in Namibia being undertaken in 10 + years?
- A. Elderly people should be cared for in families. Families who give care should be supported so that they continue. Caregivers should be paid incentives.
- Caregivers should be trained, for OAHs and home care because of current acute shortage. NGOs and private sector should be involved in training and other services. A pool of caregivers should be built through formal training, for at least 2 years in schools and training institutions for practical basic knowledge. Training workshops and media programmes should be given for short-term needs.
- Government should increase social pensions, equalise services between rural and urban areas, and equalise subsidies on utilities for all elderly regardless of place of residence. Transport allowance should be paid to elderly people.
- Government should increase community programmes, revive and support traditional values for elderly care. Local authorities – municipalities and town councils should care for poor and needy elderly and support OAHs. OAHs are expensive and not a solution, they should be built according to what works for the people in a particular area. Young people do not have time for elderly care.
- Government should also fund the National Council for Older Persons in Namibia, so that it can get more involved.
- There should be more information dissemination and media programs on elderly issues, such as health and rights. Elderly raise complaints to managers, such as, “*We like to get news about our issues. Why isn't it there?*” (Manager, Kuisebmond OAH)
- There should be better government planning for elderly care. “*White communities are not badly affected. Blacks are badly affected because they do not have money*”. (Manager, Susanne Grau Heim OAH).

**(b) WELFARE ORGANISATIONS AND NGOs**

- Q. Tell me about the activities of the organisation.
- A. General welfare of elderly, such as visits and food donations. “*We create opportunities to keep elderly active*” (Chairman ASC Windhoek). *We provide all-encompassing activities, including education on health, to registered members* (Chairman, ABB Windhoek).
- Q. What changes do you think have taken place within the community regarding Elderly care?
- A. Families and community care responsibility is reducing. Poverty hinders communities to give adequate care. Urban living also makes people fail or neglect elderly care.  
Organisations do not cover the whole country, only in towns and within the ethnic groups. Information on elderly issues is lacking in the media, the public are not sensitized on elderly people’s issues.
- Q. Do you think extended families are more likely to care for their elderly members at home?
- A. Most black Namibian elderly live in families. Elderly are better off if cared for in the family, even in poor families. Big families have potential to share and give care, but are not always doing it. Small families can also give good care at home, it depends on the individuals.
- Q. How much care would you say families/community supports the elderly in areas you cover?
- A. Support is being eroded in many families and communities but there is still good will. Poverty hampers many families from giving care. Blacks had no chance of pension before due to politics.
- Q. How/who funds this organisation?
- A. National Council for Older Persons is dependent on donations, no government support. ASC Windhoek membership is predominantly European, raises funds locally through subscriptions and hire of premises at Pioneerspark. Government provides 3 gardeners, 1 domestic help and subsidises utilities.  
ASC Walvis Bay has membership from indigenous elderly and coloureds. It is supported through municipal funding.

ABB in Windhoek is church supported, gets subscription and local fund-raising. Membership is from coloured community in Khomasdal. Namibia Christlike Vroue Hulpiens, Windhoek is donor-dependent and also operates in coloured community of Khomasdal.

- Q. Are the elderly you cater for covered by Medical Aid?
- A. A few are medically insured but the majority is not. Church-supported ABB arranges small contributions of N\$ 10 per month by members of the organisation for funeral support.
- Q. Would you say the current model of OAHs is appropriate for Namibia? Why?
- A. OAHs are not appropriate because they are expensive to government and individuals. Poverty and economic inequality means only the rich can afford. There is no OAH for middle-income people – only low and high.
- Q. What major gaps do you see in current levels of elderly care that the revised Older Persons Act should address in: Formal institutional care and Informal Family /community care
- A. Lack of trained caregivers, inadequate family support, lack of and inadequate nutritious food, and lack of activities for the elderly. Public information dissemination on elderly issues is lacking and there is no data on elderly abuse.
- Q. How would you like to see elderly care in Namibia being undertaken in 10 + years?
- A. More government support for families, community programmes, subsidised OAHs for the poor and caregiver training for home care and OAHs. Studies should be done to identify conditions and needs, and encouragement for formation of local NGOs. Private sector and NGOs should be involved in elderly welfare.
- Q. What challenges or problems do you face in your work?
- A. Lack of funds in the face of increasing numbers of elderly. Lack of transport and inability to attract young workers because of lack of funds.



**(c) POLICY LEVEL STAFF - MINISTRY OF HEALTH AND SOCIAL SERVICES**

- Q. How does the government currently support elderly people?
- A. Current government support for the elderly covers social pensions administered through the National Pensions Act (10 of 1992), benefiting 108,423 pensioners; special accommodation for older people at reduced rates (Sub-economic housing); a funeral benefit scheme up to an amount of N\$ 2000 that includes cost of a coffin for N\$ 700; and foster-parent allowance claimed by elderly caring for orphans.
- Q. What changes do you think have taken place within the Namibian society regarding elderly care?
- A. Elderly care is still predominantly by family, many elderly live in poor housing conditions and increased pressure on elderly due to HIV/AIDS pandemic. Increased deaths leads to elderly fostering orphans. Rural situation is not known because no studies have been done, lack of caregiver training and National Council is not effective because of lack of money. The rich live in good institutions and get good care.
- Q. The social welfare policy discourages institutionalisation of the elderly, how would elderly without families be cared for?
- A. Abandoned and frail elderly need institutions because there is no one to care. this gives a need for one category of OAH for these people. There should be needs assessment for establishing an OAH.
- Q. Considering poverty situation and deaths of young people from HIV/AIDS, wouldn't there be need for institutional care to be extended to Namibian elderly?
- A. The need is becoming apparent. Government has no capacity, therefore there is a need to train home based caregivers. NGOs and private sector should get involved. Communities should come up with own programmes according to needs. Institutional care should be the last resort. A percentage of the poor has to be included in expensive OAHs.
- Q. Would you say the current model of OAHs is appropriate for Namibia? Why?
- A. No. The good OAHs are too expensive. Local authorities should support OAHs for the majority to afford.
- Q. What community support is there for OAHs?

- A. Now almost no support except white communities. Communities should set up NGOs and raise funds locally and internationally. NGOs should help train caregivers.
- Q. What major gaps do you see in current levels of elderly care that the revised Older Persons Act should address in : Formal institutional care and Informal family/community care?
- A. Lack of community-based care, a need to define and legislate against abuse, and lack of transportation for elderly.
- Q. How would you like to see elderly care in Namibia being undertaken in 10 + years?
- A. Implement shift from institutional care to community care, use OAHs for the most needy, empower families to continue elderly. Information dissemination on elderly issues should be prioritised, improvement in the quality of services such as pension and foster grant processing

**(d) REGIONAL-BASED SOCIAL WORKERS**

- Q. Do you think extended families in this region are more likely to care for their elderly members at home?
- A. Not necessarily, big families sometimes do not always bother, while small ones do. Big families have more people to share but the will is being eroded.
- Q. Tell me about family care and community support for the elderly in the region.
- A. Care is not equal between rich and poor families. Most indigenous elderly are still cared for in families, though there is lack of trained and knowledgeable caregivers in modern methods of eldercare. Housing is poor and many families depend on pensions. Churches are highly involved in elderly care, such as soup kitchens and clothing. Social workers are few and visits are constrained by lack of transport. Elderly also have transport problems.
- Q. Would you say the current model of OAHs is appropriate for Namibia? Why?
- A. Not appropriate because good ones are too expensive for the majority, those who need the services cannot afford it. Community based approach is the best. It is better to revive traditional institutions and give them home based care training. OAHs built and supported by local government through municipalities are affordable by many elderly. Rural elderly do not have information of OAHs.
- Q. What gaps do you find in levels of elderly care in: Formal Institutional care and Informal family care?
- A. There is lack of research-based information on the situation of elderly people, lack of information dissemination to elderly and the public on elderly issues, such as health, frail care and rights. There are no trained caregivers, including inadequate professionals and social workers in the regions are inadequate. Elderly people lack transportation means.
- Q. How would you like to see elderly care in Namibia being undertaken in 10 + years?
- A. Government support for families that care for elderly people, such as housing, transport allowance, utility subsidy. Municipal support for OAHs should be increased and young people be taxed. Train caregivers, through workshops and formal schools, and pay them incentives. Encourage community care through supportive programmes, information dissemination on elderly issues and revive traditional care structures. Undertake research to enable formulation of realistic programmes. Boost government overall inadequate and unequal services in rural and urban areas, and in communities.

**(e) RELATIVES OF ELDERLY PEOPLE (who help most)****ELDERLY PEOPLE LIVING IN OAHs**

- Q. Who made the choice for the move? You/Elderly?
- A. Most of the elderly decided themselves some were taken by relatives. *"I made the decision and choice]. I forced her to go. She did not want to go. She is unhappy and complains daily, but I am satisfied. The attention given is good"*. (Daughter of OAH resident, Windhoek)
- Q. Would you say elderly who live in OAHs are of a different social class than those who do not?
- A. High class because it is expensive, especially those for white people, and they are mostly middle to upper class.  
All classes go (Otjozondjupa region).  
*"Yes, high class. Most children from high class do not want to be bothered. They have changed socially"* (Indigenous relative of elderly person living in Community, Kunene Region).
- Q. What do you think about mixed OAHs with all ethnic groups living there?
- A. It cannot work, people have different cultures. *"At that age, they need to be with their own people, so racial segregation cannot be taken out of institutions. Change of attitudes is not easy in old age"* (Relative of OAH resident, Khomas Region. *"Germans have their expensive one while Afrikaner are also alone. Blacks cannot afford to live in these homes in any case"* (European (Afrikaner) relative of OAH resident, Erongo Region).

**IMPACT OF ELDERLY CARE ON FAMILY ECONOMICS**

- Q. What economic, time benefits and problems are involved in caring for your elderly relative at home?
- A. There is financial pressure on the family for elderly care in expensive OAHs. Advance planning has to be done, such as savings and investments because of increasing costs. For church and municipal supported OAHs, there is benefit because there is no additional cost for OAH fees, the pension is enough. The costs in municipal OAHs are distributed to taxable municipal residents. There is also saving on daily costs and food. Family members also live in houses allocated to old people free of charge in Khorixas.  
Time benefit: Young people are released to do productive work.  
Problems involve increasing costs in expensive OAHs.

### ELDERLY PEOPLE LIVING IN THE COMMUNITY

- Q. Have you considered moving him/her to an OAH?
- A. Khomas: No. I can care for my mother.  
 Erongo: No, under no circumstances will I do that. I can sacrifice my job to care for her.  
 Kunene: *“Even if I am still an unmarried boy, I can still care for my old mother and father”* (Relative of elderly living in the community, Kunene Region).  
 Otjozondjupa: No, but if I have no means then, I will.

### IMPACT OF ELDERLY CARE ON FAMILY ECONOMICS

- Q. What are economic, time benefits and problems are involved in caring for your elderly relative at home?
- A. There is economic loss for security on the home when a strong elderly person moves out to an OAH. The family shares the social pension. Elderly provide childcare and do house chores.  
 Time benefits vary: family members get free time to socialise and do other work when house chores are taken off their hands. However, caring for the frail and disabled elderly is time consuming and stressful, and this curtails social life of caregivers.

Problems involve accommodation in small houses and lack of funds to expand or maintain them. Caregivers also lack knowledge on frail care. There is lack of transport and costs are high to go to hospitals and pension pay points. For example in Okombahe, “we have to go to Omaruru or Otavi”.

The solution is for government to support families giving care, and pay transport allowance.

**(f) ELDERLY CASE STUDIES**

- Q. Tell me about how you prepared for retirement and old age?
- A. I have been a teacher and will get pension. I also get insurance in form of pension from my late husband (Khomas Region). I have a home, work pension from Rossing and a private pension from Old Mutual (Erongo Region). I got a package from the church (Kunene). I did not prepare, it is not easy. The government was bad for blacks then. Many people of low income do not prepare, the money is not enough (Otjozondjupa Region).
- Q. Tell me whether you intend to move to an OAH, and what sort of OAH you would like to move to.
- A. Yes I will move to an OAH (Khomas Region). No, my children will care for me. I only expect government to assist with transport to health centres (Erongo & Kunene Regions). My children promised to care for me but I do not know whether they will change. If they do, I will go to an OAH. a good OAH but I only know about the municipality one. You cannot see inside white OAHs. (Otjozondjupa Region).
- Q. Do you think the current types of OAHs are appropriate for all Namibian elderly?
- A. Not for all communities. Some prefer to live with children. A model for the majority is needed (All Regions).
- Q. How do you think community can contribute to operation of OAHs?
- A. They can give care, but should be given basic training so as to help. They can teach children in schools about old age and elderly needs. There should be public education on OAHs so that the public gives support in kind. The idea of OAH has been introduced wrongly; correct information should be given to the public. *“Public needs education on new changes. OAHs are new and people should be educated on advantages and disadvantages”* (Elderly case study, Kunene Region). *“People can help if educated about it. Now people think that elderly people go there to be mistreated”* (Relative of elderly person living in the community, Khomas Region).
- Q. What can be done to ensure good care for the elderly in Namibia in 10 + years?
- A. Government should act on: Public awareness especially on new ideas like OAHs. *“The public needs education on advantages and disadvantages of OAH”* (Kunene region). Support families who care, pay incentives to caregivers, train caregivers in schools and workshops for OAHs and home care, pay utility subsidies to all or exempt elderly on utilities, improve services for rural elderly, increase pension and pay transport allowance. Municipality should support OAHs. *“Society should move with times because reverse of change in young people to continue family elderly care is not possible”* (Erongo Region).