UNIVERSITY OF SOUTHAMPTON

FACULTY OF SOCIAL AND HUMAN SCIENCES

CENTRE FOR RESEARCH ON AGEING

Ageing in Zimbabwe: Assessing Old-age Vulnerability, Care and Support in Zimbabwe in a Context of HIV/AIDS, Poverty and Out-migration

by

NYASHA C. CHIUNYA-HUNI

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ABSTRACT

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AGEING IN ZIMBABWE: ASSESSING OLD-AGE VULNERABILITY, CARE AND SUPPORT IN ZIMBABWE IN A CONTEXT OF HIV/AIDS, POVERTY AND OUT-MIGRATION

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Developing countries throughout the world are undergoing population ageing at an unprecedented pace (UN, 2009). By 2025, 70% of the world's older people will be living in developing countries (UN Population Division, 2003) where they face greater vulnerabilities than their counterparts in developed countries. Many have experienced a lifetime of poverty, malnutrition and exposure to diseases. While the majority of older people in the developed world can rely on pensions and health services as coping resources, in countries like Zimbabwe such formal sources are lacking. The onus is therefore on families and communities to provide old-age support and care to reduce vulnerability. Elderly care in Zimbabwe has always been provided by the immediate and extended family, within the family home. However, rapid ageing in Zimbabwe is occurring against a background of demographic and social changes, as well as severe economic, political, and epidemiological crises, threatening the reliability and availability of children and families for old-age support. This research uses qualitative and quantitative methods in order to investigate threats faced by older people, to examine what old-age support is available and what older people's needs are. Such knowledge would provide information about the impact of the threats on older people's well-being, in the context of risks such as HIV/AIDS, poverty and out-migration in Zimbabwe. This research fills in important gap in knowledge by focusing on care and support provision to older people, rather than viewing them primarily as providers of care as much of the recent literature has done. My other original contribution to knowledge is that no research has been done in the same environment of small scale commercial and subsistence farming areas in Zimbabwe. The thesis makes a theoretical contribution to knowledge through its application of the vulnerability framework, because no study has ever used the framework in ageing studies in Zimbabwe. The threat most commonly faced was difficulty accessing healthcare, either due to transport problems, not affording user fees, or both. Older respondents were also exposed to a lack of support and a reduction in earning capacity, resulting in increased financial problems, transport problems and poverty, made worse by hyper-inflation. Minimal and non-availability of formal care and support services exacerbates the vulnerability of most older Zimbabweans. The research findings such as the need for an improved transport network and social pensions, are expected be presented as key policy recommendations to inform policy-makers, governmental and non-governmental welfare providers of the threats faced by older persons in Dowa, with findings to be placed within a wider demographic and economic context of small scale subsistence and commercial farming areas.

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Academic Thesis: Declaration Of Authorship

I, Nyasha Constance Chiunya-Huni ……declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

[**title of thesis**]

Ageing in Zimbabwe: Assessing Old-Age Vulnerability, Care and Support in Zimbabwe in a Context of HIV/AIDS, Poverty and Out migration

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;

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7. Either none of this work has been published before submission, or parts of this work have been published as: [please list references below]:

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Acknowledgements

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I extend my thanks to The Sir Richard Stapley Educational Trust for their financial support, and thank my friends especially Valerie Lipman, for their support.

Dedication

This thesis is dedicated to my son 'Kuku', my nephews and nieces who consider me their role model. Mum/Ma/Aunt hopes this thesis makes you proud and is worth your waiting!

Definitions and abbreviations used

Abbreviations

ADL	Activities of Daily Living
ARDL	Activities of Rural Daily Living
AIDS	Acquired Immune Deficiency/Immunodeficiency Syndrome
AMTO	Assisted Medical Treatment Orders
ARV	Anti-retroviral (drugs)
BADL	Basic Activities of Daily Living
BWPI	Brook World Poverty Institute (BWPI
CPRC	The Chronic Poverty Research Centre
CRA	Centre for Research on Ageing
CBO	Community Based Organisation
CSO	Central Stastical Office
DfID	Department for International Development (UK)
DSW	Department of Social Welfare
ESAP	Economic Structural Adjustment Programme
GAA	Global Action on Ageing
GDP	Gross Domestic Product
HAC	Health Action in Crises
HAI	HelpAge International
HAZ	HelpAge Zimbabwe
HIV	Human Immunodeficiency Virus
IADL	Instrumental Activities of Daily Living
IFPRI	International Food Policy Research Institute
ILO	International Labour Organisation
IOM	International Organisation for Migration
IRIN	Integrated Regional Information Networks (Humanitarian news and analysis)

LAMA	Legal Age of Majority Act
MDC	Movement for Democratic Change
MoHCW	Ministry of Health and Child Welfare (Zimbabwe)
MPSLSW	Ministry of Public Service, Labour and Social Welfare (Zimbabwe)
NHS	National Health Service
NGO	Non-Governmental Organisation
NSSA	National Social Security Authority
ODA	Official Development Assistance
OPH	Old People's Home
OVC	Orphans and Vulnerable Children
PASS	Poverty Assessment Study Survey
PAAP	Poverty Alleviation Action Plan
(PF) ZAPU	(Patriotic Front) Zimbabwe African People's Union
PHC	Primary Health Care
PLWA/PWA	Person Living With AIDS/Person With AIDS
POBS	Pensions and Other Benefits Scheme
UN	United Nations
UNAIDS	United Nations AIDS Programme
UN (DESA)	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
US	United States (of America)
USCB	United States Bureau of the Census
SSA	Sub-Saharan Africa
SSW	School of Social Work (Zimbabwe)
US$	United States Dollar
WHO	World Health Organisation
ZANU (PF)	Zimbabwe African National Union (Patriotic Front)

ZAPF Zimbabwe Association of Pension Funds

ZDHS Zimbabwe Demographic and Health Survey

ZHDR Zimbabwe Human Development Report

ZNFPC Zimbabwe National Family Planning Council

ZIMSTAT Zimbabwe Statistics (formerly CSO)

ZW$ Zimbabwe Dollar

Definition of Terms

Active life expectancy

The number of years a person can expect to survive without significant disability (Scott and Wenger, 1995:163)

AIDS Orphan

A child under 18 who has lost one or both parents to AIDS (UNAIDS, 2006).

Agnostics

They believe that it is impossible to know the truth about matters such as God and the future or if not impossible, at least impossible at the present time

Basic Activities of Daily Living

Activities involving functional mobility (ambulation, wheelchair mobility, bed mobility and transfers) and personal care (feeding, hygiene, toileting, bathing and dressing) (James, 2008:539).

Boreholes

These are devices that drill and pump water deep from the water table (WHO:2002).

Breadwinner

A member of the family who is economically active and takes responsibility for the financial matters of the family unit.

Case Studies

A strategy of inquiry in which the researcher explores in depth a program, event, activity, process, of one or more individuals. Case studies are bound by time and activity, and researchers collect detailed information using a variety of data collection procedures over a sustained period of time (Creswell, 2009:13)

Cohort

Consists of a more specific (than a generation) age group that has a shared common historical experience. It is defined by its interaction with the historical events that affect the subsequennt life course developments of that group (Hareven 1995:4).

Ethnography

It is a strategy of inquiry in which the researcher studies an intact group in a natural setting over a prolonged time by collecting, primarily, observational and interview data (Creswell, 2009:13).

Food Poverty Line (FPL)

A level of income at which people can meet their basic food needs, which was $33 per person in April 2012 (ZIMSTAT, 2012).

Generation

It designates kin relationships, for example, parents and children, grandparents and grandchildren. The CPRC sets a generation at 15 years. A generation can be made up of a number of cohorts (Hareven, 1995).

Health

A state of complete physical, mental and social well-being, not merely the absence of disease and infirmity (WHO)

HIV prevalence

The percentage of adults aged 15-49 who are currently infected (Bongaarts et al., 2009)

Household

For the purposes of this study, the persons sharing the same eating and sleeping arrangements (as used in the CSO surveys and studies).

Informed Consent Forms

Forms which participants sign before they engage in research. The forms acknowledge that participants' rights would be protected during data collection (Creswell, 2009).

Instrumental Activities of Daily Living

Functions concerned with a person's ability to cope with her/his environment in terms of such adaptive tasks as shopping, cooking, housekeeping, laundry, use of transportation, managing money, managing medication and the use of the telephone (Katz, 1983:723).

Katz ADL

The Katz Index of Independence in Activities of Daily Living ranks the ability to perform the activities of bathing, feeding, toileting, dressing, continence and transferring using 'yes/no' answers.

Minimum Data Set

A common set of data items, definitions and standards that should be used to collect and report data (Kowal et al., 2003).

Non-Poor

People whose income is above the Total Consumption Poverty Line (Madzingira, 1997).

Old-age dependency ratio

The number of persons aged 65 years or over per one hundred persons 15 to 64 years (UN, 2009:71).

Old/elderly/older people

Those 60 years or over according to UN common usage. If there is a change in the age being used in some circumstance in the course of this thesis, such changes will be mentioned and reasons for the change will be given.

Orphan

A child under the age of eighteen who has lost his or her mother or both parents (UNAIDS).

Oldest of the old

Those aged 80 years and over (UN, 2002)

Pandemic

The emergence of an easily spread disease that infects humans and causes serious illness and one that is new to the population (WHO)

PLWA/PWA

Those infected with the HIV/AIDS virus. For the purpose of this study, it will mean a person in any of the three stages of HIV[1], through to the fourth and final stage known as 'Progression from HIV to AIDS' up to 'full blown AIDS' (WHO, 2005)

Poor

Persons whose income is above the Food Poverty Line but below the Total Consumption Poverty Line (Zimstat, 2013)

Population ageing or demographic ageing

The process whereby older individuals become a proportionately larger share of the total population (United Nations Population Division, 2002)

Population growth rate

The increase (or decrease) in the number of persons in the population during a certain period of time, expressed as a percentage of the population at the beginning of the time period (UN, 2009:71)

Potential support ratio (PSR)

The number of persons aged 15 to 64 for each older person aged 65 years or over, indicates how many potential workers there are per older person (UN, 2009:72)

Poverty

For the purpose of this research, poverty will be taken as inability of individuals or families to satisfy basic needs (food, shelter, clothing, access to essential services such as health, sanitation and safe drinking water, transport, education, employment and many others) as well as deprivation in a wide range of other 'capabilities' these being education, health, human and civil rights (Hulme, 2003; Sen, 1999).

Poverty datum line (PDL)

The cost of a given standard of living that must be attained if a person is not to be considered poor (ZIMSTAT, 2012).

Social Security

[1] Primary HIV Infection, Clinically Asymptomatic and Symptomatic HIV Infection.

The protection which society provides for its members through a series of public resources against economic and social distress that otherwise would be caused by the stoppage or substantial reduction of earnings resulting from sickness, maternity, employment injury, invalidity and death; the provision of medical care; and the provision of subsidies for families with children (ILO, 1984:2-3)

Syncretic

Believing in part Christian, part African Traditional beliefs

Total Consumption Poverty Line (TCPL)

The sum of primary income, property income, agricultural income, household and business income, transfers and other income. This was $108 per person in April 2012 (ZIMSTAT, 2012).

Total dependency ratio

The number of persons under age 15 plus persons aged 65 or over per one hundred persons aged 15 to 64, sum of the youth dependency ratio and the old-age dependency ratio (UN, 2009:71)

Total fertility rate

The average number of children a woman would bear over the course of her lifetime if current age-specific fertility rates remained constant throughout her childbearing years, usually between the ages of 15 and 49 (UN, 2009)

UNAIDS

The global body responsible for co-ordinating efforts to fight the HIV/AIDS epidemic.

Unit Tax

A form of 'development levy' which is paid to the local authority for the maintenance of roads and other public services expected to be provided by a local authority in Zimbabwe, the amounts depend on farm sizes.

Very Poor

Refers to persons whose total income is below the Food Poverty Line (ZIMSTAT, 2012)

Vulnerability

Vulnerability means not lack or want, but exposure and defenselessness. It has two sides: the external side of exposure to shocks, stress and risk. And the internal side of defenselessness, meaning a lack of means to cope without damaging loss. (Chambers, 1995:20)

Wellbeing

Refers to economic well being (or lack thereof) and the provision of welfare support by family and formal and informal public systems, together with the physical wellbeing of older people and their care and treatment when ill. It broadly relates to the treatment of older people by civil society (Johnson, 2004:23).

CHAPTER 1: Introduction

'Ageing is a privilege and a societal achievement. It is also a challenge, which will impact on all aspects of 21st Century society. It is a challenge that cannot be addressed by the public or private sectors in isolation, it requires joint approaches and strategies' (WHO, 2002:1).

Most recent research on ageing in Africa takes it as a given that older people's situation is deteriorating as a direct result of the HIV/AIDS pandemic (for example, WHO, 2002; Kautz, et al., 2010). Much less attention has been paid to their lifecourse, changes in family systems and norms and implications of the wider changes in the economy. These conditions raise important questions about old-age support and security in Zimbabwe, which have wider relevance for our understanding of ageing in some of the world's poorest and most insecure countries. Due to lack of social protection, elderly support and care has always been provided by the immediate and extended family, within the family home in Africa. The family is therefore the main focus of this thesis.

Research on ageing in developing countries is relatively sparse, compared with research in developed countries. Ageing-related issues have certainly not been prioritised by many African governments (Kowal et al., 2003; Heslop and Gorman, 2002; Madzingira, 2006; Kowal, 2003; Mkai and Ngalinda, 2000; Van der Heever and Booysen, 2000; Madzingira, 2000; Katsriku, 2000). Older people are 'marginalised in many arenas and deprioritised in government policies and programmes' (Ferreira and Kowal, 2006:20). This is because governments are faced with pressing crises such as poverty eradication, AIDS mitigation and catering for the needs of the young within contexts of severe resource constraints (Lloyd-Sherlock, 2010; Apt, 2012). In addition there is limited information on older people, and their social, physical, psychological and economic well-being (Kowal, 2003). Therefore this study aims to analyse current information on later-life vulnerability with older people as the primary targets.

This thesis focusses on assessing old-age vulnerability in rural Zimbabwe by examining the key determinants of vulnerability in later life. This involves analysing the threats faced by older people and their coping resources available to counter these threats. The different threats are faced in an environment with hardly any formal welfare systems in place. Many elderly people need support or care in later life due to health problems and resultant inability to carry out general Activities of Daily Living (ADL) such as cooking, eating, bathing, personal grooming or walking. In addition, they face economic problems due to their reduced earning capacity (Lloyd-Sherlock, 2010; HAI, 2008; Vera-Sanso, 2004; Jamuna, 2003; van der Geest, 2004a; Johnson, 2004; Caldwell et al., 1988). Especially in rural areas, older

persons have to carry out strenuous activities related to their rural environment, such as fetching water, collecting firewood, ploughing, weeding and harvesting, if they wish to remain independent (Magro-Peter Ferry, 2005; Allain et al., 1997). These vulnerabilities can lead to poor well-being. Different coping resources such as personal wealth, as well as formal, semi-formal and informal social security systems in turn can help to mitigate the threats.

Zimbabwe was chosen for this research because it is a country with a particularly deleterious combination of challenges creating severe vulnerability for older people. These challenges include economic collapse and hyperinflation, dramatic out-migration, very high HIV prevalence and political instability, which has resulted in international isolation.

1.1 Rationale

Although older adults often experience multi-faceted problems, such as chronic poverty, social and political factors which affect access to social assistance and health care, marginalisation in society and policy, in the context of a developing country like Zimbabwe, elderly people are greatly disadvantaged because most of the scarce resources are focussed on the young. Although WHO activities in ageing started in 1958, in the African region ageing-related programmes were not encouraged much in the formal sector due to the 'assumption that … the traditional family ties would take care of the problem' (Monekosso, 1986:3). It was thought that the family, both immediate and extended, would always be able to look after their older relatives, without need for outside intervention. In Zimbabwe, there was the assumption that destitution, rejection and lack of status among elderly Africans was very rare and only occured in urban areas, mainly among migrant workers with little or no kin networks as their families were in their countries of origin (Kaseke, 2012; SSW, 1986; Monekosso, 1986). In fact, as this thesis will demonstrate, the assumption that family is able to provide adequate care is more broadly problematic in the case of Zimbabwe due to widespread HIV/AIDS, poverty, effects of the recent hyper-inflation and out-migration and problems with access to resources. In 2011, Zimbabwe had a poverty headcount ratio of 72.3% (9.7million) of the total population, those living on less than $1.25 per day (World Bank, 2015). Such high poverty levels have an impact on all age groups, but even more on the ability of younger generations to provide for their ageing parents.

The research will critically analyse the determinants of old-age vulnerability in rural Zimbabwe, threats faced by older persons, their specific needs and support arrangements, coping resources and will culminate in recommendations for policy planning and implementation in small scale farming areas.

The vulnerability framework was chosen for this thesis because it applies to people with a diverse range of attributes. It is an open and inclusive approach which allows the consideration of different aspects of individuals' lives, to attain the clearest possible picture of their security or lack of it, ultimately allowing answering of the research questions. Such knowledge will contribute towards our better understanding of later-life vulnerability and security. Old-age vulnerability can present itself in any form: emotional, financial, economic, spiritual, physical or social. For example, even rich people can face vulnerabilities and even those with adequate support may still face risks such as ill health, loneliness, insecurity and lack of respect. Understanding vulnerability is not an end in itself, rather the vulnerability framework allows targeting of a range of different diverse and complex groups which would allow planning for, and providing, better and more relevant safety nets. In order to be able to obtain a better understanding of old-age vulnerability in Zimbabwe, it is important to investigate what old-age support and care arrangements are in place for older people. This allows implications and policy recommendations relevant to older people to be drawn out.

Most research on ageing in Southern Africa has examined older people as a by-product of another target group, such as women and children in 'largely youthful societies' (Ferreira and Kowal, 2006:20). The existing literature rarely considers older people as individuals with their own needs (Nyambedha et al., 2003; Ferreira, 2004; Williams and Tumwekwase, 2001; Charlton and Rose, 2001; UNICEF, 2002; HAI, 2002a; Knodel and Saengtienchai, 2005). For example, McIntyre (2002) refers to HIV/AIDS as the 'grandmothers' curse' while Wilson and Adamchak (2001) refer to the pandemic as the 'grandmother's disease', not because the research was aimed at older people, but because the results showed the important role played by older people as carers of people with HIV/AIDS or as carers of orphans left behind. Research by Ferreira and Kalula (2009); Chiweshe and Gusha (2012); Paradza (2009); Ferreira et al. (2001) and Nyoni (1986) concentrate on the plight of older women. Their research was focussed on gender, not on the respondents chiefly being older people. This present study, by contrast focusses on both older men and women equally in terms of numbers, and uses the same instruments for data collection for both genders.

This study acknowledges that, while there is some recent literature on individuals in rural areas in Zimbabwe, for example, Muruviwa (2013), very few studies focus on ageing and none have been carried out using the vulnerability framework or in small-scale commercial and subsistence farms. There is thus a need for up-to-date research on old-age vulnerabilities in Zimbabwe in order to inform academia and policy.

Let me provide a brief overview of the existing literature on ageing in Zimbabwe so that the gap in knowledge which my study addresses can be better appreciated. With the exception

of the literature by WHO (2002), Madzingira (2006), Muruviwa (2013), Nyanguru (2008), Nyanguru (2007), Hungwe (2010) and Kimuna (2005), the majority of publications on older people in Zimbabwe are quite dated (for example, Allain et al., 1997; Wilson et al., 1991; Hampson, 1990). WHO (2002) particularly focussed on the challenges faced by older people in the context of HIV/AIDS in Southern Africa. Kimuna (2005) identified existing structures of living arrangements and support and the nature of family relationships of older adults. Nyanguru's (2007) research investigated the migration experiences of older people, while Nyanguru (2008) used the same sample to investigate the health-seeking behaviour of older people and reasons for the choices they make. The most recent and biggest study in size and impact, Madzingira (2006) is the first whose focus was on support given to older persons by their adult children. However, the fieldwork was carried out in 1998, before the country underwent hyper-inflation and political unrest culminated in the formation of the Government of National Unity (GNU) in February 2009. Many of Madzingira's findings are likely not to be relevant to the changed social, economic, epidemiological and political environment of more recent years. Also, the findings may not apply to my study site as Manicaland province, where Dowa in Makoni (also referred to as Maungwe because the main Shona dialect spoken is (Chi)Ungwe) is located, is not among the provinces covered. Another main difference to this current research is that Madzingira (2006) included young adults (19-59) in her research, but the respondents were not providers of day-to-day care and some of the respondents did not live with their elderly parents or see them daily. There is therefore likelihood that some adult children were giving responses based on assumptions, which will always be the case where children do not live with their parents. In their respective studies, Allain, et al. (1997) and Wilson et al. (1991) failed to identify infirm older people. It would be interesting for this study to identify older infirm people among the respondents.

There are also a few smaller recent studies, including Gutsa and Chingarand's (2009), Chiweshe and Gusha (2012) research on residents in old people's homes and Paradza's (2009) research on the impact of intergenerational struggles on urban housing and older women's livelihoods. Hungwe (2010) sought to evaluate how older people in an old people's home in Zimbabwe perceived their quality of life. Gutsa's (2011) study explores sexuality among urban elderly people and their challenges in accessing information, education, and communication campaigns in an environment of HIV/AIDS. Dhemba's (2012) publication is a review of literature on poverty in Africa and Zimbabwe in particular. Muruviwa, et al. (2013) sought to identify challenges related to livelihood strategies of older Zimbabweans.

This study makes five major contributions to knowledge. Firstly, among the main studies on older people in Zimbabwe, none has been carried out in small scale subsistence and

commercial farming areas. My study is a community-based study rather than studies on a nursing home population (Gutsa and Chingarand, 2009; Hungwe, 2010; Chiweshe and Gusha, 2012) which are much less representative of the situation of older people in Zimbabwe. This study is in-depth and the study population face specific ecological and agricultural context-related problems. Small scale subsistence and commercial farming areas are unique because due to the sizes of land they own, land owners are often placed in socio-economic terms between large commercial farmers and communal farmers, and they are often considered on one hand not to be poor enough to require financial assistance, while on the other hand not rich enough to qualify for farming assistance given to large-scale farmers (Ranger, 1985). There is therefore need for new research on old-age support to better understand current age-related threats in this particular context of rural Zimbabwe.

Secondly, the thesis fills an important gap in knowledge by focusing on care and support provision to older people, rather than viewing them primarily as providers of care or as secondary subjects of studies, for example, (Nyambedha et al., 2003; Wilson and Adamchak, 2001). My approach to the study of ageing in Zimbabwe contrasts with others because my respondents had varied circumstances and attributes and included those who were not providing care to younger generations.

Thirdly, this research is unique in that its main focus is on vulnerability, involving threats faced by older Zimbabweans and available coping resources, as they live in an environment with risks such as poverty, out-migration and the HIV/AIDS pandemic. This will involve the lifecourse approach, to have an understanding of the present support, care and living arrangements and changes which have occurred over time. The lifecourse approach is incorporated as it provides a dynamic perspective of intergenerational relations and who would be likely to assist in the event of care and support being needed, and also helping us understand why some family members are active or inactive in care and support provision. There is a strong relationship between the vulnerability of frail older people, available resources and the willingness of kin and non-kin to provide care for long periods (van Eeuwijk, 2006). This differs from Muruviwa, et al. (2013) who applied a livelihoods approach.

Fourthly, the thesis makes both methodological and data analysis contributions to research on ageing in Zimbabwe by the nature of the empirical study being carried out as longitudinal and through the application of kinship maps for data analysis. Such maps are used as an analytical tool to have an idea of possible sources of old-age care and support in later life. Previous studies have tended to be quantitative survey-based (Kimuna, 2005; Allain et al., 1997).

The fifth key component of the contribution of this thesis lies in its critique and evaluation of the dominant theories and approaches which have been used to explain old-age support provision and loss in developing countries. These include the modernisation theory with its emphasis on value change, exchange theory which argues old-age support is provided only as a two-way transaction, altruism which asserts that support is provided to those in most need and purely materialist approaches focussing on poverty (Hulme and Shepherd, 2003; Heslop and Gorman, 2002; Narayan et al., 2000), The thesis will similarly discuss and critique the **'**vulnerability' approach (Schröder-Butterfill and Marianti, 2006; Moser, 2002; Chambers, 1995).

1.2 Research Aims

The research aims to examine determinants of vulnerability, threats faced by older people and the sources of support available to reduce old-age vulnerability in the context of risks such as HIV/AIDS, poverty and out-migration in Zimbabwe. The HIV/AIDS pandemic has resulted in the deterioration of the family support system, contributing towards an exacerbation of the plight of older people, often leaving them in a more disadvantaged position than they have ever been (Seeley et al., 2008; WHO, 2002; Kaseke, 2003a). However, other factors also contribute to the loss of familial support and will be given equal consideration.

1.3 Research Questions

The thesis aims to address the research questions discussed below.

1. What are the main determinants of an older person's vulnerability in rural Zimbabwe?

The thesis will first explore factors which play an important part in determining old-age vulnerability in rural Zimbabwe. These may include poverty, crop failure, HIV/AIDS, migration of family members, ill health or death of family members. There is evidence that there has been a change in family and support networks in Zimbabwe and the developing world more broadly, resulting in changes in living arrangements and thus the immediate availability of support (Kimuna, 2005; UNDESA, 2012; Ferreira, 2004; Harper, 2006). Given the impact of out-migration, HIV/AIDS, hyper-inflation and the recent political climate in Zimbabwe, the availability of family support can clearly not be taken for granted. Finding out how these changes impact on vulnerability and security among older persons is of critical importance in the drawing up of recommendations for policy planning. The aim is therefore to identify those

individuals affected by changes in care and support provision, the nature of threats and the availability, accessibility and effectiveness of coping resources. This thesis will examine alternatives to support from family members, who have traditionally been the key providers of care and support in the African context, by looking at the support from neighbours, NGOs, the state and faith organisations. The research will employ quantitative and qualitative methodologies in addition to literature review to answer this research question.

2. What are the key threats which older people face and how do they affect their well-being?

In order to arrive at an overall assessment of older people's vulnerability it is important to examine the threats faced by older people and their impact on well-being. Only with an understanding of common threats is it possible to specify the care and support older people require. Information about threats can inform national and local government and civil society initiatives and help identify coping capabilities to be put in place. This research question will be answered through a combination of literature review, observations, case studies and interviews conducted with older persons, key informants, policy makers and stakeholders.

3. What coping resources are available to older people in rural Zimbabwe?

Using mixed methodology, this thesis will discuss the coping resources which older people in rural Zimbabwe have at their disposal to counter the threats they face. Knowledge of coping resources available or likely to be available is necessary for assessing how vulnerable or secure an individual is. Coping strategies and resources can be in the form of formal, semi-formal, informal sources or a combination of sources. However, the availability of coping resources alone is not enough to avoid bad outcomes, equally important is the adequacy of resources and older people's ability to access and mobilise the coping resources. The size, quality and strength of the coping resources determine how reliable they are likely to be in determining older people's security.

Having presented the knowledge context in terms of existing studies and the research questions guiding my thesis, I will now provide the demographic context of population ageing in Zimbabwe.

1.4 Population Ageing in the Developing World and Zimbabwe

The population of older people worldwide is increasing at an unprecedented rate and at an even greater rate in developing countries. The world's population of people aged 60 and over is projected to rise from 8.6% of the total population in 1980, to 15% by 2025. There were approximately 810 million persons aged 60 years or over in the world in 2012 (UN,

2012). By 2025, 12.7% of the populations in developing regions and 23.6% of the populations in developed regions will be aged over 60. This is part of the absolute increase globally from 205 million older persons in 1950 to a projection of nearly 2 billion by 2050 (UN, 2009). The number of people aged 60 and over in Less Developed Regions is projected to rise from 213 million in 1980 to 836 million in 2025, which is an almost four-fold increase (Table 1.1). Population ageing creates challenges for societies, communities and families because older people are often in need of some form of support and this can result in care and support shortfalls, due to smaller numbers of younger people available to provide care and support (UNDESA, 2009). This increase is occurring at a time when resources, especially in developing countries, are not enough to meet the demands resulting from this increase (Williams, 2003; Lloyd-Sherlock, 2010; Adamchak, 1989; Myers, 1992). While absolute numbers of older people are small in many developing countries like Zimbabwe, a combination of poverty, out-migration, HIV/AIDS and changes in family support system are creating cumulative disadvantage and heightened challenges which need to be understood for policies to be put in place.

Table 1.1: Number and Proportion of Older People Aged 60+ by World Region, 1980- 2025

Region	Numbers of people 60+ (millions)			Older people 60+ (% of total population)		
	1980 (Actual)	2009 (Actual)	2025 (Projections)	1980 (Actual)	2009 (Actual)	2025 (Projections)
World	381.5	737	1.180	8.6%	11%	15%
Less developed Regions	213.6	473	836.4	6.4%	8%	12.7%
More developed Regions	168	264	343.6	15.5%	21%	27.7%

Source: UN (2009, 1999)

Developing countries are undergoing population ageing at an unprecedented pace (UNDESA, 2012; UNDESA, 2009). This can be highlighted by the fact that while it took around fifty years for the population aged 65 and over in countries in the developed world to grow from 7% to 14%, and even eighty-five years in the case of Sweden and 115 years in the case of France, most developing countries will achieve this in half or less the time (Harper, 2006). In the early 1980s, demographic predictions were already showing rises in

the numbers of older people in developing countries, and also in their share of the total population (Aboderin, 2006). This is because by 1980, already more than half of the world's older population (55.9%) lived in developing countries, where they face greater vulnerabilities than their counterparts in developed countries (Ferreira and Kowal, 2006; Skinner, 2012). This proportion was set to rise to 61% in 2000, 70% in 2025 and 80% by 2050 (UNDESA, 2012).

Data on population ageing in Africa will help to further contextualise older people's circumstances in Zimbabwe. Within Sub-Saharan Africa (SSA), the region of Southern Africa will have the fastest growing elderly population in relative and proportionate terms, although it has the lowest number of older people in absolute numbers. For example, in 2005 Southern Africa's older population represented 6.6% of the total population, which is higher than other African regions. In absolute terms this is equivalent to 3.4 million people which is less than in other regions (see Table 1.2).

Table 1.2 Population Projections for Older Persons in Africa, 2005-2050

	Population 60+ (as % of total population)			Population 60+ (millions)		
	2005	2025	2050	2005	2025	2050
West Africa	4.7	5.5	9	12	21.8	51.6
Southern Africa	6.6	10.6	12.8	3.4	5.2	5.95
Middle Africa	4.8	4.4	6.6	4.9	7.6	17.6
East Africa	4.5	4.9	7.8	12.7	20.8	47.8
Zimbabwe	5.6	5.2	12	0.703	0.879	2.66

Source: Adapted from UN (2005)

In SSA, the fertility rate fell from 6.57 children per woman in 1950, to 5.08 in 2010. This compares with a fall from 6.22 children per woman to 2.64 in Southern Africa by 2010 (UN, 2008). While the older population in Southern Africa is smaller in absolute terms than other African regions, this number is rapidly rising. Southern Africa's ageing profile is due to its earlier decline in total fertility.

All countries in SSA are projected to have a rise in the older population by 2030 (Velkoff and Kowal, 2007). Although Sub-Saharan Africa has the lowest proportion of older people compared to other developing regions of the world (notably Asia), the sheer numbers of those aged 60 and over will continue to rise rapidly from 17.8 million in 1980 to 62.7 million by 2025 (United Nations 2012). The equivalent figures for Zimbabwe are 345,000 and 991,000. Research has shown that Africa's older population will rise rapidly as a result of falling death and birth rates (Wilson, 2000; Kimuna, 2005; Lloyd-Sherlock, 2010). A rise in 20th century life expectancy has resulted chiefly from the successful control of infectious diseases and the prevention of perinatal and infant mortality (Kalache, 1994; Sen, 1994; Aboderin, 2006). Life expectancy for Sub-Saharan Africa as a whole increased from 36.2 years in 1950, going up to 52.9 years in 2010 (Table 1.3). The same trend is shown in Southern Africa, where life expectancy increased from 44.7 years in 1950 to 52.6 years in 2005 (UN, 2008).

Table 1.3: Life expectancy at birth (both sexes) and total fertility rates in Sub-Saharan Africa and Zimbabwe (1950-2015)

Period	Life Expectancy (SSA)	Life expectancy (Zimbabwe)	Total Fertility (SSA)	Total Fertility (Zimbabwe)
1950-1955	36.2	48.5	6.53	6.80
1955-1960	38.4	50.6	6.57	7.00
1960-1965	40.6	52.5	6.64	7.30
1965-1970	42.6	54.1	6.66	7.40
1970-1975	44.7	55.8	6.75	7.40
1975-1980	46.7	57.8	6.77	7.30
1980-1985	48.3	60.7	6.69	6.74
1985-1990	49.2	60.9	6.51	5.66
1990-1995	48.9	56.0	6.17	4.77
1995-2000	49.2	46.9	5.90	4.20
2000-2005	50.0	43.1	5.65	4.01
2005-2010	52.9	47.3	5.39	3.90
2010-2015	56.0	59.8	5.10	3.51

Source: United Nations (2012)

Table 1.3 shows that life expectancy in Zimbabwe was favourable compared with SSA until 1990s when there were huge declines due to HIV and economic mismanagement. By comparison with SSA over all, fertility declined more significantly in Zimbabwe from late 1980s onwards. This means higher proportion of older people (due to fertility decline) but also exacerbation of ageing due to 'missing generations' due to the HIV epidemic.

Advances in technology, economic development, medicine and public health have resulted in an increase in the number of healthy elderly persons (Mwambazi, 1986; Waterstone,

1982). The increase in the elderly population in Sub-Saharan Africa is taking place at a time when there is heightened mortality among adults due to HIV-AIDS, who are usually called upon to generate the resources with which to provide caring and support services (Williams, 2003). Population ageing is not only a matter of increasing numbers of elders, but also depends on trends in the other age groups. Of the factors resulting in population ageing, a decreasing fertility rate is the most important determinant (Lloyd-Sherlock, 2010; UN, 2009; HAI, 2004). Where there are significant gaps in the number of younger persons, for example, due to epidemic, warfare or childlessness, then the proportion of older people becomes pronounced, and their support base diminished, without change in the absolute numbers of elders. A fall in the relative number of children leads to a rise in the proportion of older age groups (Kreager, 2004). Population ageing is ocurring rapidly in SSA and Zimbabwe because apart from fertility decline, the effect of HIV/AIDS has been significant, resulting in the shortfall of middle generations and a relative increase in the population of the elderly generations (McIntyre, 2004; Kautz et al, 2010). At its worst, AIDS mortality, and other crises that remove children from elderly parents' support networks, can result in childlessness (Williams, 2003; Kimuna, 2005; Schröder-Butterfill and Kreager, 2005).

The nature of population ageing in Zimbabwe, driven both by fertility declines, improvement in life expectancy over the long term and exacerbated mortality among adults, has an effect on the provision of old-age care and support, as further argued in Section 2.4. Zimbabwe has a relatively youthful population, with only 5.8% of the population aged 60 and over (ZimStat, 2012). This is projected to rise to 11.5% in 2050 (UN, 2012). Despite similar demographic patterns with SSA, there are unique political and economic challenges in Zimbabwe which are likely to present unique population ageing-related challenges, some of which this thesis aims to bring to the fore.

1.5 Overview of the thesis

The thesis is divided into eight chapters. Chapter Two, provides the reader with relevant background knowledge about Zimbabwe, to allow an understanding of the environment in which the literature and findings are discussed. The chapter provides an insight into the contexts in which older persons in Zimbabwe are living and a first indication of the vulnerabilities they face.

Chapter Three covers a review of the literature, identifying key issues such as ageing and rural living, the impact of HIV/AIDS and out-migration on old-age support receipt, the family as the main source of support, social protection and security systems as well as the relationship between ageing and health.

Chapter Four critically reviews different theories of ageing, related to support provision and loss of old-age care and support through an examination of the relationship between ageing and modernisation, ageing and exchange theory, ageing and altruism and ageing and poverty, before focusing on the understanding of vulnerability in later life, the framework for this thesis. The lifecourse approach is discussed to help explain how a person's life history can determine old-age vulnerability and security. While the existing literature helps to provide an insight into the care and support needs of older persons in Zimbabwe, the options available and the quality of the outcomes, the aims of this research could not be fulfilled without conducting field work to examine first hand the situation of older people.

Chapter Five therefore provides a description of the methods deployed in this dissertation and justifies why those methods were chosen. The chapter explains the reasons for the choice of the research instruments, fieldwork site, including a description of the site, and the identification and recruitment of respondents. Furthermore, the chapter examines challenges faced during the fieldwork.

A detailed report on the findings of the research is presented in Chapters Six and Seven. Chapter Six focusses on an analysis of the exposure factors and threats faced by older people, while Chapter Seven moves the thesis further by examining the coping resources which older people have access to, their effectiveness and the eventual outcomes for the older persons.

Chapter Eight draws together the findings to answer the research questions. It also specifies the implications of the research findings in relation to the literature review and theories of ageing discussed. The chapter concludes the thesis by outlining the contribution to knowledge, provided by the empirical research, as well as the limitations of the study. There is also a critical evaluation of the vulnerability framework, post-fieldwork. The chapter discusses the policy implications of the research and proposes recommendations for further academic research.

Research instruments such as a questionnaire for older respondents, interview guides for semi-structured interviews with stakeholders and policymakers, and follow-up in-depth interviews of older people are included in the appendices. The appendices also include exemplars of written up case studies, tables, figures and illustrations used in the course of the thesis.

CHAPTER 2: Country Profile: Zimbabwe

2.1 Introduction

This chapter presents an introduction to Zimbabwe by discussing the background and political history of the country and how the history has impacted on the current state of affairs in the country and on old-age-related challenges and security. It provides country specific information and identifies key issues affecting older people in Zimbabwe. This will enhance an understanding of challenges facing ageing in Zimbabwe and highlights the relevance of the research questions. The chapter examines demography, the socio-economic and political situation, different indicators of wealth used, how wealth is captured in different parts of Zimbabwe and the importance of land. Religion is discussed in this chapter because it plays an important part as a coping resource not only to older persons but to many Zimbabweans. Discussing demography presents the proportion of those in the working age group, older people and those too young to work, which has implications on support and care availability. Some of the challenges Zimbabwe is facing, mainly political instability as a result of unequal distribution of resources, are a product of the country's history (Deininger et. al, 2004). Land is core because the economy is highly dependent on land, with about 67% of the total population living in rural areas and more than 75% of older persons living in rural areas and relying on land for their livelihood (ZimStat, 2012). To reflect this bias, the empirical research for this thesis was carried out in a rural area. Understanding older people's economic status is central to our understanding of their security, and where they are lacking.

Zimbabwe is a landlocked country which has an area of approximately 390,757 square kilometres (ZimStat, 2013) located in the southern region of Africa. Zimbabwe's neighbours are: South Africa, Mozambique, Zambia, Botswana and Namibia (Figure 2.1).

Figure 2.1: Map of Africa

Source: Maps of the World Website (2008)

The empirical research was carried out in Dowa, a small-scale farming area in the Makoni/Maungwe District and in the Manicaland province which contains 13.5% of the total population and has a population density of 43[2] per square km (CSO, 2002) (Figure 2.2). The

[2] This is high by Zimbabwe rural standards, the average is 33. Some provinces have population density as low as 9 and 12 (ZimStat, 2012).

map (Figure 2.2) shows the ten administrative provinces of Zimbabwe, two of them being Harare, the capital city and Bulawayo, which is the second largest city.

Figure 2.2: Map of Zimbabwe

Source: Worldofmaps.net (2002)

2.2 Brief History of Zimbabwean Politics

Historians and politicians have always contested the legitimacy of the creation of Southern Rhodesia (present day Zimbabwe). However, the country became a British colony in 1893. In 1896, the Shona and Ndebele staged a rebellion, the 'First *Chimurenga'* (liberation struggle). In 1965, a fifteen year liberation struggle, the 'Second *Chimurenga*' started. This is a period during which the current older people spent sizable parts of their adult lives. During elections which were held in 1980, the Zimbabwe African National Union (Patriotic Front) (ZANU PF) party won the majority of the seats and dominated Zimbabwe politics from

Independence Day, the 18th of April 1980 (Morris-Jones, 1980). This dominance resulted in a civil war[3] between 1982 and 1987, in which government troops killed tens of thousands of Ndebeles in Matabeleland and the Midlands provinces, suspected of supporting a PF-ZAPU dissident movement. The killings stopped after the signing of the Unity Accord between PF-ZAPU and ZANU (PF), in December 1987 (Taylor and Williams, 2002; Institute of War and Peace Reporting, 2008). ZANU (PF) then became the only political party in Zimbabwe until 1999 when the Movement for Democratic Change (MDC) was formed. Not long after, political unrest began in 2000, which is one of the main causes of the economic instability in the country. After ZANU (PF) and MDC signed a power-sharing agreement and formed a Government of National Unity (GNU), a cabinet was sworn in from both political parties in February 2009 which was in power until 2013 (Masunungure, 2009).

Religion is closely related to the history of Zimbabwe. Even before the introduction of Christianity, there was a belief in the Shona and Ndebele culture that there was a higher spirit than *wadzimu*, called *Mwari/Unkulunkulu//Musikawanhu* (God/The highest/Creator or Maker of people) in the African Traditional Religion (Mutambirwa, 1989). It would be against *Musikawanhu* to disrespect and not support older people. There are a few religions practised in Zimbabwe: 50% of the population are Syncretic[4], 25% are Christian, 24% practice Indigenous Traditional beliefs and 1% are either Muslim, Jewish or Hindu (Bourdillon, 1990). A study by Nyanguru (2008) found that 5.5% of the older respondents use religion and faith healing and 4.4% use Indigenous Traditional healing as their main source of healthcare mostly because they are free of charge. However, faith and traditional healing cannot cater for illnesses where physical medical intervention is needed.

2.3 Land distribution and farming in Zimbabwe

The history of Zimbabwe is closely related to land, and for many people who live in rural areas, ability to access and farm land determines their livelihoods. Discussing the land issue is intended to help clarify the role it plays in the life of most Zimbabweans, especially those in Dowa, Makoni, the empirical study site. The topics of land and agriculture are explored because they have a bearing on the country's economy, poverty, migration, rural living in general and challenges faced by older people in rural Zimbabwe in particular. They depend on the land to produce crops for their own consumption, for sale and to support the younger generations in urban areas.

[3] Code-named '*Gukurahundi*' (rain that washes away chaff)
[4] Part Christianity, part traditional beliefs

Land redistribution was one of the changes promised by the post-independence government and expected by the electorate to take effect after independence (Cross, 2009; Gunning, et al., 2000; Rich, 1997). However, very little land was re-distributed after independence. The land distribution inequalities and the high population density on land resulted in land degradation and exhaustion and low agricultural production (Kaseke, 1998). Over-utilisation of the land and poor agricultural production may lead to out-migration, as people look for other sources of livelihoods. It is partly because of the unequal distribution of land that the country went through the political unrest from the year 2000, including the time of the fieldwork study, resulting in economic downturn, as most of the disturbances have been attributed to the need to 'redistribute' land. Post-independence rural agricultural areas are made up of communal areas, large-scale commercial areas, small-scale commercial farms and resettlement areas (Baron Bonarjee, 2013).

The study site (Dowa, discussed in Section 5.3) is a product of the Land Apportionment Act (1930), which resulted in freehold farms[5] called purchase areas, small scale commercial areas or commercial and subsistence farming areas (Baron Bonarjee, 2013; Ranger, 1985; Land Commission/Native Land Board, 1933). Sixty-one percent of the land partitions country-wide were in low rainfall areas, 21% were in middle rainfall areas and only the remaining 18% was in high rainfall areas (National Archives of Zimbabwe (NAZ), 1951). Purchase areas gave the owners sole rights to their own arable and grazing land, a contrast to communal areas, where there is individually allocated arable land, but grazing land is shared by the whole community. However, the purchase areas were far from the markets and transportation lines, resulting in very little economic improvement (Shutt, 1997; Ranger, 1985). Also, the land in the allocated purchase areas was of poor quality (Manzungu and Machiridza, 2005; Kaseke, 1998). Apart from being sparsely populated, small-scale farming areas have an ageing population due to out-migration by the younger generations because they feel insecure in terms of inheritance[6], or there is not enough produce to meet their financial needs, resulting in fall in farm production (Shutt, 1996).

In Zimbabwe, just like in many developing countries, productivity on small and medium-sized farms lags a lot behind that of large scale farms due to the difference in ownership of resources (Kaseke, 1998). Large-scale farmers have easier access to financial assistance such as loans and subsidies, than small-scale farmers. These different land tenures result in varying security in rural Zimbabwe.

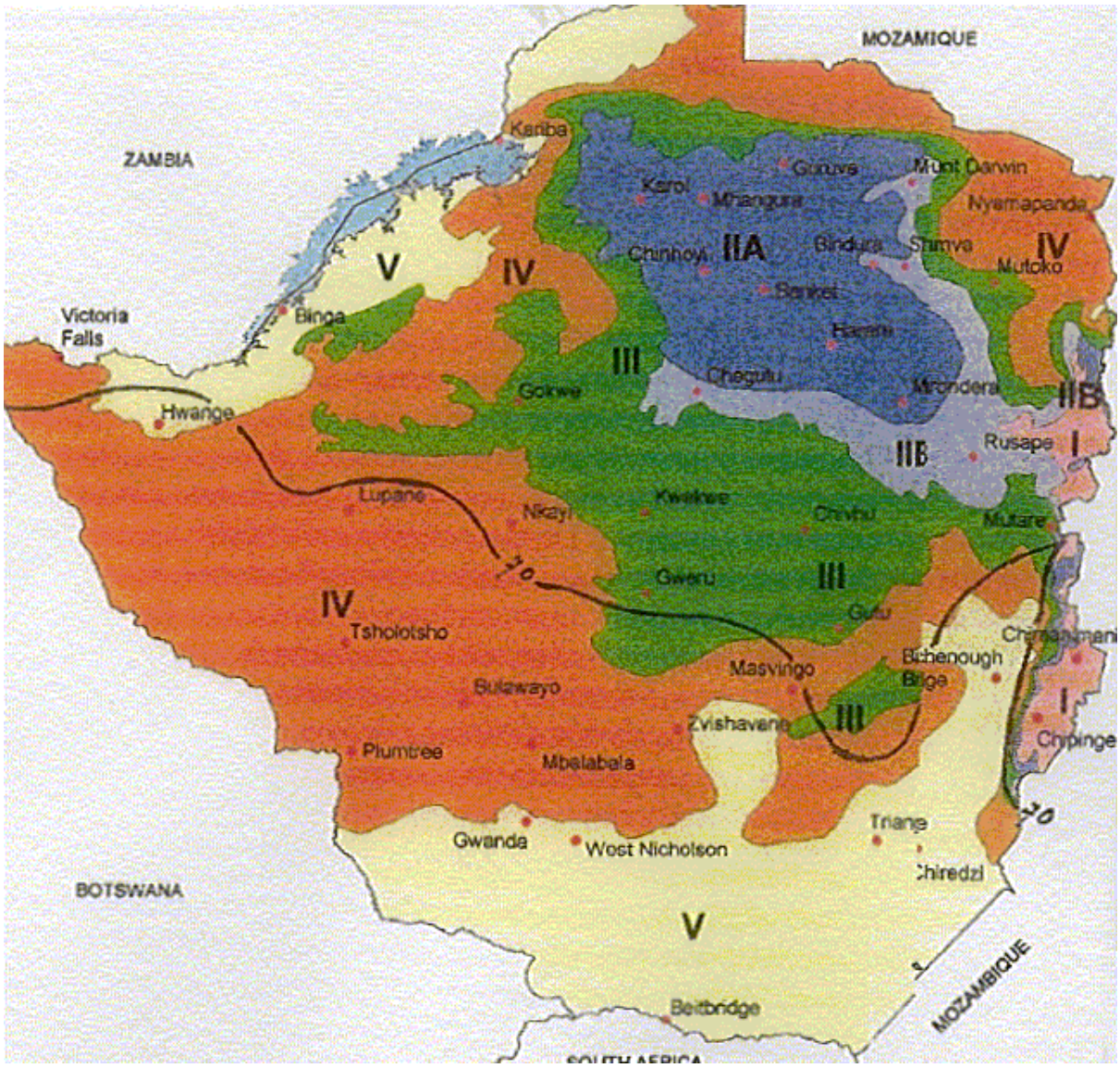
[5] Initially farmers were given leaseholds and they gained freehold after full payment.
[6] The oldest son is usually meant to inherit, leaving the younger ones feeling insecure.

The main sectors of the economy, namely: agriculture, mining and tourism are all land-based (CSO, 2007). About 50% of the economically active population are classified as being in the 'agriculture related occupations' (ZimStat, 2012:12). Of the total older population, 46% live in communal areas, 31% live in urban areas, 4% in Large Scale Commercial Areas, 2% in Small Scale Commercial Farms, 13% in resettlement schemes and other centres (for example, mines) and the remaining 4% in special Economic Areas (such as army barracks, police stations and hotels), administrative centres, growth points[7] and on state land such as Safaris and National Parks (CSO, 2002). Dowa residents are heavily dependent on land, being a small scale subsistence and commercial farming area. Unless they are of foreign origin, Zimbabweans have rural ties. Most people try to sustain their ties with their roots in rural areas by continuing to cultivate crops, visit and maintain rural homes (Potts, 2011; Kaseke, 2003; Nyanguru, 2007). It is common for people to be buried in *kumusha* (rural homes) even if they have lived all or most of their lives in urban areas. As will be argued in the results chapters, a sizable number go to live in rural areas after retirement.

The main type of farming is rain-fed cropping, that is, relying on rain water, not irrigation (Unganai, 2009). As a result, droughts are a key threat to farmers. Rainfall patterns vary in different parts of the country, thereby determining the suitable crops and animals which can be reared (ZimStat, 2013) (Figure 2.3). The rainfall patterns, also referred to as 'Natural Regions' in Zimbabwean literature according to the amount of rainfall, range between 450mm and 1050mm per annum, with only 2% of the land receiving above 1050mm (ZimStat, 2013; Food and Agricultural Organisation, 2000). Dowa is in Natural Region Two, near Rusape, to the east (Figure 2.3), receiving an average annual rainfall of 700 - 1050 mm.

[7] These are centres of economic activity in disadvantaged regions, intended to eventually become centres of economic growth (Manyanhaire et.al, 2009; Conyers, 2001; Helmsing, 1986; Carr, 1997)

Figure 2.3: Natural Farming Regions in Zimbabwe



Scale: 1:1,000,000

Source: Surveyor-General (1998)

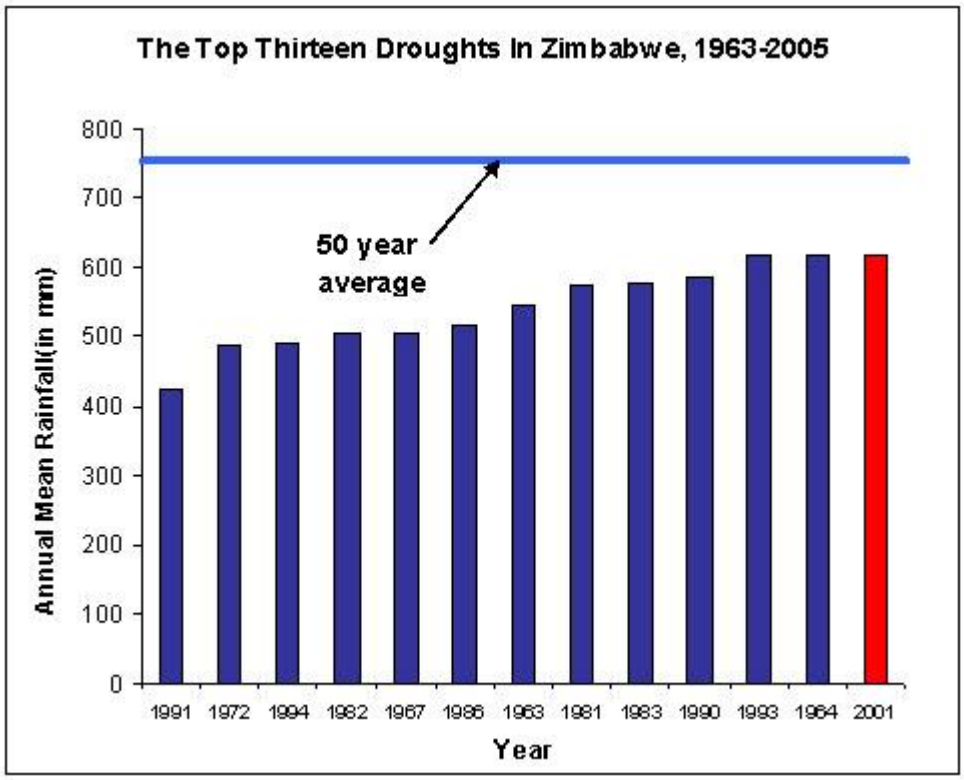
Table 2.1: Key to Figure 2.3

Natural Region	Colour code	Area (km^2)	% of total area	Rainfall Characteristics
I	Pink	7 000	2	More than 1 050 mm rainfall per year with some rain in all months.
II	Purple/Blue	58 600	15	700 - 1 050 mm rainfall per year confined to summer.
III	Green	72 900	18	500 - 700 mm rainfall per year. Infrequent heavy rainfall. Subject to seasonal droughts.
IV	Brown	147 800	38	450 - 600 mm rainfall per year. Subject to frequent seasonal droughts.
V	Cream	104 400	27	Normally less than 500 mm rainfall per year, very erratic and unreliable. Northern Lowveld may have more rain but topography and soils are poorer.
Total		390 700	100	

Some crops, such as maize, tobacco and cotton are highly labour intensive, so as people age, most of them find it harder to grow the crops resulting in fall in production. As discussed in Section 3.2, this can lead to lack of goods and services which they would have paid for from the produce (Kaseke, 1998; Hampson, 1990).

The deterioration of the Zimbabwe economy is mainly attributed by politicians to the 2001-2002 drought, yet there have been 10 episodes with lower rainfall than in 2001-2002 whose impact was less felt by the population (Figure 2.4) (Richardson, 2012/Center for Global Development, 2012). There is no information to show where the 2007-08 drought (explained on the next page) would have been placed in comparison to other years because the Government of Zimbabwe (GoZ) is limiting access to weather-related information. However, World Vision (2007) describes the 2007-08 drought as ‘Southern Africa’s worst drought in 30 years’, which gives an idea of its severity.

Figure 2.4: Droughts in Zimbabwe[8]



Source: Center for Global Development/Richardson (2012)

The forced removal of white farmers from the farms by ZANU PF supporters started in 2000 as part of a land reform initiative, generally referred to as 'land invasions' or *jambanja* (state-sponsored lawlessness) resulted in a lot of fertile land lying idle or not being utilised adequately (Pilossof, 2010; Chaumba, et al., 2001; Cross, 2009). This affected the economy because most of the new occupants lacked agricultural know-how and the capacity to finance farming at a large scale. Some had no inputs and implements or no interest in farming, resulting in food shortages (Chaumba, et al., 2003; Chipika and Kowero, 2000). Irishaid (2007:1) describe the food insecurity:

'In 2007, the combined impacts of adverse weather and severe economic constraints induced hardship and food insecurity among both rural and urban populations in Zimbabwe. Severe dry spells and unfavourable rainfall during the 2006/2007 cropping season, compounded by the devastating effects of an unprecedented decade-long economic decline led the Zimbabwean Government to declare 2007 as a drought year. Food insecurity is set to continue in 2008 due in part to severe floods in the region'.

[8] Although the record of drought is up to 2001, the authors used 2005 as the cut-off date, before the next drought of 2007/8.

The food shortage resulted in insecurity of the population, significantly reducing quality of life. Land and agriculture in Zimbabwe cannot be studied independently from demography as the two are closely linked because production is mainly dependent on those young and well enough to work.

2.4 Zimbabwe Demography

In 2012, the population of Zimbabwe was 13 061 239, up from 11 631 657 in 2002, an average rate of natural population increase of 1.1% (CSO, 2002; ZimStat, 2012). Zimbabwe's older population is increasing, just like most countries in Sub-Saharan Africa, irrespective of a fall in life expectancy due to HIV/AIDS (UN, 2008; UNAIDS, 2000; Kowal et al., 2003), examined in Section 3.3. The total age dependency ratio is 74 per 100, made up of under 15s plus over 65s (age groups considered economically inactive) in comparison to the potentially economically active population, those aged 15-64 years (ZimStat, 2012). This information is important to this thesis because firstly, it sheds light onto the likely numbers of working-age group available for production, and secondly, for policy planning because the working-age group are the future older people whose financial, physical, emotional, social and spiritual needs would need to be catered for, by an even smaller number of economically active population, due to decreasing fertility and mortality. While fertility decline does not affect the current generation of older people since the present generation of older persons in Zimbabwe still has fairly large families averaging six children per woman by 1985, the numbers have gone down to 3.3 in 2010 (World Bank, 2012). This fall would need to be taken into account for policy planning (see Section 1.4).

The average family size is decreasing and life expectancy is increasing, and this in turn means the responsibility of caring for older people increasingly falls on fewer family members (School of Social Work, 1986; Wilson and Adamchak, 2001; World Bank, 1994). This fall in family size in Zimbabwe is mainly due to the fall in fertility rate and mortality, resulting in the average family size falling from 7.4 in 1965, down to 3.8 in 2012 (ZimStat, 2012; CSO, 2007). This decrease could be due to a successful government family planning policy to encourage people to have numbers of children they could afford to look after, especially affording education and healthcare costs (Ndugga Maggwa, et al., 2001; Terceira, et al., 2003). The high literacy rate of 96% also plays a big part in reduction in the fertility rate, as educated women are more able to take control of their reproduction and have better access to contraception (ZimStat, 2012; Hindin, 2000).

The population of those aged 60 years and over made up 5.3% of the total population in the 2002 census, rising to 5.6 in 2005 (CSO, 2002; UN, 2008; see table 2.2).

Table 2.2: Population aged 60+ in Zimbabwe, Medium variant (1950-2005)

Year	(thousands)	(%)
1950	147	5.3
1955	172	5.4
1960	198	5.3
1965	226	5.1
1970	255	4.9
1975	291	4.7
1980	343	4.7
1985	401	4.5
1990	476	4.6
1995	554	4.7
2000	636	5.1
2005	703	5.6

Source: UN (2008)

Life expectancy measures the number of years an individual is expected to live. However, this measure says nothing about how many of those years are expected to be lived in good health, which is captured by the concept Healthy Life Expectancy (HALE) (WHO, 2009). In 2002, the Zimbabwe mean HALE was estimated at 33.6 for both sexes at birth, and at age 60, men were estimated to have 9.7 more years of healthy lives while women would have 10.6 more years (WHO, 2004). By 2007 the HALEs at birth for both men and women had increased to 39 years at birth, with men at 40 years and women at 38 years (WHO, 2009). This increase might be due to a fall in the HIV/AIDS infection rate (UNGASS, 2010), as argued in Section 3.3. This difference in years shows that, just like worldwide, ageing in Zimbabwe may be experienced differently by men and women. The most likely explanation for this difference is that women have higher levels of disability in old age than men. If this is the case, they are also more likely to need support and care. In all populations in SSA, women experience lower mortality in old age than men and they represent a higher percentage of older people, 55% (UNDESA, 2007; Ferreira and Kalula, 2009). Cromie (1998) argues that the worldwide trend of women living longer than men is because men are usually affected by fatal diseases such as heart disease, stroke and cancer, while women often suffer from non-fatal diseases such as arthritis, osteoporosis and diabetes, resulting in them living longer, which can mean more years lived with disability (YLDs). As is argued in Section 3.7, older people's health determines their livelihoods and ability to respond to threats, such as the ones resulting from Zimbabwe's socio-economic environment.

2.5 Zimbabwe's Recent Socio-Economic Situation

The recent political and economic situation in Zimbabwe is discussed in this chapter and in the results chapters because they contribute as major determinants of old-age security or lack of it in Zimbabwe. Zimbabwe does not have to be as poor as it is, given that it has quite rich natural resources and was a very popular tourist destination (Department for International Development (DfID), 2008; Southern African Development Community (SADC), 2008). The trajectories for Zimbabwe's economic deterioration started in the early-1990s.

On 14th November 1997 (now referred to as Black Friday), the Zimbabwe dollar (ZW$) lost 71.5% of its value against the United States Dollar (US$), the stock market crashed, resulting in 46% being lost on the shares (Brook World Poverty Institute (BWPI), 2010; ZimStat, 2013; Moore, 2003). There are no conclusive reasons for why Black Friday occurred, but a culmination of a number of causes. The reasons include economic management decisions by the government and unbudgeted expenditure such as: Firstly, the World Bank/International Monetary Fund (IMF)-proposed Economic Structural Adjustment Programmes (ESAPs) launched in 1990 and meant to increase competitive export-led industrialisation, to promote trade liberalisation, to reduce exchange controls and to reduce public spending and the growing national debt, did not go as planned (Dhliwayo, 2001; Kaseke, 2012). The programmes were a failure as they resulted in decline in average wages, mass redundancies in both the public and private sector, high prices and unaffordable school and healthcare fees. Secondly, in 1997 the government spent 3% of the Gross Domestic Product (GDP), paying compensation to veterans, who fought for independence (Chitiyo, 2000; Taylor and Williams, 2002). Thirdly, in November 1997, the government announced it would compulsorily acquire white-owned farms. This led to a decline in investor confidence, since there was no mention of the source of funding to pay for the farms (Kairiza, 2009; Chitiyo, 2000). Not long after Black Friday, there were food riots in 1998 which caused considerable damage to property. These were in protest against high food prices, after prices of basic food commodities rose as high as 42%, at a time when the unemployment rate was around 25%. The country's involvement in the war in the Democratic Republic of Congo (DRC), between 1998 and 2002, resulted in losses of millions of dollars (Taylor and Williams, 2002; Moore, 2003; Gopinant, 1998).

Zimbabwe further experienced an 'unprecedented macro-economic decline between 2000 and 2008' (ZimStat, 2013:6). The infrastructure and food security deteriorated rapidly (WHO/HAC, 2008; UNFPA, 2008). There was also widespread shortage of medicine and foreign currency between 2000 and 2009, resulting in a number of social, economic, political

and epidemiological threats faced by the general population, including older people. In 2002, Zimbabwe was ranked 147 out of 177 on the United Nations Development Programme (UNDP) Human Development Index (health, education and income) and it rapidly slipped down the ratings due to factors such as, the poor state of the economy, declining access to basic social services and staple food items, the political situation, HIV/AIDS, out-migration and droughts, among others (UNDP, 2006; U.S. Agency for International Development (USAID), 2008; Centers for Disease Control and Prevention (CDC), 2010). In 2005 Zimbabwe was ranked 169 out of 169 countries, the same position it held in 2010 (UNDP, 2010). Due to the unstable economic and political climate, most of the grants to older people from the Government and NGOs declined gradually, with some donations having stopped altogether (IRIN, 2007). Zimbabwe already received the lowest donor support for HIV-positive people, compared to the whole of Southern Africa. For example, while Zambia received US$184 per infected person per year, Zimbabwe only received US$4 per person per annum (IRIN, 2007). On the 4th of June 2008, the Zimbabwe government banned all humanitarian aid and NGO activities (UNICEF, 2008; GoZ, 2008) (Appendix 23). The ban was lifted on 29th August 2008, which was a relief in a country which depends heavily on donor funding (IRIN, 2014).

Although Zimbabwe's economy is mainly agriculture-based, the agricultural sector shrank as a result of land invasions. Up to the year 2000, Zimbabwe was a major producer of tobacco, its main foreign currency earner. However, the production of flue-cured tobacco fell from 237million kilogrammes to 70million kilogrammes due to lack of farming expertise and capital. The drought between 2001 and 2002 resulted in a lot of livestock dying, leading to reduction of draught power. Overall, agricultural produce fell by 9%, the manufacturing sector by 8% and mining by 7%. Reasons for the steep decline in production included: lack of Foreign Direct Investment, shortage of foreign currency, lack of skilled labour and unreliable energy supplies (ZimStat/IOM, 2010; ZimStat, 2013). Between 2000 and 2004, the livestock was reduced by 90% and GDP fell by 46% between 2000 and 2007 (CSO, 2008).

There was a negative economic growth leading to an economic crisis, and the country had the worst world inflation rate ever in peace time (Hanke, 2010). Political instability exacerbated the economic downturn, the economy continued to deteriorate, eventually culminating in hyper-inflation reaching 79,600,000,000% in mid-November 2008 (Hanke, 2010; Hanke and Kwok, 2009). The Central Statistical Office (CSO) announced that,

'[I]*t would be impossible to calculate the inflation rate of the dollar any further ... due to the lack of availability of basic goods and subsequent information from which to calculate the inflation rate*

from; plus, most computers had an insufficient number of digits and software' (The Herald, 27 November 2007:1)

The CSO further announced that it would stop releasing inflation figures. The impact of loss of money to hyper-inflation had knock-on effects on the population. When the currency failed to stabilise, the government introduced multi-currency (South African Rand, US$, Botswana Pula, British Pound, Euro, Zambian Kwacha and the Mozambican Metical) as legal tender in late 2008 alongside the ZW$ (Noko, 2011). This made things worse for the general population[9]. The US$ was declared the official currency in February 2009 (ZimStat, 2013). On 13 April 2009, the ZW$ was stopped as legal currency.

As the thesis will highlight, the country's poor economy has had on-going negative impact on older people, propelling them towards reduction or loss of old-age support, thereby increasing their insecurity, as there may not be enough resources to share with their adult children. The situation was worse for older parents in rural areas whose children worked in towns or in other places far from home, as the adult children could no longer afford transport costs to visit their parents in rural areas, let alone assisting them financially (Irishaid, 2007).

Formal unemployment rose to 80% by 2007, more than 85% were classified as poor and 16.2% were considered very poor and 16.6% of children were malnourished[10] (Bird and Prowse, 2009; Irishaid, 2007). The general socio-economic situation resulted in the government and private sector failing to provide the most basic healthcare and social services (UNFPA, 2008). A 2006 study found that 72% of Zimbabwean households live under the national poverty line of US$400 per month, with most workers earning below US$100 (WHO/HAC, 2007). 80% of the population lived on less than US$1 per day (Irishaid, 2007). Consequently, most of the population failed to cope with the escalating cost of essential services like housing, education, health, water and electricity. Poverty is even more prevalent and widespread in rural areas than urban areas with 76% of rural households being considered poor, compared to 38.2% in urban areas (see Section 3.2). Also, 30.4% of people in rural areas are considered very poor, compared to 5.6% in urban areas (ZimStat, 2013). However, as will be argued in Section 3.6, the main obstacles to poverty reduction are policy issues such as lack of pensions and difficulty accessing formal services. For example, in 2010, only 4.7% of the 250,000 households assessed by the Department of Social Services as being extremely poor and in need of urgent social assistance received the assistance (DSS, 2010; Kaseke, 2012).

[9] While most of the basic goods and services were charged in the numerous foreign currency which was obtained on the black market at exorbitant rates, most people were still being paid in ZW$.
[10] As measured by Millennium Development Goals (MDG) indicator 'underweight'.

Recent studies have shown that there is an improvement in food security in some rural areas as a result of the recent resettlements (Scoones, et. al, 2011; Scoones, et. al, 2010; Hanlon, et. al, 2013). However other academics have questioned the accuracy and impartiality of these studies because some of the authors are beneficiaries of the resettlement scheme (Plaut, 2013).

The government and institutions in charge of statistics assess the standards of living, poverty and wealth in Zimbabwe by using a consumption expenditure per capita poverty line, the Poverty Datum Line (PDL) (ZimStat, 2013; ZimStat, 2012). PDL is the cost of a given standard of living that must be attained for a person not to be considered poor. PDLs vary by province, for example, they ranged from $494 in Manicaland Province to $599 in Bulawayo Province (ZimStat, 2013; ZimStat, 2012). This is the same measure used in other SSA countries such as South Africa which uses 'a poverty line as the basis for presenting indicators of poverty in monetary dimensions' (Statistics South Africa, 2008:3). While institutions use datum lines to measure poverty, different indicators of wealth are used in Zimbabwe, especially in rural areas.

2.6 Summary

The history of Zimbabwe, especially historical patterns of land distribution and use, has a significant bearing on the present economic and political situation and contributes to issues faced by rural Zimbabweans. Older people are affected as part of the general population and, as older people in their own right. There has been an economic and political downturn, food and financial insecurity coupled with the HIV/AIDS epidemic, discussed in the next chapter. These difficult conditions under which older people are living in Zimbabwe are generally very closely inter-linked, and have a knock-on effect on all other aspects of life. The economic and political challenges serve to worsen the problems faced by older Zimbabweans.

Chapter 3: Literature Review: Factors affecting support and security of older people

3.1 Introduction

This chapter discusses different factors relating to the security and insecurity of older people. These are: rural living, out-migration, the family as a source of care and support, social protection, living arrangements, ageing, healthcare and healthcare provision and access. HIV/AIDS has lately been given prominence in explaining the loss or reduction of later-life support hence the discussion of HIV/AIDS in this chapter, alongside the other major risk factors (Williams and Tumwekwase, 2001; WHO, 2002). A background understanding of ageing in a rural environment is important to this thesis because the empirical study was carried out in a rural area, and because rural living entails specific challenges and opportunities for older people. This will help to identify the gaps in knowledge that need to be addressed.

I am aware of the limitations of the published material used in this chapter. Research on ageing in Zimbabwe is even less developed compared with other regions of the Global South. There is no recent research on some topics relevant to this thesis. There are few studies on the broad issue of ageing on Zimbabwe, many of them are quite dated and a number concentrate on the same study sites and samples. In some cases, the more recent publications actually refer to the dated sources. As a result, I had to refer to the dated publications as the original sources (presented in Section 1.1)

3.2 Ageing and rural living

Most older people in developing countries live in rural areas and this population is increasing (HelpAge International, 2014; UN, 2002). Some challenges faced by people residing in rural areas are universal, affecting both young and elderly people. However, as will be argued, most of the threats are felt more by older persons due to their reduced capacity to adapt, cope and recover after shocks due to advanced age. Subsistence farming is the main source of livelihood for 73% of economically active older people in Sub-Saharan Africa (HAI, 2014; Khan, 2001). Older people are particularly vulnerable due to the insecurities of rural livelihoods (Devereux, 2001). Livelihoods in rural areas involve hard labour such as planting, weeding, harvesting, fetching water, activities which strain many older people due to the physical strength required to perform them (Allain et al., 1997; Kimuna, 2005).

There is a vast amount of literature explaining the disadvantages of rural living for older people as out-weighting the advantages, for example, UN (2009); Williams (2003). Yet rural living also has a number of advantages. The main advantage of rural living is that not everything is monetary and in some cases barter trade is practised. This flexibility allows those without cash to afford and access some goods and services by offering the means of payment in kind (Kaseke, 1998; Williams, 2003). Labour, for example, can be paid for in cash or kind, such as food, clothes or lending farming equipment or animals for draught power. This flexibility is especially important where there is not much cash in the system and during periods of hyper-inflation, as was the case in Zimbabwe at the time when fieldwork for the present study was conducted. Self-production of food in rural areas allows better survival in cash stripped economies and inflationary situations.

People in rural areas typically know each other well and can check on neighbours' welfare. They also have a mutual understanding of common problems, as they face similar vulnerabilities such as being exposed to floods, drought, animal and crop disease, insect plagues, climate change and environmental degradation and underemployment (Khan, 2001; Kaseke, 2012). This mutual understanding has a bearing on the positive response and help rendered to neighbours in need. The current study will investigate how older people in small-scale farming areas benefit from their neighbours, due to farms being generally far apart.

Access to land is a major determinant of security of people who live in rural areas as it has a major impact on their livelihoods. Land ownership offers a number of options which older people can use to their benefit. Land can be used to generate wealth (Barrientos, 2007; Williams, 2003). It promotes integration into the community and social networks because land-owners are more favoured than those without. Respected people have been observed to receive better support than those without much, because they can afford to give something back. Produce can be used for barter exchange and offered as gifts. Older people can employ younger people to work on the land and pay them in cash or kind.

Thus far I have considered aspects of rural living which are beneficial to older people. There are however, many challenges that come with life in rural areas, and these tend to be exacerbated in old age. A key drawback concerns access to services. Living in rural areas typically impedes healthcare access and provision. Research has shown that older people in rural areas have limited access to social, healthcare and rehabilitation services due to long distances from service points[11] (UN, 2009; Du Guerny, 2002; Agyarko et al., 2000; Heslop

[11] This is not unique to developing countries, (see Buckwalter and Davis (2008) on rural areas in Iowa, USA; Bevan and Croucher (2006); Brooks (2012) on England).

and Gorman, 2002). Access to services may be difficult in rural areas because services are further spread out, often resulting in what Williams (2003) refers to as being socially and geographically isolated. Particularly tertiary healthcare services are not supported by sparse and widely distributed populations, but are concentrated in urban areas with high population densities. Greater distances to services mean that service use becomes closely related to economic circumstances, as to whether a person can afford to pay transport costs to the healthcare centre, in addition to the healthcare fees (ZimStat, 2013). Almost 67% of the total population reside in rural areas and 75% of these are older persons relying on land for their livelihood (ZimStat, 2012). Although the census does not provide information about older people in poverty, based on the absolute poverty indicator where 76% of rural households in Zimbabwe are poor, the majority of older persons in rural Zimbabwe could be considered poor and isolated (ZimStat, 2013; ZimStat, 2012). This in turn can have knock-on effects on health where ailments go untreated because older people are not able to travel the long distances due to being too poor, too weak or too ill.

Physical vitality is important as it determines the ability to access healthcare, visit social network members, and produce materials for consumption and sale. In small-scale farming areas, social networks can also be spread over large areas and travelling to visit may become harder as people age. Failure to keep in contact with other social network members may result in loss or weakening of some social networks, especially other elderly network members. Resources such as transport and practical support are therefore needed to maintain livelihoods and social networks (Williams, 2003).

Because people in rural areas depend heavily on agriculture, they face additional threats of agricultural and market failure, and are vulnerable to theft of livestock, crops and implements. If the crops mature, farmers are still vulnerable to difficulty accessing markets and low prices which are dependent on the market and the economic climate (Muruviwa, 2013; Najjumba-Mulindwa, 2003; Khan, 2001). Most older persons in rural areas in Zimbabwe engage in informal work and farm work which does not always yield a steady income or pension entitlements (Wilson and Adamchak, 2001; Dhemba et al., 2002). Farmers face on-going uncertainty because of unpredictable and unreliable weather which has knock-on effects on their livelihoods and general well-being. It is often difficult to make definite economic plans because of unreliable markets, therefore farmers cannot forecast what returns they will achieve from their produce. For example, prices of most perishable farm produce depend on the quantity and quality available. If there is a glut on the market, prices are low and they are high when there is a shortage. Due to rain-fed cropping, most crops are seasonal, which results in the same produce being available at the same time, resulting in low prices, or produce being disposed of. Access to the markets is also

determined by availability of transport. However, poor road networks lead to poor transport networks and in many cases results in unavailability of transport or high transport charges which can use up all the profit. This results in farmers incurring losses, and in some cases being unable to afford inputs for the next season (Najjumba- Mulindwa, 2003).

Poverty affects farmers' ability to invest in sustainable land management practices, which in turn affect soil quality, causing declining soil fertility and production (Nkonya et al, 2011; Williams, 2003). For example, some farmers may not afford fertilisers to boost soil fertility; those with little land are unable to practise land and crop rotation; those with few or no domestic animals do not have enough manure to use to fertilise the soil. Poor older people who do not have land or domestic animals face further vulnerabilities and insecurity because they have nothing to offer in return for assistance, goods and services required. Also, reliance on younger people for labour is dependent on the availability of the labour force, which is not always given. As a result, crucial farm work may be delayed, leading to reduced harvests (Williams, 2003).

Most farmers in rural Zimbabwe rely on once-a-year harvests. They therefore must spread their earnings throughout the year. When resources are depleted, they have to go without until the next harvest, unless they receive assistance from other sources. Migration plays a role in such livelihood contexts, because having migrant family members means people in such environments have others not tied to the same cycles and risks as themselves. Food availability in rural areas is highly dependent on production (Williams, 2003; Barrientos, 2007). As people age and vitality levels decline, production levels may also fall suddenly or gradually. Declining health can lead to declining livelihood opportunities (Barrientos, 2007; Devereux, 2001). Declines in income affect availability, access, quality and variety of food consumed. It is a double jeopardy when the health of older people who live in rural areas deteriorates because this usually leads to a lowering of production and can result in malnutrition which in turn impedes health (Williams, 2003; WHO, 2002b; Ogwumike and Aboderin, 2005). For example, Bakare et al. (2004) found that two-thirds of the study sample in Nigeria had poor diets. The sudden or gradual fall in production is a key determinant of old-age security or lack of it, because minor or major changes in personal situations can result in increased financial insecurity. Reduction in production results in reduced access to cash, which can lead to loss of services and goods which would have been accessed through cash or kind. Hampson (1985) asserts that where agriculture dominates, there is no retirement provision for the labour force to meet the expenses associated with their subsistence and upkeep. Most older people only stop working due to illness or disability.

Older people have different ways to adapt. They cope mostly through use of reserves accumulated over the life course such as social networks, the family which is often the main source of informal livelihood security provider, and neighbours. Households with sufficient resources are able to adapt better than those with fewer and less strong human and capital resources (Williams, 2003; Chiripanhura, 2010). Older people also rely on resources being accrued on an on-going basis, for example, through trade and cash payments. Practical support and remittances from foreign-based and in-country children make a significant contribution to livelihoods of older people (Muruviwa, 2013; Bracking and Sachikonye, 2008; Barrientos, 2007). However, Barrientos (2007) cautions that remittances are not always adequate to improve older people's livelihoods. Muruviwa (2013) only investigated remittances and no other non-financial support from migrant children, such as through communication or visits, while Bracking and Sachikonye (2006, 2008) concentrated on migrant children only. The empirical study will go further and help shed light on how the various sources of support are at play among the study population, including the role played by non-migrant children to contribute towards older people's security.

The types of productive assets owned by households in rural areas are important as they make up their subsistence base and productive technology on which they rely for their livelihoods (Chiripanhura, 2010). Without land, people are highly vulnerable in an agricultural economy, and without tools, inputs and draught power people are unable to convert their land into produce. At times, older people have been observed to sell small pieces of land to meet their needs; this was for example observed by Williams (2003) in the Kikole district in Uganda. This use of land as a coping resource, termed 'consumption smoothing'[12], labelled 'desperation sales' by Lawson (2009), can lead to farmers having insufficient land (Hoddinott, 2006; Zimmerman and Carter, 2003). Sale of productive assets such as land and cattle during a period of vulnerability can be counter-productive in the long run. Households may take longer to recover or may never recover to replace the sold assets. Williams (2003:222) argues that 'extreme action' such as of sale of land is unlikely if there are children living nearby, as they will prefer to help out their parents to the sale of productive assets which they would have inherited. This study will investigate how older people in small-scale commercial farming areas manage, in the event of financial challenges.

Health and hygiene depend among other things, on the environment and availability of clean, safe water (Poku, 2002). In many rural areas in developing countries there are significant levels of communicable diseases which are mainly transmitted as a result of poor environmental conditions such as lack of water and poor quality drinking water, poor housing

[12] Sale of assets to meet immediate consumption needs (Hoddinott, 2006)

(tuberculosis) and poor sanitation resulting, for example, in intestinal worm infections (Williams, 2003; Kloos, 1994). One quarter of Zimbabweans do not have access to safe drinking water (ZimStat, 2012). The drinking water in rural areas is usually from unprotected sources, which can lead to infectious diseases and gut ailments. These can progress into more serious health problems. The different sources of water such as wells, boreholes, springs and rivers vary in terms of accessibility and distance from residences. Sources of water in rural areas are often some distance from homes, making it harder for older people to fetch water as physical energy and health deteriorate. Some sources of water are so far away that older people need transport to get there (HAI, 2012). Fetching the water can also be a risk because stamina is needed to lift the container of water to the surface.

Lack of water affects personal hygiene and diets. For example, Williams (2003) in a study in Uganda found that some older people skipped meals because they could not cook or wash utensils due to inability to access water. They had no water and had to wait until they found younger people to fetch water for them. This support was provided for free if the helpers were relatives, while some had to pay for the services. For those older people who can still manage, carrying water is associated with back and waist pain (HAI, 2012). If there is not enough water, older people forego personal hygiene, not out of choice but because bathing ends up appearing like a luxury not an important need.

Another health and hygiene problem faced by older persons in rural areas is difficulty in using the traditional pit and Ventilated Improved Pit (VIP) latrines, used by 35% of the total population in Zimbabwe (ZimStat, 2012; Ramji, 1990). The toilets are unsafe to use for most older people because they are dark inside, due to lack of natural light and electricity. These toilets pose the risk of older people falling over since they involve squatting above the toilet hole (Wilson et al., 1991; Ramji, 1990). In Zimbabwe 24% of households have no toilet facilities at all (ZimStat, 2012). Poor sanitation aids spread of disease.

Closely associated with diet and personal hygiene is the availability of firewood. The majority of rural residents use firewood for cooking and heating fuel. For example, 63% of the total population in Zimbabwe use firewood according to the latest census statistics (ZimStat, 2012). Firewood is not readily available but has to be collected from vegetation far away from residential areas, something which older people are often unable to do. This straightforward challenge of accessing energy sources points to the importance of coping resources for older people who are no longer able to collect their own firewood. In some cases older people purchase the firewood – thus requiring cash, or they rely on support network members to assist them in this task.

Rural living and working outside the formal sector makes most older people in Zimbabwe ineligible for contributory pensions and benefits (Kaseke, 2012)[13]. As is discussed in Section 3.6, the provision of formal support for older persons in Zimbabwe is limited, and geography plays a role in accessing what little there is, such as cash transfers and Assisted Medical Treatment Orders[14] (AMTOs). As a result, in the absence of other sources of income, reduction and non-production affects older people's economic circumstances and can have a knock-on effect on their ability to afford other goods and services. Even those who are economically secure fail to cope with some issues associated with rural living, for example, toilets and mobility aids are not easy to adapt. The challenges of ageing in rural environments and eligibility to formal support, informed the design and data analysis of this thesis. A discussion of HIV/AIDS in Zimbabwe is next presented because HIV/AIDS is a key factor with a direct bearing on older people's security, alongside other factors such as out-migration and poverty.

3.3 The impact of HIV/AIDS on older people

Zimbabwe is among countries hardest hit by HIV/AIDS with the fourth highest HIV/AIDS prevalence rate in the world (15.6% in 2007), after Swaziland (33.4%), Botswana (24.1%) and Lesotho (23.2%) (Ministry of Health and Child Welfare (MoHCW), 2010; GoZ, 2012). Transmission mainly occurs through heterosexual contact and mother-to-child transmission (UNAIDS, 2006). During its peak, more than 3,000 people died of AIDS–related illnesses every week, accounting for 75% of hospital admissions and an expenditure of 8.1% of GDP on health, adding pressure to an already burdened and under-funded health service (MoHCW, 2004; UNGASS, 2008; UN, 2002; WHO, 2006). There has been a reported steady fall in the infection rate, from a peak of 26.5% in 2001, to 13.1% in 2011 (Table 3.1) despite having '10 times fewer resources for AIDS per capita than other countries in sub-Saharan Africa' (UNAIDS, 2012:1).

[13] In rural areas in most developing countries, regular wage employment is the exception rather than the norm. Formal social security services such as pensions have an urban bias (Olivier et. al., 2008).

[14] This is a fee waiver voucher issued to indigent persons to facilitate access healthcare services at provincial or national hospital or other specialist facilities.

Table 3.1: HIV Infection Rate in Zimbabwe (2001-2011)

Year	HIV Infection rate
2001	26.5%
2002	25.6%
2004	24.6%
2005	20.1%
2006	17.7%
2007	15.6%
2009	14.3%
2011	13.1%
2012	14.7%
2013	15%

Source: UNAIDS (2013); UNGASS (2010); GoZ (2012).

The effects of HIV/AIDS on the older population are multi-faceted. There are four key issues that I shall review here. Firstly older people are negatively affected by the infection and loss of younger family members, as this results in loss of anticipated care and support. Secondly, older people often bear the emotional, social, psychological, material and physical costs of caring for diseased adult children. Thirdly, older people are often involved in bringing up orphaned grandchildren. Fourthly older people are increasingly becoming infected themselves with HIV either because they are growing old with HIV or because they become infected as sexually-active individuals in later life (WHO, 2010; Kautz, et al., 2010; Negin, et al., 2014; UNAIDS, 2012; Freeman, 2012; Freeman and Anglewicz, 2012; Lloyd-Sherlock, 2010; Gutsa, 2011). Let me examine these points in more detail.

The scale of the HIV/AIDS epidemic in SSA is such that many, if not most families are affected in one way or another, which devastates individual and family life (WHO, 2002). As the United Nations has put it:

> *'The HIV/AIDS epidemic in Southern Africa, and social care needs arising from resultant morbidity and mortality, are creating a crisis in family capital, impacting family functioning, integrity and well-being'* (UN, 2003:2).

The resources which might have been accumulated and shared among family members often end up being inadequate and also depleting faster than they would have, in the absence of HIV/AIDS. There are big setbacks when the breadwinners of a family or household die or become too ill to work due to HIV/AIDS. Instead of being a source of

security, the middle generation has increasingly become a burden to elderly people. Alston (1994:176) asserts:

'In their old age, when they require support and expect to be looked after, they have to take on the role of caring for others … Lack of economic, social and psychological support, combined with poor access to health services, constantly restrict their ability to provide the care expected of them'.

HIV/AIDS impoverishes households and weakens intergenerational support systems (Slater, 2004; Wilson and Adamchak, 2001; Knodel, 2005). As dependent older people, they are deprived of support which their children might have provided them in old age (HAI, 2008; Knodel et al., 2003). Due to the nature of the extended family system, one might conjecture that healthy adult children could also have other relatives such as orphaned nieces and nephews, aunts, uncles, in-laws, grandparents or even siblings to support, resulting in their resources being over-stretched.

HIV increases poverty because it affects productivity since those dying from HIV/AIDS are mainly the younger, productive and economically active working-age cohort made up of adult children who are usually breadwinners (Kaseke, 2003a; Knodel, 2005; Jackson, 2002). WHO (2002:16) commenting on the situation in Zimbabwe argues that:

'[T]*he strong correlation between AIDS and poverty makes it difficult to explain which is the causative factor. However, qualitative data strongly suggest that the loss of remittances, economic support, income, and the increase in both financial and non-financial responsibilities due to the death of the most economically productive family members intensify poverty within the already poor households.'*

The HIV/AIDS epidemic accelerates the vulnerability of elderly people where they have to look after the children and grandchildren whom they anticipated would look after them (Wilson and Adamchak 2001; Kowal et al., 2003; UNAIDS, 2013). The WHO (2002) research in Zimbabwe found that HIV/AIDS left households worse off than they were, as families used the available resources to support the ill person and pay for their funeral, then taking over the responsibility of looking after orphans left behind, which often results in financial constraints. Williams and Tumwekwase (2001) observed increased number of burials in their study site in Uganda, due to deaths attributed to AIDS. As one older person in the Zimbabwe WHO (2002:20) study explains, '[HIV/AIDS is a]...big blow because the able-bodied are no more'. This strain can be explained by the ageing and exchange theory where support is expected to be two-way at some point in life, yet in this case it is still one-way, reviewed in Section 4.2.2. A study by Knodel and Saengtienchai (2005) in Thailand found that parents provided care as well as co-residence, as 59% of adults who died of AIDS co-

resided with parents. As a result, older people feel the effect of the chain reaction of HIV/AIDS and poverty (Zimmer and Dayton, 2003; Williams, 2003; Seeley et.al, 2008).

Older people are also affected emotionally as grandparents who are left with the responsibility of being surrogate parents for their orphaned grandchildren, coupled with anxiety concerning economic security (Knodel, 2005: HAI, 2008; Ferreira, 2004; Kautz, et al., 2010). There is a "new situation" for older persons, where they can no longer retire in their old age, but are forced into "skip generation parenting", (Agyarko, et al., 2000:2), living in what Kautz, et al. (2010:2) refer to as 'missing generation households'. In 2005, one in four children in Zimbabwe had lost one or both parents to AIDS, the highest figure in the world (UNAIDS, 2006). A study in Kinshasa, Democratic Republic of Congo found that 35% of AIDS orphans had a grandparent as their main guardian (Ryder, et al., 1994). This puts more pressure on older people.

Even those with pensions are hard-hit as the little they have is supposed to cover all the expenses, including paying fees for the grandchildren (WHO, 2002). Due to the strain HIV/AIDS places on older people, HIV/AIDS is sometimes referred to as the 'Grandmothers' curse' (McIntyre, 2002) and also as the 'Grandmother's disease' (Wilson and Adamchak, 2001). However, both these terms ignore the fact that even though there are more older women than men caring for orphans, there is still a sizable number of older men caring for their orphaned grandchildren (WHO, 2002).

While HIV/AIDS deaths are mainly in the 20-49 year age group, older people face the major problem of providing care for the sick (Knodel et al., 2003; WHO, 2002; Knodel 2005; UNAIDS, 2000). This is made worse by the fact that most affected adult children go back to be cared for by their ageing parents, some of whom did not help their parents when they were healthy (Ntozi & Nakayiwa, 1999; WHO, 2002). For example, of the 198 HIV-positive adult children in a study in Zimbabwe, 76% of them returned home because they were ill and needed care (WHO, 2002). Care provision results in loss of resources and reduction in production, and the longer the illness takes, the greater the resources used.

Older people who have lost children to AIDS, those who are caring for, or have cared for their HIV-infected children, suffer psychological pain from anticipated or enacted negative community reaction (Knodel, et al., 2003). As carers of People Living With Aids (PLWA) older people experience burn-out, stigma, discrimination, violence, fear of contracting the disease and frustration in performing the daily chores (such as cleansing, feeding, washing) (WHO, 2OO2; Knodel et al., 2003; Wilson and Adamchak, 2001). Stigma can be targeted more on those who provide personal care because there is often the assumption that care-providers contract HIV/AIDS through personal care-provision, which can result in the 'double

stigma of AIDS-related prejudice and ageism' (UN, 2002:25). Stigmatisation and discrimination of PWA and their families can lead to isolation (UN, 2004a; 2004b; HAI, 2008). Isolation can also be because care-providers are too busy providing care, leaving them with no time to pursue their other social and civic roles, or due to avoidance of social contact by others which can result in strained intra-familial and social relations (Knodel, et al. 2003; Knodel, 2005; UN, 2002).

The literature has argued that the HIV/AIDS pandemic has resulted in a deterioration of the family support system. However, although HIV/AIDS plays a role, it does not fully explain loss of later-life support. This is because, even those older people who have neither lost their offspring to AIDS, nor have looked after ill offspring, have still been seen to lose care and support (Kazeze, 2005; Lloyd Sherlock, 2010). There has been reduction in support provision even in countries without high HIV/AIDS incidence rates. For example, Aboderin (2006) found evidence of reduced later-life support provision in Ghana. That is why this thesis examines a whole range of risk factors contributing to care and support reduction in later-life. One such factor is migration. WHO (2002:34) notes that migration together with HIV/AIDS, 'have reduced the number of economically active people in Sub-Saharan Africa available to support each older person, causing enormous societal strain'. Let me now examine the impact of migration in more detail.

3.4 The Impact of out-migration of adult children on older people

'Labour migration, predominantly of younger people, exacerbates age-structure imbalances in rural areas of the developing world by removing predominantly young adults at the very time that the older population is increasing' (Kreager, 2006:37).

Migration is one of the key reasons given for loss of elderly care and support (UN, 2002; Kowal, 2003; Wilson and Adamchak, 2001). It is seen as one of the consequences of modernisation, the money economy, urbanisation and industrialisation as younger adults move to urban areas or even out of the country to seek better employment prospects. Out-migration plays a significant role in determining population ageing in rural areas because it is mainly the younger, able-bodied people who migrate thereby increasing the proportion of older people in rural areas (UN, 2009; Kreager, 2006; Williams, 2003). Migration also directly determines older people's numbers in rural areas because some of those who have been migrants return to rural areas on retirement (Potts, 2013). Like elsewhere, out-migration of adult children impacts on old-age support and care provision in Zimbabwe (UN, 2002; Madzingira, 2006; Kaseke, 1998). Let me now examine how out-migration impacts on older people in Zimbabwe.

Although agriculture is still a source of livelihood of the majority of Zimbabweans, migration has for a very long time been part and parcel of Zimbabwean families. Since the cash economy was introduced in the early 1900s, young people have long been taking up jobs in mines and urban areas, which in most cases is far from their rural areas (Manzungu and Machiridza, 2005; Hampson, 1982a, Waterston, 1982). The high literacy levels have actively influenced out-migration (ZimStat, 2012). The more educated the younger generation is, the more chances of looking for employment elsewhere where academic qualifications are often rewarded by better-paying jobs. However, due to the money economy, internal migration also affects uneducated people searching for work. Zimbabwe has the highest literacy rates in Africa[15], at an average of 96%. Apart from families prioritising education, this wide coverage has also been achieved by the Basic Education Assistance Model (BEAM) scheme where the government provides funding for children whose families cannot afford (Gandure, 2009; Kaseke 2012).

In the past two decades, there has been a considerable increase in out-migration, which has been dramatic in the past ten years due to the unsteady political situation as well as the poor state of the economy. In the 1990s, the negative effects of Economic Structural Adjustment Programmes (ESAPs) led to many professionals leaving the country (Dhliwayo, 2001; Kingston, et al., 2011). This resulted in the country's out-migrants being 38,000 more than in-migrants between 1990 and 1995, reaching a peak of 180,000 more out-migrants than in-migrants between 2005 and 2010, before the figure starts to get positive from 2010, at 60,000 more in-migrants (UN, 2010). At least three million Zimbabweans are estimated to live outside the country (IRIN, 2008). The International Organisation for Migration (IOM) estimates that Zimbabweans in South Africa are around 1.5 million. Apart from the UK, other main destinations are: Botswana, the United States of America (USA), Canada, New Zealand and Australia. However, ZimStat/IOM (2010) caution that the accurate number of Zimbabwean out-migrants is not known because:

'Use of administrative data for migration purposes in Zimbabwe is limited by lack of resources, a high number of informal border crossing points, the historical interrelation between people living on borders and irregular migration. The manual system is impeded by lack of paper, lack of training for border control agents (who experience high turnover), human error and data loss' (ZimStat/IOM, 2010:34).

There is therefore need for studies on migration and the attainment of more accurate figures.

[15] This is higher than the SSA and world rates. For the same period, SSA stood at 67.5%.The world rate was 84% (UNESCO, 2012).

Like anywhere else, remittances sent back home play a key role in survival of families and friends back in Zimbabwe. Estimates for 2009 show that remittances sent to Zimbabwe through the formal channels were around US$361 million, equivalent to 7.2 per cent of the country's GDP (ZimStat/IOM, 2010). When included, remittances sent through unofficial channels can increase the amounts by at least 50% of GDP (World Bank, 2008; UNDP, 2010). Madzingira (2006) found that migrant children gave their parents more financial support, compared to their non-migrant siblings in Zimbabwe. Half of the sample households in Bracking and Sachikonye's (2006) research received remittances and they were in better financial positions than those who did not. However, Hampson (1984) found that 31% of those with children employed in the formal sector did not receive remittances and 87% 'rarely' received any.

The following few paragraphs will review the evidence from the literature that has argued for the detrimental effects of migration on older people, highlighting four key disadvantages. First and mostly, migration removes younger adults from local networks whereby older people are affected through the loss of local support, emotional and practical assistance. Apt (2005) argues that migration creates 'social distance' between generations and results in older people being denied care and support from the usual sources. Apart from the physical and social distance between the different generations, there can also be 'emotional distance' which Hashimoto (1991:371) equates to abandonment. These perceptions require empirical investigation.

Secondly, the traditional extended family system, discussed in Section 3.5, is modified when young rural adults migrate to the cities and towns because the urban setting is not very conducive to sustaining the extended family network as in rural areas (Williams, 2003; UN, 2002). Relations with children may become severed following long term migration and prolonged separation (Schröder-Butterfill, 2006; Madzingira, 2006). Some young adults may end up not affording to send money home or to visit as they struggle to meet the expenses associated with urban life such as transport, accommodation, food and entertainment. This may result in the older generation left behind having to provide for themselves more (Williams, 2003).

The third negative impact of migration is that older people may experience the rarity and at times loss of contact and remittances. While migration may be undertaken in order to improve livelihoods, migrants are not always successful in their migration sites and therefore unable to send back much support; over time, remittances also tend to diminish (Schrieder and Knerr, 2000; Potts, 2011). Out-migration, in combination with poor communication systems weakens filial loyalty or filial piety (World Bank, 1994; Mason, 1992). This effectively

undermines older people's privileged power and status levels due to the loss of children and grandchildren (Lloyd-Sherlock, 2010; King and Vullnetari, 2006). Apart from distance, out-migrants' immigration status can also determine how often they visit their parents. King and Vullnetari (2006:32) found that in the extreme situation of Albania, where migration was very high, and much of it was illegal, therefore making regular return difficult, many older people ended up feeling like 'socially isolated orphan pensioners'.

Fourthly, consequently, lack of knowledge about the situation of elderly relatives by the absent adult children may impact negatively as the adult children cannot offer emotional and physical support (even if they provide financial support). They may not appreciate the extent to which their aged parents need support, because they cannot see the situation for themselves (Barrientos, 2007). Oberai and Singh's (1983) study in India found that only 56.4% of the 47,500 migrant respondents had ever remitted money back home. Also, continued flow of remittances does not guarantee security and relief from poverty, suggesting that it all depends on the quantity of remittances (Jackson and Collier, 1988; Barrientos, 2007).

Most literature assumes that out-migration is bad for older people, because it results in the removal of young people from older people's immediate surroundings. However, not all older people with migrant children have been seen to lose filial care and support (Knodel and Saengtienchai, 2007). Migration is not inevitably negative, it opens up new opportunities for families and remittances can make an important difference to older people's lives (World Commission on the Social Dimension of Globalization (WCSDG, 2004). For some families, migration of young people is a strategy for the younger generations to be in a position to support their older relatives financially by sending remittances back to their kin (Bracking and Sachikonye, 2008; Knodel and Saengtienchai, 2007). This is of course particularly the case where migrants have been able to establish secure jobs in their destination sites. Migrant remittances to many African countries surpass foreign direct inflows and in some cases, they are almost equal to Official Development Assistance (ODA) Dixon-Fyle and Mulanga; 2004). Knodel and Saengtienchai (2007) study on Thailand found that migrant children support their older parents financially and often return to provide care when their parents' health deteriorates.

Whether migration is a positive or negative influence depends on the setting, circumstances and the economic status of the families involved. For example, Kreager (2006:41) found that migrant children are not 'lost to the system' of local support networks, while local children are not 'esteemed or trustworthy'. Migration might be viewed as 'abandonment' where there is no improvement in older people's financial situations. This can be the case when younger

generations leave the local network and lose ties with their older parents, resulting in non-provision of support (Schröder-Butterfill, 2006; Kidd and Whitehouse, 2008; UNFPA, 2007b). If remittances are sent and older people's vulnerability to financial constraints is reduced or eliminated as a result, migration can be viewed positively. Some authors have referred to this as children practising "intimacy at a distance" (Hashimoto, 1991:371). Regardless of the positive or negative impact of migration, it results in some family members being away necessitating support networks to be reconfigured to manage the responsibility of care and support provision. This is particularly the case where formal support systems are inadequate.

However, migration of younger generations does not fully explain loss or reduction of care and support in later life. Older people with non-migrant children are also affected by loss of old-age care (Madzingira, 2006). Even if the children live near, there is no guarantee of support provision as there may just not be enough resources for the younger generation to share with their older parents, leaving them still vulnerable to inadequate support. The thesis will help to shed light on how well migrant children do or do not stay in touch, or provide support to their parents, and the quantity and frequency of remittances received. The thesis next critically reviews the role of the family, being the main source of old-age security in developing countries, its limits as well as other informal sources of care and support to supplement the family support.

3.5 The family as a source of care and support

In Africa and many low-income countries elsewhere in the world, the traditional family is considered the provider of old-age security and basic welfare (Harper, 2006; UN, 2002; Heslop and Gorman, 2002). They mainly rely on informal and semi-formal support systems due to the minimal existence of formal social security (Kaseke, 2012; Lloyd-Sherlock and Locke, 2008; UNFPA, 2002). Across the world, the obligation of supporting and caring for elderly persons falls to a considerable extent on family members, especially the adult children (UN, 2002; Organisation of African Unity (OAU), 1986). Support from other relatives and the community would be mainly in addition to that provided by adult children (Harper, 2006; UN, 2002; Aboderin, 2006).

It is difficult to paint a picture of an ideal old age in Zimbabwe, both as ideals vary for different groups and times, and because it risks setting up an apparent golden age which may never have existed. Nonetheless an attempt is made here to sketch the conditions that make up a satisfactory old age in rural Zimbabwe. In settings like Zimbabwe, where formal support for older people is rare, the family has traditionally been the main source of

assistance in later life (Wilson and Adamchak, 2001). As a result, elderly care has always been provided by the immediate and extended family within the family home (Kaseke, 1998). This used to be easy to implement because families lived within the same communities. 'Hospitality has always been a shining virtue of the natives; it is readily extended to all members of a family or clan' (Posselt, 1978:111). The community has also constituted a strong social support system for elderly people (Kimuna, 2005; Bezrukov, 1986; Waterston, 1982).

'Respect for the elderly was a fundamental value in Shona Society, reinforced through a gerontocratic system of political rule', in which older people received social security (Hampson, 1990:10). They were considered closer to spirits (*vadzimu)* and physical or mental deterioration in age was not relevant, as the Shona saying goes, *'Chembere ndeyembwa, yemurume ndibaba vavana'* (an elderly person should be treated with respect since he is the source of the younger generations) (Hampson, 1990:10). Elders used the resources in a way which assured them that the economically active members of the community would remain bound to them and wielded considerable political power which was premised on control over scarce resources. For example, land, food, livestock; presiding over ritualised meetings such as funerals and services before rains begin; control of reproduction through arranged marriages and the charging of bride price (Hampson, 1990; Rwezaura 1989; Clarke, 1977).

Families were generally big, the more children one had, the higher the likelihood of being looked after in old age (Kaseke, 1998). There was a belief that there would be a curse on the family for abandoning their relative and letting them be cared for by strangers. In Zimbabwe, the eldest son was considered as the provider of economic support in the past but he could delegate duties to his siblings (Hampson; 1990). Recently, Madzingira (2006) found that children are expected to support their elderly parents irrespective of sex or birth order. This shift could be because families have realised that it benefits the older parents if support comes from different sources (World Bank, 1994; Kimuna and Adamchak, 1999).

Economic change, new forms of social, cultural and political control and new religions threatened the dominant position of elderly people in Zimbabwe, resulting in their experiencing of exclusion due to these changes (Mhishi 2008; Hampson, 1990). For example, increases in population, a decrease in polygamy, erosion of traditional value systems and culture in general, such as the Legal Age of Majority Act (LAMA) (1982) (Hampson, 1989). The Act allows anyone above eighteen years to get married without seeking their parents' permission. This resulted in the power of gerontocracy waning, as the older people had litte to offer because respect in traditional Zimbabwe culture was based on

prominent position within the politico-economic system (Nyanguru, 1990; Clarke, 1977). Also, not all young adults living near their parents in rural areas are able to help their parents in the fields because they would be busy working on their own, in anticipation of produce to sell. Adult children living and working far from their older parents might also have other social activities, thereby reducing visits to their parents, while other children may simply not feel obliged to support their parents (Kaseke, 1999).

Although there is heavy reliance on children in most of the developing world, there are always childless people in every community, either actual (having no children) or de-facto (where the children do not support their parents) (Schröder-Butterfill and Kreager, 2005; Knodel, 2009; Asiazobor, 2009). Kreager (2004:4) asserts that the 'absence of children poses potential human and welfare problems for older people without them'. Childlessness can be either voluntary or involuntary (Bulcroft and Teachman, 2004) due to a number of causes: child bearing age falling during a time of economic difficulty, marital instability resulting in putting off having children, infant mortality or death of children, infertility, subfecundity or not being married then deciding not to have children out of wedlock. De-facto childlessness can result from some or all of the factors such as migration, divorce, remarriage, bad family relationships and conflicting priorities for younger generations. This can be permanently or over long periods of time. However, there are ways to counter childlessness, mainly adopting or fostering as is common in Indonesia (Schröder-Butterfill and Kreager, 2005; Schröder-Butterfill, 2004). Zimbabwe childless rate is about 20% (Aseffa, 2011; Runganga, et al., 2001). There is no literature on old-age and childlessness in Zimbabwe, which creates a gap for investigation. Whether there is a choice to foster or informally adopt a relative's child or children who would then be expected to look after the foster parents as their own in old age, there are still cases of childless people with no child to bring up, effectively rendering them childless in old age. Schröder-Butterfill (2004) found that kin support to childless older people is not automatic but has to be negotiated.

An understanding of the changing nature of family support is important and will be re-visited in the fieldwork findings as the contrast between past, anticipated and present support would allow assessment of older people's well-being. In the past there were fewer older people than there are today and most of those who survived were given some means of support by the family and neighbours (Wilson, 2000). This could be because the family was able to help more, or that due to their small numbers then, it was easier to support older persons. Support seemed to be more adequate in the past because it was a shared responsibility among extended family as well as low costs involved (Aboderin, 2006). The growth in the size of older people's population results in competition for resources between them and other age groups (Lloyd-Sherlock, 2010). As a result, sharing of responsibilities has

significantly reduced, because the resources might be insufficient due to most goods and services needing to be paid for, for example, uniforms, school fees, healthcare costs. As already argued in Section 1.4, the average family size is decreasing and life expectancy is increasing, leaving the responsibility of caring for older people falling more and more on the fewer family members (Lloyd-Sherlock, 2010; May, 2003; Khan, 2002). Decline in fertility rate mainly results in 'a progressive reduction in the availability of kin to whom future generations of older persons may turn for support' (UN, 2002:1).

The way younger people view older persons also has an impact on care and support they provide. There is the negative image of older people being seen as 'redundant, dependant, decrepit and inferior' (Arber and Evandrou, 1993:11). This leaves out expectations of intimacy, wisdom, pleasure, joy and love, resulting in mostly alienation and negative images (Chavhunduka, 1982). There have been cases of older people being branded witches and wizards, resulting in them being avoided and ultimately not being provided care and support by their immediate and extended families and whole communities (Aboderin, 2006; WHO, 2002). These accusations and stigmatisation can result in shutting of all the informal support networks. In some cases it results in the victims being physically attacked, being banished from the areas they live or even being murdered, a situation which has mainly occurred when the younger relatives want the older person's possessions such as land (HAI, 2009). Let me now explore living arrangements because they involve family members living together and save as support systems in later life as one type of intergenerational transfer (Velkoff, 2001).

3.5.1 Living arrangements

Co-residence with younger generations can be seen as a primary source of care and may be the only way for older persons to ensure they are provided with old-age care and support (Aboderin, 2006; McGuiness, 1999). Co-residence can also be a way of reducing emotional vulnerability as a result of loneliness in old age (Schröder-Butterfill and Marianti, 2006). The advantage of co-residence is that transition can be gradual if the older person becomes ill or in need of care in a co-resident household (Hashimoto, 1991). There would be less need for adjustments and moving residences.

A large number of older people in developing countries live in multigenerational households thereby broadening the alternatives as well as challenges of living arrangements for older persons (UNDESA, 2012; UNDESA, 2002; UNDESA, 2005; Barrientos, 2004; Ferreira, et al., 2001). In a study of 24 developing countries, Zimmer and Dayton (2003) found that on average 59% of the interviewees live with a child and 46% with a grandchild. Lone living in

old age is rare in developing countries. Although co-residence is often mutually beneficial to both generations, there are instances where co-residence actually puts older people at a disadvantage as there are cases of abuse and neglect of older persons from other household members (Naughton et al., 2010; Hareven, 1995; Casterline et al., 1991; Chan, 1997). Sharing of roof with succeeding generations most likely results in resources being pooled together, resulting in interdependence, but consumption of resources can be highly unequal in intergenerational households (Wilson, 2000; Peterson, 1993; Vera-Sanso, 2004). The living arrangements of older people can provide some indication of the strength of household support, but there must not be the assumption that co-residence results in intra-household support (Lloyd-Sherlock, 2004). For example, Case and Deaton (1996) found that pensioners in South Africa were supporting large families including adult children, from their pensions (HAI, 2004; Ferreira, 2004). Such situations put strain on the older people's financial resources.

3.5.2 Determinants of living arrangements

There are different factors which determine many older people's living arrangements. These include demographic and socio-economic factors such as: age, gender, level of education, marital status, work history, income, place of residence, existence of children, siblings or relatives, visiting patterns of friends and kin and health (Arber et al., 2003; Velkoff, 2001; Kimuna, 2005). Cultural traditions such as kinship patterns, how society values living independently or with family members and the availability of social services and social support also determine living arrangements (Velkoff, 2001; Schröder-Butterfill and Fithry, 2014). Even if they have adequate resources, some older adults may still want to co-reside with their children because they find it culturally appropriate (Apt, 1997). It has also been noted that elders prefer to maintain a separate household and still maintain close contact with the family (Hashimoto, 1991; Adamchak et al., 1991). Poverty and decline in health tend to encourage co-residence with other family members, leaving some older adults with no say over their preferred living arrangements (Hashimoto, 1991; Adamchak et al., 1991). Such lack of autonomy increases the older people's sense of insecurity and declining well-being. Kimuna (2005:6) argues:

> '[W]*ith declines in health status and increased disability, older adults experience difficulties with many activities of daily living ranging from the preparation of meals to bathing, dressing, grooming, housework, planting, weeding, harvesting, collecting water and collecting firewood. When there are such needs, it increases the need for social support and co-residence'.*

Interdependence of needs, other family members' attributes, resources and non-material factors also play a part in living arrangements of older people (Knodel, 2009; Kimuna, 2005).

For example if adult children cannot afford to live independently, they can co-reside with parents (Vera-Sanso, 2004). Co-residence is also due to grandparents living with their orphaned grandchildren in 'skipped-generation' households which have been made inevitable due to HIV/AIDS (Lloyd-Sherlock, 2010; UN, 2005; Agyarko et al., 2000). However, skipped-generation households are also common in some countries with low HI/AIDS prevalent rates, as evidenced by Schrőder-Butterfill (2004) in Indonesia, where such living arrangements were due to high volumes of migrants leaving their children behind with their grandparents. The current study will help to inform us about the motivations and preferences for various living arrangements which older people are in.

Studies in developing countries, including Zimbabwe suggest that institutionalisation is not a common form of living arrangement and care for older persons and is considered as abandonment, a sign of failure by the family and not culturally acceptable (UN, 2002; Chiweshe and Gusha, 2012; Evans, 1987). In Zimbabwe, The Older Persons Bill (2005) calls for older people to live and be cared for by their families within their own social environment and communities as this gives them a greater sense of belonging (GoZ, 2005; SSW, 1986). In 1997, 17.3% of some 2.5 million households in Zimbabwe were headed by people aged 60 years or more (WHO, 2002; CSO, 2000). Zimbabwe being a patriarchal society, elderly men would prefer to live with a son to a daughter, while women would prefer living with their daughters. However, a lot depends on whether it is a widow, widower or a couple and the care options available (Hampson, 1990). In very few cases, there is no option for co-residence and older people with no one to care for them end up in institutions under the Welfare Organisations Act (Chapter 93) 1967[16]. There are at least 58 Old People's Homes (OPH) in Zimbabwe which are all registered with the Department of Social Services who also supervises their activities (HelpAge Zimbabwe, 2013). The government gives grants to those OPHs that do not charge fees (Madzingira, 1997; Kaseke, 1991; Chiweshe and Gusha, 2012). However, the grant given to OPHs by the GoZ is not adequate, therefore it greatly affects the quality of care provided in the institutions. Many of the Homes, including private ones, rely on donations (Homes in Zimbabwe, 2012; Chiweshe and Gusha, 2012).

Research carried out in the then 71 OPHs in Zimbabwe, some of which have since closed down, found that 92% of Africans were admitted in OPHs due to destitution and 83% of Africans were accompanied to the institutions by a social worker or the police (Nyanguru, 1990). Even with limited resources, 81.9% of respondents indicated they would not place their parents in an institution (Madzingira, 2006).

[16] Needy, homeless elderly people to be placed in OPHs.

Despite progress being made in some Southern African countries (discussed in Section 3.6, page 71), the older populations in many countries have not been prioritised as a policy issue and are often excluded from programmes to access formal basic services and support due to a consistent belief that families still remain the strongholds of support for older people, which to some extent families are (Wilson, 2000; World Bank, 1994). However, this assumption negates the argument and acknowledgement that there is less family support than in previous generations. In Zimbabwe, formal support systems are limited and almost non-existent. Older people therefore have to rely on informal support systems especially the family and social networks (WHO, 2002; Kaseke, 1998). Poor families usually have poor networks and fewer buffers to provide financial support if need be, thereby requiring more support from outside the family (Wilson and Adamchak, 2001). The family should ideally be complemented by formal sources to meet the care and support needs.

3.6 Social Protection and Security

Social protection and social security refer to the whole group of measures which people adopt to restore and protect their initial standard of living (WHO, 2002). Social protection is distinct from family support. This thesis will define social protection as formal and semi-formal sources of support, although I recognise that some authors treat informal support as a subset of social protection (Kaseke, 2012; Razavi, 2007; Knodel and Chayovan, 2011).

Informal support systems are the main sources of support, as more than 70% of the world's older people rely on informal security systems (World Bank, 1994). In developing countries, social assistance programmes usually include semi-formal and non-formal organisations such as neighbourhood and organisations operating at the community level as the 'backbone' of social security systems because they play a dominant role in care and support provision (Jütting, 2000). Support networks vary in size, composition of relationships, quality of relationships and direction of exchanges and they consist of all those people with whom people have on-going relationships. Many people's support networks are part of a larger social network consisting of family, friends, neighbours, community groups such as mutual assistance arrangements, religious and voluntary organisations (Schröder-Butterfill and Marianti, 2006; Jütting, 2000). Depending on the relationship, time constraints, resources and abilities, different members of support networks provide different kinds of support. Good friends and neighbours can at times be more important than family in old age (Abrams, 1978; SSW, 1986). Eeuwijk (2006) found that in Indonesia, peers played an important role as providers of care and support, because the young fail to care for their elderly family

members due to time and resource constraints. The strength of support networks can also be determined by distance from support providers.

Informal social security in Zimbabwe is centred on the need for reciprocity and solidarity among members of the family, clan and tribe, churches and village heads, chiefs or patrons, neighbours and the community (McGuiness, 1999; Kaseke, 2006; Dhemba et al., 2002). There are four work-related systems benefiting older persons where they are still practised in Zimbabwe rural areas. *Zunde Ramambo* (chief's granary) is a traditional social security arrangement referring to the work provided for the chief or headman in his fields. It gives the subjects the right to ask for food in times of drought or famine (Kaseke, 2006). If well-managed, *Zunde RaMambo* would assist vulnerable community members such as older persons, widows, orphans and persons with disabilities. *Nhimbe* is a work party for people of the same village, to help during times of high labour demand with the host providing beer. For the *jangano* work party, the host provides food only. *Jakwara* is an open invitation where even strangers can take part, on condition that beer is provided (Hampson, 1990).

In Zimbabwe, semi-formal systems are usually in the form of mutual aid groups (Member-Based Organisations (MBOs)), for example, burial societies, savings clubs, rotating savings clubs and credit schemes (Dhemba, et al., 2002; Lloyd-Sherlock, 2006; Jütting, 2000). Although they are not governed by legislation, these security systems operate within rules agreed upon by the membership (Olivier, et al. 2008). Faith-based and spiritual support was identified as a main source of emotional support by 37% of the 4 540 respondents (WHO, 2002). Church membership entitles members to benefits such as being visited when in need, and material benefits such as money, food, firewood and clothes. Members also access moral support during illness and bereavement, a shroud and food for funerals (Dhemba, et. al, 2002). Support can also be accessed through membership of a burial society. Burial society support is limited to funeral-related services and members do not offer support before a death, or after a burial. The main disadvantage of most MBOs is that those who cannot afford contributions are excluded.

Although informal and semi-formal social support systems are the main sources of old-age support in most developing countries, including Zimbabwe, their overall effectiveness is compromised by high levels of poverty. The financial contributions made may not be adequate to meet the needs. Affected individuals are usually unable to mobilise the resources required to ensure their security, and so need help to pool the resources so mobilised (Olivier et al., 2012; Kaseke, 2012). This then brings to the fore, as discussed next, the importance of pensions and other forms of formal mitigating options to reduce older people's vulnerability.

Formal support systems provide protection on the basis of solidarity and reciprocity at the national level, involving pooling resources together and sharing risks to reduce old-age insecurity (Lloyd-Sherlock, 2004; Jütting, 2000). However, this does not include everyone, for example, where the systems are contribution-based. Where available, formal support systems can be a vital part of older people's sources of livelihood as they can fill in the gap left by informal and semi-formal support systems. This is to avoid individuals from falling below living standards considered minimum 'acceptable' by the government and society.

Pensions are important for older people's livelihoods, security, social protection and poverty reduction, and they can make important contributions to economic development (Lloyd Sherlock, 2004). Pension plans perform three main functions which are: consumption smoothing, insurance and redistribution (Barrientos, 2004) as they are collected from one group and pay benefits to a different group, from one generation to another, if they are Pay As You Go systems (Wilson, 2000; Willmore, 2004; Barr, 2000). Pensions are based on the 'generation contracts' which work on the principle that today's workers support today's elders on 'condition that the next generation of workers supports them' (Wilson, 2000:127). Pensions provide insurance against a range of contingencies which might adversely affect household consumption, especially against 'longevity risk', that people might outlive their accumulated resources, due to uncertainty over time of death (Barrientos, 2004:125). This possibility of resources running out adds on to the argument for the importance of pensions.

Social pensions or non-contributory pensions are regular cash transfers to older people. They are provided by the government and they can be means-tested or universal. Although ageing is occurring in Africa at a greater pace than in Western countries, only few countries have the economic development and infrastructure to be able to provide widespread public pensions and healthcare to the growing populations of older adults (Wilson and Adamchak, 2001; Harper, 2006). This is because there are high incidences of severe deprivation, limited development of formal social security systems and resource constraints due to poverty (Harper, 2006). Many developing countries do not have comprehensive social security systems in place and a very small percentage is spent on social protection, thereby not reaching the majority of those who need it most (International Labour Organisation (ILO), 2008; Kaseke, 2003a; Kaseke, 2012; Goedecke, 2001). However, progress is being made by some African countries. South Africa and Senegal provide means-tested pensions. Botswana, Mauritius, Namibia and Seychelles provide universal, non-contributory old-age pensions, wholly funded by government (HAI, 2004; Committee on Population (CPOP), 2006). In South Africa the coverage is high and reaches most elderly people and self-reported health significantly improved when respondents started receiving pensions (HAI, 2004). A personal income makes a significant difference to older peoples' negotiating power

as they may be able to reciprocate assistance to younger generations (Case and Deaton 1996; ILO, 2008). This suggests that social pensions can be the best source of income in addition to, or in the absence of family support and social insurance. Against this background, the thesis next discusses the social policy environment in Zimbabwe to give the reader background knowledge on support mechanisms available.

The forms of formal social security operational in Zimbabwe are social insurance and social assistance (Kaseke, 2012). Social insurance is a subset of social protection. It is contributory for both the employee and employer and members' benefits depend on contributions made. The contributions and benefits are usually earnings-related, but they can be flat rate. In 1994, the National Social Security Authority (NSSA) Pensions and Other Benefits Scheme (POBS) was introduced (GoZ, 1994). NSSA is a contributory social insurance whose coverage is open to all workers in formal employment (Kaseke, 2012; ILO, 2012). NSSA pensions are optional as there is no law to oblige employers to enrol their employees on the pension scheme (Zimbabwe Association of Pension Funds (ZAPF), 2012). In 2010 the pension scheme had 1.3 million workers, less than 20 per cent of the then 6.9 million economically active 15 to 59 year-olds (ZAPF, 2012). This low coverage results in few pension recipients. Most employers pay low wages, which automatically mean low pension benefits resulting in inadequate protection in old age (Kaseke, 2012; Irishaid, 2007). Old-Age pensions and 'Retirement Grants'[17] were both set at a minimum of US$40 per month in January 2011 (ILO, 2012).

Social assistance is a non-contributory form of social protection which is funded by government public revenue and can be in the form of social allowances or social pensions. The benefits can be either in cash or kind, to enable beneficiaries to meet their basic needs (Kaseke, 2012; Dhemba et al., 2002). Social assistance benefits provided are means-tested to ensure only the most needy people benefit. However, there is no social assistance system specially dedicated to elderly people in Zimbabwe except as a last resort in cases where individuals are unable to secure support from their families (ILO, 2012). The Social Welfare Assistance Act (1988) Clause 6 (1), states:

'The Director, or any person acting on his behalf, may grant social welfare assistance to a destitute or indigent person where he is satisfied that such person is over sixty years of age'.

Social welfare assistance can be given to older persons through Non-governmental Organisations (NGOs) and government grants through a Cash Transfer Scheme. The scheme provides for a monthly maintenance allowance to allow older people to access basic

[17] Paid to those not meeting the qualifying conditions for the pension, yet made more than one year's but less than 10 years' pension contributions.

food stuffs, payment of rentals and water (Mhishi, 2008; Kaseke, 2003). Older people in rural areas can be assisted through free cash transfers during droughts and floods (Kaseke, 2012). The government also offers poverty relief programmes such as the Public Works Programme where payment can be in cash, food items or agricultural inputs (Kaseke, 2012; Dhemba, et. al, 2002; Gandure, 2009). However, these programmes do not help most older people because many are unable to do the hard work, such as repairing roads, in exchange for the aid. Very few older people access public assistance, for example, as of May 2009, nationally there were only about 1,200 households receiving $20 a month as 'Unconditional Cash Transfers' (Gandure, 2009:8). Older people living in rural areas face difficulty in accessing formal services and are more disadvantaged than those who live in urban areas because often, healthcare facilities and resources are not as well-resourced and within short distances as in urban areas, as discussed next (UN, 2009; Du Guerny, 2002; Agyarko et al., 2000; Heslop and Gorman, 2002).

3.7 Ageing, Healthcare and Healthcare Provision and Access

It is difficult to discuss security and insecurity of older people without considering health and disability, because the ability to perform Activities of Daily Living (ADL) shapes livelihood security especially in rural areas where most livelihood opportunities are labour-based (Allian, et al., 1997). ADLs can be divided into Basic Activities of Daily Living (BADL) (James, 2008) and Instrumental Activities of Daily Living (IADL) (Katz, 1983).

The burden of disability of older persons tends to increase due to chronic health problems (Lloyd-Sherlock, 2010; Rajan and Mathew, 2008; Magro-Peter Ferry, 2005; Barrientos, 2002). These can determine healthcare, care and support needs. For example, Indrizal (2004b) found an increase in older people in Indonesia who were unable to perform ADLs, when re-visited five years later. Zimbabwean older persons face many health problems, some of which are diabetes, cataracts, chronic leg ulcers, heart disease, arthritis, bronchitis, constipation, stroke, falls and fractures, poor mobility, difficulty in respiratory functions, gastro-intestinal, pain in joints and head, vision and dental health, yet limited resources are targeted to these areas (Wilson, et al., 1991; Mushipe, 1992). There is also lack of preventative oral health, which results in poor dental health, and loss of teeth often directly leads to malnutrition due to problems with chewing and swallowing food (Madzingira, 2006; Mutamba, 1986; Allain et al., 1997). Social, physiological, psychological and physical changes and challenges to life predispose older people and make them more susceptible to mental health problems (UN, 2002; Chikara, 1986). This can be made worse by a

community's 'despairing, fearful and indifferent attitudes' to mental illness and lack of knowledge and appreciation of ageing (Chikara, 1986:10).

Although health care is one of the services most important to older people, use of health service is very problematic for most older people in developing countries due to service design and attitudes of staff, which reduces quality of life (WHO, 2002; McIntyre, 2004; Ramji, 1990). Older people with disabilities are doubly disadvantaged because the proportion of people with disabilities increases with age (Mushipe, 1992; Chiweshe and Gusha, 2012). This could result in increased dependency on their relatives and friends (Magro-Peter Ferry, 2005).

After independence in 1980, the government introduced free health care for those aged 65+ at government health facilities, which excludes local authority, private and church-run health facilities. In 1998, 85% of the population lived within 8km of a healthcare facility (WHO, 2002). However, these distances are still long and many people find it difficult to get to the healthcare centres. Although the government provides health care assistance through AMTOs, access levels are very low and they can only be used at government hospitals (Kaseke, 2012). As evidenced in the results chapters, this leaves some older people unable to access healthcare services. The other problem is that there is no training in social gerontology and geriatrics in Zimbabwe and nursing care for the bed-ridden is done by unqualified staff (Kasere, 1992; Motobi, 1986). As a result, there is little knowledge on ageing issues, even among some professionals working with older people such as nurses, doctors, social workers resulting in failure to provide older people with the best possible care and services (HAI, 2009).

3.8 Summary

In most developing countries, children have traditionally been considered an investment and an assurance to being looked after in old age and elderly people would rely on their offspring to support them. There are threats detracting from older people's general well-being which, considered either independently or combined together, increase insecurity in later-life. Although Aboderin's (2006) research was carried out in an urban area involving 51 respondents in urban Ghana, it makes a general statement about 'Intergenerational Support and Old Age Support in Africa' which is not accurate as the research was only carried out in urban Ghana. This leaves a gap, which this thesis whose empirical study was carried out in a rural area will contribute towards filling. Due to limitations of relying solely on semi-formal, informal networks and personal resources for reduction of vulnerability in old age, formal welfare provisions such as pensions, health and social services are inevitably important

(Schröder-Butterfill and Marianti, 2006a). However, pension systems in most developing countries are not well established and resourced to cater for the majority of older people. Having reviewed the main factors related to ageing in Zimbabwe, there is as yet a lack of understanding of key determinants of older people's security and insecurity, especially in small-scale farming areas. This discussion of various issues affecting older people has raised questions about how the issues have been theorised. The thesis now moves to the next chapter, a critique of theories of ageing which help explain old-age care and support provision and reduction which are central to the assessment of vulnerability and security in old age.

CHAPTER 4: Theoretical Review: Conceptualising vulnerability and support among older people

4.1 Introduction

In developing countries older people's main source of support is often the family (Harper, 2006; Kaseke, 2012; UN, 2002). Therefore understanding the logic of family support is central in understanding older people's security or vulnerability. There are a number of reasons why younger generations support older family members, which are explained by different theories of ageing. This chapter will discuss relevant theories of ageing around family support because the theories play a role in explaining reasons for support and care provision and receipt, which in turn shape old-age vulnerability. Support from children takes different forms such as monetary transfers, housework, visits and practical care-provision when the older parent becomes frail. There is lack of social protection in low-income countries. Usually the family's care and support provision ability is limited, therefore families provide a poor substitute for pensions or other income-based support systems because many families are unable to share risks and to absorb all shocks. Family support for older people is inadequate because many families in developing countries are poor and poor families may tend to have poor children and also poor networks (Kreager, 2006; Davis, 2006). All members tend to be exposed to the same risk conditions (Paul and Paul, 1995). The different theories have different implications for old-age care and support provision which will be argued.

4.2 Conceptual frameworks for understanding security and vulnerability in later life

4.2.1 Ageing and Modernisation Theory

In most societies both in the developed and developing world, there has been a decline in the familial support given to elderly parents by their offspring, which is resulting in increased numbers of older people being exposed to vulnerability and material deprivation, therefore needing public assistance (Harper, 2006; Aboderin, 2004). Although there is a confirmed fall in support provision by adult children, Aboderin (2004) points out that it is still not clear why there is a decline. Modernisation is one of the main reasons attributed to the weakening of the family support mechanism as an institution of social security. This leads to value change, notably a rise in individualistic and secular values, progress towards modernity, urbanisation, industrialisation, education, the money economy, migration, and a move from the extended family towards the modern nuclear family (Cowgill and Holmes, 1972; McGuinness, 1999).

Some authors argue that fertility decline is caused by modernisation, and so this in turn impacts on family sizes and the availability of support for older persons (Lloyd-Sherlock, 2010; UN, 2002; Harper, 2006; Wilson and Adamchak, 2001). But also there is need to bear in mind that most currently elderly people in developing countries had their children before the fertility decline, for example, current older Zimbabweans have an average of six children. The Ageing and Modernisation Theory (Cowgill and Holmes (1972) and refined by Cowgill (1974)) predicts the inevitable decline in older people's status and in familial support for older people, which has been described as abandonment in some literature (Burgess, 1960). It assumes that support is high in pre-industrial societies thanks to the existence of reliable extended family systems. This perspective sees modernisation as a process which brings changes to older people's status, leading to changes in the norm of support provision (Goldstein and Beall, 1982). Modernisation is defined by Cowgill (1974:127) as:

> *'The transformation of a total society from a relatively rural way of life based on animate power, limited technology, relatively undifferentiated institutions, parochial and traditional outlook and values, toward a predominately urban way of life based on inanimate sources of power, highly developed scientific technology, highly differentiated institutions matched by segmented individual roles and a cosmopolitan outlook which emphasizes efficiency and progress'*.

In some cases, older people's skills become less relevant due to increased 'technological sophistication and changeability of labour processes' (Lloyd-Sherlock, 2010:36). This can lead to some adult children not respecting or supporting their parents.

The ageing and modernisation theoretical perspective assumes that elderly people are seen to require external assistance only as modernisation disrupts the traditional family's integrity and economic social security it provides (Goldstein and Beall, 1982). The theory explains declining family support in terms of declining willingness to provide support to older people, not due to inability to provide. It makes assumptions of uniformity of societal development in the West, and the same development was expected to occur in developing countries, leading to the conclusion that older people would be abandoned as countries modernise.

As noted above, the literature often assumes that older people in traditional societies, especially in developing countries were well taken care of by the family, and vulnerability was a result of 'modernisation'. However, not all older people in pre-industrial societies received adequate care and support from the family (Fennel et al., 1988). Modernisation has not solely led to loss of care and support because familial care decline did not start occurring recently, it is a longer-term phenomenon than modernisation (Glascock, 1990; Aboderin, 2006). Neglect was evidenced by death hastening of poor older people who were ill and considered a burden to the family or community in pre-industrial non-western societies as

evidenced by Jamuna's (2003) study on India; van der Geest (2004a) on Ghana. Lloyd-Sherlock (2010:37) concurs that the past was not a 'golden age' for older people as there were many cases where old age was for many people 'brief and unpleasant' due to 'social violence, mistreatment and abuse'. In a study carried out in 1979 in Nepal by Goldstein and Beall (1982), older respondents reported that they felt neglected by their children and thought that the young did not care about elderly people. The study site had a traditional diet, no western health facilities, no roads (the only way to get there was two days' walk), no telephones or electricity, use of manufactured goods remained minimal, so the researchers concluded the area could be considered traditional or preindustrial as it was clearly not modernised or in the process of modernisation. Weisner et al. (1997) found cases of neglected older people among the Samia of Kenya, who were being hidden from strangers' access to conceal the neglect.

Moreover, there is evidence that family ties are still strong as the family is the main source of support and many older people still reside with kin (Aboderin, 2004; Hashimoto, 1991). Knodel and Saengtienchai (2007) found that despite rapid development, respect for elders in Thailand has endured and migrant children are actively involved in their parents' welfare, which suggests that the loss of support and respect is not a result of mainly modernisation. Proponents of the ageing and modernisation theory would expect reduction in support as being due to value change, even if the children can afford to provide assistance (Goldstein and Beall, 1982; McGuinness, 1999). However, it has been argued that reduction in care and support is not a result of modernisation as care reduction has been documented to occur in environments which are not modernised (van der Geest, 2004a; Jamuna, 2003; Goldstein and Beall, 1982). Support has not in fact declined that much; and where it has declined, it is not due to value change but other factors which will be argued in the course of this thesis.

4.2.2 Ageing and Exchange Theories

The exchange theory asserts that it is not those who need support who get most support, but that older people who are able to reciprocate in some way will often and more reliably receive support. Exchange theory, emphasises that when individuals interact, they do so with the expectation of profit, which is why people avoid punishment and work towards rewards (Silverstein, et al., 2002; Dowd, 1975). What individuals expect and what is given as rewards is based on cultural norms. Similarly, the theory would predict that younger people would be motivated by the hope of a return when providing support. The exchange theories argue that parental need should not really be taken into account, but rather, what the

parents have to offer or have offered in the past. This implies that older people who have provided in the past, at present or likely to provide in the future will be supported by their children, while those who have not provided or no longer able to provide experience decline or lack of such support.

According to some authors, human 'interactions are similar to economic exchanges' (Madzingira, 2006:29). These exchanges might be taken for granted, yet often they have an influence on old-age care provision in cases of those children who decide to base support-provision on the support they have received from their parents. The exchanges are part of older people's assets and reserves they accumulate during their life time, which they then can use as coping capacities in the face of challenges, as those helped earlier on might choose to return favours received. In day-to-day life, there is giving and receipt of different resources which are not always financial, but can be symbolic or even intangible, such as social approval. Those who receive more are more indebted than those who receive less, especially in cases where the older person is giving less or nothing in return for the support received. If exchange relations are not balanced, people with credit can dominate those without (Madzingira, 2006; Dowd, 1975). Therefore, given a choice people would prefer to be in credit than to feel indebted. Because ideas of acceptable exchanges are mainly based on societal norms, givers prefer to consider alternatives before making decisions on what, why, when and whom to give to. For example, it would not be proper to support a stranger while there is a relative who is in need because society expects family to help before helping strangers (Madzingira, 2006). If there is a strong feeling of young adults expecting exchanges and not getting them from their older parents, it may lead to reduction of care and support (Vera-Sanso, 2004), as the adult children may not be willing to give help where they think it is not needed or deserved.

In cases where care provided is dependent on reciprocity, older people try to 'counterbalance dependence with reciprocal exchanges', as evidenced by Schröder-Butterfill and Marianti (2006:25) in Java, Indonesia that being unable to reciprocate can bring about a stronger sense of vulnerability. The loss of earning capacity can also have an effect on respect and care provision to older people, as Vera-Sanso (2004:87) concludes from a research in India, 'When you stop earning, nobody listens to you'. Some older people feel more vulnerable if they are unable to reciprocate (Schröder-Butterfill and Marianti, 2006; Vera-Sanso, 2004; Daniels, 1988). As a result many try as much as they can to reciprocate to the younger generations so that they are seen to be giving something back (van der Geest, 2004a; Heslop and Gorman, 2002). In their research in Indonesia, Kreager and Schróder-Butterfill (2009) found that the exchanges do not have to be of equal monetary

value, as small contributions were considered in the maintenance of the status quo. In cases where status in the family and community is linked to ability to provide for the family, older people become marginalised if they are unable to provide (HAI, 1995). This is explained by the Zimbabwe (Shona) saying, '*Kandiro kanoenda kunobva kamwe'* (One good turn deserves another), relating to cases where, in older people's view, the younger generations stop showing them respect or even supporting them because they have nothing to reciprocate with, due to reduced earning capacity. The same is referred in Ghana as 'responsive ageing', the traditional ethic which states that if an older person has nothing to offer the younger generations, they lose the respect reserved for elders (Aboderin, 2006:114).

Old-age care and support is also provided as a gesture to thank parents for the care provided as the children were growing up and as a sign of respect (Bianchi, et al.; 2006; World Bank, 1994; Aboderin, 2006). Often parents bring up children with the hope that the children would look after them in old age. In Africa, children see it as their responsibility to thank their parents by looking after them in old age (Aboderin, 2006; Kaseke, 1998; Hampson 1990). Children's filial support is viewed as reciprocity, or a way of children paying back for the care they received from the parents as they were growing up (Harper, 2006; Bianchi, et al., 2006). For example, Aboderin (2006:91) quotes an Akan proverb, 'If your parents take care of you to grow your teeth, you too have to take care of them when their teeth are falling out'. Silverstein, et al. (2002:S3) define this as 'lagged reciprocity'. This is similar to what Wilson (2000:127) refers to as the 'generation contract', where children reciprocate by supporting their elderly parents in return for the support they received in the past.

In Africa, there is a close connection between fertility and old age security, and children are often seen as a source of social security in later life. This relationship between having children and old-age support has been referred to as the 'Old-age Security Hypothesis' for explaining persistent high fertility in the developing world (De Vos, 1999; Clay and Vander Haar, 1993; McGuinness, 1999). The expectation to rely on children and on support from them in old age can promote people to have large families, with the hope of minimising the chances of ending up without any care in settings where infant and child mortality are still high (World Bank, 1994; Kaseke, 1998; Lillard and Willis, 1997). Research by Clay and Vander Haar (1993) in Rwanda, found that 69% of respondent households received some kind of support from children who were living outside the household with assistance also coming from grandchildren, showing high reliance on offspring. Apart from old-age care and support being provided because older people need it, family members can also have different motives for support provision.

Transfers in inter-generational relationships are carried out based on 'self-interest' behaviour in anticipation of some reciprocity or exchange (Bianchi, et al., 2006:4). Support can also be given in anticipation of future benefit, for example, a bequest (Arber et al., 2003). Such situations result in older people with more resources, receiving more support from kin (Henretta et al., 1997; Spitze and Logan, 1990). In Japan, the number of younger women who reported that they would leave property to children who took care of them rose from 18% in 1963 to 32% in 1977 (World Bank, 1994). These cases of parents leaving inheritance to children who support them are a strategy of trying to obtain support from offspring. Hoddinott's (1992) study in Karateng (Kenya), further supports this assumption having found that at times parents can use manipulative tactics to get support from offspring. This is evidenced by the fact that land was only distributed equally among 40-50% of sons, while the rest of the older persons interviewed said they would distribute land according to the support they received from each son.

Inadequate support can occur whether resources are adequate or not. Some adult children could decide to take revenge on their parents by not caring for them if their parents did not provide for them when they were growing up. In a research in Ghana, Aboderin (2006) found that some older men did not receive support from their children as a result of fathers having not played an active role as the children were growing up, due to having many wives or children. Men can lose contact with children after divorce as children and this causes problems if they need care (Kreager, 2004; Schröder-Buttefill, 2004; Wilson, 2000; Apt, 1997). This is because when some men divorce, they stop supporting their families, leading to some children retaliating for the non-receipt of support through non-provision of support. One of the reasons is that often young children live with mothers after a divorce and therefore develop stronger bonds than they have with the fathers. However, those who decide to take revenge are said to assess if the parents did not provide for them willingly or because they could not afford. I now proceed to critically review the limits of the ageing and exchange theories in explaining reduction in old-age care and support provision.

While the theory helps explain the receipt and giving of support in later life by different sources, it falls short of explaining why some of the exchanges occur, for example, in cases where children support their older parents who have not provided for them in the past and not reciprocating in any way. Passuth and Bengston (1988) argue that the theory does not consider the subjective meaning of exchanges and does not take into consideration the emotional component of love which usually exists between parents and their children, even though often there is unequal flow of exchanges between the different generations. The emotional component helps the recipient not to feel indebted and the giver not to feel that they are owed for the support they provide. The theory emphasises quantification of

exchanges and overlooks the fact that individuals can constantly define and re-define the meanings attached to exchanges in relationships (Madzingira, 2006). There are also norms and expectations which exist within different communities and these norms make those who are in able positions feel obliged to support those in need. Followers of the ageing and exchange theory would argue that support is provided to parents as pay-back to thank parents for bringing the children up, in exchange of on-going support and also in anticipation of future benefits, such as a bequest. This thesis will seek to answer whether exchange theories are supported by evidence, if it is those who reciprocate who receive more and whether it is those who stand to profit most who give most. Closely related to the ageing and exchange theory is the altruism theory, which is explored next.

4.2.3 Ageing and the Altruism theory

Altruism theory argues that children take into account their parents' needs and they provide support to their parents because the parents need the support, such that the most needy parent gets the most support (Bianchi, et al., 2006). The theory can help explain why some children support their parents who did not support them when they were younger (Silverstein, et al., 2002). Altruism involves actions which are performed mainly out of consideration for another person's needs other than the giver's needs (Piliavin and Charng, 1990). For actions to be considered altruistic: they should benefit the receiver, they must be performed for a purpose, they should be voluntary, benefiting the receiver must be the main goal and they must be performed without expecting any external reward (Piliavin and Charng, 1990; Bianchi et al., 2006). This is supported by Vera-Sanso's (2004) argument that children assess whether their older parents need support or not, and may not provide the support if they perceive their parents as not needing the support, even if the parents expect the support. Vine (1983) and Wilson (1976) argue that altruistic actions are more likely to be stronger for kin than non-kin. Prior experience with the person in need is also argued to be influential in altruism. Moral values and norms also play a role in determining these gestures.

Altruism helps provide answers to some questions which are not answered by exchange theory, for example, cases where the 'children-as-security' hypothesis has been questioned, through the 'bystander effect'. The 'bystander effect' can influence altruistic behaviour in that the more the people who are available and likely to offer help, the less likely urgent action is taken. For example, a study by Simmons (1977) found that the likelihood of a sibling receiving a kidney fell from 51% where there was one sibling, to zero where there were 10-11 siblings due to a diffusion of responsibility resulting from reduced social and normative influence. This therefore implies that the number of children must not be used as a gauge of

the amount of support the parents are likely to receive, as the children might be expecting others to provide support. Such situations can result in care and support shortfalls. The altruism theory also falls short of explaining later-life care and support receipt and shortfalls. One can then conjecture that the bystander effect can negatively influence altruism.

Altruism theory argues that support and care is provided to those older parents who need it, irrespective of the role they have played earlier in life, at present or in the future. However, this does not fully explain care and support provision, decline and inadequacy because there are many cases of parents who are in need, but still do not receive support from their off-spring (Madzingira, 2006; Oberai and Singh's, 1983). There are also cases of parents who are self-sufficient and would manage without support from their younger family members, yet they receive support from their children, when they do not necessarily need the support (Silverstein, et al., 2002). It is also difficult to tell whether behaviour is altruistic or there are some hidden self-interest motives behind the support provision, for example, where there is co-residence and sharing of resources within a family. It can be difficult to distinguish between altruistic behaviour and self-interest (Logan and Spitze, 1995; Becker, 1981) and whether support-provision is altruistic behaviour or fear of receiving the same treatment later on in life, in the case of non-support provision or return of earlier intergenerational transfers (Silverstein, et al., 2002). To be able to tell the difference, an observer would need to have detailed knowledge about the nature of the relationship between the older parents and their children, personal situations such as time and economic circumstances. This would involve collecting data from the parents as well as the children to be able to get accurate results. The thesis now moves to analyse another of the theories of ageing to be reviewed in this study.

4.2.4 Ageing and Materialist theories

Older people are among the poorest in all countries, worldwide (Walker, 2005). There is no doubt that demographic, social and economic changes have disturbed the inbuilt safety nets that existed for the older population in developing countries (UN, 2002; Ferreira, 1999). While the modernisation theory places much emphasis on younger generations' unwillingness to provide support, as a result of hypothesised growing individualism (Cowgill and Holmes, 1972; Williams, 2003), deteriorating economic conditions and younger generations' inability to provide support are clearly at play (Paradza, 2009). Materialist explanations view the reasons for older people's insecurity in terms of economic constraints. The materialist theory argues that older people's circumstances and the support they receive from their families decline as a result of greater poverty and insecurity, rather than value

change (Hulme and Shepherd, 2003; Heslop and Gorman, 2002 Hulme et al., 2001). Family support declines due to greater poverty among families and therefore greater inability of families to provide support to older parents and relatives. These can be related to older people's own economic circumstances as they may be very poor, in addition to their families' inadequate economic resources and thus inability to provide support.

There is so much poverty in Zimbabwe that older people are undoubtedly in a vulnerable position because for some, this poverty has been on-going for most of their lives while for others it is a result of recent changes in their circumstances and the environment they live in. Materialists would argue that the insufficient financial resources experienced by the younger generations are the cause of their being unable to adequately support older parents (BWPI, 2010). This argument can also dispute the common claim that HIV/AIDS is the main cause of declining filial support.

However, materialist theories do not fully explain the different patterns of old-age care and support or non-support. Poverty does not adequately explain the lack of old-age support and care because it is not only older people (poor or non-poor) with poor children who face lack of care and support. In some cases, reasons for non-provision of support are not obvious to an observer or interviewer. For example, Aboderin (2006) and Kaseke (1999) cite cases of older people not being supported by their family as punishment for them not looking after their children when they were younger. This might be explained by reference to exchange theories or altruism, as some adult children may not provide support to their parents because they perceive their parents as not needing the support. While poverty can determine the monetary and material support adult children can give to their older parents, being poor does not necessarily determine the non-material support which adult children give their parents. There are many instances of older people who receive little or no support from children who live nearby who could help with visits, provision of practical care and help with chores which are forms of help unaffected by money or transport. Although materialists argue that children do not support their parents simply because they are too poor to afford to do so, this is disputed because not only poor children's parents lack support. There are cases of well-off children who have been known not to support their parents. For these different cases, altruism, exchange theory, modernisation theory still do not provide the explanation. There is therefore need to find a theory which further explains the reduction and loss of familial care and support since the theories discussed so far do not fully do so.

4.2.5 The Vulnerability framework as an alternative

The Ageing and Modernisation theory, exchange theory, altruism theory and materialist theory have all been discussed in the literature as explanations for older people's receipt of support, as well as their precarious situation and their lack of old-age care in developing countries. A number of weaknesses of the notions have been highlighted. I therefore found it necessary to adapt an alternative framework, the vulnerability framework. While this framework cannot overcome all of the theoretical shortfalls, I found the vulnerability notion to be the most useful because it allows the incorporation of value change, poverty, HIV/AIDS, changes in family support, pressure on families of older people and migration as risk factors which might increase older people's susceptibility to inadequate old-age care and support, depending on their personal reserves and coping capacities, resulting in some families coping better than others. The 'Vulnerability framework' does not give weight to one risk factor or ageing theory to explain decline of old-age care and support, but assists to show how different events and circumstances in their different ways, may push older people towards undesired outcomes.

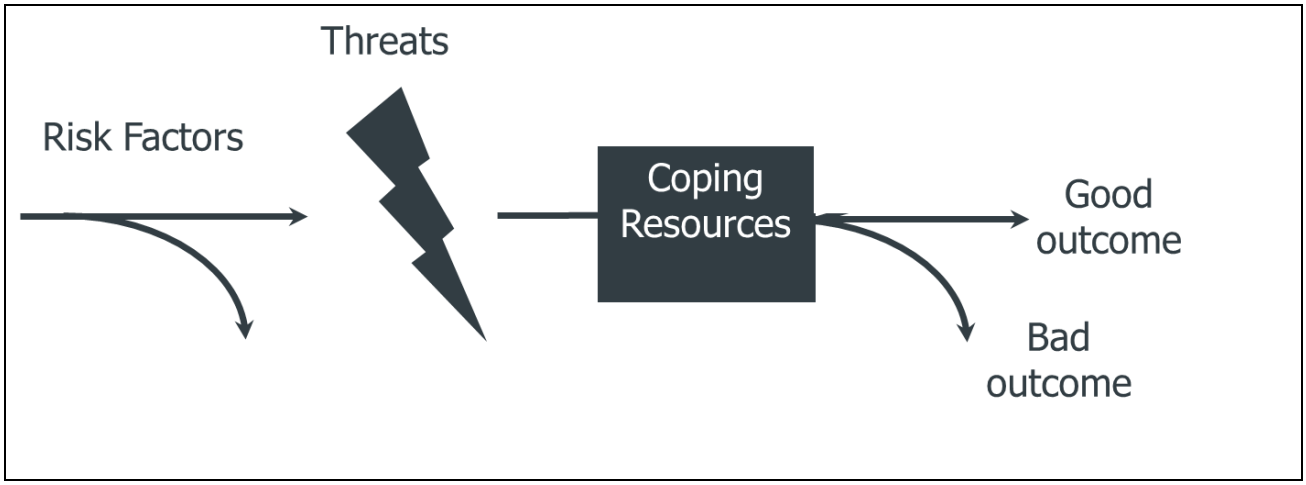
The concept of vulnerability within academia has its origins in environmental sciences. It was mainly applied to natural disasters, epidemiology, famine and social development, in order to understand the differential threats some environments pose to the inhabitants (Wisner, 2004; Wisner, 1993). Such knowledge was needed to plan and reduce risks so as to avert or minimise the likelihoods and effects of a disaster. In early studies, vulnerable people were portrayed as a passive homogeneous group, and it was assumed that technological interventions would reduce vulnerability (Heijmans, 2001). However, recent approaches to the study of vulnerability have shown that people are differentially vulnerable, some are reasonably secure while others are more susceptible to harm. The concept is being used in fields such as crime, health, mental health and human rights (Prowse, 2006). Schröder-Butterfill and Marianti (2006) have therefore broken down the notion of vulnerability into distinct domains which they summarise as: threats; exposure; coping resources and outcome, which can be good or bad (see Figure 4.1, on next page). For better understanding of vulnerability, it is important to understand the interaction between the four domains. This will involve clarifying the distinction between different kinds of risks and will include a preliminary discussion of vulnerability, which I will refer back to when discussing my fieldwork results.

4.2.5.1 Conceptualising vulnerability

While vulnerability is not a direct or inevitable outcome of ageing, 'old age involves greater risks of exposure to specific challenges and, crucially, of a reduced capacity to respond'

(Grundy, 2006:106). Vulnerability is probable and it involves different kinds of risks. Apart from exposure to a threat, it also involves the proximity of a subject to harm or the likelihood of a threat materialising, as well as its severity, leading to some people being considered more vulnerable than others. Importantly, the notion of vulnerability captures the interplay between threats and a person's capacity to cope with or recover from a threat, a point which is clarified later in this section by Chambers (1995). And, unlike poverty which is reflected in a definite outcome, vulnerability is an assessment of the likelihood prior to harm being encountered. Threats are events which have the ability to push people towards bad outcomes, depending on their coping capacities (Figure 4.1). Threats can be accumulative or sudden, for example, a man who at 78 became homeless after an accident (Crane et al., 2004). Exposure, which is also known as 'risk factors' or 'susceptibility', refers to states, e.g. marital status, socio-economic position, environment lived in, which influence the probability of encountering a threat (Schröder-Butterfill and Marianti, 2006).

Figure 4.1: A framework for understanding vulnerability



Source: Schröder-Butterfill and Marianti (2006)

To give a gerontological example of an older person facing the threat of failing health and living in a rural area in a developing country; they face the risk of inability to care for themselves if their health deteriorates and they are exposed to inadequate support as a result of the children being unable or unwilling to look after them. There can be a wide range of coping capacities which the older person can apply. Depending on their socio-economic circumstances, they might be able to give something back in return for care provision. As will be elaborated on later, their social and support networks play a role (as coping capacities) in care provision when the need arises. Their exposure to the threat in this example, and the probability of the threat materialising and its severity depend on factors such as their life history, marital status and gender. For example: women whose child-bearing time coincided with a tough economic period are more likely to be childless, due to putting off having

children, which then impacts on their old-age care as children are an important source of old-age care in many societies (World Bank, 1994; Hampson, 1990; Clay and Vander Haar, 1993; McGuinness, 1999). Schröder-Butterfill and Marianti (2006) found that in Java (Indonesia), unmarried men were most vulnerable to inadequate care, compared to unmarried women or married men or women. Ferreira and Kalula (2009) and Nyoni (1986) concur that is so because women are more able to care for themselves regardless of their marital status, while men rely on daughters and wives for care, including chores such as cooking and shopping. This upbringing puts men at a disadvantage as they are unable to care for themselves or to provide care when the need arises and they have to rely on women who may not be available (Kreager and Schróder-Butterfill, 2009).

The study of vulnerability captures the heterogeneity of people, because people face different levels of exposure to a threat, and they find themselves in situations with very different likelihoods of a threat materialising; in addition to this, they possess different coping capacities. Coping capacities or coping resources, referred by Hulme (2003) as coping capabilities, are contingencies which a person possesses or puts in place, and which are needed to reduce the harm or severity of the threat, to prevent a bad outcome. These capabilities are determined by access to a range of assets (Prowse, 2003). For example, in the event of an illness (threat), where fees are payable at a health centre, a person with poor economic circumstances faces the risk of not being able to afford healthcare and transport costs, while a person who is economically secure would afford the costs and is not susceptible to failure to pay. However, they may still be adversely affected by poor infrastructure or a lack of family member to accompany them. While financial stability is the coping capability possessed by the latter, the former may have to borrow money from family, friends, neighbours or clubs, an action which in itself might amount to a bad outcome as the debt would still have to be paid back. Whether or not it becomes a bad outcome depends on whether the lender manages to pay back the money (or not) before or when it is due. The other alternative would be not seeking healthcare at all, which would most certainly result in worsening health, which is a sign of resignation (Moser, 2002), leading to a bad outcome.

Chambers (1989, 1995) stress that vulnerability is not coterminous with poverty. The World Bank definition of poverty includes ‘material deprivation, low levels of education and health, exposure to vulnerability and risk, and voicelessness and powerlessness’ (Hulme et al. 2001:7), and portrays that ‘in addition to being a cause of poverty and a symptom of poverty, vulnerability can also be conceived as being part of poverty itself’ (Prowse, 2003:9). An important distinction between poverty and vulnerability is that poverty is an outcome which has to be measured ‘ex-post’, that is, after the event has occurred, whereas vulnerability tells us something that might happen and gives an ‘ex-ante’ view of a likelihood

of a bad outcome, before the threat materialises. This implies that the study of vulnerability allows the unravelling of exposure and risk factors, and possible coping resources in place, which can result in good or bad outcomes, depending on the availability and effectiveness of the coping resources. However, there are limitations to an approach to vulnerability which focuses primarily on poverty. Not only poor people are vulnerable, there are certain outcomes that poor and rich people alike are vulnerable to. For example, depending on the strength and proximity of their social networks, both rich and poor older persons are prone to loneliness.

Chambers (1995:20) explains that:

> *'Vulnerability means not lack or want, but exposure and defenselessness. It has two sides: the external side of exposure to shocks, stress and risk. And the internal side of defenselessness, meaning a lack of means to cope without damaging loss'.*[18]

Chambers (1995) puts equal weight on both the internal and external sides and emphasises the dual nature of vulnerability because the outcome depends on the internal capacity to cope, in response to the shocks, stress and risks. The external side includes risk of exposure to threats, the likelihood of the threat materialising and the degree of severity if it materialises. The internal side of vulnerability presents itself in response to the external side, which may be at individual, family, community or national level.

However, ownership of the coping capacities or assets is not enough to avoid a bad outcome, equally important is the ability to apply those assets, which can be human capital, productive assets and social capital[19], accrued over the life course. The outcome depends on how well people can protect themselves against bad outcomes when faced with threats, because outcomes are 'never inevitably or perfectly predictable' (Schröder-Butterfill and Marianti, 2006:30) and contingency measures can be put in place in retrospect, after a threat has already materialised. In situations where the bad outcome has already happened, the vulnerability framework could still be applied, for example, to understand pathways to that outcome, and interventions would be put in place to avoid the bad outcome from progressing or to reduce harm resulting from a sequel.

Studies by Lloyd-Sherlock (2006) and Kreager (2003) have applied the vulnerability framework in later life. These authors emphasise that to have a clear understanding of what older people are vulnerable to, the researcher should ask the concerned individuals or

[18] Loss can manifest itself in many forms, for example, psychological harm, economic impoverishment, being socially dependent, becoming physically weaker or feeling humiliated (Chambers, 2006).
[19] The elements of social organisation, such as social networks, norms or trust that enable co-ordination and co-operation among people for mutual benefit (Putman, 1995; Eeuwijk, 2006; Jütting, 1999).

group. They are the ones who can tell more accurately, what they consider as bad outcomes and are trying to avoid. By knowing what older people consider as threats, relevant interventions could be planned to counter the threats, and to avoid putting in place interventions which might be irrelevant to those meant to benefit, resulting in the feeling that services are being imposed. These interventions can be applied before the occurrence of a threat, or after it has materialised, in order to reduce the severity of the outcome. Different sub-groups may view similar outcomes differently. For example, for some older people, lone living may be due to their preference for successful independence and privacy (Schröder-Butterfill and Marianti, 2006); yet to others it may mean loneliness, and they may prefer co-residence as a way of reducing emotional vulnerability resulting from loneliness in old age (UNDESA, 2005; Aboderin, 2006; UNDESA, 2002). Migration (reviewed in Section 3:4) might be viewed as abandonment in some cases, while for some families, migration of young people is a strategy for the younger generations to be in a position to support their older relatives financially by sending remittances.

While this thesis has adopted the vulnerability framework for examining and explaining the situation of older people in Zimbabwe, the thesis also acknowledges the shortfalls of the framework. The shortfalls are mostly methodological, the challenges presented to collect information to be able to apply the vulnerability framework. As recommended by Lloyd-Sherlock (2006) and Kreager (2003) for accurate vulnerability assessment, the subjects should be involved and assessment made from their point of view. However, such situations can result in a dilemma of what information the researcher should consider, if respondents give information contrary to visible circumstances. There is the main challenge of how to deal with objective and subjective vulnerability assessments, for example, some respondents may view their circumstances as being worse or better than they are, depending on how they want the interviewer to perceive them. As will be discussed in Section 5.7, some respondents can give responses depending on what they perceive as the aims of the research. A decision would need to be made based on information from key informants. Accurate vulnerability assessment may not be possible after only one visit, as respondents may not be willing to share all the required information on the first encounter and there may be a high element of reactivity which can be reduced on subsequent visits (Kemper, et al., 2003). To come up with an accurate assessment, a researcher needs to ask probing questions so as to get as much information as possible to allow assessment of circumstances. The approach is quite demanding of data: it requires knowledge of risk factors, common threats, coping resources and how they interact. Ultimately, to assess a person's vulnerability requires following them over time to see whether their coping resources really protect them in the face of a threat. Having discussed the vulnerability

framework, I will turn my focus on the Lifecourse approach. The lifecourse approach helps paint a picture of an individual's life which includes opportunities, challenges, networks and resources accumulated over time which can determine vulnerability or security in later life.

4.2.5.2 The Lifecourse Approach

The lifecourse approach in the study of old-age vulnerability asserts that just as risks or deficiencies may be accumulated over the life course, so also are assets amassed over time as they play an important role in reducing vulnerability. The lifecourse approach emphasises that in order to have a better understanding of older people's circumstances, it is important to have an idea of their past lives and of the social, economic and political context within which lives have been lived (Arber and Evandrou, 1993; Elder, 2002; Hareven, 1995). Individuals' life courses influence vulnerability and security in old age in that they can determine older people's problems, needs, and clarify patterns of adaptation to these problems (Hareven, 1995). Grundy (2006) concurs that the 'reserve' a person brings to later life provides a picture of the resources and skills they have accumulated, as well as those which have depleted. Coping resources, social networks included, are something that people build over long periods of time and they too, are shaped by historical periods. As Schröder-Butterfill and Marianti (2006:4) explain, 'Vulnerability in old age is usually the outcome of complex and cumulative processes at individual and societal levels', because past outcomes can have a bearing on present exposures and the capacity to cope. For example, before independence in Zimbabwe, blacks were prevented from making pension contributions, resulting in them not being in receipt of pensions. Also, various risks are shaped by factors such as gender and ethnic inequalities, social stratification, cultural patterns, political and welfare systems built over long historical periods (Schröder-Butterfill and Marianti, 2006a). In cases where women are not treated equal to men, women may be more disadvantaged in old age. For instance, the preference for men owning land in communal areas in Zimbabwe leaves some widows living at their homesteads at the mercy of the men within the family (HAI, 2000; Peters and Peters, 1998; Food and Agricultural Organisation, 1993).

Gutsa and Chingarand (2009) used the lifecourse approach to investigate why older indigenous Zimbabweans were being admitted for institutional care at Bumhudzo Old People's Home in Chitungwiza, near Harare. Admission of an older black older person in an institution raises questions of unavailability of family support because, in Zimbabwe, institutional care for blacks is not widespread, is often not viewed positively by society and is usually reserved for the most frail with high healthcare needs (UN, 2002; Hampson, 1982; Waterstone, 1982). The research therefore sought to find the reasons for the respondents'

outcome of being in an old people's home. The study argues that reasons for institutionalisation have to be sought in a person's lifecourse and antecedent events. For example, in one case it was a woman's childlessness, poverty and early widowhood which account for her lack of informal support.

Davis' (2006) study on poverty in Bangladesh closely links with the lifecourse approach. Although Davis' study was not exclusively on older persons, he uses the life history method to analyse poverty dynamics in a developing country context, by examining events, episodes and 'trajectories'[20] of crisis in respondents' lives and the impact on their lives. This is relevant to our understanding of vulnerability because such episodes often have an effect on people's coping capacities when faced with threats in old age. Davis (2006) explains that a single cause can have multiple effects, for example, the illness or death (or both) of a breadwinner can lead to dependents becoming homeless, children not going to school and healthcare costs being unaffordable. Some events are affected by prior events, referred to as the 'cumulative causation'[21], for example, HIV/AIDS illness and eventual death of a breadwinner, leading to depletion of resources of the surviving family. The order in which events take place, so-called 'sequence effects,' at times have an effect on the outcome. The 'interaction effect' can also determine the outcomes. This refers to outcomes that result due to events happening close, in terms of time. The events, episodes and trajectories are applicable outside the environment studied by Davis (2006), as they have an impact in later-life. This will eventually help towards understanding individuals' vulnerabilities in old age. The lifecourse approach helps to give an idea of what coping resources may be available, and who would be likely to assist in the event of care and support being needed.

4.3 Over-lapping theories

Analysis of the theories and various situations has shown that some theories over-lap (Vera-Sanso, 2004). Older parents and their children might view the older people's circumstances differently and this can determine the receipt and provision of old-age care and support. This is likely to happen when the adult child does not have enough resources to share with parents and immediate family, becoming a question of ability to provide. Parents may feel they need support or it is their right, and may feel they have been neglected when they do not receive it. This may be contrary to the adult children's perception that their parents do not need the support (Vera-Sanso, 2004). Materialist theories argue that the younger

[20] Davis refers to crisis lasting less than one month as events, those lasting up to a decade as episodes and those lasting longer as trajectories, which could still include episodes.
[21] A prior event produces an interim outcome which changes or reinforces the effect of a following event (Davis, 2006:5).

generation is too poor to provide support, but of course the decision about what one can or cannot afford to spare for the older generation is to a large extent culturally shaped. It is also shaped by changing perspectives about what people need and deserve; modernisation can be a powerful force in changing these perceptions about what older people need. The point Vera-Sanso (2004) makes is that some situations are relevant to both modernisation and materialist theories. In cases where there are inadequate economic resources, the adult children may have to make the difficult decision of prioritising use of the resources, between their older parents or the nuclear family. There can also be an over-lap between altruism and the ageing and modernisation theory, raising the question of whether change of values or altruism determines decisions where support is not provided for older people who are deemed not to be in need. There still remains an overlap between filial obligations as well as expectations of the flow of support between older parents and their adult children (Silverstein, et al., 2002; Logan and Spitze, 1995). This thesis will combine insights from lifecourse and vulnerability approaches, and rely on case studies, for understanding support provision and vulnerability in late life in Zimbabwe. There is support-provision which occurs but is not explained by any of the theories surrounding family support.

4.4 Support-provision as an obligation

Filial support is not always a result of the good relationship between older parents and their adult children. In some instances, children feel obliged to help their parents, even if there is little affection (Aboderin, 2004; Madzingira, 2006; Harper, 2006). Quite often support is given as a 'sense of duty' and to have a clear conscience, regardless of whether the children received support or not from the parents (Aboderin, 2006:87). Bianchi, et al. (2006) concur. The need to support parents in old age is likely to have been a key element of socialisation of children, as they were brought up to see it as 'part of life' being repeatedly fulfilled around them (Aboderin 2006:87). Bandura (1977) refers to the situation as role modelling. In some cases young adults provide support to fulfil their own interests due to fear of getting the same treatment from their own children in old age (Aboderin, 2004; 2005; 2006; World Bank, 1994). For example, in Ghana, Aboderin (2006) found that the middle generation was concerned that if they did not support their parents, their own children would challenge them about it and would not provide them with support in their old age. Cox and Stark (2005) refer to this as the 'demonstration effect', where children support their older parents not because they want to, but as a way of protecting their own well-being. Some young adults support their older parents because it is expected of them and if they do not, society would see them

as failures and ridicule them. These expectations of responsibilities chime with the African Charter on Human Rights[22], with Article 29 (1) which states:

'The individual shall also have the duty to preserve the harmonious development of the family and to work for the cohesion and respect of the family; to respect his parents at all times, to maintain them in case of need' (OAU, 1986).

Support is also apparently provided due to fear of the metaphysical sanctions, that is, retribution from one's family and from God in the case of non-support. These ideas are said to change with modernisation. There is no evidence whether the feared sanctions would follow through and also, if fear of sanctions is still influential.

4.5 Summary

Most of the support for older people in developing countries is from kin, therefore five theories of ageing explaining family support have been reviewed to help explain support and care receipt, and the reduction in the care and support provided to older persons in developing countries and Zimbabwe in particular. The theories also contest many recent studies which put much emphasis on HIV/AIDS as the cause of old-age care and support loss and reduction, without acknowledging other contributing factors such as poverty and out-migration. The vulnerability framework incorporates elements of the different theories as well as factors such as HIV/AIDS, to be able to assess security or insecurity in later-life. It has been argued that vulnerability has an internal and external side and is constituted of different risks, including exposure to a threat, likelihood of the threat or risk occurring, and the risk of lacking relevant coping capacities, to mediate a threat (Chambers, 1995). Vulnerability is not a direct function of age, but old age makes some older people more susceptible to harm due to their reduced capacity to cope. The cumulative aspect and the possible coping resources can be better understood through the Life Course Approach, which could help paint a picture of the role of poverty, HIV/AIDS and out-migration, in determining older people's outcomes. The next chapter presents the methodology for the study.

[22] Adopted on June 27 1981, entered into force on 21st October 1986

CHAPTER 5: Research Design and Methodology

5.1 Introduction

The purpose of the study is to understand the vulnerabilities faced by older Zimbabweans, their care and support needs; the care and support options available, and how old-age support arrangements are adapting to the current social, economic, political and epidemiological challenges. The scarcity of research, and the fact that there are no recent studies on the impact of the extreme changes which Zimbabwe has witnessed, underline the need for new empirical research. This chapter will discuss the research methods used in other studies on ageing in Zimbabwe and those used for this study. The research design and choice of study site will be explained and justified. Basic characteristics of the site and respondents will be outlined. The chapter will examine challenges faced during empirical research and how these were overcome. The role of fieldwork was to complement and go beyond the literature in answering the research questions to facilitate the assessment of the appropriateness of the research methods selected and applied.

5.2 Overview of Methodology Used

The research used a concurrent nested design, which involves the collection of both quantitative and qualitative data (detailed in Section 5.4). Many studies in the past on ageing in Zimbabwe relied heavily on standardised surveys, for example, Nyanguru (2007, 2008); Allain, et al. (1997); Wilson, et al. (1991). Several studies have been narrowly focused on nursing home populations using qualitative methods, for instance, Gutsa and Chingarand (2009); Chiweshe and Gusha (2012); Hungwe (2010). I was interested in studying community-dwelling older people. It was important to me to obtain a balance between some quantitative information but also more detailed, contextualised data on people's circumstances, life histories and support arrangements. I therefore relied on face to face interviews with older people, key informants and stakeholders.

The main advantages of using face-to-face interviews are the direct relationship established between interviewer and interviewee, the opportunities for asking probing questions and adjusting the interview questions to the specific context, and the insights gained by observing a person in his or her natural environment.

5.3 Selection of the rural Study Site, Recruitment of Respondents and Response Rate

5.3.1 Selection of the rural Study Site

I chose Zimbabwe because older people's circumstances in developing countries are under-researched, and Zimbabwe offers a context that allows me to examine economic poverty alongside migration and HIV/AIDS as determinants of old-age vulnerability. Zimbabwe is my country of origin, so I was able to carry out interviews in Shona without the need for an interpreter. This reduced the risk of misinterpretation.

All older people interviewed live in the small-scale commercial and subsistence farming area of Dowa (explained on page 20), in Makoni District, in Manicaland Province in Zimbabwe (see Figure 2.2). During literature review I had identified a lack of research on small-scale farming areas. My father, who was once a head teacher at a local school in the 1970s, helped me to identify the particular location. In Dowa the nearest neighbour can be up to two kilometres away, making older people more vulnerable than their counterparts in more densely populated areas. This is in sharp contrast to neighbouring communal areas such as Chiduku, where some homes can be as close as twenty metres apart.

The other main difference between Dowa and other rural areas is that, being a 'purchase area', people who bought farms in the area from the 1930s onwards came from many different communal areas across what was then Southern Rhodesia (Native Land Board, 1933). As a result most of the population are not related (see p120). Only a few families knew each other prior to moving to Dowa. This has an implication on old-age support and vulnerability as most of the extended families live far.

Dowa is about 140km east of the capital, Harare and about 150 kilometres from Mutare, the capital for Manicaland Province. Manicaland has a net migration rate of -12% (ZimStat, 2012). Dowa was a result of the Land Apportionment Act (1930) (Chapter 2.3) and has nearly 200 farms. The first farmers settled in the area in 1938 (Native Land Board, 1938; Ranger, 1985). Farm sizes range between 40 and 2000 hectares. Take-up of the farms was slow so it took around twenty years for all the farms to be occupied. While most of the farmers bought their land, the majority of them used payment plans, which were in some cases passed on to their children who are now the present generation of older people.

The most common crop is maize, used to make porridge and *sadza,* Zimbabwe's staple food. Other crops include *nzungu* (groundnuts) sunflower, *nyimo* (roundnuts), and *mbambaira* (sweet potatoes). In the past decade, a number of farmers have diversified into

growing tobacco. While tobacco has good returns, the crop is labour-intensive throughout its life cycle. Most crops are for consumption and only the excess is sold. In a farming area such as Dowa, farmers are busy all year round (Table 5.1).

Table 5.1: Time frame of farming activities in the study site in Zimbabwe

Period	Activity
August/September	Clearing fields
September/October	Preparing of land and inputs
October to December	Planting season. It is important to get crops in the ground at the right time. This can mean a big difference between a good or poor harvest
December to March	Weeding, tending crops, remaining vigilant for any signs of crops disease, timely application of fertilisers and pesticides. Different crops require different moisture levels and have different life cycles. It is important to keep track of dates to ensure all activities are carried out within the right time frame
April to August	Harvesting, preparing produce for storage or sale and selling the produce

Source: Author's own compilation from field data (2009-2011)

My study site is in an area that receives above average rainfall for Zimbabwe (discussed in Section 2.3). Therefore the circumstances I encountered are likely to be more favourable than in many other areas of Zimbabwe with lower rainfall, so older people elsewhere may even be more vulnerable. Compared to most communal areas, the majority of older people in the study site would be considered wealthy due to ownership of large pieces of land.

5.3.2 Wealth differentials

There are differentials in wealth and livelihoods in different areas in Zimbabwe. Although rural and urban livelihoods are both income and asset-based, patterns of deprivation may differ in rural and urban areas in Zimbabwe and poverty and wealth measures vary between different areas, for example, between small scale commercial farming areas, communal and resettlement households (Alkire, et al., 2011; ZimStat, 2013; Scoones, 1995; Scoones, 1988). Consequently, people could be put in varying economic strata nationally and also

depending on the environment being compared to. It is beyond the scope of this thesis to compare the socio-economic circumstances of older respondents in the study site at national level.

When measuring wealth, consideration is given to ownership of certain possessions and access to certain privileges. In rural areas including the study site, wealth and socio-economic status for adults is usually measured[23] by ownership of land and cattle, adequate farming equipment, ability to buy adequate farming inputs, ability to pay for labour force, well-built home with asbestos, corrugated iron sheets or tiled roof, educated children to provide financial support especially in old age, holding a regularly paid job, receiving a pension, affording to buy groceries regularly, owning a vehicle, access to remittances[24], producing enough food for consumption and selling (Chiripanhura, 2010; Horrell and Krishnan, 2007; Gunning, et al., 2000; Scoones, 1995). Low productivity results in low or no savings because saving is only practical after basic needs have been met (Chiripanhura, 2010). The information about wealth indicators served as background knowledge on wealth in Zimbabwe and helped to make assessments through observations during fieldwork in some cases without asking the respondents.

5.3.3 Recruitment of Respondents

5.3.3.1 Older Persons

Selection of older people as respondents was done through a two-stage sampling procedure. I used purposive sampling in selecting respondents, because it allows the researcher to focus on people or events believed to be critical for the research (Denscombe, 2007; Teddlie and Yu, 2007; Bryman, 1988). Purposive sampling is meant to achieve 'representativeness' to represent 'as closely as possible, a broader group of cases' (Teddlie and Tashakkori, 2009:174). I wanted to make sure that apart from age, the sample included respondents fulfilling criteria which were less common in the population. For example, I wanted to include better-off and poorer respondents in order to examine a range of determinants of vulnerability in later life. The first stage of the sampling procedure was the use of purposive sampling, relying on the information I obtained through conferring with key informants. The prospective respondents were identified during the scoping exercise on my first visit with the aid of the ward head, my guide and a key informant (KI03). During this visit I also established links within the community, with government authorities and other

[23] Respondents reported that they considered these measurements and they were also considered by the government and agencies when assessing eligibility to receive aid (Scoones, 1988).
[24] This was suggested by participants residing in rural areas, during a Rapid Rural Appraisal exercise.

organisations dealing with older people's welfare. As Teddlie and Tashakkori (2009:173) assert, 'purposive samples are often selected using the expert judgement of researchers and informant'.

The prospective interviewees included childless older persons, older persons living alone, older persons co-residing with other people, widows, widowers and some who were in polygamous relationships. The list had an almost equal proportion of males to females. As part of the sampling procedure I also used some of the societal ways of measuring age to check the approximate ages of prospective respondents so that I would not approach people who were less than 55. Some of the respondents' exact ages were known by key informants, some approximate ages were arrived at after asking about the ages of prospective respondents' eldest children. I also identified prospective respondents' attributes such as marital status and living arrangements so that the sample would cover a range of characteristics and circumstances. All interviews were held in respondents' homes.

Twenty-seven older respondents were chosen on the basis of age, being 55 years or older. Most respondents were able to tell their dates of birth and some showed me their national identity cards.[25] The age ranges are shown in Table 5.2 (see Appendix 17 for other attributes). Initially I had intended to use 60 years as the cut-off age, in line with UN usage. However, most studies on ageing in Zimbabwe use age 55 (e.g. Allain, et al 1997; Wilson, et al. 1991; Adamchak, et al. 1991). In Zimbabwe people can be considered old by virtue of having grandchildren; most people are grandparents by age 55. It is common in developing countries that chronological age does not match functional age, with 'poverty leading to premature aging' (Madzingira, 2006:69). Chronological age is therefore not the best indicator because strength can vary greatly between individuals. Instead it is important to take note of functional, chronological and socio-politico age, where older people are defined by their roles in society (Lloyd-Sherlock, 2010; Kreager, 2006; Madzingira, 2006).

[25]Before starting the research, I had assumed that a number of respondents would be illiterate and would not know their ages. I had planned to estimate people's age using children's or grandchildren's ages or memory of major historical events such as the Second World war (Madzingira, 2006; Allain, et al., 1997; Wilson et al., 1991). In the end it was not necessary to use these indirect methods.

Table 5.2: Age and sex of respondents

Age Group	Male	Female
55-59	1	4
60-69	4	2
70-79	4	6
80+	4	2
Total (N)	13	14

Source: Fieldwork Data (2009-2011)

Out of the 27 older respondents, there were four married couples, who were all interviewed separately to avoid responses being influenced by the presence of the spouse.

5.3.3.2 Stakeholders and Policy Makers

Apart from interviews with older people, I also conducted interviews with twelve Stakeholders and Policy Makers (see Appendix 15 for a copy of the interview guide). The interviewees were representatives of government departments and different organisations and institutions involved with older people's welfare, the local chief and ward head all with a minimum 'O' Level education, some educated up to professorship (Appendix 18). Some of the contacts were referrals by the contact person at the Ministry of Public Service, Labour and Social Welfare (MPSLSW), the ministry responsible for the welfare of older persons, when I was granted clearance to carry out the research. Such interviews shed light on the extent of knowledge that Stakeholders and Policy Makers had about the situation of older Zimbabweans and any plans and interventions in place. They were often able to provide me with up-to-date information on issues affecting older people. The interviews gave the respondents the opportunity to suggest ideas for policy planning, which will be included among my policy recommendations. All Stakeholders and policy makers were interviewed during the first field trip for interviews (November – December 2009).

Key informants were people with detailed knowledge about the history of the Shona and the local area. I was directed to KI01 by the contact person in the Ministry of Labour and Social Welfare, and later approached a further three key informants with specialist knowledge of the community I was studying.

5.3.4 Response rate

All the respondents approached for interviews agreed to take part, apart from a husband and wife who are known ZANU (PF) supporters in an area which is an opposition party constituency. They were reluctant to participate as they thought the research was political and feared I would pass their details to the opposition party. Later on, they approached my guide and said they were willing to take part after all, but I preferred not to recruit them so as to prevent them worrying. All but four of the respondents agreed to be audio-taped. Three were from government departments and one was an older person (Female, 76), who was also the only respondent who preferred not to sign a consent form on account of worrying about her details being passed on to the opposition party.

5.4 Fieldwork Design, Methodology and Instruments

The research was a longitudinal study, where up to three interviews were conducted per participant in order to examine whether there were any changes in the respondents' circumstances between 2008 and 2011. This was particularly important as the empirical study started during the peak of hyper-inflation and political instability; the situation subsequently improved.

The fieldwork was conducted in four phases, involving five visits to Zimbabwe (see Figure 5.1). The first visit was a scoping exercise. I met some of the prospective interviewees and had informal conversations with people of different ages. The purpose of these conversations with different age-groups was to clear any suspicions which would probably arise from me engaging with only older people. Political violence and economic crisis made it difficult to carry out research, resulting in decline in academic research (Chiripanhura, 2010). During this trip, I applied for and was granted clearance by the GoZ to conduct the fieldwork (Appendix 7). I also recruited my guide, Lloyd, an unemployed 26-year-old with 'A' Level passes, a driving licence and an Agriculture Diploma. His role would be to drive me to respondents' homes, ease introductions, and provide me with valuable information about farming.

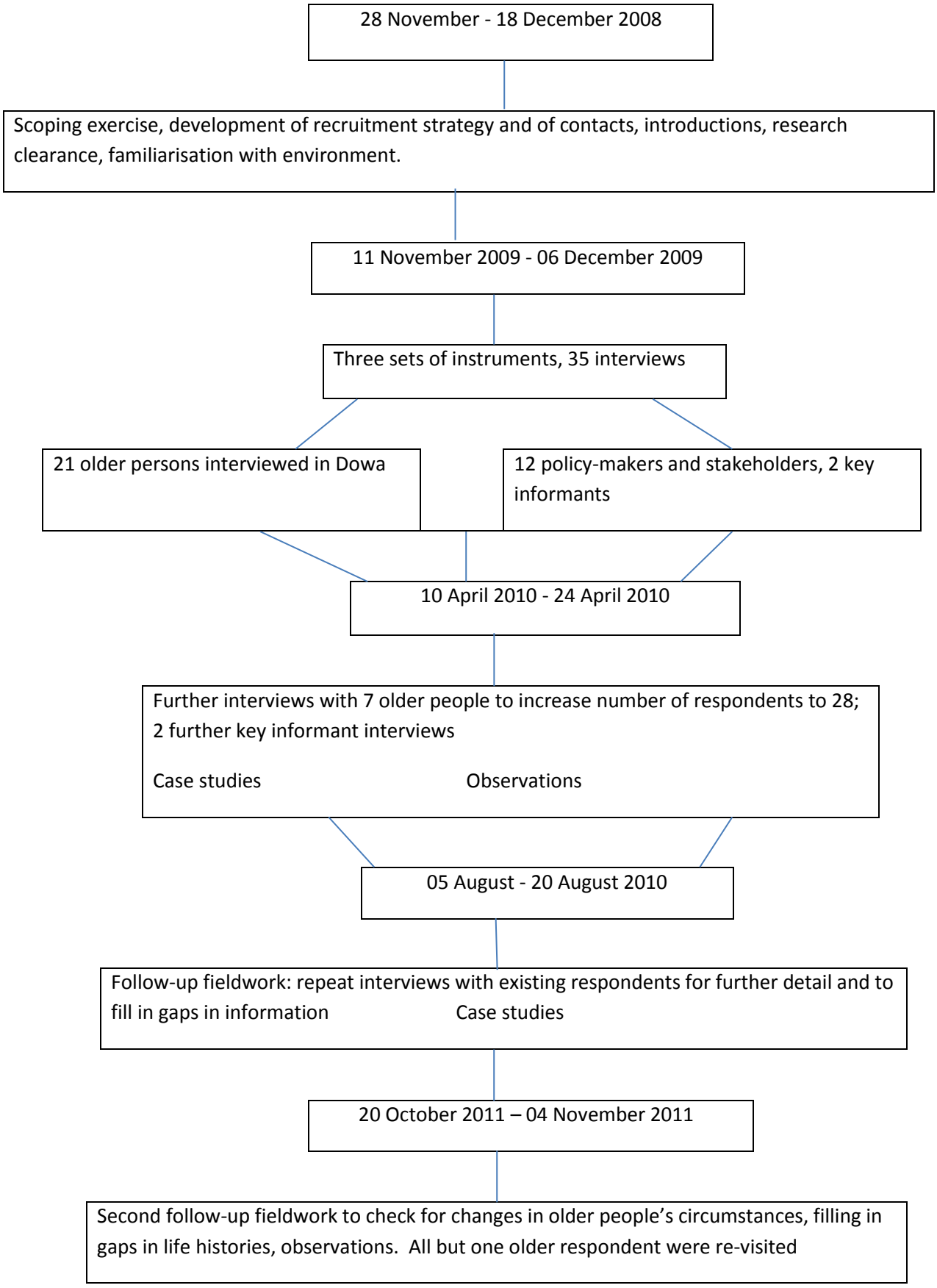
During the empirical research, five distinct instruments were employed: For data collection involving older respondents, three instruments were used, namely a questionnaire (a copy of which can be found in Appendix 10). The second instrument (Appendix 11) had questions for in-depth interviews for case studies and the third instrument contained semi-structured questions for all older interviewees as follow up on earlier interviews with questions probing about life histories (Appendix 12). The questionnaire (Appendix 10) was also used as a way of collecting background information about the respondents on the basis of which further probing questions were asked in the interviews. A semi-structured interview for stakeholders

and policymakers covered topics such as the nature of their organisation's work in relation to older people, threats faced by older people, healthcare service provision and suggestions for coping resources and interventions. Four key informants were interviewed (see Appendix 19 for attributes). The key informants were chosen through purposive sampling as I aimed to have key informants as people who know about the study site, as well as issues concerning ageing. Key informant interviews were aimed at understanding any changes in old-care and support and what interviewees consider as reasons for change in economic circumstances and in the perception of older adults by society (Appendix 12). Key informant interviews provided varying explanations for old-age vulnerability, support provision and receipt in Zimbabwe.

Interviews were held on the second, third, fourth and fifth trips. A total of 43[26] respondents were interviewed, made up of 27 older respondents (13 men and 15 women[27] aged 55 years and over), 12 stakeholders and policy-makers and four key informants). I interviewed 21 older respondents for the first time in December 2009 and a further six respondents in April 2010 to increase the overall number of respondents (see Figure 5.1). Stakeholders and policy makers were all interviewed during the second trip. I then re-visited all older respondents in August 2010 to obtain more information to allow the build-up of case studies. The final interviews were held in October – November 2011.

[26] One older respondent (OP19) was also a key informant.
[27] As explained in Section 5.3.4, only data from 27 older respondents was used.

Figure 5.1: Flow Chart Showing Field Trips



During the third and subsequent field trips, most of the empirical research was carried out in Dowa and involved only older respondents. This was in order to increase the number of older respondents, to follow up on points raised during previous field trips, and to probe where there were gaps in the information. I was also interested to see how older persons' circumstances had changed.

There were a number of notable economic and political changes in Zimbabwe during the course of this research, and it was therefore interesting to observe changes as the conditions improved somewhat after 2010. Twenty-six interviewees were re-visited. The only exception was a respondent who died in mid-2010.

Green and Browne (2005:77) assert that analysis begins at the start of data collection 'to maximise the flexibility of qualitative designs' and argue that as the researcher begins analysing, 'new theories emerge to test, suggesting new data to collect or refinements of the interview topic guide'. During the first wave of interviews I was able to collect reflection material and observational notes which were referred to in subsequent follow-up visits, aimed at providing more information, incorporating the Life course approach by obtaining life histories and eventually allowing the build-up of case studies. Interviews ranged between 30 minutes and two hours.

The thesis used a mixed methodology within the same study[28]. There is use of both in 'tandem so that the overall strength of a study is greater than either qualitative or quantitative research' (Creswell, 2009:4). Mixed methods design is also used for triangulation, where researchers employ more than one measurement procedure when investigating a research problem. Use of mixed methods can minimise the disadvantage of one method used on its own and can answer questions the other method cannot (Tashakkori and Teddlie, 2003; Green and Browne, 2005). I decided to use mixed methods because the research questions and the thesis topic would be better addressed using mixed methods than using one research method (Bryman, 2012). Qualitative approaches, such as semi-structured interviews, participant information and case studies provided me with detailed information about older people's life histories, vulnerabilities and coping resources, while the

[28] Madzingira (2006) used a structured questionnaire, in-depth interviews with elderly parents, and focus group discussions with both adult children (19 and 59 years) and elderly parents. This is the only study which used focus group discussions and was the first one to focus on support provided to older persons by their adult children. The data was analysed using both qualitative and quantitative methods. However, the adult children interviewed were not the children of the older persons who took part in the study. They were not providers of day-to-day care and did not live with the older respondents or see them daily. It is therefore likely that they were giving responses based on assumptions.

questionnaires provided quantitative information about demographic and economic circumstances.

5.4.1 Quantitative methods

The questionnaire contained closed-ended questions and some semi-structured questions, which invited suggestions for interventions. The questionnaire was adapted from various studies (CSO, 2007; WHO, 2002; Kimuna, 2005; Madzingira, 2000; Katz, 1983) and included a modified Katz[29] questionnaire which captures older people's ability to conduct Activities of Daily Living (Wallace and Shelkey, 2007; Katz et.al, 1970). WHO (2002) and Madzingira (2000) were the most influential studies in shaping the questions because between them they covered many physical, emotional, spiritual, financial and social aspects of older respondents' lives. The Katz Index of Independence in Activities of Daily Living is used to access older people's ability to perform the following six activities: bathing, dressing, toileting, transferring, continence and feeding (Katz, 1983). The information collected via the questionnaire helped to answer the research question on threats faced by older people and provided part of the answers to available coping resources.

5.4.2 Qualitative methods

Structured interviews were used for relative assessment of older respondents and their resources. They also informed and provided background information to follow-up, in instances where information provided was not clear. Interviews collected more detailed qualitative data which helped in the building up of life histories, as they were less restrictive of response. Within QUAL I used multiple methods such as observation, in-depth interviews and case studies. The mixed methods nature of the study mainly lies in the different ways in which data was collected and analysed, including structured questionnaires, semi-structured interviews and observations, rather than the equal use of both qualitative and quantitative data analysis. The study is therefore not wholly mixed methods, but is chiefly qualitative since qualitative analysis predominates. This does not stop the research from being mixed methods, as Creswell (2009) argues that in mixed methods research, priority can still be given to one method.

Qualitative methodology allowed the gathering of wide-ranging data which helped paint a picture of determinants of older people's vulnerability, threats faced and coping resources available. Qualitative methods also use non-material data including participant observation,

[29] Also used by Allain, et al. (1997).

focus groups, in-depth interviews, analysing textual data, audio taping (Green and Browne, 2005), to answer the 'why' and 'how' questions. Qualitative methods were used to answer the question on determinants of older people's vulnerability, how threats faced affect older people's well-being as well as providing detailed information on coping resources, to complement the quantitative information obtained to answer the same question. For example, the question on abuse due to AIDS-related illnesses in the family was a follow-up to the question on HIV/AIDS illnesses and deaths within the family. Qualitative data was also obtained from the questionnaire, for example, to answer questions which required respondents to give suggestions for interventions. Follow-up interviews with all older respondents using in-depth questions allowed respondents to present views with greater diversity (Brewer and Hunter, 1989). After carrying out the interviews, there were still aspects of some older people's circumstances which remained unclear, such as the old farming equipment lying idle, reasons for support provision, reduction or non-provision of support, poor family relations for which further clearer information was provided when answering follow-up questions.

Ethnography is also multimethod research in itself, as ethnographers frequently do not only act as participant observers. Their observations include other sources such as interviewing key informants, examining documents and also engaging in non-participant observation Bryman (2001). Active participant observation played an important part during the empirical research as it enabled me to collect further information without asking respondents. It allowed the establishment of rapport, and the observation of participants' behaviour in a setting which is as natural as possible (Green and Browne, 2005). When achieved, a basic sense of mutual trust is developed and allows information to flow freely, which also allows the production of rich and detailed data about one setting. For example, during the fieldwork I managed to generate an understanding of the local culture, as I lived within the community and tried to understand their circumstances from the point of view of an insider, as well as understand the respondents better. I was able to understand how different possessions such as flooring and why every household had grass-thatched roofs were used as a measure of security.

Personal or face-to-face interviews allowed long interaction with interviewees and the chance to probe ambiguous or unclear responses and also for the interviewer to judge the interviewee's accuracy and truthfulness during the survey (Green and Browne, 2005). Face-to-face interaction allowed me as the interviewer to recognise the potential significance of the context in which the questions were answered, and gain a depth of the meaning (Ritchie and Lewis, 2003). For example, by simply observing, in some cases I was able to ascertain

the possessions they owned. Semi-structured questions were used as they allowed the interviewees to respond without being limited by pre-determined choices. Use of semi-structured questions also encouraged the interviewees to respond as they would do in an everyday conversation, a trend which seemed to grow as they trusted me more. During repeat interviews, a number of respondents pointed back to earlier interviews and presented information they admitted to have not accurately provided. I made sure to remain as neutral as possible and not give any leading comments so as to avoid influencing the interviewees' responses. I obtained useful information as some respondents digressed during semi-structured questions as, while they would not be answering the question asked, they also provided some information which helped me indirectly to understand their circumstances and I would then re-direct them to the question to minimise the digression. There was the opportunity to spend time with some respondents who requested me to stay longer and have a general conversation after the interviews were over. This gave me the opportunity to observe how they live, and during conversations they also provided more information which had not come up during the interviews. Case studies were also used as a research method.

5.4.3 Case Studies

For the second part of the sampling procedure, sixteen of the twenty-seven older respondents were chosen as case studies, for detailed case analysis. After interviewing all respondents for the first time, I compared personal situations and circumstances such as: being widowed, those who seemed to be 'doing well' and coping better than most, those who appeared to be more vulnerable and showing signs of support and care shortfalls, those with no children, those who had experienced bereavement in the past five years, those who were co-residing with other persons and those living alone. I then picked 16 respondents spread across the different selection criteria, for case studies. In addition to the questionnaire, case studies answered the in-depth questions Appendix 11 in separate interviews. 'Historical forces' have a direct impact on individuals' life courses at the time they are encountered and continue to affect them through life (Hareven; 1995:4). This is also found in case studies for this thesis, exemplars of which are presented in Section 6.3. The case studies have been used because they are important in the analysis and gaining an insight into vulnerabilities faced by the different respondents. Case studies can allow generalisation through the study of a range of factors, detail of experiences and cross-case analysis (Gilson, 2012). Case studies are ideal for the 'why' and 'how' questions as they deal with investigations which may need to be traced over time to be better understood, which is ideal for the research questions for this thesis. Case studies' different experiences with HIV/AIDS contributed towards the argument of the role of HIV/AIDS in relation to risk factors such as poverty,

migration and value change. However, empirical research also uncovered different instances when the vulnerability framework can be applied independent of the lifecourse, for example, when there are sudden changes in individuals' lives.

The methodology presented a number of key strengths but also three main weaknesses. Firstly, structured questionnaires can make suggestions for respondents and encourage them to choose an answer which may not fit their intended response and may not use the option to provide any other response besides those provided. Respondents can feel frustrated if their answer is not given as an option (Tashakkori and Teddlie, 1998). Secondly, one of the main limitations of ethnography is the possibility of interviewer bias. For instance, I made some observations which were contradictory to what some interviewees conveyed and I then had to make decisions on what information to consider. For example, respondent OP06 reported that their adult daughter lived with them but his wife reported that she lived and worked far. If an interviewer gave me contradictory responses, I had to refrain from doubting their responses. Interviewees could be less honest concerning sensitive matters, for example, if they thought the research was related to the provision of aid as some respondents pointed out in Section 7.6.4. There can be an element of 'reactivity' by interviewees, which may decrease after a while (Kemper, et al., 2003). For example, as the respondents got used to seeing me more in the area, and having me visiting them on more than one occasion, there seemed to be an element of trust and most respondents began providing more information and clarified some contradictions in earlier statements.

Thirdly, participant observation requires an 'intensive period of fieldwork' which makes it difficult to have many sites (Green and Browne, 2005:88). Because interviews, transcriptions and data analysis are time-consuming, in-depth interviews usually cover small numbers[30], limit sites which can be studied, as well as generalisability (Creswell, 2009; Green and Browne, 2005). However, it needs to be noted that the aim is not to have findings which are generalisable in a statistical sense, but to understand complex situations and to generate new concepts and theoretical insights. Whilst qualitative research cannot be representative in a strict sense, it can highlight key themes and processes which may be ''typical' of individuals with similar sets of socio-biographical characteristics in similar circumstances' (Bird and Prowse, 2009:6). That is why the results of this research are not meant to be representative of the whole of Zimbabwe or all rural areas, but small-scale subsistence and commercial farming areas.

[30] Many reported in journals are based on 30 or fewer interviews, therefore they cannot be a representative sample of the whole population.

Although ethnographic participation methods like participant and non-participant observation were used, they can be considered to have been used to a limited extent due to short periods of study. The ethnographic aspects of the study included living in the community with a local family, participating in aspects of daily life, speaking the vernacular, attending local events, for example, visiting sick people, attending funerals, passing condolences for deaths which occurred in between my visits, attending school and healthcare meetings. Due to the short fieldwork period, this does not amount to fully developed ethnography because the relative short stays limited my participation.

Kinship maps (see Section 7.2) were used as memory aids during interviews and both methodologically and analytically as a method of summarising information about support flows, network size and composition. Angel (2008:33) explains of kin mapping:

> *'To understand wealth transfers between generations, it is important to map the kin networks. This process will help yield a better understanding of the arrangements of individual families and define the elder individuals and his or her relatives.... analysts map kin networks, identify individuals who provide different levels of support and distinguish between what services are provided'.*

The method involves examination of other forms of support which cannot be quantified, such as emotional support.

Audio recording was used to aid memory when writing up notes (Kemper, et al., 2003). I also took detailed notes. Interviews were transcribed as soon as possible after the interviews. The advantage of the interviewer transcribing is that I could check my notes and recall the conversations. Carrying out empirical research involved thorough planning and preparation which is discussed next.

5.5 Logistics and Ethical Implications

5.5.1 Logistics

On each occasion I conducted my fieldwork, I received free accommodation from the Ward head. I lived in a three-generation household, made up of one of my interviewees, WaNya, her son the Ward head, his wife and their two young daughters. WaNya is the head of the household. We shared all household and eating arrangements. I contributed towards food and helped with chores as and when I could. My residence in the study site may have helped my fieldwork. By living in the ward head's household, I was 'accepted' as part of the

community and I had access to a lot of information most respondents would have not shared with a person who did not live among them. I cannot rule out the possibility of some respondents not behaving as naturally as possible in my presence.

5.5.2 Research and Ethical Approval

When planning field research, it is important to take ethical issues into consideration, including informed consent, privacy and avoiding harm and exploitation (Hammersley and Atkinson, 1995). This research took each one into consideration as explained below. My guide did not attend any of the interviews. He only introduced me to the prospective respondents then left me to carry out the interviews on my own.

Before embarking on fieldwork, I applied for and was granted ethics approval by the University of Southampton Ethics Review Committee (Appendix 3). I had letters from the University of Southampton's Centre for Research on Ageing, introducing me to authorities in Zimbabwe (Appendices 4 and 5). I applied for research permission (Appendix 6) which I was granted by the Director in the Ministry of Public Service, Labour and Social Welfare (Appendix 7). The clearance letter allowed me to approach individuals, government ministries, civic or private organisations I considered relevant to the research.

5.5.3 Informed Consent

The Project Information Sheet (Appendix 8, translated in Appendix 8a) which was the initial invitation to participate was read to older participants and those who wanted a copy of the Sheet were given one. This explained the purpose of the study, giving a brief description of the study design, the timescale and an indication of how the findings would be used. A number of respondents had problems with reading due to poor eye sight, however this did not affect the research as it had already been stated during ethics application that the translated Project Information Sheet and Informed Consent Forms would be read to all interviewees[31]. After that, the respondents were requested to give their consent to contribute to the study before the study began, through signing or putting a mark on the consent form as appropriate. All the respondents were able to write and sign their names.

Before embarking on the interview, participants were given the opportunity to ask questions about the research, what would be expected of them if they decided to take part and what would happen to the material they provided. Respondents were informed before the beginning of the interviews and also during the interviews that they could withdraw at any

[31] Copies were given to those who wanted to read one, then I read aloud while they went through their copies.

stage of the interview and no penalty would be incurred by withdrawing. It was explained to the participants that at any point they could ask questions, voice any concerns they may have about the research, or withdraw their participation by contacting me or my supervisors directly. All the respondents were able to maintain concentration, so interviews were finished in single sittings. Follow-up visits were possible because all the respondents had given consent to be re-visited if need be.

5.5.4 Confidentiality

All the respondents were assured orally and through the Informed Consent forms that the information they provided would be confidential. Informed Consent forms acknowledge that participants' rights will be protected during data collection (Creswell, 2009; Kemper, et al., 2003). The forms were printed on the University of Southampton letterheads and they were different for older respondents and other respondents, such as stakeholders and policy makers (Appendices 9 and 14 respectively). The ones for older people were translated into Shona, and a Zimbabwean academic, who is also an authority in social protection, checked the accuracy of the translations. Participants were assured that their names would not be used. Pseudonyms and coded identifiers were used so that their identities could be protected.

Steps were put in place to avoid potential tension resulting in the presence of younger adults during interviews with older persons. For those living with their adult descendants, I let their family members know of the research then I sought consent from the older persons. It was important for the family to know what the research was about, and to clear any doubts that it might be political as I had been informed during the scoping exercise that some residents had experienced politically-influenced violence, while some had been left out when aid was being given, due to their political affiliation. Older people were asked if they wanted their family to be present during the interviews and, as written in the Project Information Sheet and the Informed Consent Form (Appendix 9, translated in Appendix 9a) they were advised that their taking part or not in the research, would not have a bearing on their support receipt from any quarters. I also pointed to them the importance of having them talking in private. That way, older people would be assured of speaking freely without worrying about offending the younger adults or without their responses being influenced by the presence of the adult children. There were only two cases where it was necessary to read through the information sheet and getting consent from the family[32], then the younger family members left the older

[32] These were a male (100+) and respondent OP17 whose married co-resident son was the head of household and had the title deeds to the farm in his name.

person to take part in the interview on their own. The way I introduced the purpose of the interview may also have had a positive impact on younger adults not insisting on attending the interview, as I used more general terms to describe the research and did not mention care and support provision as the main issues to be explored. All respondents agreed to be interviewed on their own and no family member showed any objection to that.

5.5.5 Compensation

As a way of supporting my research, my family helped by providing ‘thank you' parcels to older people, which I had suggested I would not be able to provide, when I applied for ethics approval. While this has important ethical implications, I was advised that it was expected in the local culture to carry gifts, when visiting, to thank the hosts for receiving me in their homes (see last paragraph for this section). The contact person at the Ministry of Labour and Social Welfare also informed me that it was acceptable practice in the culture and would not be considered unethical. As a result, each respondent was given two kilograms of sugar and two boxes of matches valued at around US$2.50 per parcel, which served as a token of appreciation for their time and hospitality. Respondents were not told of the parcels before the interviews commenced, and these were offered to them when the interviews ended, in order not to influence the interview process and make them feel like they were taking part in order to get the compensation. During the final field trip, respondents were given two kilograms of sugar each. The giving of compensation might have influenced the willingness of respondents to take part. The possibility of some of the respondents having heard from others about the compensation before I approached them cannot be ruled out. This may also have had a positive effect on the respondents agreeing to be re-visited and giving me full attention.

I was given food parcels to take away by most respondents, which was mostly agricultural produce. My guide advised me not to refuse them as that would have been taken as an insult, and looking down on the person offering the parcels. On one hand, the receipt of food parcels put me in a difficult position as I felt it challenged my ability to remain neutral. On the other hand, my acceptance of food parcels may also have helped the respondents to feel a sense of reciprocity and balance of power as both parties had something to offer one another, thereby influencing the respondents’ willingness to be re-visited.

5.6 Data analysis

5.6.1 Quantitative Data

SPSS was used for quantitative data analysis. Part of the questionnaire contained some closed-ended questions to provide quantitative data such as demographics, household composition, socio-economic circumstances, health, care and support needs. These data were entered into SPSS and used for simple quantitative analysis (frequencies, cross-tabulation). Cross-tabulation was used to capture relationships in some data, for example, to have a summary of the age, gender and percentage of respondents in each age group. SPSS was also used to calculate cumulative frequencies, for example, to find the number of respondents who required support to perform ADLs at different challenge levels, health problems experienced, presented in Tables 7.1 - 7.7.

5.6.2 Qualitative Data

The purposes of qualitative data analysis are data reduction and for the drawing of conclusions or verification (Miles and Huberman, 1994; Creswell, 2006). This study used a general inductive approach for data analysis, which allowed the discovery of emerging themes of significance to the study results. The approach allows the researcher to condense raw textual data in summary, establishing clear links between the research aims and findings as well as develop an understanding of experiences expressed in the data (Thomas, 2006; Bryman, 2001). Data analysis is guided by the research questions, and findings are derived from raw data analysis 'not from a priori expectations or models' (Thomas, 2006:237). It allows research findings to emerge from 'frequent, dominant, or significant themes inherent in raw data' without preconceptions influenced by hypothesis or expectations about specific findings (Thomas, 2006:237). As there is usually a large amount of data, the researcher should decide on what is more important and less important in the data for it to be useful. This can be achieved by the researcher having a clear understanding of the themes and events occurring in the text (Bryman, 2012; Patton, 2002). I read and re-read detailed raw data to derive themes and concepts from the data.

NVivo was used to analyse the qualitative data. The software allows the researcher to discover patterns, during coding and decoding, get insights and develop meaningful conclusions from the data. In inductive analysis, categories used in vivo coding are often derived from the actual phrases or meanings in parts of the text (Creswell, 2006; Thomas, 2006; Patton, 2002). Thomas (2006:244) recommends that, 'It is good practice to include detailed descriptions and suitable quotations from the text to illustrate the meanings of the categories', which this thesis does in the two results chapters. Data from the first interviews was analysed according to themes, which were derived from the research questions and

literature and theoretical framework, then more themes were incorporated as they emerged from the interviews, for example transport, healthcare.

Case studies data was analysed through accommodating information on current circumstances and life histories. The case studies were indicative of the sample, showed the heterogeneity of the respondents and would be able to holistically represent it and show respondents' different vulnerabilities. The information gathered gave an idea of determinants of old-age vulnerability, security and possible coping resources when needed to overcome vulnerability.

The main disadvantage of the research design was having large amounts of raw data and risking being over-whelmed by the data (Bryman, 2012; Whyte, 1984). The vulnerability framework requires detailed information about respondents' circumstances and to gather this data, there is need for many questions to be asked to cover the various concepts concerned with the demographic, socio-economic, health, emotional, political, spiritual and physical profiles of older respondents. For this study, this resulted in a long questionnaire as well as lengthy case studies and the application of more than one fieldwork instrument, with three different categories of respondents and interviewing older respondents at least two times (Figure 5.1). While the large amounts of data presented a challenge in terms of going through the raw data, coding and deciding what is more and less important, the advantage of the large amounts of data collected is that it allowed the identification of the key findings which would probably have not been achieved with the use of one methodology. I used codes which were based on the theoretical framework and research questions, as well as themes which emerged from the data. I used memos as an aid to track my decision-making. Apart from time and financial challenges resulting from the five trips, rich data were produced on determinants of old-age vulnerability, threats faced by older people and available coping resources.

5.7 Reflection on Challenges and Unexpected Situations Encountered During Fieldwork

During the course of the empirical research, there were a number of challenges due to some unexpected events, resulting in necessary adjustments to the research design. These changes were necessitated by advice from key informants (KI02, KI03) familiar with the environment in which the research was being carried out, time constraints as well as unexpected circumstances on the part of the respondents. However, the last two methodological challenges did not result in or cause change to research design.

My original plan was to spend three months undertaking fieldwork in Zimbabwe and interview 20 to 30 older people in Dowa. I also intended to interview at least 10 stakeholders and policy makers at national and local levels as well as 3-4 key informants. Interviews with older people would be held in their homes, while interviews with stakeholders and policy makers would be held where it was considered private and safe for both the interviewer and interviewees, mainly in offices and during working hours. Instead, the fieldwork had to be spread over five, shorter visits due to personal circumstances. However, the repeat visits allowed me to gain a short longitudinal perspective on people's lives and in many ways strengthened the quality of data collected. In addition, the repeated visits allowed me to reach my target of interview numbers. Focus groups would also have been a suitable methodology for my thesis research. However, due to the time constraints of respondents who spend long hours working at rural farms, such groups were deemed less appropriate for this research.

There are a number of challenges related to researching in an environment with fundamental social, economic and political change. The first three field trips were made during a time of political and economic instability, bad road and communication network and rainy weather, amid lack of basics such as local currency, fuel and food. There was suspicion and reluctance to participate and a great distrust of anyone who was carrying out research, due to fear that the research might be political and they would get in trouble by the government, especially as the research was being carried out by a person based at a foreign institution. However, with the assurance of the clearance letter from the GoZ and my guide vouching for me, they agreed to be interviewed.

At times it was difficult to maintain non-interference as I was invited to take part in the day-to-day life of the community, thereby risking getting too close and emotionally involved. However, it could have jeopardised my access to respondents if I did not take part in activities like helping less able people with chores such as fetching water, cleaning, visiting sick people. Wherever possible, I tried to remain neutral and uninvolved.

5.8 Summary

This chapter discussed the research methods used in the thesis research, the research design and its appropriateness to enable answering the thesis research questions. Justification is given for the reasons for choice of the fieldwork site, including a description of site, characteristics of respondents and how respondents were identified and recruited, the instruments used and why they were chosen. The chapter also examined challenges faced during the empirical research and how they were overcome. The multifaceted nature of the

research required use of a mixed methodology, the combination of qualitative and quantitative methodology for data collection and analysis within the same study so that data produced could complement each other (Teddlie and Tashakkori, 2009; Teddlie and Yu, 2007). Ethics approval was sought and granted before fieldwork commenced. Appropriate steps were taken to ensure informed consent, confidentiality and privacy was maintained. Purposive sampling was used for the selection of respondents, through key informants. Fieldwork was carried out over five trips, between late 2008 and late 2011, with the first trip, in 2008 being a scoping exercise. Empirical research comprised use of face to face structured questionnaires, semi-structured questions and ethnography such as participant observation and case studies. Inductive analysis was used as an analytical strategy as it accommodates qualitative and quantitative research methods and allows further fieldwork if there is need. The thesis progresses to discuss the findings of the empirical research.

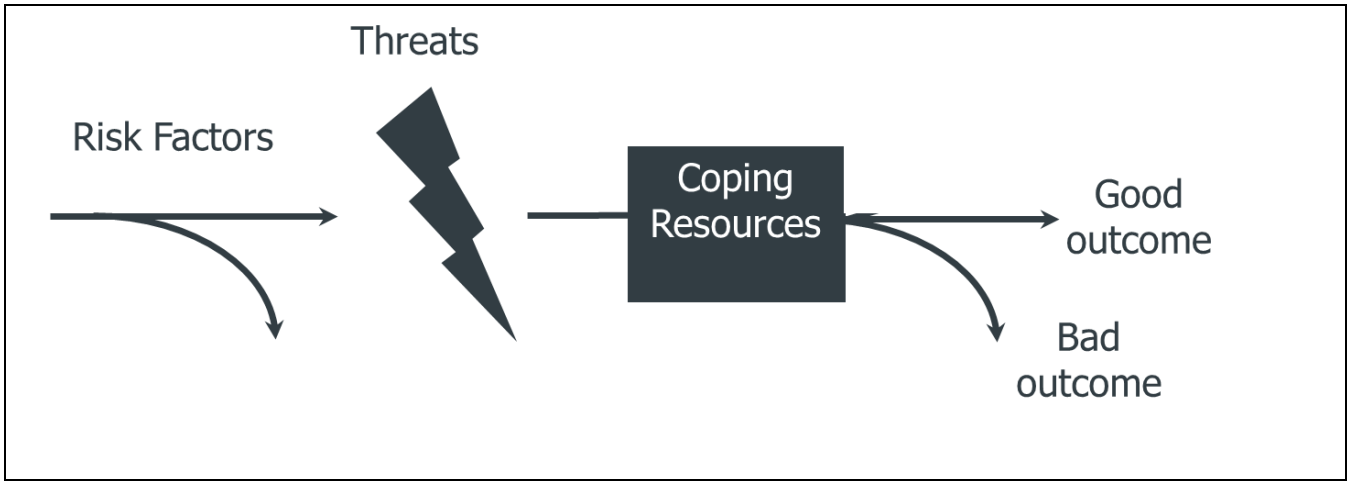
CHAPTER 6: Results: Threats Faced by older respondents

6.1 Introduction

This chapter outlines the findings of the empirical study, focussing on the threats faced by older people in the study site. As argued in Chapter 4.2.5, the concept of vulnerability involves exposure, threats and coping resources, which can determine either a good or bad outcome. The timing of threats is important as the ability to recover depends on a person's stage in life and recovery is harder as people age. People's vulnerability results from their life histories, as 'past outcomes' determine 'present exposure and coping ability' and can often influence the coping resources and outcomes (Schröder-Butterfill and Marianti, 2006a:13). The life course approach will be used to explain respondents' social, economic and political context within which their lives have been lived, as they have an influence on their current circumstances, for example, having been in formal or informal employment, childlessness, droughts or widowhood. A detailed understanding of different exposure factors and threats is important, because some of them are cross-generational as they also affect younger generations and therefore have an impact on the availability of coping resources. As stated in Chapter 1, the thesis addresses the following three research questions:

1. What are the main determinants of an older person's vulnerability in rural Zimbabwe?
2. What are the key threats which older people face and how do they affect their well-being?
3. What coping resources are available to older people in rural Zimbabwe?

Figure 6.1: A framework for understanding vulnerability



Source: Schröder-Butterfill and Marianti (2006)

This chapter, which is the first of the two results chapters, answers questions 1 and 2. The study findings examine two of the four domains of vulnerability, that is, exposure and threats, as observed during empirical research. The empirical evidence also helps to identify and better understand the determinants of old-age vulnerability among older people in rural Zimbabwe.

6.2 Main threats faced by older respondents

The respondents faced different threats, which are explored in the next few sub-sections. Respondent SPM09 described the threats faced by older people as, '*multi–faceted, socio, political, economic, macro and micro, beyond the family's ability to cope'*, attributing it mainly to the poor socio-economic situation in Zimbabwe due to the recent economic, political and epidemiological crisis from which recovery has not been fully made.

6.2.1 Changes in family and kinship support and exchanges

It is important to begin by first presenting the findings on how older people were cared for in the past because this will shed light on how family care and support provision has changed and what, if any gaps have been created by the changes. Some older people view their current circumstances with nostalgia, in contrast to the past and this determines their self-assessment (Kaseke, 2003). The empirical research sought to establish what the ideal situation constituted, in terms of care and support provision, in order to be able to compare and contrast with the present day circumstances in the study site, taking note of what older people consider as a loss of what they could have been receiving, if it was not for the changes in care and support provision by the family. In doing so I draw on findings from fieldwork interviews.

Reference points for a satisfactory old age included being supported by the children, receiving regular visits, maintaining autonomy and being consulted for decision-making, living independently, and co-residing and being cared for when the need arose. This is based on a time frame of the late 1960s to the late 1980s, when most of the older respondents were already adults and their parents or grandparents were elderly, how their parents and grandparents were cared for and the frequency and purposes of the visits.

For those older parents not living with their children, but the children lived nearby, the children would visit their parents everyday, to check on the welfare of their parents and the grandchildren they would be living with (respondent SPM01). Those who lived and worked in towns would visit monthly and weekly depending on how frequently they were paid as well

as distance from home. These visits were always accompanied by food parcels (KI02). Respondent OP01 (WaNyati, male, 75) reported that during that time it was easy to get jobs in town and people would at times leave formal jobs to go and attend to family problems, then go back and find formal employment with ease.

In the past, family sizes were big and parents gave the argument of 'spreading the risk' (KI01) to be sure there would be a sufficient number of surviving children available to look after the parents in old age, in the event of child mortality (Kaseke, 1998). While family sizes are now declining, current cohorts of elders have large families, as evidenced by the fact that 20 of the older respondents in the study site have between seven and 20 children, which is common in their generation.

The extended family played an important active role in the care of older relatives. In the Shona vocabulary there is no term 'cousin', they are referred to as either brothers or sisters (KI01, SPM01) and often there was no distinction between one's own children and nieces and nephews. The terms used for aunts and uncles help explain these relationships, for example, father's brothers and his male cousins are callled either *babamukuru* or *babamunini* (senior or junior father) and their wives are either *maiguru* or *mainini* (senior or junior mother).

Older people in the past rarely lived on their own and an older person was never expected to run short of care providers, as reported by all four key informants, all twelve policy makers and stakeholders. Ideally, most older women would prefer to be cared for by their female relatives, especially siblings or daughters. However, it was not always possible for the female care providers to leave their own homes to go and live with the older ill relative, thus if an older woman was in need of personal care and all her daughters were married, she would leave the family home and move in with a daughter (KI02). It was common for grandmothers to go and live with their married granddaughters in the granddaughters' homes while older men rarely moved away from the family home (KI01, KI03). For example, respondent OP19's (WaSoko, female, 70) grandmother moved from her home about 300km away, to live and be cared for by the respondent.

Children lived with their parents until they married, and even after marriage, older sons would set up homes within the same homestead while the youngest son and his wife and family would continue living with his parents. Thus, there would always be a younger person in the household (KI01, SPM11). However, it remained the duty of the oldest son to oversee the parents' welfare and to ensure the parents were well provided (KI01, KI03). When an older person became incontinent and needed regular care which usually got more intense as their state deteriorated, the care arrangements in place would be revised (KI01, KI02). It was

reported that no older person in the study site has ever been placed in an institution. If adult children were not available, uncles, aunts and other relatives would intervene to care for their relative. However, as explained in Section 5.3.1, and as respondent SPM01 reported about the participants current experiences, '*The people in Dowa are different from many rural area settings in that they came from faraway places. Their places of origin and relatives are very far away. When they moved to Dowa, they found themselves among strangers and they had to start forming social networks'*. As a result, most of them have less extended family than those families which did not move from their places of origin. Still, they could afford to take turns to visit the extended family and the extended families would visit and often stay longer to help care for sick relatives.

People without children were considered a responsibility of the whole extended family (KI01, KI03, SPM01, SPM11). The whole family would sit down and deliberate the support and care-related detail such as moving them in with a relative and share tasks, as reported by all four key informants and all twelve stakeholders and policy makers. Respondent SPM01 gave an example of how his mother's brother, who never married and never had a child, was cared for in his old age. Mentally infirm people were also provided for by the community. For example, respondent OP13's mentally ill older brother often moved around in the study site and was provided with food in different households. Most older respondents argued that the care and support they are receiving now is less than what their parents and grandparents received, citing insufficient economic resources on the part of their children.

Some of the changes in kinship support and exchanges have been happening gradually. Most families no longer live in close proximity as they used to, often younger families move away due to work commitments. Unlike in the past, when marriages used to be within the same neighbourhood or among familiar families, these days individuals marry others all over the country, resulting in daughters moving far away after marriage (SPM01). They would therefore be too far away to provide day-to-day care and support when their parents require it in old age. Respondents SPM01 and KI04 reported that one common practice to ensure older people did not live on their own was to send grandchildren to stay with their maternal grandparents. Respondent SPM01 added, *'That way, the daughters would always have a good reason to send parcels to their parents, as well as visit them often, on the pretext of visiting their children'.* However, this practice has become rare as parents prefer to live with their children so that they can help with their schoolwork and, simply to raise all their children in one household. This is reported to have led to reduction of support and visits to parents, especially in instances where difficult choices have to be made regarding distribution of scarce resources. Nationally, this has resulted in increasing number of black Zimbabweans ending up in OPHs. However, it has also raised inadequacies within some of the OPHs, for

example, an institution housing 54 residents had only one social worker responsible for all the residents (respondent SPM04.

6.2.2 Exposure to natural weather conditions and absence of farming insurance as a threat to livelihood

Rural living on its own is a risk factor as it exposes respondents to certain threats. Exposure to natural weather conditions is cross-generational and it can also reduce many younger people's capacity to support their older parents. During the course of the empirical study, one important finding which can have a major impact on livelihoods and older people's well-being was uncovered: despite the risk of losing crops and livestock to threats such as animal and crop disease, drought, flood, hail, too early or too late rain (see Sections 2.3 and 3.2), none of the interviewees had insurance for their crops or animals. Drought is the most common risk factor in the study site and the effects are felt more due to rain-fed agriculture. Having farm insurance would reduce or stop the threat of loss of crops or domestic animals progressing into a bad outcome. Nationwide, the concept of farming insurance has not been emphasised and has not been incorporated into policy for black farmers, although it was common among white farmers (Respondent SPM12). This shows how vulnerable the farmers are to different natural conditions, which also impacts on their livelihoods, quality of life and eventually to old-age support and care.

6.2.3 Transport shortage as exposure and threat

The fieldwork site is far from the markets and transportation lines. Transport problems affect livelihoods, relationships and healthcare. More effects of transport shortage are further discussed in Section 6.2.5, where healthcare access is examined. Respondent PSM12 summed up the importance of transport, '*The farming business needs transport right from land preparation, planting, tending to the crops, up to the harvest and sale of produce'*. The nearest fuel station is 60km away. The roads are in a poor state and they got worse in the past decade, which makes it hard and sometimes impossible for the farmers to transport farm inputs and implements as well as produce for sale, resulting in fresh produce often going bad and having to be thrown away, thereby affecting livelihoods and security.

When transport is obtained, usually exorbitant amounts are charged to make up for the wear and tear of vehicles. High and unanticipated transport costs can lead to the depletion of medium to long-term resources as the high charges result in low returns for farmers. For example, respondent SPM12 reported that while transport costs farmers in the study site about a quarter of their expected returns, those at the edge of Dowa, where roads are better,

pay about a tenth of their expected returns. When deductions for input and labour costs are factored in, some of the respondents do not have enough capital left to buy inputs for the next farming season as well as meeting their day-to-day financial needs. These estimates are based on an exercise which was being carried out by the local leadership to assess the impact of the poor transport network on farmers, with the aim of presenting the results to their local Member of Parliament, to use to lobby for improved roads (SPM11).

Lack of transport is a major threat faced by everyone in the study site, to varying degrees. Due to the poor state of the roads, public transport providers have withdrawn their services resulting in no buses running within Dowa or between Dowa and urban areas. Residents rely on private vehicles which they can board after walking distances of between fifteen and twenty kilometres one way, (I was able to ascertain these distances) to the nearest point where they can access transport with no timetable, but dependent on the availability of passengers. While some younger people can walk these distances, older people may have difficulty walking these distances due to reduced vitality. The only option is to rely on visitors from town mostly during weekends, which may mean having to wait for more than a week before being able to travel. This is because, if there are no visitors during the weekend or the vehicles are full, they would have to keep waiting until the next time there is an available vehicle.

Consequently, older people find it difficult and often impossible to travel to visit their other family members. Family relationships are important to all respondents and failure to visit relatives affects their emotional well-being. Even those with pensions cannot access the money when they need it, because it is difficult to access banking services which are not in close proximity (WaNyati; OP05 (WaBay, male, 78)). This effectively makes them vulnerable to lack of economic resources. Transport availability also affects the health of some respondents, as respondent WaNyati reported that the constant worry of whether he will access transport to get medical attention if he gets ill, might be contributing to his already poor health.

6.2.4 Ill health as an exposure factor and a threat

As argued by Lloyd-Sherlock (2010) and WHO (2002) the state of being old exposes people to the risks of ill health. Ill health can have knock-on effects, leading to more threats such as difficulty accessing healthcare, loneliness, inability to perform ADLs, or inadequate economic resources due to reduced earning capacity (Lloyd-Sherlock, 2010; Williams, 2003). Ill health is multi-faceted as it is associated with factors impeding access to healthcare, the state of

being ill and the management of health. Ill heath can also be a threat in itself. This thesis therefore considers ill health as both an exposure factor and a threat.

All respondents reported health problems (being in pain, limiting everyday activities) and of these, twelve had chronic health problems such as back ache and painful legs. Some of them had been exposed to these health problems for many years, some for more than ten years. Four respondents rated their health as 'good', 18 as 'fair', four as 'bad' and one as 'very bad'. The three most common health problems are: poor eye sight, back ache and painful legs and at times swollen feet. Nine of the respondents were experiencing poor eye sight, which affected their day-to-day life as running a farm involves substantial paperwork and reading user instructions on inputs. Poor eye sight could have been made worse by years of working in dusty conditions on an almost daily basis. Except for case study WaLeo (OP21, male, 91) six respondents could not afford to have their eyes tested and the two who did, could not afford the recommended treatment.

Back ache is common due to a lot of lifting and bending involved in farm work when weeding. Most respondents attributed painful legs to the use of legs for pushing soil to cover seeds when planting and spending long hours standing while doing farm work. Other health problems are hypertension, diabetes, headaches, heart disease, deteriorating mobility, painful teeth, and no teeth due to unaffordability of dentures. The following exemplar extracts show the varied health problems faced by older people. Brief descriptions of the respondents are presented to give a clearer picture of the particular older people, information which is helpful in showing how the threat of health impacts on their well-being:

WaRuma (respondent OP20, female, 86) reported, *'My health is bad. I have kidney problems and nausea at times and I have been told it is due to the kidney. I have hypertension, one eye doesn't see, the other one is poor, I have bad legs and painful joints, a bad back and it is difficult for me to stand'.* If she was to need urgent healthcare, the family would have to borrow an oxcart to take her to the health centre. So many health problems expose her to reduced ability to work for her livelihood, which has led to further reduced earning capacity. As a result, her household which includes eight grandchildren and her nephew does not produce any excess farm produce to sell, hence no cash in the household.

WaLeo has a number of health problems, '*I have poor eye sight and I can hardly see well, a bad hand so I can't lift my hand above the shoulder, I have arthritis'* but still rates his health as 'good', explaining that those health problems can be expected at his age.

WaSoko explained, *'My health is bad. I have headaches, poor eye sight as only one eye sees, painful legs at the top of the feet and painful shoulders'*. Despite all these health

problems, she does farm work as well as all day-to-day household chores involved in running a household with eleven members.

WaNya (OP02, female, 73) highlights her health problems reporting, *'I have diabetes, high blood pressure and sore, swollen legs'.* Although she can hardly walk a few metres and has the problem of fluctuating blood pressure, a situation which requires immediate medical attention to stabilise, she is not guaranteed immediate healthcare if the need was to arise. However, due to transport problems, she has to wait to be collected by her children and taken to Harare (about 140km one way) for healthcare when she falls ill.

'*I have high BP, asthma and bad knees* (WaSiyai, OP17, female, 62), yet as explained on page 126) she has to wait for her son to be phoned so he can collect her and take her to Harare for healthcare, to be assured of appropriate healthcare for her specific health problems. Like all the other respondents, she cannot have access to healthcare as soon as it is needed.

Respondent OP27 (WaBo, male, 60) reported, *'I have diabetes which is controlled by daily insulin injection'*. He made the difficult decision to inject himself with the insulin once a day instead of twice, as recommended by doctors because he could not afford twice. He made this risky decision because he had to buy his own medication and the testing kit for sugar levels.

WaBay, who rates his health as 'fair' reported, *'I am an invalid, I have many health problems which include walking difficulty and I feel like I have no legs anymore, therefore transport is even more important. I have diet-controlled diabetes. My children are the ones in trouble because they provide me with medication. My hearing is also bad'.* On further asking him which of his children he was referring to, he reported that it is only his son who buys the medication, and as a teacher on a low wage, this drains his resources. As a result, he had no hope of having anything done about his deteriorating hearing.

While only three of the respondents are at immediate high risk of deteriorating mobility due to already having poor mobility due to swollen legs, the threat faced by all respondents is the unavailability of effective mobility and transfer aids if they were to experience mobility problems. Apart from walking sticks which are affordable (by cutting thick wooden sticks from the bush), mobility aids such as hoists, walking frames, trolleys and wheelchairs are out of financial reach of many. Even if they were available, it would not be practical to use a wheelchair due to the unsurfaced, uneven ground in rural areas. Hoists are out of the question due to unaffordability, the need for frequent servicing and non-availability of electricity.

6.2.5 Healthcare Access

These varied health problems are being experienced in the face of two threats to access to healthcare services, these being unavailability of transport and being unable to afford user fees. I have classified the level of vulnerability of those respondents who face one of the two threats as 'low' and the vulnerability level of those who face both threats, as 'high', for example, respondent WaCelia (OP03, Female, 60) who reported, '*No, I cannot afford to pay. To go to the clinic, we have to be holding the money, otherwise there is no need to go there'.* She further reported that she would have to walk to the nearest healthcare centre, yet she could hardly walk. Access to healthcare is also determined by the availability of transport to get to the healthcare centre. All respondents are exposed to transport problems, affecting their access to healthcare.

Of the 27 respondents, only one lives less than one kilometre from the nearest health centre, two live between one and five kilometres, eight live between five and ten kilometres away, and the remaining sixteen live more than ten kilometres away[33]. As Appendix 20 shows, apart from the five who are taken to Harare by their children, sixteen have to walk to the nearest healthcare facility, while the remaining six use carts, three of which were borrowed. The sixteen respondents who walk to the healthcare centre reported that if they are very ill they do not go. WaBay cannot get to the healthcare centre unless he borrows cattle to be used for pulling the cart, '*I cannot go to the health centre anymore, because we do not have enough cattle to make a span to pull the cart. I used to go by cart'*. Respondent OP11 (WaMeck, male, 86) would have to borrow a cart, '*I used to walk. I can't go to the health centre because of transport problems, unless I borrow a cart'*. The problem with borrowing cattle or carts is that the owners may need to use them at the same time, therefore, unless it is urgent, those borrowing would have to wait. The threat of difficulty accessing healthcare was also mentioned by all stakeholders and policy makers, with respondent SPM01 asserting, '*A lot of older persons are not able to receive health care when they need it because health centres are too far for them to walk, especially in rural areas. There is lack of transport which makes it harder for them to travel long distances'.*

Shortage of doctors in rural healthcare centres, including the study site, poses the problem of exposure to lack of appropriate healthcare (UN, 2009; Lloyd-Sherlock, 2000; Heslop and Gorman, 2002*).* Due to shortage of doctors, most of the respondents are only attended to by nurses, whom some respondents were concerned might not have the adequate knowledge to diagnose and treat their specific health problems. WaSiyai reported about the local

[33] These distances are return journeys.

healthcare centre, '*They cannot cater for my health needs. I have to go to see specialists in Harare. I also obtain my medication from there. My son buys it for me. He picks me up from here and brings me back'*. The nearest health centre is run by nurses without any visits from doctors. The hospital which is between eight and twenty kilometres return journey from the older respondents homes, is also run by nurses and receives monthly visits from doctors.

Respondent SPM06 who is a trained and practising nurse described healthcare services provided to most older people as, *'Bad, very, very, very poor, if there was another word to describe worse than poor, I would use it. This is made worse by the attitude of some staff towards old people, for example, when an old person goes to a health centre and their medical condition is recorded to be 'old age', then no further investigations are done'.* This shows that some older people do not receive quality healthcare either due to lack of knowledge by staff or negative attitude towards older people. The findings in this section are similar to those by Allain et.al (1997) and UN (2009) who note that older people in rural areas have problems accessing healthcare services. Healthcare access has an impact on the ability to perform activities of daily living (ADLs), which can have a knock-on effect on older people's well-being, vulnerability and security.

6.2.6 Inability and difficulty in performing Activities of Daily Living (ADL)

Ability to perform ADLs (discussed in literature and methods chapters) is a commonly used measure of health in old age. Good health is an important asset in everyday life, especially for those who rely on farming for a living. Table 6.1 shows the respondents' ability to perform different ADLs. This difference in ability to perform these activities determines their levels of independence, need for care and support and levels of vulnerability, in the event of inadequate safety nets. This further helps illustrate my argument in considering ill health as both an exposure factor and a threat because it involves both the state of being ill as well as the likelihood of deteriorating health. As long as they can still walk, most older people have to keep on working to generate more resources. This is because their needs are the same (if not greater) as when they were still younger.

Table 6.1: Respondents' Ability to Perform Basic and Instrumental ADLs

Activity	Yes	No	Total (N)
Basic Activities of Daily Living (BADLs): Bathing, Dressing, Toilet use, Feeding, Grooming	24	3 (only with help)	27
Instrumental Activities of Daily Living (IADLs): Cooking, Making fire, Walking, Housework	18	9=(6+3, above)	27
Activities of Rural Daily Living (ARDLs): Planting, Weeding, Harvesting, Collecting water, Collecting firewood	10	17=(8+9, above)[34]	27

Source: Fieldwork questionnaire (2009-2011)

None of the respondents was unable to do BADLs, as they could all still see and were all mobile, although three respondents need help with some of the BADLs. The number for those unable to do some IADLs rose to nine, made up of six plus the three who had difficulty with some BADLs. Seventeen respondents have difficulty with most ARDLs, a term I coined, to include main productive activities in the study site (Table 6.1). This inability to do ARDLs impacts on their livelihoods because they are mostly farming-related activities. Only ten respondents can undertake all the different ADLs. Currently there are low levels of care needs in the study population, a situation which is likely to change as people grow older, as they are aged between 55 and 100+, so needing care with ADLs is a core threat which respondents face in the future, as some respondents' health had deteriorated between my first and last interviews. However, there are already high levels of support needs with ARDLs, showing exposure to the need for support and care as time progresses. The three older people not able to live independently as they require support with BADLs have urgent support needs and would need care if they became unable to perform these activities even with support. Economic resources are examined next because they emerged as being core in accessing a range of coping resources.

6.2.7 Insufficient economic resources due to the socio-economic and political environment

For the purposes of this thesis, adequate economic resources are defined as having enough food and money to purchase basic goods and services to last a month. An estimation of the cost of basics totalled around US$40 per month for a family of six. As the study site is a rural area, the thesis also considers the indicators of wealth in rural Zimbabwe, to capture the

[34] The figures became accumulative as the ability to perform ADL decreased as the ADLs got complex.

nature of economic resources owned, discussed in Section 2.5 (Alkire, et al, 2011; ZIMSTAT, 2013; Chiripanhura, 2010; Horrell and Krishnan, 2007). Respondents were grouped into 'Low vulnerability' to show inadequate economic resources due to inadequate income or assets, and 'High vulnerability' to denote both insufficient economic resources and assets, which included three who had no access to cash. These were people who were not producing enough to have excess to sell and also not receiving support with money. This indicator was derived from self-reporting and observation. Only two out of the twenty-seven respondents reported that they had adequate economic resources which was attributed to hyper-inflation, rather than longer term poverty, as argued by many respondents, with SPM09 stating, '*If the economy was doing well, they* [older people] *would have still been able to save enough for their needs as they used to. Savings have been eroded by inflation'* adding that the country went through a phase of economic instability, from which recovery has not been fully made.

The respondents had varying socio-economic characteristics. Case study respondents' economic circumstances are shown in Appendix 22. Because they live on farms, all the respondents had farm produce as their main source of income and farms are their most important possessions. Twelve respondents had title deeds to the farm in their names and fifteen[35] did not. It is important to note that ownership of land is not enough to reduce vulnerability. Equally important is having enough draught power, inputs, implements and manpower to utilise the land. As will be explained in the next chapter, land ownership in the study site also has its disadvantages. Case studies show different events in respondents' lives, which can help paint a picture of their vulnerability and security. Of the four case studies who were classified as highly vulnerable, WaRuma became poor because she lost six children to AIDS-related illnesses, among them one whom she reported that 'used to provide me with everything'; WaMani (OP23, male, 60) lost a high paying job after defrauding the company he worked for; WaReru (OP14, male, 81) reported that his farm production had gone down due to his reduced farming capacity, his personal hygiene and living space cleanliness deteriorated after his wife's death in 2007 and his daughter-in-law in 2007 and his children were finding it hard to support him financially and; for WaMuz (OP12, female, 84), farm produce had slowed down after her brother's death and her deteriorating health. These varied cases illustrate that different events and episodes can lead to vulnerability and can be rapid or cumulative. These results have an implication in terms of our understanding of old-age vulnerability. They inform us that situations can quickly unravel and deterioration can be rapid, so one cannot assume they will remain secure based on their

[35] Includes three with farms in their husbands' names

current circumstances. It is therefore necessary, as much as possible, to have contingency measures or coping resources in place, even before any threats manifest themselves.

Judging by the possessions they had in the past, and most of them affording to send their children to boarding secondary school, the majority of the older respondents can be considered to have been comfortable during their prime, and their circumstances were mainly affected by the political and economic situation in the past decade. The respondents were not peasant farmers. There were no long-term poor (those who were poor for five or more years) among them (Hulme and Shepherd, 2003; Prowse, 2003; Hulme et al., 2001). Most of them were well-off earlier in life and some of them were comfortable, except WaMuz's life trajectory which started going downhill in the early 1950s, but she was still comfortable until around 2000. Of all the respondents, only six never owned tractors, which are essential for farm work, yet out of the twenty-one who did, only two presently have tractors in working condition because they at one time owned more than one tractor, so they used spare parts from the non-functioning tractors. The respondents explained that failure to have the vehicles and farming equipment repaired was due to the poor state of the economy. They had not yet recovered from the effects of hyper-inflation. This concurs with respondent SPM01 who argued that poverty and inadequate resources were 'highly tied to hyper-inflation'. Of the five who once owned cars, only one is still in good condition and roadworthy. However, the owner still faces transport problems because he is unable to drive due to bad eye sight, and he has no one to drive him.

The political environment, as argued in the country profile chapter, contributed towards the deterioration of the farmers' economic well-being. Many younger adults were unable to support their parents, which effectively impacted on inter-generational relations, with the knock-on effect of some older people's financial circumstances further deteriorating. Respondent WaCelia argued that inadequate resources can affect older people's relationships with younger generations, *'Self-sustenance would reduce dependency and lessen worries. If we had enough resources, we would not need to rely on children, therefore we would not blame them for being unable to help us'.* Respondent SPM09 reported, *'Many older people in the community hardly have anything*. *Most people are struggling, very few people are coping*'. In late 2009, respondent SPM08 described the situation in Zimbabwe as an 'unmerciful society' where older people were left out. The numbers of people in need far exceeded the few economic resources available. He added that due to the recent political and economic unrest, although older adults were acknowledged as a disadvantaged and vulnerable group, under the circumstances it had become very difficult to separate them from the rest of the population, as the country was in a situation where almost everyone was vulnerable. To cope better, different generations in many families moved in together so as to

pool resources together. Respondent SPM10 reported that, *'There is widespread poverty and lack of basics, among older people, just like in the whole population. Most of them can hardly afford one meal a day, resulting in malnutrition'.* It had become the norm to have one meal a day (something I witnessed and had to make do with). In many families, in 2008, if there was too little food, the youngest children in the family were given more food, while the older ones had plain porridge as a day's main meal. In rural areas, there was more reliance on wild fruits and edible roots (observation during scoping exercise and also made by Mutasa (2011)). Four respondents reported of two families who almost died because they ate poisonous plants, not meant for human consumption.

It had become impossible for farmers to access credit due to a law passed by the government in 2005 which nationalised all the land, limiting use of title deeds which used to be presented as collateral for inputs and implements (Department of Physical Planning (DPP), 2006). Respondent SPM11 reported, [There is] *'Lack of access to credit due to a recent government act which nationalised all the land, making title deeds valueless, yet they used to be used as collateral for inputs and implements'.* Although these were part of political measures meant to stop white farmers from selling their farms and leave empty-handed in the event of leaving their farms, they were applied to all farms (respondent SPM12). By 2011, these measures had been relaxed and farmers could use the title deeds as collateral.

The following quotes help paint a picture of the economic situation in the study site. When asked to summarise older people's situation, SPM05 reported, *'Lack of support, financial problems, health problems, poverty, not enough resources, for example, a person in rural areas with no livestock, especially cattle for draught power, is very poor and really struggles to have enough food. Some of them lost their savings due to inflation'.* Respondent SPM04 reported that, '*Problems of older people, especially Zimbabweans, are multi-faceted and the list is endless. They face the problem of reduction of earning capacity, even for those who had pensions, since they were totally destroyed'.* Participants on pensions reported that due to hyper-inflation, there was a time when transport to go to town to collect pensions cost more than the amounts to be collected, making it pointless to make the journeys. Respondent SPM02 reported, '*NSSA* [the pensions authority] *is just a structure but is not sufficient. There is need for the economy to support the pension system, but there is the problem of young people being out of work. Zimbabwe is a unique situation'*. She is one of the many respondents who drew attention to the minimal availability of pensions and the high unemployment rate. This explains how the recent political and economic environment contributed to these threats, resulting in support shortfalls for older people. As one respondent WaCha (respondent OP18, female, 55) put it, *'The younger generations are also*

finding it difficult to support their relatives, ...many of them are also struggling to fend for themselves and their families, let alone their parents and aged relatives'. This highlights that it was not only the older people facing these economic challenges, but younger people as well, which impacted on the support they would be able to provide their older family members.

I was shown many bags of 'money' in the form of valueless ZW$ bills in many households, described by respondent KI04 as, '*It is no longer money, they are just papers, useless rubbish which we do not know what to do with'*. This was the general statement in most households which once had cash. This was proof to help to explain the financial loss they suffered as a result of hyper-inflation. Those in rural areas are observed to have ended up with more of the valueless cash than those in urban areas, because they tend to keep cash in the houses as they cannot travel to town frequent enough to withdraw or spend money as and when needed. These findings chime with Bird and Prowse (2009) who argue that in Zimbabwe, while some threats such as inflation were faced country-wide, many others differ between rural and urban areas, thereby creating different vulnerability patterns requiring different coping strategies.

Of the five older respondents who rated themselves as coping better (in comparison to the whole sample of 27), two do not actually feel financially secure. For example, WaKwen (respondent OP26, male, 76) has a contributory pension, support from his children, a very neat and well-kept home and tap and piped water in residence, yet he still could not afford dentures, which were a priority for him. WaNya reported that she does not feel financially secure. There were some success stories, including two respondents who were looking after younger generations and other older persons and still managing without strain on their resources. WaCha and WaLeo were completely satisfied socio-economically, with respondent WaCha revealing, '*I have enough of everything at the end of every month. I have home-made bread. I grow relish in the garden. I have many chickens for meat. I am very satisfied'*. WaLeo reported, '*I am satisfied with my life and economic circumstances'.* Part of his wealth included forty cattle, a car in good working condition, two working tractors, 3 oxcarts, 2 wheelbarrows and 2 ploughs.

6.2.8 Poor or inadequate diets and unsafe drinking water

A number of respondents faced vulnerabilities of not having enough food, lack of variety, food storage problems and problems with teeth, affecting their eating and effectively their health. WaMeck reported that, '*We do not have enough food. It is especially important that at our age we have a balanced diet, or else we will not survive. If there is enough food, there*

will be less worry'. Some participants were not eating a balanced diet as they could not afford bread, sugar, oil, milk or meat on a daily basis. The diets consisted mainly of tea and porridge and maize meal with fresh or dried green vegetables, whose nutritional value is mostly carbohydrates and vitamins. There is no electricity or gas so a lot of food goes to waste due to non-refrigeration. Not all food can be dried and some of the foods which can be dried lose their nutritional value in the process. Eight respondents' diets were also affected because they had problems with their teeth. WaKwen, reported that, '*Some teeth have fallen out, making it difficult to chew food and I cannot afford artificial teeth'*. Inability to afford dentures has a negative effect on diet and general health as it limits what a person can eat, in an environment where easy-to-eat food might not be available and there are no facilities for pureeing food or liquidising fruit. Madzingira (2006) argues that the co-relation between lack of preventative oral healthcare, poor dental health and loss of teeth results in malnutrition. This concurs with Ramji (1990) who asserts that poor diets reduce quality of life.

Closely linked to diet are the sources of drinking water as this determines older people's ability to fetch water to wash the dishes and cook (Williams, 2003). The respondents had varying sources of drinking water. One had a tap in residence, one had a borehole with pump, eighteen used protected wells and seven got their water from an unprotected well/spring which had the risk of water-borne diseases. Of these seven, respondent OP18 argued that although she could afford a protected borehole, she preferred the spring because the water was always cold, clean and in a secluded place.

6.2.9 HIV/AIDS within the family

A number of the respondents have been affected by HIV/AIDS. Of the 26 respondents who have children, 20 lost a total of 52 children between them. Only six of the 16 respondents who lost children to HIV-related illnesses, admitted to having lost children to AIDS. This which was probably due to the fear of stigma attached to HIV/AIDS. WaBay reported of his late son, *'It should be this disease. They say he had this problem associated with promiscuity',* while his wife MaiBay (OP06, female, 72) reported*, 'He had this disease which is there these days. AIDS, that's how we saw it'.* The conclusion that the remaining ten died of AIDS was reached based on the signs and symptoms of the illnesses reported to me, which are referred to as AIDS-related cases (ARCs) in Zimbabwe, such as swollen and aching limbs, headache, diarrhoea, mouth ulcers and skin rash. I also obtained more information from my guide and respondent KI04.

Five respondents reported that these children who died were their main sources of financial support, leading not only to emotional but also financial vulnerability. WaRuma lost seven out of eight children. Apart from one son who was shot during the war, the other six died of HIV/AIDS-related illnesses. She reported, '*Some people said it was AIDS but I believe what the doctors said, that it was immuno something*'. Her only surviving daughter Peggy's husband died of AIDS and Peggy is visibly ill, something which her mother also mentioned. She reported of her circumstances, '*One of my sons used to provide me with everything I needed, but now there is nothing. I am dissatisfied, life is tough'*. WaCelia reported of her late son, '*I think he died of AIDS. Mentally I have lost it. I am drained and strained due to constant worry. I have no will power to pray…. neighbours are saying painful issues. I have been accused of witchcraft.* [There are] *No more remittances and I have psychological trauma'*. This is similar to findings by the WHO (2002) who reported witchcraft accusation and stigmatisation among the social and emotional impacts of HIV/AIDS on older people.

Nine of the older respondents are looking after AIDS orphans. This directly impacts on their health and well-being, because with limited resources, they often prioritise providing for the orphans, over their own needs. WaSoko reported that, '*I spend sleepless nights worrying about my two orphan grandchildren whose welfare we took over since the death of my daughter-in-law. Our son, their father is not helping us at all'.* Her other daughter-in-law reported that she often prioritises the grandchildren's welfare over hers and her husband's.

Four respondents used their resources caring for their ill children, even those who did not send remittances when they were still in good health, covering funeral costs and looking after orphans left behind. The extreme example was that of respondent WaMeck. Since 2004 he had lost three daughters to AIDS '*through promiscuity'*, a son, a son-in-law and grandchildren (he could not remember the exact numbers because there had been '*so many deaths'*). His children came home to be cared for during their dying days, although they did not support him when they were still in good health. His wife provided physical care for her step-children and the couple used their own resources to care for the sick returnees. The respondent ended up with no cattle left, having slaughtered them for meat during funerals. WaDorosa (respondent OP08, female, 73) who lost a daughter and granddaughter reported, *'It was this disease which came recently. No orphan was left because both mother and daughter died'*. Four older respondents were looking after AIDS orphans they were not related to. All but two of the older respondents who are looking after AIDS orphans in the study site reported that they are not coping physically, financially, socially, spiritually and emotionally, as they try to deal with the bereavement and other demands associated with bringing up the grandchildren. HIV/AIDS has a big impact on some older respondents' vulnerability but it is not the major determinant of vulnerability among the respondents

because not all insecure respondents cared for their HIV-ill children, lost children to AIDS or are caring for orphaned grandchildren.

This section has used qualitative evidence to show the impact of HIV/AIDS on the study population. The domains of the vulnerability framework are not always clear-cut in real life and therefore HIV/AIDS should be viewed as both a threat and an obstacle which hampers coping resources. The high prevalence rate raises the likelihood of infection, which has knock-on effects on support availability. This could help explain the literature that views HIV/AIDS as the major force explaining older people's vulnerability, for example, WHO (2002); HAI (2008); Knodel et al. (2003).

6.2.10 Lack of adequate and appropriate care and support

A high number of respondents, eleven out of 27 face lack of care and support providers. I define care as the practical help given with BADLs, and support as assistance with the IADLs and ARDLs and financial, emotional, spiritual and social aspects. Lack or adequacy of care and support has been operationalised by taking note of all the available and possible sources of care and support, appropriateness, physical distance from the older person, flexibility on the part of the possible care provider and the emotional relationship between the prospective care provider and the older person concerned. For example, WaMuz antagonises her niece, thereby jeopardising the chances of being cared for by the niece. Care needs of older people with continuous chronic health problems are likely to increase with time and so is the need for care providers. Lack of care and support providers among case studies was grouped in three: those receiving or likely to receive non-normative care, that is, care from non-kin, those vulnerable to lack of care provision only and those facing the threat of lack of both care and support (Table 6.2). Three respondents face lack of care, three are at risk of receiving non-normative care, which is not considered ideal in the culture and five face lack of both care and support, the outcomes of which depend on accessible coping resources. While those receiving non-normative care are a lot less vulnerable than those not assured of any care, and they would have the advantage of being looked after in their homes, care from non-relatives is still not considered a good outcome in Zimbabwe. This was pointed out by all the twelve policy makers and stakeholders and 20 older respondents. There is also WaReru whose support network is conspicuous by the absence of women, in a culture where men usually rely on women for most household chores and physical care provision. WaReru would need coping resources in place, to mitigate in the absence of female care providers.

6.2.11 Abuse from relatives

Many older people the world over are exposed to the threat of abuse from their carers and relatives, often in virtue of their physical, emotional or financial dependence on others (Naughton et al., 2010; Weisner et al., 1997). In the study site, four older people were experiencing abuse from relatives who, ideally would be expected to provide them with care and support. They face constant verbal and emotional abuse which had been going on for years. WaNyati and WaSoko have endured incidents of verbal and emotional abuse from WaNyati's young brother and his wife and their children. The incidents have increased over time. In mid-2011, WaSoko was almost struck with an axe because she had asked her brother-in-law not to destroy trees unnecessarily. WaMani's sister-in-law and her daughter verbally and emotionally abuse him and his family. In 2009, WaDorosa was beaten by her sister-in-law, the wife to respondent OP09. WaDorosa reported to the local headman and her sister-in-law was fined a goat and US$50. Although there has been mediation by the headman between the other parties, the emotional abuse has not stopped. These four respondents and those in their households live in fear of the abuse continuing or getting worse or more frequent. WaNyati and WaSoko are at higher risk because their abuser has often been unpredictably violent and is suspected to have progressing mental health problems, although no formal assessment and diagnosis has been made. There are no commonalities among these respondents to help to explain why they are exposed to abuse while others are not. This makes it difficult to predict, note the threats and plan for coping resources to put in place to minimise the bad outcomes.

6.2.12 Loneliness

Loneliness came up among main vulnerabilities faced by five respondents, due to a number of reasons. For these five, loneliness is already an outcome. WaMeck who lived with five children aged ten years and younger reported, '*I feel lonely because I live with young children. I need transport to go and meet other adults'*. Being on farms, most people are always busy and have little time to make social visits or entertain visitors. This exposes even those older people who are still healthy enough to walk a few miles, to loneliness. For example, respondent WaMani reported, *'At times I feel lonely and would like to meet others at social places. I have time and I am still able to go there if there were others to meet with'*. For some older people, it is hard to walk to the neighbouring farm, even if they had the time. WaDorosa who lives with her five-year-old great-granddaughter reported, '*I think my social life would improve if I had an adult to stay with and talk to'*. Failure to visit neighbours and other relatives was viewed by many older respondents as something which made them feel

unhappy and affected their emotional wellbeing. This was also raised by SPM02 who has access to older people in their homes, on a daily basis affirming*, 'One main problem is loneliness'.* Apart from inadequate resources to allow older people to visit or be visited by others, the unavailability of transport also contributed to this loneliness.

6.2.13 Lack of autonomy as a threat and outcome

Autonomy is important to older people because it allows them to continue making decisions about their preferences and maintain their independence. However, in some cases older people lose autonomy when younger people make decisions which affect older people, at times on the older people's behalf, without consulting them. Lack of autonomy is argued to commonly manifest itself in living arrangements (Wilson, 2000; Lloyd-Sherlock, 2004; Ferreira, 2004). Older people's constellations shed some light onto autonomy, as certain constellations entail greater or less autonomy. Older people living alone may be viewed as the most autonomous, although such autonomy may mask neglect. This sheds light on why some of the empirical study respondents preferred living with paid help, contrary to the norm of living with younger family members. Lack of autonomy was a threat to some respondents, but also an outcome which older people are already experiencing. Table 7.5 shows the living arrangements of all the respondents which reveal that some of the living arrangements actually reduce older people's autonomy, and increase their vulnerability rather than reduce it. Seven older people are living in skipped generation households with children under 18, not out of choice because the young children had no one else to live with, nowhere to live or both. In some cases, the option of choice is not there at all. Nine of the respondents wished to be in different living arrangements, but their circumstances such as insufficient resources, ill health and lack of autonomy did not allow them their choices. Living arrangements will be examined more in Section 7.4.3 when exploring coping resources. Living arrangements are only one aspect of lack of autonomy as it can also include inability to make plans such as how to spend money. The thesis argues that the lack of transport also exposes all respondents to lack of autonomy, as they cannot make definite plans, but only dependent on availability of transport.

Lack of autonomy was specifically mentioned by two respondents, WaNya and WaSiyai. For these two, lack of autonomy is complex and there is no way to counter it, without risking upsetting family members and affecting family relations. Although both respondents are economically secure and the only ones on 'widows' pensions' from the sample, have large families who can pool resources together to support them and are assured of adequate care if the need arises, they are not in a position to make decisions for themselves. Their families,

mainly the eldest sons, make decisions for them, including deciding whom they live with, what crops to plant. For example, WaNya lives with her married son, his wife and two grandchildren, a situation she is not happy about arguing, '*I would prefer to live with a worker or maid, that way I would be independent. There is no one prepared to pay the wages for a worker'*. She reported that living with her daughter-in-law stressed her, as she could not run her household as she wished, but that it was run as her daughter-in-law wished. WaSiyai is satisfied living with her married eldest son and has resigned to having decisions made for her as this maintains good family relations, not that she would not like the freedom to make decisions. The title deeds to the farm were put in her then young son's name as suggested by her in-laws, when her husband died in the late 1970s. Both respondents reported that they have given up trying to voice their concerns, in case they jeopardise support and care receipt. The idea of living on their own with paid help has been dismissed as unnecessary and it would alienate them from the family because the family would take it that their support is not appreciated as well as needed. This tells us that in order to maintain good family relations, older people may lose autonomy and they are powerless to raise their concerns in case they jeopardise care and support receipt.

6.2.14 Homelessness

Four respondents are at risk of being homeless, and for three of them, this outcome looks imminent. WaRuma is vulnerable to homelessness due to Unit Tax arrears. Unit Tax is a form of 'development levy' paid to the local authority, Maungwe Rural District Council for the maintenance of roads and other public services at US$3 per hectare. WaRuma reported, '*Four cattle were recently impounded by a messenger of court and sold by public auction due to non-payment of Unit Tax'*. The family cannot afford Unit Tax and as the bailiffs have already sold some of the cattle, they are likely to sell more possessions and eventually the farm, to cover the costs, if the tax goes on unpaid and accumulating. WaMuz also faces homelessness due to Unit Tax arrears. The bailiff had been to the farm twice to serve notice that the farm was at risk of being sold due to Unit Tax arrears. WaMani is also at high risk of being homeless. The title deeds to the farm are at the bank, being held as collateral for the loan his now late brother Robert took. He reported, *'The title deeds are still at the bank because my late brother had used them as collateral to get a loan, they are still in his name.'* There was no insurance in place to repay the loan and no relative is able to repay the loan, so the farm is likely be sold to recover the debt. Since the death of his nephew who had the title deeds in his name, respondent OP13 (male, 56) does not know where the farm title deeds are. Such a situation exposes him to homelessness. When I enquired from respondent SPM11, who is well versed with rules regarding title deeds and inheritance, he

reported that such a position is risky as there is the possibility that the title deeds may be changed into any other relative's name, with no intention of living at the farm and they may decide to sell it. Although the respondent did not raise this concern or is not aware of the possibility, there were concerns that if the relative with the title deeds connived with some corrupt people in the deeds office, they would be able to change the name by falsifying documents. This would enable them to sell the farm or evict those currently living there if they wish, as has happened in some cases.

I now move on to present brief exemplar case studies to show different vulnerabilities faced by the respondents and how they have been accumulated over the life course. They allow a more holistic analysis of how different exposure factors and risks can interact in a person's life course, as opposed to discussing individual risk factors and threats as this chapter has done so far.

6.3 Three exemplary respondent case studies and corresponding life trajectories

Life histories are presented to show trajectories and interactions, to paint a holistic picture and allow informed assessment of older people's vulnerability. As explained in Section 5.4.3, case studies were chosen to also present a representation of variations within the whole sample. In total sixteen life histories were collected. The life histories were chosen and analysed to have a better understanding of the heterogeneity of older people, an important aspect to remember in the study of vulnerability in later life (Chambers, 1995). Comparison of detailed cases will lead to the development of analytical typologies of people's different key threats and coping capacities. The three exemplar case studies also provide an idea of available and possible coping resources which will be analysed in Chapter 7. Even when exposed to the same threats, often the outcomes experienced by different older people vary as they are dependent on availability, appropriateness, access, adequacy, reliability, quality, quantity and relevance of the coping resources. As a result, respondents with varied circumstances, life histories, coping resources and possible outcomes were chosen to answer the research questions. As will be outlined in the detailed case studies below, WaMuz's vulnerability in old age is cumulative, mainly as a result of widowhood at an early age, childlessness and poor family relationships. WaMani's circumstances are mainly a result of one key event, promiscuity in middle age. WaLeo had a tough start in life but his break came through the opportunity to receive an education, he accumulated assets which he now relies on. His case was chosen as an example of self-sufficiency and adequacy

within the sample, yet he still faces some vulnerabilities. This reminds us that old-age vulnerability is not only to be understood in material terms but can take many forms.

Visual illustrations of life trajectories are used to summarise and graphically show threats and positive turns and how they were accumulated over the respondents' lifecourse, as shown in Figures 6.2; 6.3 and 6.4. Life trajectories are according to the respondents' view, as negative or positive. Steepness in trajectories is not graphically representative, it is indicative of the upward or downward steps respondents took in life. The life trajectories are reflected in individuals' life courses and an understanding of the life trajectories will help in making an assessment of an older person's vulnerability, by painting a picture of possible coping resources. The life trajectories also show the resources accumulated over the life course, which can provide an insight into what can be drawn on to counter threats. Although I am presenting these case studies in this chapter to mainly show threats, they already anticipate some of the material from the next chapter which discusses coping resources.

6.3.1: WaMuz Case Study

WaMuz is a widow. I first met her in 2009 when she was 84, although I had already heard about her in 2008. She was referred to as the 'person you must see and talk to,' to have a picture of the 'extremely worrying' situation of some older persons in Dowa, as her poor health and circumstances are well known as being particularly precarious.

Out of seven children, WaMuz and her brother Jon are the only ones who survived beyond infancy. WaMuz's father had two wives. Her step-nephew Daniel's[36] grandmother was the second wife. The whole family moved to Dowa when WaMuz was around twelve years old. WaMuz had a promising start to life, through education and marriage. However, widowhood and childlessness left her lacking key sources of support throughout most of her adult life, hence the steady decline. WaMuz went to school for about six years. When she was aged around twenty, WaMuz had a church wedding, rare in those days. She was married for nine years then her husband died. Having refused *kugarwa nhaka* (wife inheritance[37]), WaMuz returned to her parental home. She never re-married and never had a child. There was bad blood within the family, leading to Daniel's family moving from the farm to Hwedza (about one hundred kilometres away) more than thirty years ago. Jon died about eight years ago. Daniel's mother was accused of bewitching Jon's daughter who had a sudden headache and died within a day, a day before her wedding.

WaMuz has tables and chairs and a bed, which are kept in the other hut and she does not use them anymore. She uses her round brick-walled, cow dung-floored and grass-thatched hut as the kitchen cum-bedroom and she keeps cooking utensils, food and blankets there. WaMuz farms on less than 400 square metres of land. She did not have other farming implements, apart from a culvert and hoes. There are no toilet facilities so everyone at

[36] WaMuz prefers Daniel to inherit the farm.

[37] This is usually marrying a brother-in-law, but can also involve marrying a *muzukuru* (nephew), the late husband's sister's son or paternal aunt's son.

WaMuz's homestead uses the bush. During her active days WaMuz held a very senior post in the ruling ZANU (PF) party, at provincial level. She was actively involved with the church and a number of women's clubs. She self-assessed her health as being 'bad' as she had cataracts, pain in the left side of her stomach and high Blood Pressure.

WaMuz lived at the same homestead as her niece Jan, a widow in her early 50s. After her husband died, Jan went back to live at the farm. WaMuz lived alone and had her own cooking arrangements, occasionally sharing food with Jan. She does all the chores such as washing, fetching firewood and water for herself, with difficulty. WaMuz and Jan do not get along because WaMuz accused Jan of coming back to 'snatch' the farm. She would prefer to live with Daniel who lives in Hwedza. She wanted Daniel to inherit the farm so that it remained in the family name[38].

WaMuz's four cattle had on a number of occasions invaded hers and neighbours' fields. She is worried the neighbours may lose patience and retaliate by withdrawing their support, for example, running errands and providing her with practical care as they did in 2008 when WaMuz was ill. She reported that she was 'dissatisfied' with her life and she worried about what would happen to her, often spending 'sleepless nights worrying' about who would provide her with care and support. Her main worry was about who was going to provide her with care and support. Tete Muz's exact words were, '*I spend sleepless nights worrying, asking myself, 'What am I going to do, how will I survive, how will I be looked after?'* She did not have enough of the basics needed on a daily basis, unless someone brought her a parcel. She reported, *'Who is going to help me and provide me with care and support, as I have no one to look after me? I don't mean to say I have no relatives. I have them but they may be far, while I am here suffering with no one to help me'.* WaMuz faces a lot of vulnerabilities, especially extreme destitution and lack of care and support due to minimal (made up of Jan and a few neighbours) support network and antagonism with Jan. It is clear that WaMuz is exposed to a lot of care and support challenges which are of demographic, social, emotional, economical nature as well as healthcare access. By refusing to give Jan the title deeds, WaMuz was clearly alienating and antagonising the only person who was likely to care for her in her home as she wished.

The local Catholic Church supported her through occasional visits, if she was ill. Some neighbours do not want to help her because during her time as a ZANU (PF) activist, she got a lot of neighbours who supported other parties in trouble. WaMuz is vulnerable to homelessness due to 'Unit Tax' arrears. If they are evicted from the farm, she and Jan may end up living at different places, therefore losing Jan's probable care provision. Even if Jan took over the farm, she is unlikely to afford the Unit Tax since she produces too little to sell and receive enough money to pay.

On my last visit in 2011 she looked frail and her health had deteriorated, especially her eye sight, legs and memory. Her circumstances had got worse and she was relying more on charity. As she grows older, WaMuz is likely to become more frail, leading to increased physical and material dependency, effectively increasing her reliance on community charity, whose care provision is not guaranteed due to the busy nature of farm life and the long distances between farms. One of the main vulnerabilities already materialising is the receipt

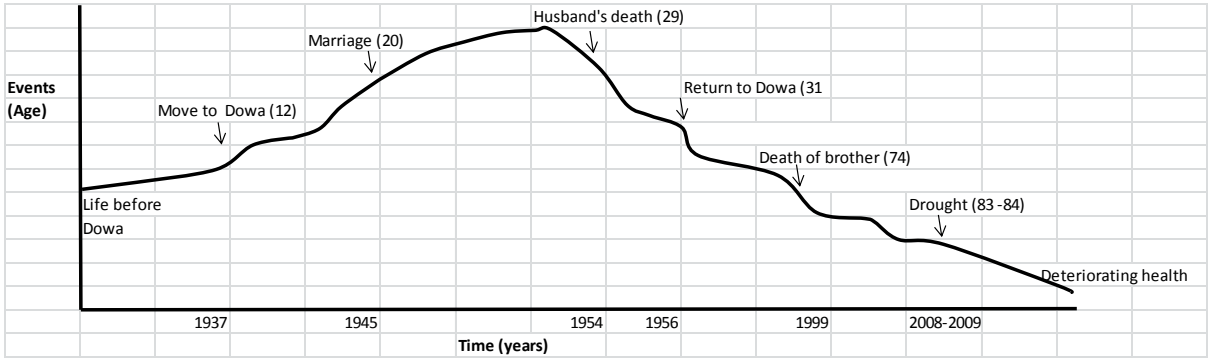
[38] If Jan got the title deeds she would pass the farm on to her children (who use their father's surname), hence the preference for a male Muz beneficiary.

of insufficient healthcare. WaMuz has narrow, poor support networks in terms of both quality and size. It is questionable whether Jan would be able to provide WaMuz full-time, all round care as she has to concentrate on working for her livelihood.

6.3.1.1: WaMuz's Life Trajectories

WaMuz is at the point of destitution. As I have just described, she relies mainly on charity from neighbours, distant relatives and her niece. She lives in a mud/cow dung-floored hut. During the pilot study, I heard about her being ill. This illness was reported to be a result of inadequate food, during the severe drought. During the empirical study, she was included in the purposive sample. At 83, although she had nothing to eat, she was considered as not meeting the selection criteria used by an NGO giving handouts: being an invalid, looking after orphans or being a widow. Although she has been widowed for more than fifty years, a number of people classify her as being divorced, including the village head who helped with the selection. Her precarious circumstances are made worse by the likelihood of becoming homeless due to arrears on Unit Tax for the farm. If the arrears go unpaid, the farm may be sold to recover costs, rendering her homeless. There is no sign of her or her niece affording to pay, so the threat is likely to materialise.

Figure 6.2 WaMuz's Life trajectories



Source: Fieldwork (2009-2011), adapted from Davis (2006)

WaMuz's had a comfortable start to life and her life took a downward spiral as a result of childlessness and widowhood around the age of 29. The death of her brother, her only close relative, exposed her to further vulnerability as she had no one to help her with day-to-day work. During my scoping exercise, my guide and hosts reported that WaMuz was very ill, as a result of inadequate food, during the 2007-8 severe drought. WaMuz's situation during the drought was so severe that she nearly starved to death, had it not been for neighbours' charity. With her ability to work on the farm deteriorating with age, WaMuz is relying more and more on neighbours' charity. WaMuz's case suggests that in some instances, the less

one has to offer others, the narrower their support networks, thereby increasing a person's vulnerability to situations such as loneliness, lack of material support and even physical support. WaMani's case study, presented next, shows that at times just a single event or episode in life can determine old-age vulnerability or security.

6.3.2: WaMani Case Study – from castle to shack

WaMani was sixty when I first interviewed him in early 2010. His life has been a 'from-castle-to-shack story'. WaMani was the youngest child in a family of six children and his family's financial circumstances were considered comfortable. WaMani had a good education then he got a job as an accountant. He married his wife Mia and they had eight children, born between 1978 and 1995. Their second born died in 1997, aged 17. The first born, Petros died in 2006, aged 28. The third born, Kenneth lives and works in Marondera (sixty kilometres away), while his wife Vera and their two children live at the farm. One daughter lives in Rusape (about 50 kilometres away), two other daughters live in Harare (about 140 kilometres away) the youngest son lives in Marondera (about 60 kilometres away), and Chipo the last born lives with her parents.

WaMani was well-paid by his employers. He bought a house in the town of Marondera. Extra-marital affairs were the cause of WaMani's downfall. WaMani overspent money, and defrauded his employer out of money. He was eventually caught and he lost his job. He sold his house to pay back the money[39]. With no job and no accommodation in town, he went back to live on the farm, around 2005. WaMani lives with his wife Mia, Chipo, his daughter-in-law Vera and two grandchildren. He is satisfied with the living arrangements. WaMani lives in a three-bedroomed house with brick walls and an iron sheet roof, furnished with a table, chairs and a bed only in the main bedroom. The house used to belong to his parents. The kitchen has brick walls and grass thatch. Both the kitchen and main house have cement floors. They use firewood for cooking. Water is fetched from a protected well, less than 100metres away. The household uses the bush, the toilet sunk in because it was very old.

WaMani's brother and his wife Grace lived at the farm and they were verbally abusive towards WaMani's family and to some neighbours. Robert died in 2008. WaMani and his family live in fear of Grace and her daughter Mutauro who often abuse them, only stopping short of being physically abusive.

Petros' two children live with their mother in Wedza, about 100 kilometres away. This situation has cultural implications as well as a psychological effect on WaMani as the children are considered as growing up within a 'wrong' lineage. Zimbabwe being a patrilineal society, traditionally children were meant to grow up among their father's family. There is inter-generational and inter-household flow of support in both directions within WaMani's family. WaMani helps his children by giving them food parcels to carry back to towns, and also helps Vera with child-minding. WaMani's sister and two brothers visit him once or twice a year.

[39] Despite all the pension contributions he made over the years, WaMani did not qualify to receive a pension because he was dismissed from work, as reported by KI02

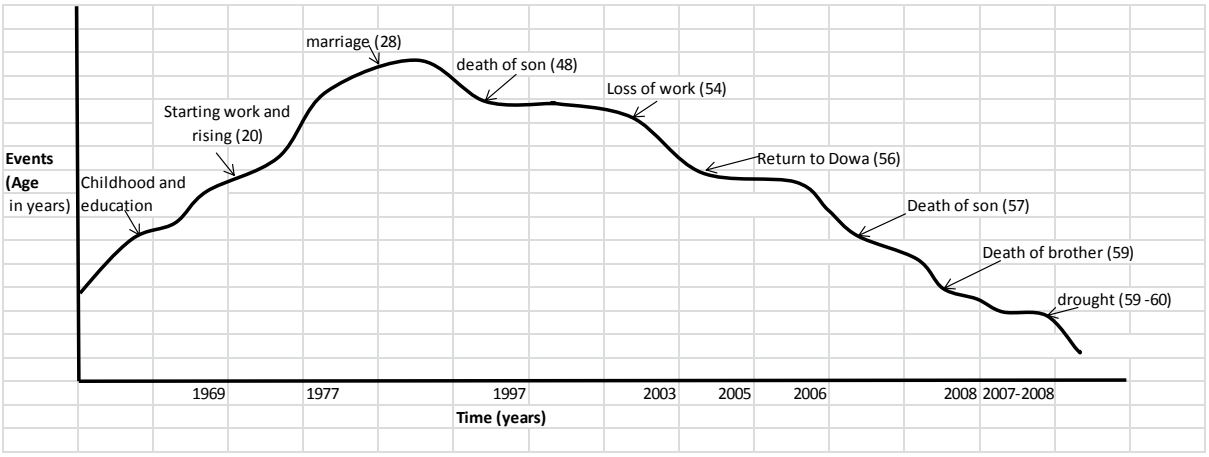
WaMani is the head of his household and shares the task of providing for the family with Mia. He can do all the activities of daily living on his own. WaMani has no other animals, except poultry. The household has a wheelbarrow and a plough, their oxcart is not working. WaMani's children support him with food parcels and clothes. WaMani's brothers also give him clothes. Mia, Vera and Chipo help with work around the house. While he was still employed, he contributed towards NSSA (discussed in Section 3.6) but he is not receiving any pension. There are signs of poverty in WaMani's household as they do not always have enough basics. Petros' death affected WaMani emotionally and financially because he was the main bread winner. WaMani reported that there was a 'huge change' in their circumstances when Petros died. WaMani is 'somewhat dissatisfied' with his economic circumstances as 'issues are not looking well'. At times he cannot afford Chipo's school fees.

WaMani self-assesses his health as 'good' apart from having sore eyes and a headache. He does not pay for healthcare since January 2010 when he was considered to be sixty even though he had not yet turned sixty. WaMani walks to the nearest health centre, a round trip of about ten kilometres. Currently no one supports WaMani with money. Mia is in an even more vulnerable position than WaMani, as she has been a victim of the way WaMani has led his life. She is HIV-positive and she is on Antiretroviral (ARV) drugs, which she has to take for life to maintain her health and general well-being. She has stayed with WaMani because she has nowhere to go and also a case of *kugarira wana* (staying for the sake of the children). By remaining in her married home, she can still command the respect accorded to married women.

The household received assistance in the form of food hand outs from an NGO for three months during the 2007-8 drought. The household got this aid because then, Mia was seriously ill. She had lost so much weight that she was considered to meet the criteria set to receive aid. Her health improved when she started ARV drugs and the two times I met her, she looked a picture of good health. WaMani does not receive any form of support from the government or the church. He has not attended church for many years. His financial needs are likely to increase as he gets older and produce less from the farm. WaMani is also vulnerable to lack of physical care providers when the need arises. Mia's ability to provide care will depend on her health remaining good enough for her to manage the task. WaMani is at high risk of being homeless, the title deeds to the farm are at the bank, being held as collateral for the loan Robert took, so the farm may be sold to recover the debt. WaMani feels emotionally, economically and socially vulnerable and lonely.

6.3.2.1: WaMani's Life Trajectories

Figure 6.3: WaMani's Life Trajectories



Source: Fieldwork (2009-2011), adapted from Davis (2006)

WaMani case study and life trajectories show that he had a comfortable early life and was well educated and had a good, well-paying job. Extra-marital affairs were his downfall, resulting in him losing his job, losing his house in town and having a criminal record with almost no chance of getting another job, thereby eventually relocating to the rural areas in 2005. As a result, he had nothing from his time in formal employment, to use as coping resources and he did not always have adequate farming equipment and inputs. WaMani's reputation makes some neighbours unsympathetic towards him as they say his economic problems were mainly self-inflicted. Two other main events in WaMani's life are the deaths of his two sons in 1997 and 2006. The 2007-8 drought made WaMani's already poor economic circumstances worse and contributed towards his overall vulnerability.

6.3.3: WaLeo Case Study 3 – Rags to riches

WaLeo is very alert and his memory appears perfect as he was precise with figures, events and dates. He walks with a walking stick. When we arrived he was smartly dressed, his feet were clean and well creamed, a sign that he was taking good care of his personal hygiene. WaLeo is the only one with whom I had my interviews mostly in English. It was his idea to use English, having seen that the information and consent sheets were written in both English and Shona.

WaLeo was the sixth born in a family of seven. He spent his early childhood about seventy kilometres from his home in Dowa, where his father Wasoka was employed. In 1927,

WaLeo's father and other workers were made redundant because the land was to be sub-divided. The family went to live a few kilometres away, on a piece of land which had not yet been designated as belonging to anyone. A year later, a white man named Dixon settled next to them. In 1929 when WaLeo was bitten by Dixon's dog, Dixon blamed it on WaLeo and threatened him not to tell his parents about the biting. Due to differences with a politically powerful neighbour, in 1930 the family was given an ultimatum to be gone by the following morning, which resulted in them leaving all their crops in the fields. The family barely had anything to eat, until the next harvest. WaSoka's family made several home moves until Wasoka bought a farm about fifty kilometres from Dowa, in the late thirties.

In 1932 WaLeo was chosen by some missionaries to continue his education at a mission boarding school. He qualified as a teacher in 1941 and got married in 1946. In 1955 he bought the farm. WaLeo and his wife had seven children, five boys and two girls, born between 1947 and 1961. They helped each of the children set up home. One son lives in Bulawayo, a daughter is in Kadoma, two other sons are in South Africa, the nearest two live in Harare and the last born, a girl, lives in America. The children were all reported to have good jobs and are well off. The family is highly regarded in the community. WaLeo has nineteen grandchildren and two great grandchildren. WaLeo's wife, Sheila died in 2003 after a short illness. Having been married for nearly sixty years, WaLeo reported that he still had not got over the loss. At the time of interview, WaLeo's household was made up of himself, his housekeeper Mrs Take, a widow in her mid-sixties, and Taku, Mrs Take's ten-year-old grandson. WaLeo considers their relationship as reciprocal because he provides Taku with school fees, accommodation and love while Taku does small chores and runs errands to neighbours.

WaLeo rates his health as good. He had poor eye sight and could not see well and had to strain his eyes to read. He did not want to get glasses arguing they got in his way when doing farm work. He also had arthritis and one of his hands was so bad that he could not lift it above the shoulder. Still, he did most of the work on his own. Although he paid for healthcare at the local health centre, about two and a half kilometres away he did not get much help from there for his main health problems.

WaLeo considered his family as the most important source of support. He observed that distance had a big impact on the support he received from his children and also on what he could give them. With the nearest child living about one hundred and forty kilometres away, WaLeo acknowledged that it was not easy for his children to visit him often. He had not seen his daughter in America for more than ten years, but she phoned him. His second son, Roy was the one who provided him with most financial support, and he also visited regularly.

WaLeo helped his children by giving them advice and food parcels when they visited. He was confident that if he needed assistance from his children, they would help him.

Of the seven children in WaLeo's generation, only WaLeo and his sister were left. The siblings no longer visited each other because of transport problems and they found travelling difficult. They kept in touch through their children who passed on messages. Demographically WaLeo had a large network, but in terms of frequent visits and support, his kin network was small in size, mainly consisting of Roy. WaLeo's small support network and distance from his children made him vulnerable to lack of practical care from immediate family. He is vulnerable to frailty as he grows older. However, while in practice WaLeo had a small kin network, he had reserves, made up of an economic-based support system which he accumulated over the years. During the time of my first visit, he did not have money of his own and he relied on money he was given by Roy to pay for services. The other children gave him money and bought him food occasionally but there was no pattern, so he could never tell when they would be giving him next. While he was still working, WaLeo made Life insurance investments and he held a number of bank accounts at the same time. Hyper-inflation brought about a big downward slide in his financial circumstances because the investments lost value. He had enough maize meal and relish which he grew and he could still manage a good diet even during the 2007/8 drought. However, up to late 2009 it was not as good as it used to be prior to hyper-inflation. His main source of livelihood was agricultural produce, although he also bought some items which he could not grow on the farm, such as soap, cooking oil, sugar.

WaLeo reported that he was content with his circumstances and satisfied with his living arrangements. Even though he did not live with his real family, WaLeo was happy because he was in his own home and psychologically, he had come to accept that Mrs Take was the one who could give him practical support, considering her 'as good as family'. WaLeo was able to do most of the ADLs even though he uses a walking stick. He needed help with cooking, housework, weeding and harvesting. He would also like transport to carry milk to the dairy depot every morning, a task which was done by Mrs Take, carrying about twenty litres on her head and walking a distance of about five kilometres return. Failure to deliver milk would lose WaLeo money and therefore have a negative impact on his livelihood.

He had the title deeds to the farm and had already written his will. The farm is 91 hectares of which WaLeo used 30 hectares for direct farming and dairy farming for the cows to graze freely. WaLeo had a variety of farm equipment and machinery such as four 'bush' pumps which were meant to be used for irrigation. He also had two working tractors, three oxcarts, two wheelbarrows and two ploughs. He had a car which was in very good condition and

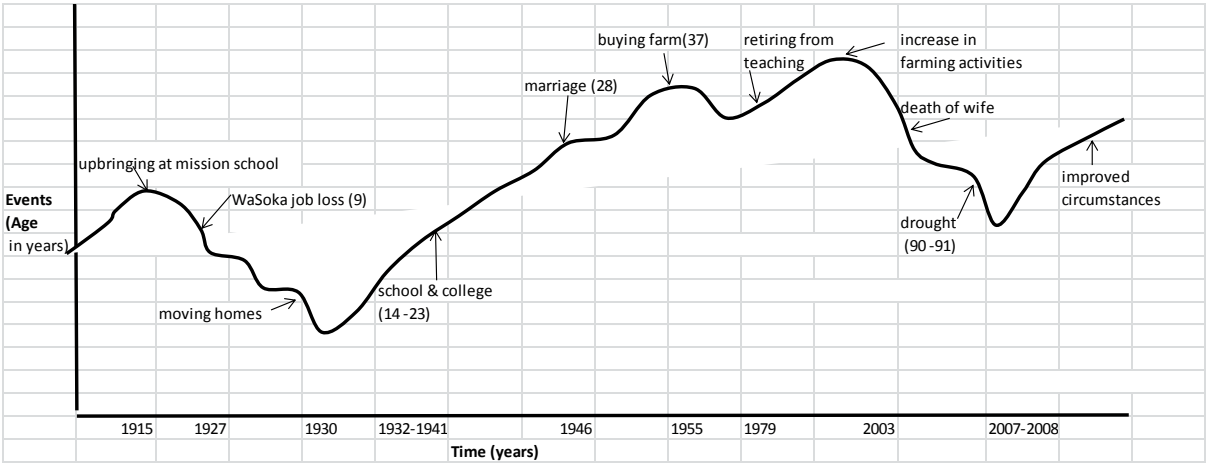
roadworthy. He had recently stopped driving due to poor sight and the arthritis in his hand. His corrugated-thatched four-bedroomed house is furnished with two radios, sofas, table and chairs, a bed in every room and a non-mobile phone. He has an en-suite bathroom. None of WaLeo's children wanted to live on the farm, so he was concerned about what would happen to the farm, the cattle and everything else when he died. Besides visits from church members and his family, WaLeo had no other source of support. He did not receive support from the government or NGOs. He paid a neighbour to take his herd of forty cattle to the dip once a week, and to milk the cows every morning. WaLeo was confident he could rely on neighbours if there was a crisis.

WaLeo was now 93 when I interviewed him for the second time. He was satisfied with his life and economic circumstances. Compared to 2009 there were no major changes in WaLeo's health, it is still 'good'. His sight has slightly deteriorated, but he considers it good for his age. His son Roy was also visiting more often than he did when I first visited WaLeo. WaLeo's financial situation had improved a lot as he was now getting US$9 everyday from milk he sold to the dairy depot, an amount which he reported was enough to meet his basic financial needs and still have some surplus. His good financial state enabled him not to rely on his family financially. WaLeo used to receive contributory pension which was stopped due to hyper-inflation in 2009. Up to 2011 WaLeo had not yet checked if it had been reinstated. WaLeo was not keen to check the pension because he was managing without it.

He can still walk and cycle, but with time his health may deteriorate and he would need more help with day-to-day activities which he can still do at present, including personal care. He would also be more vulnerable to lack of readily available transport to get him to the health centre. Apart from his personal wealth, Roy is WaLeo's key source of support. WaLeo has no other support networks apart from Mrs Take and his children, who live far. Nonetheless WaLeo is positive about life. He is aware he is vulnerable to having to rely on non-normative care and has adopted practical and psychological coping capacities. He has the cumulative advantage of wealth, which he can use to avoid bad outcomes. At present, WaLeo could still afford to fund his care without the family paying for him. He could use his assets as coping capacities, by selling some of his possessions to meet his care and support-related expenses.

6.3.3.1: WaLeo's Life Trajectories

Figure 6.4: WaLeo's Life Trajectories



Source: Fieldwork (2009-2011), adapted from Davis (2006)

WaLeo's life history is cross-generational because most of what shaped his life also affected his parents, especially being almost homeless. WaLeo's life is a 'rags to riches' story and had an upward trajectory during the last fieldwork visit. Education was his big break in life. He accumulated wealth over time, which he is using for his upkeep and is still accumulating some more. Even though his family live far, WaLeo's worst case scenario is receiving non-normative care, which he is not worried about because he can afford to pay and that will guarantee him remaining in his home as he wants.

The three case studies and trajectories inform us that some positive and negative changes came about due to varying circumstances such as mistakes and opportunities which presented themselves, hard work and some purely natural events, resulting in varying individual circumstances. For example although WaMuz's circumstances began taking a downward slope in the1950s, she was still comfortable up to her mid-seventies as she was able to work on the farm and produce enough food for consumption as well as for sale. The fact that WaLeo emerged as the most secure can imply that possessing sufficient, varied own coping resources is probably the best way to counter threats, as the wealth can always be converted into relevant coping resources when the need arises.

6.4 Summary of key threats faced and outcomes experienced

This chapter has explored the different threats faced by older Zimbabweans and discovered that they are faced at different levels of severity. The exposure factors and threats

uncovered and discussed enlighten us on the numerous determinants of old-age vulnerability in rural Zimbabwe. Some of these threats are faced nationally by all age groups, others affect older people in general and there are those affecting older people in the study site and would probably be faced by others in similar environments (Bird and Prowse, 2009; UNDP, 2010). The economy and political situation had an impact on the livelihoods and vulnerability of older people as they have knock-on effects on old-age care and support provision. Each threat was examined in detail on its own because it is important to give the reader an idea of individual threats and a reminder that vulnerability tends to increase when people face multi threats. Respondents are not particularly poor but they could be described as vulnerable because they live in an environment which exposes them to natural weather conditions and lack of some coping resources which have a knock-on effect on their livelihoods. Difficulty in accessing healthcare is felt even more because healthcare service provision becomes more important as health fails due to old age (Lloyd-Sherlock, 2010; Barrientos, 2002). Transport problems contributed to multi-threats on livelihoods, due to failure to transport farming inputs, implements and produce, difficulty accessing healthcare access, loneliness due to difficulty maintaining relations with neighbours and relatives who live far. From the results, we now know that in real life there is no clear-cut demarcation between some of the domains, it all depends on individual's personal circumstances. As a result, this thesis justified where some domains have overlapped due to their very close inter-relation.

Like all rural area residents, respondents in the study site are exposed to different natural conditions such as recurrent droughts, floods, crop failure, hail, animal and crop disease; as well as lack of adequate and appropriate care and support, difficulty accessing healthcare, inadequate resources due to reduced earning capacity, resulting in increased financial problems and poverty. Table 6.2 provides an overview of threats and exposure factors faced by older people and how common they were.

Table 6.2: Summary of main risk factors and threats faced by older respondents

Exposure/Threat	**Number of respondents facing the exposure/threat**
Changes in family and kin support and exchanges	27
Natural weather conditions and absence of farming insurance	27
Difficulty accessing healthcare	**27**
Low vulnerability (transport problems)*	14
High vulnerability (transport problems and failure to afford user fees)	13
Inadequate economic resources	**25**
Low vulnerability (inadequate income)	15
Low vulnerability (inadequate assets)	3
High vulnerability (inadequate assets and income)	7
Lack of care and support providers	**11**
Non-normative care	3
Care only	3
Both care and support	5
Health problems (being in pain, limiting everyday activities)	**27**
Chronic conditions	12
Other health conditions	15
Loneliness	5
Homelessness	4
Verbal, emotional and physical abuse	4

* Seven respondents do not pay for healthcare either because they are over 65 or they have hypertension or diabetes.

The threats faced by all respondents were difficulty accessing healthcare and transport, yet most of the respondents had health problems (being in pain, limiting everyday activities). Difficulty in accessing healthcare is either due to transport problems, not affording user fees, or both. Transport problems were a major determinant of old-age vulnerability in the study site as it led to failure to access healthcare, failure to transport farming inputs and implements and farm produce. Transport problems also contributed to loneliness, as most respondents were unable to visit or meet with people their age, and relatives. Other threats in the study site were abuse from the extended family and exposure to homelessness. These threats are faced in an environment which has not yet recovered from the impact of recent political, economic and epidemiological crises which affected the whole country. The impact of HIV/AIDS on some respondents has been highlighted, and it was also shown that it is not mainly HIV which has caused the inadequacy of resources.

Different threats faced by older people show that different individuals have different life courses which determine their coping resources and eventual outcomes. Coping resources

are the link in the inter-relation between threats and outcomes. Exposure could be cumulative or sudden and different threats occurring simultaneously have a stronger impact than those which occur singly. Vulnerability is dual in nature and this chapter has explored the external side of exposure to threats, the likelihood of the threats materialising and the degree of severity. The internal side, that is, the capacity to cope in response to the threats, is examined in the next chapter where coping resources are examined. Capacity to cope can be at individual, family, community or national level. It will be interesting to see in the coping resources chapter, how older people facing the different threats cope, and who they can turn to, for support to mitigate the threats and minimise the degree of harm. Ultimately this will lead to an understanding of old-age vulnerability in Zimbabwe as a starting point for policy recommendations.

CHAPTER 7: Results: Older Respondents' Coping Resources

7.1 Introduction

Chapter 7 focuses on the coping resources older people possess, as well as those needed in order to counter the threats faced. Having a full and accurate account of the threats faced, and coping resources accessible by older people can help to assess the appropriateness and adequacy of current policies and interventions. Coping resources can be made up of a range of elements of familial and non-familial forms, for example, social networks, remittances, current earnings, savings, pensions, assets, policies and formal support from the state such as free healthcare. Individual lives are embedded or linked to other people and are influenced by them (Elder, 2002). This link is often through social networks, who often serve as support networks such as the immediate family, relatives, neighbours, church, political affiliation, informal clubs, religious organisations, former work colleagues (World Bank, 1994). The chapter will explore different coping resources at the disposal of older respondents in the study site, starting with the family which in developing countries has been traditionally the key provider of care and support in old age.

The findings will help to address the remaining two domains of vulnerability not examined in detail in the previous chapter, these being coping resources and outcomes. In this chapter the analysis focuses on those relationships or resources which can prevent older people from encountering a bad outcome. This chapter aims to address questions 1 and 3 which are on determinants of old-age vulnerability and coping resources respectively by addressing the following research questions:

1. What are the main determinants of an older person's vulnerability in rural Zimbabwe?

2. What coping resources are available to older people in rural Zimbabwe?

The investigation of determinants of vulnerability continues from Chapter 6 because having an awareness of both the threats and coping resources allows an understanding of determinants of vulnerability. From this, we can have an idea of the outcomes people are trying to avoid or achieve. Living arrangements will be explored as they are an important component of coping resources (UNDESA, 2012; Lloyd-Sherlock, 2004; Aboderin, 2006; Arber et al., 2003). Apart from the family, the role of other sources of support in the study site, such as the community, religious organisations, the government and NGOs will also be explored. The chapter concludes by reviewing the overall vulnerability of all the respondents.

7.2 Case studies' coping resources

One of the most important coping resources older people possess to mitigate their vulnerability is their social networks. Social networks are part of the assets accrued during people's lives, needed to reduce old-age vulnerability. The size and composition of support networks are important because they portray a picture of the likelihood of there being an adequate or inadequate pool for support provision (Moser, 1998). Knowing more about an older person's social networks can suggest who would be likely to be available to provide care, especially when such care becomes intense, involving personal care as the older person's health deteriorates, since health is a major determinant of most older people's vulnerability (Van Eeuwijk, 2006; Lloyd-Sherlock, 2010). The longer the period of needing care, ideally the larger the pool of care providers needed. However, social networks are not fixed, they are fluid. They can change as members leave or die, while others may join in the support network. There is need for flexibility in a support network so as to be able to respond to a crisis and this can be achieved by members being able to communicate quickly and regularly, and being able to respond where changes occur.

Kinship maps are used in this thesis to explain the flow of support as kin networks are key coping mechanisms in Zimbabwe. Kin mapping helps to identify the kin an older person has and their location. Studied in conjunction with case studies, kinship maps help to give an idea of the human and non-human and non-family coping resources an older person has immediate access to, those which can be drawn on and those likely to be drawn on when the need arises.

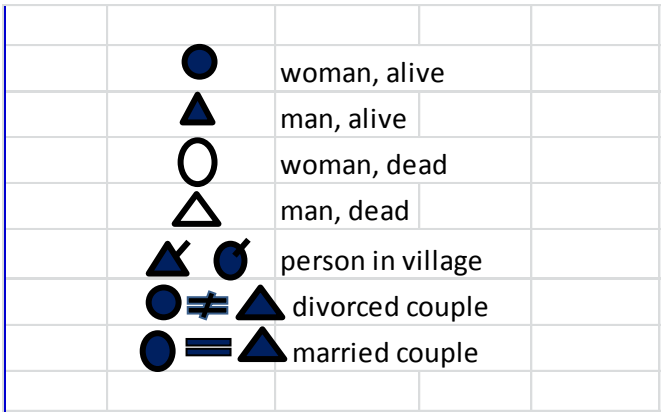
7.2.1 WaMuz's Coping Resources

Case study WaMuz's (84) closest relative within 100kilometres of her home is a niece named Jan, as shown in her kinship map (Figure 7.1). As outlined in the previous chapter, WaMuz's circumstances are very precarious, and she relies mostly on the community. If she were to fall ill and need healthcare, Jan would have to borrow a cart from neighbours to take her to the healthcare centre. For daily subsistence, apart from her little agricultural produce, WaMuz mainly relies on hand outs from neighbours,[40] especially WaBay and MaiBay (OP05 and OP06) whose farm is next to hers, her niece Jan who lives on the same farm with her and runs errands for her and WaSoko who lives about six farms away. Although they are

[40] WaSoko's generosity was mentioned by her daughter-in-law who stated that she gave away food when her own family, especially her invalid husband, barely had anything to eat.

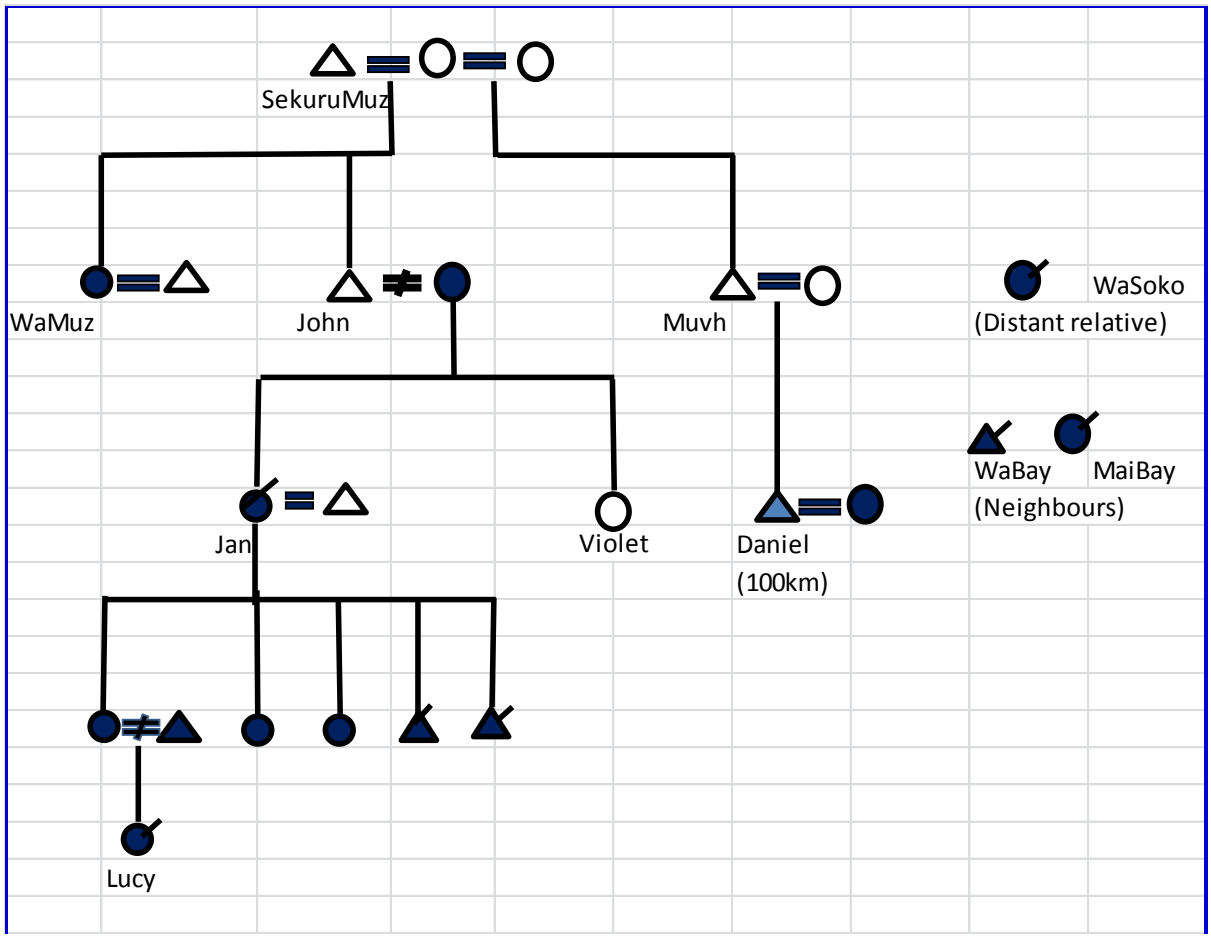
distant relatives, WaSoko is considered a close relative because her and WaMuz's parents came from the same area. At 83 (in 2008), although she had no food, she did not meet the selection criteria used by the NGO giving aid. WaMuz would not want to go into an old people's home, she would like to stay with her family. WaMuz's coping resources are minimal, mainly made up of neighbours and a niece she does not get on well with.

Key to kinship maps: The kinship maps are not drawn to scale



Source: Schrőder-Butterfill (2005)

Figure 7.1: WaMuz's Kinship Map



Source: Fieldwork (2009-2011)

Figure 7.1 shows WaMuz's kinship map, made up of her niece who lives near her with her young grandchildren and her step-nephew. WaMuz is the only one left in her generation. Three neighbours are also included in this kinship map because together with Jan, they make up WaMuz's support network.

7.2.2 WaMani's Coping Resources

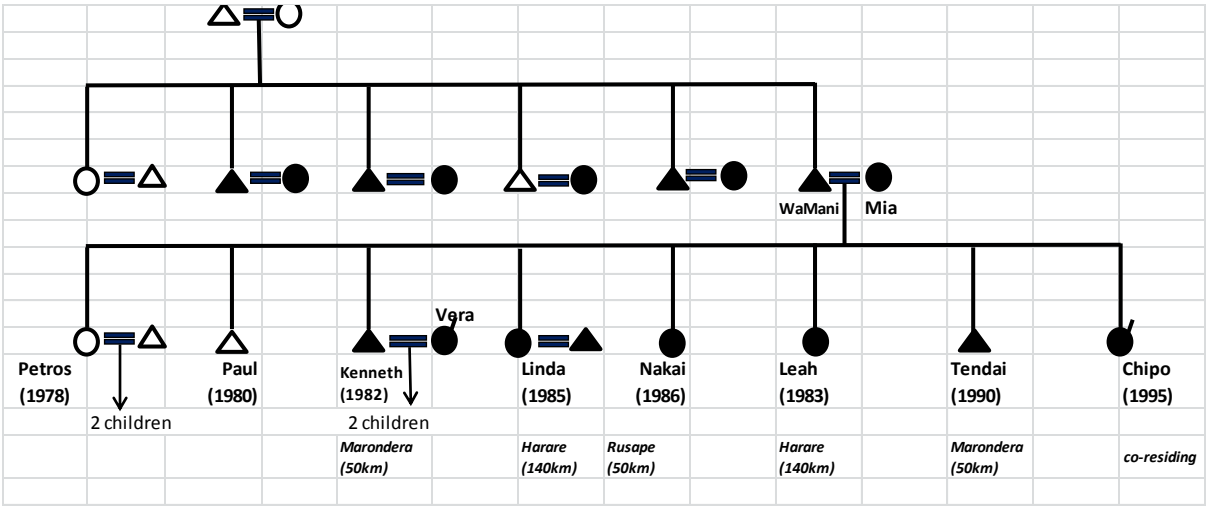
WaMani's coping resources are made up of personal material resources, kin support, community support and government support in the form of free healthcare. WaMani's household uses about 20 hectares for farming activities and the household's main source of livelihood is farm produce. The family has a garden which has water throughout the year, therefore they grow vegetables for consumption and they sell the surplus, which brings in a little money, just enough to cover expenses such as paying at the mill to have maize ground into maize meal. WaMani relies on the community to lend him cattle to use for draught power because he has no other animals, except poultry. WaMani's reputation makes some

neighbours unsympathetic towards him as they say his problems are mainly self-inflicted[41], since he lost his job and a house in town after committing fraud. Apart from free healthcare, WaMani does not receive any other form of support from the government, NGOs nor the church. As shown on the kinship map (Figure 7.2), of his six surviving children, five live far away. He co-resides with his wife, young daughter, daughter-in-law and two young grandchildren. There are no visits or support between him and his nieces and nephews who all live far away. Kenneth buys groceries and visits monthly, mainly to see his wife and two children who live in the WaMani household. A daughter and a son visit about three or four times a year, while the other two rarely visit because they do not work, so they cannot afford transport costs. WaMani's sister and two brothers visit him once or twice a year. WaMani has not paid for healthcare since January 2010 and reported it was because the healthcare centre staff considered him to be sixty given that he would turn sixty later in the year. WaMani walks to the nearest health centre, a round trip of about ten kilometres, and is vulnerable in terms of accessing healthcare should he become unable to walk the long distance. WaMani's coping resources may become inadequate if his needs increase later on in life, especially if his health were to deteriorate. WaMani reported that he would consider moving into an old people's home if he became unable to care for himself, to relieve himself of the anxiety of how to meet his care needs in old age.

Mia, Vera and Chipo (WaMani's wife, daughter-in-law and daughter, respectively) all help WaMani with household and farm work. Despite his large family, WaMani remains vulnerable to a lack of physical care providers when the need arises. There is no guarantee that Vera will always be living at the farm. She may go to live with her husband in town if his financial circumstances improve. When Chipo is older, she may find a job somewhere or get married and move away from home. This leaves only Mia as WaMani's available care provider. However, her ability to provide care will depend on her health remaining good enough for her to manage to care for him. Being HIV-positive and on Anti-retroviral (drugs) ARVs, Mia has to take the medication for life to maintain her physical, emotional and mental well-being. If Mia became unwell, WaMani would be exposed to an increased lack of care providers.

[41] I received this information from my guide.

Figure 7.2: WaMani's Kinship Map

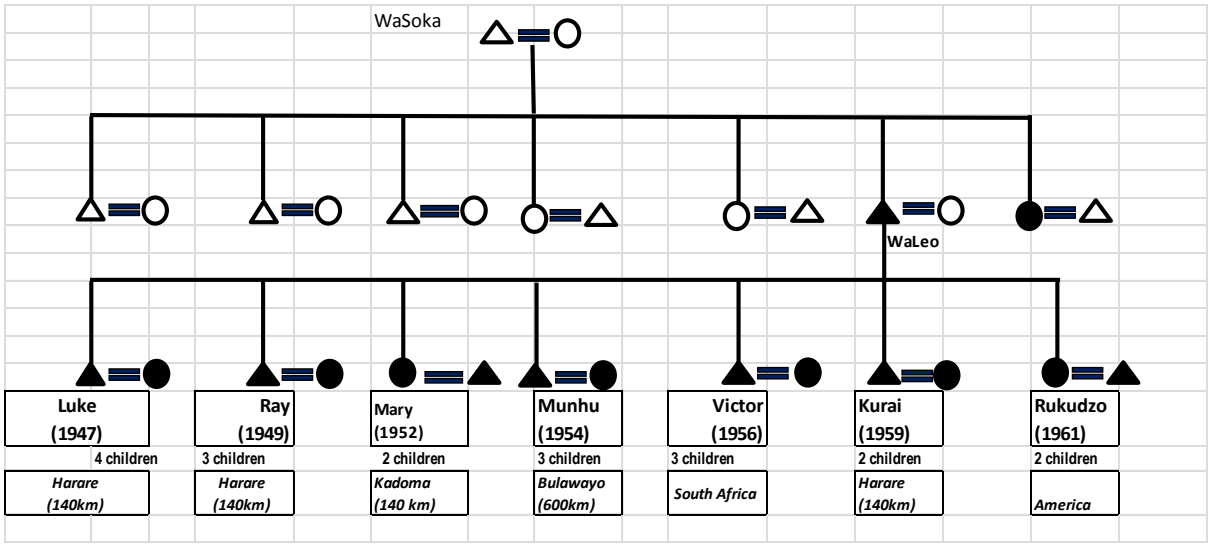


Source: Fieldwork (2009-2011)

7.2.3 WaLeo's Coping Resources

WaLeo has adequate personal resources and financial support from his children. He did not follow-up his contributory pension since it stopped being paid during hyper-inflation because he felt discouraged by the travelling and form-filling involved to have it re-instated. He managed without it, saying, *'I am satisfied with my life and economic circumstances. I have 40 cattle …I sell 20 litres of milk everyday. I have a car in good working condition, 2 tractors, 3 oxcarts, 2 wheelbarrows and 2 ploughs'*. WaLeo has the advantage of ownership of wealth which he can use to eliminate the threat of bad outcomes, such as a lack of care. If his health deteriorates and he becomes in need of personal care, it will be necessary to employ someone else to assist Mrs Take as it might be too much for her to take care of the home as well. WaLeo's main source of family support is his second son, Roy who visits him often and supports him with money. The other children gave him money and bought him food occasionally but there was no pattern in the frequency. At present, WaLeo could still afford to fund his care without the family paying for him. WaLeo is confident his family would pay for the extra help if need be. He could use his assets as coping capacities, by selling some of his possessions to meet his care and support-related expenses, especially as none of his children want to live at the farm, so eventually the assets would still be sold. Besides visits from church members, WaLeo has no other source of support outside the family. He does not receive support from the government, NGOs or the community but he reported that he could count on his neighbours' support if there was an emergency. WaLeo reported that under the circumstances, he is happy and satisfied with his living arrangements of living with a maid and his maid's grandson, considering all his children live far.

Figure 7.3: WaLeo's Kinship Map



Source: Fieldwork (2009-2011)

WaLeo's kinship map is mainly made up of his children and does not include the extended family or neighbours. This is because being the first generation at the farm, his siblings have always lived far and only one remains. Although the extended family meet during important family events, and have good relations, they do not visit WaLeo or support him in any way. None of WaLeo's nieces or nephews is likely to care for WaLeo. WaLeo is confident he would not need care or support from outside his nuclear family, not even his grandchildren. WaLeo can manage without help from the extended family because he has adequate economic resources and support from his children. WaLeo values his relationship with his children, but he observed that in his current good financial state, he does not have to rely on them financially.

The case studies show the diversity of coping resources accessed by the older people as well as their effectiveness. The coping resources are made up of the family, own resources, neighbours, the church and the government. Due to their different circumstances, some respondents rely more on certain coping resources than others and attach varying levels of importance to the same coping resources. The discussion moves forward by examining the main providers for households of the older respondents and the resources they possess. From this we can gauge what resources are available and how easily they can be drawn on.

7.3. Households' Main Economic Providers

One way of thinking about people's coping is by examining their household economic situation and who counts as the main provider of income. Main provider refers to the person

responsible for meeting the household's main financial and basic needs such as food. The findings reveal that many older people are themselves main providers, rather than relying on others. Main providers for the households varied, as 13 out of 27 older people were main providers, while children were main providers for eight of the households, as shown in Table 7.1.

Table 7.1: Households' Main Providers

Main provider	**Frequency**
Self and/or spouse	13
Children	8
Children and self/spouse	4
Community	2
Total (N)	27

Source: Fieldwork data (2009-2011)

Four respondents shared the responsibility of being main providers with their children or spouses and two were mainly provided for by the community. This has implications for our understanding of older people's coping and overall vulnerability. For example, WaLeo was the main provider for his household and was well buffered and managed with his own resources and can convert his wealth into support, while WaMani relied on his family and WaMuz relied on neighbours. This implies that a lot depends on the nature of older people's independence and financial situation. The high number of older main providers implies that measures need to be put in place in the event of them being unable to provide for themselves later on in life. Those who are mainly provided for by the children and the community would depend more on these providers, who would therefore need more resources to afford to share with them.

All of the 27 respondents, except two had farm produce as their main source of income and farms were the most important possessions for the thirteen who owned the farms. Land ownership is defined as having the farm title deeds in an individual's name. If need be, the title deeds can be used as collateral to buy agricultural inputs and implements. Table 7.2 shows farm ownership and relationship of respondents to farm owners. Nine farms had title deeds in respondents' siblings' names, while three respondents had their spouses as holders of title deeds. One respondent has the title deeds in her son's name and the title deeds for another respondent's farm were with the bank, being held as collateral for a loan taken (discussed in Section 6.3.2). Landlessness is not a threat in the study site, as all respondents had access to sizeable landholdings which they considered adequate for them.

Table 7.2: Farm ownership

Title deeds holder	Number
Respondent	13
Respondent's spouse	3
Respondent's sibling	9
Other (respondent's son, sister-in-law)	2
Total	27

Source: Fieldwork data (2009-2011)

Size and quality of houses can also shed light on past and present economic circumstances. Twenty-three respondents had either asbestos or corrugated sheet-roofed, cement-floored houses, with three or four bedrooms. Respondents WaMuz, OP13, OP09 (male, 63) and OP10 (female, 56) had mud floors in their kitchens. All respondents had grass thatch kitchens, because grass thatch lets out smoke easier than asbestos or iron sheets which can only let out smoke slower, through the windows or chimney. Too much smoke has a negative effect on eyes and can progress into poor eyesight.

Due to the large land sizes, small-scale farmers need a range of farming equipment such as: tractors, cattle, culverts, ploughs, scotch-carts, wheelbarrows, hoes for different tasks such as ploughing, planting, weeding, harvesting and transporting inputs and produce. Cattle, tractors, and carts are also often used as transport to the grinding mill as well as transporting people. Four respondents had more farming equipment than they needed, for example, WaLeo had 2 tractors, 3 oxcarts, 2 wheelbarrows and 2 ploughs, two had insufficient equipment and the rest had equipment which was just sustaining their needs in terms of quantity and being in working condition. Twenty-five respondents had ploughs and twenty-three had 6-40 cattle to use as draught power. Most of the equipment was old and non-functioning. Only two respondents still had working tractors. During the first wave of fieldwork, due to the drought and hyper-inflation, all the respondents did not have sufficient quantities of farming inputs they needed to use to give them the best chances of good harvests. However, in 2011 there was a remarkable improvement, as twenty-three had sufficient farming inputs such as seeds, seedlings, fertilisers and pesticides.

With limited coping capacities, WaMuz had the option to give the farm title deeds, her main asset at present, to Jan in order to maximise the chances of her being cared for, as has been the case in other research where older childless people sometimes use their wealth and assets to influence care and support provision (Schröder-Butterfill, 2006; 2004;

Schröder-Butterfill and Kreager, 2005). However, WaMuz refused to transfer farm ownership to Jan. WaMuz wanted to pass the farm to her nephew, and accused Jan of wanting to 'grab' the farm, worsening her already precarious situation.

Respondents SPM11 and KI02 reported that since the mid-2000s, there has been a new practice in the study site where some older people who are no longer able to farm all their land, are using their land as an economic coping resource. Four respondents rented out pieces of land to younger neighbours, referred to as *kushandisa ivhu* (use of land or *usufruct*). That way, a person who wants land accesses it and pays the land owner in cash, groceries, clothes, labour or any other form agreed. Either party can end the arrangement if they are not happy or if circumstances change. For example, in 2011 respondent OP22 stopped letting out his farm because his son was helping him out financially. Farms can also be passed on to the family for inheritance, which could earn the older people social care in return. Land could be sold as a last desperate measure by owners, which except for one, all the older respondents reported that they would not consider selling the farms, but pass them to younger family members. Farm ownership can give older people an upper hand when it comes to decision-making. For example, the younger generation is likely to consult with older people first, to avoid upsetting them, in case it jeopardises their chances of inheritance and some older people could use it as a way of ensuring care and support from children who anticipate inheriting the farms.

While on one hand land ownership has advantages, on the other hand owning land has its disadvantages in the study site and it does not always represent a safety net which people without land lack, making them eligible for government support. Land ownership has been viewed to play an influential role in the almost non-existence of support from the government and NGOs. All older respondents, respondents KI02, KI03, SPM11 and SPM12 reported that by owning or living on farms, people in the study site have not been considered by the government and donor organisations as priority. They are thought to be rich and self-sufficient, at times being referred to as *Warungu* (white people) (Section 5.3.1). However non-receipt of government support on the basis of land ownership is not justified. This is based on their economic circumstances, on past wealth, when the current older people were still able-bodied and self–sufficient, prior to hyper-inflation. Evidence from this thesis shows that despite owning land, some people are still vulnerable. Although most respondents had more land than they could utilise, land is an asset if one can still work on it, otherwise it quickly becomes a liability and a drain on financial resources, especially with the payment of Unit Tax, a form of levy.

Seven respondents have workers who help them with their day-to-day work on the land. Before their circumstances changed in the past ten or so years, all older respondents always employed full-time farm labourers. These labourers always came from surrounding communal areas and some from hundreds of kilometres away, to live and work on the farms. Farm workers have not been recruited from Dowa because either the younger generation were in formal employment elsewhere or they were busy with their own farm work, as reported by respondent KI02. There is the potential dilemma of owning productive land and assets but still being vulnerable unless there is someone able-bodied to utelise the assets. Availability of resources does not always guarantee their use to enhance coping capacity. A number of respondents mentioned that lack of young labour in the study site contributed to the under-utilisation of land and under-production, for example, WaLeo reported that while he had everything he needed, and could afford to pay for labour force, he could not utilise his land as much as he would have wanted because he could not always find the labour force. Apart from their own resources, older people can also rely on kin support.

7.4 Family and kin support

7.4.1 Family and kin support provided

The family is the first and main expected source of old-age care and support in Zimbabwe due to the minimal existence of formal support and care services. The family is the most versatile and important coping resource providing emotional, physical, economic, psychological and social support. It has the main advantages of providing emotional security and an environment familiar in one's old age. As a result, society calls for older people to be supported to live with their own families as this gives them a greater sense of belonging. This is reflected in what respondent SPM01 reported, '*The ideal thing would be for them* [*older people*] *to live with and be cared for by family. This would help to ensure they are in a familiar environment. If the family is able to provide care, that would be the first choice'*.

The family is in fact the main source of support for most of the older interviewees as evidenced by the finding that all 26 respondents with children received some kind of support from the children. The support varied in frequency, types and quantity, depending on the distance and the children's socio-economic circumstances and willingness to help. For example, some respondents were visited by their children fortnightly or monthly, others were visited twice or once a year, and still others even less frequently. Some parents received once-a-year help in the form of agricultural inputs, which they considered as more important than receiving food parcels regularly.

Older people received support from different kin, as Table 7.3 shows. The support was in various forms, depending on personal ability and availability, as shown in Table 7.4. Most kin provided more than one type of support, for example, some visited, brought food parcels and also helped doing some work; others sent food parcels and money. Money is the most convertible of all coping resources as it can be used to purchase items and to pay for services.

Table 7.3: Number of respondents receiving support from different kin

Support from	Yes	No	Not applicable*	Total (N)
Children	26	0	1	27
Spouse	14	0	13	27
In-laws	12	15	0	27
Grandchildren	12	13	2	27
Nephews/nieces	6	21	0	27
Siblings	10	14	3	27

Source: Fieldwork data (2009-2011

* These respondents do not have the named kin

Some kin are more likely to provide support than others, for example, children are expected to provide support more than nieces and nephews because usually the nieces and nephews also have their own parents to support (respondent SPM01). There is less receipt of care and support from nieces and nephews now than in the past, mainly due to conflicting financial demands in the face of inadequate resources, which forces people to choose between supporting elderly parents or their own nuclear family. This inadequate support by younger family members was attributed to economic constraints as respondent SPM10 reported, *'Most families are already finding it hard to cope financially, therefore supporting their older parents is even more difficult'.* However, this dilemma does not affect nieces and nephews only, but other relatives as well. Siblings' ability to help is determined by personal attributes such as their age, health, distance apart and socio-economic circumstances. For example, WaKwen reported, *'Right now, my sister is ill, but I cannot afford to visit her. If I have a little phone credit, I phone and check how she is. She is now too old to travel on the bumpy roads to visit me'*.

Available kin can contribute towards livelihoods in virtue of providing labour and working on the land. While all older respondents were visited by family, and the majority of them received support with food, work, visits and clothes, only fourteen received money from kin (Table 7.4). As a result, they have to meet their own financial obligations, and go without those they cannot fulfil. Of the fourteen, only two respondents (WaLeo and WaCha) had adequate cash as evidenced by the fact that they reported that they could afford to meet all

their financial needs (Section 6.2.7, page 113). Table 7.4 shows the importance of kin support, because it covers a range of needs of older people.

Table 7.4: Types of support provided by kin

Support with	Yes	No	Total (N)
Money	14	13	27
Clothes	20	7	27
Food	25	2	27
Work	22	5	27
Visits	27	0	27

Source: Fieldwork data (2009-2011)

Case studies and kinship maps (Sections 6.3 and 7.2) have been used to explain potential and active sources of care and support as well as showing the versatility and flexibility of the family. The case studies also clarify the coping resources accumulated, which older people can use as safety nets to reduce old-age vulnerability. Below is a short case study showing adequate kin support. The brief case study is an example that if available sources of support are well-co-ordinated, the older person's needs are most likely to be all met as there is no duplication of services while others are missing.

> WaMusharukwa (OP25, male aged about 100) (see Section 5.3.3 for a reminder of how respondents' ages were ascertained) got his entire support from his family. WaMusharukwa was widowed and out of ten children, four were still alive. He had 43 grandchildren, 71 great grandchildren and 10 great-great grandchildren. He lived with his son (a head teacher at a local school), in his late 50s, his son's wife who was his main support and care provider and three young grandchildren. WaMusharukwa's other children lived in towns. Apart from his co-residents, he also received support from his other children and grandchildren to meet all his needs, by visiting, providing groceries and taking him to town for healthcare. He was well looked after, provided for and was smartly dressed on all my visits. WaMusharukwa was satisfied with his circumstances, reporting, *'I am satisfied. I have nothing to worry about, apart from my health, which is fair'.*
>
> When asked if he would consider going into an old people's home, he responded *'I have such a big family and I am well looked after…… My family will keep on looking after me.' Wa*Musharukwa could still do all the basic activities of daily living, but not housework or farm work, which he was reported not to have done most of his life, preferring to delegate work to his wife and children. His daughter-in-law attributed his longevity to avoidance of hard labour. He was one of the twenty people who got his farm as compensation for fighting in the Second World War. His

neighbours visited him regularly. He received no support from the church or government and only received help from an NGO for 3 months during the 2007-2008 drought.

This case study shows the family care and support provision close to the desirable or ideal situation, where different family members help out in different ways. It shows the importance of family as a coping resource to reduce old-age vulnerability. As other case studies show, WaMusharukwa's case is not typical, the family does not always serve as an adequate coping resource. WaMusharukwa is in sharp contrast to WaMeck (discussed in Section 7.6.1) who relied on neighbours' charity despite having a brother living a few metres away and about eight children alive. Their different fates are mainly due to the level of bond they had with their families, and WaMusharukwa's children are reported to have better economic circumstances than WaMeck's. These findings chime well with Kreager's (2004) caution that having a large immediate family does not guarantee old-age care as there may just not be enough people willing or able to provide care.

Although the family is the most important coping resource, it is not always adequate to serve effectively to counter all threats. Family relationships are complex and long-lived and thus relationships can change over time. Most younger family members have multiple and over-lapping roles, for example, as children, parents, aunts, uncles, sisters, brothers, cousins, nieces, nephews, in-laws, friends, grandparents, workers. These multiple roles have a significant impact on support which older people in my study received, as economic resources and time had to be shared among numerous kin, such as balancing time between doing their own work and giving practical support to their elderly parents. Changes can occur over time as the younger and older family members' circumstances change. Such changes can affect the effectiveness of the family as a coping resource. For example, on my follow-up visit, respondent OP15's (WaPoto, female, 15) son had been made redundant from his work in town and had moved back to the farm with his wife and two children, to live with the respondent. As a result, WaPoto had lost any likely financial support.

Some older respondents reported that they received help only after asking their children, bearing in mind the Shona saying '*Mwana asingachemi anofira mumbereko'* (If a person does not ask, no one may know their needs) because at times their needs are not obvious (WaSoko). Six of the older respondents reported that they did not tell their families that they were not coping. They hid the truth to avoid worrying their children and to try to maintain their dignity and pride. This shows that families, like other coping resources, are often first and foremost potential sources of support, and that they have to be actively mobilised. If older people choose not to draw on their families out of pride or concern, then the

effectiveness of families to reduce vulnerability is reduced. This suggests the importance of formal social protection to supplement family resources.

7.4.2 Remittances from migrant children

There are high levels of migration in the study site. With the exception of WaMuz who has no child, and Cha whose only child lives and works about eight kilometres away, all the other respondents had migrant children who worked in towns and seven also had children living outside the country. Migration of adult children is viewed differently, depending on whether or not the migrant children send remittances to their parents. Respondent KI02 argued that, *'Migration has an advantage if those who migrate send remittances, to help improve the homestead and life of their parents by buying implements and inputs and meeting other needs, as well as food to improve diet'*. Of the seven respondents in the study site with children living outside the country, such children were the main source of financial support for only two of them. Three of the respondents received support from migrant children once a year and the remaining two did not receive any support. None of the respondents gave figures for the remittances received. They however put emphasis on the adequacy or inadequacy of the amounts. The data on inadequacy suggests that remittances do not guarantee security (Barrientos, 2007).

From this we can conclude that while on one hand migration can result in increased financial support for older parents, on the other hand migration can at times add to older people's vulnerability as it can result in loss of emotional, physical and even financial support which in some cases results from weakening of bonds created by distance. Empirical evidence shows that some of the children who have migrated from the study site to urban areas support their parents better than most of the foreign-based children. For example, the three respondents (WaNya, WaSiyai and WaMusharukwa) who received the most and varied support from their children did not have children outside the country. These children were also able to visit regularly and assess their parents' welfare and living arrangements. These findings are similar to Kreager (2006) whose research in Indonesia found that having migrant children does not guarantee financial support receipt and also, not all older people with migrant children have been seen to lose filial care and support. Even if the children live near, there is no guarantee of support, for example, in the study site, young adults may not be able to help their parents in the fields because they are busy working on their own. WaNyati asserted that migration cannot be used as a reason for non-support provision, as he provided for his parents, even though he spent all his working life working far away from home. Clearly, the

benefits and disadvantages of migration are an on-going debate with different results, depending on the particular sample being investigated.

7.4.3 Living Arrangements

7.4.3.1 Living Arrangements of Older Persons in Study Site

Living arrangements are explored next because they are a major determinant of old-age vulnerability to many older people. The literature shows that the majority of older people in the developing world co-reside with their younger kin, and this implies that they are in close proximity to family members who might provide them with support. The respondents had varied living arrangements, as shown in Table 7.5. Traditional multi-generational living arrangements are highly practiced in the study site as only three of the twenty-seven older respondents lived with non-family. Twelve older people co-resided with adult descendents, who also supported them with day-to-day work. Of these twelve households, only three households included younger adult couples and their children. The rest of the co-resident children were either single, widowed or had spouses living away. One household was four-generational, twelve respondents lived in three-generation households and three lived in two-generation households. Seven of the respondents lived in skipped-generation households, with grandchildren or great grandchildren under eighteen years and no middle generation(s). Household sizes varied: one household had one member, two had two members each, five had three members, two had four members and one household had five members. Five households had six members each, three had seven members, four had eight members, three had eleven members, while the biggest household had twelve members. The average household size was six members. The national average size is 4.2 (ZIMSTAT, 2012). There was no respondent who lived with their spouse only.

Table 7.5: Living Arrangements of Older Persons in Dowa

	Male	Female	Total
Living alone	0	1	1
Living with spouse, co-wife and young family member	1	1	2
Living with young family member aged under 18	**5**	**5**	**10**
child/nephew/niece*	2	1	3
grandchild/great grandchild (skipped[1])	3	4	7
Living with family member above 18	**6**	**6**	**12**
Child[2]/nephew/niece*	6	5	11
grandchild (skipped)	0	1	1
Living with paid help	**1**	**1**	**2**
Total (N)	13	14	27

Source: Field data (2009-2011)

1. 'Skipped' generation households have the middle generation(s) missing, where the older person lives with a grandchild or great grandchild only.
2. 'Child' includes biological or child-in-law.

* Includes one case each of co-resident paid help

Different living arrangements serve in different ways as coping resources, and as this research shows, there can also be disadvantages arising from co-residence with other family members. For example, respondent WaNya was not happy that she had no autonomy on how her household was run and WaNyati and WaSoko were finding it hard to care for their young co-resident grandchildren. In eight of the ten households with co-residents under 18 years with no other adults, older respondents struggled to cope with the physical, emotional and financial demands of caring for young children, such as buying uniforms, paying school fees, healthcare access, and this was a situation which increased older people's vulnerability. Most of the young children were unable to contribute much to the upkeep of the households, except helping with a few light chores and gathering cattle at the end of the day, leaving the older people to do the rest. In the twelve households with adult co-residents, only four of these children made financial contributions towards housekeeping. The other eight did not make financial contributions and they relied on their elderly kin to meet their financial needs. For example, respondent OP04 (WaRod, male, 75) reported, *'We live with our six grandchildren. They finished school but they have no jobs, they have to be looked after by*

us'. This implies that household members can also be a net drain on older people's resources.

However, there was one outstanding case where the presence of the young children was regarded positively by the respondent. WaCha viewed living with her four young nephews and nieces as of benefit to both generations reporting, *'I am satisfied with the living arrangement. It offers two-way help. I need the children, they also need me, their presence is positive as they are helping me with jobs and company'.* Young adult co-residents at times helped by representing their elderly kin at social gatherings such as funerals and meetings, which the older people would not be able to attend due to ill health or difficulty travelling long distances.

By living alone WaMuz, who was described in more detail earlier, is the most vulnerable because she rarely receives practical help and has a lot of work undone, or done late. The following responses were given as reasons for preference to living with family:

'I would like to stay with my family so they are with me when I die' (WaMuz). This statement is significant as WaMuz is childless and mostly relies on neighbours' charity and is alienating her only close relative living near her. She wants to rely on coping resources which are not there. Apart from being unrealistic, this can affect WaMuz's perception of any support from non-kin.

Empirical research uncovered that eighteen respondents were satisfied with their living arrangements, while the remaining nine preferred to be in different living arrangements, as shown in Table 7.6. However, they are staying in those living arrangements because their circumstances do not allow them their preferences of living arrangements. For example, WaNya; WaPoto would like to live with her orphaned young nieces but they would have to leave her elderly mother, who is their grandmother to live alone; WaDorosa would like to live with one of her children but none of them has offered to take her in. The fact that people do not always get what they want tells us that, there are situations where some older people still end up with bad outcomes and reminds us that vulnerability is not only due to economic resources.

Table 7.6: Respondents' Preferred Living Arrangements

Living Arrangements Preference	Frequency
Satisfied with those they are living with	18
Children	4
Nephew	1
Nieces	1
Grandchildren	2
Others	1
Total (N)	27

Source: Fieldwork data (2009-2011)

There is a recent phenomenon in living arrangements where, with resources permitting, older people live with paid-for help to provide day-to-day support, who would then provide care when the need arises. While this care is non-normative because it is provided by non-kin, this arrangement is a way of ensuring older people remain in their homes. Two respondents lived with paid help only. However, there is evidence of conflicting views on living with workers. Some locals, including a local traditional policy maker consider living with a worker as neglect, giving an example of an elderly lady in her nineties. The lady, a retired teacher: has her own pension, a car in good condition which she hires someone to run errands for her, she is a beneficiary of her husband's pension and receives financial support from her well off children who live in town. She lived with paid help and was viewed as lonely, with her children being blamed for 'abandoning' their mother. However, having older people living with paid help in their own homes is considered better than sending them to OPHs, therefore it is a welcome option. The two respondents who lived exclusively with paid help reported that they were satisfied with this arrangement as it assured them of their choice of living in their own homes, being in charge of their households and running them the way they wanted, for example, choice of meals. Seven others reported that they would have preferred to live with workers in addition to their families if they could afford to pay them or if their families agreed. This shows that with autonomy and economic resources and permitting, some older people would prefer to be in living arrangements they are happy with, than co-residing with kin, which might be inconvenient for them and their younger kin.

Another change is that if there are no other options, older parents may move out of their homes to reside with their children or other relatives. Older people can now be seen residing with any child who is available, able and willing to co-reside and provide care and support. For example, fathers can be seen living with daughters in the daughters' homes. For example, WaNyati lived with his daughter when he went to Harare for healthcare. These changes imply that while on one hand there is a reduction in support provision, on the other hand this flexibility gives the older people more choice of living arrangements. For example, WaNya lives with her sixth son, WaSiyai lives with her eldest son and WaMusharukwa

resides with his youngest son. From this, we learn that when a practice becomes common and acceptable within a culture, it is viewed less as a bad outcome.

7.5 Perception of Old-age Institutionalisation

The family is still seen as the main provider of care and support to older persons as evidenced by 20 older respondents and eleven of the stakeholders and policy makers speaking against institutionalisation of older persons, preferring the family to look after their older relatives. Old people's homes are considered as a last resort coping resource. This is because culturally in Zimbabwe it is 'almost taboo' for older people with family or relatives to be put into care homes (KI01, KI02). Although old-age institutionalisation is not considered as a good outcome by literature and many respondents as discourses below explain, this thesis examines it because it is a necessary coping resource, ensuring the availability of accommodation and care, thereby avoiding homelessness and destitution.

Twenty older interviewees reported that they expected their children or family to look after them, while one was not sure. The six who were willing to go to institutions, reported that they would leave the family to make the final decision whether they would go into OPHs or not. The few who considered institutionalisation reported that they only considered it as a last resort, to avoid destitution or as a way to take the caring pressure off their family. Except for two of the respondents who were at the point of destitution, going into OPHs was not a realistic option for some of the respondents for a number of reasons. As respondent SPM04 reports, '*They are referred by the Social Welfare Department who do the screening, because they have no relatives to look after them'*. Another respondent, SPM06 also explained the admission criteria as, '*They are referred to us by Department of Social Welfare, due to them having been destitute, desperate and vulnerable'*. They would have to go through the selection process, or go into fee-paying institutions which they would not afford.

Even though there has been an exodus of white people from Zimbabwe in the past decade, they are still the majority in most fee-paying OPHs (SPM01, SPM04, SPM06 and SPM07). It is inevitable that some older indigenous Zimbabweans end up in OPHs because there are now fewer safety nets in the form of the immediate and extended family, the institution which has traditionally been the safety net. Respondent SPM08 reported, *'Institutionalisation is not common, but with increased decimation of the extended family and many families being scattered all over the world, it is an inevitable phenomenon'*. Interviewee SPM01 acknowledged that institutionalisation is there to fulfil a need in society, '[There is] *a need which has always been there but is greater today, due to population growth and family fragmentation. The most important thing is the best interest of the older person, that the*

older person is well cared for, which is our concern in social protection'. While both these responses are from stakeholders and policymakers, who reported that ultimately decisions should be made in the best interest of the older persons, some older people were also open to the idea of institutionalisation. Although all residents in two OPHs for Blacks whose two staff members were among the stakeholders involved in this empirical research were sent there due to destitution and they were taken to the institutions by Social Services, results show a shift in attitude towards OPHs, where institutionalisation was given consideration by some respondents, as extracts below show:

WaMani reported that he would go into an OPH if need be because*, 'There would be assurance of being well looked after.* WaMani's situation is such that it is likely he would lack care when needed. Therefore for him going into an OPH would be a good outcome.

WaSiyai would consider institutionalisation for her old-age care, [In order] '*To leave the children free to take care of their own lives'.* She reported that if she were to go into an institution, her family would not feel like they were abandoning her, since it was her choice. In actual fact, this respondent is well supported by her big family and is unlikely to need institutional care.

WaCha argued that although she considers institutionalisation unsuitable for her, it is a good source of care for those whose coping resources cannot afford them a good outcome otherwise, *'My family will not agree to me going into an Old People's Home. They will be able to look after me … I say this because I have a family to care for me, but people like WaMuz and WaMeck, with nothing and relying on neighbours' mercy, would be better off in OPHs. They would be assured of being looked after'.*

WaNya, the respondent whose experiences comprised one of the case studies, reported, *'I would consider going into a home for older people if I am unable to provide myself with personal care, to relieve my family. It is difficult for a daughter-in-law to look after a mother-in-law and my children might be living far'*. This is based on the preference by mothers to be provided intimate personal care by daughters. She reported this despite being well-provided for, and having a large family who all take part in supporting her. Her nearest daughter lives about ten kilometres away with her young family. This is similar to Schröder-Butterfill and Fithry's (2014) study in Indonesia who found cases of older people who had to negotiate their care and settled for options other than their preferences due to failure to access the preferred care.

The above discourse shows that while there is the ideal image of the role of the family, reality is different and some respondents were facing up to the fact that the family may not

be able to provide this ideal care and support, hence considering institutionalisation as a positive coping resource. However, as argued in the literature, most old people's homes have always faced the problem of being under-funded. The situation had got worse during the empirical study as two respondents reported, '*The social worker begs on the institution's behalf'* (SPM04, manager of an OPH), while SPM06, the manager of another OPH explained the situation that, *'We rely on a doctor who works voluntarily'*. This section has argued that the way institutionalisation is viewed depends on the concerned older person's circumstances. However, as is evidenced in the next section, institutionalisation is considered a bad outcome by most respondents.

Respondent SPM01 reported that, '*Modalities for old age care have been expected to, and have always taken place in the family and community, and institutions would be there only to fill the gap'.* Older people and key informants pointed out that in relation to the African culture, Zimbabwe in particular, which considers institutionalisation as 'un-African' and 'unZimbabwean' (WaCha; MaiBay; WaMani; KI1; KI2), it is important that institutionalisation is not viewed as the best possible source of care and support. Respondent WaSoko reported, '*I would not consider going into an Old People's Home. I would rather suffer with the little I have than go and live a life which I have no idea of, being looked after by strangers'*.

For some, being in an institution would constitute a bad outcome from their point of view and it would affect their well-being: *'I would not feel satisfied by the idea of being looked after by strangers'* (WaNyati).

'I would like to stay in a familiar environment and culture. I would prefer to live with my family and be looked after while I am here' (WaBo).

Migration came up as one of the reasons leading to institutionalisation. Respondent SPM01 reported, '*These days some older people in OPHs are not all destitute due to having no relatives to provide for them, but they are destitute because they do not have their own resources'* adding that they have decisions made for them. There are cases of children, especially those living outside Zimbabwe, who are making arrangements for their parents to live in OPHs because they cannot identify people they can trust to look after their parents in their own homes. It is important to note that these older people are not in homes for poor and destitute people, but they are in fee-paying institutions, which respondent SPM02 reported cost at least US$500 per month, which is beyond the reach of many.

Debating how institutionalisation is viewed in Zimbabwe is meant to help the reader understand the position most elderly persons in institutions find themselves in. It shows that

in Zimbabwe, being in an institution is a coping resource which is considered a 'bad outcome' by most indigenous persons, old and young. I have argued that most of those who are in OPHs are there not out of choice but out of necessity. These findings are similar to Gutsa and Chingarand's (2009) and Chiweshe and Gusha (2012) that institutionalisation is only viewed as a last resort for care and support provision in Zimbabwe, but also uncovered a shift in attitude towards the importance of institutions in assuring old-age care in Zimbabwe. The thesis has presented arguments for and against institutionalisation from respondents' points of view. These conflicting ideas inform us about the complexity of decision-making about institutionalisation.

7.6 Support from outside the family

While there is evidence of the importance of the family as a key coping resource, it has also been noted that informal support networks, especially the family on its own, cannot provide adequate support. There are still those who fall through the web of kin support, leaving them in desperate need of outside support. These concerns were raised in earlier studies by UNPF (2002); Kreager (2006); Davis (2006); Lloyd-Sherlock and Locke (2008) who highlighted the vulnerability of older people in countries where old-age support mainly depends on family, because, often families may be too narrow to absorb the challenges associated with old-age care and support requirements.

As will be shown, formal support is minimal in Zimbabwe, especially in the study site. Most older Zimbabweans rely on the community and the church to provide them with care and support, that is additional to family support. This is shown in Table 7.7.

Table 7.7: Support from outside the family

Source of support	Yes	No
Community	20	7
Church	16	11
Government	10	17
NGOs	0	27

Source: Fieldwork Data (2009-2011)

The table shows the hierarchy of the support sources outside of family support during the empirical research, with the most helpful source in the study site being at the top. The community provides the most support, as it benefits 20 respondents, sixteen respondents

benefited from religious organisations (church[42]), while no one received support from any NGO during the duration of the research. Most of the semi-formal clubs, such as savings clubs, stopped in Zimbabwe due to hyper-inflation but there were plans to revive them during my last visit[43].

7.6.1 Community support

Community support in the context of the study site refers to the support from neighbours. This is not limited to next-farm neighbours, but includes even those who live a number of farms away, as long as they live within the study site. Neighbours are an important part of support networks in all interviewees' lives, in different ways. Neighbours help and rely on each other, as respondent WaMeck reports, '*I do not know what I would do without the help of my neighbours. They helped me throughout all the illnesses and funerals and they are still supporting me'*. Neighbours support each other through interest-free cash loans, barter trade, lending and borrowing farming implements, visiting in times of illness, and most importantly, providing companionship and emotional support in times of need, such as funerals. They celebrate occasions such as births, weddings and graduations together and in case of an occasion or an emergency, there are collections of money, food items and cooking utensils to assist at the gatherings. There were different reasons given for helping neighbours, such as '*Kandiro kanoenda kunobva* kamwe' (One good turn deserves another). Some respondents pointed out that there are situations when they identified neighbours as being more helpful than family, hence the saying '*Usahwira hunokunda ukama'* (Adult friendship is stronger than family relationships). In an emergency, neighbours are always made aware so they can assist, and the family who live far can take over when they arrive. There is also a mutual aid society in the study site, which provides funeral assistance, food, labour support and a shroud for members and their families.

For those without children or family to look after them, or those whose family is not supporting them, informal care and support networks through peers, neighbours and the church are the main sources of support. This was the situation with two respondents, WaMuz and a case study which I present next. Both experienced extreme all-round vulnerability and mainly relied on charity.

[42] None of the respondents still visited traditional healers although nineteen of them had at some point in their lives visited traditional healers.

[43] Saving club members pay in contributions weekly, fortnightly or monthly; which are distributed among members in turn. Members can also borrow at low interest rates. The amounts paid in depend on the financial circumstances of the members and those without much cash are often unable to join in.

WaMeck relied on the charity of neighbours and the church. WaMeck spent about sixty years living and working in town and retired without a pension then returned to Dowa in the early 2000s. He had a house in town which his daughter Leah, used part of and let the other part to tenants. She did not pay rent. Leah used the rent money to pay utility bills and for transport costs to visit her father about twice a year, leaving little money for WaMeck's personal use. The rent had stopped due to hyper-inflation during my two visits to WaMeck.

WaMeck and his younger brother WaRod fell out in the early 1970s. WaRod still ignored his brother when he returned home after retirement. At the time of my empirical study, WaMeck lived with his five youngest children, aged ten and below, which was almost like a skipped-generation household due to their age difference. These children do all the day-to-day household chores. WaMeck, who was widowed three times, was mainly cared for by his ten-year-old daughter Jean. WaMeck was considered to be one of the poorest elders in Dowa, economically and demographically since he mainly relies on his minor children. He was referred to by many interviewees, and was given as the example of a person with no care and support network, considered as being 'abandoned and neglected' in his old age. He reported, '*My health is very bad. I have headaches, I dribble sour stuff and I can hardly stand up. I almost fall due to painful legs'.* His poor health was supported by observational evidence, such as being unable to stand up on his own without assistance, needing a walking stick or someone to support him when walking.

He was also supported by neighbours who took turns to care for him after his third wife died in early 2009. Members of his church assisted him mainly through visits after church services on some Sundays, food handouts and ploughing in his fields. However, most of them were poor, so they were not able to help him financially. They could not do adequate farm work and could not care for him constantly because of the long distances between their homes and their own farm work commitments. WaMeck was 'dissatisfied' with his life in general. He was not currently receiving help from the government. The only aid he received from an NGO were food handouts, for three months following a drought, in 2008. WaMeck died in WaRod's presence three days after neighbours gave WaRod an ultimatum that if he did not visit his brother, neighbours would not help him if he needed help.

This intervention by neighbours shows their importance and the positive influence neighbours have on family relationships and care and support provision. While neighbours play an important role towards reduction of old-age vulnerability in the study site, as

WaMeck's and WaMuz's cases show, the community also has its limits, namely not having extra resources to share and being pressed for time and physical energy. For those who are childless and without supportive family networks, the community is the strongest source of support and was considered core by most respondents. Even for those with supportive kin, the community still has its firm position, which cannot be easily replaced by family. For example, neighbours are key in providing emotional support during bereavement and when older people are visited by others of their age. The importance and effectiveness of community and kin support differs, depending on threats faced by different individuals. Kin is important for all-round support and neighbours are important for moral support and borrowing and lending. However, community support is not adequate and sole reliance on neighbours has clear disadvantages, as they have to meet the needs of their families first. Poor neighbours are not able to assist financially, hence WaMeck, WaMani, WaMuz and WaRuma do not receive financial support from neighbours. In rural areas, bad weather conditions (reviewed in Section 3.2, see Section 6.2.2) usually affect people within the same vicinity, therefore neighbours usually face the same threats, reducing their ability to provide assistance. Neighbours can provide practical support in the absence of supportive family and also relieve family carers by taking turns to provide care. Neighbours can intervene and force family members to provide care and support which is expected of them. However, neighbours' effectiveness is often determined by farming activities. For example, at times they would have to make a choice between caring for a neighbour and leave their work undone, thereby putting their livelihoods in jeopardy or attending to farm work. All this underlines the importance of formal support to reduce older people's vulnerability. Religious organisations are also a coping resource for some respondents.

7.6.2 Religious Organisations' Support

The church is a personal source of resilience and coping for a number of respondents. Sixteen older respondents cited religious organisations as an important part of their support networks. They received support from the church mainly in the form of visits offering spiritual and emotional support which they considered invaluable. WaLeo explained the importance of the church to him, *'I consider the church as my family because I grew up in the church and never knew life without the church'.*

However, most church members do not have enough money to contribute to churches to use as reserve funds to provide financial assistance (WaReru). The visits are also infrequent due to members' busy work schedules and long distances between homes (WaCelia). By not receiving any support from the church, seven of the eleven respondents felt they were

'abandoned' by the church because they were unable to attend as regularly as during their active years. This non-attendance was due to inability to travel long distances to church or to visit other members. WaMeck (page175) and WaMuz's case studies show the limits of support available from the church. It is therefore interesting to find out what support is received from the government to a population where the community and personal resources are not strong enough to counter to avoid bad outcomes.

7.6.3 Government Support

Unlike in many other developing countries, pension payments from the government do not play a significant role in the study site. Of the 27 respondents, only ten receive some support from the government. Although six respondents received pensions, four of these are contributory pensions. I do not include these four respondents receiving pensions, under the rubric of government support because they receive contributory pensions, without government support. Two respondents receive US$40 a month in 'widow's pensions' as compensation for the death of their husbands during the war[44]. Both women receive the pension not due to their age, as they have been receiving it since the early 1980s. One respondent received agricultural input loans and the other two received both free healthcare and about 10grams of vegetable seeds. Apart from free healthcare access received by seven respondents at the local health centre, none in the study site benefited from schemes such as 'Unconditional Cash Transfers' or Assisted Medical Treatment Orders (AMTOs) to use at bigger government health centres for free healthcare, which respondent SPM04 reported were used by older people at the institution where he worked. Respondent SPM11 asserted that, *'There is nothing designed for older people in Manicaland, Makoni, Dowa,* [I have] *not come across it,* [I have] *not heard about it,* [I have] *not seen it'*. All other respondents mainly talked of unfulfilled promises by the government, '*We receive no help from the government, only promises not fulfilled. We are still awaiting agricultural inputs, half way into the farming season'* (WaSoko). With so few older people receiving public or social assistance, a number of respondents raised their concern about lack of state assistance for older people, comparing with neighbouring South Africa. For example, WaLeo asked, *'Why don't we have old age pensions for everyone, like in South Africa?'*
NGOs were pointed out as another almost non-existent formal source of support to older people in the study site.

7.6.4 NGO Support

[44] War Victims Compensation Act (Chapter II: 16, 1980).

NGO support refers to support from Non-Governmental Organisations (NGOs) as registered under the Private Voluntary Organisations (PVOs) Act (Chapter 17:05, 2007). Most of the NGOs operating in the country are foreign-funded, hence their ability to provide humanitarian aid, even during hyper-inflation. Nationally, the most vulnerable groups were considerably affected by the political climate as it led to reduced donor support. There was no aid aimed at older people from any NGO sources during the empirical study, WaBo explained by saying, '*People in Dowa are viewed as self-reliant, therefore NGOs are not willing to help us'*. Large land-ownership is used as a measure that they are wealthy and do not require support outside of family. Based on their experience during the 2007-8 drought, when only nine respondents received assistance from an NGO, all respondents doubted if they would ever get NGO support in non-emergency situations. The NGO used the criteria that the beneficiaries had to fulfil the following conditions: being widowed, being invalids or living in households with orphans. Only households with two cattle or fewer qualified for aid. Those with more cattle were considered not 'desperate enough' (WaBev, respondent OP16, female 55) as they still had the option to sell their cattle to support themselves and would only start qualifying for aid if their number of cattle fell to two. Selling cattle would deplete medium to long-term resources and leave them with no draught power for future farming. This would affect future production, and also leave them feeling worthless, because cattle are important in the life of indigenous Zimbabweans. They are a measure of wealth and status, and not affording a beast to slaughter for an adult's funeral is the highest sign of poverty.

Two organisations in Zimbabwe advocate for the scheme called 'adopt a granny' where an allowance is given to the family providing care so they can meet the older person's financial expenses (SPM04 and SPM07). Such arrangements allow older people to stay in their homes or with their families. Respondent SPM04 reported that although their organisation was mandated to cater for older people, they found it 'impossible' to separate older people from Orphans and Vulnerable Children because many older people in the areas they operated lived with OVC. They therefore use an intergenerational approach, with emphasis on older persons-headed households with OVC. As a result, older people not looking after orphans are not priority and 'very few receive help from the donor community' (SPM04). The best they have been able to do is to advocate for older people's rights through lobbying for the Older People's Bill to be made into law. This particular NGO does not operate in the study site, so even those looking after orphans do not benefit from this scheme. Since evidence has shown that most coping resources are not sufficient on their own, I now move on to examine the advantages of coping resources complementing each other.

7.7 Complementing coping resources, the role of reciprocity and limits to coping capacity

7.7.1 Complementing coping resources

Empirical research has argued that one source of care and support is typically not enough to guard against old-age vulnerability because coping resources differ in quality, frequency, effectiveness and relevance to different threats. Older people's circumstances improve when multiple coping resources complement each other to fulfil the need left out by the others as evidenced by these brief case studies:

> Case study WaNya is well-provided for by her children and she also receives a widows' pension which she reported was not enough on its own. Her circumstances are very similar to WaSiyai who also received widow's pension and was well provided for by her children, for example by being taken to town for healthcare. It is possible that the fact that she received a pension contributed to the adequacy of the family support, as they were supplementing her own resources.
>
> WaSiyai received a widow's pension since shortly after independence. She lives with her eldest son, his wife and another son who all assist her with farm work and housework. She has high blood pressure, asthma and bad knees and she can hardly walk. One of her sons collects her to go to Harare for healthcare. She can do all other basic ADLs except toilet use, for which she needs help reporting, *'The toilet is difficult to use because I have to squat, yet I cannot balance on my knees'*, because she uses a pit latrine where a user squats as there is only a hole but no seat. She is supported with toilet use by her daughter-in-law or granddaughters when they are not at school. Her other children, neighbours, brothers and church members visit her. She reported that she was 'very satisfied' with her circumstances.
>
> WaKwen has the most expensive house in the study site and financially he is only second to WaLeo. He receives a pension from when he worked for a multi-national company in Harare. WaKwen and his wife Tilda receive groceries and visits from three of their five living children. When their co-resident son is not around, a neighbour takes their cattle to the dip, free of charge. The couple are well-off due to a combination of the pension, family support and the farm produce which they consume and the cash they realise from produce sales.

WaBay and MaiBay have seven surviving children. One son lives with his family on the same yard at the farm and teaches at the local school and checks on their day-to-day welfare. In addition to farm produce, WaBay receives a contributory pension as a retired teacher, their son helps to buy him medication for diabetes and all the daughters visit and buy them groceries every three or four months and help with farm work during school holidays. Church members visit to offer prayers. Neighbours support them through visits, borrowing and lending each other and emotional support.

These four brief case studies highlight different combinations of coping resources which are available and accessible to the different older respondents. The good outcomes demonstrate the importance of diverse sources of care and support as they complement each other to reduce old-age vulnerability, in these cases the family, community and formal support in the form of pension. Empirical research results suggest that there is a relationship between pension receipt and family support, as the six respondents receiving pensions are not entirely financially dependent on their families. Having a pension commands respect, reduces poverty and emotional vulnerability as it affords older people the chance to reciprocate, which can be used to ensure better family and community support. The fact that all cases of people with pensions are secure due to the large part played by pensions, underlines the point that policy interventions would be needed to make people secure, because informal sources are insufficient.

7.7.2 Ability to reciprocate

Empirical research found evidence that there is a general two-way flow of support between most of the older respondents and their support networks of family, friends and neighbours. Older people helped younger generations mainly through giving advice, food parcels, child minding and paying school fees for grandchildren whose parents could not afford them. However, a person's ability to reciprocate can reduce with age and older people hope the younger generations will remember the support they received in the past. As WaCha reported, *'I work hard to look after, and improve my brother's home and I hope he notices this so he can reward me by supporting me when I am older'.* To a certain extent, the ability to reciprocate determines support received by some respondents because those who are better-off are observed to receive 'better quality' support and more frequent visits as they generally give more when there is need, compared to those not well-off, with less or nothing to offer. For example, WaMuz does not always get help when she needs it which she attributes to her inability to reciprocate, yet WaNyati who has a pension and helps other

neighbours, receives many visitors. By giving to others, some respondents reported that it improved their emotional well-being, making them feel they are still useful and part of the family or community. These findings are similar to numerous studies which argue that inability to reciprocate can make older people feel more vulnerable, while reciprocating can assure continued respect and care and support provision (van der Geest, 2004a; Schröder-Butterfill and Marianti, 2006; Vera-Sanso, 2004; Heslop and Gorman, 2002).

7.7.3 Limits to coping capacities

Ability to access coping resources can limit their effectiveness or make them not effective at all. For example, although he had a house in town, part of which was being let out to tenants, WaMeck did not benefit from the rentals, as explained earlier. The findings further contribute to the assertion that ownership of assets (mainly farms and farming equipment in fieldwork site) and other coping resources on its own is not enough to explain the degree of older people's vulnerability, or provide security and reduce old-age vulnerability. Equally important is the ability to access them and mobilise them in the event of a threat. WaMeck's case is similar to Paradza's (2009) findings that ownership of a property in an urban area in Zimbabwe, which is a major source of income through rentals, did not necessarily equate to benefiting from it as the rentals were used up by younger family members.

Despite all the available and possible coping resources, older people in Zimbabwe still face a number of challenges affecting their coping capacity due to the coping resources being inaccessible. For example, accessing healthcare is still a major problem because 'Assisted Medical Treatment Orders (AMTOs) are not '100% dependable', as they are not always accepted by health institutions (Respondent SPM09) and no one in the study site had ever been offered one. No one in the study site received the $20 paid in some areas, under the Social Welfare Assistance Act (1988), because as explained, they do not fulfil the eligibility criteria and are considered not 'desperate enough' to qualify. The assessment for the US$20 social allowance is based on their life histories, although most of their circumstances have since deteriorated. In addition, there is the problem of 'politicisation of aid' (Mutasa, 2011) in some rural areas where prospective respondents have to produce ruling party cards in order to access donations or subsidised items. Similarly, the distribution of subsidised items such as farm inputs was not publicised in the study site, but messages were passed through the 'Ruling Party grapevine' (WaCha). This stopped some needy people from receiving assistance.

Since empirical study was carried out during and after hyper-inflation, there were changes in all respondents' circumstances due to the improved economy. While the economic situation

was worse during hyper-inflation, for most of the respondents the effects were still visible and strongly felt in 2011. Except for WaLeo and WaCha, the rest had not yet recovered from the effects, while those whose circumstances had improved were still below pre-hyper-inflation standards. Recovery may also be slower and take longer because recovery from bad outcomes takes longer in old age (Grundy, 2006). Even if they appear to have similar attributes, older people can have different outcomes due to their different circumstances. In some cases, the older people may not be able to utilise the available coping resources, for example, WaLeo had a car in good working condition which he could not drive due to poor eye sight and arthritis in his hand. He could not find someone to drive him if he needed to go to the healthcare centre. He had a bicycle he could no longer ride, which still left him vulnerable to lack of transport. This case demonstrates that there is still need for formal support even for those who appear to be secure. Policy interventions would be the only way to reduce old-age vulnerability and increase security, for example by the provision of transport and improvement of roads.

7.8 Respondents overall vulnerability

Having explored coping resources which the older respondents have at their disposal, in response to exposure factors and threats faced, this section makes a critical analysis of the older respondents' overall vulnerability. The respondents faced different threats at different severity levels and they emerged at different levels of vulnerability. For example, although difficulty in accessing healthcare was a threat faced by all respondents, regardless of their economic circumstances, five of them were taken by their children to town for healthcare. Table 7.8 shows the different risk factors and threats faced by older Zimbabweans, available and assumed coping resources and possible outcomes, depending on personal circumstances. The idea of 'Pathways to old-age vulnerability in Zimbabwe' (Table 7.8) is the product of a combination of Schröder-Butterfill's (2005) work on Indonesia, 'Pathways to a lack of Care in Old Age' and empirical research findings. Some of the 'Pathways' are applicable even to younger people, however, some older people are more prone to exposure to the threats due to reduced ability to adapt.

Table 7.8: Pathways to bad outcomes in old age in Zimbabwe

Exposure	Threats	Coping capacity	Bad outcomes
Poor health Spouselessness Childlessness Lack of local children Poverty *Poor infrastructure – roads, transport, healthcare centres *Inadequacy of farming implements, inputs Disease and death environment, especially high HIV/AIDS prevalence Homelessness	Loss of key source of care and support (including spouse, children, grandchildren) Illness, disability Migration by younger generations *Agricultural and marketing failure *Failure to get to health centres Loss of key sources of livelihood	Social networks: friends, family, relatives, neighbours, church Remittances Savings** Formal support and pensions** Mutual assistance clubs	Lack of physical care, financial, emotional, spiritual, social support Extreme/catastrophic poverty Very poor quality of life Loss of autonomy Bad or untimely death Abuse

Source: Adapted from Schröder-Butterfill (2005:144) 'Pathways to a lack of Care in Old Age'

* Applies mainly to those in rural areas

** Very minimal in Zimbabwe

There are external threats of agricultural and marketing failure which include poor harvests, failure to till the land, failure of crops, failure to get farm produce to the market, animal and crop disease, death of livestock, floods, droughts, inflation, threats to livelihood security as a result of the climate, market collapse, infrastructure. Poor infrastructure, especially bad roads, results in unavailability of transport. When threats manifest, the internal side of vulnerability manifest itself, in the form of capability (or not) to cope due to unavailability or ineffectiveness of coping capacities. Poor production leads to lack of food and money and this may lead to debt, subsequently resulting in loss of farms to debt collectors.

The coping resources all differed in quality, quantity, frequency and effectiveness in reducing vulnerability. For example, respondent WaCha has 28 cattle, 22 goats and more than 70 poultry which she can slaughter for meat; she has sufficient farming equipment; always has

enough farm produce for consumption and sale (even during the 2007-8 drought[45]) and her only daughter and brother bring her groceries when they visit every weekend. As the study results show, not all resources are equally available to people, nor are they equally reliable or sufficient to counter different threats to afford a basic quality of life. Older people can use one available coping resource to convert into another coping resource, for example, using money to pay for transport and labour force, excess produce in exchange for labour force, child-minding in exchange for support from kin. We have also been informed about the challenges which could impede use and effectiveness of the coping resources in achieving good outcomes. Some coping resources are more versatile than others, either because they cover a range of contingencies, for example, family support can cover material, practical, emotional or physical needs or because they can be 'converted' into a range of items and services, for example, money can buy transport, food, labour, care, etc. Some coping resources are better able to be converted than others, for example, land is not easy to transfer into cash or other forms, because the farmers are not allowed to sub-divide and sell small pieces, unless it is the whole farm.

To a large extent, respondents' economic circumstances determine the availability, accessibility and effectiveness of their other coping resources, because money is the most versatile and convertible coping resource, and can be used to offset other shortcomings. Five respondents (WaNya, WaLeo, Musharukwa, WaCha and WaSiyai) emerged as the most secure. Of these five, respondents WaNya, WaCha and WaSiyai are all widows, suggesting that widowed mothers are well provided for by their children. The most secure had either adequate own resources, kin support, pensions or some coping resources complementing each other, allowing them access to other services needing paying for. Seven respondents (WaNyati, WaBay, MaiBay, WaSoko, WaKwen, WaBo and OP24) emerged as moderately vulnerable, eleven were marginally secure and the remaining four respondents (WaMeck, WaMuz, WaMani, WaRuma) were the most insecure, all-round vulnerable, as they relied on community charity for almost everything. Failure to receive the expected care was viewed as a bad outcome for older people. Added to other threats he faced, WaReru's vulnerability was made stark by the conspicuous absence of women in his household. He relied on neighbours for most domestic work and hygiene-related tasks. This absence of women is significant in a culture where men usually rely on women for most household chores and care provision. WaMuz, WaMani and WaRuma were all highly vulnerable to homelessness due to poverty, because there were no resources to counter this threat. They needed financial support to settle the Unit Tax and loan arrears in order to avoid

[45] Part of the farm consists of wetlands, which are not affected by droughts and the other part has soils which are consistent with Region 2 rainfall.

homelessness. The availability of cash would allow payment for certain services, for example, WaReru, WaMuz and WaMeck's circumstances would improve if their households could afford to employ some paid help. No coping resources were available to offset the threat of transport problems faced by all the respondents and loneliness faced by some respondents. Both these threats could be countered by the availability of transport. The issue of transport requires a response from the government, through infrastructure provision. Those respondents between the most secure and the most insecure still face a number of vulnerabilities which their coping resources cannot offset.

All older respondents had access to community support mainly through visits or whenever there was urgent physical, social, financial or emotional need, the frequency and effectiveness which varied. This research found evidence of the disadvantages of relying mainly on the family, not least due to the HIV/AIDS epidemic and poverty resulting from the economy which culminated into hyper-inflation. WaReru is among the most insecure, yet all his eight children are alive.

Overall, widowed mothers were provided for to a greater extent by their children, compared to widowed fathers, for example, WaMeck and WaReru were among those most vulnerable, despite having a large number of children each. Rural living has an impact on all respondents because they still face the threat of natural weather conditions discussed in Section 3.2, such as droughts, yet none of them has any coping resources such as farming insurance in place, so they all remain vulnerable.

Individuals may have different outcomes even when faced with similar vulnerabilities due to different levels of resilience. Even though they face great vulnerabilities, some respondents manage to cope through personal ability to adapt positively to threats, argued in Section 4.2.5.1 as the internal side of vulnerability which responds to shocks, risks and stresses. For example, WaRuma reported, '*My health is bad, I have kidney problems and nausea at times and I have been told it is due to the kidney. I have hypertension, one eye doesn't see, the other one is poor. I have bad legs and painful joints, a bad back and it is difficult for me to stand'*, yet she did most of the ADL on her own except cooking, collecting water and firewood. On my second visit, she had just got ready to walk the five kilometres to the shopping centre to attend a meeting, having heard rumours that attendees would be given some agricultural inputs. On asking some of the attendees later on, they reported that there were no plans to give handouts, but it was meant to boost numbers of people attending a ZANU (PF) party meeting. WaCha reported that her way to cope is that [She tells herself to] '*feel positive, to think and say it's not only me with the problems because feeling and looking sad does not improve situations'*. WaCelia does most of her work using one hand because

she uses a walking stick due to poor mobility. Again this is an instance of someone showing resilience in the face of serious adversity.

We learn that while respondents in the study site are exposed to different natural conditions such as recurrent droughts, floods, crop failure, hail, animal and crop disease, they have no coping resources in place to prevent these threats from pushing towards bad outcomes, such as famine, inadequate food, animal loss and general loss of livelihoods. As a result, the respondents all remain vulnerable to natural weather conditions. Despite the many threats faced, especially during the drought and hyper-inflation period, there were no sales of assets in the study site, which Lawson (2009) terms 'desperation sales', where people sell assets as coping mechanisms to meet immediate consumption needs. All respondents maintained 'asset-smoothing'[46], due to fear of declining deeper into poverty (Hoddinott, 2006; Zimmerman and Carter, 2003; Moser, 1998) as they would find themselves short of assets which would have long-term effects on their livelihoods. This was maintained regardless of an NGO suggesting that potential aid recipients sold their cattle to raise money to purchase food (discussed in Chapter 7.8.4) and would then qualify for aid when the number of cattle fell to two. From this chapter, we now know what is in place and what is lacking.

This study did not find an answer to a question I raised in literature, that earlier studies by Allain, et al. (1997) and Wilson, et al. (1991) did not identify any elderly infirm respondents. I questioned what happened to older people when their health deteriorates. Wilson et al. (1991) queried whether the rapid decline was due to withdrawal of support. I had questions as to whether this non-identification of infirm older people was due to the selection effect. Despite some of them being advanced in age (Table 5.2), the current study also did not uncover infirm older people. All respondents were still mobile and able to perform most ADLs, with only three needing help with some of the ADLs. The only older respondent, WaMeck's health deteriorated quickly and he died within the four months in between my third and fourth field trip (Figure 5.1). This may well indicate a selection effect, with many vulnerable older people dying before they reach old age, and that lack of support means that once older people become dependent they quickly perish. Therefore the empirical study had no opportunity to ascertain the specific vulnerabilities faced, needs and care and support provided to infirm older people. This gap in knowledge still remains.

7.9 Summary

[46] Preserving assets during bad economic times and not using them to meet immediate food needs.

This chapter discussed potential and available coping resources amongst older persons and the different outcomes for different respondents and reasons for those outcomes. The various older people's circumstances and the availability, access and relevance of coping resources determines the risk of encountering a bad outcome as well as the level of severity of the outcome, referred to as degrees of vulnerability (Schröder-Butterfill, 2006). Even when a group or community is exposed to the same threats and access the same coping resources, individuals may still have different outcomes. While the family is the expected main source of old-age care and support in Zimbabwe, empirical evidence suggests that in many cases, the family's reliability as a core coping resource is not strong enough to counter the threats, therefore a diversity of resources would help reduce old-age vulnerability. Different coping resources such as personal wealth, as well as formal, semi-formal and informal social security systems helped to mitigate the threats. Close examination of coping resources showed that support networks such as the extended family, friends, neighbours and mutual aid societies were affected by the exposure to threats such as HIV/AIDS, poverty, the economic downturn and out-migration and were therefore not able to help as much as they used to. Ideally, formal support sources such as the government and NGOs would be expected to be able to counter threats such as droughts, because all the informal sources such as neighbours, church members and the family have limitations and they may also be facing the same threats. However, there was hardly any support for older respondents, by the government. Past, current and the possibility of future exchanges also emerged as determinants of old-age vulnerability and security. The thesis now moves on to the discussion chapter, where empirical research evidence is explored in relation to literature to enable the thesis to discuss implications for policy and practice.

Chapter 8: Discussion and Conclusion

8.1 Introduction

This thesis investigated determinants of old-age vulnerability, threats faced by older people and the sources of care and support available to reduce old-age vulnerability in the context of risks such as HIV/AIDS, poverty and out-migration in Zimbabwe. This chapter provides a critical evaluation of the thesis by drawing together the literature and key empirical research findings, while also discussing limitations of the research. The chapter will re-examine theories on the changing dynamics of support in relation to findings, critically assessing whether the theories reviewed earlier in the thesis are supported or refuted by the empirical findings.

In addition, this chapter distils implications from the findings for policy and practice and proceeds to make recommendations for further research. This chapter will further deliberate what insights can be gained about key themes such as changes in family and kinship support, reciprocity and the relative importance of HIV/AIDS.

The study sought to answer the following research questions:

1. What are the main determinants of an older person's vulnerability in rural Zimbabwe?

2. What are the key threats which older people face and how do they affect their well-being?

3. What coping resources are available to older people in rural Zimbabwe?

8.2 Summary of key findings in relation to literature

Chapters 6 and 7 presented a large body of empirical evidence from the field research. Here I shall focus on three key findings which the thesis contributes to our understanding of ageing in Zimbabwe. The first is related to older people's threats. Research on ageing has often observed that older people living in rural areas face particular challenges and are exposed to natural weather conditions, which can affect livelihoods (Devereux, 2001; Kaseke, 1993; Williams, 2003, Section 3.2). The key threats faced by older people in rural Zimbabwe are: ill health, lack of support, transport problems, difficulty in accessing healthcare, and inadequate resources due to reduced earning capacity and the poor state of the economy, resulting in increased financial vulnerability and poverty. The other most common threat of difficulty in accessing healthcare is due to either transport problems, not affording user fees, or both (Section 6.3, Table 6.2). Among these threats, transport

emerges as a new finding compared to existing research. All respondents are exposed to transport problems, affecting other areas such as healthcare, community and family relations and support. This study goes further than studies by UN (2009); Lloyd-Sherlock (2000); Heslop and Gorman (2002) on difficulty accessing healthcare in rural areas as it provides more detail on different hurdles to health and livelihoods and how they affect older people's well-being. The study site location affects the importance of this finding due to the commonly available mode of transport and long distances from health centres. In addition to being slow and unrealistic at night, travelling on carts is very uncomfortable and some respondents pointed out that use of such transport made them feel more ill due to the discomfort of carts on the bumpy roads.

Secondly, this study recognises that having one kind of wealth (land) does not necessarily mean less vulnerability. While owning a farm may be considered as a sign of being comfortable and can be used as a coping resource by renting it out or passing it over to younger relatives with the hope of receiving care and support in return, the farms can at times be a burden in terms of upkeep, yet they cannot be sub-divided for sale. Those living in small scale farms are a sub-group of older rural residents who can face greater vulnerabilities than others in more populated areas. These findings are different from Shutt (1997) and Ranger (1985) who concentrated on land tenure.

Thirdly, poverty as a result of hyper-inflation is a major determinant of old-age vulnerability in the study site. The study acknowledges the impact of HIV/AIDS on some respondents' lives. However, contrary to most recent studies on ageing in developing countries hard hit by HIV/AIDS (HAI, 2008; WHO, 2002; Kaseke, 2003; Kautz, et al., 2010), empirical evidence uncovered that hyper-inflation was a more significant determinant of changes in family and kinship support than HIV/AIDS. For example, obsolete farming equipment and vehicles and homes not being maintained to older respondents' satisfaction were attributed to recent poverty due to the poor state of the economy. Some older respondents who reported inadequate resources, reduction or loss of care and support had not experienced HIV/AIDS-related deaths or illness within their families. In other instances, the late children did not support their parents when they were alive. There were also cases where the parents did not support or care for the adult children when they were sick.

8.3 Thesis Contribution

This thesis makes four empirical, one theoretical and one methodological contribution to new knowledge. The first empirical new contribution from this study is the results outlining the infrastructure and institutional support challenges faced by older people, which tend to be

neglected in studies on older people, as there is often emphasis on the family or community aiming at reducing old-age insecurity (World Bank, 1994; Aboderin, 2004; Madzingira, 2006; Kaseke, 1998). Unlike in Tanzania where a study was carried out solely focussed on older people and transport, there is no literature on older people and transport in Zimbabwe (International Forum for Rural Transport and Development (IFRTD), 2009). This study results show that transport is a key determinant of old-age vulnerability as it affects most livelihood activities, access to health and impacts on community and family support.

Secondly, although the living arrangement preferred by many respondents is to live with family members, there is a shift in attitude towards a broader range of acceptable options, such as living with paid help, as this allows older people autonomy and a say over running their households in the way they want.

While the literature and some of my evidence supports the view that old-age institutionalisation was a bad outcome, I found that institutionalisation is gradually being viewed positively and accepted as an alternative to co-residing and care-provision by family. Unlike in earlier studies by Madzingira (2006), Kaseke (1998) and Nyanguru (1990) where black respondents were in old people's homes due to destitution, six respondents for this study reported that they would be willing to go into institutions on their own accord, for example, to relieve their families. The changing nature of care provision and receipt was also hinted in expert and stakeholder interviews.

Thirdly, this study was carried out when the population was faced with threats of HIV/AIDS, poverty which was exacerbated by hyper-inflation and out-migration which was at its peak between the years 2000-2011 (ZIMSTAT, 2013; WHO/HAC, 2008; UNFPA, 2008; UNDP, 2010; ZIMSTAT/IOM, 2010). It therefore brings new knowledge on old-age vulnerability and security in Zimbabwe as the population lived under the challenging conditions.

Fourthly, the research makes an original contribution to knowledge in that no previous research has been conducted specifically in the environment of small scale commercial and subsistence farming areas which represent the livelihood and social circumstances of many older people in the country. The people in the study environment have to pay Unit Tax, irrespective of whether they have good agricultural returns or not. The busy work schedules and distances between farms reduces opportunities to socialise.

A fifth contribution is that, theoretically, this study is the first one in Zimbabwe to use the vulnerability framework in old-age studies. Studies such as Muruviwa, et al. (2013) use the livelihood approach. Finally, the study contributes methodologically to research on ageing in

Zimbabwe as a longitudinal study, allowing the observation of changes, positive or negative, which took place over the study period, November 2009 - November 2011.

8.4 Theories of Ageing in relation to the study findings

In Chapter Four I reviewed a number of theories relevant to understanding ageing and old-age vulnerability in developing countries. Here they are briefly revisited in the light of my empirical evidence to assess the extent to which they can explain the results of this study. I will then return to a fuller discussion of the vulnerability approach.

8.4.1 The Ageing and Modernisation Theory

Underpinning the ageing and modernisation theory is the idea that as societies modernise, the family ceases to fulfil a range of economic functions and generations are separated through migration. The thesis empirical findings suggest that this theory does not explain the changes in family and kinship support in the study site. Evidence demonstrates that those who did not receive adequate support had children with poor economic circumstances or other financial responsibilities which left them without enough resources to share with their parents.

While modernisation has brought about migration to cities and outside Zimbabwe and the receipt of remittances, there is no conclusive difference between support from migrant and non-migrant adult children, to justify the relevance of the ageing and modernisation theory. Empirical evidence suggests familial and kinship values were still being upheld in the study site, with those still able to, maintaining visits and providing for their parents. The frequency of visits had been affected by the unaffordability of transport costs and gifts which are usually associated with the visits.

Contrary to findings by Bracking and Sachikonye (2006) and Madzingira (2006) that foreign-based migrant children supported their parents more than those based in Zimbabwe, this study found that with few exceptions, children in Zimbabwe support their parents more than those who are foreign-based. While most children who migrated from the study site support their parents financially, those who live with or near the parents support them in other non-financial ways. On the one hand, migrant children supported their elderly parents, mainly with material and financial support which enabled them to pay for some services and items to reduce vulnerability. On the other hand, having children living locally was also an advantage in that younger generations provided emotional and practical support and checked on their parents more often than migrants. Kreager (2006) found more varied

results. Remittances and visits to parents differed across the three Indonesian communities studied, which were also compared across strata. Destinations were mainly determined by the social strata. Migration was highest among those from lower strata, as they were poor and had little land and faced intergenerational transmission of poverty. Those who stayed were unable to provide effective support.

8.4.2 Exchange Theory

According to exchange theory, older people who are able to reciprocate in some way will often and more reliably receive support. This implies that support is dependent on what older parents have to offer or have offered in the past. My empirical evidence from Zimbabwe suggests that the exchange theory is useful in analysing patterns of care and support provision and helps to explain the fairly high levels of support irrespective of whether it meets the older parents' needs or expectations. There is an exchange of support between different generations, and a general two-way flow of support between most of the older respondents and their support networks of family, friends and neighbours. Even though they expected their off-spring to support them, all the older respondents still made sure they were giving something back to their adult children, in different ways they could manage, to maintain the balance of reciprocity. Even though the older respondents were all still able to give something back, evidence suggests that even if older people become too frail to reciprocate, support would still be provided based on the tenets of exchange theory.

The empirical evidence from Zimbabwe uncovered that apart from the exchanges between parents and their children throughout life, care and support provision and expectations are culturally enshrined. All the interviewees, regardless of generation, reported that it was expected of children to support their older parents in return for the parents having brought up these children. However, there were conflicting findings. On the one hand I found support for exchange theory; on the other hand there is evidence that children are supporting parents out of fear of sanctions, as a result "merely" of cultural norms. It was difficult to tell between the influence of the exchange theory, loyalty and the fear of the cultural-related sanctions because a number of respondents talked about the two inter-changeably. Failure of children to provide support for elderly parents could result in ridicule by the family and society, and moreover could bring about misfortunes. There is need to follow up on this finding that support provision is culturally enshrined and younger people are expected to enact out of fear.

8.4.3 Ageing and the Altruism theory

Altruism proponents argue that it is those parents with most needs who receive care and support from their adult children. Support is given out of consideration for the recipient's needs, rather than any expectation of returns (Piliavin and Charng, 1990; Bianchi, et al., 2006). While this theory helps explain instances of support provision to parents who did not support their parents while they were growing up, this thesis was not able to ascertain the level of earlier support from the children to their parents, as the younger generations were not included in the research. Altruism was certainly not supported by my findings on family support, as the needy parents did not receive more assistance. In contrast, it was those parents who were better-off who received more from their off-spring, pointing rather to the relevance of exchange theory. However, altruism was practised at the level of the community, as the community took the responsibility of supporting those in dire need of support and also influenced families to provide support.

8.4.4 The ageing and materialist theory

Materialist or political economy theories for explaining old-age support would lead us to expect that it is particularly poor families who do not provide support, and that with growing poverty less support is provided, especially to more distant relatives and then also to elderly parents (Narayan, et al., 2000; Hulme et al., 2001). Empirical evidence lent some support to this hypothesis because most of the respondents who did not receive any support or received what they considered as insufficient support from their off-spring reported that this was due to the younger generations not having enough resources to share with their elderly parents. This was evidenced by older respondents' description of their children's financial circumstances and the jobs they did, which presented a picture of their financial positions. The inability to provide for parents was mainly attributed to recent poverty resulting from the volatile political and economic environment. Consequently, most adult children were unable to meet the needs of the immediate family, let alone the extended family, including parents.

Only fourteen of the 27 older respondents received financial help from their families. In the study site there were no chronic or long-term poor older people or families (Hulme and Shepherd, 2003; Prowse, 2003; Hulme et al., 2001). This is because the population until recently, was quite prosperous with most families owning enough land and producing enough to live on and, for example, affording to send children to boarding school. Economic circumstances deteriorated after 2000 due to the recent socio-economic and political

situation in Zimbabwe. Most of the older respondents compared the support they used to receive from their children and what they were currently receiving, which was much less or nothing. They attributed these declines to the poor economy (Clemens and Moss, 2005). The results further concur with the assertion that when families are poor, they are often unable to counter threats and therefore act as inadequate coping resources (Kreager, 2006; Davis, 2006). In such cases, poverty impacts on the nature and extent of intergenerational exchanges. Materialist theories advocate for intervention from outside the family, through formal welfare provisions such as pensions, health and social services which are inevitably important (Lloyd-Sherlock, 2004; ILO, 2008, Kaseke, 1998). Analysis of the four theories of ageing suggests that different situations are explained by different theories. This further explains the overlap of some theories. The vulnerability framework is discussed next

8.4.5 The Vulnerability framework

The vulnerability framework is distinctive as an approach because of its multi-faceted nature and it can be easily applied to various situations. The framework argues that it is important to take the study population's own perspective into account (Lloyd-Sherlock, 2006; Kreager, 2003). The vulnerability framework is not theoretical, as it allows researchers to approach the study without influence of hypothesis and the obtaining of information about subjective experiences of respondents, including a range of risk factors. It is open and inclusive and helps in framing questions, shows the pre-disposition of the respondents and can be used as a sorting device in analysis. By adopting the vulnerability framework, my research was able to include other aspects which do not arise from the more common theories of ageing reviewed in this thesis, for example, risk factors and threats such as poor road and transport network, ill health, difficulty accessing healthcare, homelessness, natural weather conditions. These were examined in light of coping resources, and also showed the disadvantages of some of the coping resources, for example, living arrangements; and they were then used as evidence to deliberate all the notions of the vulnerability framework. The use of case studies allowed the clarification of how vulnerable or secure respondents were, while the application of the life-course approach helped to explain how older people arrived at their current situations. Any older person can be potentially vulnerable, not just poor people.

8.4.6 The Vulnerability Framework re-visited post-fieldwork

The use of the vulnerability framework enables the recommendations of multi-faceted and integrated policies at more than one dimension, that is, taking into account different formal

and non-formal support sources. The vulnerability framework can be applied globally, even in regions with low HIV/AIDS infection rates, poverty or out-migration.

After using the vulnerability framework, some observations were made which can leave a researcher with conflicting responses to individual perception of circumstances, relative vulnerability and how older people view their vulnerability. For example, there is the issue concerning some older people who assess their present circumstances in comparison to a time in their lives when they could afford to help others financially. Therefore, when they become less able to help others, even when they still have enough for themselves, they make their vulnerability assessment based on the lack of excess to give away. As a result, they give an impression which does not accurately describe their circumstances. Furthermore, some participants assess their vulnerability based on their expectations of support from their children. For example, two respondents reported that they felt that their children did not support them as much as they thought they could afford to.

There is scope for the vulnerability framework to be developed further and be modified to investigate the gap on how the framework deals with objective and subjective vulnerability and level of satisfaction. For example, some respondents' assessment of their economic resources were contrary to my assessments or the key informants' points of view, due to respondents making comparison with other people's circumstances or having higher expectations than that which their families could provide. To elucidate further, respondent WaSoko's financial situation was not as dire as she portrayed it. However, she made it appear much worse because she compared herself with her well-off sister and her neighbour who was well supported by all of her eight children. There is also the challenge of absolute versus relative poverty with the question of 'relative to whom or to what?' still needing to be explored further to have more accurate understanding of old-age vulnerability. Such differences are directly accounted for by authors who argue that different groups and individuals may view similar outcomes differently (Schröder-Butterfill and Marianti, 2006; UNDESA, 2005; Hashimoto, 1991).

The vulnerability framework has the advantages of being multi-faceted in nature and allowing open-mindedness when approaching situations, which allows for a deeper understanding of the study population's varied circumstances, but empirical research found that situations in real life are not as clear-cut as the vulnerability framework shows. While the vulnerability framework appears neatly compartmentalised, in practice there is blurring between different risks and sometimes it is not easy to distinguish analytical domains in a clear cut way. Real life situations are often messy and inter-linked and issues cut through life, making it difficult to demarcate the domains in practice, due to the inter-relation between

the four domains. This can result in some factors being classified as both exposure factors and threats, or in some cases having threats also presenting as outcomes. While it is easy to distinguish coping resources and outcomes, the thin line between threats and exposure factors makes it at times difficult to classify and separate these two domains of the vulnerability framework. In order to deal with this issue, the research considered factors from both perspectives through the respondents' eyes, as they provided the focus of the research.

8.4.7 Old-age vulnerabilities beyond the family and community's ability to address

The research uncovered evidence which shows that, no matter how much adult children support their older parents, there are some risks and threats which are beyond the ability of the family to mitigate (UNPF, 2002; Kreager, 2006; Davis, 2006; Lloyd-Sherlock and Locke, 2008). These risks can only be managed through the intervention of formal organisations and institutions. For example, the poor road and transport network in the study site is one of the key determinants of old-age vulnerability because it affects older people's healthcare access, their ability to visit or be visited and maintain family relations, the transport of farming equipment and inputs, and the sale of farm produce. The other theories of ageing discussed in this thesis are limited as they concentrate on the family as the expected source of care and support and do no extend beyond the family and community. The issue of vulnerabilities beyond the family and community's scope would best be addressed by theories which incorporate wider institutional factors, such as political economy approaches and approaches that look at institutions and governance. Quality of roads, the provision of health care and transport, are all factors which depend on good governance structures. Individuals, no matter how rich, cannot provide an adequate road network and health care network, and this is an investment only nation states, perhaps with the help of development aid can accomplish. Political economists argue that to understand the problems faced by elderly people, one should have an understanding of the political and economic conditions surrounding them (Walker, 1981; 2005; Estes, 1979; Lynott and Lynott, 1996). Estes (1979) asserts that older people on their own are powerless to change their social status and condition, arguing that the structure of society has created many of the problems of old age.

This means that there is an important role for governance in improving conditions for citizens, and therefore structures of governance need considering in theories and research design. Governance includes, in addition to national governments, organisations such as NGOs, the market, philanthropists, trans-national corporations, advocacy groups and public-private partnerships of stakeholders. These can be local, regional, national, and international organisations. For example, the WHO sets standards on health, governments should meet

conditions set by the World Bank to retain membership while some trans-national corporations control pensions, especially in Anglo-Saxon countries (Bevir, 2010; Blackburn, 2002). Climate change, which has an impact on the study site for this thesis, and HIV/AIDS are some examples of issues which can best be tackled through global governance.

8.5 Implications for policy and practice

The findings of this study have a number of important implications for policy and practice. The aim is to reach people at different levels in society and positions of power and influence for effective policy and practice. Most of the recommendations have an impact on older people and inter-generational transfers because lives are linked, often what affects older people also affects other generations. Empirical research findings can be used to develop targeted interventions aimed at older people in general with some specifically for those in rural areas. Lloyd-Sherlock (2000) asserts that the needs of older people are interlinked and require inter-sectoral policy responses. Therefore the community, government and other organisations are encouraged to step in to ensure security for older adults, especially those who have to rely more on community welfare than on offspring.

As Zimbabwe is experiencing rapid demographic transition leading to population ageing (UN, 2012), there is need to carry out studies for data collection, planning, implementation, monitoring and evaluation for the current cohort of older people, to be able to uncover what measures are needed to deal with the population growth. The high proportion of older persons living in rural areas requires more elderly-centred services and public assistance programmes to be channelled to the rural areas, especially as the level of care and support required tends to increase with age (Devereux, 2001; UN, 2009). This is because an increased lifespan can result in a rising demand for healthcare and increasing medical costs, as older people are often more vulnerable to chronic diseases (Lloyd-Sherlock, 2010; Barrientos, 2002; Rajan and Mathew, 2008). This was evidenced by the various health problems which most of the respondents for this study reported, as well as deteriorations in health which were observed in between study visits, since the research was carried out as a longitudinal study. Such changes need to be taken into consideration for both short and long term policy planning.

The study recommends that the government introduces policies which encourage and support farmers to put in place farm insurance, as natural weather conditions are a major threat to livelihoods. However, this is hardly feasible in Zimbabwe. The main barriers to implementing farming insurance are financial resources needed from the planning to implementation stages, convincing farmers of the importance of insurance and the farmers'

involvement through payment of insurance premiums. The planning would need to be long term, as it would involve multi-agencies such as insurance companies and different government departments and donor governments. The uncovering of interlinked issues calls for an integrated approach to policies across government departments to make effective use of limited resources which would improve the capacity to provide effective intervention strategies.

It is important to be cautious of the potential role of the family as the empirical study found that the number of children born did not reflect on receipt or non-receipt of support. While the role of the family in old-age care and support is acknowledged, the limits of the family and possible weaknesses of too much reliance on the family need to be taken note of. When individual support ability and informal support systems fail, there is need for intervention of compensatory supports, or coping resources and formal support from outside the family such as government and NGO support. This brings to the fore, the importance of formal support systems as an intervention. The support can be in the form of social pensions and free healthcare.

Occupational pensions are not compulsory in Zimbabwe, so employers can choose not to encourage their employees to join, resulting in low coverage (Kaseke, 2000). There is need for consultation and inclusion of different stakeholders involved with employment and pensions; such as the Zimbabwe Congress of Trade Unions, the Pensioners Union Trust and the Employers' Confederation of Zimbabwe, the Zimbabwe Association of Pension Funds, the Ministry of Finance, National Social Security Authority (NSSA) under the Ministry of Labour and Social Services, to improve the current workers' pensions, as they are the future older people. However, the main obstacle is that, as reported by most respondents, the majority of the younger people are unemployed, are in informal employment (and are therefore not included in the pensions systems) or receive low wages. Moreover, most of the pensions are low due to low wages, the same challenges observed by HAI (2006) and Kaseke (2012). For example, in 2011, NSSA minimum pensions were US$40 a month, which was the amount paid to most of the pensioners.

This thesis recommends provision of social pensions for older people as the most effective way to reduce their vulnerabilities (Lloyd Sherlock, 2004; Barrientos, 2004; ILO, 2008). With a small pension older people would be able to pay for maize-meal grinding, healthcare and purchasing basic food items. Pensions would also help older people achieve a sense of independence as they would not have to rely on others for all financial-related needs. Pensions would also allow older people to reciprocate more to neighbours and younger generations even in small ways, which would promote intergenerational exchanges and

relations. Only six respondents received pensions, none of which were social pensions, which might suggest low-coverage levels. Most interviewees called for universal pensions, so that every older person is assured of a consistent income. South Africa was constantly used by interviewees as a point of reference for pension comparison purposes. Social pensions can make a positive difference even if they are small amounts. For example, if the 732,000 people over 60 in 2010 (5.79% of total population) received US$10 monthly each, this would cover about 25% of the financial needs of a household of six (the average empirical research household size) and would cover 50% for an elderly couple (explained on page 109). Even though this amount is not sufficient to last a whole month, it would reduce old-age vulnerability, and could be supplemented with farm produce. The amount of US$10 is arguably affordable as it would be equivalent to only 1.66% of GDP and 1.70% of government expenditure (HAI, 2012). The government could further help by facilitating the pensions to be collected from places where older people can easily reach, especially for those in rural areas.

Although there were appointed health visitors, none of the respondents had seen the health visitors visiting older people, but only younger people such as pregnant women and mothers with young children. Some older people reported that this made them feel neglected and not valued. As a result, these health visitors were considered as non-existent as far as older people's healthcare needs are concerned. There is also need for well-equipped and staffed health centres and free medical assistance starting universally at 60 years of age. However, this is limited by staff shortage, due to many health professionals leaving the country (Chikanda, 2005, 2011). Also, the poor transport and communication network impacts on recruitment and retention of staff in most rural areas.

Means-testing is disadvantaging some older people, leaving them worse off, as they are expected to sell their sources of livelihoods, such as cattle, before they are eligible for assistance, as reported by many respondents. Older respondents suggested that, in the event of droughts or natural disasters which would affect yields, the government should promote fairness through non-means-testing, to maintain asset-smoothing. This is because sale of assets during an economic crisis to meet consumption needs often leads to more poverty (Hoddinott, 2006; Zimmerman and Carter, 2003; Moser, 1998). Respondents also called for transparency in the selection of recipients, suggesting that using age as criteria for qualification for aid for older people would help to avoid disadvantaging some older people. This was in response to an NGO which stated that those who owned more than two cattle did not qualify for aid, and would only be considered after selling cattle to buy food during the 2007-8 drought. Short-term shocks, for example droughts can have long-term effects (Hoddinott, 2006). The concerned respondents argued that there was no justification for

them to be expected to sell their cattle before being considered for aid, as they would not be able to buy more cattle after the drought, which would have knock-on effects of shortage of draught power, resulting in poor harvests. Dethier (2007) argues that in most cases means-testing does not alleviate poverty. This suggests that detailed assessment and planning needs to be made to determine the benefits of means-testing and long-term impact on those excluded.

Existing policies either ignore older people or include them indirectly, thereby contributing to feeling neglected. Despite the pronounced vulnerabilities faced by older people, empirical evidence uncovered that the few resources from formal sources were not being shared equally among the needy groups. For example, an NGO for older people reported that they used the 'intergenerational approach' (respondent SPM03) where they gave preference to older person-headed households with Orphans and Vulnerable Children (OVC). Such selection criterion leaves out those households with older people but no OVC. Empirical evidence found that the criteria used by an NGO during the drought also did not cater for older people on their own (see Section 7.8.). Most respondents felt that older people were not considered as a group with their own needs, facing threats different from other vulnerable groups. For example, respondent WaBo stated, *'It seems they do not give old people priority, we seem to be looked at, after all the other groups, if there is anything left, but there is rarely anything left for us. We are not given preference as old people'.* Some respondents argued that they were not expecting handouts because they are elderly, but they wanted to be supported in maintaining their livelihoods. This could be achieved through facilitation of close points to purchase inputs and sale of produce. Including older people in savings clubs would benefit them as well as other members, as HAI (2000:9) argues that older people are *'the most consistent and reliable in the management of savings and return of loans'*.

While these recommendations would be practical in most countries, in the case of Zimbabwe there are many challenges to the practicality of the recommendations, mainly the availability of resources and government and NGO priorities and capabilities. It all depends on the GoZ political will and power to make the commitment to implement major programmes. The most recent information (Gandure, 2009) reports that countrywide, only about 1 200 older people receive social pensions of US$20 a month, none of whom are in the study site for this thesis.

Negative attitudes towards older people are probably due to lack of knowledge on ageing issues which result in negative images of ageing (HAI, 2000; WHO, 2002; Arber and Evandrou, 1993; Chavhunduka, 1982). 'Old-age' public awareness campaigns were suggested as ways to make people acknowledge older people as individuals with needs and

rights just like all other age groups, as there was constant mention of older people feeling they are viewed as non-existent, for example by being left out of savings and 'banking clubs' which concentrated on the younger generations. Advocacy is needed at all levels of society, from the family, community, Community Based Organisations (CBOs), district, provincial to national level, involving constituent MPs, religious organisations, civil society and the private sector to make organisations and younger generations aware of old-age vulnerability, security and contributions made by older people to help change the negative attitudes. This would help encourage intergenerational relations and improve security and reduce old-age vulnerability. This can be achieved in the study site because community solidarity is strong, and when meetings are arranged, most households attended, something which I observed. One respondent, a retired teacher suggested, that the lack of knowledge about ageing issues could be addressed nationally through schools, as has happened with gender, immunisation and HIV/AIDS awareness, which are included in the curriculum. While doing so, it is important not to appear to be presenting ageing as a problem. The discourse in this chapter so far has been on empirical findings in relation to literature and research questions, which has allowed the discovery of further research gaps.

8.6 Limitations and directions for future research

The literature and fieldwork allowed me to identify some research gaps which require priority for future research, in the area of old-age vulnerability in Zimbabwe which were beyond the scope of this thesis. There are two main limitations to this study. The main limitation is that the sample size is relatively small, with only 27 older people having been interviewed, although it is adequate for a qualitative study which has produced rich narratives of the respondents' circumstances (Bryman, 2012; Tashakkori and Teddlie, 2003; Green and Browne, 2005; Yin, 2009). The empirical research still used quantitative methods to a lesser extent (Section 5.4). The fieldwork provided adequate material to address the thesis research questions. However further fieldwork could provide additional material for a larger-scale study in this area. All empirical research and data analysis was conducted by the researcher. The results of this study can only be generalised to small scale and subsistence farming areas with the same rainfall patterns. It is therefore recommended that research similar to this study be carried out involving larger numbers to provide more definitive evidence. This would allow the results to be generalised in other small-scale subsistence and commercial farming areas. If time and money were not an issue in my research, ideally, I would have liked to plan a much larger study of for example, up to 100 cases, beyond Dowa, to see whether similar patterns in vulnerability are obtained. This would have also

given me the opportunity to employ SPSS more in analysing the data, and using tests of statistical significance.

The second limitation is that the study mainly interviewed older people without including their children. There is no data on support received during the years prior to the deterioration of the economy, so the study had to rely on insights provided from life histories. The study relies heavily on older people's reports about what their children give or do not give them and about their children's material situation. Interviewing adult children from the middle generation, who are providing care and support to their elderly parents would help obtain their perspective on support provided and received. This would help to investigate threats faced by their older parents, the impact of these threats on the children's ability to support and care for their aged parents and the changing nature of old-age support, in order to better capture a more rounded picture of old-age vulnerability and security among the older respondents. It would also be important to interview family members who do not provide support and/or do not see their older relatives often, to obtain their perspective on whether, and why they do or do not provide support and the impact the non-provision of support has on their elderly parents.

A further study could investigate the role of older men as carers and supporters of younger generations in male-led households and how this impacts on their own well-being, as this study uncovered vulnerabilities specific to such households. Except for a few studies which were all carried out in developed countries, for example, Kramer (2002); Davidson (2013), the gender aspect in most old-age-related studies in developing countries is biased towards women and no acknowledgement is made to the contribution of older men and their plight as carers (Ferreira and Kalula, 2009; Wilson and Adamchak, 2001; Nyambedha et al, 2003; McIntyre, 2002; Ferreira, 2004; Williams and Tumwekwase, 2001). For example, WaMeck had five children under ten years of age, living in his household; WaReru had two young orphans in his care; WaLeo fared well because he had a live-in maid he paid for. While WHO (2002) included older men among its respondents, considerably more work needs to be done to determine old-age vulnerability of men in Zimbabwe. My research found that older widowers of poor economic status and with no female family members living with them or nearby struggle with personal hygiene and domestic-related ADLs. This is because most of them rely on women, typically wives for such activities (Ferreira and Kalula, 2009; Nyoni, 1986; Schröder-Butterfill and Marianti, 2006). Widowed mothers were better cared-for than widowed fathers, hence this recommendation for studies focussing on older men. Thirteen of the twenty-seven older respondents for this thesis were men, which represents a better gender balance than found in most studies of ageing in developing countries.

Further research might produce specific evidence on how families adapt to migration in Zimbabwe, which the small sample could not achieve, as only seven of the respondents had migrant children out of the country. Of these seven parents with migrant children out of Zimbabwe, only two parents had such children as their main source of financial support. A larger sample would offer a clearer picture of these issues. This would enable comparisons to be made with older people with non-migrant children.

Many elderly Zimbabweans are poor and they live in rural areas, which exposes them to a multitude of challenges associated with rural living. Old-age vulnerability in Zimbabwe cannot be pinned down on any particular cause, but has been proven to be a product of a number of threats. HIV/AIDS, poverty and out-migration exacerbate the vulnerabilities faced by older people and coping is difficult for most of them because formal security systems are very minimal in Zimbabwe. Infrastructure is a neglected area in studies on ageing in Zimbabwe. The vulnerabilities uncovered in this thesis are not just about the present, but also about the future and they need to be considered for the well-being of older people, their families and for future policy planning. Ideally, formal support systems would be the best option where the family is not coping.

Appendices

Appendix 1: Research questions and evidence required to provide answers

Research Question	Evidence Required	Methodology/Instruments	Chapter
1. What are the main determinants of an older person's vulnerability in rural Zimbabwe?	Issues and situations which contribute towards old-age vulnerability in rural Zimbabwe	Literature review Older persons' questionnaire Policy Makers and Stakeholders' interviews In-depth interviews Observations Case studies	1, 2, 3, 4, 5, 7, 8
2. What are the key threats which older people face and how do they affect their well-being?	Threats faced by older Zimbabweans	Literature review Observations Case studies Older persons' questionnaire Policy Makers and Stakeholders' interviews Key informant interviews In-depth interviews	2, 3, 4, 6, 8
3. What coping resources are available to older people in rural Zimbabwe?	Coping resources accessible to older people in rural Zimbabwe	Literature review Older persons' questionnaire Case studies Kinship maps Observations Policy Makers and Stakeholders' interviews In-depth interviews	2, 3, 4, 5, 7, 8

		Key informant interviews	

Appendix 2: Studies on Older People in Zimbabwe

Studies on Older People in Zimbabwe

Study title and objectives of study	Investigator	Year	Type of study	Method of data collection and analysis	Sample size	Minimum age defining older people	Selection of cases
Impact of HIV/AIDS on Older People in Africa. Zimbabwe Case Study: to develop, test and validate methodology to examine the impact of the HIV/AIDS on older care-givers, To explore 'the feasibility of establishing a multi-centred study based on the research methodology developed for this pilot project in other sub-Saharan Africa countries (WHO, 2002). Focus: morbidity and mortality	WHO and the Ageing and Life course (ALC)	2002	Cross-sectional	Qualitative and Quantitative	685 Six[47] of the ten provinces were covered, including rural and urban areas	50	Purposive sampling through community health workers, nurses and volunteer HIV/AIDS care providers knowing older persons caring for people sick due to HIV/AIDS
The 'Third Leg' Age Support for Older Persons in Zimbabwe. To 'examine the socio-economic and demographic characteristics of adult children who support their elderly parents; to evaluate the effect of family size and number of surviving siblings on provision of this support , and to assess other determinants of support by adult children to elderly parents'. Focus: support and care provision to older person, by their	Madzingira, N.	2006	Cross-sectional (carried out in 1998)	Qualitative and Quantitative (carried out in 1998)	1,203 households Five provinces were covered, including both rural and urban	60	Purposive sampling, based on the 1992 census, two provinces with the highest number of elderly people, one with the lowest number, and two urban areas

[47] Three of the provinces in Zimbabwe were wrongly named.

adult children							
The Health-Seeking Behaviour of Older Persons in Zimbabwe To find out the 'health-seeking behaviour of older people and reasons behind the choices	Nyanguru, A.C.	2008	Cross-sectional	Quantitative and qualitative	812	60	No sampling, any people looking 60+, encountered in study sites, not more than 2 per household
Migration and aging: the case of Zimbabwe. To study the migration of older people, rural to urban, vice versa, rural to rural, foreign migrants and non-migrants, as well as their overall satisfaction with life	Nyanguru, A.C.	2007	Cross-sectional	Quantitative and qualitative	812	60	Same as above
Socio-economic Support of Older People in Zimbabwe To examine socioeconomic support of older people.	Kimuna, S. R.	2004	Cross-sectional Aging Survey	Quantitative secondary data analysis using data from the 1994-1995 Zimbabwe Ageing Survey, and the 1999 Zimbabwe Demographic and Health Survey.	278	60	Three stage random cluster sampling

Living Arrangements of Older Adults in Zimbabwe: Their socioeconomic and socio-demographic conditions. To identify existing structures of living arrangements and support and the nature of family relationships of older adults.	Kimuna, S. R.	2005	Cross-sectional	Quantitative data analysis, as above	278	60	Three stage random cluster
Morbidity and disability in elderly Zimbabweans To investigate the social, economic, cultural, demographic and physical characteristics of elderly Zimbabweans, as well as on sources of support, life-style habits, health and access to health resources	Allain, et al.	1997	Cross-sectional	Quantitative and qualitative	278[48]	55	Random cluster sampling
Poverty and Ageing in Zimbabwe Discussing the results of the Poverty Assessment Study Survey (PASS) All ten provinces were covered	Madzingira, N.	1997	Cross-sectional	Quantitative	3,913	60	Stratified sample by province, district and land use sector.

[48] The study sites and sample sizes are exactly the same with Kimuna (2004; 2005)

A Study of Well-being of Elderly People in Three Communities in Zimbabwe. To examine the 'well-being' of elderly people (general health, health resource access, nutrition, habits and physical function)	Wilson et al.	1991	Cross-sectional	Quantitative	150 In three different communities	55	Stratified cluster sampling
Elderly support and intergenerational transfer in Zimbabwe: an analysis by gender, marital status, and place of residence To identify income, cash support from all sources, noncash support, and the support of elders to others	Adamchak, et al.	1991	Cross-sectional	Quantitative	150[49]	55	Stratified cluster sampling
The Health Problems of the Elderly Living in Institutions and Homes in Zimbabwe To assess participants' mobility, ability to negotiate stairs, and handicaps, particularly deafness and blindness	Nyanguru, A. C.	1991	Cross-sectional	Quantitative and qualitative	139 older people in 71 Old People's Homes in Zimbabwe	65	10% random sampling

[49] Same study by Wilson, et al (1991)

Evaluating Older Persons' Perceptions on Their Quality of Life in an Old People's Institution: A Zimbabwean Case Study To evaluate perceptions on the quality of life of older adults and the extent to which they practiced self-determination in an institution	Hungwe, C.	2010	Cross-sectional	Qualitative (carried out in 2002)	16 older male residents, 4 officials	60	Purposive sampling
Critical Challenges to the Livelihood Options of the Aged in Rural Zimbabwe: Evidence from Mubaira To identify challenges related to livelihood strategies of older Zimbabweans	Muruviwa, et, al.	2013	Cross-sectional	Qualitative	15 older people, 2 officials	60	Purposive sampling
Gendered dimensions of old age care in a time of crisis: Experiences of elderly women at Bako Redonhodzo Old People's Home in Harare, Zimbabwe To investigate ways in which gender influenced the experiences of elderly people in an OPH.	Chiweshe, M.K. and Gusha, M	2012	Cross-sectional	Qualitative	10	56	Purposive sampling
Sexuality among the elderly in Dzivaresekwa district of Harare: the challenge of information, education and communication campaigns in support of an HIV/AIDS response To explore sexuality among urban elderly people and their challenges in accessing information, education, and communication campaigns in an environment of HIV/AIDS.	Gutsa, I.	2011	Cross-sectional	Qualitative	6	60	Purposive sampling

Changing Residential Composition in a Home for the Elderly? The Case of Bumhudzo Hospital Home In Chitungwiza, Zimbabwe To investigate whether the composition of Zimbabwean born residents in Old People's Homes is increasing	Gutsa, I. and Chingarand, S. D.	2009	Cross-sectional	Qualitative	5	60	Purposive sampling
Intergenerational Struggles Over Urban Housing: The Impact of Livelihoods of the Elderly in Zimbabwe To investigate how the lives of elderly women who own houses in urban areas have been affected by changes in urban areas	Paradza, G. G.	2009	Cross-sectional	Qualitative	4	65	Purposive sampling

Appendix 3: University of Southampton Ethics Committee Clearance Letter

Nyasha Chiunya-Huni
PGR Student
School of Social Sciences

6th August 2009

Dear Nyasha,

Approval from School Research Ethics Committee

I am pleased to confirm that the Research Ethics Committee of the School of Social Sciences has given your research project ethical approval:-

Application Number: SOC20089-32

Research Project Title: Ageing in Zimbabwe: The negotiation of old-care & support in a context of HIV/AIDS, poverty, hyper-inflation & out-migration

Date of ethical approval: 6th August 2009

In order for the University to ensure that insurance is in place for this research, please complete the Insurance and Research Governance Application form attached and return to the address below as soon as possible, along with a copy of this letter and all supporting documents relating to your project:-

Research Governance Office

University of Southampton

Building 37

E-mail rgoinfo@soton.ac.uk

It is your responsibility to complete and return this form, and work on the project should not begin until insurance is in place. The form may also be found on our intranet in the Staff and PGR Zones:- http://www.soton.ac.uk/socscinet/

Yours sincerely,

Professor S J Heath

Chair, School Research Ethics Committee

School of Social Sciences

Direct tel: +44 (0)23 80592578
E-mail: Sue.Heath@soton.ac.uk

Cc: File

Appendix 4: University of Southampton CRA Introduction Letter (2008)

University of Southampton

School of Social Sciences | Centre for Research on Ageing
Professor Maria Evandrou, Director

University of Southampton
Highfield
Southampton
SO17 1BJ
United Kingdom

Tel +44 (0)23 8059 4808
Fax +44 (0)23 8059 8649
Email
maria.evandrou@soton.ac.uk
Web
http://www.ageing.soton.ac.uk

Centre for Research on Ageing
School of Social Sciences
University of Southampton

Professor Maria Evandrou
Director
Centre for Research on Ageing
School of Social Sciences
University of Southampton
Highfield
Southampton SO17 1BJ
United Kingdom
Tel +44 (0)238059 4808
Fax +44 (0)238059 8649
Email: maria.evandrou@soton.ac.uk

18th November 2008

Dear Sir/ Madam

MPhil/PhD Student: Nyasha Chunya-Huni

This is to certify that Nyasha Chunya-Huni is registered on the MPhil/PhD Gerontology programme in the School of Social Sciences, University of Southampton, United Kingdom.

Nyasha is conducting fieldwork in Zimbabwe as part of her MPhil/PhD Gerontology and I would be very grateful if you could provide assistance. The title of her thesis is 'Ageing in Zimbabwe: The negotiation of old age care and support in a context of HIV/AIDS, poverty, hyper-inflation and out-migration'. Should you require further confirmation of her studies, please don't hesitate to get in touch.

Yours sincerely

Prof Maria Evandrou

Appendix 5: University of Southampton CRA Introduction Letter (2009)

UNIVERSITY OF Southampton
School of Social Sciences

Professor Maria Evandrou
Director
Centre for Research on Ageing
School of Social Sciences
University of Southampton
Highfield
Southampton SO17 1BJ
United Kingdom
Tel +44 (0)238059 4808
Fax +44 (0)238059 8649
Email: maria.evandrou@soton.ac.uk

29th October 2009

Dear Sir/ Madam

MPhil/PhD Student: Nyasha Chunya-Huni

This is to certify that Nyasha Chunya-Huni is registered on the MPhil/PhD Gerontology programme in the School of Social Sciences, University of Southampton, United Kingdom.

Nyasha is conducting fieldwork in Zimbabwe as part of her MPhil/PhD Gerontology and I would be very grateful if you could provide assistance. The title of her thesis is 'Ageing in Zimbabwe: The negotiation of old age care and support in a context of HIV/AIDS, poverty, hyper-inflation and out-migration'. Should you require further confirmation of her studies, please don't hesitate to get in touch. Thank you.

Yours sincerely

M. Evandrou

Prof Maria Evandrou

Centre for Research on Ageing
School of Social Sciences
University of Southampton

Appendix 6: Application to the Government of Zimbabwe for Clearance

Flat 3 Montagu Flats
6 Josiah Chinamano Avenue
Harare

09 December 2008

The Director
Ministry of Public Service, Labour and Social Welfare
[Attention: Mr. S. Mhishi]

Dear Sir

RE: APPLICATON FOR AUTHORITY TO ACCESS INFORMATION ON THE POLICY ON THE AGED, FOR EDUCATIONAL PURPOSES: LOCAL RESEARCH PERIOD 5 – 15 DECEMBER 2008:NYASHA C. CHIUNYA-HUNI:UNIVERSITY OF SOUTHAMPTON

The above subject refers.

I am a PhD student studying Gerontology, at the University of Southampton, United Kingdom. As part of the fulfillment of my studies, I am doing a thesis on 'Ageing in Zimbabwe'. It is on this subject that I seek your assistance.

Please find attached a copy of the introductory letter from the Centre for Research on Ageing, Department of Social Sciences.

Thank you.

Nyasha C. Chiunya-Huni (Mrs)

Appendix 7: Government of Zimbabwe Clearance Letter

Official communications should
Not be addressed to individuals

Telephone: Harare 703711/790721-4
Telegraphic Address: 'WELMIN
Fax: 790543/703714

ZIMBABWE

THE DIRECTOR OF SOCIAL SERVICES
P.O. Box CY 429
Causeway
Zimbabwe

Cnr Fourth Street and Central Avenue
HARARE

DEPARTMENT OF SOCIAL WELFARE
11 DEC 2008
P.O. BOX CY 429, CAUSEWAY
ZIMBABWE. TEL. 790721/2

SW 1/35

11th December 2008

TO WHOM IT MAY CONCERN

RE: AUTHORITY TO ACCESS INFORMATION RELATED TO POLICY ON THE AGED FOR ACADEMIC RESEARCH PURPOSES: NYASHA C. CHIUNYA-HUNI

Above named is a PHD student studying Gerontology with University of Southampton, U.K. and doing a thesis on Ageing in Zimbabwe.

The Ministry of Public of Service, Labour and Social Welfare is agreeable to her accessing and being assisted with the relevant information for academic purposes only.

Kindly assist her in this regard.

T. A. Chinake
For: **DIRECTOR SOCIAL SERVICES**

Appendix 8: Project Information Sheet for Older People

(Please note that the final version of this document for distribution to participants will be produced in larger print and translated as necessary)

Project Information Sheet for Older People

Hello. My name is Nyasha Constance Chiunya-Huni and I am a PhD student at the University of Southampton. I am carrying out a research to find out the experiences of older people and the care and support that they receive. The fieldwork is to be carried out in Dowa, in Makoni District, Manicaland Province.

What will the research involve doing?

I will ask you some questions relating to what it means to be old in Zimbabwe, what you as older adults view as important to you and what suggestions you can come up with, regarding care and support. The research will involve interviewing about 30 older people like yourself.

What will happen to the research?

The information I gather from you and other people will help us to understand the experiences and challenges that you face. Results of the research would be helpful as they would help give an idea of what it means to be old in Zimbabwe and care and support needs of older adults. The research aims to come up with recommendations to the government, churches and other organisations which give aid, to help the efforts of the family and community in trying to improve the welfare of older adults. We would very much appreciate your participation in this research.

What will the research mean to you?

The survey may take between 40 and 45 minutes. We will not pass on your details to anyone else and information from the interviews will be held securely. Whatever information you provide will be kept confidential and will not be shown to anyone. Your names, addresses and personal information will be known by me (Nyasha) only.

Participation in this research is voluntary and you may choose not to take part or not to answer some of the questions. However, I hope you will participate because your input is very important.

At this point, you are free to ask me anything about the interview or the research.

****

Nyasha can be contacted at the University of Southampton on her email address: ncch1x07@soton.ac.uk or by mobile phone ++ (44) 79 5604 2028. If you have any questions about any of the above please feel free to contact her at any time.

If you have any comments or concerns about this study please contact:

Professor Maria Evandrou
The Centre for Research on Ageing
School of Social Sciences
University of Southampton
Southampton
SO17 1BJ

Tel: ++ 44 (0) 23 8059 4808
E-mail: maria.evandrou@soton.ac.uk

or

Professor Nyovani Madise
Deputy Head of School (Research)
School of Social Sciences
University of Southampton
Southampton
SO17 1BJ

Tel: ++ 44(0) 23 8059 2534
E-mail: N.J.Madise@soton.ac.uk

With many thanks for your interest in this project.

Nyasha C. Chiunya-Huni
April 2009

Appendix 8a: Translated Project Information Sheet for Older People

Project Information Sheet (Yewanhu Wakwegura)

Kaziwai. Zita rangu ndinonzi Nyasha Constance Chiunya-Huni. Ndiri kudzidza paUniversity yeSouthampton, kuita PhD. Ndiri kuita tsvagurudzo kuti ndinzwisise nezveupenyu hwevakwegura uye rubatsiro rwavanowana, muDowa, maMakoni, muManicaland

Tsvagurudzo iyi iri pamusoro pei?

Ndichakubvunzai mibvunzo inoenderana nekuti zvinerevei kuve munhu akwegura muZimbabwe, zvamunokoshesa imi sevanhu vakwegura uye mazano amungape pakuchengetwa uye kubatsirwa kwevakura. Tsvagurudzo iyi ichaitwa kuvanhu makumi matatu, vakura semi.

Chii chichaitika kune pfungwa nemazano anenge awanikwa?

Mazano nepfungwa zvandichawana kunemi nevese vandichabvunza anotarisirwa kutibatsira kunzwisisa magariro evanhu vezera renyu uye matambudziko amunosangana nawo. Zviwanikwa zvetsvagurudzo iyi zvichabatsira kupa mufananidzo wekuti zvinorevei kuve munhu akwegura muZimbabwe uye rubatsiro nekuchengetwa kunodiwa nevakura. Pfungwa dzichabuda dzinotarisirwa kupihwa kuhurumende, machechi nemamwe masangano anopa rubatsiro, kubatsira mhuri nevavakidzani kusimudzira upenyu hwevakura. Ndingatende kana mukabvuma kuve mutsvagurudzo iyi.

Tsvagurudzo iyi inorevei kwamuri?

Ichatora pakati pemaminitsi 40 ne45. Handina mumwe munhu wandichaudza zita renyu kana zvamataura uye zvese zvamuchataura nezvandichanyora zvichagara zvakakiyirwa pasina mumwe munhu anovhura, kunze kwangu. Zita renyu, kwamunogara nezvimwe zvese zviri maerarano nemi zvinenge zvichizivikanwa neni chete. Kuve kwenyu mutsvagurudzo iyi ndekwekuda kwenyu uye munogona kusapindura mimwe mibvunzo kana musingadi. Zvakadaro, ndinovimba muchabvuma kuve mutsvagurudzo iyi, nekuti zvamuchataura zvinokosha zvikuru

Kana muine mibvunzo maererano netsvagurudzo iyi, makasununguka kundibvunza.

****

Kana muchida kundibata, ndinowanikwa patsambambozha inotevera: ncch1x07@soton.ac.uk kana runharembozha ++ (44) 79 5604 2028. Kana muine mibvunzo pane zvese zvatataura, makasunguka kundibata chero nguva.

Kana muine mibvunzo kana zwimwe zvamungade kubvunza, kune mumwe munhu asiri ini, batai:

Professor Maria Evandrou
The Centre for Research on Ageing
School of Social Sciences
University of Southampton
Southampton
SO17 1BJ

Tel: ++ 44 (0) 23 8059 4808
E-mail: maria.evandrou@soton.ac.uk

kana

Professor Nyovani Madise
Deputy Head of School (Research)
School of Social Sciences
University of Southampton
Southampton
SO17 1BJ

Tel: ++ 44(0) 23 8059 2534
E-mail: N.J.Madise@soton.ac.uk

Ndinotenda nekuratidza kwenyu kuve mafarira tsvagurudzo iyi.

Nyasha C. Chiunya-Huni
April 2009

Appendix 9: Informed Consent document for Older People

(Please note that the final version of this document for distribution to participants will be produced in larger print and translated as necessary)

Informed Consent document for Older Persons

Ageing in Zimbabwe: The negotiation of old-care and support in a context of HIV/AIDS, poverty, hyper-inflation and out-migration

I have read/have been read to and understood the information sheet about the project. I have been given the opportunity to ask any questions I might have about the research project and what I would be expected to do. The questions I have asked have been satisfactorily answered by the researcher.

I understand that my participation in this study is entirely voluntary. I also understand that I can withdraw from the study or stop the interview at any time, and that I do not need to give any reasons or explanations for doing so. I understand I will not be penalised in any way for withdrawing from this study and my participation in the study will not affect my social care.

I understand that in any reference to my interview made in reports, personal and place names will be changed so that I, and any other individuals mentioned, cannot be identified. Nyasha has made me aware that she is the only one who will have access to my name, address and other personal detail I will provide her with. What I say will also not be shared with other members of my family or with my friends.

I agree to participate in an interview about issues relating to older persons and how this relates to their care and support.

☐ Yes ☐ No ☐☐ Please initial/Mark

I agree to being contacted again during the project for clarification of points raised in the interview.

☐ Yes ☐ No ☐☐ Please initial/Mark

I agree to the interview being audio-recorded and transcribed for research purposes.

☐ Yes ☐ No ☐☐ Please initial/Mark

I agree to the transcription of my interview being made totally anonymous so that nothing in it, such as place or individual names can be identified. I allow Nyasha to use my contribution for education, research and publication purposes.

☐ Yes ☐ No ☐☐ Please initial/Mark

I understand that I will be sent summary of the findings of the project at the end of the project if I wish.

☐ Yes, I would want a copy of the project report

☐ No, I would rather not have a copy

I, _____, have read/been read to and understood the above information and agree to participate in this research on what it means to be old in Zimbabwe as well as care and support for older people, that is being conducted by Nyasha C. Chiunya-Huni at the University of Southampton.

Signature or mark interviewee _____ Date _____

Signature Interviewer _____ Date _____

If you have any comments or concerns about this study, please contact:

Professor Maria Evandrou at: University of Southampton
The Centre for Research on Ageing
School of Social Sciences
Southampton
SO17 1BJ
ENGLAND

Tel: +44 (0) 23 8059 4808
Email: maria.evandrou@soton.ac.uk

Community contact: Unna Kwaramba
Tel: +263 (0) 772 248662
E-mail: u.kwaramba@yahoo.co

Appendix 9a: Translated Informed Consent document for Older People

Gwaro rekupa mvumo (Rewanhu Wakwegura)

Kukwegura muZimbabwe: Kugadzirisa kuchengetwa uye kubatsirwa munguwa yeHIV/AIDS, hurombo, kushaya simba kwemari uye kuenda kunze kwewechidiki

Ndawerenga/werengerwa uye ndanzwisisa pamusoro petsvagurudzo iyi. Ndapihwa mukana wekubvunza mibvunzo yandingave nayo. Mibvunzo yandabvunza yapindurwa zvandigutsa neuyo ari kuita tsvagurudzo.

Ndanzwisisa kuti kuve kwangu mutsvagurudzo iyi kuda kwangu. Uyewo, ndinonzwisisa kuti ndinokwnisa kusiyira panzira, kumisa mubvunzi chero nguva, pasina kutarisirwa kuti ndipe chikonzero. Ndinonzwisisa kuti hapana kuripiswa kwandingaitwe kana ndikafunga kusiyira tsvagurudzo iyi pakati uye kuve kana kusave kwangu mutsvagurudzo iyi hakuna zvakunokanganisa machengeterwo angu uye rubatsiro rwandinowana/rwandingawane kune vanondipa/vangade kundipa rubasiro.

Ndinonzwisisa kuti pane zvese zvichanyorwa maererano nezvandichataura, zita rangu nenzvimbo yandinogara zvichashandurwa kuitira kuti hapana anozoziva kuit ndini ndiri kutaurwa. Hapana wemumhuri mangu kana shamwari dzangu dzichataurirwa zvandataura

Ndinobvuma kuve mutsvagurudzo iyi iri maererano nekuti zvinorevei kuve munhu akwegura, machengeterwo uye mabatsirirwo evakura

☐ Hongu ☐ Kwete ☐☐ Mavara ezita

Ndinobvuma kuzobvunzwazve kuti ndijekese zwimwe zvendingange ndataura muhurukuro iyi.

☐ Hongu ☐ Kwete ☐☐ Mavara ezita

Ndinobvuma kuti izwi rangu ritorwe uye kuti zvandichataura zvigozoiswa pabepa.

☐ Hongu ☐ Kwete ☐☐ Mavara ezita

Ndinobvuma kuti kana zvichikodzera, zvandataura kana zvanyorwa, zvigochengetwa uye zvigoshandiswa nevamwe vanoda kuita dzimwe tsvagurudzo. Kana zvandataura zvanyorwa zvikasarudzwa kuti zvichengetwe, zvichaitwa kuti zvive zvisingazivikanwi kuti ndiani uye anogarepi akataura mazwi iwayo. Ndinobvumidza University kuti ishandise zvandichataura, pakudzidzisa, kutsvagurudza uye kunyora magwaro.

☐ Hongu ☐ Kwete ☐☐ Mavara ezita

Ndanzwisisa kuti ndichatumirwa pfupiso yetsvagurudzo iyi kana ndichida.

☐ Hongu, ndingade pfupiso yetsvagurudzo

☐ Kwete, handingadi pfupiso yetsvagurudzo

Ini _____, ndawerenga/werengerwa uye ndanzwisisa nezvetsvagurudzo yataurwa nezvayo pamusoro uye ndinobvuma kuve mune iyi tsvagurudzo iri pamusoro pekuti zvinorevei kuve munhu akura muZimbabwe, rubatsiro uye kuchengetwa kwevakura, iri kuitwa naNyasha C. Chiunya-Huni, wepaUniversity yeSouthampton.

Zita kana mavara Mupinduri _____ Zuva _____

Zita kana mavara Mutsvagurudzi _____ Zuva _____

Kana muine mibvunzo kana zwimwe zvamungade kubvunza, kune mumwe munhu asiri ini, batai:

Professor Maria Evandrou pa: University of Southampton
The Centre for Research on Ageing
School of Social Sciences
Southampton
SO17 1BJ
ENGLAND

Tel: +44 (0) 23 8059 4808
Email: maria.evandrou@soton.ac.uk

Ari pedyo nemi: Unna Kwaramba
Tel: +263 (0) 772 248662
E-mail: u.kwaramba@yahoo.co

Appendix 10: Questionnaire for Older People

A. DEMOGRAPHIC CHARACTERISTICS AND BACKGROUND

1. How old were you on yout last birthday?
Zera renyu

☐ 60 - 64 ☐ 65 - 69 ☐ 70 -74 ☐ 75-79 ☐ 80+

2. Sex ☐ male ☐ female

3.Questionnaire administered in: Shona ☐
English ☐

4. Would you please tell me your marital status?
Panyaya dzekuroora/roorwa mungapinde pane boka ripi?

☐	Married	*Makaroora/ Makaroorwa*
☐	Separated/ Divorced	*Makarambana*
☐	Widowed	*Makafirwa*
☐	Never married	*Hamuna kuroorwa/ kuroora*
☐	Remarried	*Makaroorazve/ roorwazve*
☐	Living together	*Muri kubika mapoto*

5. How many wives do you have/how many wives does your husband have?
☐ Monogamy ☐ Polygamy

6. Do you have children? If so how many and what are their ages?
Mune vana here? Kana munavo, vangani, mazera api?

7. Are they all alive? ☐ Yes ☐ No If yes go to 9.
Vese vapenyu here?

8. If no, how many died?
Vakashaya vangani?

9. Do you have grandchildren/great grandchildren ☐ Yes ☐ No If no, go to 11.
Mune vazukuru here?

10. If yes, how many?
Vangani?

11. How far do they live from you?
Vanogara kure sei nemi?

12. What is your religion/denomination?
Chitendero chenyu ndechipi?

☐	1. Protestant	☐	2. Roman Catholic
☐	3.African Traditional Religion	☐	4. Pentecostal
☐	5. Moslem	☐	6. Atheist

☐ 7. Syncretic ☐ 8. Agnostic

☐ 9. Other (please elaborate)

13. Highest level of education obtained/number of years of education
Makadzidza zvakadini?/ Makaita makore mangani kuchikoro?

☐ 1. None ☐ 2. Some primary (1 - 7 years)

☐ 3. Some secondary (8 - 11 years) ☐ 4. High School (12 - 13 years)

☐ 5. tertiary (14 plus) ☐ 6. Completed University

☐ 7. Other

14. Please rank the following according to their importance to you. (1 for most and 5 for least)
Pane zvinotevera, mungandiratidze here kuti chinonyanya kukosha, zvichitevedzana, kwamuri ndezvipi?

Your health 1☐ 2☐ **3**☐ 4☐ 5☐
utano hwenyu

Self sustenance 1☐ 2☐ 3☐ 4☐ 5☐
Kuzvimirira mega

Relationship with kin 1☐ 2☐ 3☐ 4☐ 5☐
Ukama nehama

Upkeep of your home 1☐ 2☐ 3☐ 4☐ 5☐
Kuchengeteka nekushambidzika kwepamusha

Transport 1☐ *2*☐ 3☐ 4☐ 5☐
Kuwana chekufambisa

Availability of toilets 1☐ 2☐ 3☐ 4☐ 5☐
Kuva nechimbuzi

Availability of clean water for drinking, washing and bathing
Kuwana mvura yakachena yekunwa, kubikisa ne kugezesa
1☐ 2☐ 3☐ 4☐ 5☐

Adequacy of food and clean clothing
Kuwana chikafu chakanaka nembatya dzakashambidzika
1☐ 2☐ 3☐ 4☐ 5☐

Welfare of orphans under your care
Kuchengeta vazukuru nherera vamakasiyirwa
1☐ 2☐ 3☐ 4☐ 5☐

Adequacy of agricultural implements and inputs
Kugutsikana nekukwana kwezvekurimisa
1☐ 2☐ 3☐ 4☐ 5☐

B. LIVING ARRANGEMENTS

15. Who is the head of your household?
Ndiani musoro wemba yamunogara?

16. Who do you live with and what is your relationship?
Munogara nani uye ukama hwenyu hwakamira sei?

17. Whom would you prefer to live with, and why?
Mungade kugara nani, sei masarudza iyeye?

If living with the preferred person, go to 19.

18. Why do you not live with that person?
Sei musingagare nemunhu iyeye?

C. SOCIO-ECONOMICS

19. Who is the main provider of this household?
Ndiani anoshanda kuriritira imba yenyu?

20. Do you own the farm, that is, having Title Deeds for the farm?
Ndimi muridzi wepurazi here/ mune mapepa epurazi racho?

21. How many acres of land area are used by members of this household for agricultural purpose
Munorima pakakura zvakadini papurazi pano?

22. What is your main source of livelihood?
Munowanepi zvamunoshandisa kurarama kwenyu zuva nezuva?

23. Are your resources enough every month to buy the following:
Zvamunazvo zvinokukwanirai here mwedzi nemwedzi kutenga zvinotevera:

commodity	**Yes**/*Hongu*	**No**/*Kwete*
maize meal/ *upfu*		
Sugar		
Bread/ *Chingwa*		
Soap / *sipo*		
Salt / *munyu*		
Tea/ *masamba*		
Meat/ *nyama*		
Relish/ *muriwo*		

24.How far is your nearest neighbour?
Muri kure sei nemuvakidzani ari pedyo nemi?

☐ less than 100metres ☐ 100-500metres

☐ 501metres to 1km ☐ 1 to 2km

☐ more than 2 km

25. What is your main source of drinking water?
Munochera mvura yenyu yekunwa kupi?

☐ 1.Tap in residence ☐ 2. Borehole[3] with pump

☐ 3. protected well ☐ 4. Communal tap

☐ 5.Tap on yard ☐ 6. tanker/ cart with small tank

☐ 7. unprotected well/spring/river/ stream ☐ 8. Other

26.Who fetches water for the household?
Ndiani anochera mvura?

☐ 1. Myself ☐ 3. adult child

☐ 4. child under 15 years ☐ 5. other (please specify)

27. How far is the nearest water point from the house?

☐ 1. Less than 50 metres ☐ 2. Between 51 and 100 metres

☐ 3. Between 101 and 500 metres ☐ 4. Between 501 metres and one kilometre

☐ 5. More than one kilometre

28. Which toilet facilities do you use?
Zvimbuzi

☐ 1. own flush ☐ blair latrine

☐ 3. communal/pour flush ☐ 4. pit latrine with slab

☐ 5. field/ bush

29. What is your main source of energy for cooking?
Munobika nei?

☐ 1. Electricity ☐ 2. wood

☐ 3. paraffin/ kerosene ☐ 4. solar

☐ 5. Coal, lignite ☐ 6. charcoal

☐ 7. cow dung

30. Type of dwelling/*pekugara*

☐ 1. brick wall with iron sheets/asbestos/tile roof

☐ 2. brick wall with grass thatche roof

☐ 3. pole and mud with grass thatch

☐ 4. shack

31. Flooring material

☐ 1. cement ☐ 2. carpet

☐ 3. dung/ mud/earth/sand ☐ 4. wood planks

32. Does the household own any of the following animals?
Mune zvipfuwo zvipi pane zvinotevera?

	yes	**no**
1. cattle/ *mombe*	☐	☐
2. horses/donkeys/mules/ *madhongi/ manyurusi/mabhiza*	☐	☐
3. goats/ *mbudzi*	☐	☐
4. poultry / *huku nemadhadha*	☐	☐
5. pigs/ *nguruve*	☐	☐
6.sheep/ *hwai*	☐	☐
33. Do you have a bank account?	☐	☐

34. Does your household own any of the following agricultural implements?
Munezvipi pane zvekurimisa zvinotevera;

	Yes	**no**
1. Tractor / *tarakita*	☐	☐
2. Oxcart / *ngoro*	☐	☐
3. wheelbarrow / *bhara*	☐	☐
4. plough / *gejo*	☐	☐
5. water cart / *ngoro yemvura*	☐	☐

6. Others (please specify) ☐

35. Do you have any of the following property in your household?
Mune midziyo ipi pane inotevera?

	Yes	no
1. television	☐	☐
2. radio	☐	☐
3. sofas	☐	☐
4. table/ chairs	☐	☐
5. bed	☐	☐
6. fridge	☐	☐
7. non-mobile phone	☐	☐
8. mobile phone	☐	☐

D. PHYSICAL HEALTH

36. How would you rate your health?
Utano hwenyu munohuona sei?

☐ 1. Very good ☐ 2. Good

☐ 3. Fair ☐ 4. Bad

☐ 5. Very bad

37. During the course of your everyday life are you able to do the following?
Munokwanisa here kuita mabasa anotevera ekuzviriritira kana kuzvichengeta?

	yes, on own *hongu, ndega*	**yes, with help** *ndichibatsirwa*	**No** *kwete*
1. Bathing *Kuzvigeza*	☐	☐	☐
2. Dressing *Kupfeka mega*	☐	☐	☐
3. Toilet use *Kuenda mega kuchimbuzi*	☐	☐	☐
4. Feeding *Kudya mega*	☐	☐	☐
5. Grooming *Kuzvipfekedza mega*	☐	☐	☐
6. Cooking *Kuzvibikira*	☐	☐	☐
7. Make fire *Kubatidza moto*	☐	☐	☐
8. Walking *Kufamba mega*	☐	☐	☐

9. Housework ☐ ☐ ☐
Basa remumba

10. Planting ☐ ☐ ☐
Kudyara mbeu

11. Weeding ☐ ☐ ☐
Kusakura

12. Harvesting ☐ ☐ ☐
Kukohwa

13. Collecting water ☐ ☐ ☐
Kuchera mvura

14. Collecting firewood ☐ ☐ ☐
Kunotsvaka huni

E. HEALTH AND SOCIAL CARE

38. Has a member of the household suffered from chronic illness or died in the past five years?
Pane munhu wemuno mumhuri akarwara zvikuru kana kufa mumakore mashanu apfuura here?

Yes/*Hongu* ☐ **No**/*Kwete* ☐

39. If yes; what was diagnosed as the cause of death?
Vakanzi navanaChiremba vakafa nei/ imi munofunga akafa nei?

40. What in your opinion was the cause of death?
Semaonero nemafungiro enyu, akafa nei?

41.Are there any household members who have died as a result of an AIDS-related-illness in the past five years?
Pane munhu wemhuri yenyu akafa nechirwere chemukondombera here mumakore mashanu apfuura?

42. If yes, how many and what ages?
Vangani vakafa, uye vanga vari mazera api?

43. To what extent has the death/illness affected remittances on livelihood opportunities?
Kubatsirikana nemari kwamaiita kare kwakavhiringwa here nekufirwa kwamakaita?

44. Number and sex of orphans due to chronic illness resulting in death of one or both parents
Vangani nherera dzamakasiyirwa nechirwere ichi, vakomana? Vasikana?

	Yes	**No**
	Number	Sex
If yes, number and sex	☐	☐

45. How does the presence of orphans impact on your household as older carers?
Kuvapo kwenherera kunobata zvakadii imba yenyu uye magariro evakwegura?

46. How would you describe health provision and services in your area?

☐ Very good ☐ Good

☐ Fair ☐ Poor

☐ Very poor

47. How far is the nearest health centre to and from your home?
Muri kure zvakadini nekwekurapirwa?

☐ Less than 1 km ☐ Between 1 and 5km

☐ Between 5 and 10 km ☐ More than 10km

48. What is the main mode of transport to get there?
Munoenda nei kana marwara kuchipatara?

☐ Car/Truck/Bus ☐ Walking

☐ Bicycle ☐ Other/ specify

49. How much do you pay for transport to and from the Health Centre?
Munobhadhara marii kuenda kuchipatara?

☐ none ☐ less than US$2

☐ US$2 to US$5 ☐ more than US$5

50. Do you pay for Health Care services?
Munobhadhara kurapwa here?

☐ **yes** ☐ **No**

51. If no, why do you not pay?
Kana mati kwete, sei musingabhadhare?

☐

52. If yes, how much?

☐ less thanUS$2 ☐ less than US$2

☐ US$2 to US$5 ☐ more than US$5

53. Are able to pay this amount?
Munoikwanisa here mari yacho yekurapwa?

☐ **yes** ☐ **no**

54.Would you visit a Traditional Healer or a Faith Healer for health-care?
Mungaende kun'anga kana kumapurofita kunorapwa here?

55. Have you visited a traditional healer or faith healer for healthcare provision in the past?

☐ **yes** ☐ **no**

F. SUPPORT AVAILABLE/ NEEDED

56. Do you think you need help and support from others?
Munofunga mungade rubatsiro kubva kuvamwe vanhu here?

☐ **yes** ☐ **no**

57. Do you get support with any of the following?
Pane ruyamuro rwamunowana here nezvinotevera?

☐ **money/***Imari* ☐ **clothes/***zvipfeko*

☐ **food/***zvekudya* ☐ **work around the home/***basa repamba*

☐ **visits/***kushanyirwa* ☐ **others (please specify)/***zvimwewo*

If no, go to Question 60.

58. If `yes` where do you get the support from?
Munowana rubatsiro kubva kupi?

59.Apart from the ones giving you support, who else do you expect to support you?
Mati hamusi kuwana rubatsiro, ndevapi vamunotarisira kukubatsirai?

60. You say you are not receiving any support, whom would you expect to support you?
Kunze kweavo vari kukubatsirai, ndevapi vamwe vamunotarisira kuti vakubatsirei?

61. What do you think are the reasons for not getting support from the expected sources?
Munofunga sei musiri kuwana rubatsiro kubva kune vamunotarisira kukubatsirai?

62. Apart from your family, where else are you getting support from?
Kunze kwemhuri yenyu, muri kuwana rumwe rubatsiro kubva kupi?

63. Are you getting any support from/ *muri kuwana rubatsiro here kubva ku:*

the government	☐ **yes**	☐ **no**
community	☐ **yes**	☐ **no**
NGOs	☐ **yes**	☐ **no**
Church	☐ **yes**	☐ **no**

64. Do you in any way help younger members of your family? If 'yes', how?
Pane zvamunobatsirawo nazvo vadiki mumhuri yenyu here? Zvakaita sechii?

65. In your opinion, what immediate strategies need to be in place to provide support to households of elderly people?

Zvimwe zvamungaone sehurongwa hungabatsire mhuri dzevakwegura mudunhu rino ndezvipi?

Issue	Intervention
financial	
health	
psychological	
social	

66. How satisfied are you with your life and economic circumstances at present?

Muri kugutsikana zvakadii nemamiriro akaita upenyu hwenyu uye nyaya dzemari pari zvino?

☐ very satisfied ☐ satisfied

☐ somewhat dissatisfied ☐ Dissatisfied

67. Would you consider going into an Old People`s home to be cared for?

Mungade here kunogara kumisha inochengetwa chembere neharahwa nevanhu vasiri hama dzenyu?

☐ yes no

68. Why?

Sei madaro?

69. Do you have any other comments or questions pertaining to this interview?

Mune zvimwe zvamungade kubvunza kana kutaura maererano nehurukuro yedu iyi here?

Appendix 11: In-depth interviews for older persons

1. Can you please briefly describe what it is to be an older person in Zimbabwe?

Mungandiudzewo here maonero enyu ekuti kukwegura muZimbabwe kunorewei?

2. What would you consider a good old age/bad old age?

Chii chamungati kukwegura kwakanaka kana kwakaipa?

3. What things make old age easier/more difficult?

Chii chinoita kuti kukwegura kuwe nyore/kwakaoma?

4. In the Shona tradition in general and MaUngwe in particular, what living arrangements were in place for older persons if they were unable to look after themselves due to old age?

PaChishona uye patsika dzechiUngwe, vanhu vakwegura vaigara nani kana vasisakwanisi kuita mabasa ekuzvichengeta pachavo?

5. Do you think having or not having children has a bearing on support provision? Please explain your answer.

Munofunga kuwe kana kusawe newana kune chekuita here nerubatsiro runowanikwa newanhu pakukwegura kwawo?

6. How illnesses/death(s) impact on your welfare?

Mararamiro enyu akakanganiswa sei neurwere kana kufirwa kwamataita?

7. Have you experienced incidents of any of the following stigma, violence, abuse, witchcraft accusation in this family due to your association with AIDS? If yes, please explain in what way.

   Violence

   Abuse

Witchcraft accusation

Stigma

Pane here pamakashushikana, kurwiswa, kuvhiringwa, kana kupumhwa huroyi nenyaya yemukondombera? Nditsanangurireiwo zvakaitika.

8. Younger people help their older parents and relatives for a number of reasons. Can you please tell me reasons older people are helped, even if this does not apply to you in particular?

Mungandiudzewo here zvikonzero zvamunofunga kuti zvinoita kuti vemazera echidiki vabatsire vabereki kana hama dzavo dzakwegura?

9. In your opinion, does being male or female affect the support provision in old age? Please give reasons for your answer.

Munofunga kuwe mukadzi kana murume kune zvakunobata here parubatsiro rungawanikwe nevakwegura kubva kumhuri dzavo kana masangano anobatsira vakwegura? Ndipeiwo chikonzero chemhinduro yenyu.

10. Does distance between where the older person lives and where their children live have an effect on support provision to older persons? Please tell me why you say so.

Kuwe kure kana pedyo kwemufambo pakati pevakwegura nevana vavo kunobata rubatsiro runowanikwa nevakwegura here? Ndipeiwo chikonzero sei mapa mhinduro iyi.

11. Does the support you get always what you want, or the decision is made by the providers of support? Please explain your answer.

Rubatsiro rwamunowana runobva pakuti ndizvo zvamakumbira here kana kuti mafungiro evanokubatsirai. Munofunga sei zvichidaro?

12. Could you please tell me about events which have taken place in your life, leading to major changes, starting from the earliest?

Mungandiudzewo here zviitiko zvamunoyeuka pakukura kwenyu, zvakakonzera kushanduka kweupenyu hwenyu, kutanga nezvakatanga?

13. What were the implications of these crises?

Chii chakaitika nekuda kwemamiriro ezvinhu asina kunaka aya?

14. How did you manage in the course of bad events/crises?

Matambudziko aya makaabuda sei?

15. Of the crises named, can you please rank the strength of their effect on you, starting with the one with the greatest effect?

Pane izvi, taurai kusimba kwekutambudzika kwazvakakonzera, kutanga nezvakanyanya.

16. Do you have fears or worries about your life, at present and in the future? If yes, what are the fears or worries you would want to try to avoid?

Mune pfungwa dzekutambudzika nezveupenyu hwenyu pari zvino kana remangwana here? Kana zvirizvo, ndezvipi zvamungade kudziwirira?

17. If you have any other comments or questions pertaining to this interview please ask.

Kana muine mubvunzo, bvunzai henyu kana kuwedzera pahurukuro yataita iyi.

Appendix 12: Topic guides for follow-up interviews

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General stock-taking, circumstances, changes

Who is the main provider for your household?

Ndiani muchengeti wemhuri yenyu mukuru?

What is your main source of livelihood?

Ndeipi nzira inokuwanisai uraramo hwenyu hukuru?

For how long have you been married? How many times have you been married? Children from previous marriages, step-children?

Mune makore mangani makaroora/roorwa? Makaroora/roorwa kangani? Mune wana here wabvandiripo, wamakawana waripo?

Are you able to do the following activities: bathing, dressing, toilet use, feeding, grooming, cooking, making fire, walking, housework, planting, weeding, harvesting, collecting water, collecting firewood; on your own, with help?

Munokwanisa kuita mabasa anotewera here: kugeza, kupfeka, kushandisa chimbuzi, kudya, kuzvishongedza, kubika, kubatidza moto, kufamba, basa remumba, kudyara, kusakura, kukohwa, kuchera mvura, kutsvaga huni; mega kana muchibatsirwa?

Who assists you with the activities you are no longer able to do?

Ndiani anokubatsirai nemabasa amusisakwanisi kuita?

How many siblings, their ages, how far they live, frequency of visits and communication?

Mune wakoma/wanin'ina/hanzvadzi ngani, mazera api, wanogara kupi, munoshanyirana nekutaudzana kakawanda sei?

How is your health?

Utano hwenyu huri sei?

Care and support needs

What does each of your children do for a living?

Wana wenyu wanoita mabasa api?

Where do they live?

Wanogarepi?

How does the physical distance to your children affect the contact and support between you and your children?

Kuwe kure kana pedyo kwewana wenyu kunobata sei kufambidzana nekubatsirana pakati penyu newana wenyu?

What support do you currently need?

Rubatsiro rupi rwamunoda?

What support do you think you may need in future?

Rubatsiro rupi rwamunofunga mungade mune remangwana?

Who do you think would provide you with care and support when you come to need it?

Ndiani wamunofunga kuti anozokuchengetai nekukupai rubatsiro kana mawe kuruda?

Why do you think they would provide you with support/care?

Sei muchifunga kuti wanozokubatsirai nekukuchengetai?

How important are children in old age?

Wana wanokosha sei pakukwegura?

Sources of support

Who provides you with care/support?

Ndiani anokubatsirai/anokuchengetai?

What are the reasons for them providing you with support?

Sei wachikubatsirai/wachikuchengetai?

Who is your most important source of support?

Rubatsiro rwenyu rwamunonyanya kukoshesa runobva kunani?

Who else, apart from your family provides you with care/support?

Kunze kwemhuri yenyu, ndiani mumwe anokubatsirai/anokuchengetai?

If there was a crisis, who do you think would be the first to attend to you, why do you think so?

Kuri kunzi pane dambudziko raitika ndiani wamunofunga kuti anotanga kusvika kuzokubatsirai, sei muchifunga kudaro?

What support, if any, do you get from those who live in your household?

Munowana rubatsiro here, rwei kubva kune wamunogara nawo?

Why does this child support you, but that one does not?

Sei mwana uyu achikubatsirai, asi uyo asingakubitsirei?

Do you still support any of your children, which one(s), how, why?

Mune mwana/wana wenyu wamuchiri kuchengeta here, upi/wapi, sei?

Did you help any of your children to set up home? If yes, in what way, why?

Pane wana wenyu wamakabatsira kutanga imba here? Kana mati hongu, nenzira ipi, sei?

If you have any other comments or questions pertaining to this interview please ask.

Kana muine mubvunzo, bvunzai henyu kana kuwedzera pahurukuro yataita iyi.

Appendix 13: Project Information Sheet for Stakeholders and Policy Makers

Project Information Sheet for Stakeholders and Policy Makers

Hello. My name is Nyasha Constance Chiunya-Huni and I am a PhD student at the University of Southampton. I am carrying out a research on 'Ageing in Zimbabwe: The Negotiation of Old-age Care and Support in a Context of HIV/AIDS, Poverty, Hyper-inflation and Out-migration' whose fieldwork is to be carried out in Dowa, in Makoni District, Manicaland. The purpose of the field work is to find out: challenges faced by older Zimbabweans, and what care and support they require, and also how old-age support arrangements are adapting to the current social, economic, political and epidemiological challenges.

What will the research involve doing?
I would like to ask you some questions related to sources of care and support available to older adults, what the older adults view as important to them, what is lacking and what suggestions interviewees can come up with. The research will involve interviewing older people (60 years and over in the small-scale commercial and subsistence farming area of Dowa, in Makoni District, Rusape in Manicaland Province in Zimbabwe and policymakers and stakeholders. The research will be carried out using a combination of qualitative and quantitative methods.

What will happen to the research?
The results of the research would be helpful as they would give an insight into the care and support of older adults, not only those in Dowa and similar rural environments but others in Zimbabwe as a whole, and come up with recommendations for stakeholders such as the government, National and Non-Governmental organisations, churches, to complement the efforts of the family and community in trying to improve the welfare of older adults. We would very much appreciate your participation in this research.

What will the research mean to you?
The survey may take between 40 and 45 minutes. We will not pass on your details to anyone else and information from the interviews will be held securely. Whatever information you provide will be kept confidential and will not be shown to anyone, apart from the small team of staff who are supervising the research at the University of Southampton.

Participation in this research is voluntary and you may choose not to take part or not to answer some of the questions. However, I hope you will participate because your input is very important.

At this point, you are free to ask me anything about the interview or the research.

****

Nyasha can be contacted at the University of Southampton on her email address: ncch1x07@soton.ac.uk or by mobile phone ++ (44) 79 5604 2028. If you have any questions about any of the above please feel free to contact her at any time.

If you have any comments or concerns about this study please contact:

Professor Maria Evandrou
The Centre for Research on Ageing
School of Social Sciences
University of Southampton
Southampton
SO17 1BJ

Tel: ++ 44 (0) 23 8059 4808
Email: maria.evandrou@soton.ac.uk

or

Professor Nyovani Madise
Deputy Head of School (Research)
School of Social Sciences
University of Southampton
Southampton
SO17 1BJ

Tel: ++ 44(0) 23 8059 2534
E-mail: N.J.Madise@soton.ac.uk

With many thanks for your interest in this project.

Nyasha C. Chiunya-Huni
April 2009

Appendix 14: Informed Consent Document for Stakeholders and Policy Makers

Informed Consent document for Stakeholders and Policy Makers

Ageing in Zimbabwe: The Negotiation of Old-age Care and Support in a Context of HIV/AIDS, Poverty, Hyper-inflation and Out-migration

I have read and understood the information sheet about the project. I have been given the opportunity to ask any additional questions about the research project and what I would be expected to do and these questions have been answered by the researcher.

I understand that my participation in this study is entirely voluntary, and that I can withdraw from the study or stop the interview at any time, and that I do not need to give any reasons or explanations for doing so. I understand I will not be penalised in any way for withdrawing from this study.

I understand that in any reference to my interview made in research presentations, reports and articles and so on, personal, organisational and place names will be changed (anonymised) so that I, and any other individuals mentioned, cannot be identified. What I say will also not be shared with other members of my family or with my friends or colleagues.

I agree to participate in an interview about my organisation's interest in issues relating to older persons and how this relates to their care and support.

☐ Yes ☐ No ☐☐ Please initial

I agree to being contacted again during the project for clarification of points raised in the interview.
☐ Yes ☐ No ☐☐ Please initial

I agree to the interview being audio-recorded and transcribed for research purposes.

☐ Yes ☐ No ☐☐ Please initial

I agree to the possibility of the transcription of my interview being archived and made available for use by other bone fide researchers. If the transcript of my interview is selected for the archive, the transcript will be totally anonymised so that nothing in it, such as organisation, place or individual names can be identified. I assign the copyright for my contribution to the university, for use in education, research and publication.

☐ Yes ☐ No ☐☐ Please initial

I understand that I will be sent a summary of the project findings at the end of the project if I wish.

☐ Yes, I would want a copy of the project report

☐ No, I would rather not have a copy

I, _____, have read and understood the above information and agree to participate in this research project on *'Ageing in Zimbabwe: The Negotiation of Old-age Care and Support in a Context of HIV/AIDS, Poverty, Hyper-inflation and Out-migration'* that is being conducted by Nyasha C. Chiunya-Huni at the University of Southampton.

Signature interviewee _____ Date _____

Signature interviewer _____ Date _____

If you have any comments or concerns about this study, please contact:

Professor Maria Evandrou at: University of Southampton
The Centre for Research on Ageing,
School of Social Sciences,
Southampton
SO17 1BJ

Tel: 023 80 594808
Email: maria.evandrou@soton.ac.uk

Appendix 15: Questionnaire for Stakeholders and Policy Makers

Questionnaire for Policy Makers and Stakeholders

A. About your organisation

As we discuss I will be using the terms ‘older persons’, ‘older people’, and ‘elderly people’ interchangeably.

1. What term do you use in your organisation to refer to older people?

2. What is your role in the organisation?

3. When was your organisation formed and how did it come into being?

4. What cut off age do you use in your organisation to determine an older person?

5. How did you come to that cut off point?

6. Would you please briefly tell me what your organisation is mandated to do, concerning older persons?

7. What criteria do you use to determine who needs help?

8. Is your work concerned with all older people or a certain group of older people?

If ‘no’ please go to question 10.

9. If yes, which group(s) in particular?

10. Are you able to meet your targets?

11. If not, what challenges do you face?

12. As an organisation, what do you aspire to do to improve the plight of older persons?

13. As an individual, what do you feel should be done for older persons?

14. Roughly, what is the gender proportion of the older people you provide your services to?

15. Which other organisations do you work in partnership with?

16. Do you get in contact with younger generations, that is, families of older persons? If yes, in what way, if not what are the barriers?

17. Some older persons may be economically dependent, but with enough resources they might be able to look after themselves. Would you please tell me if you have projects to promote their independence and reduce dependency?

18. As an organisation, what do you think about the institutionalisation of elderly people?

19. Would you please give me your personal opinion on the above question?

B. Older people's support needs

20. What are the main sources of livelihood for older persons in Zimbabwe?

21. Could you please list problems/challenges which you are aware of that older people face?

22. Where do you think older persons should get support from?

23. Do you think older people are getting enough support from the sources you have named? If 'yes', please go to question 25.

24. If 'no' what do you think are the reasons?

25. What do you think are the reasons why families help their ageing relatives?

26. Please rank the following according to what you perceive to be their importance and priority to older persons.

- ☐ Their health
- ☐ Self sustenance
- ☐ Transport
- ☐ Relationship with kin
- ☐ Availability of toilets
- ☐ Upkeep of their homes
- ☐ Availability of clean water for drinking, washing and bathing
- ☐ Adequacy of food and clean clothing
- ☐ Welfare of orphans under their care
- ☐ Adequacy of agricultural implements and inputs

27. What in your opinion could be effective and sustainable interventions to support and improve the lives of elderly people?

28. 27 years after the First UN World Assembly on Ageing in Vienna in 1982 where ageing was put on the agenda of developing countries, how much do you think the plight of the older persons has improved?

29. After the Madrid Second World Assembly on Ageing (SWAA), 2002 entitled: 'Focussing on Old Age Economic Security Policy Needs', how far has your organisation gone in trying to improve old-age economic security?

30. How would you describe healthcare and services offered to older people?

31. To what extent have deaths/illnesses affected remittances and livelihood opportunities for older persons?

32. How does the presence of orphans impact on the households of older carers?

C. Way forward

33. With resources permitting, what would you consider to be the best care and support sources for older persons if they are unable to care for themselves?

34. Do you have anything you would like to ask me or add to what we have discussed?

Appendix 16: Key Informant Questions

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1. In the Shona custom, what criteria were used to determine an older person?
   Mutsika yeChishona, ndedzipi nzira dzinoshandiswa kutarisa kuti munhu anzi akwegura?

2. What challenges were associated with old age, when older people could not care for themselves?
   Npeapi matambudziko anobatanidzwa nekukura, kana wakwegura wasisakwanisi kuzvichengeta?

3. How was your grandmother/grandfather/mother/father cared for when s/he was old?
   Mbuya/sekuru/mai/baba wenyu wakachengetwa sei pawainge wakwegura?

4. Who did s/he live with?
   Waigara nani?

5. Who made the decision that s/he lives with that person?
   Ndiani akafunga kuti wagare nemunhu/wanhu iwawo?

6. What role do relatives like brothers, sisters, uncles, aunts, nephews, nieces, in-laws, grandchildren traditionally play in the old-age support provision?
   Kugara nekugara, hama dzakaita semadzikoma, wanin'ina, hanzvadzi, wanasekuru, wanambuya, wanatete, wazukuru wane basa rei pakuchengetwa kwewakwegura?

7. Has this changed, if so, why?
   Zvashanduka here, kana zvadaro, sei?

8. What role did older people play to reciprocate the support they got from younger generations?
   Wanhu wakwegura waiitei kudzosera rubatsiro rwawaipihwa newechidiki?

9. How were those without children cared for in the past?
   Wanhu wasina wana waichengetwa sei kare?

10. What were economic conditions like in the past?
    Nyaya dzeupfumi dzaiwe sei kare?

11. Comparing life in the past and now, was life better then or now? Please support your answer.

Kuenzanisa upenyu hwakare nehwanhasi, upenyu hwaiwe nani kare here kana nhasi? Ndiudzeiwo chikonzero chemhinduro yenyu.

12. How common was migration, what were the reasons for migration and where was migration mainly to?
    Kufamba kwewanhu wachienda kure kwaiwanzoitika sei, zvikonzero zvaiwe zvei uye waiwanzoenda kupi/

13. What were the dis/advantages of migration to older persons?
    Kuenda kure uku kwaibatsira/kwaikanganisa wakwegura sei?

14. What are the advantages and problems associated with migration these days?
    Ndezvipi zvakanaka kana matambdziko anokonzerwa nekuenda kure uku?

15. Are farm sizes shrinking or growing? Why?
    Mapurazi ari kukura here kana kudupuka? Sei?

Appendix 17: Older Respondents' Attributes

ID	Pseudonym	Gender	Age at first interview	Marital status	Number of children	
					Total	Alive
OP01	WaNyati	M	75	Married	9	8
OP02	WaNya	F	73	Widowed	11	8
OP03	WaCelia	F	60	Married	11	8
OP04	WaRod	M	70	Married	4	2
OP05	WaBay	M	78	Married	8	7
OP06	MaiBay	F	72	Married	8	7
OP07	WaMuchengeti	F	72	Divorced	3	2
OP08	WaDorosa	F	73	Widowed	10	5
OP09	WaMufari**	M	63	Married	14	13
OP10	WaMunyarari	F	56	Married	7	7
OP11	WaMeck*	M	86	Widowed	20	+/-7
OP12	WaMuz	F	84	Widowed	0	N/A
OP13	WaMartin	M	56	Married	11	10
OP14	WaReru	M	81	Widowed	8	8
OP15	WaPoto	F	55	Married	5	5
OP16	WaBev	F	55	Divorced	4	4
OP17	WaSiyai	F	62	Widowed	11	8
OP18	WaCha	F	55	Widowed	1	1
OP19	WaSoko	F	70	Married	9	8
OP20	WaRuma	F	86	Widowed	8	1
OP21	WaLeo	M	91	Widowed	7	7
OP22	WaMudzoki**	M	67	Married	15	13
OP23	WaMani	M	60	Married	8	6
OP24	WaShonga	F	76	Widowed	12	9
OP25	WaMusharukwa	M	100+	Widowed	10	4
OP26	WaKwen	M	77	Married	7	5
OP27	WaBo	M	60	Married	5	5

*He was widowed three times.

** They have two wives each

Respondent OP01 is married to OP19; OP03 is married to OP22; OP05 is married to OP06; OP09 is married to OP10

Appendix 18: Stakeholder and Policy-maker interviewees

Respondents' IDs	Organisation	Role/Job Title	Educational Level
SPM01	Specialising in Social Protection	Director	PhD
SPM02	Pensioners' Support Organisation	Director	Degree
SPM03	Senior Citizens Club	Librarian	Diploma
SPM04	Older People's Support Organisation	Programmes Manager	Degree
SPM05	GoZ, Ministry W	Policy and Strategy Development Officer	Degree
SPM06	Old People's Home	Manager	Degree
SPM07	Older People's Residential Project	Manager	Degree
SPM08	GoZ, Ministry X	Government Minister	Degree
SPM09	GoZ, Ministry Y	Director	Degree
SPM10	GoZ, Ministry Z	Commissioner	Degree
SPM11	Chieftainship	Chief	Diploma
SPM12	Neighbourhood	Headman	'O' Levels

Appendix 19: Key Informants

ID	Pseudonym	Description
KI01	Social	academic who specialises in social protection
KI02	Model	local older male who has lived in Dowa for more than 60 years
KI03	Soko	local older female who has lived in Dowa for nearly 60 years
KI04	Mutarisi	local younger person

Appendix 20: Distance from Healthcare Centres and Accessible Transport

Respondent ID	Distance to and from nearest Healthcare Centre (kilometres)	Mode of Transport
OP01	10+	Unreliable car
0P02	10+	Cart
OP03	10+	Walking
OP04	10+	Cart
OP05	10+	Cart
OP06	10+	Walking or cart
OP07	Between 5 -10km	Walking
OP08	10+	Walking
OP09	10+	Walking
OP10	10+	Walking
OP11	10+	Borrowed cart
OP12	Between 5 -10km	Borrowed cart
OP13	10+	Walking
OP14	Between 5 -10km	Cart
OP15	10+	Walking
OP16	10+	Walking
OP17	Between 5 -10km	Cart
OP18	Between 5 -10km	Walking
OP19	10+	Unreliable car
OP20	Between 5 -10km	Borrowed cart
OP21	Between 5 -10km	Walking
OP22	10+	Walking
OP23	10+	Walking
OP24	Less than 1km	Walking
OP25	Between 5 -10km	Cart
OP26	Between 1 -5km	Walking/cycling
OP27	Between 1 -5km	Walking

Appendix 21: Map of study site (available in hard copy)

Appendix 22: Case Studies Vulnerability Assessment

Case study and age at first interview	Sex	Marital status	Living arrangements	Threats	Sources of livelihood and support	Economic Stratum
WaLeo 91	M	Widowed	Lives with a maid and her grandson	Health problems, including poor eye sight Non-normative care Difficulty accessing healthcare (transport)	Own wealth Children, mainly distant son (money, food, visits) Farm produce (consumption and income) Paid-for help[50] Church (spiritual support) Co-resident young 'grandson' (running errands)	1
WaCha 55	F	Widowed	Lives with two young nieces, two young nephews and a maid	Difficulty accessing healthcare (transport) Health problems Lack of care providers	Farm produce (consumption and income) Paid-for help Nearby daughter (money, food, weekly visits) Brothers (local brother- companionship, distant brother – money, food, weekly visits) Step-sisters-in-law (companionship) Young co-resident nieces and nephews (domestic work and farm work)	1
WaNya 73	F	Widowed	Lives with her married son, two young granddaughters and a maid	Health problems Lack of autonomy Difficulty accessing healthcare (transport)[3]	Widow's pension Farm produce (consumption and income) Children, mainly distant son (transport, food, money), co-resident son and daughter-in-law (domestic work and farm work) Paid-for help Co-resident young grandchildren (running	1

[50] 'Paid-for help' refers to both domestic work and farm work. Farm work can be either 'permanent work', paid on a monthly basis, or *maricho* (occasional work, paid on a daily basis or on completion of a set task).

[3] WaNya, WaSoko and WaNyati are collected by their children to go to Harare for healthcare. Even if they were to be taken to the local health centre, the children would still have to travel from far to transport them the short distance, that is why they always take them to Harare.

					errands)	
WaKwen 77	M	Married	Lives with his wife and their adult son intermittently	Health problems, including poor eye sight Non-normative care Difficulty accessing healthcare (transport)[4]	Farm produce (consumption and income) Contributory pension Wife (farm work and domestic work) Three distant children (visits, food) Neighbours (practical help) Co-resident son (farm work)	2
WaNyati and WaSoko 75 and 70	M/F	Married	Live with their widowed son, his son and daughter and a 'grandson'	Health problems, including poor eye sight Difficulty accessing healthcare (transport)[3] Abuse Inadequate economic resources	Contributory pension Children, mainly nearby son and daughter-in-law (farm work and domestic work), daughter in the UK (money, food), two distant daughters, (food, visits, transport[51]), distant son (transport) Farm produce (consumption and income) Neighbours (companionship, emotional support) Paid-for help (farm work, domestic work) Young grandchildren (running errands)	2
WaBo 60	M	Married	Lives with his wife, their four sons, daughter-in-law and granddaughter	Difficulty accessing healthcare (transport and user fees) Inadequate economic resources Health problems	Farm produce (consumption and income) Co-resident children (farm work), distant son (money) Wife (domestic work, farm work Church (spiritual support) Government (agricultural input loans) Neighbours (companionship) Co-resident daughter-in-law (domestic work and farm work)	2

[4] WaMani, WaKwen and WaRuma get free treatment at the local health centre. WaBo was told he could stop paying when he turned 65. There are contradictions in the criteria used for non-payment, for example, WaMani was exempted from paying, yet others over 65 still pay.

WaCelia 60	F	Married	Lives with her husband and their two young grandchildren	Inadequate economic resources Health problems Lack of care and support providers Difficulty accessing healthcare (transport and user fees)	Farm produce (consumption and income) Children, mainly distant son (food, payment of Unit Tax) Husband (domestic work, farm work) Co-resident young grandchildren (domestic work, running errands) Neighbours (loans, emotional support, companionship)	3
WaPoto 55	F	Married	Lives with her three daughters, her married son and his wife, and four grandchildren	Difficulty accessing healthcare (transport and user fees) Inadequate economic resources Inadequate living space Health problems	Farm produce (consumption and income) Co-resident children and daughter-in-law (domestic work, farm work) Neighbours (loans, emotional support, companionship)	3
WaBev 55	F	Divorced	Lives with her young son, Bev's mother is usually away	Inadequate economic resources Difficulty accessing healthcare (transport and user fees) Health problems Lack of care providers	Farm produce (consumption and income) Distant children (occasional visits, food), co-resident young son (running errands) Brother, for half a year (farm work) Neighbours (loans, companionship)	3
WaDorosa 73	F	Widowed	Lives with her young great granddaughter and two workers	Non-normative care Health problems, including poor eye sight Difficulty accessing healthcare (transport and user fees) Loneliness Inadequate economic resources Abuse	Farm produce (consumption and income) Neighbours (loans, child minding her great-granddaughter, emotional support) Children, mainly distant son (money, visits, food) Young great granddaughter (running errands) Co-resident paid-for help (domestic work and farm work)	3
WaRod	M	Married	Lives with his wife, three young	Lack of care and support providers	Wife Farm produce (consumption and income)	3

75			grandsons and two granddaughters-in-law	Inadequate economic resources Difficulty accessing healthcare (transport and user fees)	Co-resident young grandchildren and granddaughters-in-law (domestic work and farm work) Neighbours (loans, emotional support and companionship)	
WaMani 60	M	Married	Lives with his wife, young daughter, daughter-in-law and two grandchildren	Inadequate economic resources Health problems, including poor eye sight Difficulty accessing healthcare (transport) Loneliness Homelessness Lack of care providers Abuse	Farm produce (subsistence, no cash in the system) Wife (domestic work and farm work) Co-resident daughter-in-law (domestic work and farm work) Co-resident young daughter (domestic work and farm work, running errands) Distant children (clothes, food, visits) Neighbours (draught power)	3
WaReru 81	M	Widowed	Lives with his widowed son and two young grandsons	Inadequate economic resources Lack of care and support providers Health problems, including poor eye sight Difficulty accessing healthcare (transport and user fees) Loneliness	Farm produce (consumption and income) Neighbours (companionship, occasional domestic work) Co-resident son (all domestic work and farm work) Co-resident young grandsons (running errands)	4
WaRuma 86	M	Widowed	Lives with her eight grandchildren, her great nephew and one of her grandson's wife	Homelessness Lack of care and support providers Health problems, including poor eye sight Inadequate economic resources Difficulty accessing	Co-resident young and adult grandchildren, great nephew (domestic work and farm work) Farm produce (subsistence) Neighbours (loans) Church (companionship, spiritual and emotional support)	4

				healthcare (transport)		
WaMuz 84	F	Widowed	Childless and lives alone	Inadequate economic resources Health problems, including poor eye sight Lack of care and support providers Homelessness Difficulty accessing healthcare (transport and user fees) Loneliness	Nearby niece (running errands, care) Neighbours (food, companionship, charity) (Very little) farm produce (inadequate for own consumption)	4

Source: Field data, table adapted from Schröder-Butterfill and Kreager (2005)

Key

1. Rich: ownership of land, ownership of or access to many cattle, adequate farming implements and inputs, access to remittances, well-built, furnished and maintained home, producing enough for consumption and sale for income, adequate finances
2. Comfortably off: land ownership, access to remittances, producing enough for consumption and sale, occasional inadequacy of finances
3. Marginal: inadequate finances, minimal excess produce to sell, occasional or no access to remittances
4. Poor: very little or no access to remittances, reliance on charity, risk of homelessness, little or no draught power, no excess produce to sell

Main threats faced by Case Studies

Threat	Number of respondents facing the threat
Difficulty accessing healthcare[1]	**16**
Low vulnerability (transport problems)	7
High vulnerability (transport problems and failure to afford user fees)	9
Inadequate economic resources	**12**
Low vulnerability (inadequate income)	8
Low vulnerability (inadequate assets)	1
High vulnerability (inadequate assets and income[2])	3
Lack of care and support providers	**11**
Non-normative care	3
Care only	3
Both care and support	5
Health problems[3] (being in pain, limiting everyday activities)	**15**
Chronic conditions	10
Other health conditions	5
Loneliness	4
Homelessness	3
Verbal, emotional and physical abuse	3

[1] All cases are exposed to transport problems, affecting their access to healthcare.

[2] There is lack of cash in the households

[3] All the cases with health problems had experienced them for 'a number of years', about half of them for over ten years

Appendix 23: Letter to Non-Governmental Organisations

Telephone: 790871/7
Telegrams: "SECLAB"
Private
Bag 7707/7750,
Causeway

MINISTER OF PUBLIC SERVICE, LABOUR
AND SOCIAL WELFARE
Compensation House
Cnr Fourth Street and Central Avenue
HARARE

Reference: SW/21/3

4 June 2008

TO: ALL PRIVATE VOLUNTARY ORGANISATIONS (PVOs)/NON GOVERNMENTAL ORGANISATIONS (NGOs)

It has come to my attention that a number of NGOs involved in humanitarian operations are breaching the terms and conditions of their registration as enshrined in the Private Voluntary Organisation Act [Chapter 17:05], as well the provisions of the Code of Procedures for the Registration and operations of Non Governmental Organisations in Zimbabwe (General Notice 99 of 2007).

As the Regulatory Authority, before proceeding with the provision of Section (10), Subsection (c), of the Private Voluntary Act [Chapter 17:05], I hereby instruct all PVOs/NGOs to suspend all field operation until further notice.

Hon. N T Goche (MP)
MINISTER OF PUBLIC SERVICE,
LABOUR AND SOCIAL WELFARE

Glossary

The glossary contains Shona words and phrases which were commonly used during the interviews. Most of the terms are written in the Ungwe dialect, a sub-dialect within the Shona language, since the empirical study was carried out in Makoni/Maungwe District in Manicaland Province where most of the population speaks (Chi)Ungwe and are referred to as WaUngwe.

Ambuya	Mother-in-law (wife's mother, can also refer to grandmother)
Baba	Father (also means Mr, followed by the surname)
Babamukuru (senior father) or cousin	Uncle/father's older brother or cousin/husband's older brother
Babamunini (junior father) brother or cousin	Uncle/father's younger brother or cousin/husband's younger
Barika	Polygamy
Basa	Work/job
Basa remumba	Housework
Bato riri kutonga	Ruling political party
Bato riri kukwikwidza	Opposition party
Bazi	Department (also means a branch)
Bhanga	Bank
Bhizautare/bhasikoro	Bicycle
Chando/kutonhora	Cold
Chekufambisa/zvekufambisa	Transport (singular and plural)
Chembere	Older woman/older women
Chibhorani	Borehole
Chibvumirano/chitenderano	Agreement
Chii?	What?
Chiitiko/zviitiko	Event/events
Chikonzero/zvikonzero	Reason/reasons
Chikoro	School

Chikwereti	Debt
Chimbuzi	Toilet
Chingwa	Bread
Chipfambi	Prostitution
Chiremba	Doctor
Chirwere/hosha/urwere	Disease/illness
Chitendero	Religion
Dambudziko	Crisis/problem
Dangwe	First born child
Denga remarata	Iron sheet/asbestos roofing
Denga rehuswa	Grass thatch
Dzinza	Clan
Faniro/kodzero	A right/rights
Gore/makore	Year/years (also means cloud/clouds)
Gotwe	Last born child
Gumbo/makumbo	Leg/legs
Hama	Relative(s)
Hanzvadzi	Brother/Sister
Harahwa	Older man/older men
Hembe/zvipfeko	Clothes
Hondo	War
Hongu	Yes
Hukama	Relationship(s)
Huku	Chicken
Huni	Firewood
Hupfumi	Wealth
Huraramo	Livelihood
Hurombo/nhamo	Poverty

Huroyi	Witchcraft
Hurukuro	Conversation/Discussion
Hurumende	Government
Hutano	Health
Imba	House/household (also means sing)
Imba yekubikira	Kitchen
Imba yekurara	Bedroom
Ivhu	Soil/land
Kare	Past
Kubatana/kuwadzana	Unity
Kubatidza moto	Making firewood
Kubhadhara	Paying
Kubika	Cooking
Kubuda munzvimbo/munyika	Migration
Kubudirira	Prosperity
Kubvuma	Agree
Kubvunza	Asking
Kuchema	Crying/mourning
Kuchembera/kukwegura	Being old
Kuchengeta	Looking after/caring for/providing for/saving
Kuchengetwa	Being looked after/being cared for/being provided for
Kuchera mvura	Fetching water
Kudya	Eating
Kudyara	Planting
Kudzidza/kufunda	Learning
Kudziwirira	Avoiding/preventing
Kuenzanisa	Comparing
Kufamba	Walking/travelling

Kufamba-famba	Slang for prostitution
Kugadzira	Making/repairing
Kugara	Staying/living (*kugara* also means sitting down)
Kugarika/kupfuma	Being rich
Kugarisana	Co-residence
Kugashira/kutambira	To receive
Kugeza	Washing/bathing
Kugutsikana	Satisfaction
Kuipa/zvakaipa	Bad
Kukohwa	Harvesting
Kukosha	Important
Kukwana	Adequate
Kukwanisa	Being able
Kukwazisa	Greeting
Kukwegura/kuchembera	Ageing
Kukwereta	Borrowing
Kukweretesa	Lending
Kumbira	Ask for/request
Kumwa	To drink
Kunaka/zvakanaka	Good
Kunyora	Writing
Kunzwa	Hearing
Kupa	Giving
Kupanana	Reciprocity
Kupisa	Hot/burning
Kupfeka	Getting dressed
Kupi?	Where?
Kupindura	Answering/responding

Kupiwa	Being given
Kupumhwa	Being accused
Kuramba	To refuse
Kurapwa	Receiving healthcare
Kurasikirwa	Losing
Kure	Far
Kuremedza	Burdening
Kuremekedza/kukudza	Respecting
Kurera	Bringing up/rearing
Kurima	Farming/ploughing
Kuroora/kuroorwa	Being married (male)/being married (female)
Kusakura	Weeding
Kusakwana	Inadequate
Kusanaya kwemvura	Drought
Kusarudza	Choice/choosing
Kushanda/kusewenza	Working
Kushandira pamwe	Co-operation
Kushandisa chimbuzi	Toilet use
Kushanduka	Change
Kushandura mafungiro	Change of mind
Kushanya	Visiting
Kushanyirwa	Being visited
Kushaya mwana	Childlessness
Kusurukirwa	Loneliness
Kusuwa	Being unhappy/missing someone or something
Kutakura	Transporting/carrying
Kutama	Moving homes/houses
Kutambudzika	Suffering/struggling

Kutambudzwa/kushungurudzwa	Being made to suffer
Kutarisira/tarisiro	Expecting/expectation(s)
Kutaura	Talking
Kutaurirana	Negotiating
Kutemwa nemusoro	Headache
Kutenga	Buying
Kutengesa	Selling
Kutsenga	Chewing
Kutsvaga huni	Collecting firewood
Kutya	Fear/worry
Kuungana/ungano	Gathering
Kuwerenga/kudzidza	Studying/reading (also means counting)
Kuwiga	Burying (also means hiding)
Kuwoma	Hard/dry
Kuyeuka/kurangarira	Remembering
Kuzvichengeta	Self-caring/self-supporting
Kuzvifungira nekuzvirongera	Autonomy
Kuzvigeza	Bathing
Kuzvimba	Being swollen
Kuzvishongedza	Grooming
Kuzorora	Resting
Kwekurapirwa	Healthcare centre
Kwete	No
Mabiko	Celebration
Magariro	Living conditions
Magetsi	Electricity
Mai	Mother (also means Mrs, followed by the surname)

Maiguru Senior mother (mother's older sister/older cousin, father's older brother's wife)/sister-in-law (older brother's wife/husband's older brother's wife)/senior step-mother

Mainini Junior mother (mother's younger sister/younger cousin, father's younger brother's wife)/sister-in-law (younger brother's wife/wife's younger sister/younger cousin)/ junior step-mother

Makakatanwa Disagreement(s)

Mambo Chief

Mamiriro ehupfumi Economic conditions

Mararamiro Way of life

Mari Money

Maricho Occasional work, paid on a daily basis or on completion of a set task.

Marii? How much (cost)?

Mbesa/mbeu Crops

**Mbuya* Grandmother/aunt (mother's brother's/cousin's wife)

Mhinduro Answer/response

Mhuri Family

Mombe Cattle

Moto Fire

Motokari Car

Mubvunzo/mibvunzo Question/questions

Muchengeti wemhuri Bread winner

Muchero/michero Fruit/fruits

Mudyandigere Pension

Mudzimai Wife/woman

Mudzimu/wadzimu Ancestor/ancestors

Muenzaniso Example

Mufambo Distance

Mugodhi Deep water well

Mugwagwa	Road
Mukadzi	Female/woman/wife
Mukomana	Boy
Mukondombera	HIV/AIDS
Mukoti	Nurse
Mukuwasha	Son-in-law/brother in law (male referring to sister's husband
Munda/minda	Field/fields
Munhu/wanhu	Person/people
Munyama	Bad luck/curse
Murapi	Healthcare professional
Murimi	Farmer
Muriwo	Relish (such as meat, vegetables, milk)
Muroora	Daughter-in-law/sister-in-law (female referring to brother's wife)
Murume	Husband/male/man
Musangano/ungano	Meeting/gathering
Musha	Home
Mushandi/musewenzi	Worker
Mushonga	Medicine
Musoro/misoro	Head/heads
Musoro wemba	Head of household
Mutemo/mitemo	Law/laws
Mutorwa	Non-kin
Muwakidzani/wawakidzani	Neighbour/neighbours
Mvumo	Permission
Mvura	Water/rainfall
Mwana/wana	Child/children
Mwanakomana/mukororе	Son

Mwanasikana/muzvare Daughter

Mwari/Musikawanhu God/Creator

Mweni/muenzi Visitor

Musha Home

Musikana Girl

Muzukuru/wazukuru Grandchild/grandchildren (also refers to nephew(s) and niece(s) – male referring to sister's children; female referring to brother's children)

N'anga Traditional healer

Ndiani? Who?

Ngoro Scotchcart

Ngozi Avenging spirit

Nguwa Time

Nhaka Inheritance

Nhasi Present/today

Nherera Orphan(s)

Nyama Meat

Nzara Hunger/starvation (can also mean finger nail/toe nail)

Nzenza Being of loose morals

Nzwisisa Understand

Pedyo Near

Pekugara Place of residence

Pfungwa nemazano Ideas and advice

Purazi Farm

Remangwana Future

Rini? When?

Rubatsiro/ruyamuro Help/support

Rudo Love

Rufu/nhamo Death

Runhare	Telephone
Runharembozha	Mobile phone
Rusununguko	Independence
Ruwoko/mawoko	Hand/hands
Rwendo	Journey
Sabhuku	Village head
Sadza	Maize meal
Sahwira	Adult friend
Sei?	How?
Sei/ngei?	Why?
**Sekuru*	Grandfather/uncle (mother's brother/male cousin)
Shirikadzi	Widow
Simba	Energy/strength
Tete	Aunt (father's sister), sister-in-law (husband's sister)
Tezvara	Father-in-law/brother-in-law (wife's brother)
This disease	HIV/AIDS
Tsanangudzo	Explanation
Tsika	Culture/tradition (also means stepping on)
Tsime	Water well
Tsvagurudzo	Research
Tsvimborume	Widower
Uriri	Floor/flooring
Uriri hwendowe	Cow dung flooring
Wadzimu	Spirit mediums
Wamwene	Mother-in-law (husband's mother)
Wasina wana	Childless
Zera/mazera	Age/ages

Zino/mazino	Tooth/teeth
Zita/mazita	Name/names
Zvakanyanya kukosha	Most important
Zvekudya	Food
Zvekurimisa	Farming implements
Zvikohwewa	Farm produce
Zvinhu	Things
Zvinyorwa	Reports
Zvipfuyo	Domestic animals
Zvirimwa	Crops
Zviwanikwa	Findings
Zunde raMambo	Chief's granary
Zuwa/mazuwa	Day/days (zuwa also means the sun)

* The terms *mbuya* and *sekuru* are also often used to show respect to older women and men respectively, even if there is no relationship. As a result during empirical study I referred to older respondents as *mbuya* or *sekuru.*

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