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Ageing and Care of Older Persons in Southern Africa: Lesotho and Zimbabwe Compared

Jotham Dhemba, *Department of Sociology, Anthropology and Social Work; National University of Lesotho*

Bennadate Dhemba, *Formerly Department of Social Services, Harare*

Introduction

The United Nations Department of Economic and Social Affairs observes that the population of the world is ageing rapidly and that this is particularly so in low income countries including those in Africa (Gomez-Olive et al cited in Van Rooy, Mufume and Amadhila 2015). On this basis Van Rooy et al (2015) contends that all countries will be obliged to deal with aspects of an ageing population. On the same note Patel (2005) posits that the Southern African region where Lesotho and Zimbabwe are situated has the largest number of older persons on the continent.

Although Tran (2012) contends that population ageing is a phenomenon found in all countries it is happening fastest in poor countries. He observes that life expectancy at birth has risen substantially across the world and that "in 2010-15, life expectancy is 78 in rich countries, 68 in poor countries". It is also expected that by 2045-50 life expectancy will have risen to 83 in developed countries and 74 in developing countries. The UN (undated) also observes that the global population of older persons is expected to more than double from 542 million in 1995 to about 1, 2 billion in 2025. On the same note WHO (undated) asserts that the global population of older persons is predicted to increase from 672 million in 2005 to almost 1.9 billion in 2050 (Ndabeni, Mbandazayo and Hlatswayo 2014:10). **In addition** HelpAge International cited in Ndabeni, et al (2014:10) corroborates this view contenting that older persons aged 60 years and over will outnumber children under the age of 14 years by 2045.

Furthermore, Kofi Annan, the former United Nations Secretary General postulates that "where once population ageing was mostly a concern of developed countries it has gained momentum in developing countries as well" (UN 2002:1). Longevity is attributed to declining fertility rates and increasing survival at older ages, courtesy of improved health, medicine and sanitation enabling lives to extend far longer than before. As will be shown later Lesotho and Zimbabwe are also experiencing an increase in the population of older persons.

Though there is no consensus on the definition of older persons, also referred to as the elderly or older adults, this article adopts the United Nations definition which embraces any human being aged 60 years and above that was agreed at the World Assembly on Ageing in Vienna in 1982. The United Nations (UN) (2009) reveals that 6% of Zimbabwe's population of 12,523 million people comprises of older persons and that it will rise to 12% by 2050. According to the UN (2009) a similar demographic trend obtains in Lesotho as its senior citizens consist of 6% of the total population and this is also expected to rise to 12% by 2050.

According to the Ministry of Social Development of Lesotho (2014) older persons are the fastest growing population in Lesotho and that on average they are living longer than before.

As Phillips, Ray and Marshall (2006) observe, older persons tend to have multifaceted needs that put them at risk of abuse, neglect, poverty and institutionalisation. It is also their contention that the elderly are likely to experience chronic conditions, physical degeneration and frailty as a result of the ageing process. While Sung and Dunkie (2009) assert that older persons experience a variety of social and psychological problems it is also their contention that they often depend on service providers to resolve these problems. They also assert that social workers "become a significant part of the world of the elderly in later years" (Sung and Dunkie 2009).

In addition old age is often accompanied by a reduced capacity of income generation, poverty, loneliness, senility and a growing risk of serious illness. HelpAge International (2004:5) asserts that poverty and social exclusion are the major challenges facing older persons. The situation is much worse in sub-Saharan Africa where Ferreira (2005) observes that older persons are consistently among the poorest of the poor. As Ambrosino, Heffernan, Shuttleworth and Ambrasino (2012:360) observe,

Many older people have been self-sustaining members of society and have developed problems of adaptation only at an older age. Without support, accumulated interpersonal losses (such as the loss of a spouse, friends, families, familiar environment, job income, physical health) threaten the fulfilment of their daily living needs and life satisfaction.

Tran (2012) also contends that "while both men and women face age discrimination, older women face the cumulative effects of gender discrimination throughout their lives, including less access to education, health, lower earning capacity and limited access to rights to land ownership".

The plight of older persons continues unabated in spite of the adoption of the United Nations (of which Lesotho and Zimbabwe are member states) Principles for Older Persons Resolution 46/91 by the General Assembly in 1991 and the subsequent adoption of the Madrid International Plan of Action on Ageing in 2002 by the Second World Assembly on Ageing imploring Governments to respond to the opportunities and challenges of population ageing in the 21st century. These principles include the need for older persons to have access to adequate food, water, clothing and health care through financial, family and community support. The need to ensure their full participation in societal activities and that they should benefit from family and community care and protection is also emphasised.

A number of factors are to blame for the plight of older persons especially in developing countries, inclusive of Lesotho and Zimbabwe. These include an economic environment which is underdeveloped and the perception that demographic ageing is a phenomenon associated with the rich countries of America and Western Europe which enjoy an advanced level of economic development and are therefore in a position to provide for their needs. Boggatz (2011:11) also points out that "the common image of the demographic situation in these countries (developing countries) is a higher fertility rate combined with low life expectancy."

However, on the same note Boggatz (2011:11) contends that this view should be revised as "the developing world is undergoing a demographic transition. It is also conveniently

believed that poor countries have more pressing problems and competing demands on state resources, which makes it difficult to provide for older persons.

Furthermore, in the African context it has always been thought that the strength of tradition and family solidarity would prevent situations where older persons experience social and economic insecurity. However, Kaseke and Dhemba (2007) contend that new values of individualism emerging in African societies have exposed vulnerable populations to social insecurity. Ferreira also observes from a vantage point that changes in family structures as a result of modernisation and urbanisation have diminished kin support for older persons. Similarly globalisation has also reduced the family into a non- viable economic institution for older persons as it promotes values of individualism and the pursuit of self interest. Estes, Biggs and Phillipson (2003:104) also point out that these changes are part of a new political economy shaping the lives of current and future generations of older persons. Furthermore, they argue that there is a shift "to more individualised structures –private pensions, privatised health and social care –which increasingly reflect the transformation of policies in the period from 1980 onwards."

However, in spite of the reality that social change is irreversible, the erroneous view that traditional social support systems should be responsible for the care of older persons still obtains. In the case of Lesotho and Zimbabwe this is evident in their social welfare policies, particularly public assistance which is means-tested and is only granted when the investigating officers are satisfied that there are no relatives in a position to assist.

Whilst "care" literally refers to care-giving activities, care of older persons is multifaceted. Therefore, for purposes of this article care refers to policy and practice for the upkeep and wellbeing of older persons. Specifically it refers to the configuration of social protection measures designed to ensure the economic, health and social wellbeing of older persons and their contribution to familial, community and societal activities. According to the Department of Health quoted in Newman, Glendinning and Hughes (2008) the outcomes to which the care of older persons is oriented include,

- Fostering independence and control
- Promoting wellbeing and preventing ill health
- Protecting vulnerable adults.

Tran (2012) also asserts that financial security and health are cited as among the most urgent concerns by older persons.

Therefore, given the bourgeoning population of older persons in most developing countries Lesotho and Zimbabwe included and available evidence pointing to their exclusion and marginalisation, it is necessary to explore the existing arrangements including their efficacy in the protection and care of the elderly. This is critical in order to come up with suggestions for responding to the realities of 21st century demographics.

1 Location and socio-economic context

Lesotho and Zimbabwe are both landlocked countries situated in Southern Africa. Lesotho is completely surrounded by South Africa, which makes it her only neighbour leading to some analysts commending that it is located in the "belly" of South Africa. On the other hand

Zimbabwe is encircled by four neighbouring countries, namely South Africa to the south, Mozambique to the east, Zambia in the north and Botswana in the west.

According to the United Nations (2009) Lesotho is a very poor country as 40% of its population of 1,880,661 people is living below the "official" poverty line of US$1,25 per day. This is corroborated by the World Bank (2011) which points out that Lesotho's Gross National Income (GNI) per capita is only US$1.910. The socio-economic situation obtaining in Zimbabwe is not very different from Lesotho as its economy is also underdeveloped and poverty, food insecurity and unemployment have reached unprecedented levels. Zimbabwe's situation has been compounded by the prolonged political and economic meltdown (from the year 2000 to 2009) which was exacerbated by the international isolation of the country as a result of contested election results in 2002, 2008 and 2013. Poverty in Zimbabwe is estimated to be over 70% and the Staff Reporter (2011) estimates the rate of unemployment to be 85%.

Bello, Maluke, Letete, Rapapa and Chakobane (2008) also maintain that one of the greatest problems facing sub-Saharan African countries is the chronic state of poverty. It is perhaps on the basis of this reality that member states of the United Nations inclusive of Lesotho and Zimbabwe committed themselves to halving poverty in their countries by 2015 among other Millennium Development Goals targets. Poverty, food insecurity, unemployment and the scourge of HIV/AIDS characterise the socio-economic situation obtaining in both Lesotho and Zimbabwe and as can be expected, the pervasiveness of these problems creates challenges in the social protection of vulnerable groups including older persons.

2 Methodology and objectives

To explore and compare the phenomenon of ageing and care of older persons in Lesotho and Zimbabwe the study utilised two types of data sources, namely secondary and primary sources. The study examined literature, inclusive of research reports and policy documents on ageing and care of older persons.

The study also adopted the qualitative research method to acquire primary data about the experiences of social workers in the Ministry of Social Development in Lesotho and Department of Social Welfare Zimbabwe respectively, which have the mandate to provide for the welfare of older persons, among other vulnerable populations. Furthermore, Azulai (2014:11) contends that, "without question, thousands of social workers over the next two decades will serve older clients within their caseloads, regardless of their specialization or special interests."

Within the framework of available time and resources qualitative data were collected from two officials (key informants) each, from the Ministry of Social Development in Lesotho, the Department of Social Services, Zimbabwe and Reitumetse Centre, an old people's home in Lesotho. The key informants were selected on the basis of purposive sampling because of their knowledge of the care, policies, services and programmes for older persons in their respective countries.

In–depth interviews using semi-structured interview guides were carried out to elicit information from the key informants. However, while the same interview guides were used for the officials from the Ministry of Social Development and Department of Social Services the one for the officials from Reitumetse also had questions on institutional care for older persons.

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The qualitative data that were generated was analysed thematically on the basis of identified themes. The objectives of this study were:

1. To explore and compare the existing arrangements for the protection and care of older persons in Lesotho and Zimbabwe.

2. To come up with suggestions for enhancing the protection and care of older persons in Lesotho and Zimbabwe.

3 Situation of older persons in Lesotho and Zimbabwe

Generally the majority of older persons in both Lesotho and Zimbabwe are poverty stricken, food insecure and ill-served by health and social services in their respective countries. As pointed out elsewhere, a major development challenge in the case of Lesotho is that almost half the population lives below the poverty datum line. Bello et al (2008:79) maintain that poverty among older persons and their households has been worsened by the retrenchment of Basotho mine workers who used to provide assistance through remittances. They also observe that the HIV/AIDS pandemic is leaving an increasing number of older persons caring for orphaned children and that the seniors are also experiencing a sharp decline in asserts mainly as a result of stock theft. Turner (2001) also observes that poverty studies carried out in Lesotho show that older persons who live alone or without a younger adult are mostly vulnerable to poverty.

On the other hand, Madzingira cited in Dhemba (2013) reveals that the 1996 Poverty Assessment Study Survey classified 78, 5% of older persons in Zimbabwe as very poor or poor. They experienced shortage of food, clothing, lack of or poor accommodation, poor health and lack of draught animals (older persons in rural areas). The situation of older persons in Zimbabwe is also worsened by the fact that poverty in the country is pervasive. According to the Poverty Assessment Study Survey of 2006 poverty trends in the country have risen significantly in both urban and rural areas (Gandure 2009). The Poverty Assessment Report states that 53 % of the households in urban areas and 63 % of the households in rural areas were living below the Total Consumption Poverty Line in 2003.

The massive exodus of political and economic refugees to foreign lands (during the period 2000 to 2009) also exacerbated the situation of older persons, leading to Homes in Zimbabwe (undated) a charity organisation registered in the United Kingdom in 2004 observing that "hundreds of older persons have been left behind, alone, destitute and without enough to eat". As will be shown later, the exclusion of older persons in existing social protection measures has also contributed to insecurity in old age.

Kasere, quoted in Kaseke and Zimunya (eds) (1992:59) also contends that it is well documented that a significant proportion of older persons suffer from various ailments some of which are chronic. He laments that "there is almost a total absence of a health care delivery system specifically for the needs of the elderly. The elderly have to make do with an existing general care system which is not only inadequate for their specific needs but is also not easily accessible to them".

The crux of the problem is that both Lesotho and Zimbabwe, are unprepared for this unprecedented age wave which is occurring at a very fast pace. The Ministry of Social Development (2014) points out that older people are the fastest growing population group in Lesotho. This demographic transition is occurring in the absence of comprehensive policies

and measures to address the syndromes of poverty and ill-health in old age. Furthermore, existing social protection measures are not broad based in their coverage of older persons. Tsuinyane (2012) a Programme Manager, in the Ministry of Social Development in Lesotho bemoans this state of affairs lamenting that "ageism is rife in most African countries and that this explains the underdevelopment of policy and practice for older persons."

In traditional African culture, care for older persons was provided within the extended family system. However, the demise of the extended family system as a result of modernisation and urbanisation has diminished the capacity of the family to care for older relatives thereby necessitating the need for substitute mechanisms to plug this yawning gap. As Boggatz (2011:5) points out "families have to find solutions for the care of dependant older persons while at the same time social changes threaten the traditional system of family care. The care of older persons in Lesotho, followed by Zimbabwe is examined in the sections below.

4 Care of older persons in Lesotho

The care of older persons in Lesotho as elsewhere in Southern Africa is a shared responsibility of the nuclear family, government and voluntary organisations. However, as will be shown later the dominant view is that the extended family support system should shoulder most of the responsibility to provide for its members, including older persons. Lesotho adopted the Policy for Older Persons in 2014 and the existing social protection measures in Lesotho are both formal and non-formal arrangements, including public assistance, old age pension, occupational pension, institutional care and family and community care which are examined below.

4.1 Lesotho Policy for Older Persons

There was no specific policy for older persons in Lesotho prior to the adoption of the Policy for Older Persons in Lesotho in 2014. According to the Ministry of Social Development (2014:14) the objectives of the Policy are to advocate for observance of the rights and respect of older persons and to establish structures and programmes to promote their well-being. Therefore, the government is now ceased with the implementation of the policy though not much has been achieved so far. Suffice therefore to say that the Ministry of Social Development established the Department for Elderly Care Services in 2013 which is expected to spearhead the implementation of the Policy for Older Persons.

4.2 Old age pension, public assistance, occupational pension and free health policy

Though it is indeed commendable that Lesotho is one of the six countries in Southern Africa that provide non-contributory old age pensions, the others being Botswana, Mauritius, Namibia, South Africa and Swaziland, it does not have a national policy on the care of older persons. Resultantly, as stated elsewhere social safety nets for older persons in Lesotho are fragmented and rudimentary. However, one of the key informants (Tsuinyane) from the Ministry of Social Development indicated that Lesotho was in the process of developing a policy for older persons which has since come to fruition with the adoption of the Lesotho Policy for Older Persons of 2014.

While the newly created Ministry of Social Development (previously the Department of Social Welfare) has the responsibility for administering welfare programmes, inclusive of personal social services for older persons, this is disconnected from the old age pension scheme as it is administered by a different Ministry, the Department of Pensions within the

Ministry of Finance. The universal Old Age Pension Scheme caters exclusively for older persons aged 70 years and above.

The Ministry of Social Development administers a public assistance scheme for vulnerable groups in the population inclusive of older persons. The public assistance scheme is also means-tested and resultantly not all applicants qualify for assistance. Inadvertantly it excludes many older persons as it is operated under very strict eligibility criteria as it is always poorly funded. Also of concern is that the public assistance allowance is only M250 Maloti (about US$22) a month which is way below the United Nations poverty line of US$1,25 a day and is therefore not enough to lift older persons out of poverty.

Therefore considering that older persons aged 60 to 69 years are not covered under the Old Age Pension Scheme and that they do not have automatic entitlement to public assistance allowances, their situation is quite precarious. Furthermore, Lesotho does not have a compulsory occupational pension scheme for formally employed workers and as such retirees are unlikely to be receiving retirement pensions. Furthermore, given the high levels unemployment in the country, the majority of the labour force would not be covered under this scheme.

Tsuinyane also laments that shortage of staff and inadequate budgetary allocation to the Ministry of Social Development, formerly Department of Social Welfare are incapacitating the Ministry from carrying out its mandate to promote the inclusion of older persons among other vulnerable populations. However, in a speech marking the celebration of the United Nations Day for Older Persons on 29 October 2014 the Principal Secretary in the Ministry of Social Development (MOSD) pointed out that they had established a Department of Elderly Care Services to spearhead the development and implementation of policy and other measures on the care of senior citizens.

It is also worth noting that older persons in Lesotho benefit from the country's free health policy, but only at clinic level. However, while the World Health Organisation (WHO) (2009) acknowledges the existence of clinics that are designed to meet current health standards in Lesotho, it maintains that there is a human resource crisis in the health sector. There is a shortage of skilled staff and drugs. Furthermore, facilities for geriatric patients in need of long term care are almost non-existent, a situation forcing patients to either travel beyond the country's borders mainly to Bloemfontein in South Africa or to just die quietly in their homes.

Arguably old age pension in Lesotho is contributing towards strengthening the care of older persons in their families, thereby averting the need for alternative care. One of the key informants from the Ministry of Social Development (Tsuinyane) observed that, "family members suddenly appeared and uprooted their elderly relatives from institutional care when the old age pension was introduced in Lesotho. Given the high levels of poverty in Lesotho the monthly pension of M 500 (about US$ 45) can make a big difference to the household economy".

This was also confirmed by one of the key informants from Reitumetse Church Project (old people's home) who indicated that there was a decline of about 80% in the number of older persons at the institution since the introduction of old age pension, from an all-time high of 70 to 14. While she acknowledged that some of the older persons had passed on, they contended that, "the majority of them left and went back to their places of origin. "Older people value their independence and living in their village with their own people and so most of them left

of their own volition when they started receiving old age pension", commented one of the key informants from Reitumetse. In a study on the impact of old age pension in Lesotho, Croome and Mapetla (2007:78) the majority of the participants indicated that their family and home were the best things in their life.

However, while Tsuinyane (2012) acknowledges that old age pension is playing a very important role in the lives of older persons in Lesotho she maintained that the pension which is a fixed amount should be based on household size in order to achieve its objectives. Therefore, notwithstanding their advanced age, older persons want to be independent and to "age in place", in their social milieu. On this basis, it is also evident that what older persons need is assistance which makes this possible. It also needs to be emphasised that it is not just the material needs that are crucial for older persons, their health and social needs are critical if they are to age in security and good health.

4.3 Institutional care

Institutional care in Lesotho is not well established and this is probably because of the dominant view that older persons should be cared for in their families and communities. There are only two centres which provide residential care to destitute older persons in Lesotho, namely Pitseng in Leribe and Reitumetse Church Project in Mazenod in Maseru. Both centres are church related and therefore rely mainly on donations. However, one of the key informants from the Ministry of Social Development also indicated that registered institutions get subvention from government to assist in the funding developmental projects at these centres.

It is also important to note that the two care centres for older persons in Lesotho are of the "B" scheme arrangement, which is a dormitory set up. The care centre also runs a small clinic but it does not have facilities for geriatric care. Patients in need of geriatric care are referred to Queen Mamohato Memorial Hospital, the only major hospital in Maseru. Asked about their admission policy at the centre, one of the key informants at Reitumetse had this to say, "We cannot admit older persons who have suffered strokes or are disabled as we do not have facilities for their care". This is obviously a major problem considering that older persons are prone to strokes and disability owing to advanced age.

4.4 Family and community care

The main objective of old age pension and public assistance for older persons is to promote care within the family and community. However, given that both the public assistance programme and the old age pension scheme have limitations, not all older persons are catered for. Consequently, it is difficult for households with older persons to care for them without adequate support levels from the government and other stakeholders. The lack of direct measures and incentives such as tax relief to enable families to care for older persons is also a major problem.

It is however also important to note that voluntary organisations like Maseru Women Senior Citizens Association and Lesotho Red Cross are involved in developmental programmes to support older persons at individual, family and community levels but they are also constrained by inadequate resources. Maseru Women Senior Citizens Association is involved in sensitization and awareness campaigns on the needs and rights of older persons, skills training and training of care givers among other activities.

5 Care of older persons in Zimbabwe

Though Zimbabwe enacted the Older Persons Act of 2012, the first piece of legislation specific to older persons, its implementation is still pending because of lack of funding. According to Veritas (undated) the Act provides for public assistance allowances and other social welfare services to older persons. The Act is therefore not any different from the traditional public assistance scheme except that this is now specific to older persons. It is also not surprising that the Act has been criticised for not providing for adequate benefits and for using means-testing to screen applicants. A number of formal and non-formal provisions for the care of older persons also exist in Zimbabwe and these are examined below. They include public assistance, occupational pension, free health policy, institutional care and family and community care.

5.1 Public assistance, occupational pension and free health policy

The absence of policy or legislation specifically on older persons in Zimbabwe until the passing of the Older Persons Act of 2012 was and still is contributing to their marginalisation as this made it difficult for government to allocate resources for the same. The only programme that provides for financial and in- kind assistance to older persons and other vulnerable groups in the population is public assistance which is provided for under the Social Welfare Assistance Act of 1988. It provides for means-tested benefits (financial and in-kind assistance) to qualifying applicants.

However, as Dhemba (2012) observes, this is not a reliable source of support because firstly, older persons do not have automatic entitlement to assistance as they have to go through a means-testing process. Furthermore, even for the lucky few who manage to get the assistance, it is very little (US$20 monthly per household) and this cannot be expected to make a difference in the quality of life of the beneficiaries.

One of the key informants from the Department of Social Services also pointed out that "in 2012 public assistance recipients, inclusive of older persons, only got allowances for one month that is for the period January to October, 2012". The public assistance scheme in Zimbabwe is therefore evidently an unreliable and erratic source of income for older persons.

Furthermore older persons in remote rural areas also have problems accessing the Department of Social Services which is responsible for administering the scheme. Though its offices have been decentralised to all the 55 districts in the country they are still not easily accessible to the majority of older persons on account of the transport costs involved and the low level of benefits. It is also important to point out that in the event of a drought older persons are entitled to free food assistance under the public assistance programme, but even this is also not guaranteed.

Though the government of Zimbabwe passed the Oder Persons Act in September, 2012, not much can be expected from this safety net. Firstly the Act is still to be implemented and indications are that this is unlikely to be sooner than later. Secondly, considering that the benefits are not provided universally as applicants will be subjected to means-testing the scheme is likely to face the same fate with the public assistance scheme which is grossly underfunded leading to erratic disbursement of benefits and selective coverage of older persons.

Furthermore, while older persons are entitled to free medical assistance at government hospitals the majority of them are not benefiting from this service as the hospitals are always

congested and there is a shortage of drugs. The hospitals are also not always within easy rich and resultantly older persons have to contend with numerous challenges in attempting to access services.

The only other social security scheme in Zimbabwe that caters for retirement pensions in old age is the Pensions and Other Benefits Scheme which was introduced in October, 1994. This is a contributory National Social Security Scheme for formally employed workers and it provides for contingencies such as old age among others. Notwithstanding that participation in this scheme is compulsory for formal sector employees; it is also of limited effectiveness as the majority of older persons are unlikely to be covered given the high level of unemployment in the country. Gandure (2009) points out that while the ratio of the working age population protected in old age improved between 2000 and 2003 there was a drastic deterioration in subsequent years owing to retrenchments and poor economic performance. Furthermore, as Dhemba (2012) points out, retirement pension in Zimbabwe is pegged at US$40 which is not enough to meet even the most basic needs of older persons.

5.2 National Action Plan 11 for Orphans and Vulnerable Children

The key informants from the Department of Social Services also revealed that a donor funded National Action Plan (second phase) for the period 2011-2015 provides cash transfers to orphans and vulnerable children and households headed by grandparents, among other vulnerable groups in the country. This is a pilot social protection project covering 10 of the poorest districts in each of the country's 10 provinces. The cash transfer is US$25 per household or US$10 for a beneficiary living alone. The main weakness of this programme is that many older persons are likely to be excluded as it is means-tested. As one of the key informants from the Department put it, "it focuses on households that are labour constrained" and therefore older persons with adult children and relatives are not likely to be considered. Also of concern is that this programme may not be sustainable as it is dependent on donor funding.

5.3 Institutional care

While it is believed that older persons should be cared for "in place", the problem is that Zimbabwe does not have policies and programmes to ensure that older persons remain in their families and communities. However, though institutions have become an integral part of the care of older persons in Zimbabwe, especially the sick and homeless this form of care is still shunned and is only adopted as a last resort. Resultantly institutional care in Zimbabwe is provided solely by private and voluntary organisations.

5.4 Family and community care

Though to a large extent the nuclear family, especially adult children are still caring for older persons it is evident that this is at premium and as result many of them are experiencing poverty, neglect and abandonment, ill-health and abuse. Care of older persons in the community is also weakening as the traditional support structures of the *Zunde raMambo* (chief's granary) under the chief is now virtually extinct courtesy of social change and the modern values of individualism. Care of older persons in the community is only practiced with the mobilisation and support of voluntary organisations and NGOs.

Some of the non-governmental organisations assisting older persons in their families, institutions and communities include Red Cross and HelpAge Zimbabwe which is implementing food security and livelihoods projects among other programmes.

There is also need to mention that another form of alternative care in Zimbabwe is the cooperative model whereby destitute older persons are provided with opportunities for self help and mutual aid. However, HelpAge Zimbabwe (undated) asserts that the only cooperative, Melfort Farm Cooperative, in Zimbabwe, is faced with serious financial challenges as it does not have permanent donors.

6 Social work and older persons

The Ministry of Social Development in Lesotho and the Department of Social Services, Zimbabwe employ social workers in the administration and implementation of social welfare policies and programmes inclusive of social services for older persons. Therefore, social workers in these agencies have a mandate to ensure the welfare of older persons among other vulnerable groups.

Weaver (2006) also maintains that the commitment to assisting disenfranchised people has always distinguished social workers from other helping professions. This is consistent with the value base of social work specifically that they serve the people, particularly those who are marginalised and socially excluded. Social workers also believe in social and economic justice and the dignity and worth of all human beings. Therefore, on this basis it would be an abrogation of responsibility and a disservice to their profession and society at large for social workers to accept the status quo with regard to the plight of older persons.

Furthermore, considering that it is only recently (in 2012 for Zimbabwe and 2014 in Lesotho) that policies specifically for older persons were introduced it is necessary for social workers to sensitise policy makers on the need to prioritise the care of older persons to enable them enjoy their rights. Without the development and implementation of comprehensive policies the problems of older persons are likely to continue and to get worse. Social workers should also be involved in the development and implementation of policies for older persons because of their knowledge of the problems and needs of their charges. In the same vein it is also imperative that social workers carry out research on a regular basis in order to be current on the needs and interventions to problems faced by older persons.

The multifaceted needs of older persons also necessitate the need for social workers and other helping professions to assume proactive and preventive roles to challenges faced by older persons. As pointed out elsewhere social workers should be fully informed about the causes of some of the chronic conditions in old age and how these can be prevented or treated. They should provide health education, counselling and advocacy on the rights of older persons.

It is also documented that some vulnerable groups, inclusive of older persons in both Lesotho and Zimbabwe are not benefitting from existing social safety nets because of lack of awareness of these programmes (Nyanguru 2007: Kaseke, et al 1998). It is therefore incumbent upon social workers to promote awareness of and availability of services for older persons and to link them to appropriate resources and resource systems. In addition, as ageing is characterised by diversity in terms of the ageing process, gender and access to social services and needs of older persons among other dimensions it is also imperative that social workers must have the skills to work with older persons in all situations.

7 Comparative analysis and discussion

The care of older persons in both Lesotho and Zimbabwe is underdeveloped and this can be attributed to fragmented and rudimentary policies and legislation for older persons. It is also evident that there is negativity towards social welfare services which is manifested in the

perennial underfunding of the Ministry of Social Development of Lesotho and the Department of Social Services in Zimbabwe (Nyanguru, 2003: Kaseke, et al 1998).

Arguably the fragmentation and rudimentary nature of policies catering for older persons is compromising the welfare of older persons in Lesotho and Zimbabwe. As an example, the public assistance schemes in both countries are designed to address the problem of destitution among vulnerable groups in the population; older persons included. The objective of these schemes is however not being achieved because of inadequate resources and poor funding.

Lesotho should however be complemented for introducing a universal old age pension for older persons aged 70 years and above. In spite of its shortcomings, it is well documented (Bello, et al 2007: HelpAge, 2004: Nyanguru, 2007: Tanga 2008) that the money is used to buy protein foods such as beans, meat and eggs and to care for orphans, disabled persons and the sick in the family. It was also found that older persons who are in receipt of the pension are feeling more satisfied with their situation. Furthermore, as pointed out elsewhere, older persons in Lesotho suddenly became a force to reckon with as they now have a guaranteed source of income and can contribute to the household economy. The massive decline in the number of institutionalised elderly at Reitumetse (of about 80%) with the introduction of old age pension in 2004 is indicative of the shunning of residential care for older people and the desire for "ageing in place."

Though the key informants from the Department of Social Services in Zimbabwe indicated that the Older Persons Act enacted in September 2012 which provides for old age benefits is yet to be implemented, its implementation is doubtful. Firstly the scheme is means-tested and as with the public assistance it is likely to be seriously underfunded as administrators of the fund can always renege on payment of benefits on account of inadequate resources. Furthermore, because the scheme is selective, the majority of the older persons are likely to be excluded on the basis that they have relatives and children who should support them.

However, if one considers that a number of countries in Southern Africa inclusive of Lesotho have universal old age pensions; it should be possible for Zimbabwe to adopt such a scheme. What is required is the political will and in any case the country boasts of a wide range of minerals including diamonds, platinum, gold, nickel, copper, chrome, and iron ore, among others. Therefore, in its current form, the Older Persons Act in Zimbabwe has failed older persons before it has even been implemented.

Lesotho on the other hand should lower the threshold for qualifying for old age pension from 70 to 60 years so that there is broad based coverage of older persons in the country. It would also be necessary to raise the level of pension from the current M 500 (about US$ 45) as this is certainly not enough to meet all their basic needs.

It is also evident that in spite of the free health policy operative in both countries the health needs of older persons are not being addressed adequately. The existing health delivery systems in both countries are not older persons friendly as they do not cater specifically for the health needs of older persons. The emphasis is on general care which is also compounded by the fact that the health centres are not always within easy reach for older persons.

Furthermore, there are not enough clinics and hospitals to serve the people and as a result there is a lot of congestion at health facilities. G.O.L. (2013) reveals that Lesotho has only one doctor per 20,000 people compared to approximately 1 to 400 in the United States of

America. Furthermore in Lesotho where about 80% of the land is mountains, the terrain also makes it difficult to access health centres as the main mode of transport in these areas are donkeys and horses (Makoa, Mpemi, Tsekoa, Tlali, Ralejoane, Biesma, Brugha and Odonkor 2009). Makoa et al (2009:133) also point out that the health care delivery system in Lesotho "continues to be dogged by a perennial problem of health workforce shortages which of late has reached crisis proportions." Inadvertantly, in such situations older persons are likely to have challenges accessing health services. Ndabeni et al (2014:24) also assert that "older persons in Africa continue to experience vulnerability and abuse in spite of the existence of national legislations and policies that provide a broad framework for the protection of older persons."

Perhaps both Lesotho and Zimbabwe can take a leaf from the experience of China and Singapore. The Singapore News (2012) quotes the Minister of Health in that country saying "Our goal is to eventually make every neighbourhood a senior friendly neighbourhood by having aged care facilities that can provide accessible care to seniors." On the same note, according to Hodin (2012) population aging has also become a policy priority in China with emphasis on "strengthening the role of families and developing an ageing industry to respond to the health care needs of the elderly". Hodin also notes that China aims to keep 97% of older people either living at home or depending on community based services.

In addition, social workers along with health care providers are the professionals most likely to have older persons as their charges. In this regard social workers should play a lead role in the development of elder friendly policies as they are better placed to know their needs.

8 Conclusions and recommendations

Both Lesotho and Zimbabwe are experiencing an increase in the number of older persons but the existing measures for their protection and care are not comprehensive. Older persons in Lesotho and Zimbabwe are therefore vulnerable to poverty, poor health, ageism and its attendant problems. However, though the situation of older persons in Lesotho is comparatively better (owing to universal old age pension) than in Zimbabwe, it is not contestable that old age in both countries is characterised by low levels of living. The care of older persons in both countries is seriously underdeveloped owing to the poor performance of the two economies and fragmented policies and legislation for older persons.

In this regard it is necessary to transform the existing social protection measures in both countries to ensure broad based coverage of older persons. These include public assistance which is means-tested thereby excluding many potential beneficiaries. Public assistance allowances in both countries are pathetically low and have no bearing to the cost of living. Old age pension in Lesotho also excludes older persons from 60 to 69 years, which is an anomaly that needs to be corrected.

In addition the need to review the level of benefits under this scheme cannot be over-emphasised. It is also critical to ensure the full implementation of the Policy for Older Persons (Lesotho). Similarly there is need for Zimbabwe to review and implement the Older Persons Act of 2012 as it only provides for social welfare assistance and is based on selectivity due to the condition of a means-test for applicants. There is need to align the Older Persons Act to similar schemes in Lesotho and other countries in Southern Africa that provide universal old age pensions.

The provision of care for older persons within their families and communities is not only sustainable and less costly but it allows for "ageing in place" which is in line with the United Nations Principles for Older Persons Resolution 46/91. Therefore, it should also be emphasised that while there is a need to keep older persons in their families and social milieu, for "ageing in place" to occur, this can only be achieved if concerted efforts are made to strengthen families and communities. It is also imperative to establish community centres where the right mix of health and other social services for older persons can be accessed and coordinated.

On the basis of the foregoing it is important for social workers employed in the Ministry of Social Development in Lesotho and the Department of Social Services in Zimbabwe to play a lead role in the development of policies and programmes for older persons. In the case of Lesotho the adoption of the policy for older persons in 2014 is indeed a welcome development as the Department of Elderly Care Services now has the mandate to develop programmes for older persons and to advocate for their protection and care.

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Author´s Address:
Jotham Dhemba (Principal author)
Senior Lecturer and Head of Department
Dept. of Sociology, Anthropology and Social Work
National University of Lesotho.
Email: jotham_dhemba @yahoo.com

Author´s Address:
Bennadate Dhemba
Formerly Acting Provincial Social Welfare Officer
Department of Social Services
Harare. Zimbabwe.
Email: bennadatedhemba@gmail.com