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## A Discussion Point: A Strategy for Primary Health Care for the Elderly in Zimbabwe

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### 1. Introduction

This discussion paper will focus on social networks, pensions schemes, health and the nutritional status of the elderly.

The few studies that have been conducted in Southern African tend to be concerned mainly with the urban elderly living in institutions. Information about social networks, pension schemes, and the health and nutritional status of the elderly living in the rural community is still to be collected and compiled. In addition, there is a growing need to obtain information about grandchildren, including those orphaned by AIDS, who are in the care of the elderly (see case study). Such studies are important to assess the current social position and health status of the elderly, and to form the basis for the development of future policy and planning for the elderly.

"Instead of perceiving an increasingly elderly population as a growing burden upon the nation, we should regard it as a cultural blessing and seek to enhance its position in our society in a variety of ways. One point which needs to be borne in mind is that traditionally elderly parents have relied, to a large extent, if not wholly, on the virtues of the extended family with a large number of children, grandchildren and other relatives to support them in old age. However, because of the general trend in which the average family size is decreasing and life expectancy is increasing the responsibility of looking after elderly parents and grandparents is tending to fall more and more on the shoulders of fewer children and grandchildren. Thus, policy should be principally aimed at ensuring some measure of security for those who in their old age will tend to rely more on the benefits of community welfare than on their offspring."

Robert G Mugabe, 15th December, at age 62 (School of Social Work, 1986).

"We don't get older, we get riper." Pablo Picasso, at age 90.

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"Health affects everybody - the unborn and the dying. Change policies on health and you automatically change attitudes towards ageing."

Maggie Kuhn, at age 76, Founder of the Gray Panthers (quoted in *New Internationalist*, 1982).

"In African countries, as in many other developing nations, the family and the extended family network is the provider of basic welfare - the safety net when illness, misfortune and death strikes. This is one big asset, according to AIDS counsellors at the AIDS Service Organisation (TASO) in Uganda." (Panos Institute, 1989)

There is a need for more baseline information on the elderly living in rural and urban areas, and more participation by this group in making suggestions for a national pension scheme and a programme of nutrition intervention as part of Primary Health Care for the elderly. Data on household size and composition would give information on the number of grandchildren, including those orphaned by AIDS, dependent on the elderly. The first case study at the end of this paper illustrates the potential impact of the care of AIDS orphans by the elderly (Hillock Ogola, in Panos Institute, 1989).

## 2. Who are the elderly in Zimbabwe?

To answer this question, several issues have to be considered. People born in 1900 are 90 years old today and are quite obviously elderly. The adverse socioeconomic conditions of Zimbabwe's colonial era have meant that many Zimbabweans who are less than 60 years old may already look physically old. According to the 1982 Population Census, the total population of Zimbabwe was 7 500 000 people, including 3 700 000 males and 3 800 000 females, a gender ratio of 96 men to 100 women. About 25 % of this total population live in the urban areas, which are defined as cities and towns of 2 500 people or more (CSO, 1984; 1985; 1986). Zimbabweans aged 60 years and above make up four percent of the total population; and are defined as the elderly of Zimbabwe.

Demographic information about the elderly is limited and only available from the 1982 Population Census. However, the Central Statistical Office (CSO) has projected the number of elderly people in Zimbabwe for the period 1987 to 2007, as follows:

Year	Total Population	Table Elderly Population Aged 60 + Years		
		Male	Female	Total
1987	8 639 823	164 328	188 646	352 974
1997	11 153 853	215 333	253 910	469 243
2007	13 918 121	315 290	377 110	692 400

It is believed that the majority of the elderly in Zimbabwe live with their multi-generation extended families in the rural areas. There are only about 70 institutions and homes for elderly in Zimbabwe, with a residential population of less than 2 000 elderly. The official age for retirement in Zimbabwe is 60 years old for women and 65 for men. This retirement age applies mainly to civil servants, professionals, domestic workers, and factory and transport workers. The age of retirement for workers in privately owned mines and plantations is often lower and arbitrary, depending on the availability of younger workers to fill vacancies. There is, of course, no clear retirement age for peasant farmers, most of whom are women. Racially, the Zimbabwean population, including the elderly, consists of three main groups (The people of mixed racial parentage, the coloureds, usually being grouped with one of the other existing groups) (see Table 2).

Table 2

## Elderly population aged 60 years and above in Zimbabwe by racial groups

City Province	Africans		Coloureds		Asians		Europeans	
	M	F	M	F	M	F	M	F
Harare	6 794	3 659	114	157	111	141	1 909	6120
Chitungwiza	1 192	1 057	0	0	0	0	0	0
Bulawayo	6 469	3 997	205	239	84	93	2 917	3311
Manicaland	25 828	27 401	28	18	20	24	580	632
Midlands	25 244	24 841	67	42	24	17	729	746
Masvingo	22 775	25 887	15	4	3	2	257	255
Mat North	11 279	12 582	4	3	0	2	113	86
Mat South	15 238	16 319	25	16	4	4	201	62
Mash East	19 877	20 175	7	3	1	3	307	343
Mash Cent.	17 289	14 164	27	11	2	0	201	183
Mash West	27 689	18 200	43	18	15	11	784	716
Total	179 674	168 282	535	511	264	297	7 998	12 454
Gender ratio	107 : 100		105 : 100		89 : 100		64 : 100	

Source: Central Statistical Office (CSO) Census 1982, compiled by Shiraz Ramji, 1987

a. *Africans and people of mixed racial parentage (see case study)*

This group forms 93,5 % of the approximately 370 000 elderly in Zimbabwe. The majority of elderly African women are peasant farmers, and the majority of the elderly African men are retired workers. This is reflected in the gender difference pattern in rural/urban migration. About 8 % of elderly men and 5 % of elderly women live in urban areas. The higher number of elderly men in urban areas may be due to the fact that retired migrant workers often settle in the urban areas. A

significant number of these men were born in Mozambique, Malawi, Zambia or South Africa. They came to Zimbabwe to work on the railways, plantations and mines (Muchena, 1978). Adamo *et al* (1984:58) say:

"An important aspect of relations between Mozambique and Zimbabwe during the colonial period was the supply by Mozambique of migrant labour to Zimbabwe. The cumulative effect of decades of recruitment was that by 1974 there were an estimated 79 978 Mozambican men and 8 048 women working on the farms, mines and industries in Zimbabwe."

A large number of the elderly are known to be integrated into the extended family structure and continue working as peasant farmers in the rural areas. Some of the elderly women serve as traditional midwives on an occasional basis. Very few of these elderly receive a pension, money from social welfare schemes, or are beneficiaries of medical aid schemes.

Today's African elderly grew old under British colonialism. The majority lived and worked under harsh conditions of forced labour on plantations, farms, mines, the railways and factories with very little remuneration. The women lived separated from their husbands who were often away working in other parts of the country for extended periods. Consequently children grew up without going to school or receiving adequate parental care and attention.

#### b. *Asian immigrants*

This group of the elderly population (less than 1 %) came to Zimbabwe from Asia, mainly India, via Mozambique and South Africa (Mandivenga, 1983). They are either housewives or retired businessmen. About 74 % of the elderly men and 79 % of the elderly women live in urban areas. They are known to be integrated into their extended family and religious structure. Some of them (Hindus and Muslims) get support from their own religious social welfare system. None of the elderly Asians live in institutions or homes for the elderly.

#### c. *European immigrants (see case study)*

European immigrants came to Zimbabwe from England, Scotland, Ireland, Netherlands, Portugal and Italy, as part of Cecil Rhodes and the British government's colonial programme to invite European settlers to grow cash crops, mainly tobacco and cotton, for export (Arrighi, 1967; Mandaza, 1986). The European elderly consist of 6% of the total population of the elderly in Zimbabwe. They are retired commercial farmers, businessmen, civil servants, teachers, nurses, doctors, housewives and politicians. About 75% of the elderly women and 44 % of the elderly men live in urban areas. The significantly higher number of European elderly women living in the urban areas may be explained by the fact that they

moved from the rural commercial farming areas after the deaths of their husbands, possibly to join their children and grandchildren.

The majority of elderly Europeans receive a pension from the government, a relic of the racial policies of British Colonialism. A few are property owners and may have savings in the bank. Some of them live in established old people's and nursing homes.

### 3. Primary Health Care

Primary Health Care, with its commitment to providing health for all by fostering self-reliance and social action of an intersectoral nature, has to cater specifically for the needs of the underserved and underprivileged in order to help bring about equity in the field of health (WHO, 1983). The pronounced aim of the 1978 Declaration of Alma Ata is Health for All by the Year 2000, through Primary Health Care defined as follows (Section VI, Alma Ata, 1978):

"Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods, and technology made universally accessible to individuals and families in the community, through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community.

It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where the people live and work, and constitutes the first element of a continuing health care process."

Primary Health Care has five underlying universal principles, and a number of components which vary and change in and between countries and over time. These principles are: equitable distribution, community participation, a preventive/promotive approach, appropriate technology, and a multisectoral approach.

Since Zimbabwe's Independence in 1980, the Ministry of Health has adopted the policy of Primary Health Care for All and has expanded health services to the majority of the rural population. Zimbabwe's Primary Health Care Programmes for the elderly are integrated into the general health care services for the whole population. This paper proposes ten components of a Primary Health Care system for the elderly: namely social networks; pension, social security and welfare schemes; housing; nutrition; water; sanitation; rehabilitation and disabilities; control and treatment of diseases; health education; and a demography and health

information system. Details of these components are described in the following sections.

### 3.1 *Social networks*

Social networks of relatives, neighbours and friends may help to control and prevent problems related to mental health, such as loneliness, worries, tension and loss of interest in life. Participation of the elderly in social, cultural, political and religious activities may improve their quality of life; including talking, reading, cooking, walking, attending literacy classes, and playing games and sports.

### 3.2 *Pension, social security and welfare schemes*

“The International Labour Organisation (ILO) predicts that only 25% of retired men and 6% of retired women will be receiving a pension by the year 2000. The rest will have to work as long as they are able and then turn to their children and other relatives for help.”

(*New Internationalist*, 1982).

In Zimbabwe, at present, there is no national social security scheme for the elderly. However, the 1989 National Social Security Authority Act provides for the establishment of social security schemes for employees. There is no provision for self-employed elderly peasant women and men living in the rural areas. Some form of pension or a social security scheme for all the elderly in Zimbabwe would contribute towards the cost of fulfilling the basic needs like food, clothing and shelter. Pensions are often calculated at a percentage of the previous working wage. The ILO recommends that state pensions should be between 65% and 80% of the working wage (*New Internationalist*, 1982). However, this may not be a useful formula for peasant farmers.

### 3.3 *Housing*

Provision of permanent housing and shelter can be an important component of a Primary Health Care strategy. Elderly women and men in the rural areas are known to build their own hut as part of their investment for the future. Some elderly people in urban areas may have a flat or a house as part of their property. However, a significant number of elderly who have worked on commercial farms, mines and industries do not have proper shelter. Should investment in housing be a part of a national pension scheme? (The National Railways of Zimbabwe is reported to be experimenting with this idea.)

### 3.4 *Nutrition*

The elderly have an appetite for a good diet to satisfy their physiological needs and to keep up their quality of life. The pleasure of having a good meal with other people

is an important part of consolidating social networks for the elderly. The type of food eaten by the elderly is closely connected to tradition and culture, and the socioeconomic status of the elderly.

According to the few case studies which include a dietary history of Zimbabwean elderly (Ramji and Thoner, 1990a), breakfast tends to consist of tea with milk, maize porridge (*sadza*), and other types of cereals. Some elderly eat fruit as well. Lunch consists of cereals together with either vegetables, meat, fish or eggs. Occasionally fruit is eaten as dessert. Dinner is the same as lunch, with some variations in quantity and quality. Some of the elderly have tea and biscuits in the mornings and possibly in the afternoons (see case studies). This pattern was also observed in some of the institutions and homes for the elderly. This meal pattern may not apply to the majority of elderly in Zimbabwe.

The dental and health status of the elderly may contribute to differences between their past (ie when they were younger) and present diet. For example, elderly people often have difficulty chewing meat or problems with digestion. Although energy requirements for the elderly decrease with age, the demand for nutrients does not. According to the WHO and FAO publication *Energy and Protein Requirements* (1978), the energy requirement is thought to decrease by 5% for each decade between the ages of 40 and 59 years, by 10% from 60 to 69 years, and for age 70 and above another reduction of 10% is suggested. A diet lacking in energy and/or nutrients will affect the nutritional status of the elderly.

This nutritional status could be assessed by different anthropometric measurements and/or blood parameters, and there is a need for such a study including measuring height and weight for the calculation of an anthropometric parameter for nutritional status, Body Mass Index (BMI). Garrow (1981) has classified BMI values into the following weight categories:

BMI Value	Weight Category
<20	underweight
20-24	normal weight
25-29	moderate overweight
30+	severe overweight

Some calculations of Body Mass Index have been done among elderly displaced Mozambicans living in Zimbabwe and Mozambique (Ramji and Thoner, 1990b). The number of elderly Mozambican women with a Body Mass Index of less than 20 was 69 out of 131 (53%). According to Garrow this would be classified as underweight. The corresponding figure for elderly Mozambican men was 49 out of 109 (45%). The distribution of BMI for elderly Mozambican men and women living in displaced people's centres in Mozambique and Zimbabwe is shown in Table 3. This data was collected among displaced people and cannot be taken as representative of the elderly living in the community. Similar results

were observed in a survey done among elderly refugees living in Sudan (Godfrey, 1986).

**Table 3**  
**Nutritional status - BMI Values of Displaced Mozambican Elderly Men and Women Living in Mozambique (Zambezia Province) and Zimbabwe, June 1987.**

Body Mass Index (BMI)	Mozambique		Zimbabwe	
	Male n = 43	Female n = 58	Male n = 56	Female n = 73
< 15	1	5	0	0
15-19	21	41	27	23
20-24	20	12	27	39
25-29	1	0	2	11
30+	0	0	0	0
BMI < 20	51%	80%	48%	33%

Note: Body Mass Index (BMI) = (weight kg)/(height m \*\* 2)

### 3.5 Water

Adequate supplies of safe water is one of the components of the National Programme of Primary Health Care for All by the year 2000. The 1988/89 Annual Report of the National Action Committee of the Rural Water Supply and Sanitation Sector notes that the project is aiming at 100% coverage of safe drinking water supplies and 50% coverage of adequate sanitation facilities in the rural (communal) areas by the year 2000. Regarding rehabilitation, the same report writes that:

"of the total existing water points, close to 30% may be either completely or partially non-functional, due to a variety of reasons, for example below-ground technical problems, drought, siltation/blocking and handpump breakdowns... The number of water points needing rehabilitation [includes] 2 400 deep wells serving 360 000 people, and 2 500 boreholes serving 625 000 people."

The 1988 Annual Report of the Department of Environmental Health Services, Ministry of Health, reports that 5 352 protected shallow wells were constructed in the rural areas between 1986 and 1988. The elderly, as part of the general population, will benefit from this free rural water programme. However, there is a suggestion that rural people should pay for this water service. In such an instance, it is to be hoped that the elderly will continue to benefit from the water programme without having to pay for the service.

Saugestad (1990) has made the following observations in her study:

"Old people use less water than young families... An old lady we met the day after the survey was finished was asked why she had not been to the well the two days before. She told us that she had collected one bucket of 18 litres

the day before the survey, and this lasts her for three days. This means she uses 6 litres a day for cooking and a rather modest amount for washing."

### 3.6 *Sanitation*

The National Programme on sanitation promotes the construction and use of latrines at household level. There are various types of latrines used in Zimbabwe. These include flush-toilets, ventilated pit-latrines and other types of pit-latrines. The most common one promoted by the Ministry of Health for construction in the rural areas is the Blair ventilated pit-latrine (VIP). The number of new VIP latrines constructed in rural areas between 1986 and 1988 was 109 667. It is not yet clear whether the elderly are comfortable using VIP latrines, which are dark and have no access to natural light.

### 3.7 *Health Education*

Health education or education concerning prevailing health problems and the methods of identifying, preventing and controlling them, is one of the components of a general Primary Health Care strategy. Health education must be based on a knowledge of people, their customs, habits, beliefs and it must be planned (Scotney,1976). The question is, who should plan for the elderly?

"It is assumed, that only health professionals are in a position to assess the health needs and priorities of the elderly. This approach blames the sick, the poor and the miserable for their illness, their poverty and their misery. It ignores the fact that in a number of situations it is not the individuals who need to be changed but the social environment they live in." (WHO,1983).

In other words, the political, economic, social and environmental factors that have a negative or neutralising effect on healthy behaviour may need to be modified.

In addition, for effective planning of health education activities and services, the elderly should participate in formulating policies and strategies, and in implementation and monitoring of progress. There is a conventional wisdom in every community, and people, including the elderly, are able to think and act constructively in identifying and solving their own problems (WHO,1983).

Health education on smoking, excessive use of alcohol and medicaments should be extended to younger age groups so as to prevent the disease conditions of old age, such as coronary heart diseases and malignancies/cancer.

In Zimbabwe there is a Health Education Unit at both national and provincial level. The Unit communicates health messages through the media, schools and health institutions. Politicians, teachers, journalists and village health workers are involved in giving health education. It is proposed that the elderly should also be involved in health education as part of a strategy of broad community participation.

### 3.8 *Control and treatment of diseases*

Since Independence in 1980, the Ministry of Health has expanded health services to the rural areas through a programme to train Village Health Workers and other paramedic workers. New health clinics have been built, and district hospitals have been expanded to cover an increasing population. Health services are provided free to those people, including the elderly, earning less than Z\$150 per month (Hifab International/Zimconsult, 1989).

According to Waterston (1984) the typical problem list of the elderly at clinics and hospitals includes bronchitis (cough), hypertension (high blood pressure), congestive cardiac failure (heart failure), arthritis, anaemia, constipation, cataract (disease of the eye leading to poor vision), and chronic leg ulcer.

The elderly, consisting of 4% of Zimbabwe's total population, benefit from the National Control and Treatment Programme for communicable diseases. For example, in 1986 out of 5 233 tuberculosis cases under treatment, 19% were elderly (Ministry of Health, 1986). The control programme also covers diseases like leprosy, malaria and bilharzia. In the case of malignancies, the Zimbabwe Cancer Registry (Ministry of Health, 1989) recorded 20 cases of elderly women out of the total number of 106 women with cancer of the cervix. There were 18 cases of elderly men out of a total number of 48 men recorded with cancer of the liver.

The total number of AIDS cases reported in Zimbabwe in the period 1987 to the first quarter of 1990 was 2 357. The bulk of these cases were in the productive age group 20-49, but around 20% were children under 5 years and 2% adults over 50 years old (Ministry of Health, AIDS Control Programme, 1990).

Should all elderly get free health services as part of a national social security system, and as a way of acknowledging their services to the nation during their pre-retirement life? There are very few elderly who are millionaires.

### 3.9 *Rehabilitation and disabilities*

According to the Ministry of Labour Report on the National Disability Survey (1982) there were a significant number of elderly with disabilities. Some of the disabilities mentioned were visual, lower limb, upper limb, hearing and mental capacity.

Since Independence in 1980 the Ministry of Health has created a Department of Rehabilitation which has Rehabilitation Assistants, Physiotherapists, Occupational Therapists and Speech Therapists working at district and provincial level, to provide the necessary tertiary services to both rural and urban communities. They also do outreach work and promote community-based rehabilitation. These services are likely to improve the quality of life of the elderly through restoring

their independence and quality of life.. A random sample of reported statistics from districts showed that one in three persons receiving rehabilitation services were elderly (School of Social Work, 1986).

### 3.10 Demography and health statistics

The standard age to define a person as elderly should be 60 years and above for both Zimbabwe and other countries in Africa. The Central Statistical Office (CSO) could provide a useful service, and further understanding of the elderly group, by publishing a profile of the elderly in Zimbabwe, using figures from the Zimbabwe 1982 Population Census. At present the morbidity and mortality figures for the elderly are combined with the figures of other adults in the routine health information system and publications of the Ministry of Health. Should diseases and death figures for the elderly aged 60 years and above be compiled and published separately?

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### Case Studies

1. *"Grandfather cares for 14 orphans"*  
(Hillock Ogola, in Panos Institute, 1989)

Danson Kilama is 15. When his parents died of AIDS, he and his eight younger brothers and sisters found shelter with their grandfather, Emanuel Kilama, at Kasheny Village, Bukoba rural district in Tanzania's north-western region of Kagera. The 68 year old grandfather also cares for five other grandchildren left orphaned after the death of one of his sons. "The children live under difficult situations because I am old, and my income cannot keep them," he says.

Emanuel Kilama's deceased sons had supplemented his income from sales of coffee from a small plot. But since their deaths, and a decrease in coffee yields, his income has fallen from 100 000 Tanzanian shillings per year to less than 15 000 shillings in 1988.

Danson, who must supplement the family's income with odd jobs, is therefore unable to attend classes regularly. And he has difficulty finding work because many villagers have negative feelings about the disease that killed his parents. "In the three years since my parents died, I have learned that people are not sympathetic with my situation.

AIDS is looked upon as a shame, and they look at me as a symbol of that shame. It is like AIDS is a result of a mistake of my own making," he says.

But economic hardship and rejection have strengthened bonds of solidarity among the 14 children. "We like each other. Maybe it is because we suffer together. When there is no food we all go hungry and at night we all sleep in one room."

## 2. Sarah (Ramji and Thoner, 1990a)

Sarah was born at home in Rusape district on the 6th of June 1927. She was the first born in the family, and has two sisters and one brother. Her father worked in Harare before returning to the village.

At the age of three years, Sarah became blind in one eye after being bitten by an insect while playing with her friends. Despite this handicap, she studied for three years at St Cassian Mission Primary School, Rusape district. She could not continue schooling because her parents moved to another village and there was no school nearby.

In 1949, at the age of 22 years, Sarah married her husband who had been a cook for a European family in Kwekwe district. They lived in Nyanga district and she gave birth to ten children, but one baby was still born. The other nine children were three boys and six girls.

Two babies, one boy and one girl, died at eight and nine months respectively, because of diarrhoea. Another girl died at the age of eight years because of herbal poisoning (medicine given by traditional healer).

One other daughter, a policewoman and a combatant/freedom fighter during the Zimbabwe liberation war, died in Harare at the age of 26 years because of herbal poisoning.

Presently, one son, the eldest in the family, is working as a cook at the Post and Telecommunication (PTC) hostels. The other son is studying at All Souls Mission Secondary School. One daughter is a soldier and working in the army. They visit their mother Sarah during Christmas holidays and annual leave time.

Sarah's husband died in Nyanga in 1962. He fell off a lorry. He used to work for the Tsetse Fly Control Programme and was on his way to a farm. Since then Sarah lives with her youngest daughter Callista (19 years old) and three grandchildren. One grandchild, 12 months old, belongs to her daughter who got pregnant when she was doing her Grade 7 primary school. At present this daughter is living with Sarah and doing Form 2 in the nearby secondary school. The other grandchild, aged seven years, belongs to the daughter who died of herbal poisoning in 1986. The third grandchild belongs to her daughter Anatolia who got pregnant in Mozambique. At present Anatolia lives in Nyanga town with her husband who is a school teacher, and their two children.

Regarding her health status, Sarah does not feel well. She gets body pain and has back problems. She takes anti-malaria tablets regularly and goes to the government health clinic for her illnesses. She feels lonely, especially at night during the rainy season. Sarah is afraid of sleeping long hours because she is worried that she may die in her sleep.

Sarah does not smoke tobacco (cigarettes), but takes local beer during various celebrations including marriages and birth of babies in her village. The elderly in the village also sometimes drink together to discuss (informally) problems of the village. Sarah is a Christian, and a member of the Roman Catholic Church.

Sarah grows maize, pumpkins, groundnuts and green vegetables. She earns Z\$40 per year from her agricultural activities. She has fifteen goats valued at Z\$300.

She slaughters a goat when her children visit her during Christmas and other occasions. Sarah has problems of chewing meat, but she enjoys eating meat when it is available, that is once a month. Sarah does not like drinking milk, but uses milk for her occasional tea in the morning. That is her breakfast. Her lunch is maize porridge (*sadza*) with green vegetables. The supper is what is left over.

Her daughters and her son provide her with clothes and blankets.

Her house in Katerere ward, Nyanga district, is a one room hut with a thatched roof and mud walls. The roof leaks during the rainy season. She has no private latrine, but has an improvised bathroom. Her daughter and her three grandchildren sleep in a similar hut.

Since Independence in 1980, the water situation in the village has improved. She used to walk more than five kilometres to fetch water from a stream. Now the Government, as part of Primary Health Care Programmes for the community, has dug a borehole for water which is less than one kilometre from where Sarah lives.

Regarding her future plans, she will continue to struggle to get enough food and survive.

### 3. Edna (Ramji and Thoner, 1990a)

Edna was born on the 4th of February, 1921, in Manchester, England. Her father was a hair dresser and her mother worked at a fabric warehouse. They were four sisters in the family, but one died at an early age.

Edna finished her secondary education at the age of 15 years, and did odd jobs for the next six years, selling shoes, gloves, etc. In 1942 she attended Deaconess training college for two years to be a Methodist Deaconess. For the next eleven years she worked as a Deaconess in the Methodist Church.

In 1947, at the age of 26 years, she went for the Methodist Missionary Training Course. She had planned to go and work as a missionary in China, but instead she was posted to Zimbabwe. Edna arrived in Bulawayo in 1948 at the age of 27 years and started to work with the Methodist Church organising church meetings and doing the work of the Deaconess.

Edna met her husband John, a methodist, in Bulawayo in 1951 and they bought a house to settle down after their marriage in 1953. Her husband worked as the estates officer for National Railways of Zimbabwe.

John was born in Birmingham, England, and was doing his first year medical studies at Cambridge when he was called for service in the British Army. He was posted to India where he trained to be a radiographer. In 1945 he was posted and then discharged/demobilised in South Africa. He tried to continue his medical studies, but dropped out in the second year because he became more interested in race relations. He worked for the Federation of African Welfare Societies until 1953. He tried to get a job as a radiographer, but was refused because all the radiographers at that time were women and no men were allowed to practice as radiographers. He then joined the National Railways of Zimbabwe.

Edna had four children with her husband; three boys and one girl. One of the sons, now aged 35 years, is married and working in the South African mines in Transvaal. The daughter, now aged 34 years, is married and living in Harare. She makes cakes at home for sale, and teaches cake icing. Edna's second son, aged 32 years, is in Johannesburg, South Africa, together with his family, working with computers for a company making planes. Her last son, aged 30 years, and also married, is living in Bulawayo. He works as a chartered accountant for the National Food Company.

During the period when the children were growing up, Edna stayed at home. In 1963, she got a job as a headmistress of Sizane Secondary School in Bulawayo. She worked for this school for 13 years. After Sizane she went to work as a lecturer in Education Psychology at the United College of Education. While she was working at the college to train teachers, she did a Master's degree course in Curriculum Studies with the University of Zimbabwe. After her retirement, Edna was invited by a friend to teach English and Bible Knowledge at St Bernard's Secondary School in Bulawayo. She thought it would only be for one year. Instead she was asked to teach for four more years. Edna finally retired in 1986 at the age of 65 years.

Edna is a very active woman with a variety of interests, and she has accepted her life as a retired person. She has had a driver's licence since 1951, and at present she has her own car. She enjoys driving and her mobility. Every alternate week she attends a meeting of young married women who call themselves "The Homemakers". The women come from all racial backgrounds, and they discuss every thing that affects making a stable home. Edna sometimes leads Bible studies, and she shares her experiences and knowledge with the younger women, some of whom have children.

When we asked Edna if she ever felt lonely or got bored, she replied "No, I am too busy." Besides being active with young married women's group, she is a care giver volunteer for the Island Hospice Service for terminally ill people and their families who are going through a hard time.

Edna left the Methodist Church in 1965, and joined the Religious Society of Friends (the Quakers) because she wanted a silent worship meeting. Her husband remained a methodist, but one of the things they do together is Bible studies. They enjoy their regular short walks and they also do some of the cooking together. John and Edna share the cooking work. In the morning Edna and John eat their home made 'muesli', yogurt, fruit and herbal tea. For lunch, they have baked potatoes, vegetables, and sometimes boiled eggs or tinned tuna fish. For supper, Edna prefers a light meal; vegetables, meat or fish or macaroni cheese. Her husband prefers a bigger supper, so Edna makes a big portion.

Edna has been told by her doctor that she has a low level of calcium and potassium in her blood, so she eats a lot of bananas and drinks milk before going to bed. Edna says that the biggest difference between her past and the present diet is that now she eats less meat and more fruit.

Regarding her health status, Edna has slightly high blood pressure. To control her blood pressure she has to have pills alternate days, and go for a regular medical check up every six months. The doctor has not told her anything about changing her diet to lower her blood pressure.

Both Edna and John meet their children and 11 grandchildren on a regular basis. In Bulawayo they meet their son and his family at least twice a week. Last year they made three visits to South Africa to meet their children and grandchildren.

Edna's advice to other elderly is: "Do not give up. Find out what you can do."