

The State of Health and Ageing in Ethiopia: A Survey of Health Needs and Challenges of Service Provisions



HelpAge International helps older people be empowered and overcome poverty, so they can lead dignified, secure, active and healthy lives.

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Acronyms

AU	African Union
AUPFPA	African Union Policy Framework and Plan of Action
BoLSA	Bureau of Labour & Social Affairs
BPR	Business Processing Re-engineering
CBOs	Community-Based Organisations
DFID	Department for International Development
DSWP	Developmental Social Welfare Policy
EEPNA	Ethiopian Elders and Pensioners National Association
FGD	Focus Group Discussions
FGM	Female Genital Mutilation
FSP	Food Security Programme
GTP	Growth and Transformation Plan
HAI	Help Age International
HEP	Health Extension Programme
HEW	Health Extension Worker
HHs	Households
HMIS	Health Management Information System
IGA	Income-Generating Activities
KII	Key Informant Interviews
MDGs	Millennium Development Goals
MoH	Ministry of Health
MoLSA	Ministry of Labour and Social Affairs
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organisation
NPAOP	National Plan of Action on Older Persons
OCM	Older Citizens Monitoring
OVC	Orphan and Vulnerable Children
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
PMC	Population Media Centre
PVA	Participatory Vulnerability Analysis
RHBs	Regional Health Bureaus
SNNPR	Southern Nations Nationalities and Peoples' Region
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organization

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Foreword

HelpAge International Ethiopia is pleased to launch the report of the study on “State of Health and Ageing in Ethiopia: A Survey of Health Needs and Challenges of Service Provisions”. The survey was conducted in five regions; namely, Tigray, Afar, Amhara, Oromia, and Southern Nations Nationalities and Peoples Regions (SNNPR) as well as the Addis Ababa City Administration over the period of December 2011 to March 2012. We hope that the results of the survey are reasonably good in representing the situation in the country.

It is alarming to note that older people in the surveyed areas are subject to multi-faceted problems, which are physical, psychological, economic and health-related in their natures. Older people are also found particularly susceptible to non-communicable diseases (NCDs) such as blood pressure and diabetes, which can be traced at their advance stages to check out and control their negative effects before they get worse.

HelpAge International in Ethiopia, as the only international NGO working on ageing, has been operational in the country for the past 20 years to improve the lives of disadvantaged older men, women and their dependents. We are proud that the commissioning and launching of this report would hopefully contribute towards creating a future in which all older people fulfill their potential to lead dignified, active, healthy and secure lives.

The survey report is also authentic in its nature which makes it ultimately useful to all concerned stakeholders who are engaged or interested to be engaged in improving the lives of older people particularly health and other services. HelpAge International hopes that its stakeholders will, therefore, find the report helpful in tackling health problems of older people and addressing the health issues of older persons.

HelpAge International in Ethiopia Country Programme greatly appreciates its partnership with all its stakeholders. Our appreciation is extended to the consultants who conducted the survey and to HelpAge team member, Ato Abate Fulas, for coordinating the entire survey work. We have enjoyed the full cooperation and institutional support of our government partners, particularly the Federal Democratic Republic of Ethiopia (FDRE), Ministry of Health as well as regional and *woreda* health bureaus; we thank them for their strong partnership. Our gratitude also goes to Big Lottery Fund of UK for its financial support to conduct the survey and publish the report.

Feleke Tadele
Country Director,
HelpAge International in Ethiopia Country Programme

Executive summary

Studies indicate that the number of people aged 60 and above is rapidly increasing in the 21st century. Globally, the percentage of older people is projected to double from 10 per cent in 2000 to 20 per cent in 2050. Moreover, these studies indicate that by 2050, nearly 80 per cent of the world's older population will be living in less developed countries (UN, 2010). The rise in the number of older people increases the burden of providing social services, including health-care services, on duty bearers in developing countries, who may be forced to leave much of the needs of these groups of people unaddressed.

The situation in Ethiopia is not any different. Yet there is hardly any exhaustive data on the livelihood, health status and health service availability of older people, making tailored intervention difficult. Hence, with the intention to fill this gap, HelpAge International Ethiopia has conducted this national survey, with the aim of acquiring comprehensive information on the health problems and health service needs of older people in the country.

The survey was conducted in five regional states, namely, Tigray, Afar, Amhara, Oromia, Southern Nations Nationalities and Peoples Regions as well as the Addis Ababa City Administration over the period of December 2011 to March 2012. The study design followed a multi-stage sampling procedure whereby study *woredas*¹ were determined purposively by taking into account the geographic locations within the study regions. Whereas study *kebeles*² were randomly selected at first stage from each of the study *woredas* and sample households where older people are members were randomly selected at second stage from the selected *kebeles* to administer the household interviews.

Quantitative and qualitative data from primary and secondary sources were collected and analysed. The quantitative data was gathered from 768 sampled households (where at least one older person lived) through structured questionnaire. Semi-structured key informant interview questions and focus group discussion checklists were used to get the necessary qualitative information. Desk reviews of policy and strategic documents, academic researches and other relevant literatures were also reviewed. CS Pro software is used to organise the quantitative data and SPSS software is used to analyse the data.

Result of the survey showed that older people are subject to multi-faceted problems, which are physical, psychological, economic and health-related. Like anybody else, they are

¹ Districts or *woreda* are the third-level administrative divisions of Ethiopia and are managed by a local government

² A *kebele* (Amharic "neighbourhood") is the smallest administrative unit of Ethiopia similar to a ward, a neighbourhood or a localized and delimited group of people. It is part of a *woreda*.

vulnerable to various communicable diseases. What makes them exceptional is, due to ageing-induced functional decline of the body they are particularly susceptible to non-communicable diseases (NCD).

During the survey period, about 75 per cent of the respondents reported to be suffering from at least one chronic disease and of these 77.5 per cent of them were undergoing medical treatment. The first three most common diseases older people were receiving medical treatment for are eye problems (29 per cent), followed by arthritis (20.17 per cent) and hypertension (11.83 per cent). Urinary tract, hearing, and heart conditions are also important health problems that older people are seeking medical treatment.

Among the respondents, 23 per cent of them were reported not to be taking medical treatment for reasons that include; lack of money, physical incapacity to go to health facilities, and lack of trust in the healthcare service. Although the Ethiopian government has a system in which the poor (which includes the older poor) get free medical service, it seldom serves as intended, because the “beneficiaries” have to, most of the time, buy drugs from private pharmacies/drug stores and/or are given referrals to private laboratories. As such, they are exempted only the payment for cards (for physical examination).

It was also possible to learn from the survey that the physical structures of health facilities are not age-friendly. Indeed, the very idea of a physical structure that is friendly to older people is alien to many of the health personnel we interviewed.

The current endeavour by regional Bureaus of Labour and Social Affairs (BoLSA) to alleviate the economic and health problems of older people seems mainly encouraging the latter to establish associations, which, according to these bureaus, would help channel support mainly in the form of income generation activities (IGA). This was observed in almost all the surveyed regions.

Government representatives mentioned government support, such as the safety net programme at rural settings from which older people are made to benefit without being obliged to do any manual work as one form of support. What they get from the programme is, however, negligible - about Birr 50 (less than USD\$ 3) per person per month. Although the involvement of community-based organisations (CBOs) in the effort to address older people’s health and other problems, the overall effort being made by the government and other actors is not tantamount to the problem. It could, therefore, be concluded that a lot remains to be desired concerning the health and overall wellbeing of older people in the country. This reality calls for a concerted action by all concerned bodies. Accordingly, the following major recommendations are forwarded:

- The government should establish (or reinstate) an authority or a unit that would be solely responsible for planning, coordinating and executing interventions concerning older people.
- Revitalise the traditional extended family and mutual-help system through extensive promotional work, using all available media, including community conversations. Traditional social institutions such as *iddirs*³/*mahbers*⁴ should also be re-oriented to support their older members.
 - The Ministry of Health (MoH) should outline how older people could best access healthcare services. The prevention and treatment of NCD should be given due attention, health personnel should be trained, requisite drugs should be made available in all health facilities.
- Accelerate the process of introduction of health insurance system and giving equal attention to the community health insurance initiative.
- Devise a mechanism to understand clients' complaints and ethical standards of the activities of health professionals so as to take rectifying measures.
- Make physical structures of health facilities older people friendly.
- Establish and/or strengthen mechanisms of facilitating referrals from health centres to specialised care facilities.
- Encourage IGA being provided by the government and NGO. The NGO should also consider funding CBOs working on and with older people.
- International NGO, such as HelpAge, should do extensive advocacy work in order to make decision-makers recognise the needs of older people and take appropriate measures.

³ *Iddirs* – Burial Societies of Ethiopia are the dominant form of autonomous and voluntary indigenous associations in Ethiopia.

⁴ *Mahber* – A community association.

1. Introduction and literature review

1.1. Introduction

The 21st century is witnessing a rapid demographic change due to a worldwide increase in the number of people aged 60 and above. Globally, the percentage of older people is projected to double from 10 per cent in 2000 to 20 per cent in 2050. Moreover, relevant studies indicate that by 2050, nearly 80 per cent of the world's older population will be living in less developed countries (UN, 2010). According to this estimation by 2050, there will be 9.2 Africans, 8.2 Latin Americans, and 5.5 Asians over the age of 60 for every 10 Europeans of the same age group (Barrientos, 2006). This is due to the advancement in medical treatment and technology, prevention and eradication of many infectious diseases, and improved nutrition, hygiene and sanitation (WHO, 2004).

Older people in developing countries are highly vulnerable group of the society exposed to hardship, malnutrition, poverty and old-age-related diseases (Fouad 2004). In these countries, the major problems associated with old age are poor diet, ill-health and inadequate housing, which are all exacerbated by poverty. These and other factors render older people to be among the poorest of the society (WHO, 2004).

Older people are often unable to accumulate savings so that they can take care of themselves financially when they are ill or in poor health. Only a few developing nations have health insurance/social security or pension schemes in place to care for older people, unlike the case in most of the developed countries.

A desk research done by HelpAge International (2010) in African countries identified under-financing of health systems, over-stretched health workforces, poor health management information systems (HMIS), unreliable supply of medicines, physical barriers to access health-care and distance-related barriers, as the main constraints that contribute to older people's poor access to health-care services .

In Ethiopia, the 2007 Central Statistical Authority report shows that 3,565,161 (4.8 per cent) of the total Ethiopian population are 60 years and above⁵. Of these, about 532,093 (14.9 per cent) live in urban areas, whereas the rest 3,033,068 (85.1 per cent) live in rural areas of the country. In spite of the fact that there is a general consensus that the living and health conditions of older people in Ethiopia is precarious, alike the situation in most

⁵More recent data, other than the 2007 census report on the population size of older people in Ethiopia could not be found.

developing countries, there is hardly any exhaustive data on their livelihood and health status, making tailored intervention difficult.

In recognition of this fact, HelpAge International Ethiopia commissioned Nolot Professionals Business PLC to undertake a baseline study on older people's health problems and health services needs. The result of the survey is believed to help in the design of interventions responsive to the actual healthcare needs of older people, on the one hand, and for setting a benchmark against which the impacts of future interventions would be measured, on the other.

1.2. Literature review

1.2.1. The concept of ageing

According to the World Health Organization (2004: 35), ageing refers to "...a normal biological process defined as those time-dependent, irreversible changes that lead to progressive loss of functional capacity after the point of maturity." The changes, that the World Health Organization listed include "...physiological, psychological and social that are progressive, decremental and irreversible, of structural and functional body organs." The organisation (2004: 35-36) affirms that normal ageing is not a disease, but eventually leads to structural and functional decline and involves increased susceptibility to diseases due to intrinsic and extrinsic factors.

The chronological definition of old age differs from country to country, depending on the cultural, economic, and overall developmental stage of the society in question. For example, in many developed countries, a person is considered older at the age of 65, which is an age at which a person is entitled to pension or retirement benefits.

For the purpose of this study, we take the definition of the United Nations (2007), which puts age 60 as "the dividing line between older and younger cohorts of the population." This definition, we believe, would not only save us from debating on a relativist concept, but is also in line with the definition of older people in our country as used by the Ministry of Labour and Social Affairs (MoLSA) and other relevant governmental offices.

1.2.2. Societal perception of ageing

Each society has attitudes towards, and beliefs about, ageing that are embedded in the culture (Grant 1998, as cited by WHO 2004). In what we could call a "Pan-Ethiopian" culture, older people are most commonly seen as wise, worthy of carrying responsibility, resolvers of conflicts (peace makers), community advisers, persons with great experience

and authority (seasoned in specific expertise), and a lot more positive traits. What comes to mind when we hear the Amharic word *shimagile* (literally, old man) is often a person who would resolve conflicts and make peace. Accordingly, the process of resolving conflicts through arbitration has come to be called *shimgilina*.

Similar difference is also given to older women. While in almost all Ethiopian communities older women play significant role as traditional birth attendants and advisers on child-raising, there are many localities where older women take part in conflict resolution, too. The tradition in South Wollo is a case in point. In that area there is a traditional conflict-resolution mechanism called *yedubertti wodaja* in which old Muslim women referred to as *dubertti* (literally, woman in Afan Oromo) involve in resolving conflicts, including homicides (Kelklachew 1997). Old women are thus highly respected; their blessing is highly sought, while their curse is much feared.

On the contrary, alike in other parts of the world, ageing and older people are also perceived negatively. The Amharic word *shimagile* (old man) or *arogit* (old woman) may imply physically fragile persons, easily susceptible to diseases, persons who could have little or no involvement in certain kinds of work, especially menial work, persons who need and deserve to be supported, etc. In extreme cases, there are also sayings that portray older people as no longer useful, as expressed in the Amharic saying *kareju aybeju*.

1.2.3. Poverty, ageing and access to healthcare

A publication of the United Nations (2010) stated “...while much data and analysis are available on population ageing, data and information about the lives and situation of older persons are strikingly lacking and seldom included in ageing-related publications.”

Despite this fact, however, the few available studies disclose that the living condition of older people worldwide is often precarious.⁶ One such study done by HelpAge International referred to as *Insights on ageing survey* (HelpAge International 2010) gives a glimpse into what life is like for older people worldwide today. This survey covered 32 countries across Africa, Asia, Eastern Europe, Western Europe and the Caribbean countries and asked the views of 1,265 older people, aged 60 years and above. The major findings of the study showed the following:

- 88 per cent of older people would like to see their governments do something to make their lives better;

⁶ More than half of the elderly have no guaranteed minimum income. Unless action is taken now to improve the situation, 1.2 billion of the elderly will be living without secure incomes by 2050 (HelpAge, May 2009).

- 63 per cent (65 per cent in rural areas and 60 per cent in urban areas) of older people find it hard to access health-care when they need it; and
- 72 per cent (76 per cent in the rural areas and 67 per cent in the urban areas) of older people say their income does not pay for basic services such as water, electricity, health-care, food and decent housing.

Another study done by HelpAge International and the United Nations Populations Fund (2011) assessed government actions on ageing. The key findings of this survey showed that in developing countries, despite some recent progresses observed, particularly, in areas of social protection and health-care, in terms of mainstreaming older people's needs into sectoral policy, resource allocation and hence implementation are often lacking to actually improve older people's lives.

In Ethiopia, only very few studies are available on older people. Although these studies are not national, they provide valuable insights that could be taken as applicable at the broader level. One such a study is the survey on *The living condition and vulnerability of poor urban older people in Addis Ababa, Sep 2010*. The other is *An assessment report on the care, support and treatment situations of older people in Southern Nations Nationalities and People's Regional State (SNNPRS), Nov 2009*.

Despite the obvious differences between the study areas (Addis Ababa, which is metropolitan, and the SNNPRS), in terms of infrastructure, availability of social services, life styles, and so on, the findings of the two surveys demonstrated the desperate situation of older people in a very similar way.

The former had conducted Participatory Vulnerability Assessment (PVA) exercises in all the sub-cities of Addis Ababa and identified food insecurity (which is worsened by inflation) as the top priority concern of older people. The study also disclosed that among 1,070 older men and women respondents, 79 per cent eat only once or twice a day, 78 per cent have health problems, 51 per cent receive no family support, and about 50 per cent carry out household activities, such as housekeeping and caring for grandchildren (HelpAge International, 2010).

Likewise, the other study done in the SNNPRS identified poverty (including food insecurity, poor health-care system, lack of housing and decent living environment) and low/limited family support that resulted from the gradual erosion of the culture of extended family and mutual support, as the major problems older people are facing. "Limited social welfare, lack of awareness of the special needs of older people [by duty bearers] and

unavailability of institutional care providers also contributed their share to the problems” are shown as the main problems (Medhin Ethiopia, 2009).

1.2.4. Ageing and healthcare problems

Besides the fact that the natural process of ageing leads to a functional decline of the body and increases susceptibility to diseases, in most developing countries, changes in lifestyles over the past few decades have led to change in the patterns of disease prevalence - from communicable to non-communicable diseases. This change is commonly referred to as the *epidemiological transition* (WHO, 2011, Keller et al, 2002). This term describes the increasing importance of morbidity and death attributable to non-communicable diseases (Keller et al, 2002).

According to the World Health Organization (WHO, 2009, WHO, 2011), almost half of the disease burden in low and middle-income countries is now from NCD, and these diseases are turning into a global pandemic that threatens the health of a large number of people and their economies.

Though NCD affect older people of all nations, those in low- and middle-income countries are at peculiarly high risk of NCD, such as cardiovascular diseases, hypertension, stroke and diabetes, as well as Alzheimer’s and other dementias. People over 60 years of age accounted for 75 per cent of the 35 million deaths from NCD worldwide in 2004, the majority being from low- and middle-income countries (WHO, 2010).

In developing countries, where there are no adequate resources to meet the health service needs of the general population, governments find it very difficult to meet the special needs of older people. In these countries, primary healthcare remains largely focused on other groups, such as mothers and young children, rather than older people and on treating communicable and infectious diseases rather than non-infectious diseases. That is why it is often said that NCD are exerting a double-burden on the developing countries, alongside infectious diseases, maternal mortality and child survival (WHO 2011).

A cross-sectional study done on risk factors for non-communicable diseases among older adults in three rural sites of three African countries — Malawi, Rwanda and Tanzania — disclosed that high rates of smoking and alcohol consumption among men and women aged 50 years and older in rural Africa puts them at risk of NCD. It thus highlighted the importance of reaching out to older adults with appropriate messages regarding diet, smoking, alcohol use and general health throughout the continent (Neign, et al 2011).

In Ethiopia, thus far, there is no country-wide research that shows the effect of non-communicable diseases on the health of older people. On the other hand, the health management information system (HMIS) that the Ethiopian government tried to establish recently is not yet well developed. The survey team could not, therefore, get a reliable statistical report on the health status of older people and available older people-specific health services.

Understandably, making healthcare services age-friendly is more difficult in the developing world, even when there is the will to do so. However, a study done by HelpAge disclosed that such an effort is often negligible (HelpAge, 2011). The same is true about Ethiopia. Shortage or non-existence of people trained in geriatrics and management of chronic NCD, de-prioritizing of older people for essential services, unaffordable health-service costs, and distance from health facilities are among the major healthcare problems of older people.

1.2.5. Old age, health seeking behaviour and access to medical services

Studies conducted in Kenya, South Africa and Pakistan identified that lack of finance, absence of family support, physical inaccessibility of health service providers and practicing quacks are the major factors deterring older people from seeking healthcare services (Wawaru et al, 2003, Paxton 2008, Ladha et al, 2009).

Under-financing of health systems, over-stretched health workforces (from doctors to community health workers), poor health management information systems, unreliable supply of medicines, physical barriers to access healthcare and distance-related barriers are other factors that contribute to older people's poor access to healthcare. Financial constraint is, however, their main barrier.

Since older people are not usually covered by health insurance schemes, that are commonly available to the better-off and to those who are in the formal-sector of employment, they are usually required to pay for almost all the medical treatments they receive.

Older people also often lack access to a steady income, such as pension, or retirement benefit, or salaries from good employment. Hence the higher prices they pay for health services put them in a higher risk of impoverishment. Even those who do receive pensions will find it difficult to cover their healthcare needs. In rural areas, in particular, older people and their families usually depend on agriculture as their main source of income, and hence the availability of cash money can vary significantly depending on harvest season.

Moreover, in rural areas where lack of transportation is common, older people have little means of getting to hospitals, other than walking. That, of course, discourages them from accessing health services.

2. Objectives of the study

The objectives of this study were to assess the health and health-related problems of older people, their health service needs and the accessibility and affordability of the services.

More specifically, the study aims to:

- Determine the magnitude and determinants of health and health-related problems of older people in Ethiopia ;
- Examine the perception, beliefs and attitudes of older people and the community concerning the health problems of older people;
- Assess the availability and the accessibility of health services to the old people;
- Examine the modality of the provision of health services, the physical accessibility of the health facilities and the affordability of the services for old people; and
- Recommend interventions to tackle the identified health-related problems of older people.

3. Methodology

As indicated earlier, the survey was conducted in five regions, namely, Tigray National Regional State, Afar National Regional State, Amhara National Regional State, Oromia National Regional State, Southern Nations Nationalities and Peoples Region as well as the Addis Ababa City Administration over the period of December 2011 to March 2012. The undertaking included collection and analysis of quantitative and qualitative data obtained from various primary and secondary sources, using a basket of methods and tools by applying both quantitative and qualitative research methods.

Quantitative data were gathered through a structured questionnaire from sample households where at least one older person lived. Qualitative data were collected through key informant interviews conducted with various relevant institutions, and participatory discussions held with representatives of older people and other community groups, using a range of participatory techniques and tools. Secondary data were collated through desk reviews of various policy and strategy documents, previous studies, reports and other relevant documents.

The total sample size for quantitative survey was determined by taking the alpha level ($\alpha=0.05$) that represents 5 per cent risk or 95 per cent confidence level, and 5 per cent margin of error ($d=0.05$) at estimating the population parameter. An estimate of variance is taken as $p=0.5$, assuming that the population is split 50/50 on a dichotomous question. Accordingly, the sample size has been technically determined with two stages of sampling to be 768 households as detailed here below.

Table 1: Sample size for the household (HH) survey

Parameter	Value
Sample size formula	$n = \frac{k*(z)^2*p*q}{(d)^2}$
P	0.5
Q	0.5
D	0.05
Z	1.96
K	2
N	768

The study design followed a multi-stage sampling procedure where study *woredas* were determined purposively by taking into consideration the geographic locations within the study regions. Then *kebeles* were selected randomly from each of the study *woredas*. A list of households that capture the demographic characteristics of household members (including age) with special mark for households with members aged 60 years and above, was prepared by supervisors and enumerators with support from *kebele* representatives. This fresh list was used as a sampling frame where sample households where older people are members were selected randomly. For households where two or more older persons live, only one was considered. In total, quantitative data were collected from 768 households.

The quantitative data thus gathered were organised using CS Pro, software developed by the US Bureau of Census for large-scale surveys and even censuses. The data entry was made by qualified data entry personnel employed to undertake this task. The electronic data were then converted into statistical package software called SPSS and same was used to analyse the data.

Moreover, important data/information related to older people's healthcare demands, attempts to respond to these demands by the government and other actors, etc. were captured by employing qualitative method. Particular data collection techniques, such as focus group discussions (FGD), key informant interviews and observation were employed to acquire such types of data/information that supplemented what was acquired through the quantitative method.

Accordingly, 14 FGD involving about 112 community members were conducted. Representatives of most relevant government sector offices/institutions and non-governmental institutions/organisations, namely, the Ministry of Labour and Social Affairs (MoLSA), the Regional Bureaus of the Ministry of Labour and Social Affairs (BoLSA), the Ministry of Health (MoH), Regional Health Bureaus (RHBs), Tesfa Le Aregawiyen (an NGO in Addis Ababa) and the Addis Ababa Pensioners' Association were interviewed, using semi-structured checklists developed to guide the interviews. Moreover, the physical conditions (their friendliness to older people) as well as the programmatic and service provision conditions of several health facilities, at both the federal and regional levels were observed. One health centre in every *woreda*, three hospitals in Addis Ababa (Black Lion, Zewditu and Menilik hospitals), the Addis Ababa Pensioners Association Clinic, were among the major health institutions approached. Three in-depth inquiries that generated interesting cases/narratives related to older persons are also among the pieces of

information used for this report. The qualitative data collected through in-depth interviews and group discussions were analysed by the researchers, using thematic techniques.

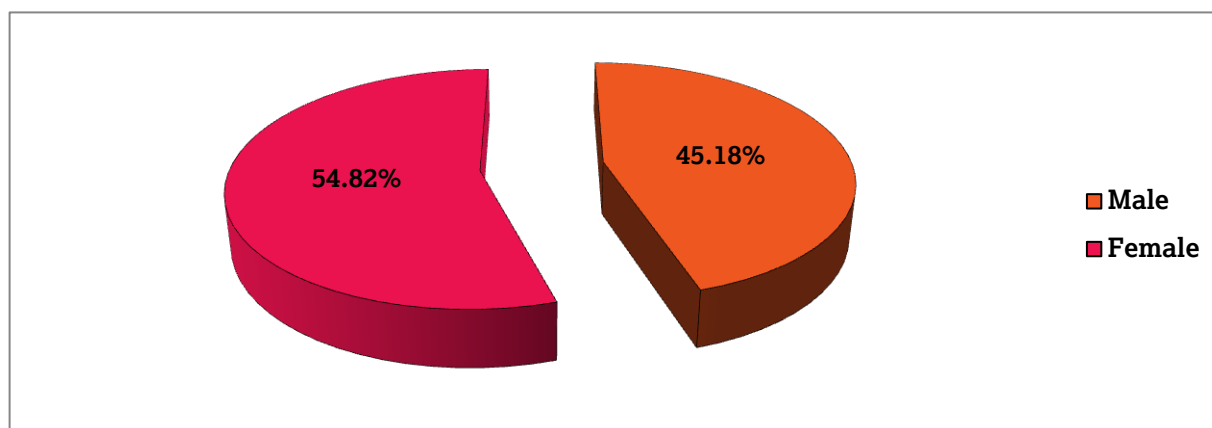
Finally, the data/information collected through the different data collection methods discussed herein above, were triangulated (compared and contrasted with information and data obtained from secondary sources and with each other), for the purpose of authenticating them, before they were made part of this report.

4. Results and discussions

4.1. The socio-demographic characteristics of the respondents

As shown in Figure 1 here below, the sex composition of our respondents was found to be more or less balanced.

Figure 1: The sex distribution of respondents



Concerning the age distribution, we have respondents in all ranges of age categorised into seven as shown in the table here below. It was found that the proportion of respondents between the ages of 65 and 69 were slightly higher (about 24 per cent) followed by those in the range of 70 to 74 (22 per cent) and 60 to 64 (21 per cent), as shown in Table 2 here below.

Table 2: Age distribution by sex

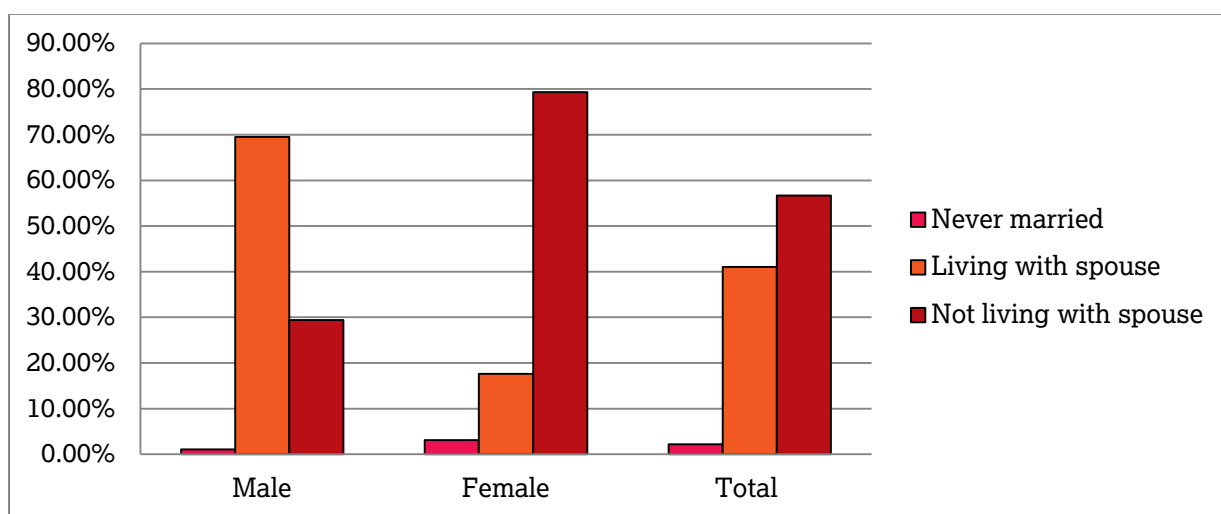
Age Category	Sex				Total	
	Male		Female		Count	%
	Count	%	Count	%		
60 - 64	60	17.29	101	23.99	161	20.96
65 - 69	71	20.46	113	26.84	184	23.96
70 - 74	81	23.34	88	20.90	169	22
75 - 79	49	14.12	42	9.98	91	11.85
80 - 84	47	13.54	50	11.88	97	12.63
85 - 89	18	5.19	10	2.38	28	3.65
90 and above	21	6.05	17	4.04	38	4.95
Total	347	100	421	100	768	100

When it comes to marital status, the survey result shows that, nearly 57 per cent are not living with their spouses. This group includes divorcees, widows/widowers and separated older people.⁷

The findings also indicated that female folks constitute the great majority (79.3 per cent) of those who are not living with their spouses. On the contrary, out of the 41 per cent who are now living with their spouses, 69.5 per cent are found to be male. The survey also showed that the proportion of female respondents reported to be separated is significantly higher than that of male. In a country where man is predominantly the breadwinner of the household, this figure indicates that a considerable number of women are subject to economic hardship because of widowhood, separation or divorce.

About 2 per cent were reported to be never married. It was indicated by interviewees that, in such cases, the possibility of having a carer when they get older and weaker would be less likely than those who got married, as the former might not have children.

Figure 2: Older people's marital status by sex



Regarding education, the findings disclosed that the majority of respondents (about 75%) are non-literate and the illiteracy rate is about 68% in the urban areas, whereas it is 85% in the rural areas. Few (less than 1%) reported to have College diplomas or higher-level education.

⁷ The questionnaire is stated in Amharic as “persons who were married, but are no longer living with their spouses,” without singling out the reason.

Table 3: Education level by sex

Highest Education Level Completed	Sex				Total	
	Male		Female			
	Count	%	Count	%	Count	%
Non-literate	215	61.96	362	85.99	577	75.13
Read and write	60	17.29	42	9.98	102	13.28
1 – 8	57	16.43	15	3.56	72	9.38
9 – 12	9	2.59	2	.48	11	1.43
College diploma and above	6	1.73	0	0	6	.78
Total	347	100	421	100	768	100

4.2. Economic situation and means of livelihood

4.2.1. Current means of livelihood

The survey showed that support from relatives is the source livelihood of larger portion of older people. As can be depicted from the figure below, about 47 per cent of older people reported their livelihood depend on support from their relatives, while about 19 per cent of the respondents reported they depend on pension. It should be noted that despite the fact that the current government has tried to make more than two increments on the pension rate, the lowest payment still remains to be Birr 292 (about USD\$ 16) per month, which is very meagre.

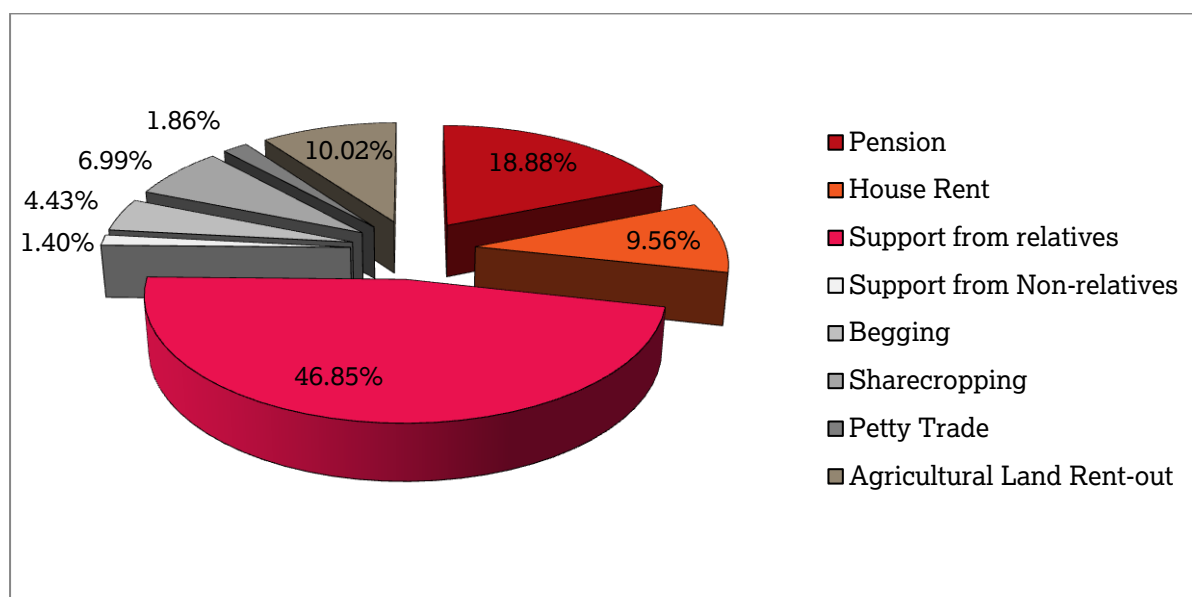
Focus group discussants and interviewees in several places pointed out that older persons that receive pension, especially those who get lower rates, lead very difficult lives. Given that, only the well-educated are better paid and that 75 per cent of our respondents are non-literate, the assertions of our informants hold true to the great majority of pensioners. This economic condition is even more aggravated by the ever-increasing cost of living. Hence older people are often dependent on their families. Informants further noted that the living conditions of older people, who receive support from their relatives, may not also necessarily be better, since the support providers themselves are often poor and the supports they give to their older relatives are meagre.

In the rural areas, the percentage of those who rent out their plots of land to others, or give their plots of land for share-cropping, account for 10 per cent and 7 per cent, respectively. It is understandable that people rent out their lands or give it for share-croppers when they

are unable to cultivate it themselves either because they have no means of production (oxen, seeds, farm implements) or are physically too weak, or both.

Under normal circumstances, it is single women who have no adult labour force at home who rent out their plots of land or contract out the same (the plots of land) to sharecroppers mainly because they cannot plough, since for women ploughing is culturally proscribed. In our case, the proportion of male-headed households who give their plots of land in such a contract is high. This fact indicates that the problem is not the culture-based division of labour, but their physical inability due to ageing and/or lack of means of production. Hence it shows the desperate situation older people are in. The worst part of the situation is that 4.43 per cent of older people's livelihood is dependent on begging, an engagement that is taken as a last resort and is perceived as embarrassing for both the individuals and the society they live in.

Figure 3: Main source of livelihood



4.2.2. Where and with whom older people live

The current situation of respondents' residences indicates the degree of old-age poverty and the dependency as well as the extent to which nuclear and extended families are sharing the burden of older people. Accordingly, it was attempted to elicit information about where and with whom they (the older people) are currently living. The result was that 29 per cent are living alone, whereas 27 per cent are living in their children's homes. About 38 per cent of them are living with their spouses. The proportion of those living with relatives, other than their offspring, and with people who are not consanguinal relations, is minimal (0.78 per cent and 0.4 per cent, respectively), indicating the very limited degree of

the role being played by the extended family and/or by the community, in terms of supporting helpless older people.

The difference between cases in rural and urban areas in relation to many of these variables is minimal.

Yet, there is a difference of about eight percentage points when it comes to living with spouses, indicating that divorce or separation may be relatively less common in the rural areas. The difference between urban and rural areas is also considerable regarding older people who live with house maids (2.45 per cent and 0.63 per cent, respectively).

Table 4: The current place of staying of older people by urban and rural

Response	Location		Total
	Urban	Rural	
Alone	30.51	26.96	29.04
Son's/daughter's home	27.17	26.33	26.82
With spouse	35.19	43.26	38.54
With house maid	2.45	.63	1.69
Own house with relatives	3.12	2.19	2.73
With relatives	1.34	0	.78
With non-relatives	.22	.63	.39
Total	100	100	100

4.2.3. Last main employment

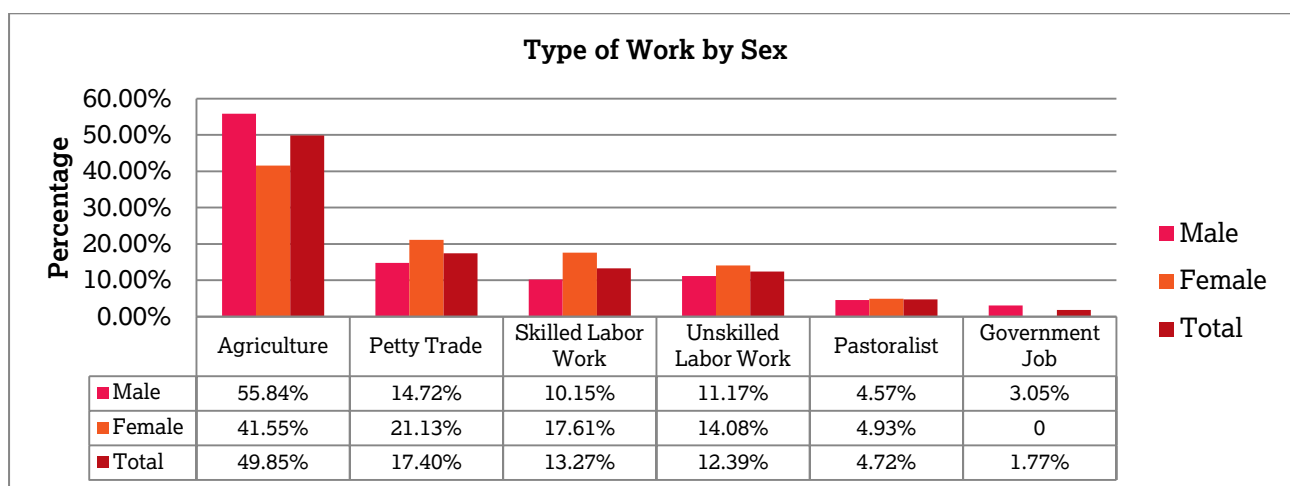
Respondents were asked what their last occupation was. The responses to that question showed that nearly 40 per cent were engaged in small-scale agriculture. This does not, nonetheless, mean that all those engaged in agriculture are rural dwellers. It could be learnt from the qualitative data that a considerable number of them actually live in the urban centres, after they gave their plots of land to share-croppers or renters. Moreover, some people living in semi-urban sites have some plot of land at the periphery of the urban centres. Only 1.77 per cent (all male) were government employees, whereas 4.7 per cent reported to have been engaged in livestock herding (pastoralism).

Engagement in skilled and unskilled labour was almost equal, in the cases of both men and women.

4.2.4. Current involvement in income-generating work

Asked whether they are currently engaged in any kind of work from which they derive income, about 44 per cent responded in the affirmative. The sector in which about 50 per cent of these people are involved is the agricultural sector, followed by petty trade (17.4 per cent), skilled labour (13.2 per cent), and unskilled labour (12.4 per cent), as shown in figure 4.

Figure 4: Types of work respondents currently do by sex



4.2.5. Additional source of income

As shown herein above, 44 per cent of the respondents reported to be currently engaged in some kind of work. They were thus further asked to tell if they have any additional source of income. 21.5 per cent responded in the affirmative. Of these, about 37 per cent get additional income by letting their houses, whereas 30 per cent are pensioners. About 7 per cent reported that their income is augmented by financial support from relatives, whereas 12.3 per cent are getting additional support from NGO. Moreover, 5.48 per cent are engaged in some kind of income-generating activity (IGA), besides their current jobs.

4.2.6. Average monthly income

Although people may be engaged in one or another kind of work, or get additional income from one or another source, in the last resort, what determines whether these people are leading a decent life or not is the amount of money they get every month. Accordingly, respondents were asked to tell their average monthly income. About 36 per cent of them

get less than Birr 292⁸ (USD\$ 16) a month, while about 14 per cent get something between 292 and Birr 500 (between USD\$ 16 and 27). That means this proportion of older people get less than a dollar a day. About 25 per cent of them reported that they get more than Birr 2,000 (about USD\$ 111). The distinction between urban and rural settings, in terms of income up to Birr 1,000 (USD\$ 50.5) is insignificant. It, however, becomes significant when it comes to incomes ranging between Birr 1,001 and Birr 2,000 (USD\$ 50.5 - USD\$ 111). Again, the distinction diminishes when it comes to income exceeding Birr 2,000.

It is, nonetheless, important to note that rural people are not predominantly wage workers or seldom have cash income and would often have difficulties to speak of their income in terms of cash (at monthly basis) and it is possible that some might have unwittingly exaggerated (see figures 5 and 6 on next page).

⁸The reason for making Birr 292 (USD\$ 16) monthly income as a starting point is that it is the minimum monthly payment of government pensioners after the last increment has been made.

Figure 5: Monthly income by sex

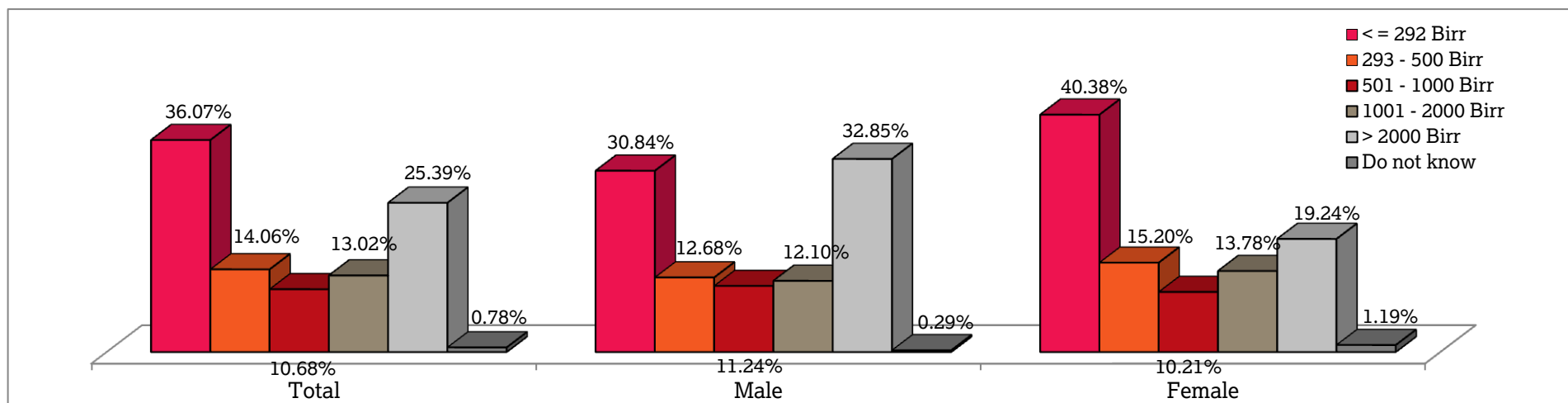
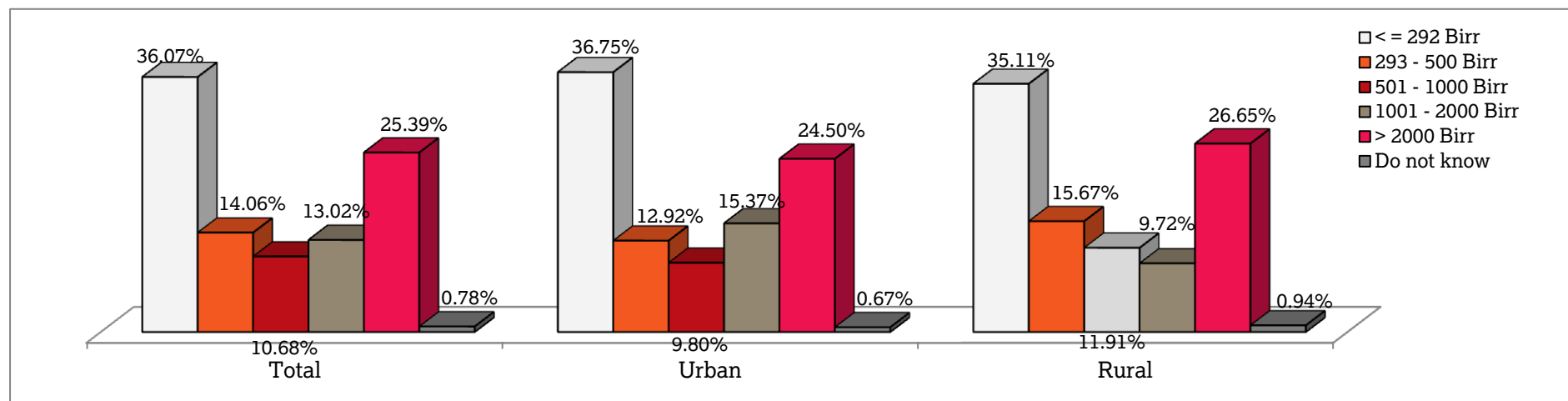


Figure 6: Monthly income by urban/rural areas



4.2.7. Economic dependence on other people for survival

37 per cent of respondents reported that they depended on other people's support for their survival. Of these, 82 per cent depended on their sons/daughters, about 6 per cent on their sons'/daughters'-in-law and 5.24 per cent on their grandsons/granddaughters.

Only 1.4 per cent depended on neighbours/communities. Despite the fact that the number of those who depended on their neighbours/communities is insignificant, it still shows that there is some remnant of the culture of sharing by the haves to the have-nots. Incidentally, all of the older people who reported that they depended on their neighbours/community were from urban centres (see figure 7 and Table 5 here below).

Figure 7: Dependency status

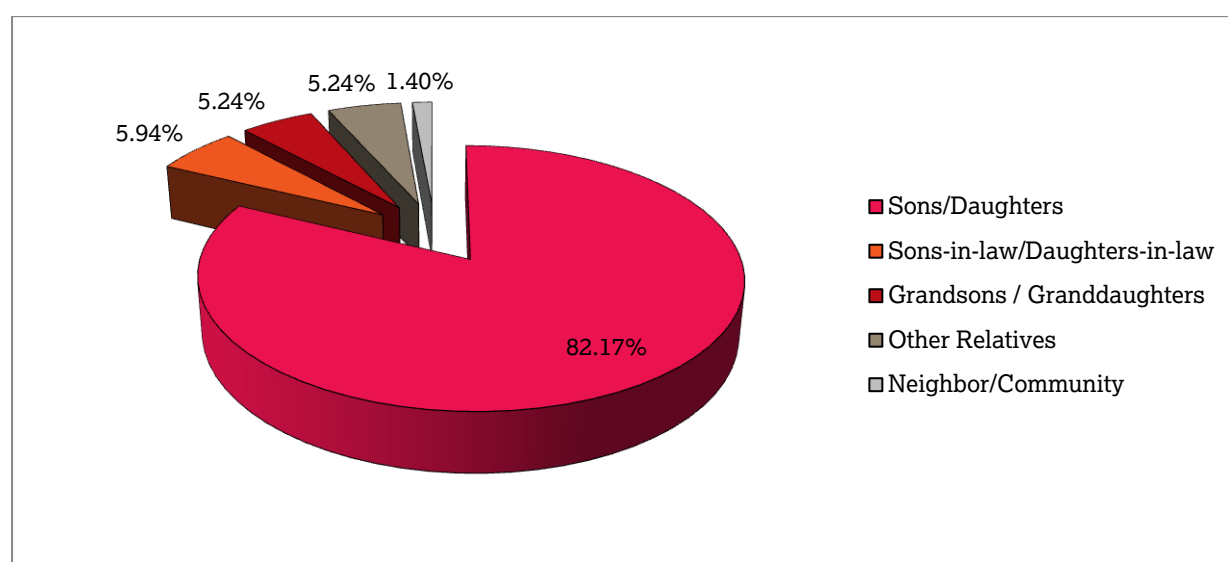


Table 5: Dependency by urban/rural

Response	Location		Total
	Urban	Rural	
Sons/daughters	81.03	83.93	82.17
Sons-in-law /daughters-in-law	4.60	8.04	5.94
Grandsons /granddaughters	4.60	6.25	5.24
Other relatives	7.47	1.79	5.24
Neighbours/community	2.30	0	1.40
Total	100	100	100

An attempt was made to see whether there is significant difference between older men and women as well as between urban and rural residents regarding dependence on other people for survival. The result showed that there is significant difference ($p=0.010$) between older men and women in this regard, where older women are more dependent on others than men, while there is no such significant difference ($p=0.304$) between older people living in urban and rural places.

4.3. Health problems of older people

4.3.1. Current health conditions

A little more than three-quarters (75.2 per cent) of our respondents reported that they were, affected by at least one type of disease, at the time the interview took place. Of these, 77.5 per cent were undergoing medical treatment.

Table 6: Currently undergoing medical treatment by urban/rural

Response	Location		Total
	Urban	Rural	
Yes	78.22	76.59	77.51
No	21.78	23.41	22.49
Total	100	100	100

It is worthy of noting that this finding (the proportion of older people affected by disease) is in conformity with what was shown in the HelpAge-sponsored survey of Addis Ababa, cited herein above under Section 1.3. The first three most common diseases older people are receiving medical treatment for are eye problems (29 per cent), followed by arthritis (20.17 per cent) and hypertension (11.83 per cent). Urinary tract, hearing, and heart conditions are also important health problems that older people are seeking medical treatment for.

The qualitative data indicated that one kind of disease seems to be most common in one area, and another in another area. For example, FGD participants in Hirna (in eastern Oromia National Regional State) almost unanimously asserted that constipation and gastritis are the most common diseases among them, whereas those in Afar National Regional State pointed out women's urinary tract infection as being commonplace in their

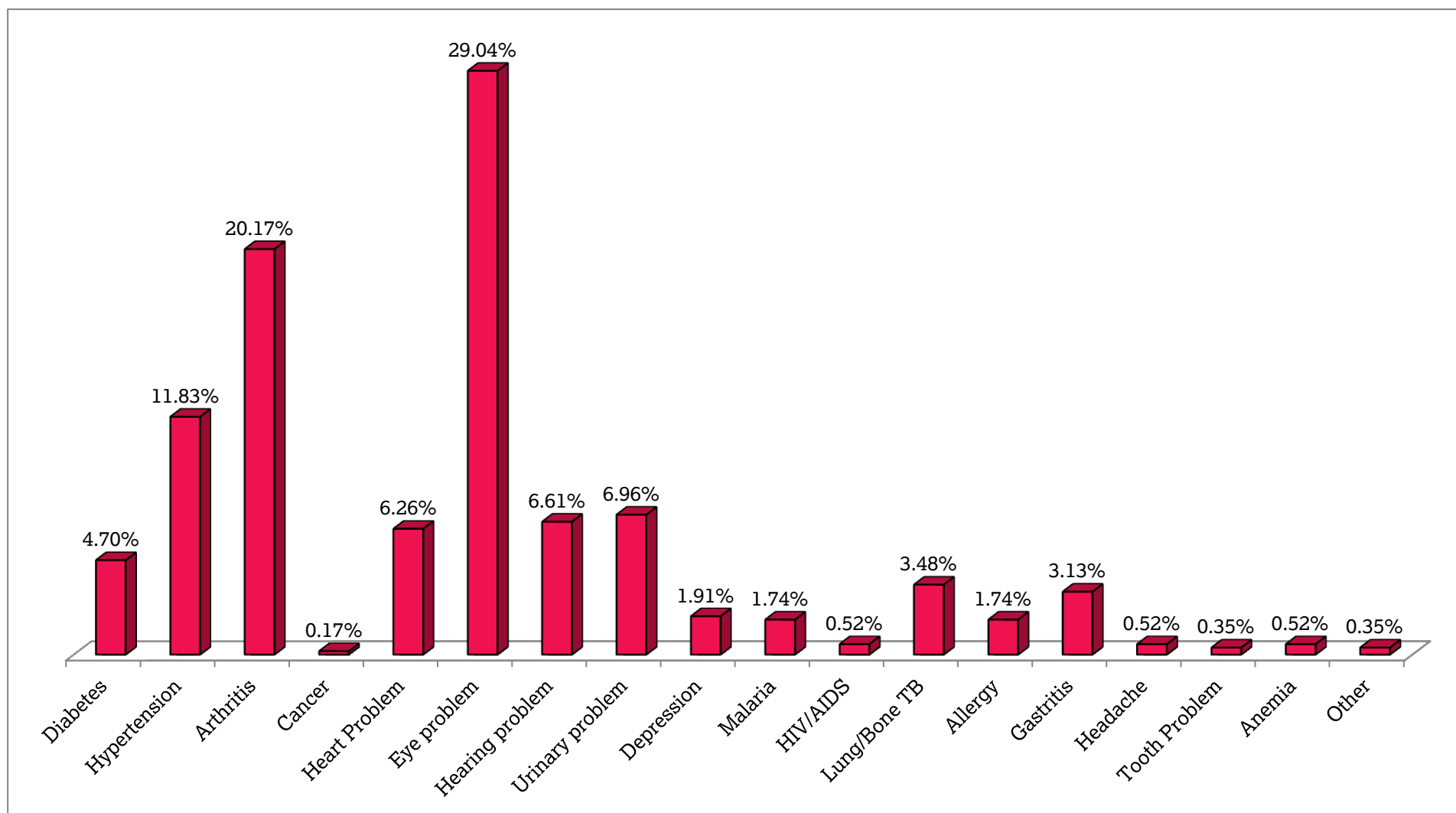
area. Similarly, FGD discussants in Degan, Kalu (in the Amhara National Regional State) reported that eye problem is the most common disease that affects older people in the area. Attempts were made to probe deeper and ask about the possible reasons. Although it is difficult to confidently speak of the reasons, the FGD participants in Hirna associated the constipation and gastritis problems with the custom of *khat* (narcotic leaves) chewing, which is a wide-spread practice in the area.

Similarly, the FGD participants in the Afar National Regional said that urinary-tract infection might have some connection with female genital mutilation (FGM) that almost every Afar woman has to experience. It is to be recalled here that FGM is not only a wide-spread traditional practice in the Afar National Regional State, but the kind of FGM they exercise known as infibulations involves the excision of the genitalia and the closure of the vaginal opening by stitching and is generally considered to be the most extreme form of FGM (PMC, 2010).

In general, FGD discussants and key informants from health institutions, identified diabetes, hypertension, cancer, heart attack, cataract, prostate enlargement, constipation, gastritis, hearing and seeing impairments, arthritis, and mental diseases as the most common non-communicable diseases (NCD) affecting older people. They then pointed out that these NCD require continuous care and medical treatment, often with follow-ups by medical personnel with specialisation. Such treatments are, more often than not, unavailable and/or inaccessible to the great majority of older people.

The survey also showed that there is a distinction between urban and rural residents, in terms of the kinds of disease they are exposed to, though the distinction may not be significant. For example, the proportion of people affected by diabetes and hypertension is 6.23 per cent and 14.45 per cent respectively in urban areas and 2.25 per cent and 7.66 per cent in rural areas, respectively. On the other hand, arthritis and eye problems affect more rural people (20.72 per cent and 32 per cent, respectively) as compared with urban people 19.83 per cent and 27.2 per cent, respectively.

Figure 8: The types of disease older people are currently undergoing medical treatment for



State-owned health centres are the most frequently visited health institutions by older people. That is because health centres are the most available health institutions, next to health posts, and that they are the lowest tier where primary health care is provided. Next to these are state-owned hospitals.

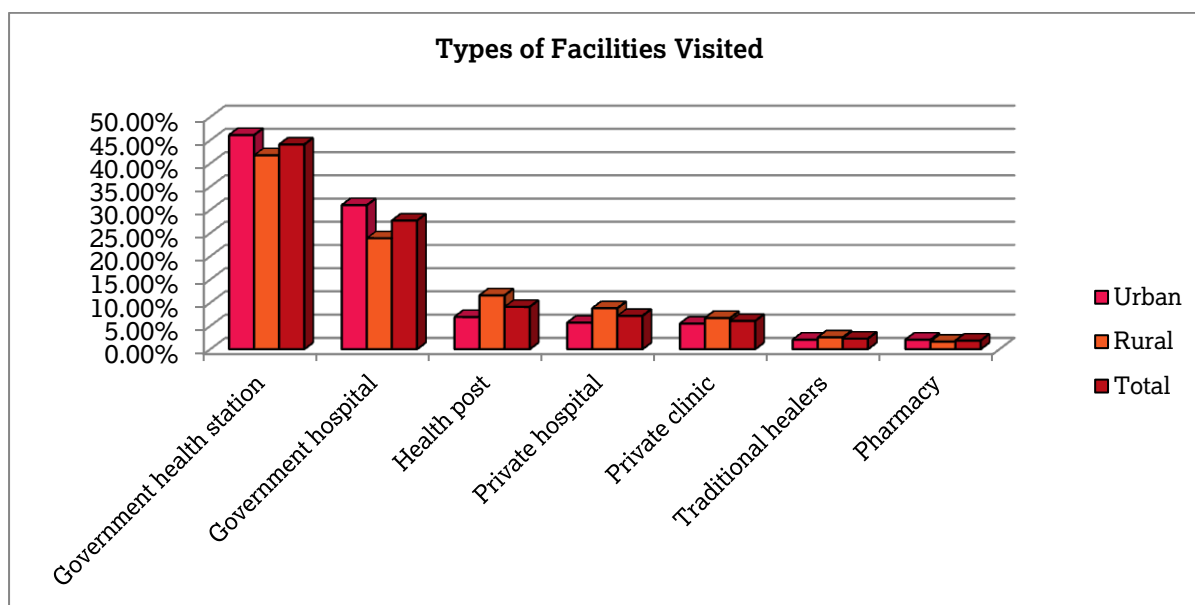
Since there is a significant difference, in terms of cost between state-owned and private health institutions, the possibility of older people visiting the latter is minimal. Indeed, despite the fact that the highest number of private health facilities are found in the urban areas, and that it is the town dwellers that are expected to visit them, the proportion of older people who live in the urban areas visiting these institutions is found to be even less than that of their counterparts from the rural areas, probably indicating the level of urban poverty.

The reported use of private health facilities in the rural areas at a relatively similar rate with those found in the urban areas may be due to the fact that rural people take all providers, including unlicensed individuals, drug vendors, etc., as private facilities.

Traditional healers are also visited by older people who live in both the rural and urban areas for various reasons, including beliefs that attribute the causes of several diseases to supernatural forces.

But affordability of the cost is the most important and tangible reason for the poor to use any kind of health care. In fact, FGD participants in almost all research sites emphasised that traditional medicines are sought primarily by people who cannot afford visiting “modern” health facilities, in terms of money, time, or capacity to travel.

Figure 9: Health institutions visited for medical treatment by urban/rural dwellers



The distance of health facilities, especially of those that provide curative services (health centres and above) also determines older people's opportunity of getting medical services. The proportion of health facilities found within a 10-kilometre radius is much higher (99.6 per cent) in the urban centres than in the rural areas, though the prevalence in rural areas is also significant (88.54 per cent). Since health posts are included, however, these statistics do not show the availability of institutions that provide curative services that are most relevant for the health problems of older people.

Table 7: Distance to the nearest health facility by urban/rural

Distance	Location		Total
	Urban	Rural	
< 10 KM	96.66	77.12	88.54
>= 10 KM	3.34	22.88	11.46
Total	100	100	100

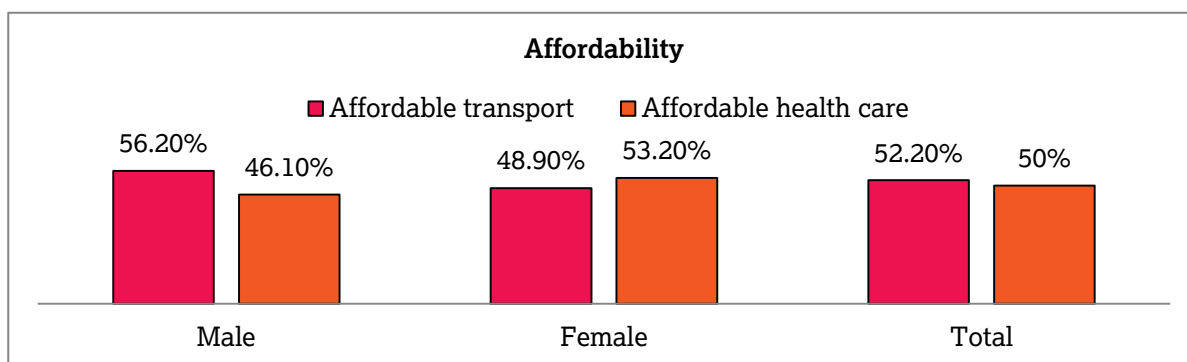
Smaller proportions of respondents are visiting health posts-instead of other types of medical facilities. This is because older people often seek medical services mainly to NCD, which health posts are not mandated to provide.⁹ Hence they may be compelled to go to either private or state-owned higher medical facilities.

The cost of transportation to these medical facilities and back is reported to be unaffordable for 52 per cent of the respondents (56.2 per cent male and 48.93 per cent female). That means that almost half of older people may not visit health institutions because of the unaffordable cost of transportation.

About 50 per cent of the respondents reported that they had been unable to visit health institutions because of financial problems. When seen by gender, the proportion of female folks that could not visit health institutions because of financial constraints was found to be a little higher than that of males (53.2 per cent).

⁹ In the Ethiopian healthcare system, the primary duty of health posts is promoting preventive healthcare through extensive awareness-raising activities, but not to provide curative services, except for a few communicable diseases, such as malaria.

Figure 10: Affordability of transportation and medical costs by sex



As is the case concerning economic dependence, there is significant difference ($p=0.045$) between male and female in terms of affordability of transportation costs in which case females are less capable.

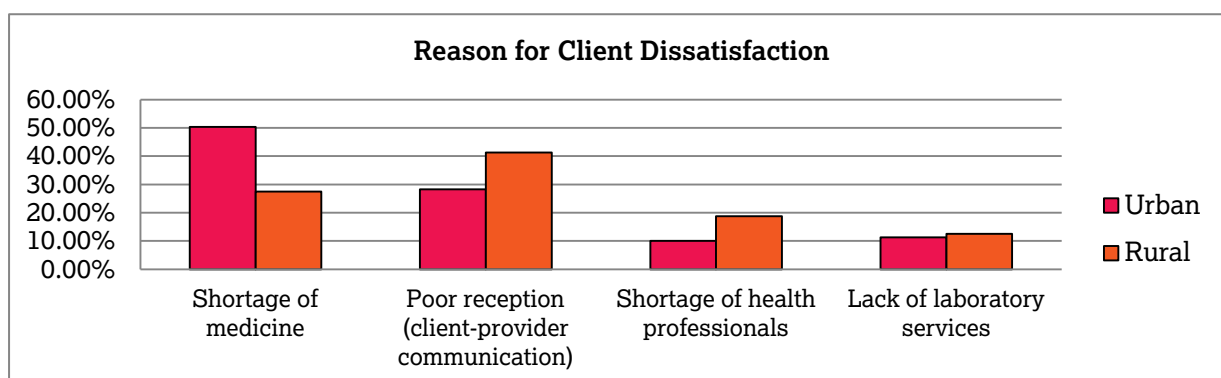
4.3.2. Level of satisfaction with available health services

An attempt was made to see the extent to which older people perceive the services they are getting as satisfactory or not. The result showed that about 40 per cent were dissatisfied with the available services.

The dissatisfaction, as perceived by respondents, is attributable to allegedly improper treatment by health personnel, shortage of qualified health personnel, shortage or non-availability of medicines and lack of laboratory services in some health facilities.

Shortage of medicine was mentioned by 50.31 per cent urban dwellers as a cause for the dissatisfactory service, as opposed to 27.5 per cent reported by the rural people. There was no difference between the situation in the urban centres and in the rural areas with regard to the availability of laboratory services.

Figure 11: Reason for unsatisfactory health service by rural/urban dwelling



Key informants, especially health personnel and administrators of health institutions in all sampled study sites, were asked whether the complaints of older people about the quality of the health services they are providing them with were valid, and if so, what the reasons for the low quality services were. They all admitted that the services were not up to the desired standards.

An official from Zewditu Hospital, in Addis Ababa, for instance, acknowledged the absence of high-quality healthcare services to older people affected by non-communicable diseases, because the Ethiopian healthcare policy gives priority to the prevention of communicable diseases. He mentioned that since there is no adequate health information and awareness-raising programme for older people affected by non-communicable diseases, they go to the hospital when the illness reaches a critical stage. He further noted the following:

“...patients need a close follow-up, and they have to be advised and counselled on the type of food they should eat and be informed about the side effects of smoking and taking alcohol. We are too busy to do that for the society. The other thing is, older people come as mere patients, and their specific case is dominated by other common diseases. In this case, the doctor uses the same approach for all patients, without giving special attention to the older people as she or he should, and undertaking proper evaluation. It is hard to say that the society is being provided with good health services. On the other hand, doctors might not be able to properly follow the procedure, as they have much workload. Thus the patient might not be given the chance to speak of his/her diseases in adequate detail.”

Our informant from the Amhara Regional Health Bureau saw the attention given to the prevention of communicable diseases in the primary healthcare policy approvingly, but he also said that he believed that it is high time that NCD are given due attention. He argued as follows:

“The government was right to give priority to communicable diseases, which is obviously a threat to everyone, including older people. But it is a little late in considering the specific problem of one of the most vulnerable segments of the society (older people). Now the problem of non-communicable diseases is making itself increasingly felt. Indeed, recent studies and casual facility-based statistics indicate the magnitude of the problem is growing from time to time. In short, it is no longer a problem to be ignored.”

He then pointed out that there was an endeavour to tackle the problem at the federal level. Key informants from the Federal Ministry of Labour and Social Affairs (FMoLSA) explained that the inadequate health services older people are getting are largely attributable to attitudinal problem both on the part of the public at large, and the health professionals. People perceive that the health problems that old people suffer from are merely manifestations of oldness. These informants argued "...This kind of perception has restrained older people from being adequately treated by health-service providers, health professionals and even by people very close to them." They further pointed out that "the aforementioned misconception starts from old age people themselves. Some of them believe that their problem is associated with their old age and cannot be treated, whereas some do not believe that modern health services can relieve them from their health problems."

Yet he admitted that the special health service needs of older people have not been taken into account while carrying out the hospital management reform or designing of the health sector development programmes. "For example", he said, "there is no geriatric ward in all the hospitals".

A key informant in the Oromia National Regional State also pointed out "in responding to the health needs of older people a different approach has to be used, in terms of taking their medical history and physical examinations. If there were specialised services aimed at non-communicable diseases that affect older people, there would be specialists to specifically examine and counsel older patients". According to this informant, the hospitals and health centres face problems in terms of human resource and infrastructure. Hence even the ordinary services that patients are provided with are inadequate, let alone services that require specialty, such as geriatrics. He further noted the following:

"The pattern of living is changed due to urbanisation and the adoption of a western way of life. This, in turn, alters the pattern of diseases. As part of my observation, I think this will increase the prevalence of non-communicable diseases. Hence we need skilled human resources, diagnostic facilities and intervention to deal with the new diseases. For this purpose we need a hospital setup. Although the number of medical professionals is increasing, and the rural areas are being provided with health workers and hospital infrastructure is in place, a lot remains to be done. I think it is high time that we started a specialised management on non-communicable diseases so as to provide quality services....

Government organs have to, therefore, work toward implementing ageing-

related policies. On top of that, the management and professionals of the various health facilities have to attend continuous training.”

Health institutions are expected to give priority to the top 10 health problems (communicable diseases) recognised at the national level. That, of course, makes them give less attention to geriatrics. Key informants argue that this can be a challenge to train professionals in the area and create an independent ward that treats exclusively older people. Key informants from the Tikur Anbesa Hospital and the Addis Ababa University College of Medicine described the problem in this regard as follows:

“We are in great trouble, in that no single health professional in the hospital has expertise in diagnosing and treating older people. In fact, no one seems to be interested in doing that. We were not taught that way. Nor do our medical schools have special training programmes. We know that the number of older people is increasing from time to time. We also know that the health problems of older people are getting more and more complicated not only because of the age-related degenerative conditions, but also because of the kind of life they are passing through, which is full of all kinds of stress. The way the health system is handling the health problems of older people is way behind from what is required. We can do it right only if the overall health system designs a proper mechanism.”

4.3.3. Financial source for medical expenditures

Asked how they cover expenses for the medical treatments they receive, about half (50.19 per cent) said that they use their own savings, whereas nearly 39 per cent said they get money for such expenses from their sons/daughters. About 8 per cent have to borrow money from someone whenever they fall ill. 5 per cent also mentioned sons/daughters-in-law and grandchildren as the sources of the money for covering their medical expenses. Although the proportion is small, the survey showed that some older people use begging as a source of money to cover their medical expenses (See table 8 on next page).

Table 8: Financial sources for treatment by gender

Sources	Gender				Total	
	Male		Female			
	Responses	%	Responses	%	Responses	%
Own savings/income	2210	61.9	173	40.42	394	50.19
Take loan from someone	22	6.16	40	9.35	62	7.90
Son/daughter	81	22.69	153	35.75	234	29.81
Son-in-law/daughter-in-law	11	3.08	12	2.80	23	2.93
Grandson /granddaughter	1	0.28	12	2.80	13	1.66
Free medication	4	1.12	8	1.87	12	1.53
Other relatives	2	0.56	13	3.04	15	1.91
Beggar	2	0.56	2	0.47	4	0.51
Non-relatives	5	1.40	8	1.87	13	1.66
Not stated	8	2.24	7	1.64	15	1.91
Total	357	100.00	428	100.00	785	100.00

It is worth mentioning that poor older people, like other poor people of any age category, are exempted from paying for their medical services at government medical facilities. It is done in such a way that the *kebele* administration issues special ID cards for all its members who are identified as poor, including older people. However, in practice this does seldom save poor older people from being exposed to highly expensive private laboratory diagnosis and purchasing drugs from private pharmacies, as the kind of required lab chemicals and/or prescribed drugs may not be available in the health facilities.

Indeed, in Fogera (in the Amhara National regional State), a health professional told the researchers that it is not only because of the absence of medicines that older people are told to buy medicines from outside. But, in accordance with the new health-financing system, every health facility is expected to be financially self-reliant. It could not, nevertheless, be so, if it goes on giving away drugs for free. He pointed out that Article 13 (1) of the draft Proclamation states that citizens who can present evidence that they cannot afford to pay for their medical expenses are entitled to a fee-waiver scheme. Article 13 (2), however, puts an obligation on the government body that is providing the waiver certificate to the patient to cover the medical costs thus incurred. But the *kebele* has no

budget for such expenses and therefore cannot afford doing that. Thus the *kebele* ID card for free medical services is simply nominal.

The draft Proclamation also lists health services that will be provided free of charge services to all citizens, regardless of the level of their incomes and ages because their illnesses may widely affect the public. The exemption is thus intended to improve the health seeking behaviour of the society toward such services. But, non-communicable diseases (NCD) that affect older people are not on the list of the services that are provided free of charge.¹⁰

Respondents were also asked by whom they were accompanied whenever they went to health institutions. The result was that the majority (about 57 per cent) were accompanied by their sons/daughters, followed by their spouses (14.2 per cent) and grandsons/daughters (about 6 per cent). It is, however, interesting to know that about 11.11 per cent of reported are accompanied by their neighbours, indicating the persistence of the culture of respecting one's social obligation to support the poor and the weak in one's community, despite a significant social change (See Table 9 here below). It should be noted here that almost all FGD participants and key informant interviewees emphatically reflected their assumptions that this tradition has been eroded through time.

Table 9: Persons accompanying older people to health services by gender

Accompanied by	Gender				Total	
	Male		Female			
	Responses	%	Responses	%	Responses	%
Alone/myself	10	6.33	21	9.17	31	8.00
Spouse	43	27.22	12	5.24	55	14.21
Son/daughter	84	53.16	137	59.83	221	57.11
Son /daughter-in-law	5	3.16	3	1.31	8	2.07
Grandson/granddaughter	6	3.80	17	7.42	23	5.94
Neighbours	8	5.06	35	15.28	43	11.11
Domestic carer	1	0.63	2	0.87	3	0.78

¹⁰ Family Planning Services, pre-natal, delivery and post-natal services in primary health care units, immunisation of mothers and children, diagnosis, treatment and follow-up of tuberculosis, voluntary counselling and testing of HIV and AIDS, transmission from mother to child are some of the services that are going to be given free of charge. The payment for leprosy management, epidemic follow-up and control, fistula management, and yellow fever vaccine are also exempted.

Accompanied by	Gender				Total	
	Male		Female			
	Responses	%	Responses	%	Responses	%
Other relatives	1	0.63	2	0.87	3	0.78
Total	158	100	229	100	387	100

4.3.4. Available support from local governments

The respondents were asked whether the local government is providing them with any support. Only 18.23 per cent responded in the affirmative. As for the kind of available support, 57.6 per cent said that they received financial support, whereas about 7 per cent said that they were supported to be engaged in some form of income generation scheme. For 22.7 per cent of these respondents, the support comes in the form of exemption from payment for health services, whereas 9.22 per cent of them considered getting priority for medical treatment at the health facilities as a support from the government. Those who reported to get government support in the form of food were very few (3.55 per cent).

Table 10: Supports from local government by gender

Kinds of Support	Gender				Total	
	Male		Female			
	Responses	%	Responses	%	Responses	%
Financial support	30	50	51	62.96	81	57.45
IGA	6	10	4	4.94	10	7.09
Discounts to health services	13	21.67	19	23.46	32	22.70
Priorities for treatments	10	16.67	3	3.70	13	9.22
Food aid	1	1.67	4	4.94	5	3.55
Total	60	100.00	81	100.00	141	100.00

59 per cent of the male and 74 per cent of the female respondents reported to be beneficiaries of the support provided by the local governments.

4.3.5. Available support by NGOs and CBOs

The respondents were also asked whether there is any kind of support for older people by

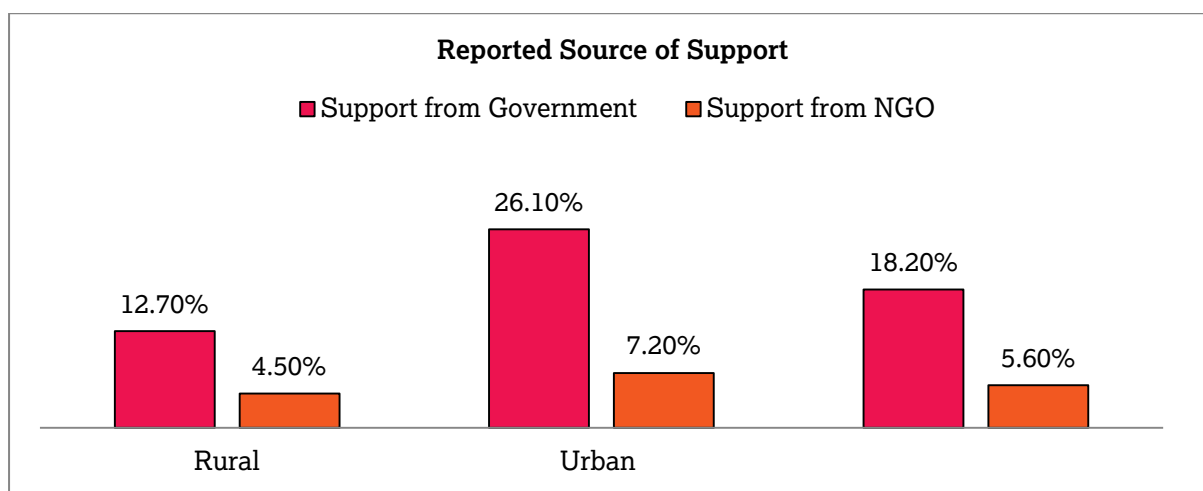
NGOs, to which only 5.6 per cent said yes. Of these, 60.47 per cent said the support is financial. 7 per cent said NGOs are helping them to be engaged in some kind of income-generating activity (IGA). Unlike the situation with government support, 25.58 per cent of the respondents pointed out that NGOs provided them with food aid.

The FGD participants mentioned a few NGOs that are engaged in supporting older people in their area, include Mary Joy in Hawassa City, Moms for Moms and HelpAge International Ethiopia in Tigray National Regional State. Some faith-based organisations, such as the development wing of the Catholic Church, are also serving poor older people, though in a very limited way.

Some community-based organisations (CBOs) are also being involved in the national effort to address the problem. The Djibruk Community-Based Development Association of Mekele City and the Halaba *Iddir* Union are cases in point.

One key informant in the Afar National Regional State described the low regard given to the plights of older people thus: “In our region, there are more than 30 NGOs working on children and women, but there is none working on older people”.

Figure 12: Support from local governments and NGOs



4.3.6. Older people as carers of orphan and vulnerable children (OVC)

Respondents were asked whether they are taking care of orphans or abandoned children, and about 25 per cent answered in the affirmative.

Although they were not asked to tell the reasons that rendered the children orphan and/or vulnerable, the issue was raised by participants in most of the FGDs, particularly when they were asked to list factors that make the economic life of older people hard. In almost all the study sites, the FGD participants mentioned HIV and AIDS as the main cause of

orphanhood.

In Degan (in the Amhara National Regional State), a different version of the problem was reported. They noted that the death of their children from AIDS is not the only reason that is making older people carers of their grandchildren. Extreme poverty, too, plays a role. According to these informants, in many situations, unemployed single women who were frustrated and unhappy about being dependent on their parents, may also face unwanted pregnancy and childbirth. To be dependent on parents with their newborn children would be more than they could bear. So the only alternative they have would be to go somewhere else in search of jobs, leaving their children in the custody of their older parents. Some of these young women migrate to the Middle-Eastern countries. The FGD participants added that in Degan not a single woman has been reported to have been successful in obtaining a job and coming back to care for her child or for her ageing parents.

Those who answered in the affirmative were further asked how many children they were taking care of. The result showed that about 46 per cent were taking care of one child, 32.82 per cent were taking care of two, whereas 21.21 per cent were taking care of three or more children.

Table 11: Number of OVC being cared for by older people by gender

Number of children	Gender				Total	
	Male		Female			
	Count	%	Count	%	Count	%
One	38	42.70	53	48.62	91	45.96
Two	31	34.83	34	31.19	65	32.83
Three and above	20	22.47	22	20.18	42	21.21
Total	89	100	109	100	198	100

Since the age of the children being taken care of has implication on the kind of care older people are providing, respondents were asked the age range of the children in their custody. The result showed that 20.26 per cent are between a few months and five years old, 37.44 per cent between six and nine, 42.29 per cent between 11 and 14.

Asked whether they have faced problems because of their responsibility as carers of OVC, close to 72 per cent answered in the affirmative. For the great majority (92.41 per cent) the main problem they faced was financial, whereas the remaining 7.59 per cent said they got sick because of the said undertaking.

4.4. Responses to the problems of older people

4.4.1. At the international level

The survey showed that the endeavours made to respond to the problems of older people are seldom healthcare-specific. The other problems have, nonetheless, implications on the health situation of older people and on the healthcare services they would get. .

Although different international human rights instruments contain provisions that concern older people in one way or another, it is the *Madrid International Plan of action on ageing (2002)* that is older people-specific, and the major global level guiding framework document on ageing issued by the UN Department of Economic and Social Affairs Division for Social Policy and Development. It was created at the Second World Assembly on Ageing in Madrid in 2002. The framework is the second internationally agreed programme to offer recommendations and guidance to countries seeking to develop and implement their own policies and programmes on ageing. The first plan of action on ageing, the *Vienna International Plan of Action*, was adopted by Member States at the first World Assembly on Ageing in 1982. At that time, it was already apparent in developed countries that their populations were ageing, whereas the issue remained on the distant horizon for most developing countries.

The Madrid Plan of action considers the fact that the implementation of the *Vienna Plan of action* was uneven particularly in developing countries with high rates of poverty and limited resources that is, lack of capacity at many levels, lack of skills, insufficient financial or human resources, low levels of organisational and institutional capacity, low political priority given to issues of ageing, which affected the ability to implement policies and programmes that were adopted.

The framework sought to guide users (state parties) in making their own decisions with regard to appropriate policy choices, based on the perspectives contained in the *Madrid Plan of action* and their own national context.

At continental level, the African Union (AU) has issued several policy documents based on the consensus that all development processes must enhance human dignity and ensure equity among age groups in the sharing of society's resources, rights and responsibilities. Among these, the 1984 *Kilimanjaro Plan of action* urges the African governments to develop and implement appropriate policies for the social security of older people. But the most recent and more specific policy document is *The African Union Policy framework and plan of action on ageing*, approved in 2002 at the 38th Session of the African Heads of

States/Governments that was held in Durban, South Africa. It recognises 13 areas of concern to older people including poverty, health, fundamental rights of older persons, food and nutrition, housing, and living environments, social welfare, gender, education and training. As already indicated in the preceding sections, none of these policies and action plan documents was healthcare-specific.

4.4.2. At the national level

At the national level, although older people have been recognised as “vulnerable” in various national legal and policy documents ranging from the *Constitution to the growth and transformation plan* (GTP), which is Ethiopia’s current five-year plan, the effort to address their health problems has remained minimal. Indeed, when we compare it with the attention being given to equally vulnerable groups such as children, women, etc., the one given to older people has been negligible. Nevertheless, a relatively better attention seems to be in the making. The following policy documents are the most relevant to our task at hand.

4.4.2.1. The Developmental Social Welfare Policy (DSWP)

This policy, which is known in short as DSWP, was enacted in 1996 by the Ministry of Labour and Social Affairs. It deals with the various problems that older persons are exposed to, due to aging. After stating the various problems (physical, psychological, financial, and socio-cultural) older people face in this fast-changing world, it suggests what should be done to tackle the problems. As the name indicates, the policy is neither older people specific nor health-specific. Yet it has implications on older people, since they are among the most vulnerable groups, whereas the social and economic aspects of their problem have health implications.

Although it is stated in the policy document that the implementation of the document will be checked by putting in place a follow-up mechanism, by ensuring the active participation of the community at all stages, and by building the capacity of both the Federal and Regional Labour and Social Affairs Offices, what has been achieved so far leaves much to be desired.

4.4.2.2. The National Plan of Action on Older Persons (NPAOP)

Following the issuance of the DSWP, the government developed the *National plan of action on older people, 2005/6-2014/15* (1998-2007 Ethiopian Calendar). The document states the rationale for the enactment of the plan of action, listing down the various social, economic,

demographic factors that generated or aggravated the problems of older people. In relation to the proper implementation of relevant policies, it states that the efforts have remained uncoordinated and hence, establishing national and regional focal bodies is imperative.

The NPAOP has six goals and 13 key issues based on two priority directions (the development and humanitarian aspects of ageing), together with detailed objectives and activities under each issue. It states in the introductory part that it is developed based on, and is in line with, the *UN Principles for older persons* (1991), the *Madrid International Plan of action on ageing* (2002) and the *African Union Policy framework and plan of action on ageing* (AUPFAA, 2002).

4.4.2.3. The Five-Year Strategic Framework for the Prevention and Control of Non-Communicable Diseases 2012 (MoH)

In recognition of the fact that NCD, particularly cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes are increasingly becoming leading threats to human health and development, the Ministry of Health (MoH) has drafted a five-year strategic framework for preventing and controlling these diseases. Furthermore, it has issued an *Action plan for the prevention and control of communicable diseases for 2012*, based on the just-mentioned framework. The plan is reported to be designed with the aim of establishing an organisational structure for NCD at the Federal MoH and at the regional health bureaus and integrate chronic diseases prevention and control with primary healthcare unit focusing on the Health Extension Programme (HEP). Although NCD are not diseases that exclusively concern older people, understandably they predominantly affect older people. Thus the strategic framework can, in a way, be considered as an attempt to address the plights of older people.

It will be recalled that critiques who argue that the health problems of older people are not given adequate attention often refer to the HEP's primary focus on the prevention of communicable diseases and on the fact that the lowest tier of health facilities is a health post that could not provide curative services, especially to non-communicable diseases. Hence the desire to aggressively work on the prevention of NCD, particularly the intention to integrate the endeavour with the HEP, seems a timely and positive response. The *Strategic objective two* of this document states the intention for integrating the prevention and control of NCD with the Health Extension Programme and will be accomplished by, among others, "updating the health extension workers' (HEW) refresher training manual and developing guidelines for the prevention and control of NCD."

4.4.2.4. The National Social Protection Policy (NSPP)

The *NSPP*, too, was drafted in April 2012 and is expected to be proclaimed soon. It is claimed, that this policy introduces a shift from the social welfare approach of the *Developmental social welfare policy* to a more complete framework, leading to coordinated actions to protect citizens from economic and social deprivation through emergency interventions and targeted cash transfers. It is a “preventive actions designed to avert deprivation or to mitigate the impact of adverse shocks, including health and unemployment insurance, promotional actions that aim to enhance assets and human capital and income earning capacity, and transformative actions, including legal and judicial reforms, budget analysis and policy evaluations to help the nation better manage social protection”.

There are also considerations to deal with the problem of affordability of health expenses for the “poorest of the poor” community members. Although this consideration is not specifically concerning older people, it obviously concern most older people, and there is a plan to put in place mechanisms for the provision of free medical treatment and pilot health insurance scheme both at the federal and regional levels.

Regarding the latter, the government has declared the establishment of a social health insurance scheme (Proclamation No. 690) in August 2010, the main objective of which is “providing quality and sustainable universal health care coverage to beneficiaries through the pooling of risks and reducing financial barriers at the points of service delivery.”

The beneficiaries of the scheme are “members and their families”, while the members are formal-sector employees (entitled for pension) as well as current pensioners.”

However, in a country where more than 80 per cent of the citizens are rural people whose livelihood is based on agriculture and considerable proportion of the urban dwellers have no pension entitlement, the scheme could not be said to have adequately addressed the health problems of older people. Cognizant of this fact, another, relatively broader, scheme referred to as “Community-based health insurance” is being piloted in 13 *woredas* in the four big national regional states (Amhara, Oromia, Tigray and SNNPR). The latter is said to have a much larger coverage and to have considered the peculiar conditions of all older people. Accordingly, it is proposed that older people’s contribution be 1 per cent, whereas others are expected to contribute 3 per cent.

There are also different efforts that are being made at different regions, some of which are considered by MoLSA as exemplary and replicable in other regions or at national level, though they are yet to be piloted.

One such initiative is the Tigray Social Transfer Pilot Project. This initiative is run by the Regional Bureau of Labour and Social Affairs and is funded by UNICEF¹¹. It is a scheme that “aims at improving the quality of life of orphan and vulnerable children (OVC), older people, and persons with disabilities.” It is thus claimed to focus on “building the existing initiatives and local capacity on improving the lives of the target groups.” As made clear in the objectives of the initiative and being a UNICEF funded project, it is clear that it is not an older people-specific initiative.

In the Amhara and Afar, Regional Bureaus of Labour and Social Affairs (BoLSAs) are encouraging older people to establish associations and are providing technical and financial supports for those already established or for those that are in the process of establishing.¹²

4.5. Rhetoric versus practice

These initiatives have many important elements that could considerably mitigate the problems of older people if implemented as envisaged. However, some are at planning stage and a lot remain to be done.

Our informants from the health sector (officials of MoH and RHBs) admitted that there exist implementation shortfalls on programmes and policies available concerning older people. For example, “no budget is allocated for the NCD prevention initiative, and it is not included in the core plans of the health sector.” This shows that NCD is not yet a priority. Notwithstanding the importance of the current efforts, therefore, it should be noted that these policies and plans of actions could not help, unless due attention is given to their proper implementation. Indeed, it should be added that a lot remains to be desired even beyond the implementation of the existing plans.

Lack or shortage of qualified personnel is often mentioned as the major drawback for the implementation of the plans. But it was learned from the key informants that the conflicting nature of the different directives has also negatively impacted the implementation process. For example, an official from MoLSA pointed out that “following the issuance of the *National plan of action on older persons* (NPAOP) a team of experts was assigned at both the federal and regional levels and made exclusively responsible for issues concerning older people. However, the Business Processing Reengineering (BPR)

¹¹ The Tigray Transfer Pilot Project was later joined by HelpAge International through financial contribution.

¹² MoLSA in collaboration with the Ethiopian Elderly and Pensioners National Association, supported by HelpAge International, commencing to exert similar efforts in Addis Ababa City Administration, Amhara, Oromia and Tigray National Regional States as well as SNNPR.

changed the organisational setup from function-oriented to process-based, whereby all issues are dealt with through the process, and hence there is no longer a unit exclusively dealing with the issue of older people”. Whether this arrangement is better than the previous one or not, needs a focused study. We did not go to such details. But we believe that the potential problems of implementation of a certain plan or initiative need to be anticipated and appropriately taken care of from the outset.

The HelpAge International in Ethiopia survey on *the Living condition and vulnerability of poor urban older people in Addis Ababa 2010*, also identified that the implementation of the policies, especially the DSWP, was not as stated in the policy document and states “though it is attempted to establish coordination offices at MoLSA and BoLSAs, the offices were not adequately staffed and budgeted, and hence could not accomplish the tasks they were established for”. Plans of action regarding older people’s healthcare, which are more relevant to our survey, are either at the pilot level and/or ill-implemented.

The majority of our informants from MoLSA, BoLSAs, MoH and RHBs had one thing in common: they believed that “older people’s specific health problems are not adequately considered in the national health sector plans, and that it is only recently that these problems started to be taken into account.”

5. Conclusion and recommendation

5.1. Conclusion

The result of the survey, in a nutshell, disclosed that older people are subject to multifaceted problems, which are basically physical, psychological, economic and health-related. These problems are inter-linked and mutually reinforcing, and all have implications on the health situations of older people.

- The problems of older people were not given adequate attention by the government.
- Though very few NGOs are working on and with older people, their number is nominal as compared to the existing need.
- Nonetheless, as of recent times the problems seem to be getting relatively better attention as various policies and strategies are being issued. Yet, there is clear evidence for the shortcoming in terms of translating the policies into action.
- The latest policy document, the *National social security policy*, has several articles that aim to tackle the health and non-health problems. The document recognises the significance of appropriate planning and implementation of cash transfer in positively affecting the lives of poor older people, especially in a situation where a

very small proportion of the population has pension entitlement. However, the document is at draft stage. And previous experiences do not make one very optimistic about the proper implementation of the policies.

- The Social transfer pilot project that is being piloted in Tigray National Regional State is an important project provided that it will be scaled-up at regional and national levels.
- Lack of a unit solely responsible for the planning, coordination and execution of older people-specific interventions is believed to contribute to the implementation problem.
- Government health recoding system lacks older people-specific health information, mainly because the health management information system (HMIS) is not disaggregated by age. In general, the HMIS is at its nascent stage.
- In terms of medical treatment, there is lack of drugs and trained personnel. Geriatric training is not given in any of the health training institutions in the country.
- While older people are vulnerable to various communicable diseases like anybody else, they are peculiarly more susceptible to NCD, especially to the most common ones such as diabetes, hypertension, eye and hearing impairment, cardiac ailments, arthritis and the like. However, getting medical service has never been an easy thing, since the health-care policy focuses on prevention of communicable diseases and also due to the fact that cost for medication and transportation to medical facilities is, nonetheless, unaffordable for most of them.
- Although the Ethiopian government has a system in which the poor get free medical services, it seldom serves as intended, because the “beneficiaries” almost always have to buy drugs from private pharmacies/drug stores and/or are given referral to private laboratories, and, in the final analysis, they are exempted only the payment for cards.
- It is also possible to learn from the findings of the survey that the physical setting of health facilities is not at all older people –friendly. Indeed, the very idea of older people-friendly physical structure was alien to many health facility workers, so much so that they showed some kind of bafflement when asked about this issue as if the questions were inappropriate.
- The traditional system of community mutual support is reported to be increasingly being eroded. It might, however, be poverty rather than the erosion of the culture that incapacitated communities to support older people. This implies that

concerned organisations should work on the revitalisation of the culture, while exerting every effort on poverty eradication/reduction.

- Mainly due to the devastating effect of the spread of HIV and AIDS and other causes related to poverty and unemployment, many older people are obliged to take care of orphan or abandoned children. In almost all cases, these children are their grandchildren. This situation has further aggravated the financial problem older people are facing.
- Although the involvement of some CBOs in Tigray National Regional State, Halaba and Addis Ababa City Administration could be seen as a good start, such involvement is absolutely limited, in terms of the capacity of the actors, the geographical coverage and the kinds of activities they are engaging.
- Many older people, both male and female, and urban and rural residents are visiting traditional healers. But, not all prefer traditional medicine because it is better than the “modern” one, but because it is easily accessible and much cheaper. This is true especially when it comes to herbal medicine. On the other hand, little or no effort is made to integrate traditional medicine with the modern one to make it not only accessible but also safe.

With due recognition of what is being attempted, it could be plausibly argued that the effort being made by the Ethiopian government and other actors is not tantamount to the multifaceted problem of older people. It could, therefore, be concluded that a lot remains to be desired concerning the health and overall wellbeing of older people in the country. The reality on the ground thus calls for a concerted action by all concerned to address the plights of older people.

5.2 Recommendations

Based on the survey findings presented above and the suggestions made by older people, community members, appropriate institutions and other stakeholders in response to the study tools, as well as the experiences of other countries reviewed the following recommendations are forwarded.

1. Strengthening government and community support

- The central government should establish or reinstate an authority or a unit that would be solely responsible for planning and executing activities concerning older people, which will also be in charge of networking and mobilisation of stakeholders at both federal and regional levels.

- The government needs to strengthen the HMIS in a way it captures data on older people. International NGOs and multi-and bilateral organisations could provide technical and financial support to this end.
- The traditional extended family and mutual-help system should be revitalised by extensive promotional work, using all available media, and public fora such as community conversations.
- Continuous and integrated effort shall be made to re-orient traditional social institutions such as *iddirs /mahbers* and funeral/religious associations so that they could support older people whenever they fall sick or needed support.

2. Concerning health problems

- *The MoH* should outline how older people would best access healthcare services, including protocol and reception, such as giving them priority at all service points, assigning support staff to help their movement within the facilities, assigning ambulance service for at least emergency cases and appointment dates, allocating waiting places particularly for them within the facilities, and so on
- Treatment for NCD should be given proper attention, and the proper implementation of policies and strategies regarding NCD should be ensured. To this end, the following points should be considered.
 - Establish mechanisms to enhance the capacity of health personnel.
 - Ensure that basic drugs and medical equipment for NCD are available in all health facilities.
 - Establish a mechanism to facilitate referrals from health centres to specialised care facilities
 - Initiate an introduction of geriatric training into the curriculum of the institutions of higher learning.
 - Accelerate the process of the introduction of the health insurance system and give equal attention to the community health insurance initiative.
 - Strengthen the database on the health and other problems of older people.

Moreover, the Federal MoH should do the following:

- Provide communities with continued health education on ageing-related health problems.

- Put in place a mechanism of follow-up on client complaints and ethical standards of the activities of health professionals, which is being partially implemented in some health facilities as a result of the Business Process Reengineering (BPR) and Hospital Management Reform, in order to enhance the quality of services provided to customers regardless of their ages.
- Physical structures of health facilities should be made older people-friendly (the laboratory, cash office and pharmacy should be easily accessible and located adjacently, the different rooms should be accessible by wheelchair, there should be older people specific waiting rooms, and the like).
- NGOs, especially those working on health, should incorporate or mainstream issues of older people into all their health programmes.
- Some older people may need palliative care services at home (including washing their clothes, fetching water, do shopping, etc.). This could be done by mobilising young people and providing them with the necessary training. NGOs and CBOs could play significant roles in this regard.

3. Concerning Economic Problems

- Addressing the economic problems of older people means partially addressing their health problems. In this regard, schemes of income-generating activities (IGA) should be encouraged by the government. Indeed, the government has to be engaged in, and guide, NSAs in providing IGA opportunities to the healthy capable older people.
- NGOs need to make the problems of older among the focus areas of their intervention. It would be critical to encourage, support, and scale-up best practices of CBOs already working on and with older people.

4. Advocacy

- Advocating the health service need of older people is vital to get decision makers recognise the health problems and health service needs of older people and respond appropriately. International NGOs like HelpAge International, should take initiatives in designing advocacy work projects, create forums, and seek the collaboration efforts of stakeholders.

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