SOCIAL INSECURITY AND VULNERABILITY OF THE ELDERLY TO POVERTY: A CASE STUDY OF MOROGORO MUNICIPALITY

By

Sidina Mathias

A Dissertation Submitted in Partial Fulfilment of the Requirements for Award of the Degree of Master of Science in Development Policy (MSc. DP) of Mzumbe University.

2013

CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University a dissertation entitled ***Social Insecurity and Vulnerability of Elderly to Poverty: A Case Study of Morogoro Municipality,*** in partial fulfilment of the requirements for award of the degree of Master of Development Policy of Mzumbe University.

……..

Major Supervisor

…….

Internal Examiner

Accepted for the Board of Institute of Development Studies (IDS)

……

CHAIRPERSON, FACULTY/DIRECTORATE BOARD

DECLARATION

I, ***Sidina Mathias***, declare that this dissertation is my original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

Signature……..

Date. ……

©COPYRIGHT

ACKNOWLEDGEMENT

I would like first to thank God the Almighty for giving me strength and capacity to complete this work. I am particularly indebted to my research supervisor Ms. Fatuma Nyihiran whose constructive criticism of the early draft of this study and her tireless effort and endless support during the writing of this work was of much help to me. Her scholarly guidance helped me to shape this work to its present standard. Much appreciation goes to the elderly respondents in Morogoro Municipality whose willingness to participate in this study enabled me to obtain requisite information.

Special thanks also should go to my beloved husband Prof. Esron Karimuribo, my sons David and Daniel who kept encouraging me throughout the MSc studies during my entire academic life at Mzumbe University.

My heartfelt thanks are extended to my mother Ester Michael for constant motivation, prayer, parental care and support during my entire life. I would also like to recognize academic support from Mr Onesmo Selejio who contributed to imparting skills and confidence in developing research tools, planning and data collection in the field.

I am also indebted to my employer, Morogoro Municipal Council, for granting me full-time studies permission which enabled me to undertake MSc studies at Mzumbe University.

Last, but not least, my thanks are owed to all lecturers and my fellow MSc DP students of the 2011/2012 group for their company, advice and support.

DEDICATION

This work is dedicated to my beloved husband Prof. Esron Karimuribo and my sons David and Daniel. They have significantly contributed to the successful completion of this work.

ABBREVIATIONS AND ACRONYMS

HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
IGA	Income generating activities
MMC	Morogoro Municipal Council
MOREPEO	Morogoro Elderly People Organization
MVC	Most Vulnerable Children
NBS	National Bureau of Statistics
NGO	Non-Governmental Organization
REPOA	Research on Poverty Alleviation
TASAF	Tanzania Social Action Fund
TIKA	*'Tiba kwa Kadi'*, a form of Community Health Fund in Morogoro Municipality
UN	United Nations
UNDP	United Nations Development Programme
URT	United Republic of Tanzania
US	United States
WB	World Bank
WEO	Ward Executive Officer
USD	United States Dollar

ABSTRACT

Social insecurity and vulnerability of elderly are among problems that are still facing the elderly in Tanzania. This study was designed to assess how the elderly access social services, establish the magnitude and identify factors which contribute to increased social insecurity and vulnerability as well as assessing existence and adequacy of institutional support to these elderly in Morogoro Municipality. The study employed a cross-sectional study design which involved visiting and interviewing 96 elderly people from four wards namely, Chamwino, Mwembesongo, Kichangani and Boma. It was observed that the majority of male elderly were married (76.7%) while the majority of female elderly were widows (66.0%). It was also found that more than 90% of elderly persons interviewed were not employed. Fifty nine percent lived below poverty line. The majority (67.7%) of respondents were supported by their children and relatives while few reported to depend on crop farming (40.6%) or business (21.9%) for livelihood. Access to food and balanced diet was a big problem and approximately 40% reported to skip a lunch every day. The major complaints of the elderly on health services included lack of diagnostic facilities, unavailability of medicine and specialized clinics for the elderly diseases. A big number of elderly was suffering from chronic diseases (69.8%) and supporting other vulnerable groups such as orphans (53%). However, the support of government and private institutions for elderly was limited. It is concluded that the majority of elderly people in Morogoro Municipality are poor and consequently they are socially insecure and vulnerable. It is recommended that the Government should support them through provision of universal pension to all the elderly above 60 years to improve their social security. The formulation of laws and regulations to guide the implementation of the national ageing policy is pertinent.

TABLE OF CONTENTS

CERTIFICATION i
DECLARATION ii
©COPYRIGHT iii
ACKNOWLEDGEMENT iv
DEDICATION v
ABBREVIATIONS AND ACRONYMS vi
ABSTRACT vii
LIST OF TABLES xi
LIST OF FIGURES xii

CHAPTER ONE 1
INTRODUCTION 1
1.1 Background Information 1
1.3 Objectives 3
1.4 Research Questions 4
1.5 Scope of the Study 4
1.6 Significance of the Study 4

CHAPTER TWO 6
LITERATURE REVIEW 6
2.1. Introduction 6
2.2 Poverty Concept and Definition 6
2.3 Types of Poverty 8
2.3.1 Absolute Poverty 8
2.3.2 Relative Poverty 9
2.3.3 Income Poverty 10
2.3.4 Non-Income Poverty 10
2.4 Measurements and Indicators of Poverty 10
2.4.1 Monetary Indicators of Poverty 10

2.4.2 Non-monetary Indicators of Poverty 11
2.5 Causes of Poverty in the Society 12
2.5.1 Poor Production Technology and Low Levels of Productivity 12
2.5.2 High and Rising Levels of Unemployment and Underemployment 12
2.5.3 High Prevalence of Diseases 13
2.5.4 Hunger and Malnourishment 13
2.6 Vulnerability to Poverty and Social Insecurity of Elderly People 13
2.6.1 Meaning of Vulnerability and Social Insecurity 13
2.6.2 Measurement of Social Insecurity and Vulnerability 14
2.6.3 Causes of Social Insecurity and Vulnerability 15
2.7 Factors Contributing to Poverty among Elderly People 15
2.8 Tanzanian Policy, Laws and Regulations Related to Social Care and Protection of Elderly People 16
2.9 Conceptual Framework 17

CHAPTER THREE 18
RESEARCH METHODOLOGY 18
3.1 Research Design 18
3.2 Study Area 18
3.3 Sampling Procedure and Sample Size 20
3.4 Data Collection 20
3.5 Data Analysis 22

CHAPTER FOUR 24
RESEARCH FINDINGS AND DISCUSSION 24
4.1 Introduction 24
4.2 Respondents' Characteristics 24
4.2.1 Gender of Respondents 24
4.2.5 Source of Income and Livelihood for the Elderly in Morogoro Municipality 29
4.3 Access to Social Services by Elderly in Morogoro Municipality 32

4.3.1 Health Services 34
4.3.2 Clean Water Service 37
4.3.3 Transport Service 38
4.3.4 Food 38
4.3.5 Shelter 40
4.4 Poverty Levels Among the Elderly People in Morogoro 43
4.4.1 Monthly Income and Expenditure of the Elderly People 43
4.4.2 Ownership of Assets 45
4.5 Factors Contributing to Increased Insecurity and Vulnerability of the Elderly to Poverty 47
4.5.1 Responsibilities of the Elderly to Dependents 47
4.5.2 Suffering from Chronic Diseases 48
4.5.3 Lack of Preparation of Retirees and Access to Retirement Benefits 49
4.5.4 Inability to Access Loans from Financial Institutions 52

CHAPTER FIVE 55
CONCLUSIONS AND RECOMMENDATIONS 55
REFERENCES 58
APPENDICES 64
Appendix 1: ..... **Error! Bookmark not defined.**
Appendix II 74
Appendix III 79

LIST OF TABLES

Table 3.1: Distribution of respondents by study wards in Morogoro Municipality....20
Table 4.1: Main sources of income as reported by respondents.....30
Table 4.2: Distribution of actors supporting different social services to the elderly in Morogoro.....33
Table 4.3: Chronic diseases/conditions prevalent in elderly people in Morogoro.....48
Table 4.4: Factors contributing to vulnerability of the retired elderly in Morogoro...52

LIST OF FIGURES

Figure 2.1: Conceptual framework to analyze relationship between causes and effect of poverty on social insecurity and vulnerability of the elderly 17
Figure 3.1: Location of study wards in Morogoro Municipality. 19
Figure 3.2 Face to face interview of an elderly person in Morogoro Municipality 21
Figure 3.3: A cross-section of a group during data collection by FGD in Morogoro . 22
Figure 4.1: Distribution of respondents by wards 25
Figure 4.2: Distribution of respondents by age categories 26
Figure 4.3: Distribution of respondents by marital status 27
Figure 4.4: Education status of the elderly who participated in the study 28
Figure 4.5: Highest education level attained by respondents who had gone to school (n = 61). 29
Figure 4.6: Main source of income for the elderly people in Morogoro (n=96) 31
Figure 4.7: Provision of social services to the elderly people in Morogoro (n=96).... 34
Figure 4.8: Distribution of responses on where elderly get health services in Morogoro (n= 96) 35
Figure 4.9: Distribution of health seeking preferences by ward (n=96)..... 36
Figure 4.10: Reasons provided by respondents (n=65) for not getting health services when needed 36
Figure 4.11: Distribution of support of access to clean water by marital status 37
Figure 4.12: Distribution of meals in the participating wards..... 39
Figure 4.13: Shelter of the elderly people in Morogoro Municipality (n = 96) 41
Figure 4.14: Different people staying with elderly people (n=80)..... 41
Figure 4.15: Materials used to make walls and roofs of the elderly people in Morogoro 42
Figure 4.16: An example of a house owned by the elderly in Morogoro Municipality in un-surveyed area..... 42
Figure 4.17: Perception of the elderly with respect to satisfaction on provision of social services 43
Figure 4.18: Average monthly income in Morogoro Municipality (n=69) 44

Figure 4.19: Expenditure profiles as reported by the elderly in Morogoro.....45
Figure 4.20: Ownership of assets among the elderly (n=96) interviewed.....46
Figure 4.21: People supported by the elderly persons in Morogoro 47
Figure 4.22: Distribution of retirees by year of retirement 49
Figure 4.23: Distribution of retirees by ward of residence.....50
Figure 4.24: Distribution of sources of retirement benefits as reported by 13 respondents.....51

CHAPTER ONE
INTRODUCTION

1.1 Background Information

Old age and aging is a concept that defines the final stage of human growth from childhood through youth to old age. In Tanzania, an individual is recognized as an older person based on age, responsibilities and his or her status (United Republic of Tanzania [URT], 2003a). Poverty is considered to be a major risk of ageing in developing countries (Sen, 1994). It is well known that economic wellbeing of people depends on both the ability of current income and in-kind services or support from other people and institutions (Holden & Smeeding, 1990). Nevertheless, the majority of elderly people in Tanzania and other developing countries can hardly earn adequate income as most of them are either retired people and/or have less energy to carry out income generating activities (Najjumba-Mulindwa, 2013). This increases risk of them being exposed to social insecurity and vulnerability to many calamities. The report by the World Bank for example, has revealed that in most of developing countries, the elderly people are poor and vulnerable to many risks (World Bank [WB], 1994).

Due to insecurity and vulnerability problems, most of the countries including developing ones have designed mechanisms of supporting older people financially and socially. For instance, the United Republic of Tanzania came up with the National Ageing Policy in 2003 which clearly defines how to plan, implement and evaluate service delivery to older people in Tanzania (United Republic of Tanzania [URT], 2003a). However, since the inception of this policy to date, there are no laws or regulations that govern support and delivery of services to the elderly people.

Based on the United Nations demographic estimate, the number of Tanzanians over 60 years of age is expected to triple between 2020 and 2050 (REPOA, 2010). Such demographic change is likely to increase even more poverty and vulnerability of elderly people to prevailing economic situation. For instance, in recent years, the

world has experienced economic crisis whose consequences have most impacts in developing countries including Tanzania (Kilminister, 2008; Lunogelo, Mbilinyi & Hangi, 2009). In such a scenario, the government plans to support elderly people who are likely to be affected too. The recent household budget survey carried out in Tanzania showed that households with higher proportions of dependants (children and adults with 65 years and above) are relatively poor (National Bureau of Statistics [NBS], 2007). It was also found that the majority of elderly people were non-employees and even retired elderly people are ill-prepared to embark on new lifestyle with little or no savings (United Republic of Tanzania [URT], 2003a).

The general global trend indicates that life expectancy has increased over the past several decades and will continue to rise (World Health Organization [WHO], 2013). In the early 1950s, the average life expectancy was approximately 46.6 years. The life expectancy has been projected to be 68.9 years during 2010–2015 period. Likewise, the increasing of life expectancy as predicted by the WHO, will inevitably increase population of elderly people in the world.

Morogoro Municipality has approximately 10,661 elderly people (Morogoro Municipal Council [MMC], 2011). Of these elderly people, more than 39%, take care of orphans and vulnerable children in the municipality. However, the magnitude of insecurity and vulnerability of the elderly people in Morogoro Municipality as well as factors contributing to the vulnerability are not well understood.

Therefore, this study intended to investigate the social insecurity and vulnerability of elderly to poverty in Morogoro Municipality. This will help to devise appropriate strategies that will help to reduce social insecurity and vulnerability of the elderly people in Tanzania.

1.2 Problem Statement

The demographic trend shows that the number of elderly people in Tanzania and Morogoro region in particular, will continue to increase with time (Morogoro Elderly' People Organization [MOREPEO], 2012). It is also understood that the elderly people do support other disadvantaged and vulnerable groups such as orphans and most vulnerable children (MVC). The majority of the elderly people are therefore insecure and vulnerable to poverty. Most of these people are unemployed and as they grow old they are less energetic to perform intense-labour economic activities. The situation is worsened by likelihood of such group being at risk of contracting communicable diseases such as HIV/AIDS attributed to close contact with victims of these diseases. Suffering from such communicable diseases is likely to increase their insecurity and vulnerability to poverty and consequently their sustained inability to meet even their basic needs (Herrin, 1997). It is from these perspectives that it was important to carry out this study in order to assess social insecurity and vulnerability of elderly people in the country as well as factors contributing to this problem. Findings from this study will be helpful to advice local and central governments to formulate and take effective measures aimed at providing permanent solutions to the existing problems of insecurity and vulnerability among the elderly people.

1.3 Objectives

1.3.1 General Objective

The overall objective was to assess the current status of social insecurity and vulnerability of the elderly to poverty in Tanzania.

1.3.2 Specific Objectives

i) To assess how elderly people access social services in Morogoro Municipality
ii) To establish the magnitude of social insecurity and vulnerability of elderly people to poverty in Morogoro Municipality
iii) To identify factors which contribute to increased insecurity and vulnerability of elderly people to poverty in Morogoro Municipality

iv) To determine roles of Government and Non-Governmental (NGOs) institutions in supporting elderly people in Morogoro Municipality

1.4 Research Questions

The following research questions will be addressed by this study:

a) Are social services provided to elderly people in Morogoro Municipality adequate?
b) To what extent does social insecurity problem exist among elderly people in Morogoro Municipality?
c) What factors contribute to insecurity and vulnerability of the elderly people to poverty in Morogoro Municipality?
d) What are the roles played by Government and NGOs in supporting elderly people in Morogoro Municipality?

1.5 Scope of the Study

The study was undertaken in Morogoro Municipality where four wards namely Chamwino, Mwembesongo, Kichangani and Boma were used as a case study. During the study, elderly people had been interviewed as well as government and non-governmental organizations and financial institutions involved with support and provision of services to the elderly people.

1.6 Significance of the Study

The findings of the study will support government efforts on poverty reduction among elderly through different programmes in terms of helping to advise local and central governments to formulate effective measures aiming at improving the existing problems of social insecurity and vulnerability among the elderly people. The recommendations of the study will also enable various stakeholders in the council to identify areas of improving the elderly social security system. In addition, this study will provide useful reference material for researchers who are interested in pursuing further research on the social security of elderly people**.**

1.7 Study Limitations

Some areas in Morogoro Municipality which were not easily accessible by public transport were not included in the study. This had impact on limited sample size and coverage area too. Data collection and survey in this study were also much limited by time and financial constraints. It was not possible to reach all respondents at their homes, particularly elderly who participated in FGDs The researcher was forced to depend on collected information through interviews from some of them at their *mitaa* offices.

The study results presented are the outcome of the data collected from respondents who mostly depended on memory recall and who were willing to respond. Therefore the researcher was very keen and cautious to get answers for making sure that proper and correct data are collected.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

Social insecurity and vulnerability of elderly due to poverty as stated in chapter one have attracted academic discourse. This chapter reviews some selected literature on poverty and social insecurity and their impact on elderly people in Tanzania.

2.2 Poverty Concept and Definition

Poverty is a relative term which generally defines the state of an individual in relation to the material possessions or even in monetary terms. The poverty can also be defined in non-monetary terms and therefore different scholars have adopted different definitions of poverty. For instance, poverty has been defined in terms of absolute levels of deprivation or the relative social positions of individuals and groups (Seers 1969; Sen 1976; Sen 1981).

Poverty is a multidimensional concept (Chambers 1983; Sen 1999; Alkire 2002). It does not only refer to physical deprivation of resources but it is also related to the lack of opportunity and even loss of hope of an individual in a society. Poverty can, therefore, be seen in different forms such as deprivation of most basic needs and materials such as shortage of land, crops or livestock in agrarian societies or lack of employment and income in industrial and post-industrial settings. A set of purely economic indicators is unlikely to capture the complexity of these manifold dimensions; cross-disciplinary research is required instead (Hulme and Toye, 2006).

Poverty can also be defined in terms of risks and vulnerabilities of individuals or communities to the unwanted outcomes or consequences (Adger and Winkels, 2007). In most cases, poor people lack the capability to make choices for themselves or, failing that, to obtain help in times of need. Rutasitara (2002) defines poverty as a situation of lack of sufficient means or income for minimum level of living; food, shelter, clothing, a job, a piece of land to till, vulnerability to changing economic and

natural conditions. In social context poverty means lack of a wider array of human non material needs such as rights of or access to community or state provided goods, freedom, and respect.

According to REPOA (2005), poverty may be regarded as a situation of lack of sufficient means or income for minimum level of living like: food, shelter, clothing, job, a piece of land to till, vulnerability to changing economic and natural conditions. In other words, poverty means lack of a wider array of human material needs such as rights of or access to community or state provided goods, freedom and respect. Thus poverty goes beyond lack of material requirement. Thus, poverty is associated with the level of income obtained by households or individuals that includes lack of access to social services. The Electoral Commission in Tanzania has correctly affirmed poverty as the inability to participate in society, economically, socially, culturally or politically (The Electoral Commission, EC, 2005). Despite of National Policy initiatives to curb social insecurity to elderly people in Tanzania as stated earlier, this dissertation argues that, relatively little attention has been given to eradicate poverty or sustain social security systems to poor elderly persons.

The United Republic of Tanzania defines poverty by using income and non income indicators including level of education, survival rate, nutrition status, clean and safe drinking water, social well-being and high vulnerability (URT, 1998). In order to understand poverty, it is essential to examine the economic and social context including the state of markets, communities and households (Sen, 1993).

This study acknowledges the contribution of previous research on social security system in Tanzania. However, there is a gap in terms of insufficient literature on the social insecurity and vulnerability of elderly to poverty in Tanzania. Many scholars have written on social protection such as pensions without addressing the problem of social insecurity and vulnerability of elderly to poverty.

It must be pointed out that, elderly people are key contributors to household such taking care of orphans and most vulnerable children. Older persons especially women support households through fetching water and other important household chores. More importantly, both older men and older women act as primary caregivers for children and grandchildren. Elderly people prefer to work and keep themselves busy as a way of remaining self sufficient and economically productive. For example, it has been acknowledged that, older persons have the primary contribution in the society in terms of their daily household activities, mobilizing funds including begging and soliciting donations, sales of agricultural and livestock production, participating in subsistence farming for both household consumption and sales, doing the daily household chores and taking care of children and grandchildren especially orphans (Erb, 2011a).

2.3 Types of Poverty

There are different types of poverty, based on categories described by different scholars. Common types of poverty are described in the following sections.

2.3.1 Absolute Poverty

Absolute poverty is the inability to attain a specified minimum standard of living. Absolute poverty is the state of living on or less than US $ 1 per day (World Bank 1990 cited in Allen & Thomas (1992).

Allen & Thomas defines absolute poverty as identifying the poor through having an income (including own production) insufficient to provide a minimum standard of living. Therefore those people in absolute poverty lack basic human needs such as fresh water, food, health and education. Absolute poverty is a quantitatively defined standard of poverty and is often the most useful way for making broad comparison between standards of living in different region in the World.

The definitions focus on the absolute economic well being of the poor, in isolation from the welfare distribution of the entire society. It implies the minimum standard of living commonly referred as the poverty line. The poverty line is expressed in real terms i.e. estimated expenditure figure per day. It is specified basing on basic needs necessity in which minimum standard of nutrition and other non – food basic necessities are included.

2.3.2 Relative Poverty

Semboja (1994) defines relative poverty as one that focuses on the economic well being of the poorest percentage of the population. This takes into account the welfare distribution of the entire society. Relative poverty therefore refers to lacking a usual or socially acceptable level of resources or income as compared with others within a society or country. This approach considers both political and socially because individual relate to each other at all levels of economic well being, implying that poverty is a dynamic concept which changes with time and space as well as the level of education and communication. Allen and Thomas (1992) define relative poverty as failure to get enough food, adequate health care, access to clean water and sanitation and to be functioning member of the society.

Allen and Thomas (2000), argues that relative poverty is when an individual, families and groups in the population can be said to be poor when they lack the resource to obtain the type of diets, participate in the activities and have the living conditions and amenities which are customary widely accepted in the society they belong. It is when their resources are so seriously below those commanded by the average individual or family that they are in effect, excluded from ordinary living patterns customs and activities.

2.3.3 Income Poverty

According to Maliyamkono (2006), income poverty is defined in terms of the income required to provide basic necessities or a decent standard of living. In calculating Income poverty, the baseline use to be developed, by taking the cost of ones basic food requirements and compare it with ones income. For those who have the income that can meet these requirements are considered to be not poor, while those who are below are considered to be poor. Example of poverty line is the World Bank baseline of one (1) US$ per day, that a person earning one (1) US$ per day is considered to be not poor, while those earning below this line are considered to be poor.

2.3.4 Non-Income Poverty

Non-income poverty can be defined as lack of access to social services, such as health, education and clean water, and vulnerability to unforeseen events (Maliyamkono, 2006). In defining non-income poverty is important to take into consideration the three "a" , that is, accessibility, affordability and ability, in the sense that accessibility of social services does not guarantee ones to afford these services and the *vice versa*.

2.4 Measurements and Indicators of Poverty

Measurements and indicators of poverty can be broadly divided into two categories, namely monetary and non-monetary indicators of poverty.

2.4.1 Monetary Indicators of Poverty

Different countries have adopted different measurements and indicators of poverty. For instance, the European Union countries adopted a relative poverty measure based on 'economic distance', a level of income usually set at 60% of the median household income, as the measure of poverty. In the United States (US), an absolute poverty measure is commonly used. The US poverty line was created in 1963–64 and was based on the dollar costs of the U.S. Department of Agriculture's 'economy food

plan' multiplied by a factor of three. The US line has been critiqued as being either too high or too low.

Both the absolute and relative poverty measures are usually based on a person's yearly income and frequently take no account of total wealth. Some people argue that this ignores a key component of economic well-being.

The World Bank (WB) defines poverty in absolute terms. Absolute poverty measures set a 'poverty line' at a certain income amount or consumption amount per year, based on the estimated value of a 'basket of goods' such as food, shelter and water necessary for proper living. For instance, the WB defines extreme poverty as living on less than US$1.25 per day, and moderate poverty as less than $2 a day.

2.4.2 Non-monetary Indicators of Poverty

A number of criteria are used to measure poverty using non-monetary indicators such as household assets, housing characteristics, and household size and composition.

For instance, the work in data on assets owned such as durable assets (e.g. bicycles, motor cycles) or household characteristics are very useful measure of poverty which are not influenced by recall problems of the respondents (Daniels, 2011). Some household characteristics which can be used as indicator of poverty include location (urban *versus* rural), age-gender composition, education of head of household, type of house, floor and roofing materials used, type of toilet, source of power (e.g. solar or grip power electricity) or source of water. An advantage of using non-monetary indicators of poverty is that respondents do not have recall problems as the assets and household characteristics are easily observable and recordable unlike the monetary data. Other factors non-monetary indicators of poverty which have been used or recommended include: risky livelihoods, living in excluded locations, problems in social relationships, lack of security or weak community organization.

2.5 Causes of Poverty in the Society

A number of causes of poverty have been reported in different societies. The following are common causes of poverty:

2.5.1 Poor Production Technology and Low Levels of Productivity

Poor production technology is the main causes of poverty in Africa in different sector of economy especially in the agricultural sector. Peoples in Africa depend much in this sector and also use low technology for production which causes poverty to persist for stance in Tanzania most of the farmer still use hand hoe for cultivation and have low production technology for manufacture and storage of agriculture products which result to low productivity. According to Mlambiti (1982) and URT (2004), the people's well being in Tanzania can be improved by improving the agricultural sector, which is the source of livelihoods of the rural dwelling population. Thus any attempt to alleviate poverty is likely to succeed if it focuses on developing the agricultural sector.

2.5.2 High and Rising Levels of Unemployment and Underemployment

Unemployment refers to those people who are able and often eager to work but for whom no suitable jobs are available. Underemployment refers to those people, both rural and urban who are working less than they could either daily, weekly or seasonally. Underemployment also includes those who are normally working on full time bases but whose productivity is so low that a reduction in hours would have a negligible impact on total output. High population especially the young people in Africa contribute much in problem of unemployment high proportion of young people cause the labor force to growing rapidly and exceed growth in employment opportunity

In Tanzania it is estimated that 50% of labour force is under 30 years old. The number of new entrants into the labor market has been increase more rapidly than the population growth rate and the average of workers has been decline. About 50% of the labor force is currently under 30 yrs old. Tanzania has almost 400,000 to 600,000

new job seekers each year (WB, 1996). This lead to have high level of unemployment in the country which causes poverty.

2.5.3 High Prevalence of Diseases

The HIV/AIDS pandemic and Malaria poses a major threat for eroding gains made in human development. The HIV/AIDS in Tanzania is estimated to be between 7.0 and 8.1% (Whiteside, 2002; Msuya et al., 2006) and is both a health problem as well as economic development problem. It is depleting disproportionately the productive and skilled segment of the population, thereby raising the dependency ratio. Malaria contributes to poverty in the country adding significantly to high morbidity and mortality rates

2.5.4 Hunger and Malnourishment

Hunger is a desire of food and the pain felt from fasting, whereas famine is a crisis in which starvation from insufficient intake of food, combined with high rates of disease is associated with sharply increased death rates (Allen & Thomas, 2000). Hunger makes people think of where they can get food for the survival of their families and ill health thus do not concentrate in production. It is closely associated with low income to meet basic needs to sustain daily life. A hungry person cannot work and therefore becomes even poorer.

2.6 Vulnerability to Poverty and Social Insecurity of Elderly People

2.6.1 Meaning of Vulnerability and Social Insecurity

Pelling (2003) defines vulnerability as 'the exposure to risk and inability to avoid or absorb potential harm'. Chambers (1989) and Moser (1998) define vulnerability as 'exposure to contingencies and stress, and difficulty in coping with them'. From the two definitions, vulnerability has an external side which is the risks and shocks that an individual or household faces, and an internal side which relates to the lack of means to cope with the risks without sustaining damaging loss. It does not mean lack or want but rather defenselessness and insecurity. Moser (1998:3) defines

vulnerability as 'insecurity and sensitivity in the well-being of individuals, households and communities in the face of a changing environment, and implicit in this, their responsiveness and resilience to risks that they faced during such negative times'. Vulnerability, on the other hand, is the probability of being poor or experiencing negative threats to social welfare in the future (Tesluic and Lindert, 2002).

Furthermore, Clark *et al* (2000) defines vulnerability as the risk of adverse outcomes to receptors or exposure unity (human groups, ecosystems and communities) in the face of relevant changes in climate and social conditions.

Vulnerability has also been defined as a human condition or process resulting from physical, social economic and environmental factors which determine the like hood and scale of damage from the impact of a given hazard (UNDP, 2004).

Social insecurity refers to the lack of action programmes of government intended to promote the welfare of the population through assistance measures guaranteeing access to sufficient resources for food and shelter and to promote health and wellbeing for the population at large and potentially vulnerable segments such as children, the elderly, the sick and the unemployed.

2.6.2 Measurement of Social Insecurity and Vulnerability

In most studies, social insecurity and vulnerability are measured using non-monetary indicators (Saunders, 2008). The most commonly measurement is social exclusion and deprivation. Under this concept, it is possible to link low income and lack of resources to vulnerability and social insecurity. The most common indicators of social insecurity are disengagement, service exclusion or even economic exclusion. For instance, disengagement can be easily measured by the proportion of members who have no regular contacts with other community members or even lack of participation in community activities (Saunders, 2008). The community activities may include

things like participation in religious, political, sports or even community obligations such as weddings and funerals in the community.

Social insecurity attributable to exclusion from social services comprises inability to access key social services such as health/medical services when sick, lack of social care or even inability to access loan facilities services which would be required to boost economic wellbeing of an individual.

Economic exclusion as measure of social insecurity is usually defined by inability to access key economic activities and services requisite for the economic wellbeing of individuals. These may include un-employment or inability to participate in other income generating activities (IGAs) or lack of emergency savings so that the individual would not be able to cope with any emergency should it happen any time.

2.6.3 Causes of Social Insecurity and Vulnerability

Apart from the factors established as measurement indicators of social insecurity and vulnerability, there other many factors that cause social insecurity and vulnerability. These factors act to undermine the capacity of self protection, diminish access to social protection, delays recovery and expose some groups to greater or more frequent hazards than other groups. The factors include rapid population growth, poverty and hunger, gender inequality, low level of education, poor health, lack accesses of resources and services, fragile and hazardous location, disintegration of social patterns, lack of access to information and public awareness (Aysan, 1993).

2.7 Factors Contributing to Poverty among Elderly People

Old age is one of the three periods in the life cycle when there is at an increased risk of poverty (Alcock, 1997). Elderly and poverty strongly associate with reduced capacity to work arising from the ageing process, that it is both a function and cause of inter-generational poverty (Heslop and Gorman, 2002). Lloyd-Sherlock (2000) also asserts that a reduced capacity for income generation and a growing risk of serious illness are likely to increase vulnerability of elders to fall into poverty.

Although it generally perceived that the poverty levels among elderly are attributed to a number of factors which are unemployment , persistent ill health and chronic diseases, lack of capital, lack of support ,lack of savings, caring of orphans due to HIV/AIDS and lack of assets. Other factors which contribute to poverty among elderly people are lack of insurance policies or private pensions.

2.8 Tanzanian Policy, Laws and Regulations Related to Social Care and Protection of Elderly People

In Tanzania, the National Ageing Policy was enacted in year 2003, aiming to put ageing into the development agenda of the nation due a number of problems facing elderly which include poverty , inadequate health services, pension and lack of participation in important decisions affect national development. The weakening of traditional ties has greatly affected the lives of the majority of elderly (URT, 2003a)

The National Ageing Policy recognizes human rights as stipulated in the Tanzanian constitution of 1977 as amended in 1984 and 1995 respectively. Moreover the policy has taken into consideration the United Nations Organization declaration No. 46 of 1991 on the following older people's rights, independence, participation, care, self–fulfillment and dignity.

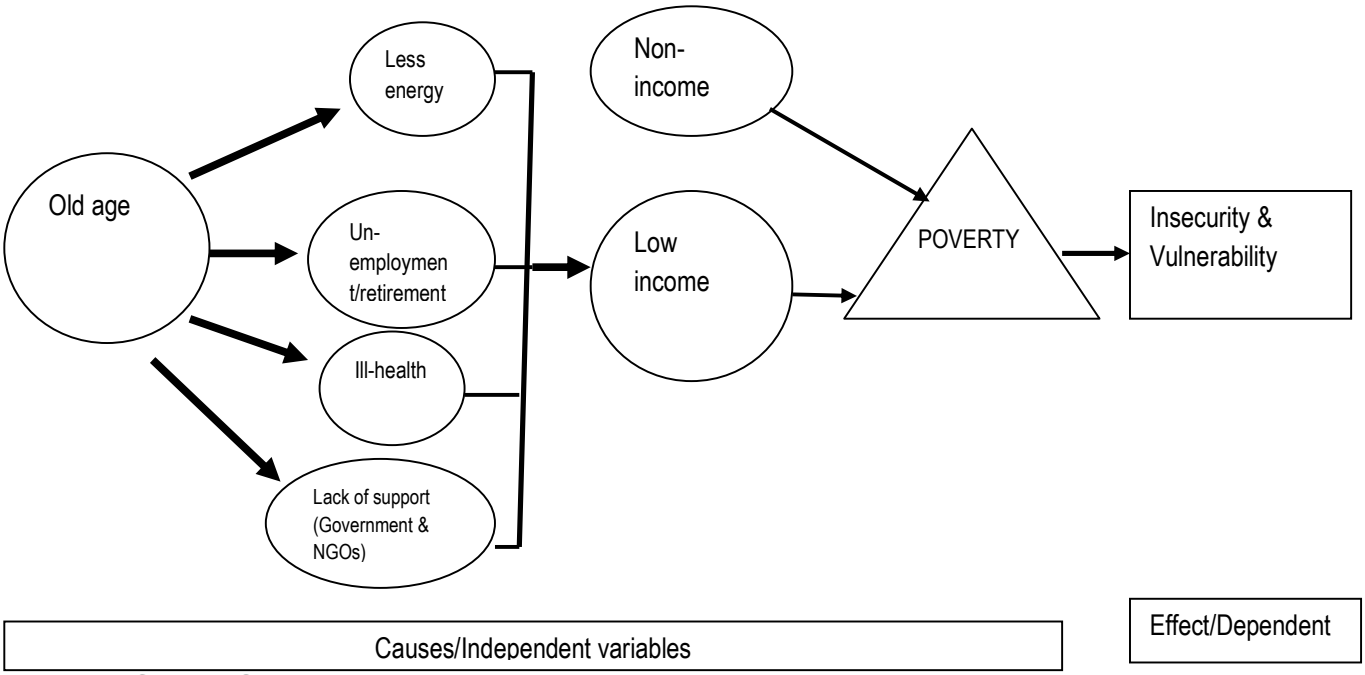
Nearly a decade now since the formulation and approval of National Ageing Policy but not accompanied by act and regulation which would otherwise facilitate the implementation. The implementers of the policy are normally not taken to tasks soon after the approval of the policy because the guidelines against which the cause of action can be assessed are unavailable, (Tungaraza, 1990). Thus on the absence of the policy guidelines the assessment and evaluation of the development policy could be more difficult as the result the whole procedures of policy formulation become meaningless.

2.9 Conceptual Framework

Conceptual frame work is a set of coherent ideas or concepts organized in a manner that makes them easy to communicate to others (Schwartz, 2006).

The conceptual framework for this research is summarized in Figure 1. The framework shows relationship between independent variables and dependent variables which are social insecurity and vulnerability to poverty of the elderly in Morogoro Municipality. Operational definitions for key variables that were examined in this study are also shown in the framework as presented Figure 2.1.

Figure 2.1: Conceptual framework to analyze relationships between causes and effect of poverty on social insecurity and vulnerability of the elderly



Source: Own construct

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Research Design

The study employed a cross-sectional study design which involved visiting and interviewing elderly people as respondents drawn from different households within the study area. A structured questionnaire (Appendix 3.1) was used to collect data by face-to-face interviews. Additional information was collected by in-depth interviews of key informants involved with provision of services to the elderly people in Morogoro Municipality. These included Government and Non-governmental institutions providing services to the elderly in Morogoro Municipality. Different checklists used for different institutions are presented in Appendix 3.2.

3.2 Study Area

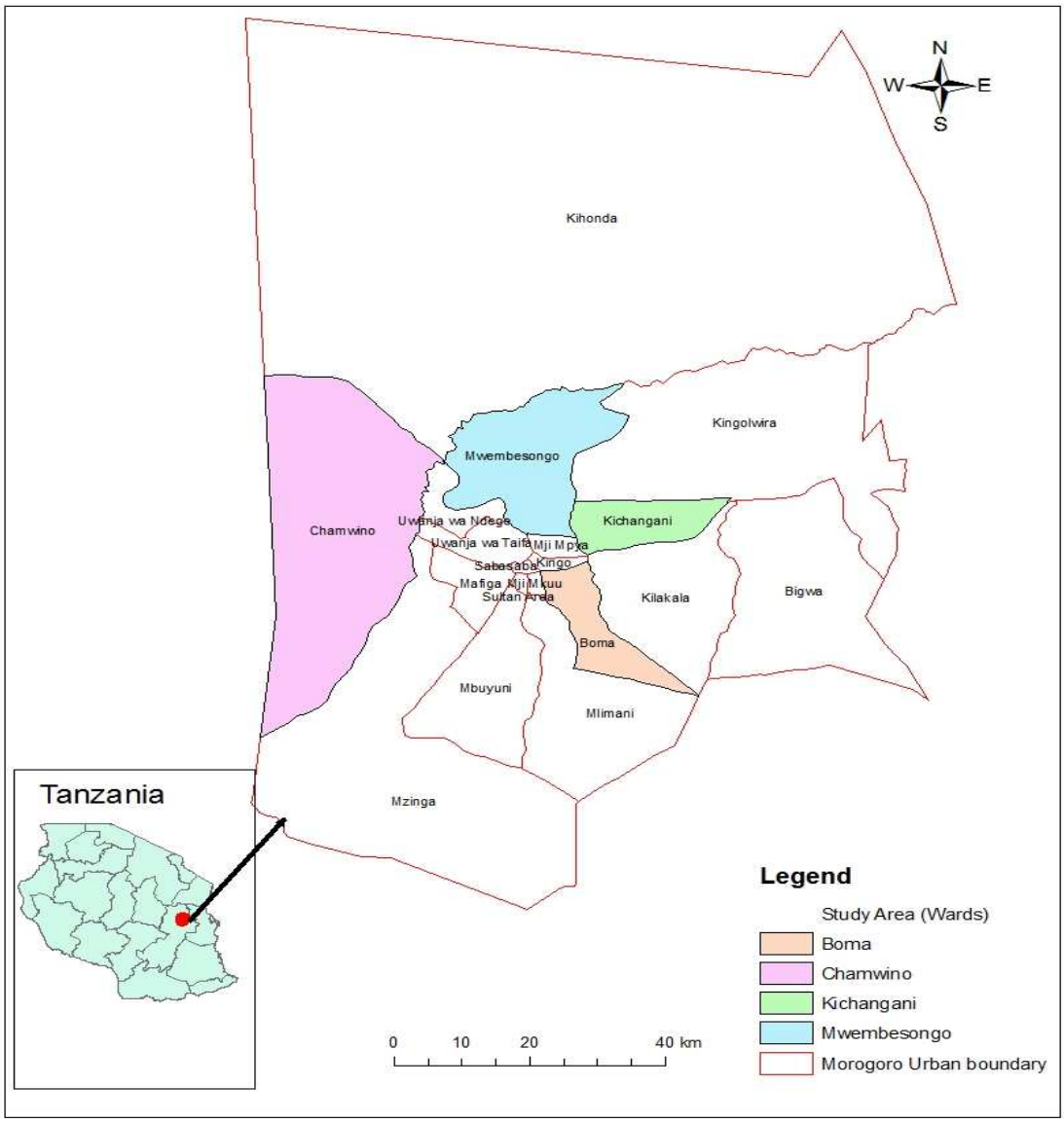
The study was carried out in Morogoro Municipality, also called Morogoro Urban district, which is one of the seven districts in Morogoro Region. The district was selected because it has a good number (10,661) of elderly people (MMC, 2011). On top of that the researcher is familiar with the area as she works in the district.

Morogoro Municipality covers an area of 531 km^2 (MMC, 2012). The municipality headquarters is located at latitude 6^o 49'S and longitude 37^o 40' E, approximately 195 km west of Dar es Salaam. Morogoro experiences average daily temperature of 30^oC with a daily range of about 5^oC. The minimum temperature is during June to August period when the temperatures go down to about 16^oC. The mean relative humidity is about 66% and drops down to as far as 37%. The total average annual rainfall ranges between 821mm and 1,505mm.

Major economic activities include industries of primary and secondary level, subsistence and commercial farming, small scale enterprises and commercial retail as well as wholesale.

Administratively, Morogoro Municipality has one division, 29 Wards and 272 streets popularly known as *Mitaa* with a population estimate of 387, 945 (MMC, 2012). This study was carried out in selected four wards which are Chamwino and Mwembesongo which represent low income wards and; Kichangani and Boma wards which represent high income wards (Figure 3.1).

Figure 3.1: Location of study wards in Morogoro Municipality



Source: Own map produced during the study (2013)

3.3 Sampling Procedure and Sample Size

A total number of 96 elderly people were selected to participate in the study. This sample size was guided by resources (time and funds) that were available for the study. However, proportional sampling was employed to select the elderly people to interview in each ward so as to make the sample representative. Initially, permission to collect data was sought from Morogoro Municipal Director who approved to collect data in writing (Appendix 3.3). This was followed by visiting study wards where Ward Executive Officers (WEOs) provided '*Mitaa'* Executive Officers (MEOs) to assist in introducing the researcher to the '*Mitaa*' Chairpersons. Using these chairpersons, a list of elderly people (60 years and above) in each '*mtaa*' was prepared to be used as sampling frame in random selection of elderly people who served as respondents in the study. Using a simple random selection approach, 96 respondents were selected from Chamwino (24), Mwembesongo (23), Kichangani (28) and Borma (21) wards (Table 3.1).

Table 3.1: Distribution of respondents by study wards in Morogoro Municipality

Ward	No. Respondents	%
Chamwino	24	25.0
Mwembesongo	23	24.0
Kichangani	28	29.2
Boma	21	21.9
Total	96	100.0

Source: Study findings (2013)

3.4 Data Collection

The study collected both primary and secondary data from various sources. The methods used to collect primary data were structured questionnaire, in-depth interviews, focused group discussions (FGDs) and researcher observation.

Collection of qualitative data (in-depth interviews and FGDs) was guided by a pre-defined set of steps and instruments of defining events and observations e.g. check-lists for key questions and observations were noted. The qualitative data collection aimed at complementing and validating data collected using questionnaire survey as well as collecting data from Governmental and Non-Governmental Organizations which support the elderly in Morogoro Municipality.

Every selected elderly person was visited once at his/her residence where a structured questionnaire was used to collect data using the face-to-face interview technique (Figure 3.2). Data collected included personal particulars of the respondents (age, sex, marital status and education), employment status and main sources of income. Other data collected included access to social services such as health, clean water, food, shelter, transport, outreach, networking and counseling. In addition, the questionnaire contained questions on assessing poverty levels as well as other factors contributing to increased insecurity and vulnerability of elderly people in Morogoro Municipality.

Figure 3.2 Face to face interview of an elderly person in Morogoro Municipality

Source: Study findings (2013)

The qualitative information such as materials used for building house and physical appearance of elderly was recorded by the researcher. Conducting in-depth interviews to service providers (health, financial institutions and organizations supporting elderly people in Morogoro) as well as Focus Group discussions to groups of elderly people was done as seen in Figure 3.3.

Figure 3.3: A cross-section of a group during data collection by FGD in Morogoro

Source: Study findings (2013)

3.5 Data Analysis

Data collected through administering a structured questionnaire from individual elderly people were entered and analyzed using Epi Info version 7.1.0.6 (CDC, 2012). Quantitative data were analyzed by computation of descriptive statistics (mean, median, standard deviation and range). The categorical data were analyzed by computing percentages of responses Cross tabulation was used to assess the

relationship between two or more variables e.g. stakeholders and different social services they offer, accessibility to social services in relation to sex and age of respondents. Graphical presentation of findings was also made using Excel program.

Data collected by in-depth of key informants and Focus Group discussions were analyzed qualitatively using different approaches such as content analysis, describing and connecting findings from the study (Dey, 1993).

CHAPTER FOUR
RESEARCH FINDINGS AND DISCUSSION

4.1 Introduction

This chapter presents findings of the study and discussion. It is organized in logical flow of information beginning with respondents' characteristics followed by findings under each objective presented in Chapter One.

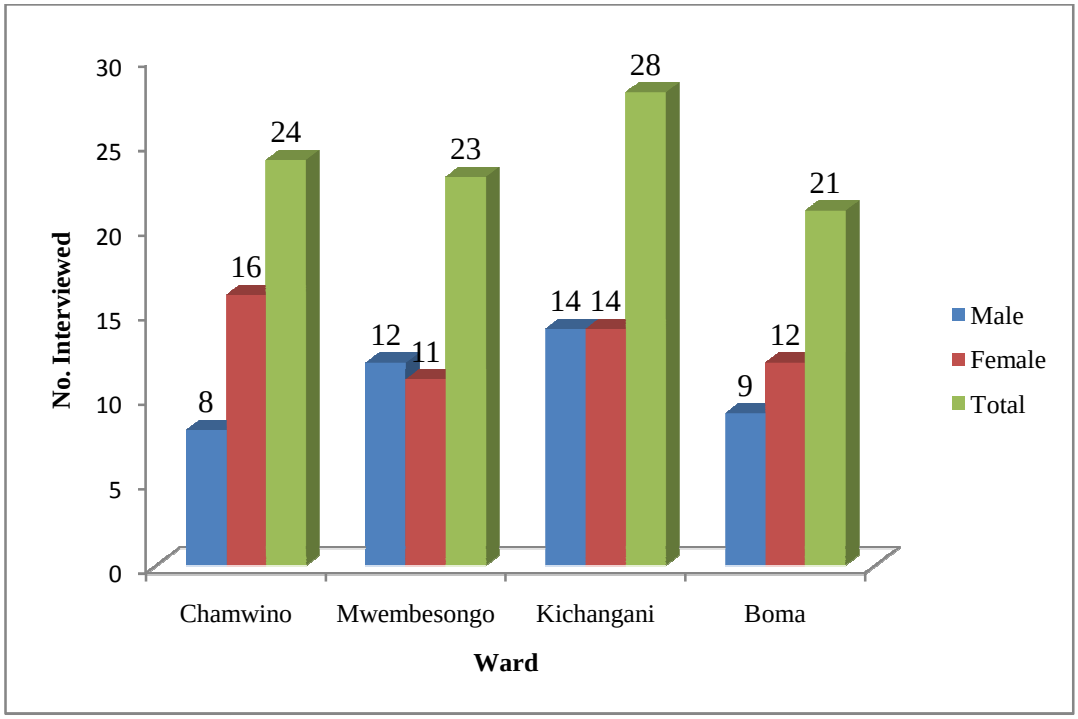
4.2 Respondents' Characteristics

The characteristics of the respondents (elderly people) sampled in the study area cover the gender, age structure, marital status, education level and household source of income. These respondent's characteristics are important determinants of insecurity and vulnerability of the elderly and guide in formulation of different programmes to support the elderly.

4.2.1 Gender of Respondents

Overall, out of the 96 respondents interviewed, 44.8% were males while 55.2% were females. Distribution of respondents by sex in the four wards which participated in the study is shown in Figure 4.1.

Figure 4.1: Distribution of respondents by wards



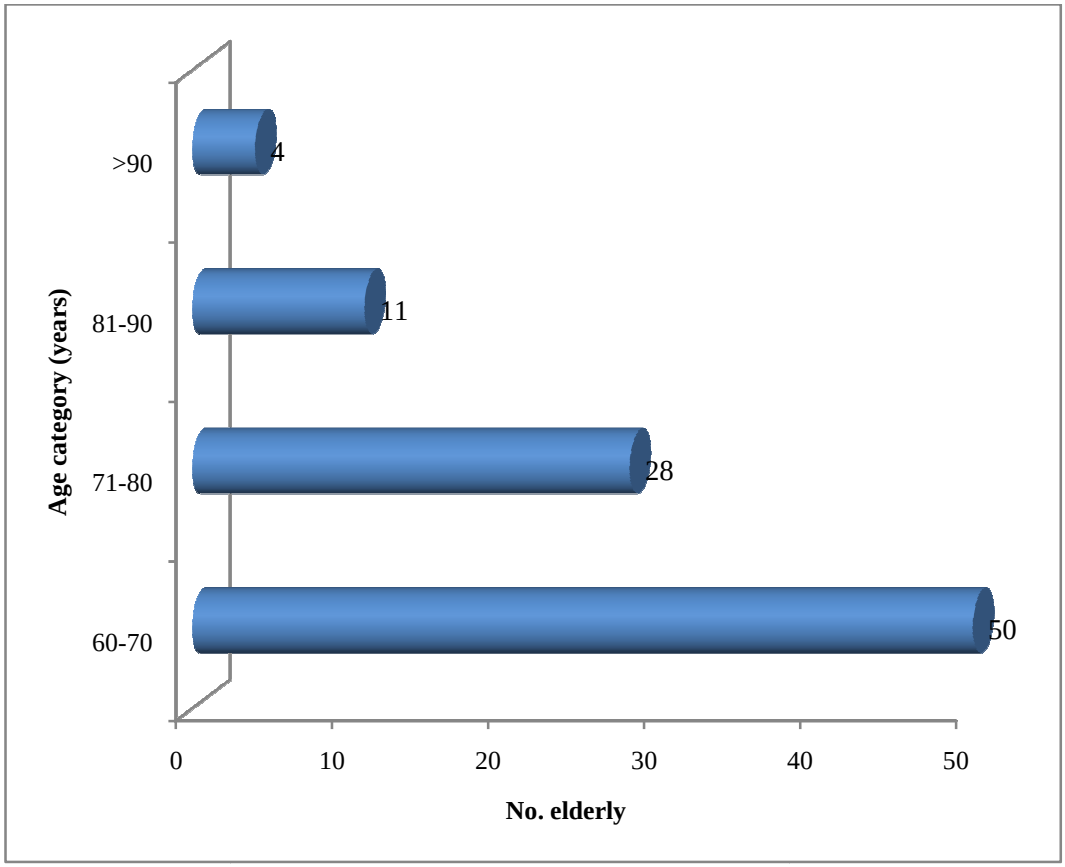
Source: Study findings (2013)

Since the study sample was selected using random sampling technique, the difference in number between males and females concur with population census which show that the number of females is greater than that of males in Tanzania (URT 2003, 2013).

4.2.2 Age of Respondents

Out of 96 respondents interviewed, 96.9% had their age known and recorded in years. The average age of the respondents was 71.9 (range= 60-98 years). Distribution of the respondents by age category is summarized in Figure 4.2. From the Figure, the largest number (50%) of respondents was in age category of 60-70 years implying that the elderly people in Morogoro Municipality, if they are supported, can still engage in income generating activities, thereby reducing poverty.

Figure 4.2: Distribution of respondents by age categories

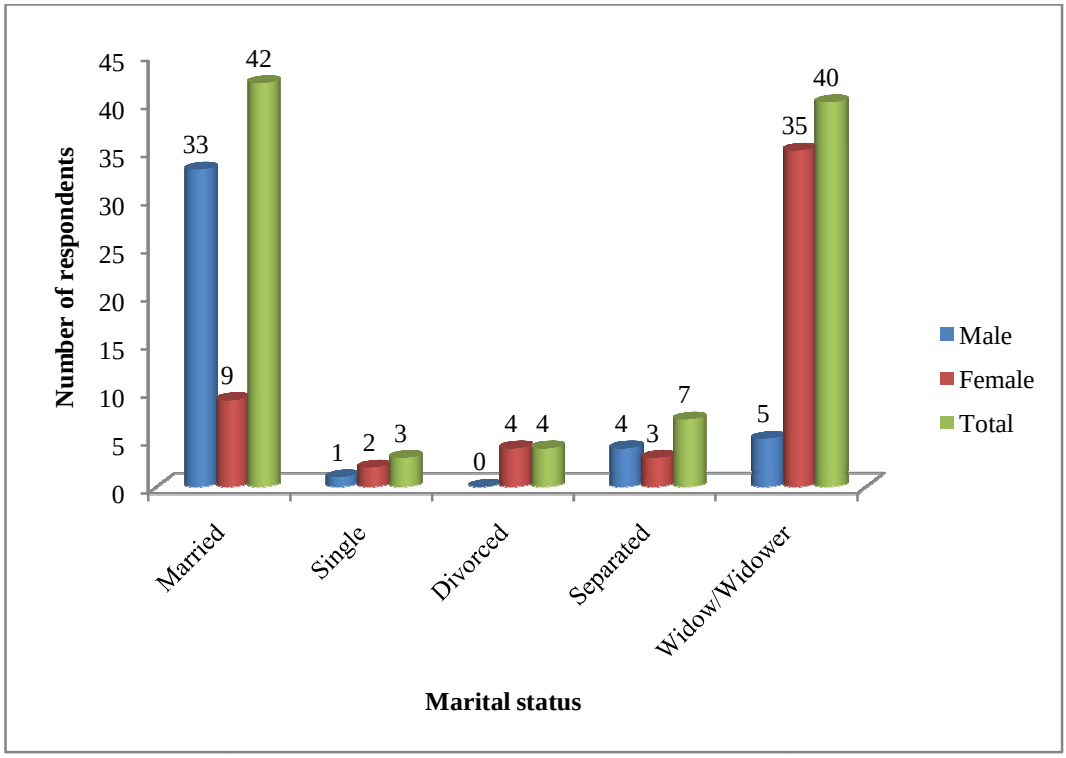


Source: Study findings (2013)

4.2.3 Marital Status of Respondents

Marital status of respondents is shown in Figure 4.3. Overall, the majority of respondents were either married (42 out of 96) or widows/widower (40 out of 96). Other categories were single (3 out of 96), divorced (4 out of 96) or separated (7 out of 96). Disaggregation of marital status by sex indicated that the majority of male elderly were married (33 out of 43) while the majority of female elderly were widows (35 out of 53). These results reveal that the majority of the elderly do not have partners/spouse as they are either widows/widowers or divorced a situation that may contribute to their social insecurity and vulnerability.

Figure 4.3: Distribution of respondents by marital status



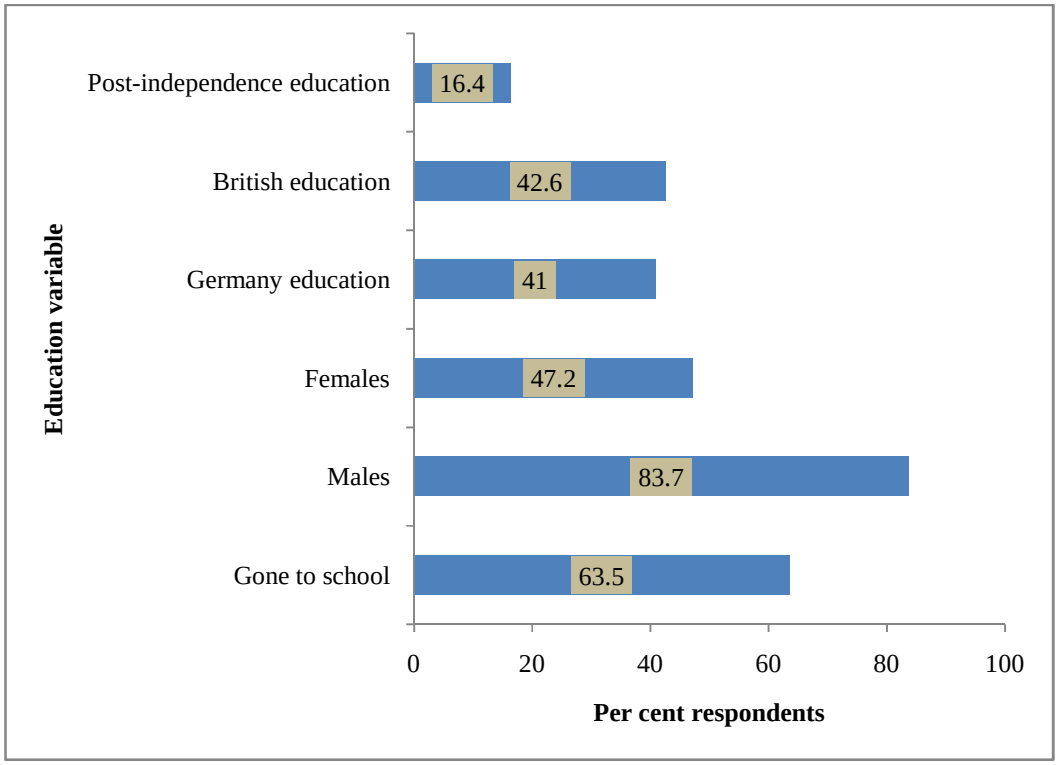
Source: Study findings (2013)

4.2.4 Education Acquired by the Respondents

Information on education possessed by the elderly who participated in this study is shown in Figure 4.4. Out of 96 respondents, 63.5% reported to had gone to school. It was noted that the majority of male respondents had gone to school (36 out of 43, 83.7%) while the majority of female respondents had not gone to school (28 out of 53, 52.8%). It was also observed that the majority of respondents had acquired either the British (42.6%) or Germany (41.0%) education while only 16.4% of the respondents had post-independence education. Distribution of respondents by the highest education attained is shown in Figure 4.5. The majority had reached primary school education which is a good level during their time as majority acquired British and Germany education.

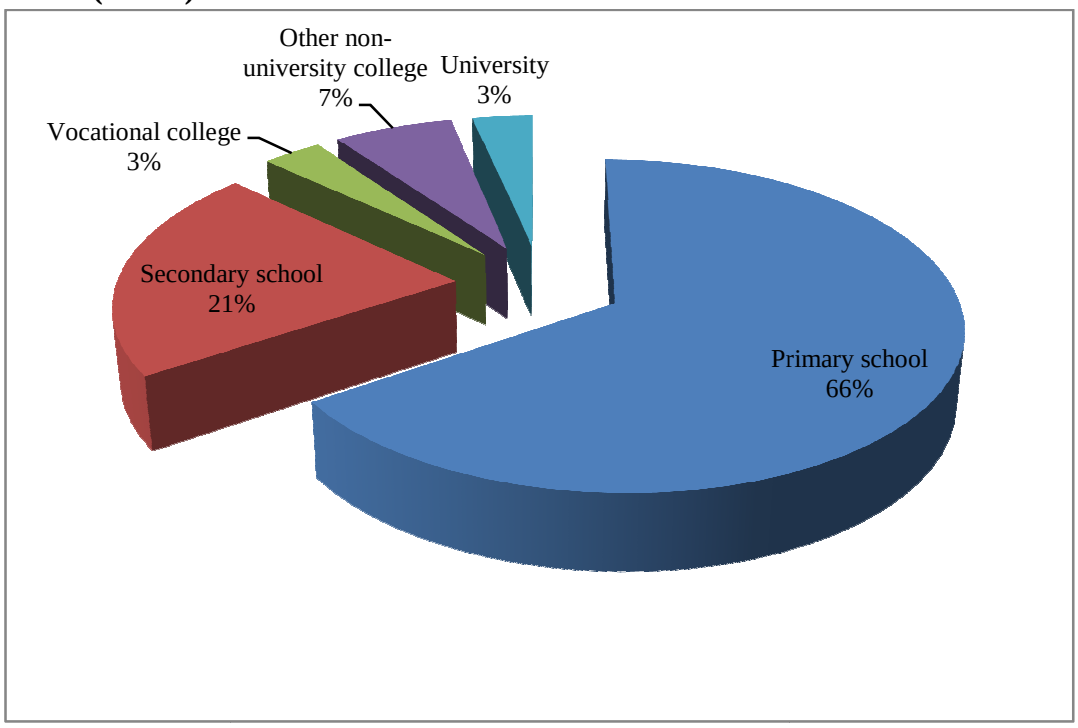
These findings indicate that more than 36% of the respondents had no formal education. This group is even more vulnerable to poverty as they could not be employed throughout their entire life time. Even those who had gone to school, most of them had attained primary school level which made them victims during retrenchment in the 1980s in Tanzania (Sawe and Maimu, 2001). Education problem was more critical in female elderly than male elderly respondents making them more vulnerable to poverty and social insecurity.

Figure 4.4: Education status of the elderly who participated in the study



Source: Study findings (2013)

Figure 4.5: Highest education level attained by respondents who had gone to school (n = 61).



Source: Study findings (2013)

4.2.5 Source of Income and Livelihood for the Elderly in Morogoro Municipality

The main sources of income and livelihoods as reported by the 96 respondents are summarized in Table 4.1 and Figure 4.6. The majority of the elderly reported to depend on support/remittances from their children and relatives (67.7%) followed by crop farming (40.6%). Other respondents reported other sources of income such as business, livestock keeping and few employees reported to depend on their salaries. Very few were depending on retirement benefits. This observation tallies with findings from other countries such as Ethiopia, Uganda and India which showed that the majority of elderly people's livelihoods depend on remittance from their children or other relatives (Erb, 2011a; Erb, 2011b, Najjumba-Mulindwa, 2013). It was also noted that few respondents were depending on begging to get their daily support.

It was found that the majority (>90%) of elderly persons interviewed were not employed. This implies that their livelihood depended on support from their children and other relatives

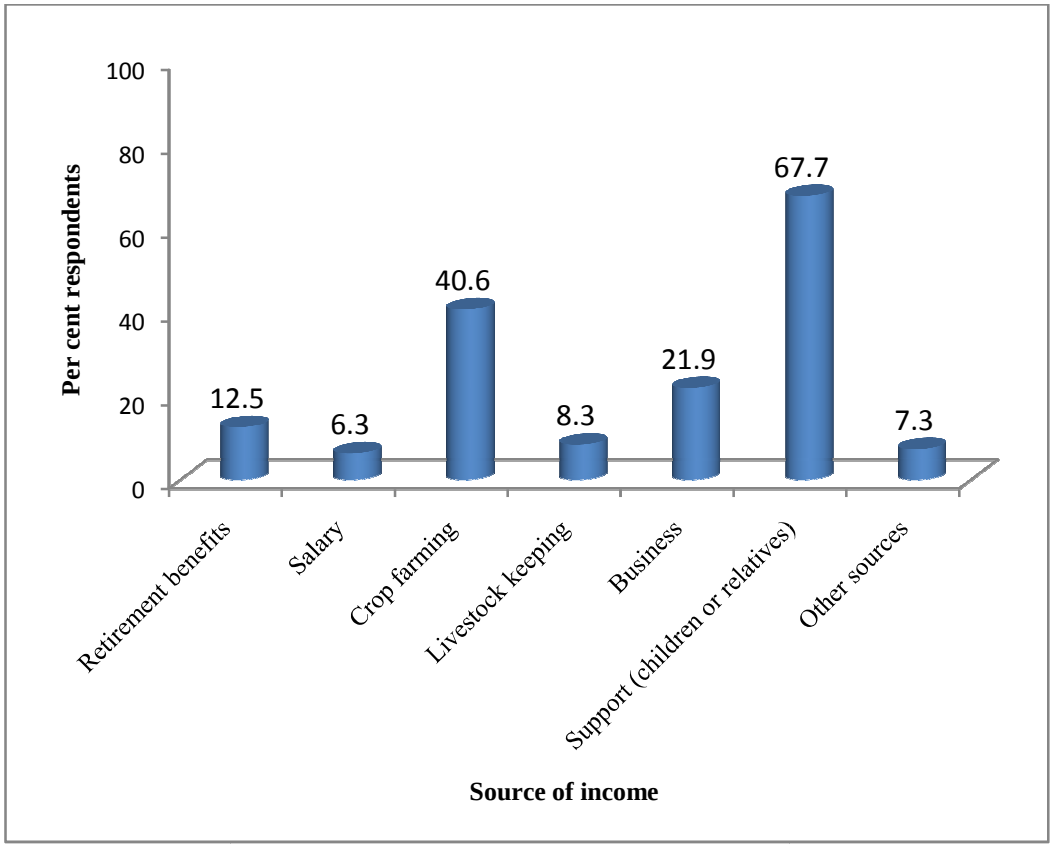
Table 4.1: Main sources of income as reported by respondents

Source of income	No. Respondents	Proportion of income from the source reported (Mean±StDev[1]) (%)	Range of proportion from the source, %
Retirement benefits	2	40.8±24.8	5-80
Salary (those in employment)	6	65.8±19.1	40-95
Crop farming	39	57.9±25.4	20-100
Livestock keeping	8	28.8±22.8	5-70
Business	21	61.4±32.0	10-100
Support (Children or relatives)	65	67.5±34.6	5-100
Other sources	7	71.1±28.7	20-100

[1]*Standard deviation is a statistical indicator of variation in the mean observed*

Source: Study findings (2013)

Figure 4.6: Main source of income for the elderly people in Morogoro (n=96)



Source: Study findings (2013)

As indicated in the Table 4.1 and Figure 4.6, the majority of elderly people interviewed were not employed as 87 out of 96 respondents reported not to be employed during the study. Of the 9 respondents who were employed, 5 were self-employed while only 1 and 3 respondents reported to be employed by the public and private sector respectively. It was also noted that 8 out of the 9 respondents of those employed were males. It is obvious that the elderly employment in all sectors is limited by their age. Further analysis was done to know if unemployed elderly during the study had ever employed at one time.

The findings indicate that majority (63.5%) were never employed during their life time. It was further observed that the majority of those who reported to had been never employed were females (43 out of 61 respondents) The distribution of those never employed by age category was 42.6% (60-70 years old), 27.9% (71-80 years old), 18.0% (81-90 years old), 6.6 % (>90 years) and 4.9% (age not known). Employability of the elderly was also a big challenge even during their working age. This low employment is attributed to lack of formal education and retrenchment of most unskilled employees during 1980s as result of implementation of the Structural Adjustment Policies (SAPs). Those who had gone to school, the majority (83%) had acquired colonial education which could not be relevant to demands and requirements for the employment. This is also supported by the observation that most of them had attained Primary school as the highest level of education which limits employment opportunities.

4.3 Access to Social Services by Elderly in Morogoro Municipality

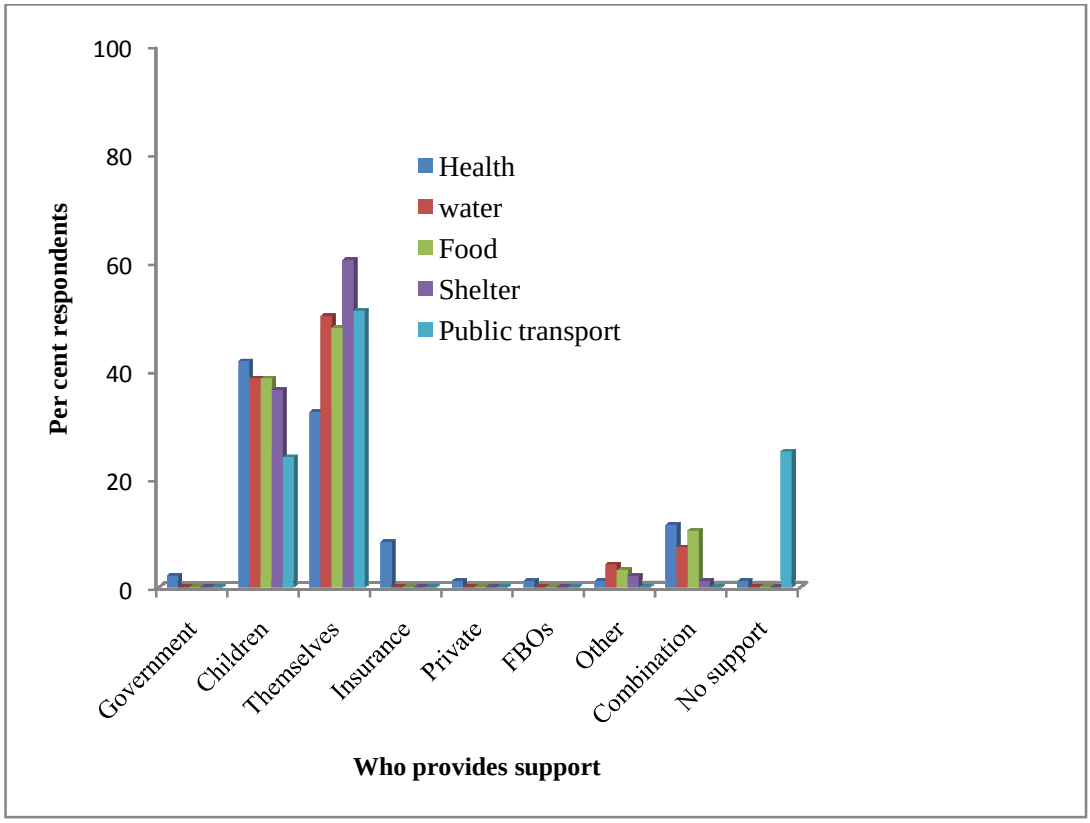
Assess to social service among elderly was generally found to be poor. Table 4.2 and Figure 4.7 summarize access and support of social services which included health, clean water, food shelter and transport. It was observed that most of the social services were supported by either elderly people themselves or their children. Other services such as counseling and sports/recreation were not available to the elderly at all. Opinions from respondents on each service are highlighted in sections 4.3.1 to 4.3.5.

Table 4.2: Distribution of actors supporting different social services to the elderly in Morogoro

Supported by	Social service, n (%)				
	Health services	Clean water	Food	Shelter	Transport
Government	2 (2.1)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Children	40 (41.7)	37 (38.5)	37 (38.5)	35 (36.5)	23 (24.0)
Themselves	31 (32.3)	48 (50.0)	46 (49.9)	58 (60.4)	49 (51.0)
Insurance	8 (8.3)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
NGOs/CBOs	1 (1.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
FBOs	1 (1.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Other	1 (1.0)	4 (4.2)	3 (3.1)	2 (2.1)	0 (0.0)
Combination	11 (11.5)	7 (7.3)	10 (10.4)	1 (1.0)	0 (0.0)
No support	1 (1.0)	0 (0.0)	0 (0.0)	0 (0.0)	24 (25.0)
Total	96 (100.0)	96 (100.0)	96 (100.0)	96 (100.0)	96 (100.0)

Source: Study findings (2013)

Figure 4.7: Provision of social services to the elderly people in Morogoro (n=96)



Source: Study findings (2013)

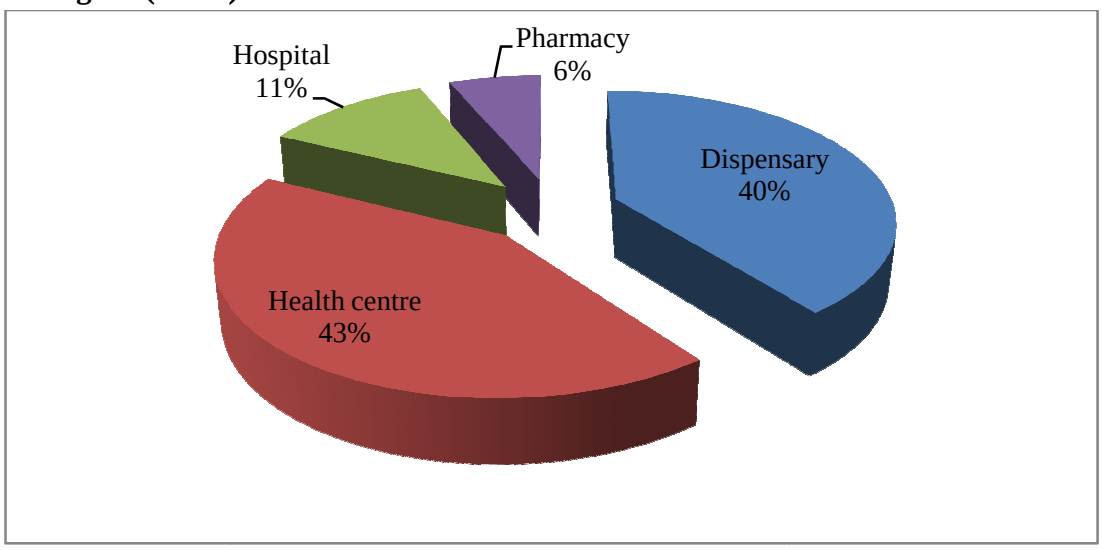
4.3.1 Health Services

Distribution of responses on where the elderly people get health services in Morogoro Municipality is shown in Figure 4.8. More than 82% of the respondents reported to get health services from either dispensaries or health centres. It was also noted that there was variation between wards with the elderly in some wards preferring to seek more health services from dispensaries (e.g. Mwembesongo and Kichangani) while others prefer to go to health centre (e.g. Chamwino and Boma) (Figure 4.9). Out of 96 respondents interviewed, 67.7% reported not to get health services when they need them and stated reasons were unavailability of services (diagnostic and medicine), financial constraints and lack of medical staff specialized in elderly

diseases/conditions (Figure 4.10). Access to health services was also observed to be a big challenge.

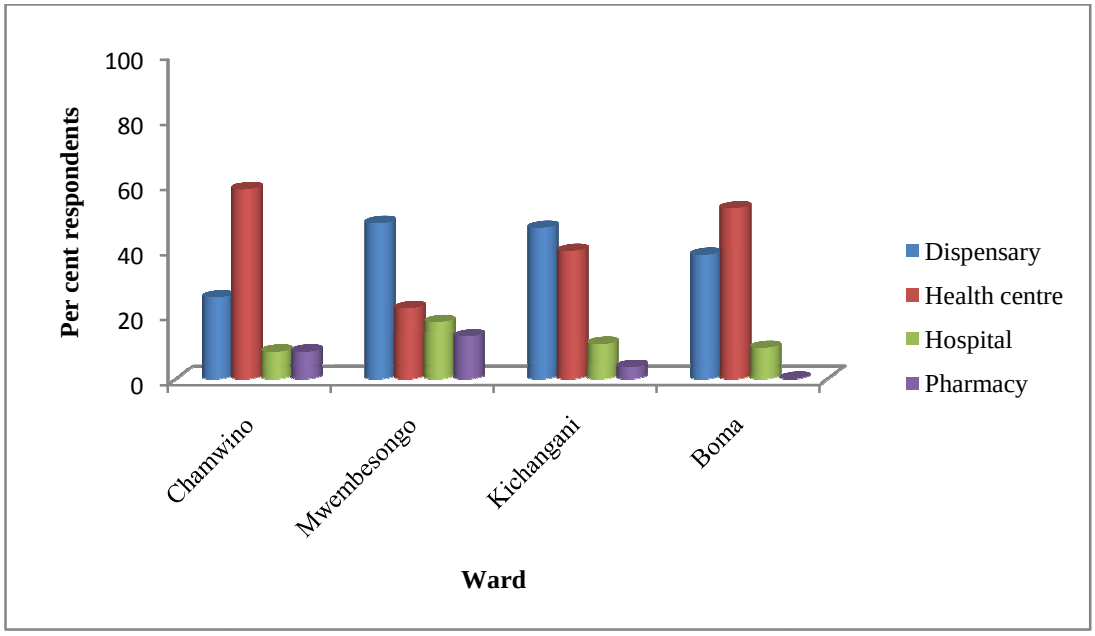
Whereas the majority of elderly go to dispensaries for health services, they also complained of lack of diagnostic facilities, medicine and specialized clinic for the elderly diseases at these facilities. Such observation indicates that most of disease conditions affecting the elderly people are not properly diagnosed and treated and consequently aggravates health problems in this age group. It was also noted that other elderly people do not go to seek for medical services as they would be asked to pay consultation fees before meeting the physician or they have no hope of getting medicine. It was also noted that most elderly resort to visiting pharmacy or essential drugs stores to buy cheap medicine such as panadol when they feel sick. Payment of fees by the elderly people is contrary to the existing National Ageing Policy of 2003 (URT, 2003a) and the National Health Policy of 2003 (URT, 2003b). Both policies recognize poor and vulnerable groups including the elderly to be exempted from user fees for health services from public health facilities.

Figure 4.8: Distribution of responses on where elderly get health services in Morogoro (n= 96)



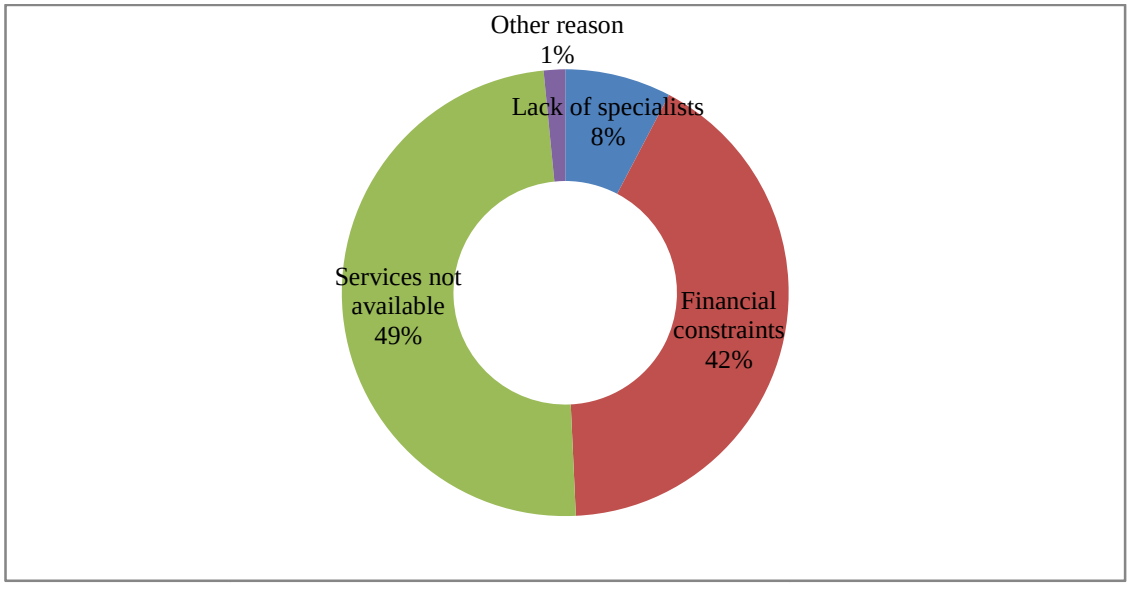
Source: study findings (2013)

Figure 4.9: Distribution of health seeking preferences by ward (n=96)



Source: Study findings (2013)

Figure 4.10: Reasons provided by respondents (n=65) for not getting health services when needed



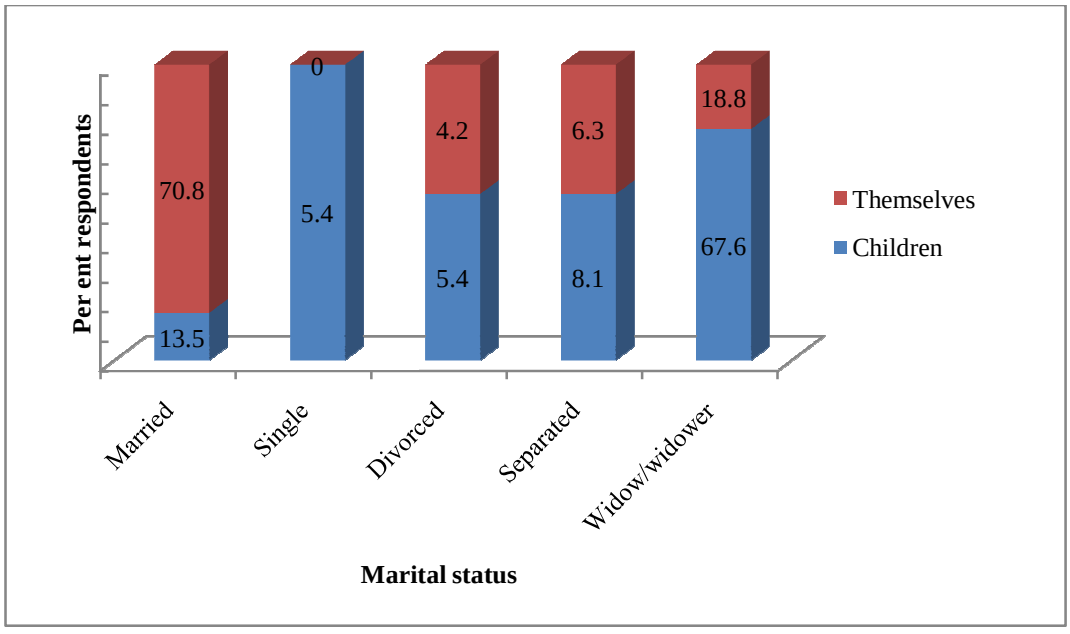
Source: Study findings (2013)

4.3.2 Clean Water Service

It was observed that the majority of respondents reported to access water service by support from either themselves (50%), by children (38.5%) or combination of the two. Very few (4.2%) reported to use other means to get access to water (Table 4.2). There was no significant difference with respect to access to water services by sex and age of respondents. It was however observed that whereas the majority of married elderly depend most on accessing water themselves (70.8%), the widows and widowers are largely supported by their children to access water (Figure 4.11).

These findings indicate that the widow and widowers are more vulnerable and for those who don't have children or relatives who can support them; their welfare is at risk as lack of clean water is likely to expose them to other health problems such as diarrhea, cholera, trachoma, scabies and other water scarcity-related conditions.

Figure 4.11: Distribution of support of access to clean water by marital status



Source: Study findings (2013)

4.3.3 Transport Service

It was found that out of the 96 elderly people interviewed, 16.7% complained not to access transport. The majority (51.0%) of respondents reported to pay for public transport themselves, the means they frequently use to move within Morogoro Municipality. It was found that very few own vehicles (5.2%), motorcycles (1.0%) or bicycles (19.8%).

These findings suggest that it may be important for the government to formulate and adopt a policy on subsidized public transport for the elderly in the country. This will encourage and support mobility of the elderly and thus assisting increased social networking and increased physical activities that are likely to reduce the risk of non-communicable diseases such as heart attack, high blood pressure, diabetes, kidney problems and other health problems associated with inactivity. Such recommendation is also supported by findings of this study where it was found that diabetes, high blood pressure and painful legs were among the leading health problems affecting elderly in Morogoro as discussed Section 4.5.2

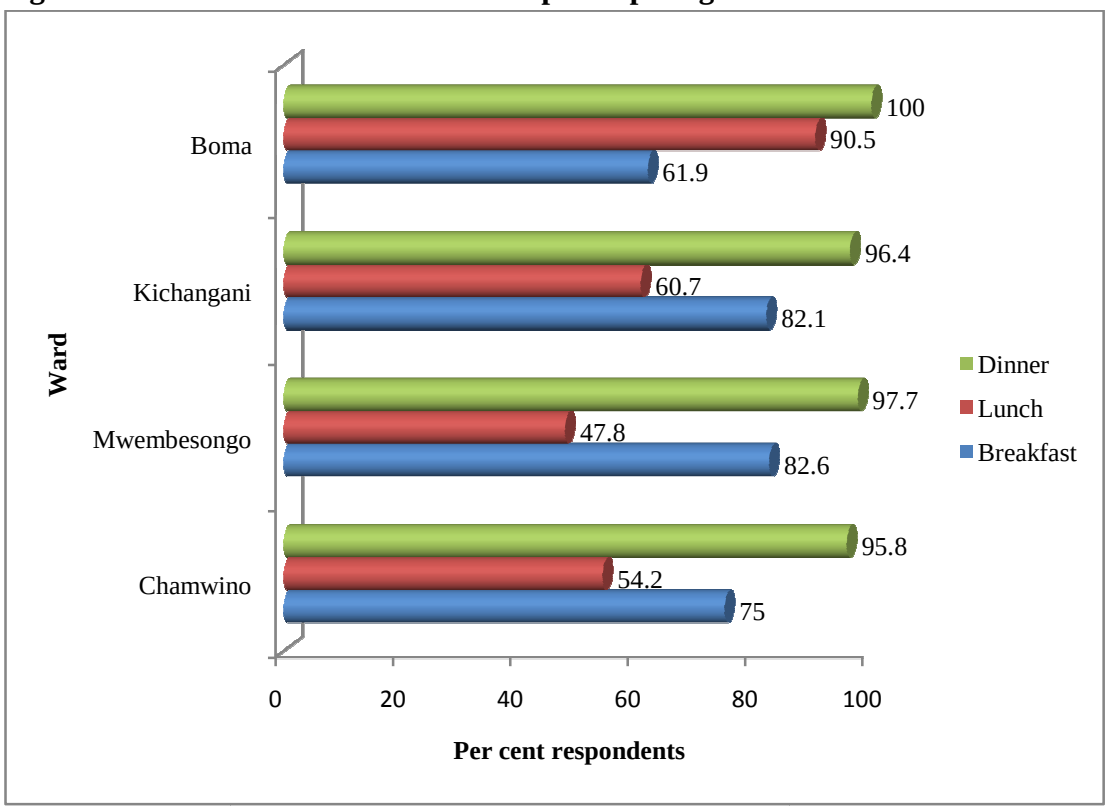
4.3.4 Food

Findings of this study indicate that there was variation in access to food as reported by the elderly. Overall, the proportion of elderly people interviewed reported to have breakfast, lunch and dinner every day was 76.0%, 62.5% and 96.9%, respectively. However, it was also noted that the situation varied according to the location. For instance, whereas good proportion of the elderly in Boma ward reported not to take breakfast in the morning, they compensate by taking lunch and dinner every day. On the other hand, the majority of respondents in Mwembesongo and Chamwino wards reported to take breakfast in the morning but almost half of them do not take lunch until late evening when they take dinner (Figure 4.12). It was observed that approximately 40% of the elderly in Morogoro Municipality do not get lunch every day. This is a coping mechanism to allow saving money in order to get at least a breakfast and a dinner on daily basis. Information obtained from FGDs on type and

quality of food eaten by the elderly shows that most of the elderly take boiled cassava with black tea as daily breakfast and in the evening they eat stiff porridge (‘*ugali*’) with salted fish, popularly known as ‘*Nguruka*’ and/or traditional vegetable relishes popularly known as ‘*mlenda*’.

This indicates that the elderly gets unbalanced diet dominated by carbohydrates with little protein and vitamins. Such unbalanced diets predispose the elderly to different health problems such as diabetes, heart problems and cancer diseases (Meydani, 2006).

Figure 4.12: Distribution of meals in the participating wards



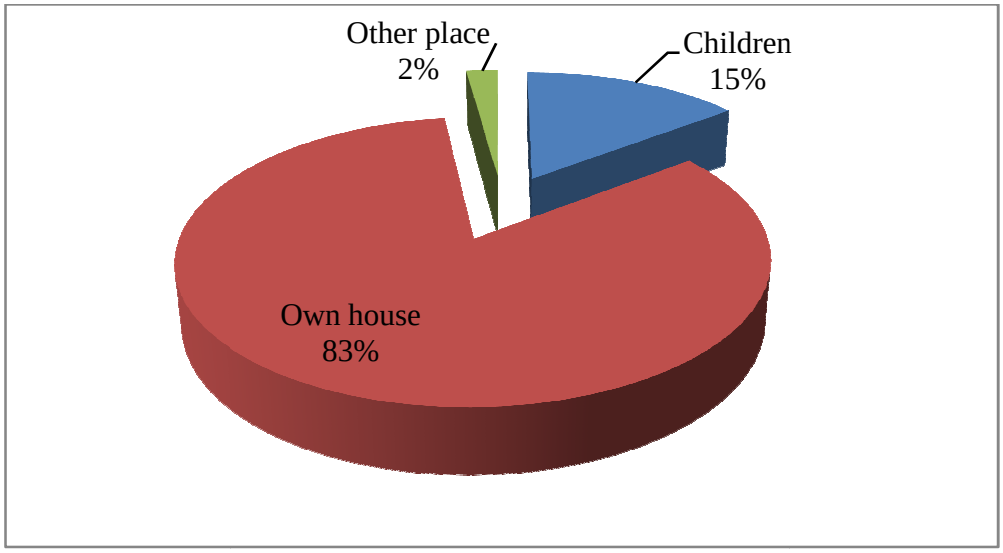
Source: Study findings (2013)

4.3.5 Shelter

Out of 96 respondents interviewed, 83.3% were staying in their own houses (Figure 4.13). Few respondents were staying at son's/daughter's house (13), other relative's house (2) or son-in law's house (1). Out of the 80 respondents who were staying in their houses, the majority were living with grand children (42.5%).

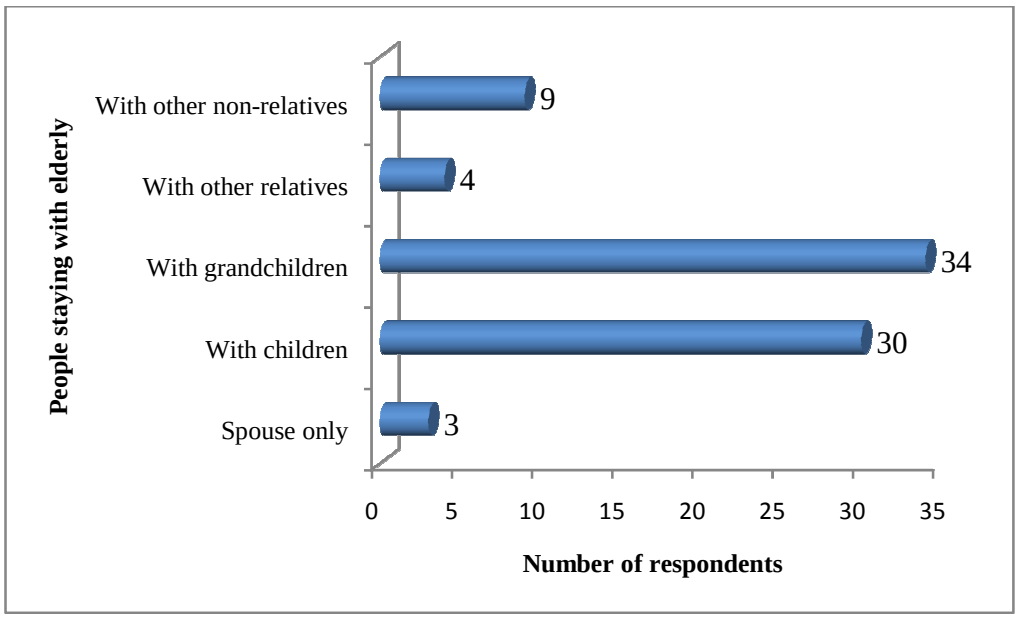
Others were also staying with their children (37.5%) or other non-relatives (5.0%) (Figure 4.14). Those who reported to stay either alone/singly (11.3%) or with their spouses (3.8%) were low in numbers. From these findings, about 80% of the elderly are staying with dependants such as children, grand children and relatives who are supported by the elderly. This implies that the little income from the elderly people has to be used to support services to the dependants such as health, education, food and transport. This finding agrees with observations in other countries such as Ethiopia, Uganda and India (Erb 2011a, 2011b; Najjumba-Mulindwa, 2013). It was further noted that most of houses were located in un-surveyed areas (squatter areas) and were in bad condition roofed mainly with old metal sheets (Figure 4.15 &4.16). In this respect, it difficult to use the houses as collaterals to access loan facilities by the elderly people in Morogoro Municipality aggravating the problem of insecurity and vulnerability to poverty.

Figure 4.13: Shelter of the elderly people in Morogoro Municipality (n = 96)



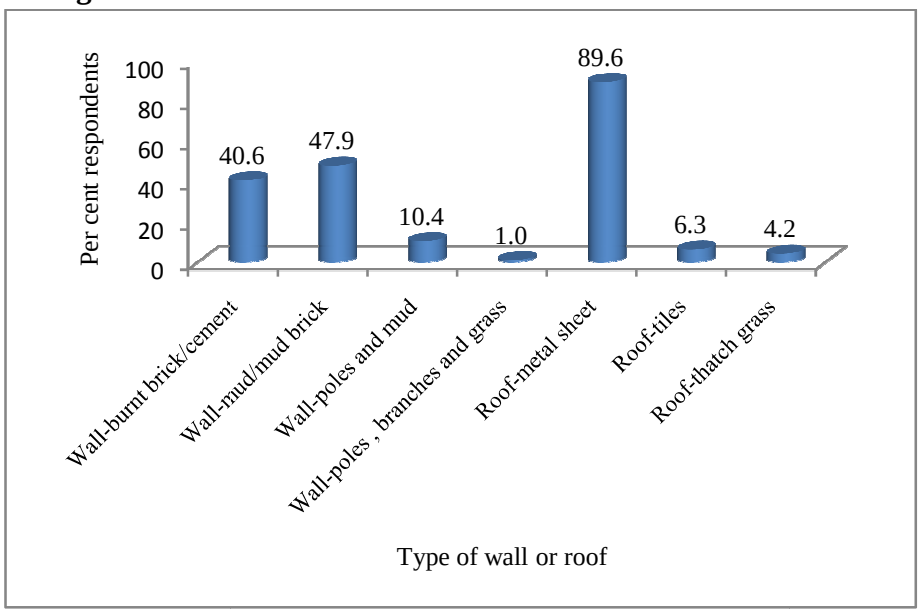
Source: Study findings (2013)

Figure 4.14: Different people staying with elderly people (n=80)



Source: Study findings (2013)

Figure 4.15: Materials used to make walls and roofs of the elderly people in Morogoro



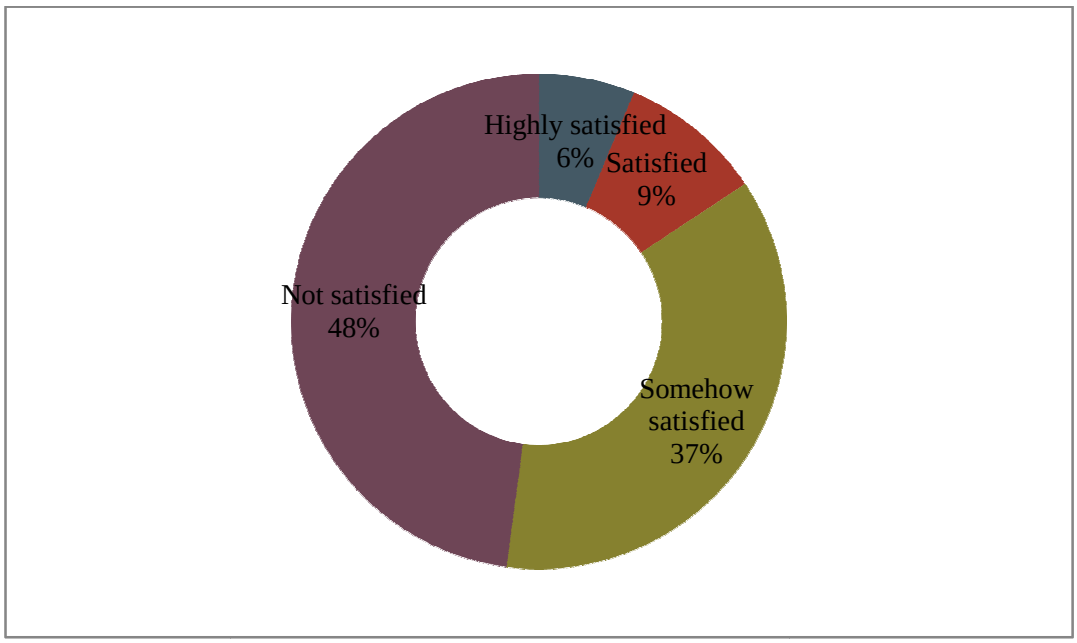
Source: Study findings (2013)

Figure 4.16: An example of a house owned by the elderly in Morogoro Municipality in un-surveyed area

Source: Study findings (2013)

Assessment of level of satisfaction with respect to provision of social services in Morogoro Municipality was poor (Figure 4.17). Only 15% of the respondents reported to be either highly satisfied or satisfied with the services. On the other hand, 37% and 48% of the respondents were moderately and not satisfied with the social services, respectively.

Figure 4.17: Perception of the elderly with respect to satisfaction on provision of social services



Source: Study findings (2013)

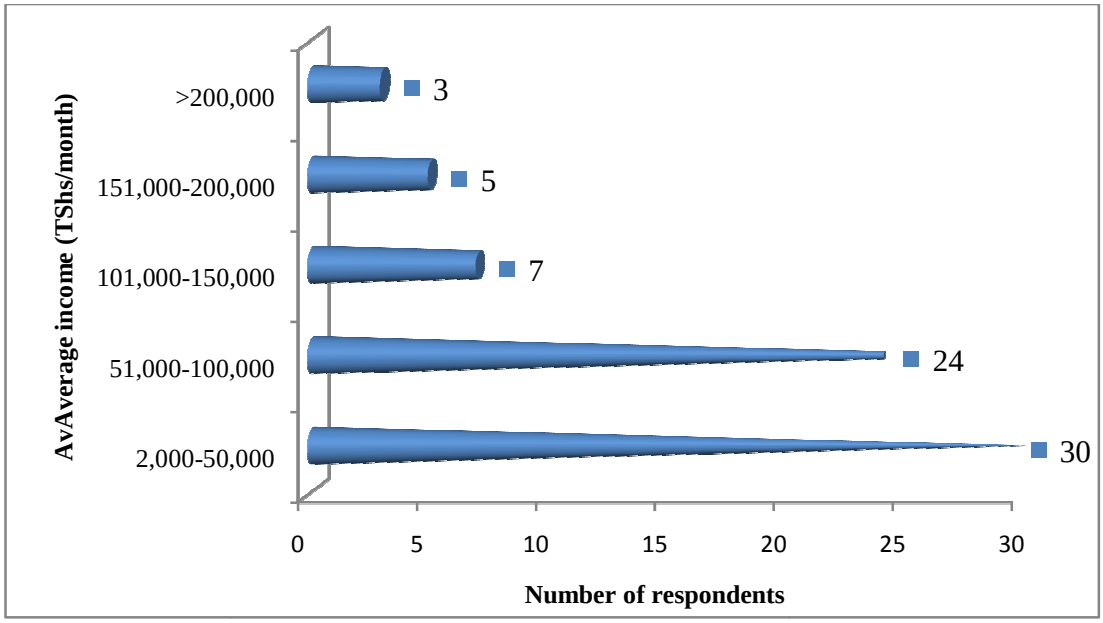
4.4 Poverty Levels among the Elderly People in Morogoro

4.4.1 Monthly Income and Expenditure of the Elderly People

Out of 96 respondents interviewed, 69 (71.9%) were willing to disclose average amount of money they obtain as income per month. Most of those who were unwilling to mention monthly income were entirely supported by children or relatives thus unable to estimate their income. It was noted that the average income was TShs 83,463.77 ±67,343.97 (range= 5,000/= to 350,000/=) per month. However, it was also

observed that the majority of respondents had income below TShs 50,000/= per month (Figure 4.18). Using the Exchange rate of 1 USD=TShs 1,600/=, all respondents who earned less than TShs 50,000/= per month (i.e. approximately 44%) were poor based on monetary indicator of 1 USD per day. When these respondents are combined with those who were unable to estimate income, the proportion of those living below poverty line of 1 USD per day increased from 44% to 59.4% (i.e. 57 out of 96 elderly interviewed in Morogoro Municipality). Estimation of the magnitude of poverty among the elderly indicated that 59.4% of the respondents lived below poverty line based on income of less than 1 USD per day. Such findings are better than what had been reported recently as an overall proportion of 96% in the country (The Citizen, 12 June 2013). This difference could be explained by the fact that this study was carried out in urban area while the majority of Tanzanian population, including elderly people live in rural areas where poverty is worse than in urban areas.

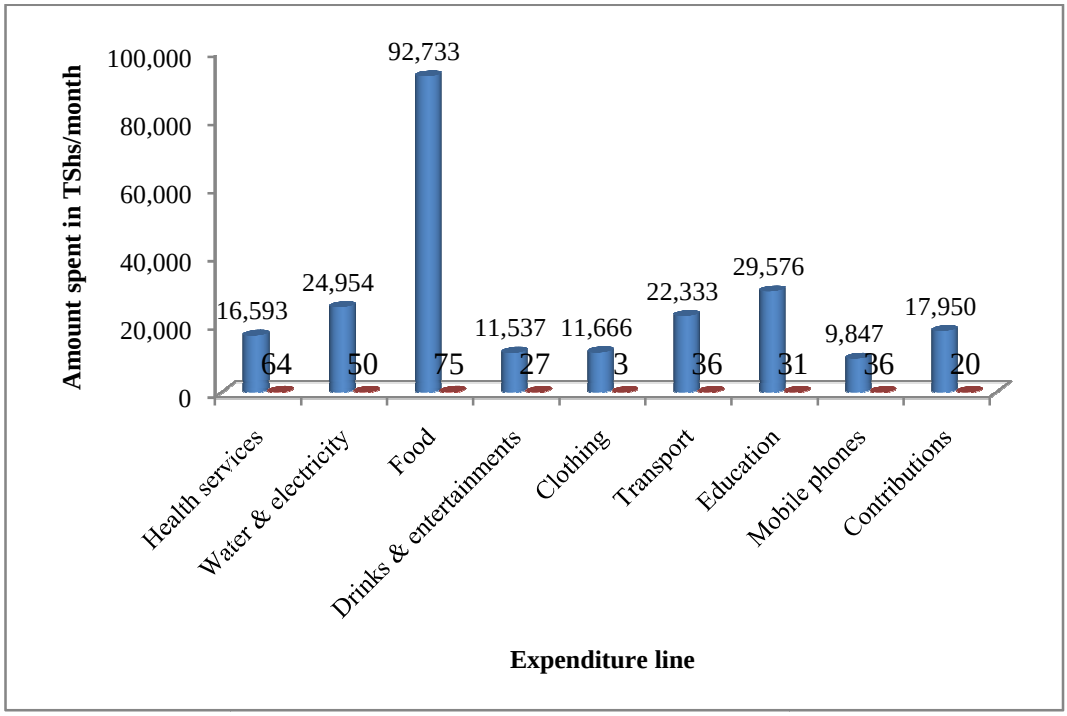
Figure 4.18: Average monthly income in Morogoro Municipality (n=69)



Source: Study findings (2013)

Out of 96 respondents interviewed, 76 (79.2%) respondents provided information on amount of money spent per month per household. The average expenditure was TShs 167,565 per month (Range= 15,000/= to 700,000/=). The expenditure profile of the elderly people in Morogoro is summarized in Figure 4.19. The majority of respondents reported to spend their money on food (n=75), education (n=69), health services (n=64) as well as water and electricity bills (n=50). The highest amount spent per month was on food followed by education and water& electricity bills.

Figure 4.19: Expenditure profiles as reported by the elderly in Morogoro



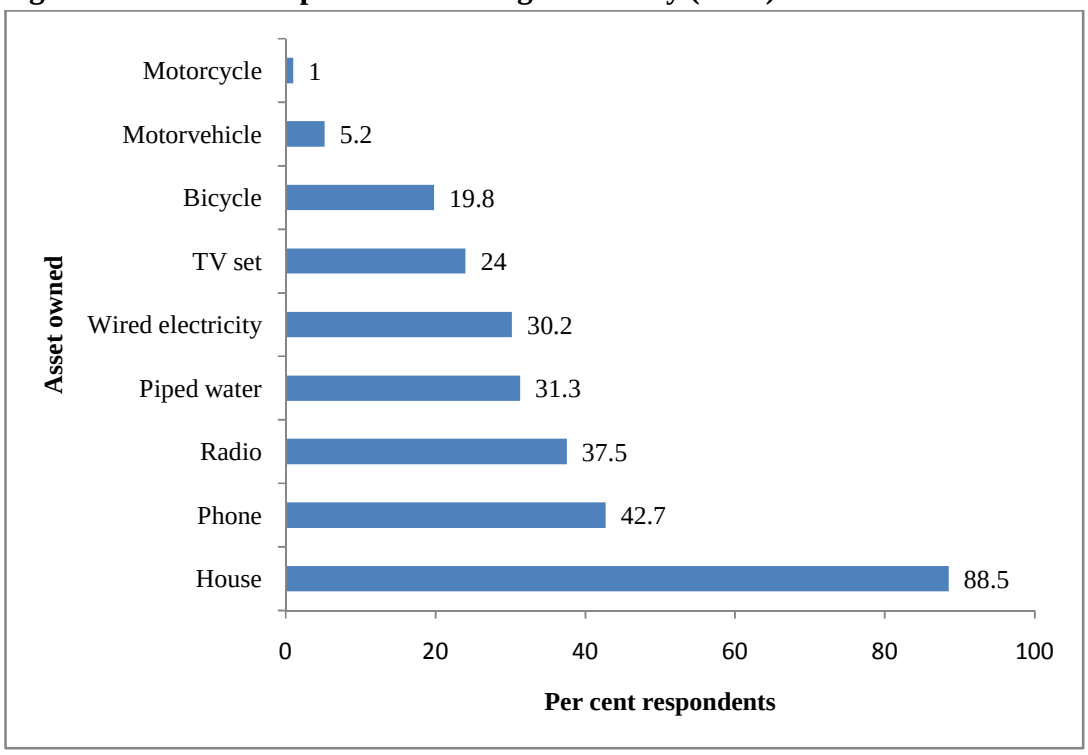
Source: Study findings (2013)

4.4.2 Ownership of Assets

It was observed that the majority of respondents (85 out of 96) own their own houses. However only 31.3% and 30.2% of the respondents had piped water and wired

electricity in their houses (Figure 4.20). Moderate number of the respondents reported also to access news by watching TV (24.0%) or listening to radio (37.5%).

Figure 4.20: Ownership of assets among the elderly (n=96) interviewed



Source: Study findings (2013)

Findings in this study show that not only that the elderly have limited sources of income but also face difficulties in respect to asset ownership. Except for the ownership of house which was possessed by more than 80% of respondents, the majority of the elderly had no valuable assets such as motor vehicles, motorcycles, TV set, bicycles, sewing machines or even livestock. Again this shows their low purchasing power as indicated by the average monthly income. Despite the low earning, the majority of the elderly in Morogoro Municipality have additional responsibilities such as taking care of grandparents, children and other non-relative

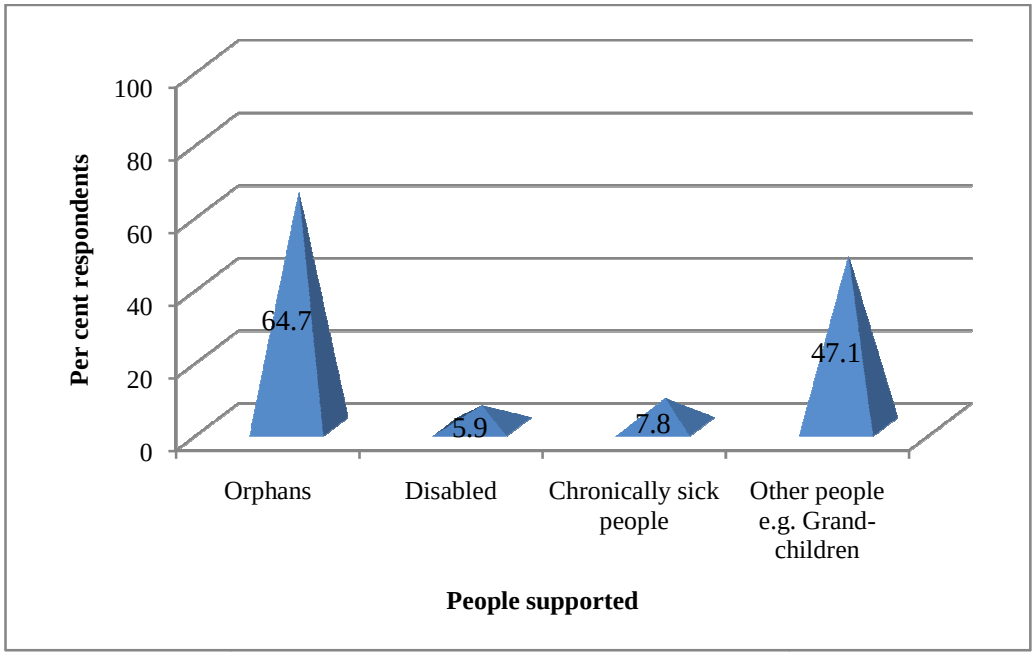
persons. Obviously, such added responsibilities force them to spend most of their monthly income to essential needs such as supporting purchase of food or sending the dependants to schools to get education.

4.5 Factors Contributing to Increased Insecurity and Vulnerability of the Elderly to Poverty

4.5.1 Responsibilities of the Elderly to Dependents

Out of 96 respondents interviewed, 53.1% reported to have other responsibilities through supporting other people. Of the 51 respondents reported to support other people, most of those supported were orphans (64.7%) or grand children and/or sisters or brothers (other people) (47.1%) as shown in Figure 4.21. A few number of the respondents also reported to support chronically sick (e.g. HIV/AIDS victims) or disabled persons.

Figure 4.21: People supported by the elderly persons in Morogoro



Source: Study findings (2013)

Regarding the type of support the elderly provide to orphans and disabled, respondents mentioned to support food, health services and sometimes education. Chronically sick people are supported with food and health services.

4.5.2 Suffering from Chronic Diseases

It was observed that out of 96 respondents interviewed, 69.8% reported to be suffering from chronic diseases (Table 4.3). The most commonly reported problems were high Blood Pressure, painful legs, diabetes and eye problems. A few proportions of respondents reported other health problems such as asthma, kidney and heart problems, prostate gland cancer, leprosy and abdominal swelling.

Table 4.3: Chronic diseases/conditions prevalent in elderly people in Morogoro

Variable	Category	Number	Per cent
Has chronic disease/condition (n=96)	Yes	67	69.8
	No	29	30.2
Type of problem (n=67)	Diabetes	12	17.9
	High Blood Pressure	21	31.3
	Blindness	1	1.5
	Deafness	2	3.0
	Painful legs	16	23.9
	Eye problems	11	16.4
	Other problems	4	6.0

Source: Study findings (2013)

These findings imply that vulnerability of the elderly people in Morogoro Municipality is increased by the high prevalence of chronic diseases. Such diseases contribute significantly to draining even the little money they have on purchasing medicine. On the other hand, the elderly are out of action with respect to participation in other income generating activities. This is supported by findings of this study that

only a limited proportion of respondents were engaged in other income generating activities which would have provided opportunities of earning more income from informal employment.

4.5.3 Lack of Preparation of Retirees and Access to Retirement Benefits

It was found that only 9% of the 96 respondents were in either formal or informal employment during the study. Out of 96 respondents, 27% were retirees.

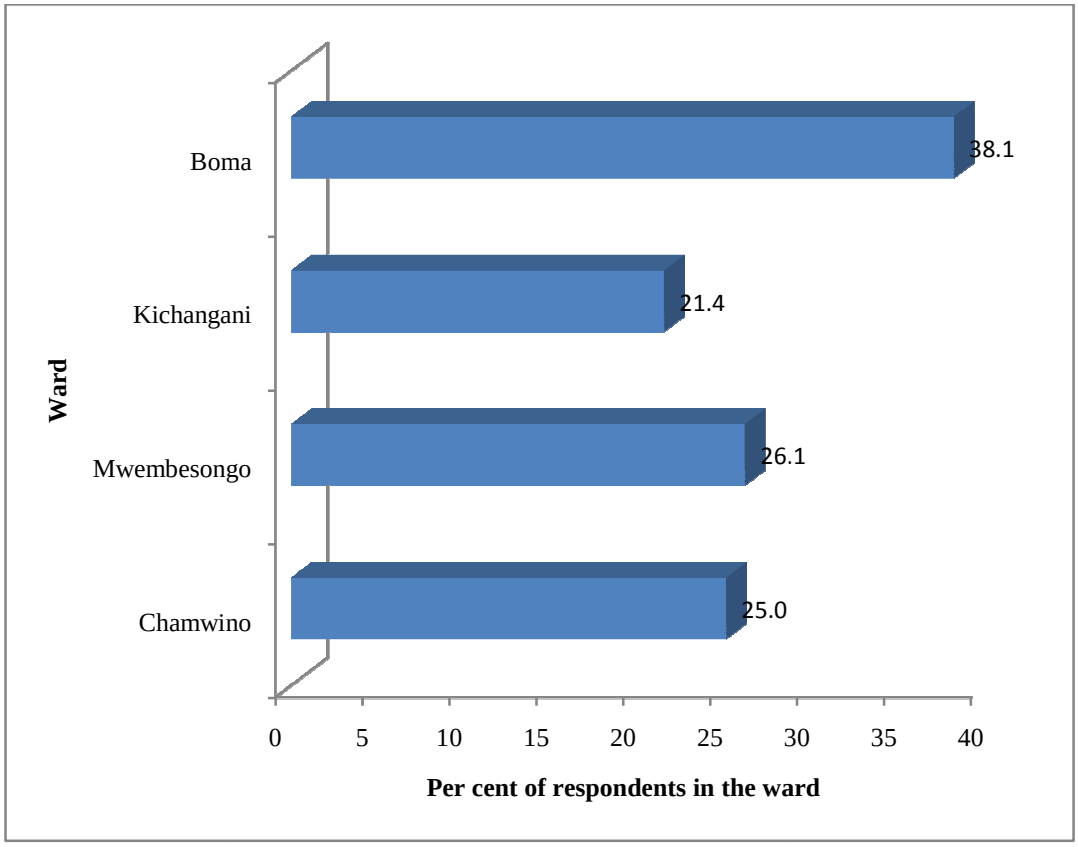
The trend of retirement by calendar year is shown in Figure 4.22. The average number of years after retirement was reported to be 13.6±8.9 with a range of 4 to 36 years after retirement.

Figure 4.22: Distribution of retirees by year of retirement

Source: Study findings (2013)

It was noted that approximately 38.5% of the retirees were retired during 1995-1998 period and a relatively higher number of retired people resided in Boma ward compared to other wards (Figure 4.23). It was also noted that only 8 (30.8%) of retirees had prepared before retirement.

Figure 4.23: Distribution of retirees by ward of residence



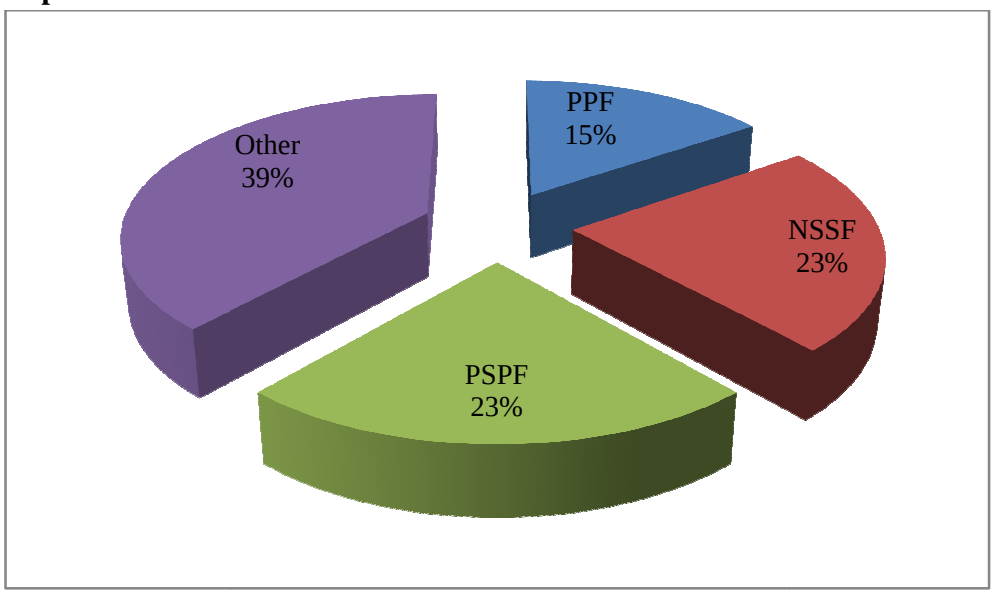
Source: Study findings (2013)

Different Social Security funds were reported to be sources of retirement benefits (Figure 4.24). Out of 26 elderly who reported to had been retired, only 13 of them reported to get retirement benefits. It was observed that some respondents were not aware of exact information on source of retirement benefit. For instance, some reported to get their benefits from Government Treasury. The average amount received per month was approximately 120,000/=. Detailed findings on vulnerability factors of the retired elderly are shown in Table 4.4. Findings from this study suggest that elderly in Morogoro Municipality rarely depend on retirement benefits.

The situation is aggravated by inability to access to loan facilities from most financial institutions operating in Morogoro Municipality as also highlighted in section 4.5.4.

The little amount paid to the retirees (approximately TShs 120,000/= per month) is not enough to support them together with other dependants. As a result, the retirees are forced to find alternative sources of income or support from children and relatives as it has also been found in this study. It was also found that retirement benefits were provided to employees who reach 60 years of age. There is a need to address this situation by provision of pension to all people who reach 60 years of age as this has proved to be beneficial in other countries (Case and Menendez, 2007).

Figure 4.24: Distribution of sources of retirement benefits as reported by 13 respondents



Source: Study findings (2013)

Table 4.4: Factors contributing to vulnerability of the retired elderly in Morogoro

Factor	Level	No.	Per cent
1. Retiree gets benefits (n=26)	Yes	13	50.0
	No	13	50.0
2. Source of benefits (n=13)	PPF	2	15.4
	NSSF	3	23.1
	PSPF	3	23.2
	Other	5	38.5
3. Amount received per month (n=12*)	(mean±StDev)	119,333.3±48,165.12	NA
	Range	50,000-220,000	NA
4. Engaged in informal income generating activities	Yes	15	57.7
	No	11	42.3
5. Prepared before retirement (n=26)	Yes	8	30.8
	No	18	69.2
6. Sex of retiree (n=26)	Female	9	34.6
	Male	17	64.4
7. Marital status	Married	18	69.2
	Widow/widower	8	30.8

*One respondent was removed from analysis as his benefit was outlying observation (i.e. 700,000 per month)

Source: Study findings (2013)

4.5.4 Inability to Access Loans from Financial Institutions

It was also observed that only 10 out of 96 (10.4%) respondents had ever accessed loans from various financial institutions in Morogoro.

Sources of loans to the elderly were reported to be Village Community Banking (VICOBA), individuals, banks or elderly associations such as MOREPEO. Possible factors that contribute to inability of the elderly to access loans include lack of collaterals such as assets and poor houses. Other reasons include lack of awareness on opportunities and importance of accessing loan facilities to improve economic status of the elderly in Morogoro Municipality.

4.6 Institutional Support of the Elderly in Morogoro Municipality

As it was noted in to a large extent (83.0%), the social services support to elderly is provided by their children or themselves. Analysis of the policy documents found that the National Ageing Policy limits the role of the central government to mobilization and sensitization of families to care and support older people (URT, 2003a; URT, 2007). The policy delegates responsibility of supporting the elderly to the local governments which in most cases are not financially strong to support multitude of responsibilities to the community. The policy also recognizes the role of voluntary non-governmental institutions to support and take care of the older people who have no one to care for. However the study findings from interview with individual elderly show low support from local government and NGOs.

4.6.1 Support from Central and Local Governments

Although it was found that the Morogoro Municipal Council has established desks responsible for the elderly people matters within two departments of Health and Community Development, the local government faces challenges in implementation of support of the elderly people in the municipality due to inadequate financial resources. The department of Health has at least dedicated a special room to attend elderly at Sabasaba Health centre.

The special room is meant to attend the elderly health problems as fast as possible by avoiding them to queue for long time. However, this is the only health facility for the entire municipal area and there are no specialists to deal with health problems of the elderly people. It was also found that the department of Community Development

supported one group of the elderly people residing in Boma ward. The group was given a total of TShs Nine Million (9,000,000/=) through Tanzania Social Action Fund (TASAF) in 2008 to support agriculture. The Community Development department had also a supported 3 elderly people to attend Commemoration of the Elderly Day on 1st October 2011 in Mtwara region.

4.6.2 Support from Non-Governmental Organizations

It was observed that only one NGO called Morogoro Elderly People Organization (MOREPEO) exists in Morogoro Municipality to support the elderly people. This organization was established by retired teachers in 1997. The roles of MOREPEO are: to advocate the rights and entitlement of elderly from '*mtaa* ' level to national level, to educate the public and leaders on entitlement and rights of the elderly, and to create awareness of the public on provision of services needed by the elderly to improve their social security. With respect to these roles, the following achievements were observed:

i) Establishment of the in-trust scheme where elderly are provided with goats and poultry.
ii) Provision of loans to the elderly without interests
iii) Supporting dependants under the care of the elderly people in Morogoro Municipality.
iv) Paid Community Health Fund (TIKA) to the elderly people who live with orphans in order to support the orphans to access free health services in Morogoro Municipality
v) Provision of mosquito nets to the elderly people in Morogoro Municipality

The main challenges faced by MOREPEO include lack of the reliable financial resources as the main sources of funds for MOREPEO is through mobilization of resources through writing projects submitted to different donors such as the Help Age International and Cordaid. In most cases, once the projects are completed, support of the MOREPEO also ceases.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

This chapter presents summary of key findings of the study together with the issues that could be taken up by policy makers. Implications and recommendations of this study are also highlighted.

5.1 Conclusions

Based on study findings, it can be concluded that:

The elderly people have limited or no access to basic needs and other social services such as food, health services, clean water, transport as well as recreational and counseling services.

The majority of the elderly people in Morogoro Municipality are poor based on both monetary and non-monetary indicators of poverty as more than 40 % of elderly were living below poverty line. The poverty was higher among women elderly than men and it was increasing with age.

Some factors contributing to social insecurity and vulnerability of the elderly people are: increased responsibilities to the dependants, suffering from chronic diseases and lack of preparations before retirement as well as access to retirement benefits. It has been found that most of the elderly (64.7%) support other dependants such as the orphans, grand children or sisters and brothers. The study has also indicated that there is high prevalence of chronic diseases among the elderly such as Blood Pressure and diabetes. It is apparently that the presence of chronic diseases among elderly and the burden of supporting other dependants exacerbate the problem social insecurity and vulnerability of the elderly people in Morogoro Municipality.

The study found that retired people rarely depend on retirement benefits and most of them have no preparations before retirement, the factor that aggravates the problem of insecurity and vulnerability. They have no access to loan facilities from most

financial institutions operating in Morogoro Municipality as they do not have assets that can be used as collateral. Although the majority of the elderly people in Morogoro Municipality own houses, the houses are of poor quality and low value which cannot be used as collaterals to get loans from various financial and microfinance institutions.

The findings have shown that the social services support from government and private institutions to elderly is still low as most of them depend on their children and themselves. Although Tanzania formulated and adopted the National Ageing Policy in 2003, there have been neither laws nor regulations to guide provision of social services to the elderly people. In this situation the policy can neither implemented nor attain the targets of supporting the elderly.

5.2 Recommendations

In the light of the above conclusions, the following recommendations can be made in order to reduce the elderly social insecurity and vulnerability to poverty:

5.2.1 Policy Recommendations

There is an urgent need to operationalize the National Ageing Policy of 2003 by the government through enacting laws and by-laws as well as regulations that should guide provision of social services to the elderly people. The policy should consider introduction of Universal Pension to all the elderly above 60 ages which should be used to support them rather than over-dependency on children and relatives.

It has been found that the prevalence of poverty among the elderly people in Morogoro Municipality is high and women elderly are mostly affected. Special programmes and strategies should be implemented through Public-Private Partnership in order to address poverty among elderly people by taking into account the gender and age differences. Special support or soft loan window should be established for elderly accompanied with special entrepreneurial training to the elderly that covers information on MFIs, banks and market accessibility.

Since the social services support from the government and private institutions is very low, special public and private initiatives should be encouraged to support the elderly to reduce insecurity and vulnerability they face. The Government and Non-Governmental institutions should consider improving access to social services to elderly by providing the services freely or under reduced cost. These institutions need to support elderly in relation to care of orphans and most vulnerable children. For example, provision of free public health by the institutions so as to support the elderly who caring the orphans.

5.2.2 Area for Further Research

Although the study has come up with promising results on access to social services and factors contributing to social insecurity and vulnerability among elderly among Morogoro Municipality, it was not able to collect much quantitative data to carry out rigorous analysis in order to establish the effect of contribution of each factor quantitatively. The study findings and conclusions are also limited to urban settings as it covered only Morogoro Municipality. Hence, this study recommends further study that can increase sample size from both urban and rural areas in order to capture the differences across the urban and rural areas. The study should collect more quantitative information that can measure the accessibility of social services and factors that contribute to elderly social insecurity and vulnerability to poverty.

There is also a need to establish how different groups of elderly are socially insecure and vulnerable across different age categories in order to have comprehensive and realistic policy for different groups. This can be achieved by using panel data.

REFERENCES

Adger, W.N. and Winkels, A. (2007) *Vulnerability, poverty and sustaining well-being*. In: Handbook of Sustainable Development. Elgar, Cheltenham, pp. 189-204.

Alcock, P. (1997). Understanding poverty. Second edition. Macmillan Press Limited. London.

Allen, T. and Thomas, A. (2000), Poverty and Development into the 21st century, Oxford, London.

Aysan, Y.F. (1993). Keynote paper: Vulnerability Assessment. In: P. Merriman and C. Browil (Eds). Natural Disasters Protecting Vulnerable Communities. pp 1-14.

Case, A. and Menendez, A. (2007). Does money empower the elderly? Evidence from the Agincourt demographic surveillance site, South Africa. *Scandinavian Journal of Public Health.* **35:** 157. DOI: 10.1080/14034950701355445.

Chambers, R. (1983). Poor relative speaking, Oxford Economic Papers, New series 35(2).

Daniels, L. (2011). Measuring poverty trends in Uganda with non-monetary indicators. A paper presented at the Fourth Global Conference on Agricultural and Rural Household Statistics. Wye City Group, 9-11 November 2011, Rio de Janeiro, Brazil. Retrieved from http://typo3.fao.org/fileadmin/templates/ess/pages/rural/wye_city_group/2011/documents/session3/Daniels_-_Paper.pdf

Dey, I. (1993). *Qualitative data analysis: A user friendly guide for social scientists*. Routledge Taylor & Francis Group.

Dwyer, A., Zoppou, C., Nielsen, O., Day, S., and Roberts, S. (2004). *Quantifying social vulnerability: A methodology for identifying those at risk to natural hazards. Commonwealth of Australia*. Canberra City.

EC, The Electoral Commission, 2005. Social exclusion and political engagement, Research Report (unpublished). Retrieved from http://www.electoralcommission.org.uk/__data/assets/pdf_file/0007/63835/Social-exclusion-and-political-engagement.pdf

Erb, S. (2011a). A study of older people's livelihoods in Ethiopia. Help Age International and Cordaid. Unpublished report.

Erb, S. (2011b). A study of older people's livelihoods in India. Help Age International and Cordaid. Unpublished report

Herrin, A. N. (1997). Designing Poverty Monitoring Systems for MIMAP. Paper presented at the Second Annual Meeting of MIMAP, 1997, May 5-7, IDRC, Ottawa

Heslop, A. and Gorman, M. (2000). Chronic poverty and older people in the developing world. HelpAge International. CPRC Working Paper No. 10.

Hulme, D. and Toye, J. (2006). The Case for Cross Disciplinary Social Science Research on Poverty, Inequality and the Quality of Life. *Journal of Development Studies*, 42(7), pp. 1085-1107.

Kilminister, A. (2008). The economic crisis and its effects. International Viewpoint. Retrieved from http://internationalviewpoint.org/spip.php?article1581.

Lloyd-Sherlock (2000) Old age and Poverty in Developing Countries: New Policy Challenges.

Lunogelo, H.B., Mbilinyi, A. and Hangi, M. (2009). The global financial crisis and Tanzania: Effects and policy responses.

MaliyaMkono T.L, and Mason H, (2006), The Promise, TEMA Publisher, Company DSM.

Meydani, M. (2006). Nutrition Interventions in Aging and Age-Associated Disease. *Annals of the New York Academy of Sciences.* 928(1). DOI: 10.1111/j.1749-6632.2001.tb05652.x

Mlambiti, M. E. (1982). *Agricultural sector analysis for Kilimanjaro region: A basis of decision making and planning*. Thesis for Award of PhD Degree at University of Dar Es Salaam, Tanzania 421pp

MMC, Morogoro Municipal Council (2011). Municipal Annual Report. Morogoro.

MMC, Morogoro Municipal Council (2012). Morogoro Municipal Council website. Retrieved from http://www.morogoromc.go.tz/about_us/location.php

MOREPEO, Morogoro Elderly' People Organization (2012). Strategic plan to 2020. Retrieved from http://envaya.org/morepeotz/news.

Msuya, S.E.; Mbizvo, E.; , Hussain, A.; Uriyo, J.; Sam, N.E. and Stray-Pedersen, B. (2006). HIV among pregnant women in Moshi Tanzania: the role of sexual behavior, male partner characteristics and sexually transmitted infections. *AIDS Research and Therapy.* 3:27.

Najjumba-Mulindwa, I. (2013). Chronic poverty among the elderly in Uganda: perceptions, experiences and policy issues. Makere Univerty, available at http://cprc.abrc.co.uk/pubfiles/Mulwinda.pdf

NBS, (2007).Household Budget Survey 2007. Retrieved from http://nbs.go.tz/tnada/index.php/catalog/2.

REPOA (2005). *Researching Poverty in Tanzania, Problems, Policies and Perspectives*. Mkuki na Nyota Publishers, Dar Es salaam, Tanzania. 45pp.

REPOA, (2010). Social protection of the elderly in Tanzania: Current status and future possibility. Special Paper 10/5. Dar es Salaam.

Rutasitara, L. (2002), Economic policy and Rural poverty in Tanzania, A survey of three Regions, Research on poverty Alleviation, Mkuki and Nyota Publishers, Dar es Salaam , Tanzania.

Saunders, P. (2008). Measuring wellbeing using non-monetary indicators: deprivation and social exclusion. *Family Matters* 78: 8-17.

Sawe, D. and Maimu, D. (2001). Retrenchment: Case Study 3 in Tanzania. Available at http://www1.worldbank.org/publicsector/civilservice/casestudy3tanzania.pdf.

Seers, Dudley. (1969). "The Meaning of Development." *International Development Review*, 11, 2: 2-6.

Semboja, J (1994), Poverty Assessment in Tanzania: Theoretical Conceptual and Methodological Issues, Net work for Research on Poverty Alleviation, Dar es Salaam University Press, Tanzania.

Sen, Amartya. 1976. "Poverty: An Ordinal Approach to Measurement." *Econometrica* 44, 2: 219-231.

Sen, Amartya. 1981. *Poverty and Famines: An Essay of Entitlements and Deprivation*. Oxford: Oxford University Press. 26.

Sen, A. (1999) *Development as Freedom*, Oxford: Oxford University Press.

The Citizen newspaper (2013, June 12). Thinking differently: Care for the elderly a challenge for our times.

Tungaraza, F. (1990). The development of social policy in Tanzania. *Journal of Social Development in Africa*, 5(2), 61–71.

UN, United Nations Commission for Social Development (2005). Report of the forty-third session of the Economic and Social Council. (unpublished report available at http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N05/261/95/PDF/N0526195.pdf?OpenElement accessed on 23/02/2013).

URT (1998). *The National Poverty Eradication Strategy.* Vice president's Office. Government printer, Dar es salaam, Tanzania. 56pp.

URT, (2003a). The National Ageing Policy. Ministry of Labour, Youth Development and Sports. Dar es Salaam.

URT, (2003b). The National Health Policy. Ministry of Health. Dar es Salaam

URT (2004). *Poverty Reduction Strategy*. Government Printers Dar es Salaam, Tanzania. 56pp

URT, (2007). Tanzania progress report: Review and appraisal of the MIPAA. Expert group meeting on aging in Africa. Addis Ababa, Ethiopia.

Wellman, N.S, Fada, RD, Weddle, D.O., Kranz, S, and Brain, C.T. (1997). Elder Insecurities: Poverty, Hunger, and Malnutrition. *Journal of the American Dietetic Association*, 97(10). S120-S122.

Whiteside,A. (2002). Poverty and HIV/AIDS in Africa. *Third World Quarterly*. 23(2): 313-332.

World Bank, (1994); *Tanzania – Agriculture* A World Bank Country Study Washing to DC:

World Bank, (1996) *Tanzania: The Challenge of Reforms: Growth, Incomes and Welfare Volume.* Washington, D.C

World Bank report,(2002). Causes of poverty and a framework for action. Available at http://siteresources.worldbank.org/INTPOVERTY/Resources/WDR/English-Full-Text-Report/ch2.pdf

World Health Organisation, WHO, (2013). The Word health report: Trends in life expectancy. Accessed at http://www.who.int/whr/1998/media_centre/press_release/en/index1.html

Wisner, B. (2009). Vulnerability. International Encyclopedia of Human Geography. 176-182.

APPENDICES

APPENDIX 1

A QUESTIONNAIRE FOR ELDERLY PEOPLE IN MOROGORO MUNICIPALITY

INTRODUCTION *(to be used as self introduction before interviewing each respondent)*

Good (morning/afternoon/evening)! My name is Sidina Mathias. I am an MSc (DP) student at Mzumbe University. As requirement to complete my studies, I am supposed to carry out a research which will generate useful information to assist the government in solving or improving elderly people problems. You have been chosen to participate in this study. I would like to assure you that the information provided will be used for the intended purpose only and your identity will never be disclosed when such information is presented. Please feel free to answer the questions that will be asked.

PART A: RESPONDENT'S PARTICULARLS

Q1	Ward: *1. Chamwino, 2. Mwembesongo, 3. Kichangani, 4. Boma* _____	
Q2	Name of '*Mtaa*':_____	
Q3	Name of Respondent (*has to be an elderly person (above 60 years)*):_____	
Q4	Sex of Respondent: 1= **M**ale 2= **F**emale: _____	
Q5	(a) Age of respondent (*in years*) :_____ (b) Or Age not known:_____	
Q6	Marital status of Respondent: (1. *Married, 2. Single, 3. Divorced, 4. Separated,* *5. Widowed/Widower)* _____	
Q7	Did you ever go to school (1. Yes or 2. No.):_____	If No skip to Q10
Q8	If Yes in Q7, what type of education did you receive? (1. Germany, 2. British or 3. Post-independence)	
Q9	Highest Education Level attained by the Respondent (1. Primary school, 2. Secondary school, 3. Vocational training school, 4. Other non-university colleges (certificate/Diploma), 5. University, 6. Other level specify)_____	
Q10	(a) Are you employed? 1 = Yes 2 = No _____ (b) If Yes in Q10a, who is your employer? (1. Government 2. Private sector3. Self employed 4. Others (Specify) _____ (c) On which basis are you employed? (1. Short (< 1 year) renewable contract 2. Long (> 1 year) renewable contract 3. Short non-renewable contract 4. Long non-renewable contract 5. Other basis, specify _____ (d) If No in Q10a, what applies to you here? (1. Retired person, 2. Never employed):_____	If No skip to Q10d
Q11	(a) Main source of income: (1. Retirement benefits, 2. Salary (*if still in employment*), 3. Crop farming, 4. Livestock keeping, 5. Business, 6. Support from children/relatives, 7. Other source, specify):_____	
Q12	(a) Relation with the Head of Household (1. Father, 2. Mother, 3. Father in-law, 4. Mother-in law, 5. Head of the Household myself, 6. Other, specify):_____	

	(b) If you are the Head of household, are you living with other people in the household? (1. Yes, I live with my spouse only, 2. Yes, live with my spouse and sons/daughters 3. Yes, I live with my spouse and grand children, 4. Yes, I live with my spouse and other non relative people 5. I live alone) : _____	

PART B: ACCESS TO SOCIAL SERVICES

Q13 How do you get the following services

Type of service	*How to access (1. Support from government, 2. Support from Children, 3. I pay myself, 4. Through insurance, 5. Support from private institutions/NGOs, 6 Support from FBOs, 7. Other means specify, 8. Not available at all) (NOTE: You can record more than one if applicable)*
1. Health services when sick	_____ _____ _____ _____ _____
2. Clean water	_____ _____ _____ _____ _____
3. Food	_____ _____ _____ _____ _____
4. Shelter/house	_____ _____ _____ _____ _____
5. Public transport	_____ _____ _____ _____ _____
6. Outreach and networking	_____ _____ _____ _____ _____
7. Counselling	_____ _____ _____ _____ _____
8. Sport and recreation facilities	_____ _____ _____ _____ _____
9. Other service, specify_____	_____ _____ _____ _____ _____

<table>
<tr>
<td>Q14</td>
<td>(a) Are you satisfied with the current access and provision of social services in Morogoro Municipality? (Rate your satisfaction) 1. Highly satisfied 2. Satisfied 3 Somehow satisfied 4. Not satisfied at all)
_____

(b) Do face difficulties in accessing the social services? 1 = Yes 2 = No
_____

(c) If Yes in Q14a, indicate the services in which you get difficulties to access by rating the intensity of difficulty
<table>
<tr><th>Type of service</th><th>1. Rating
1. Most difficulty
2. Difficulty
3. Not difficulty</th><th>2. Mention the difficulties you get for each service</th></tr>
<tr><td>1. Health services when sick</td><td></td><td></td></tr>
<tr><td>2. Clean water</td><td></td><td></td></tr>
<tr><td>3. Food</td><td></td><td></td></tr>
<tr><td>4. Shelter/house</td><td></td><td></td></tr>
<tr><td>5. Public transport</td><td></td><td></td></tr>
<tr><td>6. Outreach and networking</td><td></td><td></td></tr>
<tr><td>7. Counselling</td><td></td><td></td></tr>
<tr><td>8. Sport and recreation facilities</td><td></td><td></td></tr>
<tr><td>9. Other service, specify_____</td><td></td><td></td></tr>
</table>
..</td>
<td>If No skip to Q15</td>
</tr>
<tr>
<td>Q15</td>
<td>For each social services, what mainly should be improved/done to ensure access to and provision of the services:
<table>
<tr><th>Type of service</th><th>What should be mainly improved</th></tr>
<tr><td>1. Health services when sick</td><td></td></tr>
</table></td>
<td></td>
</tr>
</table>

	2. Clean water		
	3. Food		
	4. Shelter/house		
	5. Public transport		
	6. Outreach and networking		
	7. Counselling		
	8. Sport and recreation facilities		
	9. Other service, specify_____		

PART C: POVERTY LEVELS IN ELDERLY PEOPLE IN MOROGORO

Q16	On average, how much do you spend per month (TShs/month): (a) As head of household _____ (b) As individual _____	
Q17	What proportion of your total expenditure do you spend per month on the following items?	

Need	**Proportion of expenditure (%) per month**
(a) Health services	
(b) House rent & bills (water, electricity)	
(c) Food consumption	
(d) Alcoholic drinks & entertainments	
(e) Clothing	
(f) Transport (public and/or private)	
(g) Education (personal & others)	
(h) Mobile phone calls	

	(i) Contributions e.g. wedding parties, funerals, initiation ceremonies, church offerings etc.		
	(j) Other, specify_____		
Q18	Do you get the following meals every day?		
	Meal	*Get on daily basis? 1. Yes or 2. No*	
	(a) Breakfast		
	(b) Lunch		
	(c) Dinner		
Q19	Type of house where the elderly people live (*Observe and record during visit*)		
	a. Building materials used for wall	*Tick*	
	1. Burnt brick/cement		
	2. Mud/Mud brick		
	3. Poles and mud		
	4. Poles, branches, grass		
	b. Building materials used for roof		
	Metal sheets		
	Tiles		
	Thatch grass		
	Other (specify) _____		
Q20	Type and quality of health services the elderly get (a) Where do frequently obtain your health services? (1. Dispensary, 2. Health Centre, Hospital, 4 Referral Hospital, 5 Just buy from pharmacy 6. Others (specify) _____ (b) Do you get the health service when you need it? 1 = Yes 2 = No (c) If No, what is the problem? (1. The health facility too far, 2. Lack of some one to take me to health facility 3. Lack of specialist 4. I am not entitled to get some health services as elderly 5. Financial constraints 6. In most cases the services are not available from the health facility 7 Others, specify)		
Q21	Do you own the following assets:		
	Asset	*Specify if owned by the elderly person (1. Yes or 2. No)*	

		(a) Personal house		
		(b) Wired electricity/power		
		(c) Mobile or fixed telephone		
		(d) Diesel power generator or similar		
		(e) Water pipe to house		
		(f) TV-set		
		(g) Radio		
		(h) Bicycle		
		(i) Motor vehicle		
		(j) Motor cycle		
		(k) Sewing machine		
		(l) Cattle		
		(m) Structures for rain water harvesting		
		(n) Watch		
		*(o) Other asset, specify*_____		

PART D: OTHER FACTORS CONTRIBUTING TO INCREASED INSECURITY AND VULNERABILITY OF ELDERLY PEOPLE

<table>
<tr><td>Q22</td><td colspan="4">Do you have other responsibilities like taking care of other people? 1. Yes or 2. No</td><td>If No, skip to Q23</td></tr>
<tr><td>Q23</td><td colspan="4">If yes, who do you support?
<table><tr><td>1. People supported</td><td>2. Involved in support? 1. Yes or 2. No</td><td>3. Number of Dependants</td><td>3. If yes, what support do you offer them?
1. Food, 2. Health services, 3. School fees, House rent, 5. Other specify (multiple responses)</td></tr><tr><td>(a) Orphans of my relatives/children</td><td></td><td></td><td></td></tr><tr><td>(b) Disabled</td><td></td><td></td><td></td></tr><tr><td>(c) Chronically sick people e.g. TB, HIV/AIDS, diabetic patients etc.</td><td></td><td></td><td></td></tr><tr><td>(d) Other people, specify_____</td><td></td><td></td><td></td></tr></table></td><td></td></tr>
<tr><td>Q24</td><td colspan="4">(a) Do you (or does your spouse) have any chronic health/body physical problem? 1.Yes 2. No _____
(b) If Yes what type of chronic health/ body physical problem? (1. Diabetes 2. Blood Pressure 3. Blind 4. Deaf 5. Others (specify) _____</td><td></td></tr>
<tr><td>Q25</td><td colspan="4">Do you engage in other informal income generating activities? 1. Yes or 2. No</td><td></td></tr>
</table>

Q26 If yes, what other IGA do you own? *Allow multiple responses and rank*

1. Income generating activity (IGA)	*2. Owned 1. Yes or 2. No*	*3. Rank in order of importance using 1= most, 2, 3,4 least important) etc.*
(a) Commercial chicken project		
(b) Food vending (mama/baba lishe)		
(c) Vegetable/horticultural gardens		
(d) Tailoring mart		
(e) Petty business		
(f) Shop		
(g) Selling used clothes (mitumba)		
(h) Selling women clothes (vitenge/khanga)		
(i) Keeping other livestock (pigs, goats etc.)		
(j) Charcoal selling		
(k) Selling raw food (genge)		
(l) Other business, specify_____		

Q27 Have you ever accessed loan from financial institutions? 1. Yes or 2. No _____

Q28 If yes, mention type of institutions and frequency of loans received.

Financial institution type	*Received loan? 1. Yes or 2. No*	*How many Times (frequency)*
(a) Bank, specify_____		
(b) Microfinance institution (. 1. PRIDE, 2. FINCA, 3. BRAC 4. Others (Specify) _____), _____		
(c) SACCOS		
(d) Village Community Banking (VICOBA), specify _____		
(e) Elderly Associations e.g. MOREPEO, HelpAge etc. Specify_____		

	(f) Government Projects e.g. TASAF, specify_____				
	(g) Religious organisations, specify_____				
	(h) Individuals				
	(i) 'Money-go-round'/Rockers (Michezo/upatu)				
	(j) Other type, specify_____				
Q29	What is your average income per month (TShs/month)_____				
Q30	Provide the proportion of sources of your income (both in cash and in kind sources)				

Source of income	*Proportion of stones/fingers (%)*
(a) Retirement benefits	
(b) Salary (if still in employment)	
(c) Crop farming	
(d) Livestock keeping	
(e) Business	
(f) Support from children/relatives	
(g) Other source	

APPENDIX II

INTERVIEW CHECKLIST FOR DIFFERENT INSTITUTIONS

(a) GOVERNMENTAL AND NON- GOVERNMENTAL ORGANISATIONS

1. Name of the organization.....

2.Name of Respondent (*optional*).....

3. Designation: .....

4. Contact.. : (i) Mobile phone _____ (ii) Email _____

(iii) Postal address _____

5. When was this organization established in Morogoro?

6. What are the key roles (responsibilities) of this organization to support the elderly.

……
……
……
……
…….

7. When did it start to offer services to the elderly?

8. Mention types of services provides to the elderly

……
……
……
……

9. Conditions or criteria used when offering services to elderly?

10. Number of elderly served for the past five years

Year	Female	Male	Total (*To add later*)	Amount (if involved money allocation)	Comments
2012					
2011					
2010					
2009					
2008					

11. What are the common problems/issues reported by the elderly who visit your organization? What do you think are causes of these problems?

12. Do you meet your target of offering services to elders? (1) Yes (2) No. If No why?

13. What other stakeholders do you think can assist the elderly to solve their problems?

14 Any problem do you face in providing support to elderly and what are the suggestions for improving the situation?

(b) FINANCIAL INSTITUTIONS SUPPORTING THE ELDERLY IN MOROGORO

1. Name of the organization.....

2.Name of Respondent (*Optional*) .....

3. Designation.....

4. Contact phone:_____; email:_____

5. In your institution who is eligible to get financial loan i.e. what criteria do you use?

6. Do you support elderly people to apply and access loans?

7. Do you have any special component to lend elderly?

8. If yes what is the condition

9. If you do not lend the elderly or have special loan component for elderly why?

9. How many elderly have been provided with the loan in the past 5 years?

Year	Female	Amount (TShs/year)	Male	Amount (TShs/year)	Total (*To add later*)
2012					
2011					
2010					
2009					
2008					

10. What can be done to provide loan to elderly?

(c) HEALTH SERVICE PROVIDERS IN MOROGORO

1.Name for health facility.....

2. Category of the facility *(tick the relevant one*)

i)Hospital

ii) Health centre

iii)Dispensary

3.Name of Respondent (*optional*).....

4. Designation .....

5. Contact.(i)(Phone).....(ii)Email:.....

(iii)Postal address:…….

6. Roles of Health Provider (General and specific to elderly)

Assessment of Services provided to elderly

7. Does the facility provide any service to the elderly people?

8. If yes, what criteria do you use to identify elderly people?

9. Which services are provided to the elderly?

10. Is there any favour/priority given to the elderly? (e.g. no queuing, payment etc).

11. Is there any specific season (months) of the year when elderly people visit your facility more frequently than usual? If so why?

12. What are the common health problems affecting elderly people as reported by those attending your facility? What is the cause / source of the problems

13. Trend of number elderly attend for services for the past five years (If statistics are available, provide record for the past.

Year	Male	Female	TOTAL (To add afterwards)
2012			
2011			
2010			
2009			
2008			

If the number is increasing /decreasing explain why.

14.Do you have any special facilities for elderly like

i) Special room (for medical consultation)

ii) Drugs

iii Other special facilities, specify _____

15. Have you ever faced any problem while attending elderly people?

If yes, explain

15.Wha can be done to improve services to the elderly

(d) FOCUS GROUP DISCUSSIONS WITH GROUPS OF ELDERLY

1. Type of group:_____
2. Ward:_____; Mtaa:_____

3. Group composition
   Gender .(Male/Female) …….....
   Age .....
   Education…….....
4. What are the common problems faced as elderly?

5. What the causes of these problems?

6. Do they get services from Government/ Non Governmental Organizations? Explain

7. What kind of services received from Government and Non Government institutions?

8. Are they satisfied with the services (*assess each of the services mentioned under question no. 7 above*)

9. What are common challenges faced by the elderly to get the services? What can be done to improve services to the elderly?

   Whom do you think can provide the elderly with good services and why?

Appendix III Introduction letter from Morogoro Municipal Council Director

HALMASHAURI YA MANISPAA MOROGORO

Simu/Fax Na: 023 – 2614727
Simu ya Upepo "Mji"
Barua pepe: info@morogoromc.go.tz.
Tovuti: www.morogoromc.go.tz
Unapojibu tafadhali taja:

Ofisi ya Mkurugenzi wa Manispaa,
S.L.P 166,
MOROGORO,
TANZANIA

Kumb. Na. E.10/MMC-56/VOL.V/29 **Tarehe:** 10 Aprili, 2013

Sidina Mathias,
Chuo Kikuu Mzumbe,
S.L.P. 63,
MOROGORO

YAH: KIBALI CHA UTAFITI

Husika na kichwa cha habari cha hapo juu, sanjari na barua yako ya tarehe 03 Aprili, 2013.

Napenda kukujulisha kuwa kibali kimetolewa kufanya utafiti wa ***"Social Insecurity and Vulnerability of Elderly to Poverty"*** katika Halmashauri ya Manispaa Morogoro katika kata za Chamwino, Kichangani, Boma na Mwembesongo kwa ajili ya kukamilisha mafunzo yako ya Shahada ya Uzamili.

F.A. Mabira
Kny: MKURUGENZI WA MANISPAA
MOROGORO

R.S.V. MKURUGENZI WA MANISPAA MOROGORO

Nakala: Maafisa Watendaji wa Kata,
Chamwino, Kichangani, Boma na
Mwembesongo - ***mpatieni ushirikiano***