Aging and Social Problems in Tanzania, a Demographically Young Country in Africa

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1. Introduction

Demographic change and social aging have been discussed for a long time mainly in the context of Western countries or industrialized countries of the so-called global north, and later the Asian countries came up to the discussion. Meanwhile, there are fewer studies on how population aging affects the African societies compared with the above areas, because the accumulation of researches started recently (Aboderin 2010)[1], and because the African social aging is inconspicuous, having small ratio of older population[2] to the whole population (see Section 2). Demographic change in Africa, especially in Sub-Saharan Africa (SSA), is, however, getting more and more attention because it is the only part of the world that is anticipated to continue increasing its population until the next century.

There are 54 countries in SSA, and each country has its distinct situation. This paper focuses on the United Republic of Tanzania (henceforth Tanzania), located in the eastern part of the African continent. This paper aims to examine demographic changes and the accompanied social problems especially about social security for older people. The Tanzanian society shares with other less developed countries in SSA a typical pattern of demographic change and social welfare condition concerning older people. Through contemplating Tanzania's context regarding social aging, we can grasp what is going on with social aging in SSA. The official and universal social security system for older people in Tanzania is less prepared, and some cases demonstrate severe insecurity of older people in Tanzania. This study is based on reviews of official demographic data and reports and academic works on social security system in Tanzania, partly supported by my personal interviews and field observations in Dar es Salaam. In conclusion, I assert that even demographically "young" society contains problems related to social aging.

The remainder of this paper is organized as follows: Section 2 gives an overview of demographic data on SSA and Tanzania respectively. Section 3 illustrates the Tanzanian context related to social aging problems: Firstly, on official safety nets for older population, and secondly, on informal care in intimate sphere regarding three situations, namely rural, urban, and shelters. Section 4 sums up the issues argued in each section and synthesizes into a general assumption of the social aging problems that might confront Tanzania in the near future. Overall, we will argue that the

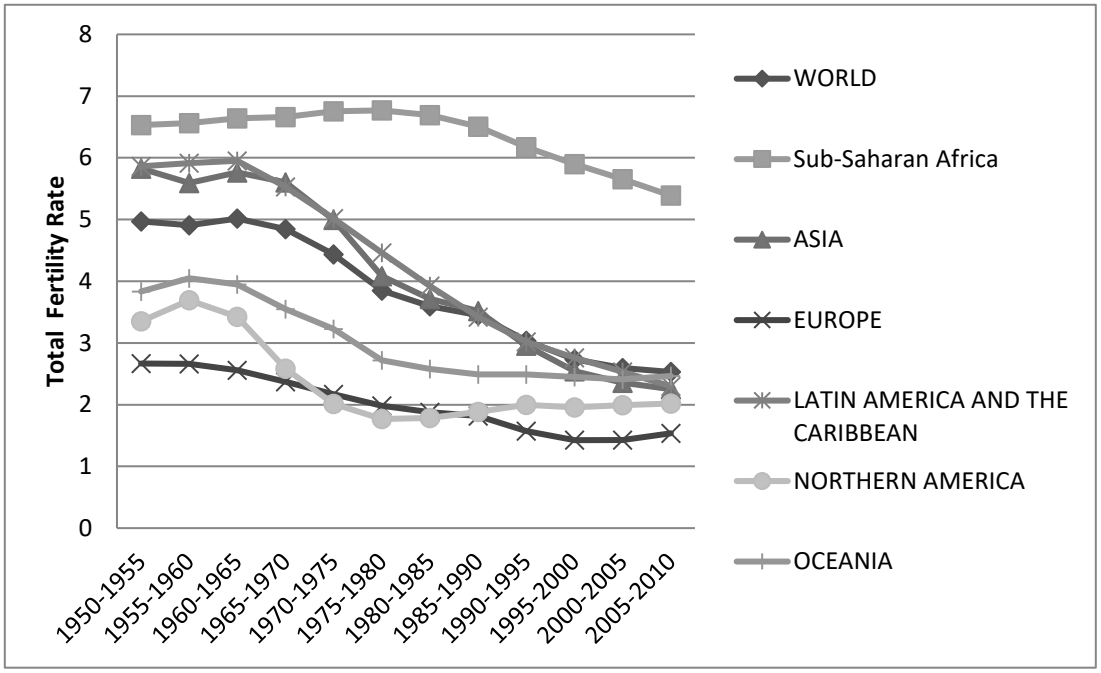
Tanzanian society should not be considered just as a “young society,” but rather an unprepared society holding unprecedented augmentation of older population.

2. Overview of Demographic Changes

2-1. Sub-Saharan Africa

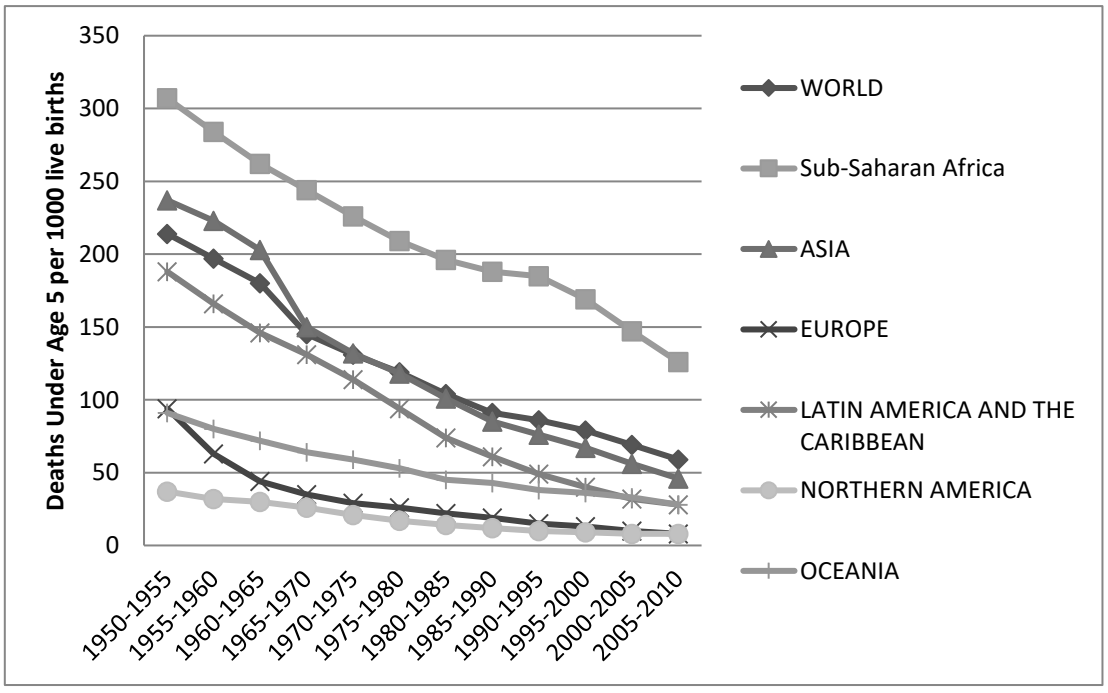
Let us begin our assignment by looking at the regional proportions of the population aged 60 years and over (henceforth 60+) to the entire population in 2010 using data sets offered by the United Nations Population Division in Department of Economic and Social Affairs (UNPD 2013). The world average is 11.1%; Europe marks the highest proportion of 21.9%, followed by Northern America (18.6%), Oceania (15.2%), Asia (10.1%), Latin America and the Caribbean (9.8%), and the lowest by Africa (5.3%). SSA (African countries except Northern Africa)’s 60+ proportion is 4.8% (UNPD 2013). At the first sight, the data seems to show that Africa, especially SSA, is far from the social aging problems. However, we need to check the absolute number of older people to understand how social aging may greatly affect the societies in SSA and even the whole wide world. The total population of SSA is anticipated to keep growing through this centry: In 2100, Africa is predicted to be the second populous part in the world with 3.6 billion people, following Asia’s 4.6 billion (UNPD 2011). Thus the absolute number of older people will also be growing rapidly.

This consistent population growth is supported by the combination of the stable total fertility rate (TFR) and decline of under-5 mortality. As Figure 1 shows, the TFR in SSA stays the highest in the world. It peaked during 1975-1980 with 6.8 shortly followed by a gradual decrease until 2005-2010 when it marked 5.4, which is roughly the same as that of Asia or Latin America and the Caribbean in the late 1960s. What makes SSA unique is the gap between the diachronic change in the TFR and the under-5 mortality. Remarkably, the TFR of SSA started to decrease only after the 1990s, but the decline of under-5 mortality in SSA was early to start in the 1950s (Figure 2). Moreover, since improvement of public health has brought more long life expectancy, the population growth rate of SSA is kept as high as over 2.6 (UNPD 2013).



Source: UNPD (2013)

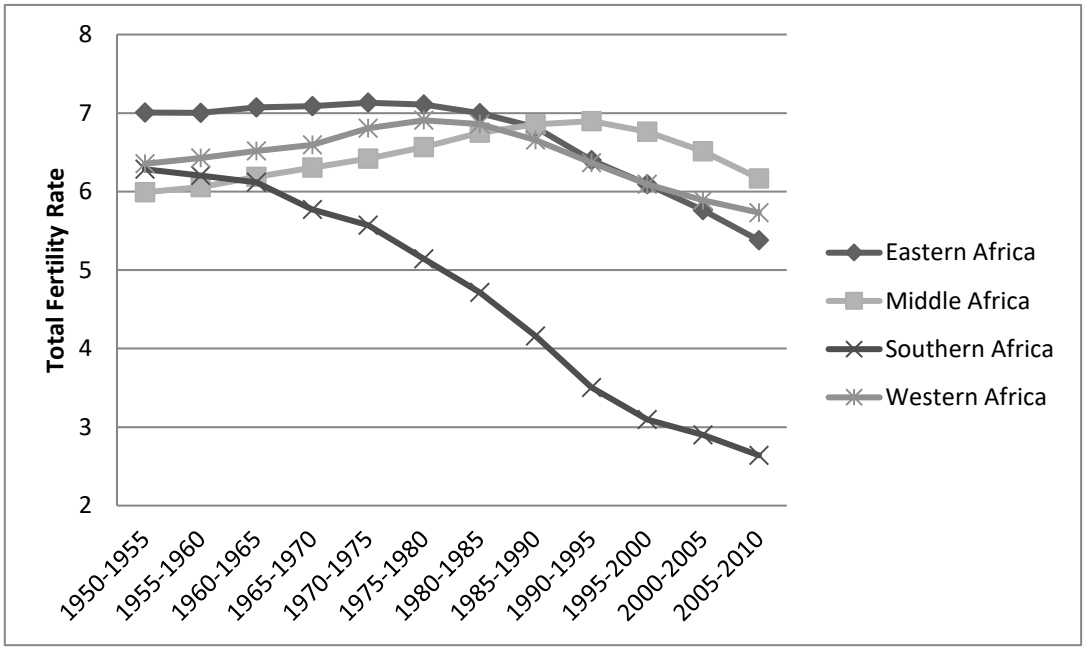
[Figure 1: TFR Changes by Major Areas of the World]



Source: UNPD (2013)

[Figure 2: Under-5 Mortality Changes by Major Area of the World]

Next, let us examine the regional TFR in more detail to find out the diversity among SSA countries. Figure 3 shows that there is a clear-cut difference between Southern Africa and the rest: Considerable and consistent decline is observable in Southern Africa, economically the most developed part of SSA, whose social aging is more progressive than the rest with 7.8% of the total population aged 60+. The other regions[3] keep stable TFR, but East Africa shows gradual but consistent decrease after the late 1980s. Although, all of the latter three regions have almost the same proportion of people aged 60+: 4.5% and over.



Source: UNPD (2013)

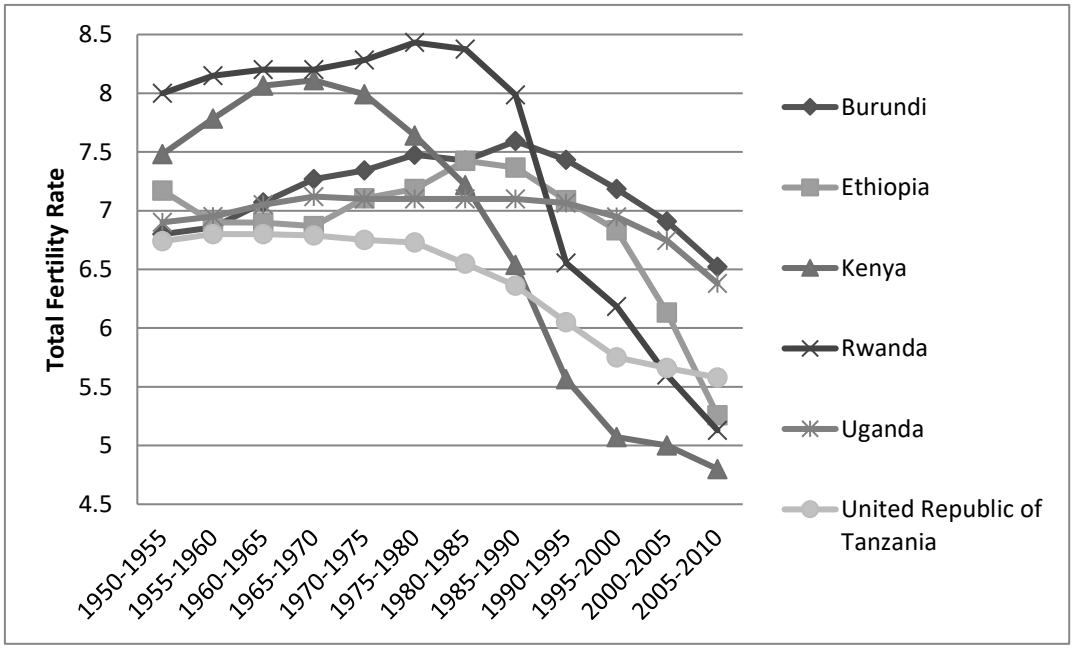
[Figure 3: TFR Changes by Regions in SSA]

2-2. Tanzania

Tanzania is one of the countries whose population is youngest and growing at the highest speed in the world. It holds 44,929,000 people according to the 2012 Census (NBS and OCGS 2014). Its growth rate is as high as 2.7% per annum, and the population has almost tripled in the last 40 years, and it is projected to double by 2038 (Agwanda and Amani 2014: 3). The proportion of the population aged under 15 is 44.8% or 43.9%, and proportion of the population aged 60+ is only 4.9% or 5.6%, according to UNPD (2013) and NBS and OCGS (2014), respectively.

TFR in Tanzania in 2010 is 5.6 or 5.4 according to UNPD (2013) and the Tanzania Demographic and Health Survey (TDHS) (NBS and ICF Macro 2011), respectively. Tanzania keeps a higher TFR in SSA: It is ranked 14th of 50 SSA countries, whose average TFR is 5.4 (UNPD 2013). Figure 4 shows that Ethiopia, Kenya, and Rwanda have obviously been dropping their TFR so far,

and Burundi and Uganda rather keep its TFR. Tanzania's TFR shows moderate decline among the selected countries: It peaked in the 1970s, and shortly after that it started to decrease. This trend slowly accelerated in the 1990s (Mturi and Hinde 2002). Under-5 mortality change in Tanzania share common features with that of SSA: It has consistently declined since the 1950s, and in 2010 it marks 92 or 81, according to UNPD (2013) and TDHS (for trends in TDHS, see Agwanda and Amani 2014: 24), respectively.



Source: UNPD (2013)

[Figure 4: TFR Changes by Selected Countries in East Africa]

With such high TFR and decreasing mortality, the population of Tanzania is projected to triple in 2050, and grow by 6 times in 2100, compared with that of 2010 (NBS and OCGS 2014: 15; UNPD 2013). Although currently the Tanzanian population looks "purely young", we must be aware that Tanzania is surely confronting the rapid increase of population aged 60+. Some data underpin this fact; The increase of contraceptive use and increasing awareness of family planning indicate that TFR will surely continue decreasing; due to increase of life expectancy at birth since middle 2000s, the average life expectancy has exceeded 60 years both in male and female populations (Agwanda and Amani 2014). Thus, the number of older people aged 60+ is estimated to grow much rapidly than the total population does—it will quadruple in the next 40 years (Stiglitz 2011: 35).

As such, SSA's demographic change has its characteristics in high population growth rate, supported by stable TFR despite of consistent decrease of under-5 mortality. With such condition, aging in SSA is less apparent, but the population growth rate of people aged 60+ is estimated very

high compared to the rest of the world. In SSA, most parts except Southern Africa have kept as high TFR as over 5, and as small proportion of people aged 60+ as about 4.5%. Tanzania has a demographic feature typical of the less developed countries in SSA. Since it keeps high population growth rate, Tanzania is predicted to be confronted by a rapid growth of population aged 60+ in the next decades. In the next section, then, let us see how the Tanzanian society is currently dealing with this demographic situation.

3. Tanzania's Context Related to Older People

3-1. Weak Official Safety Nets for Older People

Tanzania has just begun making policies for social aging after the 2000s. The first action in policy making was resulted in an enactment of the *National Ageing Policy* in 2003 (URT 2003). This policy follows the essence of the *United Nations Organization Declaration No. 46* (1991), which assured older people's rights, especially independence, participation, care, self-fulfillment, and dignity (URT 2007:7). In the context of developing countries, in the meantime, there had been some progresses concerning the problem, represented by the *World Summit on Social Development* held in Copenhagen in 1995, and the *Millennium Development Goals* in 2000, which contained indirect approaches toward older population as categorized under the "poor" populations (Spitzer and Mabeyo 2009: 45-47). Along such international trends since the late 1990, the African Union in collaboration with the HelpAge International[4] has launched the *Policy Framework and Plan of Action on Ageing* in 2002, as a blueprint for SSA countries to incorporate aging issues into social policy papers and development programs (Stiglitz 2011: 47-49). Tanzania was one of the first respondents for this by launching the *National Ageing Policy*. After that, the government has been making efforts for improving life conditions of older people. For instance, the government has proclaimed free access to medical care at governmental hospitals, health centers, and dispensaries for "older people" as defined in the policy as people aged 60+ (URT 2003).

The implementation is problematic, however. Despite the development of policies related to older people's lives, some researches have demonstrated a tip of tough reality for older people. For example, despite the governmental proclamation, a recent study conducted in a rural village indicates that most (in their survey 78%) older people have to pay for medical treatment (Spitzer et al. 2009: 35-37).

This result is also supported by a case study I conducted in Dar es Salaam during 2013-2014[5]. In order to look into how much official social supports the people with disability can access, I had interviews with some people with physical impairments including a man aged 61, about services they can enjoy at public health institutions. Indeed, all of them answered they pay for medicine, nevertheless the government proclaimed that people with disability are also assured free medical

care at public health institutions. Constant scarcity of medicine in public health institutions made all my interviewees buy medicine at pharmacies.

Income security is another big issue of official safety nets for older people. There are some pension schemes for retired older people, but all of them are contributory and are designed to accommodate only the older people who have worked in formal sectors[6], despite the reality that currently only less than 10% of the nation is working in formal sectors: 90% or more of active labor force are in agriculture or other informal sectors (Agwanda and Amani 2014: 55; NBS and OCGS 2014: 112).

In a research conducted in 2008 in Dar es Salaam (urban) and Lindi region (rural) on income security of older people (Spitzer et al. 2009), only 5.5% out of 400 respondents (200 each) were beneficiaries of pension scheme. Their result shows, first, school education (and its result of literacy) is one of the necessary conditions for enjoying official pension, but it is never the sufficient condition. Second, even for those who succeed in becoming eligible for the pension fund, the amount of the pension is extremely small[7] and the payment often delays. These two points clearly indicate that there is almost no actual social security fund scheme for older people in Tanzania. Moreover, note well that the percentage shown in the survey (5.5%) could be much more optimistic than the reality, because the half of respondents was residents in the megacity (Dar es Salaam) on which most of educational and economic institutes of the country concentrate. However, indeed more than 70% of the nation resides in rural areas (Agwanda and Amani 2014).

Stiglitz indicates the severe condition of older people in Tanzania in the following sentence. Note, however, that "pension" (that he focuses on) is not the only case, and we can also replace it by "official safety net" including official support in health services.

> *In Tanzania only a small portion of about five per cent of the older generation benefits from pensions, hence the predominant majority relies on informal and non-state regulated forms of social protection which are mainly provided through family and community support structures* (Stiglitz 2011: 18).

Thus, a majority of older people in Tanzania have no way but relying on care from intimate sphere.

3-2. Questioning Informal Care in Intimate Sphere

In fact, most of older people in Tanzania think that intimate sphere—their relatives or the community, especially the former—is the primal one that they can rely on to get care (Spitzer et al. 2009), and the Tanzanian government also expects that older people should be cared in the intimate sphere (URT 2003). Then, today, are older people in Tanzania adequately secured by informal care in their intimate sphere?

Against the expectation by older people and the government, some researches indicate inadequacy of informal care for older people. A survey conducted by Spitzer et al. (2009: 42-45) resulted to demonstrate that as average 46% of older people (in rural 59.5 %, in urban 33 %) totally lack any kind of family support[8]. The authors allege that the mutual care mechanisms "which are traditionally embodied in the extended family and kinship systems" are being eroded and affected by some social factors like "liberalized and free market economies as well as the impact of HIV/AIDS".

> *Although the supporting power of families and relatives is obviously still a strong force towards social protection for older people as could be seen in our research, it can also be stated that its scope seems to be in a process of being weakened day by day* (Spitzer et al. 2009: 42)

Stiglitz (2011: 18) also exaggerate problematic social condition around older people, and as the background of this he refers to the "rapid modernization processes [such as] [g]lobalization, urbanization, rural-urban migration as well as cultural and social change…[and] persistent and widespread poverty".

So far some are mentioned as crucial factors negatively affecting it, such as; (a) Increase of urban migration among younger generation and general poverty (Aboderin 2010; Spitzer and Mabeyo 2011: Spitzer et al. 2009): older people cannot expect adequate amount of remittance from their younger relatives, because younger generation also are struggling to earn their daily needs. Today about 90% of people works in informal sector. It is speculated that only a minority can send enough amount of remittance to older relatives, since the majority of the nation lives on the international poverty level: According to the World Bank data of 2012, 73% of the Tanzanian people are living on less than 2 USD at 2005 international prices[9]; (b) Moral change (Nyangweso 1998): Modernization (Nyangweso mentions urbanization, individualism, secular education, import of Western culture, extension of life expectancy) changed people's thinking way so that older people became to be regarded more as a burden than respected dean in the community.

Although evaluation of reliability of informal care for older people in today's Tanzania—whether the informal care in Tanzania is in danger or just changing its form—needs more articulation of research, the cases shown in this part demonstrate some of typical social problems regarding older people.

Older Women's Vulnerability in a Rural Society

Gender severely matters when we consider the older people's conditions in Tanzania. In some societies in Tanzania and other regions in SSA also (Aboderin 2010) gender splits the older people's condition radically. An instant case to show this is in income security that we saw in 3-1: most of pension beneficiaries are male. But it is more notable in cultural domain. Although generally male

older people are respected as local leaders in their community and can exert powers in local sociocultural contexts, in some ethnic community, female older people often have to play the opposite role.

For example, murder of old women is very common in some regions like Mwanza, Shinyanga, and Rukwa in Tanzania (LHRC and ZLSC 2012; Mesaki 2009; Reisman 2013). They are condemned for "causing" bad luck or sickness to other member(s) of the community and killed as a "witch". This kind of "witch killing" is often interpreted in relation with the traditional belief among Sukuma people, the largest ethnic group among more than 120 different ethnic groups of Tanzania[10] (Mesaki 2009), while some others assert that it is motivated by economic reasons, such as envy of the elders' resources or incapability to take care of them (Reisman 2013: 77). What is important is that the victims of the "witch killing" are often identified by physical features commonly caused by aging[11], and the number of murders of older (female) people has been increasing since 1970 (LHRC and ZLSC 2012: 33-36; Mesaki 2009: 73; Reisman 2013: 24): 3,693 cases between 1970-1984, and 3,000 between 2005-2011. Although the killings seem to be related to modern social change, the reason of augmentation of killing of older (female) people is unclear. But this severe stigma on older women is not a negligible matter regarding aging in Tanzania.

Older People as the Urban Poor

Migration into cities from rural areas have been accelerated since the 1960s: proportion of urban residence in Censuses increased from 6.4% in 1967 to 29.6% in 2012, with a high growth rate as 5.2% per annum, while the rural population growth rate is 1.8% per annum (Agwanda and Amani 2014; NBS and OCGS 2014). This trend is accompanied by the increase of unemployed population (Agwanda and Amani 2014: 55, 56). Older people can be the most vulnerable group in urban situation, because of scarcity of the most fundamental resource for urban life: cash. Ishumi (1984), on the unemployed in urban areas in the late 1970s and the early 1980s, categorizes the jobless into three types: the pavement beggars, the jobless-corner youths, and the 'part-time' urban school truants, and we can find older people as beggars in his writing.

> *Of the three categories, the able-bodied jobless youths are the largest group. Beggars are much fewer in comparison, but they are the oldest, as a category, in chronological age and probably also in the total length of their urban appearance and stay... The typical pavement beggar tends to belong to the age group above (but sometimes below) 40 years, while the part-time school truant tends to belong to the age group up to 15 or a little more… [the] jobless-corner youth sweeps through age level from 16 years to 35 or above* (Ishumi 1984: 72).

Ishumi does not detail the backgrounds of these beggars, but possibly they migrated to town before getting "old" and losing their jobs. In other words, these beggars aged 40 and above could be considered to be *too old to work* and need supports and care from others—they had no choice but to beg on the street.

This trend has not changed so much even today. Another more recent empirical research also suggests that old age can be a factor to start begging (Namwata et al. 2012: 140). Even in my fieldwork in Dar es Salaam, a man who moved to the city from a far rural village in the 1970s told me that for a long time he had worked as a small entrepreneur on the streets selling flowers, fruits, or clothes, but after all he started begging when he was *46 years old*. These facts demonstrate a reality that if a person had worked in informal sectors and lost job in his/her 40s, s/he would have slim chance to start another job. Let us now remember that currently nearly 90% of Tanzanian people are working in informal sectors that are not covered in pension schemes. This means that the potential number of elders who have troubles in earning their lives is considerably large.

Beggars are never the only case. During seven months of fieldwork, I frequently witnessed younger people giving a little money by hand to their older relatives or friends when they meet on the street or at their homes. This practice is, as such, very common. Some of the younger people told me "they are poor, so we have to do so".

Shelters for Older People Who Are Eliminated from Community

If an older person is neglected by their intimate persons, and could not live by their own even by begging, another way is to gather in a shelter. In Tanzania, there are 41 shelters for the older people named "Homes for the Elders (HFEs)",[12] of which 17 are run by the government and 24 are run by non-governmental institutions (mostly Christian organizations)[13]. HFEs, however, "are the last places for the elders," told me an officer of the Social Welfare Division in the Ministry of Health and Social Welfare. It is because only old people who cannot live by themselves and do not have any care givers for themselves come to the HFEs. The Tanzanian government expects older people to be cared in the intimate sphere before using institutionalized care system (see URT 2003: 10, 11). Thus, these shelters are often in poor condition (LHRC and ZLSC 2012: 157-158). This officer explained the history of HFEs as follows: HFEs are established in the context of social difficulties under *Ujamaa* policies[14] in the 1970s. Before that, the older people who needed care had been looked after within their community or family. After the 1970s, poor and isolated older people came into the nearest lepers' colonies and settled there. As more and more old people settled into the colonies, the government finally started supporting the colonies as HFEs. Nowadays, residents in the HFEs consist of people aged 60+ who cannot live by themselves and the (ex-)leprosy patients (of any age). They receive services to meet human basic needs, such as food, medical service, shelter, recreation, and learn life skills such as handcrafts and gardening[15].

4. Discussion and Conclusion

Now, let us summarize the points made above. Section 2 illustrated that Tanzania is one of a demographically "purely young" countries typical of SSA, keeping a high population growth rate supported by the high TFR and the consistent decline of under-5 mortality. Its social ageing shares with many other SSA countries the rapid growth of the absolute number of older generation. Section 3 pointed out that despite the enactment of some policies related to aging, official security system for older people is actually unavailable to the vast majority. It appeared clearly that the majority of older people have to rely on informal security systems from their families and communities. Nevertheless, some examples demonstrated that even informal security systems also seem inadequate under current social condition: In rural area, older women are confronted by severe harassment, and in cities, instability of employment affects not only younger generation but also older generation, making them an economically vulnerable group. Shelters for those who are neglected from informal care certainly exist, yet they are limited in number and the conditions are poor.

These facts indicate that what matters in today's Tanzanian society is the inadequacy of care systems for older people, either in institutionalized one or informal one. The gap between official care system and informal care is making older people vulnerable, and this vulnerable population is predicted to increase at an unprecedented speed. Extremely saying, Tanzania is not just a "young society", but *an unprepared society having unprecedented increase of older vulnerable population*.

Actually, these social problems related to older population—lack of official security system due to problematic implementation of policies, and various changes in intimate sphere—are not the unique feature of the Tanzanian society: These problems are shared in many countries in SSA[16] (Aboderin 2010; Aboderin and Ferreira 2009). As reasons of the policy impasse on social ageing in SSA, Aboderin and Ferreira (2009) find three factors: "(a) persisting assumptions that families continue to care for elders adequately; (b) an insufficient awareness of, or interest in policy needs of older people; and/or (c) a focus on other priorities for "development" spending, with older persons largely excluded from development agendas" (Aboderin and Ferreira 2009: 57).

In this paper I tried to illustrate that social aging in Tanzania, one of the "youngest" countries in the world, would be impacting the society, and we cannot stay optimistic about the social condition of older population. Today the Tanzanian society continues changing, facing expanding social inequality, which is caused by neoliberalism brought by the global north since the late 1980s. By taking account of this social change, the situation must continue and become even more severe. Today most of younger people have no choice but working in the informal sector. Interpreting Stiglitz (2011: 20)'s words that, "in Tanzania only 2% of the total population or 4% of the total labor force are covered by one of the existing social security institutions", it means that only less than 5% of working younger generation are assured their income when they lose their current job, and more

than 95% of younger generation are not covered by any official security system. This means much more than a lack of care system buttressing up older people's lives, because the younger generation is the latent older sufferers from lack of security system. Therefore, the Tanzanian society is predicted to be confronted by a much severer situation later, because of the high growth of population who cannot contribute social redistribution and moreover need multiple supports.

Repeating Aboderin and Ferreira's arguments (Aboderin 2010; Aboderin and Ferreira 2009; Ferreira 2005), I assert that social aging in SSA is a crucially important issue that more academic attention should be paid on. For most of SSA countries like Tanzania, various social problems prevent social aging from getting awareness from the government, non-governmental actors, and academia. Therefore empirical data on social aging in the area is scarce and most of empirical researches are limited in both the scale and variety of research style. As most studies are launched by administrative or developmental motivation, it is often based on ideological assumptions or lacks scientific quality, and theoretical framework which is necessary to capture the phenomena in SSA as a whole has not yet developed. As result, most of SSA countries have not succeeded to take effective action against social aging.

Finally, I would like to mention another problem which is not discussed enough in this paper. It is necessary to reconsider if it is appropriate to define a priori older people chronologically as people aged 65+ or 60+ (See also endnotes 2). In the Tanzanian social context, as we have seen, people can be perceived "old" at a much earlier stage. Some researchers asserted that people aged 50 and above should be counted as "older people" taking account of the Tanzanian situation (Spitzer et al. 2009; Spitzer and Mabeyo 2011)[17]. In reports on "witch killing", people aged 50+ are also targeted as "old witch" (Mesaki 2009: 78), and as noted in the case of urban beggars, people aged even less than 50 also are exposed to virtual retirement from economic activity. By taking account of these facts, perhaps the definition of "older people" should be broader to include those under 60. Thus, it seems safer to suppose that the Tanzanian society contains a larger number of "older people" than the number estimated using universally standardized demographic data based on the chronological age.

Aknowledgement

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5. Endnotes

[1] Despite the physical distance, African studies in Japan have a long history beginning in the 1960s. Nowadays some Japanese researchers have started projects for accumulating research data on elders in SSA in the last couples of years. For example, see Tagawa et al. (2015: 2-22).

[2] In this paper, "older population/people" is defined as the people aged 60 years and over. The definition of oldness in the African context is, however, very controversial because people in SSA generally recognize oldness by physical features, reproductive experiences, or social roles in communities, rather than by chronological age. Moreover, in

SSA unignorably large numbers of people do not know their accurate age (Aboderin 2010, Ezeh et al. 2006; Spitzer et al. 2009; Tagawa et al 2015).

[3] UNPD defines Middle Africa as Angola, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of the Congo, Equatorial Guinea, Gabon, and Sao Tome and Principe.

[4] HelpAge International is an international NGO, which is active worldwide especially in developing countries in order to improve well-being of older people. See < http://www.helpage.org/ > (Accessed 17th October 2015).

[5] I conducted 7 months of field research on lives of people with disability in Dar es Salaam during 2013-2014. This research was funded by the Grant-in-Aid for the Japan Society for the Promotion of Science Fellows, research project number 12J05334.

[6] For example, there are National Social Security Fund, Local Authority Pensions Fund, Public Service Pensions Fund, Government Employees Provident Fund, Parastatal Pensions Fund, National Health Insurance Fund, and Zanzibar Social Security Fund.

[7] In the survey, out of the 22 older people, 4 receive less than 15,000 Tanzania Shillings (Tsh) [about 6.75 USD] a month, 12 received between 15,000 and 30,000 Tsh, 6 received more than 30,000 Tsh (Spitzer et al. 2009: 31).

[8] In this survey, "support" means one of or combination of following forms: monetary, material (food, clothing), medical, housing.

[9] The data is available at < http://data.worldbank.org/ > (Accessed 30th June 2015).

[10] There is no official data on population size by ethnic groups after National Census 1967. Mesaki (2009) estimates 35 million of Sukuma people in Tanzania.

[11] According to Reisman (2013: 77), "the community identifies the alleged witch based on suspicious behavior (not uncommon for elderly who struggle with hearing/memory/vision loss) and/or having red eyes (again, not uncommon as a process of aging, and a reaction to smoke from cooking fires)". See also LHRC and ZLSC (2012: 34).

[12] This is an English translation used by a governmental officer, who was in charge of issues on older people at the time interview conducted, of general term for this kind of institutions. These institutions are called "Nyumba ya Wazee" in the national language, Swahili. Thus there are some varieties of English name for it, e.g. "Homes for Old People".

[13] Information about the HFE is based on memoranda by the Social Welfare Division in the Ministry of Health and Social Welfare, and my interviews with them (conducted between September and November 2014, in Dar es Salaam). I appreciate them here for kind cooperation.

[14] *Ujamaa* is a Swahili term coined by the first President Julius Nyerere for achieving African socialism during 1967-1980s. Under the policy, companies and lands were nationalized, and in the 1970s the government radically reorganized traditional rural communities to construct artificial rural units for state plantations.

[15] Accompanying promotion of community based care of (ex-)leprosy patients, co-residence of older people and leprosy (ex)patients in leper's colonies is getting not so strange. See the Nippon Foundation (2014: 6) for a similar case in Romania.

[16] Majority of SSA countries have not prepared official security system for older people, as Aboderin and Ferreira (2009: 55) notes "only a handful of countries operate a formal old age social security system (Botswana, Lesotho, Mauritius, Namibia, Senegal and South Africa)".

[17] For the reason of this definition, Spitzer and Mabeyo (2011: 28) cite an unpublished study which examined people's perception of old age. According to the study, ages of women categorized as old are ranged between 49 and 70 years, and ages of men categorized as old are ranged between 53 and 90 years.

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