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Aging and surviving: elderly women living with illness in rural areas of Senegal

The principle of intergenerational indebtedness undermines the authority of elderly parents, placing them in a position of dependence on their children and exposing them to financial, health and social vulnerability. The first part of this paper examines the living conditions of old people in terms of their position as heads of households. The oldest member of the household is usually described as the head, without taking account of his or her economic status or authority within the household. But the elderly experience a drop in their incomes. They are supplanted as the principal contributors to the household economy by their juniors, who begin to take decisions for them. This is particularly true for elderly women. The second part of the paper starts from observed differences between the positions of men and of women in the household, and aims to show that elderly women are more vulnerable than men in terms of their access to medical care. They tend to be older, and their households have lower incomes, receive lower levels of remittances and have fewer helpers than those of men[1].

Introduction

Old age is often perceived as signifying wisdom, and brings with it an enhanced social status. This is related to the position of the old person as a household head - usually the man who is the oldest household member, with the highest income, and who is the household decision maker. But the polysemic concept of household head is potentially confusing. It can refer to at least three distinct meanings: the head of the (co-residential) house or "*Yaal Mbin*", the head of the (commensal) hearth or "*yaal Ndaak*", and the moral authority or "*Kilifa*". Recently there has been some tentative recognition of the gender aspect of the definition of household head (Tichit, 2002, Pilon, 1996). The household's standard of living does not however depend solely on the income of its head. As well as the composition of the household, the number of resource-persons, and the level of financial transfers and remittances to the household, the characteristics of the head also vary with gender. In general male household heads have higher incomes and are younger than females. Women tend to be heads of households which have lower incomes because there are fewer working members, and also because of the gap in salaries between men and women. Even where women earn more, their responsibilities for domestic expenditure and children's needs are also higher. By contrast, men tend to have control over expenditure relating to livestock and household goods, even if their own earnings are low. In households where the adult men are mostly absent, women heads of households are responsible for both these two spheres of decision making (Posel, 2001). They are more likely to be widows, are less educated, and have fewer economic resources. But their family responsibilities are greater (Schoumaker, 2000).

This paper explores the differences between elderly men and women in terms of their status as household head, and then examines whether these differences in gender, income and age are indicators of a health vulnerability to which women living in rural areas are more exposed. More than half of old people live in rural areas: 63.8% compared with 32.2% in urban areas (Mbaye et al., 2012). They face problems of access to health care, because the majority (70%) do not have old age pensions or state social security. Providing health care for these aging members is a difficult problem for families. The

[1] The findings presented here form part of an ANR project "Harmonising households: the implications of standardised household data collection for the understanding of inter-generational relations in Africa and Europe".

question is how the status of the elderly person in the household may positively or negatively affect him or her, in terms of the care provided by those around them.

The striking inequalities we observe between the households of elderly people in terms of gender, composition and living standards lead us to examine more closely the conditions governing access to medical care by elderly women living with long term illness in intergenerational residential households. The high level of vulnerability of the elderly women studied in this research is notable. In general, they live in households with low incomes derived from artisanal fishing and from agriculture or migration. Furthermore these women have had to stop working because of their illness. Without state social protection, they have become the responsibility of their children. Those who are still dependent provide daily care for them, and those who are employed in jobs or are on migration support them financially to meet their domestic and health costs.

The research methodology is based on qualitative interviews with elderly people living in the Serer rural area and with their helpers[2]. The interviews covered their perceptions and their experiences of old age. We used four indicators of the vulnerability which is characteristic of the majority of the old people in the study: number and sex of children; level of financial means; marital status and age. Data analysis aimed to answer the question: are elderly women more vulnerable than elderly men?

Being a household head: inequalities in status as a factor in old age

Recent research has shown that the statistical criteria used to determine the headship of a household (male sex, age and income) do not reflect the reality of households. Priority is given to the social and economic status of the man or woman (Gning, 2012). In other words, in households where there is an old person, the household head means the oldest family head, recognised as the moral authority or "*kilifa*" in the compound. This person has a certain power over all the other members of the household, who consider him the reference point of the family. He is consulted on all the affairs of the household, he arbitrates, takes decisions and resolves conflicts. As a moral authority, he strives to ensure the stability and cohesion of the household. However, when his age or state of health means that he can no longer manage the household and therefore the family, he passes this power on to one of his children. But even then expectations concerning the functions of the household head remain alive. The aged parent is still perceived by those around him as the mainstay of the household, despite having retired and stopped work. It is a position accorded to him because of his income, in addition to his age. To make up for their decline in income and consequent loss of social status, household heads are expected to satisfy the social demands of the kinship group. It is only elderly people who have more resources who are able to cope with pressure of this kind, which carries the risk of being socially downgraded. In particular this means those elderly people who have the support of their children.

[2] Twenty interviews were conducted with old people in the Saloum delta, in the Fatick region, whose occupation is fishing or agriculture The survey involved asking them about how they perceived their health in old age, and about the different strategies they use to treat diseases they report as being "linked to old age". Given that it is mainly their children who take charge of this, it seemed important also to survey these helpers. Thus about thirty interviews were carried out with these sons, daughters, spouses, co-wives and relatives, either living with an old person in households which are mostly intergenerational, or on migration to towns and cities. For those helpers who have migrated, the analysis relies on the data from research carried out in the suburbs of Paris on the relationships between Senegalese migrants and their parents back in Senegal.

Supporting an elderly relative is done in different ways depending on his or her position in the household[3]. The support may be provided on a daily basis, in the form of personal care (washing, feeding, shopping, domestic tasks, representation at family ceremonies etc.) as well as financial contributions. cThese ways of providing help seem to weigh differently on sons and on daughters. They may involve forms of cohabitation, de-cohabitation or re-cohabitation between generations, depending on whether those providing the assistance are in difficulties themselves or live in relatively favourable economic circumstances (Renaut, Rozenkier 1995). From this point of view, the wives, daughters and daughters in law of the elderly relative have a key role to play, which is not always reflected in the status they enjoy in the household. The physical dependency of the elderly relative is actually managed at home, largely by the female children. Cohabitation is the most appropriate form of support for providing this kind of care. By contrast, financial support, which is more highly esteemed, is provided by working age children and/or those on migration. It is this type of support that enables the elderly person to maintain a position of social prestige. They do this by redistributing the money which is sent to them, making a display of their economic power and consolidating their function as the source of moral authority in the household. Thus they effectively appropriate the status of their migrant children, which they employ to counteract their own loss of social position. This type of financial assistance also provides parents who have no old age pensions with a form of social insurance. It is important to note that it is age that confers and reinforces power in the home. Women have an important role to play once the male head of the household retires, stops work, or becomes dependent. They replace him in managing the basic needs of the household (expenditure, paying bills…). Women are also in charge of cooking – which entitles them to be called heads of the kitchen or "*Yaal Ngaak*". They involve their children not just in the management of the house but in providing them with daily care.

Regular or occasional financial remittances from migrants and working children who are living outside the elderly person's household may be able to prevent a loss of status. However they are not sufficient to shield protect the old from financial poverty which has an impact on their health. Old people who receive regular monetary support from their migrant children have been found to be in no better health than those who do not receive such support (Gning, 2013). These transfers allow them to get by in old age by having a balanced diet –for example being able to afford sugar if they are diabetic - or by paying for a maid, or to consult a doctor and to buy inexpensive medicines *"for the moment"* [4] when prescribed, rather than by having more specialised medical attention. Furthermore this money gives them an extra resource to meet domestic expenses, especially if they are household heads. In short, the financial support provided by migrants and working age children is at a low level, and although it may be vital for its immediate beneficiaries, it is insufficient to guarantee access to medical care for elderly relatives.

This vulnerability in old age is less acute for elderly men than for elderly women. It is men who receive the main financial transfers from their migrant children. In addition they have the advantage of the daily help given to them by their various wives, grandchildren and daughters-in-law in "polygamous households" (Gning, 2012). Their advantage derives from being the oldest and also

[3]The relative may be an old person who is retired but who continues to live with his or her children and family, or the moral authority figure in the household of one or another of their children who is the economic head of household; or the elderly person may be a member of the household who is not related to the other members.

[4] This expression appears in italics to reflect the discourse of the interviewees, who used it repeatedly to signify the provisional nature of the treatments they undergo as a form of self-medication.

being male. Men can get support from a spouse, whereas women essentially have to depend on their children (Schoumaker, 2000).

Are older women more vulnerable than older men ?

The precariousness of the living conditions of older women is related to a number of factors. In particular these have to do with their status in the household, their capacity to generate resources, their chances of being the beneficiaries of financial transfers, the number and sex of their children, their marital status and their age. Some situations of extreme poverty and social isolation for women living in households with or without their children will be described below. Their supporters may be on migration, unmarried or simply still dependent themselves, with a range of situations of continuous intergenerational cohabitation or re-cohabitation (Attias Donfut, 1997). The supporters in turn are faced with the problems of mass unemployment, constraints on migration, marital instability and difficulties in accessing health services for themselves and their families.

Four qualitative portraits are given below to illustrate more clearly the factors underlying the health vulnerability of elderly women, and to show how they get by.

Is it more important to have a son than a daughter as an accompaniment in one's old age?

Having children is still highly valued in rural areas, and children, particularly sons, are seen as an important resource for managing one's old age. Sons are perceived as the future drivers of the household economy, and their wives also provide their husbands' mothers with successors in the domestic management of the household and in looking after their parents in old age. Parents see having only daughters as a disadvantage for their declining years; once married, these daughters will go to live with their in-laws, and will be busy with looking after the needs of their parents-in-law. Their mothers will be helped by the daughters or daughters-in-law of their co-wives. In a system of polygamy, wives cohabiting can combine to make up for such gaps. But on the other hand, wives who have only daughters, only a single son or no children are at a disadvantage in terms of inheritance when a family head dies. Those without children have to leave or be looked after by the children of one of their brothers or sisters. In such cases, a woman who has a long term illness is condemned to isolation on several levels: social, economic, and in terms of health and relationships. The following example illustrates this clearly.

Rama (aged 68) is a widow living in a village. She lives in a hut near the entrance in a large compound where her two other co-wives also live with their grown up married children and grandchildren. Her daughter has left to live with her husband, her son is in the city, and she has to look after her grand-daughter aged 5, who has been ill since birth. Rama has had joint problems for about 10 years and has to live with these, because she has never been able to afford to follow a course of treatment. Her son has difficulty in making a living in the city. He sends her a bit of money from time to time for the needs of the little girl, but cannot meet her health expenses, nor those of his mother. Luckily for her, the household cooks and eats together. Since the death of her husband, who looked after her well, Rama has had no-one to support her. But since the execution of his inheritance, her situation has deteriorated seriously. She is not in the same situation as her two co-wives, who had more children than her, and particularly sons. These sons and their wives are now taking care of their mothers. Rama

does benefit indirectly from the resources brought into the household by the sons of her co-wives living in the same household, because she shares meals with them. However she feels lonely and deprived, as much in relational as financial terms. Her son's absence weighs heavily on her. Her needs are partially met by the daughter-in-law of one of her co-wives, who attends to her, and by the remittances of money sent by her co-wives' sons. *For the moment*, she calms the pain in her feet by the use of powders and roots.

There is a tendency to stress the importance of having male children to discharge inter-generational debt, but this requires some qualification. Sons may be subject to the same risks and vulnerabilities as their parents. In particular a sudden event may prevent them from working – an accident, a divorce, or loss of a job. In other words, rising age at first marriage, poor job opportunities and marital instability are interdependent factors which call into question the easy assumption that sons are more valuable as an insurance against old age. The case of Ndela is a good illustration of this. Since her husband's death, she has been living alone with her children. The oldest, a market trader, has just divorced. The youngest, who is unmarried, has a back problem which prevents him from working. In this situation it is Ndela herself, at the age of 66, who does the housework. *For the moment*, until her sons can pay for her to be treated by a doctor, she makes infusions for herself to calm her dizziness, palpitations and tinnitus, which are due to her hypertension. She can rely on the help of the children of her neighbours to keep her company and do some housework for her. Although she re-married as a widow, Ndela says she has not seen her husband since three rainy seasons ago. He lives in town with his other wives and their children. Her example reveals a degree of social and relational isolation, which affects most elderly widows after their children have left home. It also shows the lack of regular contact with their "*takkoo*" or husbands by widow-remarriage. Indeed the remarriage of elderly widows seems to be a real family issue.

The fact is that having children is not enough to ensure being looked after in one's old age. Daughters leave to live with their husbands, and sons have such difficulty in finding employment that they have many years as bachelors, when they do not protect their old mothers from insecurity. What happens to those widows who are re-married?

Confronting or coping with the absence of polygamous widow-remarriage husbands?

Elderly women can more easily become household heads after the death of their husbands. The prolongation of polygamy through widow remarriage means that they form independent budgetary units, alone or with their children. Thus they take on all the responsibilities for the expenses of the household and of its members, sometimes with very low levels of income. The new husband remains resident in his main household and sees his latest wife occasionally. Indeed, in this type of marriage, the *"takkoo*[5]*"* is not subject to the usual demands which apply to members of a couple. It is a marital link, but one which nevertheless does not afford the wife the possibility of having a life as part of a couple. She is not alone, but is under the aegis of a man who sees her rarely, or indeed hardly ever if she is very old. This type of widow re-marriage resembles some of the new forms of living arrangements in Europe which have been called *Living Apart Together* (Coast et al., 2012). The difference here appears to be linked to the fact that it is only the husband who can take the initiative to see his partner. The converse would be socially disapproved of. The result is that elderly women who have been re-married as widows usually suffer from the effects of this asymmetry. Their situation

[5] This is a Wolof term from the verb "Takk" which means entering a union without the traditional marital obligations such as keeping up a household or cohabiting with the spouse.

reflects a form of male domination, because it is not thought right that they should remain widows. For the children of the elderly widow, in particular the sons, it is not always easy to adapt to such a decision. On the other hand, this does not seem to be a problem when elderly men re-marry, often with younger women who are generally known as “retirement wives”, who can keep them company and help them to “age well”. This social context tends to prolong the sexual life of men, whereas women are led to suspend theirs or to give it up altogether. Re-marriage is therefore more disadvantageous for widows. Apart from geographical distance, other factors such as the cohabitation of co-wives and of generations prevents the spouses from receiving visits from each other in their respective households. This is even more awkward for women like Fatou (aged 64). As the youngest of the wives of her husband, now deceased, Fatou did not remain a widow for long. The family arranged for her to be re-married to a relative of her husband. Her *takkoo* came to see her two or three times in the first year, but since then she has had no news of him; he lives in another region of the country with his first family. It has now been nearly 5 years, but Fatou does not try to see him, because, as she says “people will think I am looking for men”. Instead she prefers to concentrate on her livestock trading, and on her youngest daughter who is at college. She is worried because she has back pain which affects her as far down as her knees. But she makes do with applying an occasional massage balm and taking a potion made from roots. Although she has the help of her young daughter who is still unmarried, she still fears ending up like her mother, who died following a paralysis of her feet: she passed away on her return from the fields, and neither Fatou nor her brother were able to help her; by the time her mother’s neighbours let them know, it was too late. This example suggests that having children and being married may conceal a form of health vulnerability which affects some elderly parents. This vulnerability is all the more evident when members of their social circle live at some distance from them.

How to look after an elderly relative without sufficient resources?

It is important to recall how the unequal distribution of economic resources between members of a household adds to the social and health vulnerability of old people. In the social context of polygamy, this inequality is notable. Each wife with her children forms a budgetary unit, which is mobilised to meet household and health expenses. In this way polygamy creates an important set of issues in the familial economy of dependency when there are insufficient monetary resources. Apart from resorting to the wider family network to meet health costs, a provisional solution seems to be provided by the hierarchy of care provided for the old person. But this temporary response has a way of becoming a long term measure. Here intergenerational inequalities have the effect of inducing those providing help to prioritise health care for younger members and women before their elderly relative. In order to manage in an emergency, they are forced also to define an order or a neighbourhood health centre. The essential feature of these structures is that they are easily accessible and do not require much money to use.

In these kinds of situations, living with and coping with chronic diseases seems a less urgent health problem than an acute infection. Like others in her situation, Méry (aged 71) takes advice from her neighbours about how to treat herself : from ordinary soap to kerosene, she has tried everything, but her eyes still itch. Going to the dispensary is out of the question. Her son is a farmer. He cannot afford to pay for her to see a doctor and then for specialised treatment. For four years Méry tried to cure herself using the local traditional healer. His treatment based on roots and leaves seemed to her to be good value. But in the end she gave up on him and resigned herself to her situation. By contrast, when she had an attack of diarrhoea, her son had no hesitation in taking her to the dispensary. She recovered

after a course of treatment lasting 2 days. But her eye problems persist. She says that as long as she manages to live with them, her relatives seem not to worry.

This example shows how a scarcity of economic resources within a polygamous situation, with no inward monetary transfers from migration or a job, encourages self-medication. This kind of treatment is often reliant on people who are themselves in old age. It is worth pointing out here that this course of action is not simply an effect of lack of means; self-medication is also a matter of the survival of traditional knowledge, reassuring in itself because it is known to the patient. However, going to a dispensary or hospital tends to be negatively perceived by elderly people. For most of them the idea arouses a degree of mistrust, which is linked to the nature of the treatment prescribed there, but is also due to the idea these old people have that approaching such institutions signifies a sort of invitation to come in and die. The consequence is that fear of approaching public health establishments drives some of them towards choosing to self-medicate. The portrait of Dior, who is 73, illustrates this notion. Dior has been living more or less in retirement in her compound with her aged co-wives, and resides in the same courtyard as the wife of her second son. Her oldest son is a migrant in the city. Her daughters have left home. Dior lives with a fractured knee, an injury she has had before. The first time it happened was when she was pounding millet. The second time was last year, when a sheep bumped into the same spot. She chooses to treat herself at home by massaging her knee with shea butter every night before going to bed. Later on, her neighbours persuaded her to go to see a traditional masseur who lives nearby, to re-set the bone. Dior's knee is still painful and she does not sleep at night. She has become worried, but her relatives say she is "pensive" because of her age. Here we find a series of perceptions linked to old age. There is a physical decline which leads to economic and social vulnerability, and those around the old person take this retirement from ordinary life to be an effect of old age.

To conclude on this point, we may say that while the resort to self-medication may seem at first sight to be linked to lack of resources, it does also reflect an attachment to traditional knowledge. It is practised in a way which corresponds to how the disease is perceived. Especially when the ailment is thought to be induced by old age, the treatment has a reassuring rather than curative function. Self-medication also enables old people to treat themselves in privacy and not to upset their family, because in the popular imagination the advance of old age is an approach to the grave[6].

Is medical care accessible if one is too old ?

Old age is perceived as a risky stage of life, prone to a number of pathologies which both old people themselves and those who support them call "diseases of aging". These are difficulties with memory, hearing, and sight, with cataract and high blood pressure being more common, not to mention senile dementia, diabetes, paralysis, nervous depression etc. With the passage of time, there is a progressive loss of capacity to cope. The old person's supporters see their physical and mental shortcomings as inevitable. Investing in an aging person's health does not seem to be a priority, given that the old are viewed as a symbol of continuity but also of finality. It is the younger generations who are seen as more important (Gning, 2012). Those who are "departing" therefore manage their various ailments in private. These personal and private forms of coping range from simple denial of illness to taking more dangerous risks in treating it, including duplicating remedies and using approximate dosages. All this

[6]Some of our most interesting interviews were conducted with old women whose family had warned us beforehand that they were deaf, senile or depressed, in short too old to understand the questions we wanted to ask.

may take place without the old person's family suspecting anything. In the case of Méry this went as far as putting kerosene in her eyes while the rest of the household were out in the fields, in an effort to cure her problem. The case of Khady (aged 91) is a striking example. A great-grandmother several times over, Khady is in relatively good health for her age. As the third wife of a husband who is now deceased, she lives in a large compound with the children of her co-wives, also now dead, and their families. Her three daughters are all married, and have moved elsewhere. Her only son, who worked in the civil service and was his mother's main support, was killed in a road accident. Khady has had an eye problem for some years. Some of her teeth are loose, and others have fallen out. Her hearing is not good. Her family believes that all these problems are a matter of old age – it is not worth seeking specialised treatment for them, according to her daughter-in-law. All this time Khady has been relying on little grandmother's remedies, such as tying a band of leaves round her head, or eating biscuits and milk to stop the diarrhoea which attacks her every time she eats millet couscous. Her neighbours in the compound are unaware that she treats herself out of their sight. "They mustn't find out I am in pain, they will think I am about to die", she says. Her testimony reveals an important point, which is that of beliefs about death. Aging is perceived as an indicator of morbidity in retired people. In this context, old age is a time which is dedicated to the preparation for death (Attias Donfut, 2005). It becomes possible to imagine reincarnation in another life as "Pangools", "Serpent" or "Bois sacré" (Gravrand, 1990).

In conclusion to this second part, we may say that old women are more vulnerable than old men. The four qualitative portraits, selected from about twenty, taken together show the health vulnerability elderly widows are exposed to. This can be defined as: exposure to the risk of not getting access to medical care because of their secondary position in the household; lack of financial means of the women or their children; and the absence or loss of a spouse together with advancing old age. The interdependence of all these factors exposes elderly women to a health risk which results from the economic, structural and relational vulnerability studied by Valérie Golaz and Philippe Antoine (2011). It can be seen in both the simple and the "polygamous" households, where the women whose cases we have seen here live, alone, with or without their children.

CONCLUSION

This article has highlighted the situation of elderly people in terms of their access to health care, and in the light of their position within a household. Elderly women's exposure to health risks is greater than that of elderly men. Examining their living conditions and those of their children, in the absence of their spouses, we have seen that their social networks shrink with age. Family solidarity is overwhelmed by the demands of the multiple diseases of old age. Old people therefore resort to self-medication strategies which in themselves undermine principles of intergenerational debt, because those who incur the debt are not strong or stable enough to be able to honour it. Old people's health deteriorates, and they become even more isolated. They could perhaps have been able to benefit from national social security in old age, if they had been aware of it. The implication is that it is not enough to make access to health care easier, but the health care offered also needs to be targeted.

"For the moment", then, growing old in a rural village means surviving and living with cardio-vascular diseases such as hypertension, degenerative diseases such as diabetes, dementia, and joint and bone disorders, with the prospect of either treating them one day or resigning oneself to coping with them for the rest of one's days. For families who are poor, emergency solutions have to be set up on a sustainable basis to manage the conditions referred to as "diseases of old age". Even if it is true that

the support given by the children of elderly parents, in the form of practical help and of monetary transfers, saves them from extreme social isolation and economic vulnerability, this is not enough to ensure them a reliable and acceptable state of health. Preference for sons rather than daughters, as a strategy for support in old age, seems no longer to provide a guaranteed form of insurance. In addition, there is a lack of ability to afford specialised treatment, in a polygamous setting or when husbands by widow re-marriage are absent. These husbands are often hampered by being far away, and are themselves affected by the treacheries of old age. Their health and their economic situation worsen, but their concern is to maintain their social status. They are striving to remain in their position as the oldest man, with enough resources to take decisions for the members of their main household. In any case, the issues are not the same for an elderly man as for a woman. By insisting that the real status of household head depends largely on economic resources, elderly men are condemned to lose this status. Meanwhile, elderly women aspire to a social retirement in which they do not have a household head's responsibilities. In this way they hope to be able to provide for their own health needs for as long as possible, thanks to the care taken of them by their more prosperous children.

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