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SPECIAL ISSUE • Family care of older people in Southern Africa

research article

Equitable, sustainable and acceptable long-term care in Malawi? Unpacking the implied universalism of key terms in international ageing policy discourse

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Indications of a care deficit for older adults in Africa and the need for long-term care that is acceptable for recipients and providers is well established, as are calls for its format to be 'home-grown'. However, there is a discrepancy between the desire for evidenced African solutions, and the framing of both the problem and possible solutions derived from the Global North. This article draws on qualitative data from men and women needing and providing care in rural southern Malawi to challenge the implied universalism of the key terms of reference in the African long-term care discourse: 'care' and 'family'.

Key words long-term care • Africa • ageing policy • international discourses of care

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Introduction

The problem of a realised or potential care deficit for older adults across Africa is widely accepted. While the body of robust evidence from the region is still relatively small, it is considered sufficient to indicate a series of alarming current and likely future realities (Aboderin, 2019). Policy, advocacy and much research writing tends to follow a broadly similar narrative: first, aggregated, often regional, demographic projections of a rapidly growing population aged over 59 years are presented; second, comparatively advanced evidence of the prevalence of functional impairment at older ages is used, to varying degrees, to reason that a significant proportion of this population will require long-term care (LTC); third, an assumption is made – explicitly or implicitly –

that (direct and indirect) providers of care are typically aged under 60 years old; and, finally, a prediction is made that the balance between the population of younger would-be care providers and older would-be care recipients has been compromised by demographic and social change, and will be further compromised in the future.

This understanding has shaped social science research on African ageing and set the ageing policy agenda since the late 1980s (Freeman, 2012). Initially framed by modernisation theory, over the past decade, political-economy perspectives and ecological frameworks have been used to shape a discourse of pan-African macro-level demographic, social, economic and/or environmental shifts (for example, fertility decline, longevity gains, migration, increased female participation in the labour market, persistent poverty and climate change) creating conditions in which families – the primary providers of care – are not able or not willing to provide required care. Focusing on the consequences for care at the individual level, the body of work that has followed has pointed to poor outcomes for (would-be) care recipients, as well as providers. Studies from across Africa have identified older adults' experiences of insufficient, inconsistent, poorly timed or inappropriate care activities (Hoffman, 2018; van der Geest, 2018; Zelalem et al, 2021), especially among those with more advanced needs (Mwendwa et al, 2021; Adedeji et al, 2022), as well as high direct and indirect costs, psychosocial distress, and poor health outcomes for carers (Shaibu, 2000; Faronbi, 2018; Mwendwa et al, 2021).

Some authors have argued that care is in crisis. All appear to agree that the indications of at least a *potential* care deficit for older adults requires a response. Although calls to critically engage with the assumptions and implied homogeneity of experience in the accepted narrative of declining family care have been made (Aboderin and Hoffman, 2015) – and, to an extent, answered by contextually specific presentations of older age care in societies that are, *and always have been*, continually changing (Hoffman and Pype, 2018) – in the dominant policy discourse, the insufficiency of both family and non-family care continues to be taken as the starting point to ask: 'How can the African family be formally supported to provide appropriate care in these circumstances?'

Indeed, the 'African family' is a central tenet of the spectrum of regional and national policy responses to strengthening care for older adults developed over the past 20 years. For example, the African Union's *Policy Framework and Plan of Action on Ageing* includes recommendations that member states 'Enact legislation requiring adult children to provide support for their parents' (HAI and AU, 2002: 8), 'Learn from traditional values and norms to inform legislation about family values and the care of older persons' (HAI and AU, 2002: 16), and 'Identify, support and strengthen traditional support systems to enhance the ability of families and communities to care for older family members' (HAI and AU, 2002: 16) – a commitment repeated in the body's *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons*, adopted in 2016 (AU, 2016).

Despite apparently slow progress in the domestication of many other AU protocols, policy standards and frameworks (State of the Union, 2015; Boateng, 2017), the emphasis on family in the strengthening of care systems is consistently applied across the various country-level instruments relating to ageing in the region. Malawi's *National Policy for Older Persons* for example, lists the promotion of 'the role of communities and families in care and support of its older members' as both a key objective in itself and a central strategy for meeting policy priorities to bolster the rights of older people and food security (Government of the Republic of Malawi, 2016: 14, 26, 28). Welfare support and state provision of housing and shelter is limited

to the 'destitute' in recognition that 'the family remains the main and most appropriate form of support for older persons', notwithstanding '[changing] traditional patterns of care such [that] extended family values are no longer guaranteed' ([Government of the Republic of Malawi, 2016](#): 18, 16, 15).

Within the discourse shared across existing policy architecture, focus on the family reflects more than the reality of its dominance in the current provision of care to older people – a situation that is mirrored around the globe. Instead, the 'African family' is presented as being unique: a distinctive strength of the region that offers advantages that cannot be attained in the West. The narrative is thus recognised as being shaped by the broader 'African Renaissance' political philosophy of liberation from colonial and neo-colonial ideology and subjugation ([Aboderin and Hoffman, 2015](#)). At the heart of the African Renaissance project lies a push towards 're-Africanisation' ([Rabaka, 2022](#)) and the search for new ways of thinking and responding to problems ([Ntuli, 1998](#)) – ways that are essentially 'home-grown'. Following from the understanding that families were unvaryingly more willing and able to provide care for older adults in the past, policy and advocacy work has called for the exploration of innovative, *African* solutions to the care deficit that are sustainable, equitable and acceptable to families and communities, and that would retain their central role in care provision ([WHO, 2017](#)). Some research ([Freeman, 2015](#)) and calls for further research ([Aboderin, 2019](#)) have noted the importance of exploring norms around family caring with older adults (receiving and not receiving care) and families (providing and not providing care); the application or relevance of these norms within concrete care arrangements; and how these intersect with understandings of, and possibilities for, formal, non-family care services ([Aboderin, 2019](#)).

There is a discrepancy, however, between the desire for home-grown solutions that are grounded in contextualised evidence of caring realities and the framing of the care deficit problem, the nature of the solutions considered and the key questions about them: the conceptualisation of the two key terms of reference in the discourse – older age care and the family/community members who provide it – are neither home-grown nor developed inductively from evidence of care realities across the region.

The concept of care that informs policy, programme and advocacy activities, whether it is specified as LTC or simply 'care for older persons', typically involves adults who have spent most of their lives functioning independently being assisted with these functions in old age when they can no longer do them independently. For example, the AU's *Draft Common Position on Long-Term Care Systems for Africa* states: '*Africa's cultural identity, common heritage and shared values demand the development of systems of long-term care provision ... [for] elders who can no longer live independently*' ([AU, 2017](#): 2, emphases added). What it means to live or to function independently in specific African settings, as well as the extent to which a reference point of living independently makes sense in (any) context, are rarely questioned. For the issue with this, one need only look to the global body of work on the centrality of care in everyday life. Within the African region, for example, empirical work on the care economy has highlighted that much care time is dedicated to meeting the needs of healthy adults ([Folbre, 2014](#)), while beyond it, long-standing and influential theoretical work on care ethics has stressed the reality of human interdependence in *all* settings, challenging constructions of care focused only on tasks concerned with children, the sick and the elderly, rather than all activities motivated by others' needs and carried out for the maintenance, continuation and repair of the world we live in ([Tronto, 1993](#)).

While the applicability of a conceptualisation of care centred on independent living may therefore be limited for most people in most parts of the world, the adoption of this conceptualisation in the *African* policy discourse is particularly surprising. African scholars have dedicated much intellectual energy to developing understandings of personhood in direct and mindful opposition to the perceived individualism of Western thought that apparently underpins international definitions of care. These philosophers and theologians propose a communal orientation to traditional African conceptions of personhood, discussing, with slightly different emphases, the central role that interaction and relationships within communities play in producing the individual (for a critical overview, see [Kaphagawani, 2004](#); [Flikschuh, 2016](#); [Klaasen, 2017](#); [Onyebuchi, 2018](#)). In the field of care, it is specifically this *lack* of individualism in African social systems that has been heralded as key to ‘traditional family care’ ([Cattell, 1993](#)) and echoed in calls for an African Renaissance. An understanding that there is little ‘living independently’ at any age in the region underpins shifting debates about family roles and unpaid care more widely. For example, while more recent regional policy commitments and political statements have stressed the importance of recognising, valuing and reducing women’s unpaid care work ([Moussié and Alfers, 2018](#)), contrasting earlier AU agreements and policies that privilege a familistic framework ([AU, 2004](#)), there nevertheless remains an understanding of, and aim towards, ‘shared responsibility within the household and the family’ ([UN, 2015](#)) for members’ welfare at all ages.

Nevertheless, while a conceptualisation of LTC or eldercare focused on independence requires hypothetical thinking that seems not to ‘fit’ with the ‘African family’ narratives of the policy sphere, it may be perfectly serviceable, provided the emphasis is placed on ‘ability’. For example, in the World Health Organization’s ([WHO, 2015](#)) international definition of LTC, subsequently applied to Africa ([WHO, 2017](#)), LTC is presented as a phenomenon that supports persons lacking *health-related functional ability* ‘to be and to do what they have reason to value’, based on the interaction between ‘intrinsic capacity’ (a composite of all the physical and mental capacities of an individual) and an individual’s environment. Recent efforts to identify objective, internationally valid measurements of intrinsic capacity aim to shape clinical practice, moving from a disease-based to a functional perspective of health in older age ([Cesari et al, 2018](#)). However, beyond clinical practice, in the sphere of the majority of care – that primarily provided by family members – (in)ability, or ‘intrinsic capacity’, for independent living or valued activities is not universally defined and recognised. Decades of research from India, for example, has explored the complexities, ambiguities and contingencies inherent in whether or not older adults are identified as requiring support ([Vera-Sanso, 2005](#)). As I explore in this article, the point at which health-related attributes in a particular environment are recognised by an individual and those around them as making a person *unable* to care for themselves is embedded in local value systems and meanings. It may be that further empirical work comparing the timing of these tipping points and what shapes recognition of (in)ability for self-care in different settings (African and non-African) will highlight whether ‘loss of functional ability’, ‘intrinsic capacity for valued activities’ and ‘ability to live independently’ can stand as comparative concepts or are instead too contextually derived to be used internationally without qualification.

The second element in the conceptualisation of care used in the African ageing discourse – the activities that support older adults’ functional abilities – are similarly

challenging. Where explicated at all, these activities are defined either with regard to LTC specifically (and therefore include both health and social care, as well as contributions to supportive environments, such as education and transport [Pot et al, 2018]) or, more vaguely, as involving assistance with activities of daily living (eating, bathing, dressing and toileting) and/or instrumental activities of daily living (for example, those that require walking, remembering/concentrating and communicating easily). By implication, the latter include both direct ‘hands-on’ support (assistance with washing and movement) and supposedly ‘indirect’ support (providing goods or money). While the nature of caring is widely accepted to differ globally (Tronto, 1993), in the dominant discourse, reference is rarely made to what ‘functioning’ may look like to local populations in the different settings considered, and thus to which activities count as ‘care’ in context (geographical and personal). Consequently, subsequent discussion of buttressing familial older age care systems with formal provision of ‘care’ is ambiguous: what kind of care? Further, that the care Africa must find solutions to obtain is *good* care is implicit in the narrative about declining or insufficient care. This opens up dilemmas about what good care is in different contexts, who decides if care is good and who care is good for (for example, recipients, family providers or the state). What is the nature and focus of the equity strived for? These opacities and dilemmas further remove the dominant narrative from the normative expectations and lived realities of those the policies concern.

Finally, pan-African, national and more local policy and advocacy documents all refer to ‘family care’ or support from ‘family and community’, without explicating these key concepts or exploring the nature of these relationships with regard to care. The image of the African family presented in the dominant discourse is implicitly positive. Upheld as a social structure to be proud of, revered and/or strengthened, the African family is unified and cohesive in its attitudes and aim: it is not self-serving; it is collectively oriented towards the care of others – especially the (easily identified) most vulnerable; it is typically extended; and it is situated within communities of like-minded members. Research from the region, however, has explored the power and passivity of (would-be) care recipients, conflict within families, changing understandings of who in a family or community are (in)appropriate carers in various contexts, and how families, communities and care recipients may have different understandings of the care needed and delivered (Hoffman and Pye, 2018). Rather than bring specificity or nuance to the framing of the problem or potential solutions, this research, according with non-African research on the complex ambivalence, tensions and differing foci of care in the real world (Yates-Doerr, 2014), has typically been used only to support arguments of the present inadequacy of African family care (which may or may not include ‘elder abuse’).

On the one hand, vague and ambiguous concepts serve a useful purpose. In the African LTC/eldercare policy, advocacy and research arenas, the opacity of key terms described is helpfully used both to focus attention on care (whatever that might look like) for people in later (rather than earlier) life and, importantly, to mobilise support for implementing systems to secure it from as many sectors and stakeholders as possible. Wittgenstein taught us that words are given meanings in practical use, not in the abstract (Rayner, 2014). Need we worry where the key terms originated and how they are defined if those using them do so without problem?

On the other hand, I have referred in this introduction to the dominant understanding of the care problem and its possible solutions as a ‘discourse’. In doing

so, I refer to Foucault's concept of contextually contingent social systems composed of ideas, attitudes, beliefs and actions that systematically construct the objects – the world – of which they speak. Foucault's 'discourse' shapes social processes of legitimisation and power (Foucault, 1989 [1969]). Without questioning the care crisis discourse, the reality of insufficient family care and the unacceptability of Western models of formal care to African people become self-evidencing. In this context, exploring the meanings and relevance of the key concepts employed in the discourse for the societies considered is not mere pedantry.

In this article, I reflect on support for older Malawians from the perspectives – the language, meanings and practices – of those involved. I explore normative expectations of when older adults are understood to require 'LTC', the type of care required to achieve 'optimal functioning' and, subsequently, the nature of 'good' care. In doing so, I present a context in which questions or assertions about the acceptability or unacceptability of formal care to support family care, or the promotion of family care, as set out in the dominant discourse, miss the point. The article draws attention to the missing narrative of social protection in calls to strengthen family care for older adults.

Methodology

The article draws on data from two distinct but linked qualitative data sets. The first, generated during 2009–10, primarily comprises verbatim translated transcripts of multiple interviews ($n = 146$) with 44 older men and women living in Balaka district, southern Malawi (for more detail, see Freeman, 2012). The second, generated in 2017, primarily comprises verbatim translated transcripts of single interviews ($n = 66$) with older men and women with care needs, and adults providing and not providing care to older relatives, living in rural areas of Balaka and Blantyre districts, southern Malawi. For this article, I analysed a subset of interview transcripts from Balaka relating to: eight individuals first interviewed in 2009 and again in 2017; five family carers interviewed in 2017 and linked to older adults first interviewed in 2009; and seven older adults and six family carers interviewed only in 2017 and selected as linked caring dyads or triads. The data therefore provide both a longitudinal perspective and insight into how perceptions of caring may differ within families.

While older participants in the original study were recruited based on age (along with other non-care-related factors), older participants and family members in the later study were recruited based on older adults having a widely recognised need for care. In the resulting 2017 sample, older adults were aged in their 60s–90s and typically towards the upper end of this age range. Family members were aged from 19 years to the same age as those they cared for. The gender balance in the full data sets and subsample analysed here is skewed towards women.

In both studies, interviews were carried out in participants' preferred languages (Chichewa and Chiyao) and translated by trained Malawian research assistants. All interviews analysed for this article were conducted in Chichewa. Permission to conduct the research was granted locally by village heads, nationally by the College of Medicine Research Ethics Committee (during 2009–10) and National Commission for Research in Social Sciences and Health (in 2017), and internationally by the London School of Economics and Political Sciences Research Ethics Committee (2009–10; 2017).

I used a generative analysis technique involving careful reading of the transcripts, coding and the development (writing, questioning and rewriting) of a series of linked

and building analytical memos. Translated data presented in the article are illustrative and accompanied by pseudonyms.

Context

Poverty and food insecurity

The endemic poverty and rurality of Malawi's population is central to understanding older age care in this context. The country is consistently ranked as one of the least developed in the world (UNDP, 2020). Over half the population is multidimensionally poor (encompassing health, education and standard of living), and more than 70 per cent live below the international poverty line (US\$1.90 a day) (UNDP, 2020).

Eighty-four per cent of Malawi's population live in rural areas (NSO, 2019), the vast majority working as smallholder farmers depending primarily on self-sufficiency in maize production for survival. Livestock ownership is low (NSO, 2019). Depending on the time of year, *ganyu* (piecework) on the fields of wealthier smallholders in exchange for needed money or food may be available, though this is likely to involve missing important farming periods on one's own land.

Smallholders rely on once-yearly rainfed, low-input farming done by hand without the assistance of animals or mechanised power. Clearing, ploughing, sowing, weeding and harvesting are done either using hands or a handheld tool, necessitating physical agility and strength. Agricultural production levels are on average only a fifth of that achieved in Tanzania, Uganda and Kenya (Ellis and Freeman, 2005, quoted in Verheijen, 2013). Most rural Malawian households cannot consistently produce enough food to sustain themselves, nor can they rely on Malawi's weak markets to profitably sell agricultural products or purchase additional food when needed. A 'good' yield is enough for an average household to feed itself for around seven months. The scarcity of income-generating opportunities and high prices due to scarcity and huge demand in the remaining five months leads to an annual 'hunger season'. This peaks in January and February, coinciding with the period when most labour-intensive agricultural activities must be carried out.

Stable nutrient consumption declined for all rural households regardless of wealth between 2010/11 and 2016/17 (Gilbert et al, 2019). More than a third of children under age five are stunted, a sign of chronic undernutrition (NSO and ICF, 2017). As Verheijen (2013: 65) reminds us, 'hunger is not just one of the many faces of poverty – it is the ultimate sign of it', indicating ownership of few other possessions. Both the incidence of multidimensional poverty and the prevalence of malnutrition are highest in the country's southern region (NSO, 2021), the site of this study.

Economic transfers

While around 97.5 per cent of Malawi's older adults have no access to a pension, the Social Cash Transfer Programme, targeted to ultra-poor and labour-constrained households, is expected to closely align with old age. Nevertheless, its reach is limited. Very few participants in the present studies received it.

A normative moral imperative for those with resources to support those without underpins the economic realities of daily life in Malawi, along with understandings of 'formal care' that I explore in this article. In her detailed ethnography of life in a southern Malawian village, Verheijen (2013) tracks the 'social life of money' and the

dynamics at play. She describes how money, entering the system rarely, is quickly circulated within the village. Recipients spend, gift and lend money, accumulating social capital and access to loan repayments that can be called upon when required. While there is limited access to formal finance and few people have savings, depending on the past generosity they have shown, individuals may be able to access money (typically small sums) in times of need. Village outsiders with money – government and non-government organisations, as well as foreigners – are expected to share with rural Malawians who do not have it (see also [McNamara, 2022](#)).

Older adults' environments

Most village communities in Malawi's south are matrilineally and matrilocally organised. Women inherit land and remain resident near their maternal kin. Men typically join their wife's home at marriage, assisting her to cultivate her land and building a house that would be hers to keep in case of divorce. Marriage and divorce are fluid and dynamic, as is household and compound composition. Nevertheless, household survey data from across the country indicate mean household sizes of around six ([Myroniuk and Payne, 2019](#)) and that most older adults live with some of their children and grandchildren, just their children, or just their grandchildren ([Kendall and Anglewicz, 2018](#)). In the field site, it was not unusual for older adults to live alone or with extended families (for example, siblings and nieces/nephews). Increasing household size is associated with higher wealth, primarily driven by the presence of younger adult men ([Myroniuk and Payne, 2019](#)).

Homes in the field site mainly consist of one room, containing a reed mat for sleeping on, a blanket, limited clothes and few other possessions. They are constructed of burnt mud bricks, thatched with grasses or, more rarely, corrugated metal sheets, and set within bounded compounds.

Adult family members living within the compound each have their own single-room building, shared with a spouse and sometimes children. Except for sleeping, sex and the bedridden, life happens outside of these buildings. Open-air bathrooms, where water collected from village boreholes is heated over a fire for washing, are towards the edge of a compound and screened. Some compounds have a separated pit latrine within this area, while other families use neighbours' latrines or bushes.

Compounds are typically, though not exclusively, arranged in villages. Residents' fields are usually between compounds or to the edges of villages but can be some distance away. Where they exist, roads between villages are dirt and often difficult to pass, especially during and immediately following the rainy season.

Care for older adults

There are few specialist healthcare services available for older adults. There is one 'elderly care clinic', located in Blantyre. Public general healthcare services are delivered through the Essential Health Package, which does not adequately respond to the needs of an older population ([Nyasa et al, 2019](#)).

There is no government provision of social care. An underfunded local charity sector provides sporadic, geographically limited relief to small numbers of older adults, such as fertiliser subsidies and blankets. There is one residential care facility for older adults, catering to fee-paying elderly Europeans.

Most care is delivered by family. As identified globally, normative expectations of support are carer specific. In the field site, spouses are presented as the most appropriate primary providers of support for an older adult in need, especially personal care. As at younger ages, remarriage in older age is an accepted and recommended strategy for securing support.

Both alternative and supporting carers should be drawn from the older adult's maternal family (for example, siblings and older nieces/nephews) and adult children, who will be sent for if not co-resident. Both men's and women's contribution to caring is expected, though personal care that involves handling the (especially naked) body is expected from, and most likely carried out by, same-gendered kin, or women if they cannot be sourced. Where a willing fellow older adult (spouse or same-gender sibling) is available for personal care delivery, adult children's care roles should complement this, focusing on the provision of financial support and assistance with farm and housework and any 'heavy lifting' that may accompany personal care delivered by others, regardless of gender.

Grandchildren and great-grandchildren occupy contradictory positions in expectations of care. Normatively, children and young adults should help with housework and offer some level of company for an older adult, and if young enough, they can be relied upon not to be distracted from giving care by their own lives. 'Giving' an older adult a child to live with is a frequently discussed familial care strategy. Nevertheless, children and young adults are concurrently understood to lack the skills, means and maturity to provide much of the care needed by older adults. In the field site, it was common for older adults living only with the assistance of children to describe themselves as being without support. Regardless of relation, caring of any kind is only expected by those who the older adult has invested in physically and emotionally (Freeman, 2018).

Results

Most international definitions of LTC centre on activities carried out with the primary goal of enabling individuals to achieve and maintain optimal levels of personal functioning (Freeman et al, 2017). Interview narratives across both data sets are remarkably consistent about what optimal personal function at older age for any individual looks like. Reflecting daily realities for the poorest and wealthiest participants alike, having adequate food was the primary attribute. Participants' focus on sufficiency of ingredients, rather than, for example, ability to prepare and eat food (that is, feed oneself), is likely to contrast contemporaries in settings in which basic food security is not exceptional and people can expect to live longer with advanced need for personal care. Following food, a watertight home and accessible latrine, soap, medicine and clothes are the key features of a 'good life'. While these things are not guaranteed at any age, participants understood that the possibility of securing them for oneself through physical labour lessens in older age.

Even when participants were giving, receiving or lacking needed assistance with the most rudimentary activities of daily living, such as bathing, toileting and mobility, it was basic needs for food and shelter that were prioritised in discussions, rather than direct 'hands-on' assistance. Mercy, for example, lost her sight a year before our interview in 2017, and an impaired nervous system severely restricts her movement. Since her three children migrated from the area, she lives in a compound with her

married granddaughter. Mercy provides an unambiguous report of lacking needed personal care:

‘My life is so miserable.... I cry every day because there is no one who is here to take care of me.... My grandchild prepares water for me ... [and] though my body is weak, I do force myself to go and take a bath. Sometimes, I have to crawl to the bathroom, and it means that when I am coming back from there, it is like I have not taken any bath because I still look dirty because I was crawling [across the compound].... Every human being deserves a dignified life, but ... when I want to go to the toilet, sometimes I do it in the house and have to cover it with dust and take it out in the morning. Sometimes, I use the bush which is behind my house.... I think people think because I am blind my nakedness has no need to be respected.’

However, when asked her greatest concern and the assistance she would most value, Mercy did not prioritise more personal care – someone to assist her going to and from the toilet and bathing area – but rather changes to her environment that would secure her basic needs. She was quick to answer that it is primarily food – something she is, by her and her granddaughter’s accounts, already provided – followed by money that she could use to pay someone to farm her land and construct her own bathroom and latrine, which would improve her life. As I will explain, such answers do not appear to be (solely) aimed at motivating researchers’ aid.

When assistance is needed to enable optimal personal functioning, two different types of support are required. These are easily conflated in international discourse about ‘care’, but while both are intimately connected to the quality of assistance received and the consequences of providing it, they are quite distinct for participants. First, *chithandizo* (translated as ‘help’) comes in the form of financial or material assistance: the giving of goods (for example, food, blankets and building materials) or significant physical labour, such as constructing a latrine or house, rethatching a roof, and farming. Second, *chisamaliro* (translated as ‘care’) comes in the form of assistance with household activities like collecting water, cooking and sweeping, and with activities internationally defined as being those of daily living, such as supporting an older person to use the latrine, as well as assistance understood to be required only when someone is very ill, such as constant supervision.

Reflecting long-held norms around the transfer of economic resources from rich to poor, *chithandizo* is expected from, and provided by, not only family members who have the resources available, but also government and non-government organisations. Healthcare provided by a hospital, for example, is *chithandizo* (*chithandizo cha mankhwala*), while the supportive care provided by the person accompanying the patient – food, water and keeping the patient comfortable (as is common in the region, this not being provided by the hospital) – is *chisamaliro*. *Chithandizo* may additionally be given by friends with whom the recipient has sufficient social capital. *Chisamaliro*, on the other hand, is expected from, and provided by, primarily family members and, more rarely, friends and community organisations (for example, church groups). More than *chithandizo*, *chisamaliro* implies affective concern (‘caring about’ in English), in addition to practical action (‘caring for’ [see Buch, 2015]). Its provision is therefore highly dependent on the strength and nature of the relationship between giver and recipient. *Chisamaliro* without affective concern is unlikely.

While *chithandizo* is given sporadically and *chisamaliro* may be much more regular, both are ongoing throughout people's lives, corresponding to periods in which such assistance is essential, as well as only helpful. For example, financial assistance and resources like relish and soap are widely expected to be shared by family members who have them with those who do not, regardless of age; house and latrine building and maintenance (for example, yearly rethatching) should be carried out either by male family members or men paid by the *chithandizo* provider throughout adulthood. Similarly, while cooking is unlikely to be shared between any family members who farm separately for most of the year, during 'hunger season', sharing limited maize among family (*chithandizo*) may include cooking it too (*chisamaliro*). Assistance with other household tasks, such as sweeping, washing clothes and collecting water (*chisamaliro*), may also be provided when the recipient is capable of doing these things themselves.

In contrast, some *chithandizo* and *chisamaliro* activities are reserved only for when an adult is *incapable* of performing essential tasks independently, as recognised by the older adult and those called upon to assist them. Personal care and supervision are in this category, as is farming assistance given by those not expecting to share the yield. Significantly, for many of the cases discussed in these transcripts, the timing of the recognition of dependence and need for assistance of this nature meant that, in practice, this 'aged-' or 'long-term care' (in the parlance of the international policy arena) might equally be termed 'end-of-life' care.

Despite sampling on locally established need for care or participation in interviews as an older adult almost a decade earlier, most of the older adults we spoke to or about in 2017 were still working for their and their families' physical subsistence – usually farming, though at least shelling the family's maize or weaving mats for sale. Rather than reflecting their experience of good health into old age, older adults' continued (direct) food-generating work was understood by all to be a necessity. Take, for example, the following excerpt from one conversation with Davidson in 2009:

'I can't stop farming; what am I going to eat? Eee, I go and do the work [but] know that at night, I will be in pains. If I am lucky and wake up in the morning, I take a hoe and go to work in the garden. Though I cry at night, I know that I will get food. Our elders used to tell us ... "It's better to die in the garden because tomorrow you will get something from it."'

Consequently, when his wife Emma talked to us in 2017 about the relatively short time Davidson stopped farming and became fully dependent before his death in the intervening period, we should not, I think, interpret that as Davidson having farmed until that moment with ease, or without what might be recognised elsewhere as need for assistance. While in other settings, ceasing directly food-/income-generating work may be a first stage of dependency, with an older adult still able to function independently in other areas of life (for example, bathing and preparing meals) and perhaps provide care that is indirectly income generating ('care work', such as childcare, so that other adults can carry out directly income-generating activities), evidence from across the two data sets examined here suggests that older adults in the field site typically continue food-generating work until they require support in most other areas of their life. 'Not working' – primarily farming – therefore becomes shorthand for high need for both *chithandizo* (food the older adult cannot provide) and *chisamaliro* (supportive care around the home).

Significantly, illness, rather than old age itself, was widely understood as the reason an individual would cease working and receive this support. Participants discussed the cases of older adults who had both shorter periods of incapacity before death, lasting a few weeks or months and frequently understood as being *unexplained* illness, and longer periods during which incapacity grew and dependency became absolute. Again, for these latter older adults, symptoms and inability to work were linked with chronic ill health, rather than age. For example, from reports of their symptoms, I expect that some older adults discussed in the transcripts were experiencing undiagnosed dementia. However, their symptoms are not dismissed as old age as they may have been in other settings (Musyimi et al, 2021; Oliveira et al, 2021), but regarded as ‘mental illness’. Other participants discussed instances of older age that were marked by increasing episodes of ill health necessitating intensive *chithandizo* and *chisamaliro* and between which the older adult would continue to work.

Drawing on 2009–10 data, I have previously discussed the importance of continued productive activity for people’s identity in this setting, based on understandings that ‘work’ (in participants’ [translated] parlance, and including domestic and care work, especially when lacking strength for farming) is essential for physical and social survival (Freeman, 2018). Data generated in 2017 support this interpretation, providing further evidence of the context and consequences of an individual failing to work. Central to both younger and older adults’ understandings of when inability for self-care and need for support begins is the high cost borne by providers of the *chithandizo* required when an older adult can no longer contribute to food generation, and the intensive *chisamaliro* that frequently coincides with this, should these periods last more than a few weeks.

When an older adult cannot farm or earn money, in most families, their calorie needs cannot be met by simply sharing out the food secured by others. In the absence of savings, someone must farm on the older adult’s behalf, earn money to buy food, appeal to family living elsewhere to send remittances or appeal to any friends with whom sufficient social capital has been built. Where the latter appeals are unsuccessful or not timely, as is frequently the case, families without sufficient bodies to compensate for the older adults’ labour experience (increased) food shortage.

When need for *chithandizo* overlaps with need for intensive *chisamaliro*, food production by two previously productive bodies is halted, as the carer stays home to provide *chisamaliro*. Should this last for more than a few weeks, the consequences for the carer and their dependants can be severe. Even if the period of required *chisamaliro* is only a few months, if it falls within a vital period for farming, for families without bodies to compensate for the loss of productive labour or members sending sufficient remittances to support the older adult, the carer *and* the carer’s dependants during this period *and* for subsequent periods, food insecurity is increased not just for that year, but possibly several years.

Esther’s case illustrates this well. She lived with her sons and a daughter-in-law, along with her mother and grandmother, for whom she provided *chisamaliro* simultaneously. During this period, which coincided with the planting season, she could not farm, but was among the most fortunate: her sons could continue to farm their shared land. Nevertheless, unfavourable weather and reduced labour meant that they produced just three bags of maize that year, rather than the 20 needed. To ensure she and her family had enough food for the coming year, Esther planned to find *ganyu* to

get money to buy maize to meet their immediate demands, rather than farm her own land, while her sons would continue to farm for food the following year and her daughter-in-law would stay in the compound to care for Esther's mother (her grandmother having died). Losing Esther's and her daughter-in-law's farming labour in the period following intensive *chisamaliro* will leave the family experiencing food shortage for subsequent years.

Similarly, Agness and Charity, both older women themselves, cared for their sister and mother together for a seven-month period, during which they were unable to farm. Both women have children, so there 'should' have been enough bodies to compensate for their being unable to farm for this period and/or someone to 'find' money for essentials like medicine. This was true to an extent – their two sons continued to farm, though this was not sufficient to make up for the loss of labour, and a grandchild in a neighbouring town was eventually able to send money, though not when it was required. As a result, the women not only did not farm their land, but also sold their maize supplies and withdrew their savings from the village cooperative for money that was needed urgently. Poignantly, both women reiterate that these were sacrifices willingly made:

'I did not farm during that time, and it affected our crop yield; I was not worried because I knew that we can buy maize but we cannot buy life.... I loved her, and I did not want her to be suffering.... I am not worried that this year I will not harvest maize because I was caring for my mother ... that is the most important thing.' (Charity)

While Agness and Charity present their decision to provide *chisamaliro* at the expense of their own food security as obvious in light of their relationships, for other participants and those they discussed, the choice is more difficult. This was especially the case for those without the additional family support that Agness and Charity benefited from, or those with dependent children. With such high provision costs, need for intensive *chisamaliro* for longer than a few weeks frequently involves a difficult decision in which, sometimes, *chisamaliro* cannot be prioritised:

'[My husband had been sick for one year.] It was very difficult to have the things we needed. I would still go to the field and farm because I knew there was no one who would come and help me [provide *chithandizo*]. So, when it came to the time of harvesting, my friends would come and help me to harvest. [But] my friends would only come to help me when they saw that my husband's condition was at the end [close to death]. I have suffered a lot. It has been a long time of suffering. His relatives? Even up to now I have never seen their faces.... I was selling maize [because] I did not have any form of *chithandizo*, and I would use the money to buy the basic things which we needed at home.' (Emma)

The trade-off between supporting an older adult and supporting oneself and other dependants often meant that the *chisamaliro* and *chithandizo* provided was insufficient. Transcripts describe cases of older adults receiving support only intermittently during periods of need, or of a lower quality than they would have liked: being given *chithandizo* just once; being brought meals sporadically and unpredictably; and

a lack of vigilance to need, so that an older person was left stranded in their house unless they could ‘crawl’ to tell someone. Narratives of older adults themselves circled between sadness/frustration with the support they received and acceptance that their families could not do otherwise. Similarly, several older adults lamented – though understood – receiving *chisamaliro* and *chithandizo* when they have been very ill and unable to work, but receiving neither as soon as they were deemed able to do some work again, despite, they felt, still needing support.

Loveness, for example, did the best she could for her grandmother but is candid about not being able to provide the *chithandizo* needed:

‘I still feel that I would have done more.... In terms of money, I am not able to provide her with anything which she wants.... When my children started school, it was very difficult to support them with their school needs and at the same time find means to support grandmother with her needs.... [To prioritise], you start in your house and later on go outside.... I would first make sure that my children have the school uniform and all their needs have been met, and after that, I would then start thinking about my grandmother and provide for her needs if the money is still available ... she understands that there was nothing I could have done.’

These realities underpin why descriptions of what constitutes good *chithandizo* and *chisamaliro* centred on their reliability. Across all reflections on both real and hypothetical support given or received, both sufficient and insufficient, the underlying goal is the same: support that is regular, adequate and ongoing, and does not jeopardise the provider and their dependants’ core well-being. While only *chithandizo* seems immediately to be concerned with money, these data strongly indicate that the type of *chithandizo* and *chisamaliro* required during a longer period of dependency have an unaffordable financial cost that precludes most from delivering ‘good support’.

In light of these understandings, the acceptability of ‘care’ provided by an organisation, as it was initially phrased – the question having been formulated naively and in English – was obvious to participants and somewhat confusing. Regardless of the specificity of the language eventually used to pose questions about non-family support, participants answered with regard to the support they understood as *most needed* if an older adult cannot work and most relevant to anyone wishing to help: *chithandizo*. The following excerpt is typical:

Interviewer: ‘What do you think are the care needs of [your grandmother] in future? [Silence.] We are talking about *chisamaliro*, that’s bathing, feeding ... not *chithandizo*.’

Participant: ‘Agogo? She will need food and good sleeping place. She will also need good place for bathing and soap [*chithandizo*].’

Chithandizo is, by definition, help provided by both family *and* non-family. Whether or not they had been beneficiaries, participants were all aware of *chithandizo* provided by organisations throughout the life course, if one was lucky (for example, fertiliser coupons or maize relief during drought years). There was no debate about whether a dependent older adult or their family providing *chisamaliro* would be happy to

receive *chithandizo* – money, maize, compensatory assistance farming or construction – provided by *anyone*. Moreover, and despite experience to the contrary from aid programmes in the area, participants universally understood that unlike support provided by families, organisations could and would provide *chithandizo* that was sustained and reliable: ‘good care’.

But what of non-family providing *chisamaliro*? The question baffled most participants and answers became stilted. This was not something anyone had considered before; only a few participants knew of non-familial *chisamaliro* in the form of church and community groups occasionally visiting sick older adults to help with housework. Accepting or refusing this kind of assistance was difficult to conceptualise in the context of their lives, or within the meanings of *chisamaliro*.

A minority of participants expressed discomfort with the idea of non-family providing personal care, blaming the likely indiscretion of such carers or the negative reflection on their family’s care that it would convey. More common was suspicion about why someone without a close relationship with the recipient would offer to provide *chisamaliro* given the difficulty of the tasks and high personal costs involved. However, when the possibility was explored of *chisamaliro* being provided by a funded charity or the government, rather than the village ‘well-wishers’ that had first come to mind, these participants understood providers’ motivations to be unproblematic and in keeping with moral norms of intra-national sharing of resources. In the hypothetical (but *unlikely*) situation of organisations offering *chisamaliro*, refusing it would run counter to the mutual affective concern (‘caring *about*’) integral to the construct of ‘*chisamaliro*’: older adults would naturally prefer care that did not burden their family, while their families would be happy that older adults were receiving more timely and consistent care than they could provide. Such a situation would ostensibly be a win-win, according to older participants, such as Yamikani, cared for by his two wives and son:

- I: ‘Do you think you can be taken care of by someone who is not related to you?’
P: ‘No, someone who is not related to me cannot take care of me. You need to be cared by someone who knows you very well. What the others can do is just to come and greet you, and off they go. They will not be having the concern as your relatives.’
I: ‘What about if an organisation comes with concern for caring for the old people? Would you be willing to be cared for by the organisation if they provide the same care as your relatives do? Which one will you choose?’
P: ‘I will choose the organisation to take care of me.’
I: ‘I mean *chisamaliro*, not *chithandizo*.’
P: ‘Yes, I know. I would prefer to be taken care by the organisation.... [It] will provide care for a long period of time. My relatives will be *kukodwa* [trapped/have hiccups].... What I am saying is that my relatives may have some shortcomings, while the organisation can provide the care for a long time. My relatives may face problems and challenges, while the organisation has plans which will have to be undertaken.’

Nevertheless, while these reflections on previously unconsidered and decontextualised ‘formal care’ (*chisamaliro* from organisations) may indicate desire for it, especially given the more established meanings of *chisamaliro* drawn upon, it would be naive to expect the reported views to represent participants’ conclusive thoughts on the topic.

Discussion

I have suggested that without critical engagement with the discourse of a realised or potential crisis of care in Africa, the reality of insufficient family care and the need either to strengthen it and/or provide non-family care becomes self-evidencing. In the field site, the discrete concepts of *chithandizo* ('help', including transfers of goods and money, and farm and construction labour) and *chisamaliro* ('care', including household support and personal care) describe activities that in English, as well as the language of the discourse, are collectively considered 'care'. Without an appreciation of the distinction linguistically, translated interview narratives are ambiguous and available to evidence adequate or inadequate care, depending on the reader's perspective. Without an appreciation of the meanings, contexts and norms around these two constructs, the question of whether family care requires strengthening with formal care is the obvious analytical next step. Likewise, when approached within the discourse, the difficulty with financing care that participants discuss merely substantiates the account of declining family care in response to economic conditions. This maintains international attention on the role familial care could or should play, rather than on addressing the entrenched structural inequities played out in it.

However, the evidence presented here challenges the implied universalism of the key concepts in the dominant presentation of the aged-care problem and possible solutions. *Chithandizo* and *chisamaliro* are given and received across the life course. However, both older adults experiencing need for support and families (not) providing it recognise a period of incapacity for self-care in which both types of support become more intensively required: 'long-term care' in international (or, more accurately, Global North) locution. Understandings about the onset of this period are based on the imperative for self-sufficiency in this setting and normative expressions of familial love by the older adult, in turn, based on understandings about the high cost of providing support and rooted in the local economic landscape. Subsequently, in practice, 'functional inability' arrives late in an individual's life and is frequently all-encompassing. The expectation of gradual decline in self-care, from retirement to initially limited and then increasing support needs, observed in the Global North is not echoed in rural Malawi. '(In)Ability to live independently' is contextually defined, and in the field site, it is based on when older adults and their families can afford to recognise it, reflecting the communality of (social and physical) life in this setting. Policymakers and programme funders will need to grapple with these important differences in the normative timings of LTC, as well as the understandings, meanings and environmental conditions behind them, to target recommendations and interventions appropriately and sensitively. Whether interventions should support the delivery of LTC from an internationally or locally defined point of need will entail both ethical and practical consideration.

Similarly, participants' understandings of the activities that compose 'long-term care', as well as the most important among these, are based on local conceptions of 'optimal functioning' that may or may not be shared in other settings. Participants universally prioritised *chithandizo*, especially food provision for older adults and carers prevented from farming, as the key LTC need and activity. However, since sufficient *chithandizo* was rarely readily available, carers made difficult choices between using their time to farm to secure their and their dependant's well-being (*chithandizo*) or providing needed *chisamaliro*. In such cases, an older adult may receive patchy, insufficient or mistimed *chisamaliro*, as well as insufficient *chithandizo*. These realities underpin why descriptions of what constitutes good support (*chithandizo* and *chisamaliro*) centred on its reliability.

Consequently, questions about the *acceptability* of non-familial eldercare to families and older adults make little sense in context: *chithandizo* is understood to incorporate transfers of resources from non-familial sources; both *chithandizo* and *chisamaliro* from non-familial sources is expected to be plentiful and reliable – definitional qualities of ‘good care’. In Malawi, more pertinent questions may centre on the nature, funding, management and delivery of a *chithandizo* system to support older adults and family carers.

Such questions are not at odds with research and policy on Africa’s broader care economy (inclusive of care for children and sick and disabled people), which is seemingly rarely cross-referenced by that focused on ageing and care. Within this work, the importance of ‘infrastructure development, social service provisioning, and social protection programmes’ (UNRISD, 2010: 2) in influencing the supply of care has been noted for some time, along with their likely benefits for the development of human capabilities, including economic advancement (Folbre, 2014). More recent proposals within the ageing and care space for LTC to be included in the sustainable development agenda (Pot et al, 2018) are therefore promising.

However, the meanings of ‘good care’ presented in this article suggest that caution is required. Strong critiques of the assumed congruence between development agencies’ and Malawians’ understandings of sustainability have been levied with regard to HIV/AIDS programmes (Swidler and Watkins, 2009), and development practice more broadly (McNamara, 2022). They have highlighted a lacuna between donors’ understandings and prioritisation of interventions that do not depend on external resources, such as training and ‘sensitisation’, and beneficiaries’ definition of sustainability that centres on ongoing resource transfers from rich to poor. The result is ‘development’ that is neither sustainable nor equitable. Formal *chithandizo* (and possibly *chisamaliro*) would be welcomed by participants in this study. However, for this assistance to be ‘good care’, it must be continuous and reliable. Promoting ‘the role of communities and families in care and support of its older members’ (Government of the Republic of Malawi, 2016) cannot be achieved by training or ‘sensitising’ families to do better; given long-standing global economic inequities, neither will it be achieved by Malawians providing or funding such support (McNamara, 2022).

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Conflict of interest

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