Ageing and its problems in the era of HIV/AIDS in the Mafikeng Local Municipality of the North West Province of South Africa

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DECLARATION

I, PAUL BIGALA, HEREBY DECLARE THAT THIS DISSERTATION IS MY OWN ORIGINAL WORK THAT HAS NOT BEEN PREVIOUSLY SUBMITTED BY ME FOR A DEGREE AT THIS OR ANY OTHER UNIVERSITY, AND THAT ALL MATERIAL CONTAINED HEREIN HAVE BEEN DULY ACKNOWLEDGED WITH COMPLETE REFERENCES AND ACKNOWLEDGMENTS.

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ABSTRACT

The aim of this study was to examine the socio-economic and demographic problems affecting the elderly in the era of HIV/AIDS, with a specific focus on the Mafikeng Local Municipality of the North West Province of South Africa. These include issues of poverty, health, violence, lack of housing, limited funds and the responsibilities of care-giving and its burden.

Two primary sources of data were used. In the first instance, a structured questionnaire was used to collect data from 506 elderly households randomly selected from rural and urban enumeration areas in the Mafikeng Local Municipality. In the second instance, an instrument was designed for focus group discussions on HIV/AIDS and how these impact on the elderly. The focus groups consisted of elderly care givers who were carefully selected from centres where they usually met to discuss their common challenges in as far as care-giving is concerned. Bivariate analysis was used to establish any relationship between variables while multi-variate was used to show the predictor variables.

The study found that the main problems faced by the elderly include income poverty, lack of access to health services, physical safety, lack of respect from the community, poor housing and living conditions. The main effect of HIV/AIDS on the elderly was that related to the caring of both their own sick children and their often orphaned grandchildren following the death of one or both of their parents due to HIV/AIDS-related illnesses. This involves their healthcare, clothing, education and the provision of food not to mention emotional support. Older women in particular provide the bulk of the care for the adults and the young children while they are themselves at a great risk of being infected by the HIV/AIDS virus. This study ultimately provided insights into the socio-economic and demographic issues still affecting the elderly. Although this study focused on a particular area of the North West Province, thus limiting its overall findings, in terms of area, it does give an indication of the concerns that require urgent attention especially those who have taken up the role of care-giving throughout South Africa, a nation that is worst affected by the HIV/AIDS pandemic.

In light of the main findings, the study recommends a drastic change in the pension scheme for this category of the population, user-friendly health services, direct education support for the orphans and access to proper nutrition.

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANOVA	Analysis of variance
CEB	Children Ever Born
EA	Enumeration Area
GEPF	Government Employees' Pension Fund
ID No	Identity Number
MRC	Medical Research Council
NCDS	Non Communicable diseases
PRB	Population Reference Bureau
SPSS	Statistical Package for the Social Sciences
UNFPA	United Nations Population Fund
UN	United Nations
WFP	World Food Programme
WHO	World Health Organization

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CHAPTER ONE

INTRODUCTION

1.0 BACKGROUND

The rapid global growth of the elderly population has created an unprecedented demographic revolution that started in the most developed countries at the beginning of the 19th century (United Nations, 2002b). For example in 1950, there were about 200 million people aged 60 and above compared to 2000 when there were about 580 million, and by 2025, the number of people over the age of 60 is expected to reach 1.2 billion (Ramashala, 2002:2). Similarly, by the year 2050 the number of older people in Africa alone will be between 204 million and 210 million (Help Age International, 2002b). In 2006, 64 percent of the worldwide elderly population were living in the developing countries, and this number is projected to increase to nearly 73 percent by 2030 (Velkoff and Kowal, 2007:1). A decline in mortality followed by a decline in fertility to below replacement levels in some European countries has led to the upward increasing trend of the elderly population. This phenomenon has been due to improvements in hygiene, water supply, urbanization, control of infectious diseases and the status of women in all aspects of life (Ramashala, 2002:1). Currently, socio-economic improvements in the developed nations have started filtering through to most parts of the developing countries. As a result, the proportion of the elderly people is increasing throughout the world at a very rapid rate.

The rise in the overall proportion of the elderly populations in the developing world is likely to create new challenges for the future. Unlike in the developed nations where the elderly people are able to sustain themselves, either covered by social security schemes or supported by their own savings (UNPFA, 2002:21b), the situation in the developing world is totally different. Most of the elderly in developing areas, such as in Africa, live in impoverished conditions, resulting from poor socio-economic conditions with inadequate support. The lack of social security leaves the elderly people at a distinct disadvantage, more especially at a time when the family and the community are unable to offer the support and care that was traditionally given to them. This could largely be ascribed to urbanization and the migration of the younger generation to find better job opportunities (Help Age International, 2002c).

It is noteworthy that most developing countries, particularly sub-Saharan Africa, still have youthful populations due to persistently high fertility and moderately declining mortality as a result of medical advancements (PRB, 2004:6). However, there are some sub-Saharan African countries that have moved past the second stage described in the demographic transition theory, leading to lower fertility rates (Makinwa-Adebusoye, 2001). This means that they have relatively youthful populations as well as considerable elderly populations, thus creating a long-term challenge of sustaining their elderly populations in addition to their youthful populations. Demographic data for the older population is scarce due to more pressing political, demographic and health issues, such as HIV/AIDS that have confronted the continent. This limits the understanding of the situation of older people in sub-Saharan Africa and necessitates systems to collect data essential for accurate demographic estimates and projections. In addition, older people generally constitute a relatively small proportion of the overall populations and are growing fairly slowly compared to other areas in the world (Velkoff and Kowal, 2007:1).

In the era of HIV/AIDS, the situation of the elderly population particularly in sub-Saharan Africa has further deteriorated. In the past two decades or so, the developing world, particularly sub-Saharan Africa, has been hit by the HIV/AIDS epidemic with devastating and under-reported economic, social, health and psychological repercussions. Large numbers of households have lost their breadwinners to the pandemic, with the elderly having to stay at home to look after relatives that are sick. Further, the health sector has been put under enormous strain because of the rising demand for care for those living with HIV, as well as the number of health workers being affected (Kanabus et al., 2007:2). In 2003 for instance, an estimated 26.6 million people in sub-Saharan Africa alone were living with HIV/AIDS and the pandemic killed approximately 2.3 million people with an estimated 3.4 million infected in the same year (UNAIDS, 2003:7). The HIV prevalence varies considerably across the continent with Botswana and Swaziland having the highest HIV prevalence rates, which stood at 34% in 2007 and 39% in 2006 respectively. This presents a grim picture of the situation particularly in these two countries and in others that have high HIV prevalence rates that may lead to high mortality rates (UNAIDS, 2003:9). Already there are rising numbers of orphans that have to be looked after by their relatives, mainly the elderly, and now in most cases the elderly are not

adequately equipped to provide financial assistance in terms of clothing and feeding (UNAIDS, 2003:10; 2008:21).

However, in South Africa, the HIV pandemic is likely to become a greater burden to the elderly people in addition to their existing socio-economic and health problems. It is estimated that 5.3 million South Africans were living with HIV at the end of 2002. Given the country's recent trends, it is assumed that AIDS deaths will continue to rise. HIV prevalence figures that are based on data taken from antenatal clinics and hospitals reveal that in five of the country's nine provinces: Kwa-Zulu Natal, Gauteng, Free State, Mpumalanga and North West at least 25 percent of the pregnant women are HIV positive[1].

The epidemic has had a negative impact on the lives of millions of children worldwide, with the immediate impact of being directly or indirectly orphaned through the loss of parents (and/or other adult guardians). Over and above this, the disease infects them as well (Drimie, 2002:21). UNAIDS data shows that nearly 12 million children are currently living with AIDS and an estimated 13.2 million have been orphaned by the epidemic since it began. About 90 percent of those affected by the global HIV/AIDS epidemic were children living in sub-Saharan Africa despite the fact that only a tenth of the world's population lives in this region (Drimie, 2002:21; Help Age International, 2004:6).

Traditionally, the African extended family system acted as a bulwark for orphans, offering opportunities for proper care and upbringing within the context of the norms and values of the society they lived in. However, the impact of the pandemic is so acute that extended families can no longer absorb the huge number of orphans, particularly in the most affected countries. As children lose one or both parents to the epidemic, these children are suddenly burdened with responsibility (Ayieko, 1998). Children in such conditions are deprived of their childhood and the opportunity to go to school. Economic hardships lead them to look for means of subsistence which increase their vulnerability to HIV infection, substance abuse, child labour, sex work and delinquency (Ayieko, 1998). In other instances, they are likely to suffer from malnutrition and are vulnerable to recruitment by criminal groups and rebels in conflict areas (Fouad, 2005).

[1] The adult HIV-prevalence for South Africa, according to Statistics South Africa, was 15.2% in 2004.

In the case of South Africa, a research commissioned by the Nelson Mandela Children's Fund found that South Africa's AIDS Orphans were being ostracized by their communities and exploited financially by relatives who had taken them in, primarily to receive a state grant (Drimie, 2002:21; Help Age International 2007a).

Consequently, the elderly people have now assumed the role of care-givers, having to take care of their grandchildren and at the same time, look after their sick children. A number of studies indicate that in Sub-Saharan Africa, older people, especially older women, irrespective of their situation, care for the majority of orphans. In South Africa and Uganda, 40 percent of orphaned children are living with their grandparents and in Zimbabwe up to 60 percent of orphaned children are living with their grandparents (Nhongo, 2004:4). The fact that these elderly people lack information on HIV/AIDS would definitely limit their ability to provide adequate care and to protect themselves and their families. To date, this role of older people as educators and counsellors has not been exploited in community-based and national HIV/AIDS prevention programmes (Help Age International, 2003:9c).

Although the AIDS epidemic is projected to reduce life expectancy in affected countries like Botswana, Lesotho and Swaziland amongst others, the proportion of the older population of sub-Saharan Africa will continue to grow with South Africa expected to have the highest proportion of the elderly reaching about 12% in 2030, compared to other sub-Saharan countries. Globally, since mortality affects more men than women, there would be more women than men of advancing ages in almost all countries (Help Age International, 2003:6d; United Nations, 2002d).

South Africa's demographic profile is unique in the sense that it depicts both a developing and developed world's regime of fertility levels. This can be attributed to different socio-economic divisions along racial and urban – rural lines that are a spill-over from the apartheid era. In 1998 the country's total fertility rate stood at 2.9 children per woman with Blacks and Coloureds at 3.1 and 2.5 respectively, compared to Asians and whites at almost below replacement level at 1.8 and 1.9 respectively (Moultrie and Timaeus, 2002:21; National

Population Unit, 2001: 42).[2] Some of the contributing factors that have led to the fertility decline were South Africa's past population policies which date back to the 1960's when the government encouraged family planning, birth spacing and abortion. Contraceptive use by 1998 had stood at 61 percent with non-marital fertility, which has proved to be the dominant force in fertility transition in South Africa, contributing to further decline in fertility (Department of Social Development, 2003:11; News24.com:2004a).

Similarly, socio-economic factors like improved women's status and education, a decline in infant and childhood mortality, have been contributing factors to the decline in fertility. In addition to the above, an increase in per capita income may also have contributed to overall fertility decline (News24.com:2004a). Consequently, South Africa is one of the few sub-Saharan African countries with the highest proportion of the older populations with nearly 7 percent aged 60 years and above, and this is expected to rise to nearly 10 percent by 2025[3] (Kinsella and Ferreira, 1997; Ferreira and Van Dongen, 2004). In 2006, South Africa's elderly population stood at 7.9% of its overall population, making it one of the 'oldest' countries in sub-Saharan Africa followed by Lesotho at 7 % (Velkoff and Kowal, 2007:10).

In the developed countries an elderly person is usually linked to the time such an individual would be reaching retirement age which was 60 to 65 years and thus receive pension benefits (WHO, 2010;United Nations, 2003). But in the context of most developing countries most definitions of an elderly person may be influenced by social norms particularly in regard to daily work activities, their roles in society and their knowledge of important events such that if a person did less work as a result of his or physiological decline, such a person may be considered an elderly person (Nhongo, 2004:1;Du Tlesis,1999:3). The age at which such a person would be considered an elderly would be far less than in the developed world which is between 50 to 55 years. This therefore creates a challenge of doing any comparisons between elderly people in the developed and developing world. Due to lack of birth certificates it may also not be possible to tell the actual ages of most elderly in rural areas of most developing countries particularly in sub-saharan Africa. As a result several studies done on the elderly in

[2] According to Statistics South Africa's mid-year estimates Total fertility rate as of 2004 was estimated at 2.77 based on cohort projections of four population groups from 1970 when the last census was taken prior to 1996.
[3] Kinsella and Ferreira indicate that the proportions of the older population vary by race with the Whites having more older population compared to the blacks.

the developing world particularly in sub-Saharan Africa have arbitrarily defined the elderly as those 50 to 55 years and over. In the context of South Africa, a person was regarded as an elderly person if they got a pension at the age of 60 years and over.

1.1 STATEMENT OF THE PROBLEM

Traditionally, elderly people were well looked after by their extended families together with the communities they lived in and were respected as elders of society (Help Age International, 2001:7). However, the advent of modernization has led to the reduction in family size together with changing values and cultural practices (UNPFA, 2002:24b). This means that the elderly populations have been left to survive on their own with little or no support from society, particularly from their own children and grandchildren who have opted to migrate to the urban areas for job opportunities.

Attitudes of children regarding their duty towards their parents and the tradition of caring for their elders are rapidly changing. In some parts of the developing world, particularly in sub-Saharan Africa, conflicts and political instability have also led to the disintegration of the family through displacement or separation, as is the case in the Darfur region of Sudan (Economic Commission for Africa, 2001:2; Help Age International, 2006b). This has created a variety of socio-economic and demographic challenges for the elderly population, which in the long run may inhibit their ability to take part in societal activities and therefore contribute to their development. In many developing countries, poverty, lack of social security schemes, rapid urbanization and fragmentation of families, may have contributed to the erosion of traditional care for elderly people (WHO, 1999). In South Africa, most of the elderly have spent much of their lives under the system of apartheid where employment, settlement, movement and other opportunities were restricted, particularly for the elderly. This was especially true for Black South Africans, who happened to be the majority of the total elderly population of South Africa. Consequently levels of inequality in education between races and within races are far greater among those older cohorts than they are for younger elderly cohorts (Cohen and Menken, 2006:216)

The South African Government has tried to provide some kind of relief in the form of social security to its elderly people. However, it has been argued that the amount of R940 per month

they received in 2008 is too little, given the fact that older people, particularly those living in the rural areas, spend much of their pension on basic necessities like food, education and clothing, including medical bills required to pay for their extended families' expenses, which are several times higher than the pension given to them by the National Government (Joubert and Bradshaw, 2003). The high unemployment rates especially in the rural areas have put pressure on the elderly to support both their adult children and their children, creating huge extended kin amongst the households (Cohen and Menken, 2006:216; Brown, 2003). As a result, most elderly have had to focus much of their small incomes on sustaining their families' needs, leaving very little or no savings to cater for their own needs.

The HIV/AIDS pandemic has also disrupted the family structure in such a way that much of the responsibilities of the family have now been shifted to those members that are ill prepared to perform tasks that they had already done many years ago (Nhongo, 2004:3), making survival for the elderly more difficult since they lack the skills and awareness necessary to look after people living with HIV/AIDS (Mail and Guardian online, 2004:1). This is further exacerbated by the fact that media information on HIV/AIDS is targeted at "young and sexually active age groups" with the assumption that the elderly populations are no longer sexually active. A substantial number of elderly people, particularly those in the rural areas, are already taking care of orphaned and infected grand children with little or no support base. This, in addition to their own challenges, is worsening their already precarious situation.

The end of apartheid brought hope to all South Africans regardless of their age and/or race in terms of access to basic services like health care, proper sanitation, receiving proper education and being employed. However, the democratically elected South African Government has faced challenges of meeting needs that include catering for the elderly population with respect to their socio-economic well-being. The fact that the elderly population forms the minority of the overall population may suggest that their plight may not be adequately addressed as more emphasis is placed on the needs of children and the youth (Ferreira and Van Dongen, 2004:3). This has left the oldest citizens of the country feeling marginalized and discouraged. Recently, other factors like the rising cost of living are also threatening to push them further into poverty since whatever little savings they may have are being eroded by higher prices of basic

commodities like food and clothing. Yet there is no clear policy on how best to alleviate their problems, given the role they currently play in societies.

In many less developed nations, government policies and programmes give low priority to the concerns of the elderly with, expectations that the immediate families would provide them with the necessary bulwarks of survival (United Nations Population Fund, 2002:28a). This may also explain why there are no pension systems or social security systems that may help them sustain their livelihoods and thus prevent them spending the reminder of their lives and possibly those they support in abject poverty. The HIV/AIDS pandemic is ravaging the region, particularly in the rural areas where the bulk of the elderly people live; this is bound to make the situation more difficult with little or no financial and emotional support being received for care-giving responsibilities. Most assumptions focus on the idea that the elderly, due to their frail state, are not in a position to provide care, yet today they play a crucial role in providing support and care to the young and sick. For instance, in studies done in Zimbabwe and Zambia, the majority of care-givers were grandparents between the ages of 60 and 85 years. In the United States of America, grandmothers were most often the surrogate parents to children of HIV infected parents (Nampanya – Serpell, 2008). As a result little attention is given to how the lives of elderly care-givers in countries with a high burden of HIV/AIDS are affected (Ssengozi, 2002).

A few studies have highlighted the socio-economic concerns of the elderly population, but more extensive research is still required especially in the rural areas where there are no "safety nets" to rely on in times of need. In addition, the impact of HIV/AIDS in South Africa particularly the Northwest Province, needs thorough understanding so that the required assistance could be given to the elderly, who desperately need help with care-giving, particularly for those infected with the virus.

1.2 SIGNIFICANCE OF THE STUDY

South Africa's demographic structure appears to manifest an increasing trend towards an ageing population. This calls for consideration in the whole development processes of the country geared towards their needs. The elderly have to grapple with socio-economic issues like lack of basic services, inadequate health facilities and poverty. In addition, the

urbanization process has also meant that most able-bodied families have moved to the urban areas, leaving behind the elderly destitute with the burden of caring for the sick and orphans resulting from the HIV/AIDS pandemic. Very few studies in South Africa have focused on the needs of the elderly and the impact of the pandemic on their overall well-being brought about by their care-giving activities. Most information related to HIV/AIDS prevention strategies do not factor in elderly care-givers' efforts, putting them at risk of contracting the virus. With this in mind, it is hoped that that this study would contribute towards filling the gap in understanding the socio-economic needs of the elderly and how the pandemic has directly affected their livelihoods.

Most elderly, return to their places of origin to stay with their communities after their economically active years. However, in the case of South Africa many elderly people did not have the opportunity of being employed due to the oppressive apartheid laws. This means that they have to rely on the community for support (Ferreira and Charlton, 2004:2). With the coming of a new government, opportunities opened up for all South African people, with no more restrictions on movements from place to place. The North West Province is mainly rural, which means the youth leave for urban centres and other provinces in search of job opportunities.

This study therefore seeks to enhance knowledge about the socio-economic problems of the elderly in the era of HIV/AIDS in the North-West Province of South Africa. It is hoped that the results of this study will give a clear indication of the situation of the elderly in South Africa in general and the North West province in particular. This may help the National Government through policy makers, to take the appropriate steps in trying to help the elderly population, particularly those care-givers that desperately need assistance and the know-how on HIV/AIDS related issues.

1.3 OBJECTIVES OF THE STUDY

This study undertakes an analysis of the socio-economic and demographic needs and concerns facing the elderly population in the era of HIV/AIDS in the Mafikeng Local Municipality of the North West Province of South Africa. As already indicated, the ageing population in South Africa is set to rise because of the low mortality and a sharp decline in fertility (Kinsella and

Ferreira, 1997; Ferreira and Van Dongen, 2004). It is imperative that a study of all aspects of the plight of the elderly is undertaken to fully comprehend their overall situation, in addition to the AIDS pandemic that has also had a negative impact on their social and economic well-being.

The specific objectives include:

- To examine the growth in the number of the elderly population over the years between 1996 and 2001 in the Mafikeng Local Municipality in the North-West Province;
- To examine the socio-economic, health and demographic concerns of the elderly people in the area under study;
- To investigate the impact of HIV/AIDS on the elderly as care-givers in the selected areas of the Mafikeng Local Municipality;

1.4 THE RESEARCH QUESTIONS

The study bears the following main investigations:

- Has there been an increase in the population of the elderly in the Mafikeng Local Municipality?
- What are the socio-economic, health and Demographic concerns of the elderly in the Mafikeng Local Municipality?
- To what extent has HIV/AIDS affected the elderly as care-givers in the Mafikeng Local Municipality?

With these in mind the next two chapters critically examine the growth of the elderly population and the socio-economic challenges faced by the elderly in the face of the HIV/AIDS pandemic.

1.5 THE ORGANIZATION OF THE STUDY

Chapter one constitutes the introduction that provides a background of the global growth of the elderly population, the problem statement, significance and rationale, together with the objectives of this study

Chapter two examines the theoretical perspectives and trends in ageing and their relevance to the current ageing phenomena. In addition, the ageing trends of both developed and developing countries are examined with particular reference to South Africa, a developing country, to ascertain if the ageing process is really taking place. Several sociological theories are also examined to understand society's perceived views of ageing. Using existing census information (1996 and 2001), the Ageing trends in the North West Province and the Mafikeng Local Municipality are examined to determine if the ageing process is indeed taking place

Chapter three looks at current research on issues affecting the elderly from a socio-economic, health and psychological perspective and the impact of the HIV/AIDS pandemic on the elderly.

Chapter four describes the setting, design, implementation and analytical techniques mobilized by the study and also describes the socio-economic and demographic variables that are to be used to explain issues affecting the elderly. Also, a conceptual framework is used to show the inter-relationship between socio-economic and health issues and ageing

Chapter five presents the general socio-economic and demographic characteristics of the elderly population under study using cross- tabulation and multi-variate analysis.

Chapter six presents the health characteristics of the elderly population under study using cross-tabulation and multi-variate analysis

Chapter seven presents the characteristics of elderly care givers in relation to HIV/AIDS awareness and the challenges of care giving. In addition chapters five, six and seven also incorporate the focus group discussions of the elderly respondents in relation to the socio-economic, health and care giving challenges.

The last Chapter provides a summary of key findings of this study, highlighting the major socio-economic and demographic concerns of the elderly and how this has been further

aggravated by the HIV/AIDS pandemic and concludes by giving recommendations on how elderly people's challenges may be solved. In addition, areas for future research are also indicated, especially in understanding the scope of their needs

CHAPTER TWO

THEORETICAL PERSPECTIVES OF AGEING

2.0 INTRODUCTION

This chapter examines the relevance of the demographic transition and leading theories that explain the growth of the elderly populations in the now developed countries followed by that in the developing countries. Further, a sociological perspective is used to explain the role of the elderly in society.

Over the last five decades, the world's population has undergone a remarkable transition - from a state of high birth and death rates to one characterized by low birth and death rates (United Nations, 2003). At the heart of that transition was the growth in the number and proportion of the ageing population as a result of a drastic decline in fertility. Average life expectancy at birth has increased by 20 years since the 1950s to reach about 66 years and is expected to extend a further 10 years by 2050 (United Nations, 2002b,PRB,2002). The world's elderly population may have been growing for centuries, although it is only recently that the pace of growth has accelerated (Kinsella and Philips, 2005: 4) and indications are that the annual net gain of the elderly population will continue to exceed 10 million over the next decade.

2.1 THE DEMOGRAPHIC TRANSITION THEORY AND AGEING POPULATION

This theory explains the growth of the population through several stages, first in the developed countries followed by the developing countries. According to this theory, population growth was initially very minimal due to high birth and death rates, while the final stage in which most developed nations are currently in shows declining birth and death rates leading to the rise in the proportions of the elderly population. This theory is relevant to this study since it shows the growth of populations which were mainly youthful as a result of the high birth and lower death rates to the current situation of older populations as a result of lower birth and death rates in the developed and some developing countries like South Africa.

In the developed world, the size of the population aged 60 years and over is estimated to be about 10 percent of the total national population. This figure is projected to account for about

25 percent by 2050 and about 33 percent by 2150. Of the total elderly population, about 55 percent and 65 percent constitute women aged 60 and 65 and over respectively. Globally in 1950, there were 205 million persons aged 60 or over with only three countries having more than 10 million people 60 or older: China (42 million), India (20 million) and the United States of America (20 million). Fifty years later, the number of persons aged 60 or over increased by about three times to 606 million (United Nations, 2002:11b). According to Kinsella and Philips (2005:4) in 1990, 26 nations had elderly populations of at least 2 million and a decade later 31 nations had reached the 2 million mark. In 2000, there were 12 countries with more than 10 million people aged 60 years and over, including 5 with more than 20 million older people.

However, there are striking differences between regions where one out of five Europeans is 60 years and older compared to one out of twenty Africans 60 years and older (UNFPA, 2002:6a). This arises from different stages of demographic transitions among the regions. The main discussion in population debates is mainly on two fronts; one emphasizes the continued growth of populations in the less developed regions and the socio-economic, environmental and political straits associated with high population growth that will add a few billion more people, while the other focus looks at the unprecedented low fertility in several countries like China, most of Europe plus North America with socio-economic, environmental and political challenges associated with ageing and eventually dwindling populations (PRB, 2004).

2.1.1 The Demographic and Epidemiological Transitions in developed countries

The epidemiological theory explains the slow growth of overall populations due to pestilence and disease. With improved weather conditions, there was a decline in disease leading to the rise in population growth first in the developed countries and later in the developing countries (Omran, 1971; Caldwell, 1978). With improved health facilities more people are able to live to older ages, which partly explain the significant proportions of the elderly populations in most developed countries, which is filtering through to the developing countries.

Before the early 17th century, much of the developed countries' population growth was very low. This was a period when most countries were still in the first stage of the demographic transition characterized by high birth and death rates (Omran, 1971). Natural fertility levels during this period were kept artificially high by religious doctrines, moral codes, laws,

community customs, marriage habits and family organizations that partly offset the high mortality levels (Caldwell, 1978).

However, in the early 17th and 18th centuries population growth started rising with the decline of mortality that started in North West Europe (Montgomery, 2005). This was the second stage of the demographic transition where mortality started declining, with fertility remaining relatively high. The underlying factor of the phenomenon is an improvement in socio-economic conditions (Omran, 1971). The first proposition of Epidemiological transition suggests that mortality is a fundamental factor in population changes. It was after the 18th century that population growth in the now developed countries started rising exponentially as epidemic peaks became less frequent or disappeared all together. This led to the rise in life expectancy, which was initially between 20 to 50 years. Most countries had now moved to the second stage of the demographic transition that was characterized by receding pandemics. This led to the rise in a youthful population resulting from a high child survival rate, which led to high births and in turn more girls replacing their parents causing GRR/NRR to increase (Montgomery, 2005). This meant that the overall age structure comprised a mainly youthful population since more and more children survived to adulthood. Omran (1971:515) indicated that mostly children and females benefited from improved health care since they were most vulnerable to pandemics.

The reasons for the decline in mortality were determined primarily by exobiological and socio-economic factors[4] and the influence of medical factors was only felt in the twentieth century (Omran, 1971:515; Caldwell, 1978). Montgomery (2005) indicated that improved food supply due to improved agricultural methods of farming as a consequence of the agricultural revolution, led to the rise in the population since incidences of famine were less frequent[5]. Consequently there was a steady rise in the population

[4] The disappearance of the Black Rat towards the end of the 17th century led to a rapid decline of Plague and improved standards and habits of living led to a decline in mortality.
[5] The Agricultural Revolution brought in new farming methods and equipment like crop rotation, selective breeding and seed drill technology with maize and potato from Americas increasing food quantity.

As a result, most developed countries moved into the third stage of the demographic transition where fertility started lowering as a result of further decline in mortality. Caldwell (1983) argues that smaller families replaced the large extended families that dominated pre- modern Europe since it became increasingly expensive to maintain large families because of "the growth of huge and mobile city populations". According to Omran (1971:516), the decline of pandemics led to a steady rise in man-made and degenerative diseases as overall life expectancy continued to rise. This was a clear indication that the population structure slowly shifted from a youthful population to a middle aged and an older population.

This suggests that the now developed countries already had a growing elderly population by the early 20th Century. Omran (1971:516) has indicated that there was a distinct rise in degenerative diseases before 1920, a sign which gave rise to significant increase of the elderly population in the now developed nations (Mumford, 1976). Birth rates continued to fall further even after mortality declines had reached very low levels suggesting that the age structures had been altered with overall dependency ratios below 50. Most developed countries had completed their demographic transition which is characterized by low birth and death rates.

It should be noted that some of the developed countries' demographic transition took much longer than others and Omran (1971) classified regions like Europe and North America as the classical (western) model since their transition was gradual, while countries like Japan, that had a much shorter transition from age of pestilence and famine to the age of degenerative and man-made diseases were classified as the accelerated model. Medical advances and a slow process of modernization favoured the decline in mortality. Government interventions and individual aspirations encouraged fertility regulation. Abortion also played a role in fertility reduction (Omran, 1971).

Globally, the percentage of young people under 15 years old increased from 34.3 percent in 1950 to 36.7 percent in 1975 and subsequently declined to 30 percent in 2000 (UNFPA, 2002:6a). According to the United Nations (2005), total fertility rates for the most developed countries stood at 1.56 between 2000-2005 periods. This would slightly increase by 2050 to 1.84 births per woman while life expectancy would stand at 76.2 years with infant mortality at 7.7 deaths per 1000 live births (life expectancy for females is 79.9 years compared to 72.6

years for males). This slight rise in births could result from international migration, which has partly contributed to the total fertility rate of the United States remaining above replacement level (United Nations, 2002b).

Thus, the proportions of the elderly population have continued to rise in many developed countries which have been highlighted by the rise of deaths from degenerative and man- made diseases like cardio vascular, cancer and lower respiratory diseases. Some other examples of degenerative diseases include Alzheimer's disease, Prostatitis, Osteoarthritis, Osteoporosis, Parkinson's disease and Atherosclerosis (Answers.com 2008)

According to Omran (1971:517), this is related to advancement in age due to increasing life expectancy. Such diseases result partly from changes in diet, activity levels and behaviours such as smoking that is characteristic of the above diseases (Levenson, Patrick and Gaziano, 2003). It is estimated that 35 percent to 65 percent of all deaths in developed countries are attributable to cardio-vascular and coronary heart diseases.

Further medical advancements, however, have led to the reduction of cardio-vascular diseases leading to most developed nations, reaching the final phase of the epidemiological transition called 'the age of delayed degenerative diseases' (Levenson et al., 2003). Measures like coronary care units, revascularisation procedures and thrombolytic therapy are now available to manage the acute manifestations of cardio-vascular diseases. Other preventive strategies such as smoking cessation and blood pressure management have been widely implemented leading to delayed old age mortality and therefore leading to the rise in life expectancies (Levenson et al., 2003). It is during the age of delayed degenerative diseases that age-adjusted death rates from cardio-vascular disease level off to below 50 percent of total mortality. This clearly indicates that with further improvements in the medical advancements of degenerative and man-made diseases, the older population will have a greater chance of surviving well into the advanced ages. This clearly suggests that the proportions of older elderly people will rise because of better health care for elderly care. It is expected that by 2050, 33 countries will have more than 10 million people aged 60 or over, including 5 countries with more than 50 million older people (United Nations, 2002:11b), with the number of elderly exceeding the number of young people for the first time in history (UNFPA, 2002:5a).

2.1.2 Demographic and epidemiological transition in less developed countries.

Unlike most developed countries, many developing countries, particularly in sub-Saharan Africa, are still going through the demographic transition with varying degrees of success. By the mid-twentieth century, most developing nations had moved into the second stage of the transition which today is representative of the population explosion that is characteristic of many developing countries (PRB, 2004:7). Death rates fell much faster in the developing countries than in the developed countries due to the introduction of medical advancements from the now developed countries. As Omran (1971) points out, much of the public health measures have successfully manipulated mortality downwards while leaving fertility at substantially high levels. However, Montgomery (2005) has argued that it was not just medical drugs that led to the rapid decline of deaths, particularly childhood mortality, but the rise in female literacy and behavioural changes that brought about improved hygiene. But, due to traditional values and lack of economic development in most of the developing countries' populations, fertility change has been slow to take place. Many parts of Sub-Saharan Africa remains rural, hence attitudes and values are not affected at all (Montgomery, 2005).

Teitelbaum (1975) has, however, questioned the relevance of the demographic transition theory to developing nations based on the differences in certain socio-economic and demographic aspects central to the theory. He points out that mortality declines in the less developed countries were far more dramatic and fell much faster than the developed countries as a result of reliance on imported technologies and was marginally related to the level of development. Fertility levels of the now developing nations are much higher than those in the developed nations resulting from early and nearly universal marriages[6], contrary to late marriages and extensive non-marriages in the developed nations, particularly Europe. This has resulted in most developing nations having very youthful populations that may have serious implications in terms of population growth and socio-economic development.

[6] Unlike in other sub-Saharan African countries formal marriage in South Africa however is not universal.

Other differences that Teitelbaum (1975) highlighted were that migration was much easier for the populations of the now developed countries that helped to mitigate overcrowding in some areas. It was easier for populations in the now developed countries to migrate from place to place without any restrictions. However, today the political and economic realities mean that substantial international migration is no longer a potential outlet for excessive population growth due to international boundaries between countries limiting free movement.

Furthermore, growth rates of developing countries currently are as high as 3.4 percent, with averages of about 2.5 percent. Given these rates of population growth in the now developing countries doubling times would be less than thirty years and yet, when the currently developed nations were going through their transitions, doubling times never went below fifty years. This has drastically increased the population momentum for it is going to be much more difficult to halt the rate of population growth in the near future. This suggests that less developed countries will continue to have a youthful population resulting from high fertility regimes. Consequently it is difficult for governments in the now developing countries to adequately provide basic services like health, education and food to its people. In particular, the short doubling period of age cohorts, creation of job opportunities has been and is still one of the biggest problems facing developing countries mainly because of a huge labour supply against labour demand (Teitelbaum, 1975). The substantially different socio-economic and demographic characteristics of modern developing countries leave little doubt that their patterns of fertility decline will differ markedly from the now developed countries.

Despite these differences, recent gains have been made in mortality such that life expectancy has risen from 41 years to 63 years between 1950 and 2000 (PRB, 2004:9), which has been one of the major achievements of the 20th century. This was brought about by advances in medical technology and nutritional healthcare, extending the human life span after pre-modern era of the late 17th century when life expectancy was just over 30 years (World Press Review, 2002:1), with infant mortality rates continuing to fall from 180 deaths per 1000 live births to 61 deaths per 1000 live births in the same period (PRB, 2004:9). But despite the gains in mortality rates, some developing countries, particularly in sub-Saharan Africa, still have fertility rates

that have remained relatively high which may result from the fact that cultural norms of most societies who are based in rural areas still encourage high fertility regimes[7]

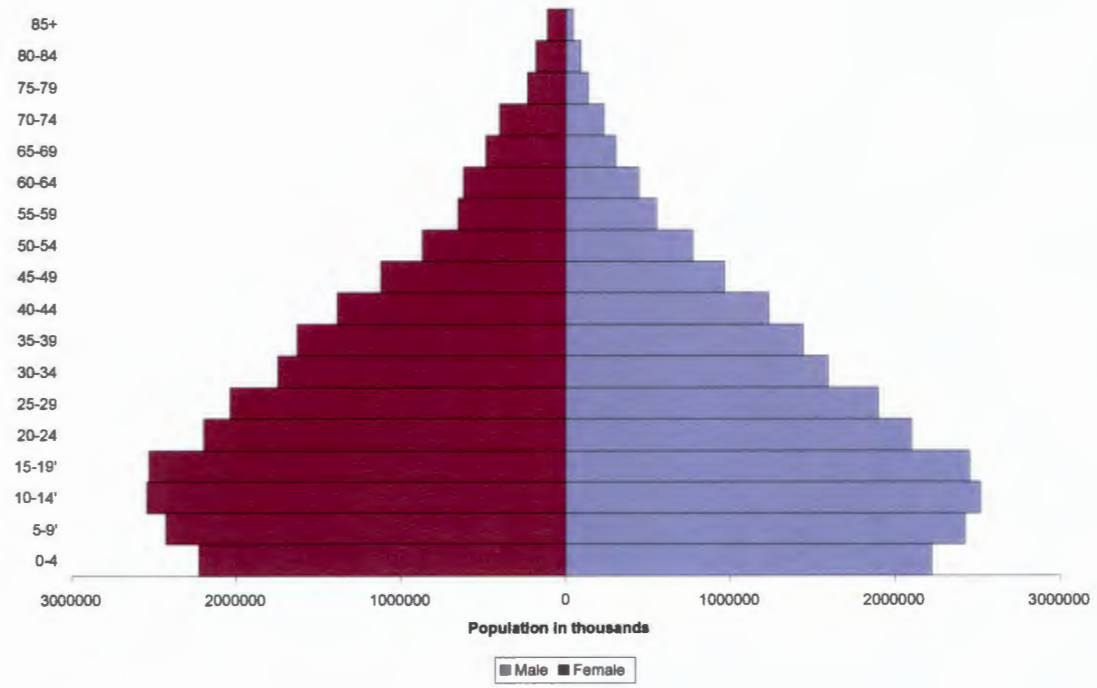
The increase in life expectancy has long-term implications on development planning for most sub-Saharan African governments because of a very youthful population. However countries like Nigeria, Kenya, Rwanda, Botswana, Zambia, Zimbabwe, Egypt and Tunisia have demonstrated a demographic transition from high to lower fertility rates (Makinwa-Adebusoye, 2001) suggesting that the age structures of these nations are no longer that youthful but heading towards a middle aged population and in the longer run would increase the elderly populations. For instance, studies indicate that Zimbabwe's elderly population is rapidly increasing and will continue to do so over the years (Madzingira, 1998:136). Other studies also indicate that in the last decades, fertility in less developed countries continues to decline at a fast pace. In 2002, the total fertility was below replacement level in 33 less developed countries, mostly in Latin America, the Caribbean and parts of Asia, and continues to decline steeply in many other less developed nations (Kinsella and Philips, 2005:13).

2.1.3 Demographic transition in South Africa

South Africa is one of very few countries with the most advanced fertility transition, which is the lowest in the Southern African region (Amoateng et al., 2004,News24.com,2004b). In 1999, the total fertility rate stood at 2.9 children per woman,[8] with infant mortality rates at 43 per 1000 live births (PRB, 2005:13). Several studies have indicated that fertility in South Africa is falling with the median interval between births per woman rising from 30 months to 50 months (Theunsissen, 2002; Caldwell and Caldwell; 1988). This is an indication that South Africa was well into the third stage of the Demographic transition. Figure 3 below gives an illustration of South Africa's population age structure indicating that the pyramid is not broad-based showing that there are lesser births at the first age groups than the previous age group. This is an indication that fertility decline is already taking place.

[7] Caldwell's theory of wealth-flows where there is intergenerational flow of wealth from children to parents.
[8] The 2005 World population Data sheet of The Population Reference Bureau indicates that fertility is at 2.8.

Figure 2.1 Population Pyramid of South Africa (Census 2001)

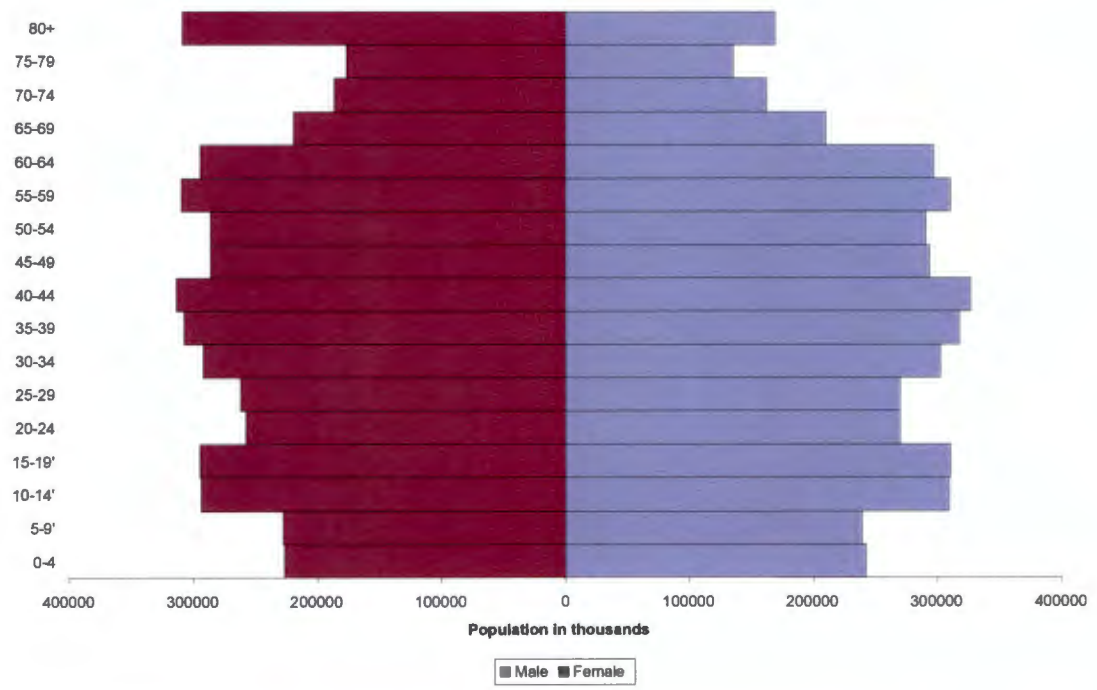


Source: Statistics South Africa, 2005.

As a result of the continued decline in mortality and fertility rates, the population age structure will change over time to become a predominantly middle aged population. As already pointed out, Kinsella and Ferreira (1997:1) have alluded to the fact that South Africa has one of the highest proportions of the older populations at nearly 7 percent, a clear indication that the falling fertility rates have impacted on the overall age structure and is said to continue with the rise of the elderly population to nearly 10 percent projected for 2025. From the 1996 and 2001 census data, there are indications that the elderly population is growing faster than overall population growth rate. For example, between the two censuses, the percentage increases of the elderly population grew by nearly 3 percent. The overall population between 1996 and 2001 grew by 2 percent. The 2007 community survey shows that the proportion of the elderly had grown to 7.8 percent, which further shows that their populations are indeed rising (Velkoff and Kowal, 2007). In contrast, Figure 2.2 below shows the population age structure of Sweden whose demographic transition started in 1750 (Jackson and Hudman, 1990). By 1930 Sweden

was well on its way into the fourth stage of the demographic transition with fertility rates still falling as a result of low infant mortality rates. Thus much of the country's population lies in the middle ages of 15-64 years as indicated in the figure below. This constituted about 64 percent of Sweden's entire population which is in total contrast to South Africa's population pyramid (figure 2.2) where slightly more of its population is in the younger age groups

Figure 2.2 Population pyramid of Sweden (2001)



Source: United States Census Bureau, International Data Base, 2001

By 2006, Sweden's Population stood at 9,081,100, with a population growth rate of 0.72 percent (United States Census Bureau, 2001). Its total fertility rate slightly rose from 1.55 in 1985 to 1.85 in 2006, with an infant mortality rate of only 2.8 deaths per 1000 live births. As a result of its low birth and death rates, Sweden has a relatively high elderly population of about 17.8 percent as of 2001(United States Census Bureau,2001) compared to South Africa's elderly population of less than 10 percent by 2001. Furthermore, Sweden has one of the highest

life expectancies in the world which stands at 76.8 years compared to South Africa's just 53 years (Statistics South Africa, 2006:5).

However, HIV/AIDS poses one of the biggest problems globally, which may reverse any gains the world has made over the past decades, particularly in the developing countries. As a result, the population structures of countries mostly affected by the pandemic will show higher proportions of older people and infants because of high adult mortality rates (PRB, 2005). Even infant and child mortality rates are on the increase because of HIV/AIDS-related illnesses and overall fertility might also decline/if not decline further as more women get infected, leading to fewer children. It is suggested that this may lead to premature ageing of the population since the proportion of older people would rise much faster, particularly those aged 60 to 80 years (PRB, 2005).

Botswana is one such country with the highest HIV/AIDS prevalence in the world and, as a result, mortality rates have been rising due to HIV/AIDS related illnesses (Nair, 2004:3). Indications are that the number of children has been declining partly because of infant mortality and it was expected that the proportion of the older people would rise, but this has not been the case especially between 1971 and 2001 period. The rise in the proportion of the economically active population has been the residual effect, suggesting that the dependency ratio has declined with a rise in the labour force. The implications are that the country's expenditures on the social sector, like education and health for the smaller, young and old aged population will decline resulting from a smaller proportion of the elderly and the young (Nair, 2004:5).

In South Africa, just over 5 million people out of a total of 46 million South Africans were HIV positive in 2004 (Dorrington et al., 2004). Life expectancy was estimated to be 48.5 years for males and 52.7 years for females with infant mortality rate at 56 per 1000 live births. Dorrington et al. (2004) used population projections to highlight the impact of the pandemic, particularly on the economically active population where the cohorts are smaller than they would otherwise have been without the pandemic. This has serious implications in terms of dependency ratios, as these are the groups that traditionally support older and the younger people. At this rate, this may suggest that the proportions of the elderly population may

increase faster than expected resulting from the high death rates of the middle-aged population. It is assumed that HIV/AIDS may have stunted South Africa's population, with the growth rate declining from 2 percent between the 1996 to 2000 period to 1.3 percent in the 2001 to 2004 period (Dorrington et al., 2004:2).

However, regardless of the pandemic, the ageing phenomenon is still going to continue into the future, with most developed countries having completed their demographic transitions. This, together with the increase in the old-age dependency ratio, especially in the developed countries, has had socio-economic and health implications (Gavrilov and Heuveline, 2003). For instance, according to the United Nations (2001), the median age for the United States stood at 36 years, which is almost, the same for other developed countries and twice the median age for Africa (Gavrilov and Heuveline, 2003). The percentage of the world population that was 65 years and over, increased slightly from 5.2 percent in 1950 to 6.9 percent in 2000, with the fastest growing segment of the older population being in the oldest old comprising persons in the 80 years and more group (World Press Review, 2002:1).

Globally, the growth rate of the older population, which is 1.9 percent, is significantly higher than that of the total population at 1.2 percent, with the difference between the two expected to widen as the "baby boom generation" of the 1950s reaches older ages in several parts of the world (United Nations, 2002:11b). Kinsella and Philips (2005:7) have indicated that the number of people aged 80 and older is projected to jump nearly 50 percent between 2000 and 2010 and another 37 percent between 2010 and 2020. This is in contrast to the 65 and older population which is projected to increase to just 24 percent between 2000 and 2010. More than half of the oldest population lived in six countries: China, the United States, India, Japan, Germany and Russia.

2.2 SOCIOLOGICAL THEORIES ON GROWTH OF THE ELDERLY

It must be pointed out that ageing should not be just about living longer but also about being in a position to add life in years. People grow old in a socio- economic environment that impacts on their well-being in regards to their feelings of self-esteem, value and place in the community (Kinsella and Philips, 2005:32; McNichol, 2009; Langst, 2009,Kart,1994). In this connection, there are a number of social theories of ageing offered by gerontologists and

sociologists that may explain why some people remain active and healthier at older ages. These theories highlight what the communities perceive of the elderly which in some instances has created problems for the elderly as is discussed in the next chapter.

2.2.1 Role theory

The role theory is one of the oldest social gerontological theories that explains the adjustment of people based on cultural roles they play in society as they grow older, based on age and sex. According to Corttrell (1942:618), a consideration of adjustment to any social category role centres around two closely associated aspects:

a) Adjustment to a role called for by the social age group to which the individual presently belongs;

b) The adjustment to the shifts in the role made necessary by the progression from one age group to another.

Corttrell (1942), therefore, indicates that people as they enter into another age cease certain roles as is the case with the elderly who are accorded respect based on their seniority in the community. Chronological age often determines some changes such as attaining voting age for the youth or as in the case of the elderly, retirement age (UNFPA, 2002:32a). However, cultural norms by society also determine the roles of people based on age and sex, where for instance, manual labour is accorded to the young able-bodied males while the elderly lead the society through their advice to the young and most probably provide leadership to the community.

2.2.2 Activity theory

The activity theory suggests that older people who take on several activities and roles stand a greater chance of living positively into older ages and can adjust better to old age (Kart, 1994). It highlights some of the problems and negative beliefs that older adults face and which prevents people from reaching, or maintaining their full potential (Wilken, 2002:1). Wilken (2002) uses this theory to show some of the myths of ageing that are perceptions created by society painting a picture of dependency, loneliness, disability, crime and above all, disrespect.

However true they may be, it is upon the elderly and society to embrace "Ageism" as part of positive living since everyone will have to pass through that stage.

2.2.3 Continuity theory

Continuity theory holds that middle aged and older adults often attempt to keep ties with their own past experiences by engaging in current roles that are similar to those in the past. This tries to maintain some form of consistency and thus avoids the prospect of adjusting to any new roles that they may not be familiar with. However, this approach tends to emphasize individual behaviour and neglects the societal constraints that deter older people from continuing some activities (UNFPA, 2002:33b). This may be the case particularly in those areas that may require physical and emotional strength. But it, nevertheless, looks positively at the continuation of activities such as sports, religion, reading or teaching.

2.2.4 Exchange theory

The exchange theory suggests that all human beings bring with them certain resources when interacting with other social actors. This suggests that elderly individuals do not necessarily do anything but their roles change based on their ages and can serve as resources to their adult children and vice versa (Nilsson et al., 2005:365). This has already manifested itself through the help they give to their adult children and grandchildren by providing the basic necessities especially in the rural areas. Also, elderly people tend to provide care to grandchildren when their parents are in the urban areas searching for work. The above theories highlight an important aspect of the growing understanding of ageing and the place of older people in society. However, as shall be seen in the next chapter, they also have led to some of the problems they face. For instance, the exchange theory that highlights the continued assistance to their adult children has contributed to their poverty situation as a result of lack of support.

From the above theories, the exchange and continuity theories may best describe the current roles of the elderly respondents, which includes care-giving and supporting their extended families together with the roles that they have always performed. However, it is worth noting that some of the above roles are due to the socio-economic challenges facing the communities such as unemployment.

2.3 Summary

This chapter has shown the relevance of the demographic and epidemiological transition theories in showing that the ageing process is well under way, particularly in developing countries where numbers are rising faster than the developed countries where it initially started. Several factors were responsible for the rise in the ageing population according to the above theories. However, these factors differ between developing and developed countries. The sociological theories examined like the continuity and exchange theories highlight the continued norms of how society relates to the elderly based on their physical nature which in most cases is linked to their age, that include offering support to their extended families as is the case in most rural areas of South Africa. The activity theory clearly suggests that elderly people can still perform their duties to society even at their advanced ages albeit at a lesser pace. This theory resonates with role theory, where elderly continue to serve their communities with the activities they have always done.

Aging trends and current research issues affecting the elderly in the era of the pandemic are discussed in detail in the next chapter.

CHAPTER THREE: LITERATURE REVIEW

AGEING TRENDS AND CURRENT RESEARCH ISSUES AFFECTING THE ELDERLY

3.0 INTRODUCTION

This chapter critically examines the trends in ageing, the socio-economic, health and psychological issues affecting the elderly and how from a socio-financial point of view the HIV/AIDS pandemic has further exacerbated their situation as care-givers.

As already pointed out in chapter two, South Africa has an ageing population that is currently facing a host of challenges. Anderson and Van Zyl (2002) put the plight of the current elderly population into perspective by saying that the socio-economic problems that they face particularly in the era of HIV/AIDS are issues of national policy and scientific interest. This is compounded by the fact they are now faced with the growing prospect of looking after their adult children and their children with very limited financial resources (Help Age International 2002:2a).

3.1. TRENDS IN AGEING

The previous section examined the relevance of the demographic transition in explaining the ageing phenomena. Various sociological theories highlighted how society looked at the various roles of the elderly and also highlighted some of the challenge currently faced by the elderly which is discussed in the next chapter. This section looks at the growth of the elderly population throughout the world, initially in the developed countries that have had significantly higher elderly population relative to their overall populations, and its implications for future development which partly account for the challenges they face. This is followed by ageing trends in the developing countries that currently have the fastest growth in elderly populations, especially in Asia (United Nations, 2002:1b).

3.3.1 Ageing trends in developed countries

Europe alone had the largest proportion of the elderly population at 14.7 percent in 2000, with Italy in the South with the largest proportion of the elderly population at 18.1 percent. This is followed closely by Greece (Gavrilov and Heuveline, 2003, Kinsella and Philips, 2005:5). This is projected to remain so for at least the next 50 years (United Nations, 2002:12b). Currently, 20 percent of Europe's population is made up of the elderly and is expected to grow to 37 percent by 2050 with the 65 years and older also expected to rise to 30 percent, up from 5 percent in 2000. In some European countries like Austria, Czech Republic, Greece, Slovenia and Spain, the elderly constitute one fifth to one fourth of the population. By the year 2000 the under 15-year olds constituted over 18% of the total population and would continue to decline to 15.5% by 2050 (UNFPA, 2002:6a). Consequently, Europe's median age was the highest in almost 30 years, which was evident as far back as 1950. It is assumed that by 2040 the median age would reach 49 years. Japan is the only developed country outside Europe with a relatively higher elderly population at 17.2 percent.

In the light of the above ageing trends in the developed countries, more emphasis has been put on social security programmes that must be suited to the growing numbers of elderly people. Most developed countries are urgently looking at ways of sustaining their social security programmes in the wake of an increasingly rising elderly population. These have included cuts in benefits to the working class and later retirement ages. However in the developed countries were the influx of migrant labour has been taking place, their contribution to the tax system may help to sustain the social security system. As a country ages, the shift from communicable and infectious diseases moves to the prevalence of disability, frailty and chronic diseases like cerebrovascular diseases that are associated with ageing (Siddhisena, 2008). In the case of the developed countries, this has led to a significant demand for healthcare and the composition of services specifically qualified to handle the elderly population. Health expenditure as a proportion of the gross national product is already on the increase in most of the developed countries with a significant ageing population, particularly in Europe and Asia with such costs set to continue rising (Ageing in Europe, 2005:1;United Nations, 2002b)

In addition, a falling working age population may reduce the growth of output and income, with an impact on overall economic growth of any country resulting from a decline in tax revenues and social contributions. In most developed countries, social security payments are linked to current contributions that may impact negatively on a shrinking workforce shifting the burden of providing social security to the governments (Schrier, 2007).

In relation to the above, there is now a growing shift in demand for goods and services, in line with the elderly population's demands like housing provision, tourism, leisure activities, health care and transport [9](Ageing in Europe, 2005:4).

In most situations, the social implications of population ageing are linked to economic outcomes, with the elderly population being marginalized due to their frailties, and those that worked in the informal sector losing out on pension contributions, leading to poverty and an inadequate health care system. One of the strategies used to maintain current economies and thus social security systems may be international migration (Hollander, 2000: 146). For instance, the United States uses its immigration policy to attract skilled young personnel that would contribute to economic growth and thus boost tax revenues and social security contributions. It has been assumed that international migration could help stem both overall declines in the size of working-age populations. However, the level of international migration may vary from country to country based on their proportions of elderly. As already discussed, Italy has the highest proportion of elderly in Western Europe and may require a significant number of immigrants to maintain its economy (Hollander, 2000:147).

3.3.2 Ageing trends in less developing countries.

Having looked at the ageing situation in the developed countries and its implications, this section examines the process of population ageing in developing countries and some of the challenges they may face. These challenges differ from one country to another because of the differences in socio-economic conditions and the pace of the ageing process (United Nations, 2001,2002:1b). Unlike in the developed countries, the proportions of the young still exceeded those of older persons by 32.8 percent to 7.7 percent respectively with the difference expected

[9] Adaptation to the new patterns of demand is vital by governments and the private sector in the development of new technologies and creation of markets.

to be minimal by 2050 when just 21.6 percent of the population is expected to be under age15 years compared to 19.3 percent who will be 60 years and over (UNFPA, 2002:6a; Economic Commission for Africa, 2001:2)[10]. However the median age for some of the developing regions like Asia had increased from 20 years in 1980 to 25 years by the year 2000 (UNFPA, 2002:7a;United Nations, 2002b). This is an indication that in some of the region's demographic transition was already underway. However, Africa, of all the developing regions was still at the incipient stages of the ageing process. As a result of the 'extreme youthfulness of the continent's population, the median age by 2040 will not be much higher than 24 years of age.'[11] Some of the contributory factors for this persistence of youthful populations lie in their weak economies and socio-cultural backgrounds that have perpetuated high fertility regimes (Economic Commission for Africa, 2001: 2).

Nevertheless, the rate of change is expected to accelerate steadily as the century proceeds and because of Africa's huge populations, may lead to considerable elderly populations. Currently, Africa's population is made up of 5 percent of the elderly population 60 years and over which is expected to rise to about 10 percent in 2050, with the projected rise of the 65 year olds and over from just 3 percent to 7 percent in the year 2000 (United Nations, 2002:12b).

It must be pointed out that rural-urban migration has led to the rise in the proportion of the elderly in rural areas. This is because most elderly, retire to the rural areas, while the young people migrate to the urban areas in search of job opportunities (United Nations, 2002:1c; Stloukal, 2001:1; Charlton, 2000:2). The 1992 population census of Zimbabwe indicated that the rural areas had the highest proportions of the elderly population at 6.2% compared to the urban areas at just 2.76 %(Madzingira, 1998:136).

It is expected that the number of elderly people living in the rural areas of Africa, Latin America and Asia will double by 2025, with the numbers expected to increase to 50 million for Africa and in Asia to 337 million (United Nations , 2002:2a).

[10] The Economic Commission for Africa indicates that those 15 years and younger will have declined to 28 percent in 2050 from 43 percent in 2000.
[11] The median age was just above 17years in the period 1965-90, and still only a little above 18 years in 2000

It is worth noting that even within the older populations there is a growing older segment of the elderly population compared to the younger segment of the elderly population. As Madzingira (1998:136) pointed out in his study of the levels and trends of the elderly in Zimbabwe, the older elderly age groups will increase more rapidly than the younger elderly age groups, with more elderly women than men in each old age group. It is estimated that the growth rate of persons aged 80 years or over is currently twice as high as the growth rate of the population over 60 years of age at 3.8 percent and 1.9 percent respectively. Currently, six nations account for 54 percent of the total number aged 80 years and over and they include China, with the largest number followed by The United States of America, India, Japan, Germany and The Russian Federation (United Nations, 2002:23b).

Despite the substantial growth in overall numbers of older persons worldwide, the numbers of elderly women continue to exceed the numbers of men, age for age (UNFPA, 2002:21a, Stloukal, 2001:4) partly because they get married at younger ages (Stloukal, 2001:4). The sex ratios for these old age groups are lowest in those countries with the largest and longest established proportions of older persons. The more developed nations averaged sex ratios of 684 males per 1000 females compared to 889 males per 1000 females in the developing nations in 1970. The sex ratios for populations aged 80 and over reflected the increasing preponderance of women with the developed nations having a sex ratio of 1 male to 2 females (500 males to 1000 females) compared to 630 males for every 1000 females in the developing nations at the beginning of the twenty first century (UNFPA, 2002:22a). In most developing nations women never re-marry and are thus left without any form of support. Traditional or cultural settings in the rural areas are such that women in agricultural areas may have no legal rights to their late husbands' land and property due to customary laws leading to discrimination on account of old age, widowhood and gender. As a result, older women in rural areas are more vulnerable and bear the burden of maintaining a household with very little support, which has been worsened by the HIV/AIDS pandemic.

In general, the United Nations (2002:13b;2002:10b) has indicated that the number of older people is growing significantly faster with the number of the elderly increasing globally by about 8 million persons per year, with 66 percent growing in the less developed countries. It is expected that in the less developed countries, the older population will more than quadruple

between 2000 and 2050, from 374 million to 1.6 billion. It was expected that by the year 2000, there would be 229.5 million people 60 years of age and over in the more developed nations compared to 373.3 million in the less developed nations (Skeldon, 1999).

The ageing process in most developed nations, it must be noted, took over 50 years for the proportion of 60 years and over to double from 7 percent to 14 percent, Japan being the exception where it took 26 years (between 1970 to1996) to double. Yet in the less developing countries, particularly in the east and South East Asian Nations of China South Korea, Taiwan and Thailand, it will take less than 40 years for their ageing populations to double from 7 percent to 14 percent.

Apart from the current socio-economic challenges faced by developing countries, there is a need to start preparing for the ageing of their populations, with the ageing process expected to proceed much more quickly compared to the industrialized countries. For instance, it took France 115 years, from 1865 to 1980, for the proportion of older persons to approximately double, from 7 percent to 17 percent and yet it will take China only 27 years from 2000 to 2027, for the proportion aged 60 years and over to double from 10 percent to 20 percent (United Nations, 2002:3b). In Africa, Northern Africa is undergoing a much more rapid ageing process than other sub-regions, because fertility started to decline in the 1960s or 1970s (Marcoux, 2001:1). It is estimated that Egypt, Morocco and Tunisia will have an elderly population of over 10 percent between 2010 and 2020 with Mauritius surpassing the 10 percent mark by between 2000 and 2010.

As a result of rural–urban migration, many of the elderly are left alone, sometimes in isolated areas to look after themselves thus losing out on some of the benefits due to them like pensions and health insurance while any remittances sent to them by their migrant children in cities may dwindle due to the pressures brought about by living in the cities (Ferreira and Charlton, 2004). This creates a gap between those in the urban areas and rural areas that can lead to poverty and marginalisation due to lack of finances and access to proper housing, health and the inability to participate in social and economic life.

Furthermore, agriculture in the rural areas is labour intensive, but with the lack of able-bodied people to help in planting of crops, older farmers may change to crops that are less labour

intensive and the pace at which farming activities may proceed could be frequently interrupted due to ill health or death. In areas where older farmers own much of the land, chances are that their land could be sold or transferred as a result of low productivity due to their frail nature (United Nations, 2002:1c).

Adaptation to change in terms of new technology in farming areas has become necessary due to increasing population growth and adverse climatic conditions that required crops that are drought resistant and at the same time yield more than the indigenous crops. However, it may not be easy for the elderly farmers to adapt to new technology partly because of their diminished capacity to take up new knowledge or loss of physical functions. In many situations, the elderly perceive any new changes as a waste of time owing to the fact that their remaining active time is short (Stloukal, 2001:4). As a result, the response to agricultural intensification by older farmers may be inadequate leading to poor crop yields and ultimately malnutrition. In comparison to the developed countries, a partial solution to the above problem may be the promotion of lifelong learning. This suggests that the elderly population would be regularly taught how to adapt to any developments. This is believed to have the potential to neutralize the issue of age and adaptability (Stloukal, 2001:4).

It should be noted that the financial implications of a rapidly ageing population could not come at a worse time when most developing countries are facing severe financial constraints resulting from the ills of globalization that have contributed to slow or low levels of socio-economic growth. Expenditure on public health and the demand for health care is likely to rise resulting from an elderly population that is more prone to disease. The changing family institutions brought about by demographic, social and economic change may require most governments to create public financial health services to cater for the elderly (Economic and Social Commission for Asia, 2004). The financial implications of ageing is already being felt in countries like China, Georgia, Republic of Korea, Sri-Lanka and Thailand where population is ageing rapidly.

3.3.3 Ageing trends in South Africa

In South Africa, in 2000, the elderly population represented by 7 percent of the entire population and is expected to rise to 11.5 percent in 30 years time. It is projected that by 2015

both the number and proportion of the elderly will increase to 4.24 million (Joubert and Bradshaw, 2003: 151). Looking at the median age of each of the population groups using the 1970 census, the white population was already ageing and currently may be classified as an 'old' population, while the other three population groups were classified as 'young' populations but are at an intermediate stage of ageing (Udjo, 2004:6).

According to the mid-year population estimates of 2006, South Africa's population currently is 47 million (Statistics South Africa, 2006:10). As previously shown, between 1996 and 2001 the annual growth rate of the national population was 2 percent. However, the growth rate of the elderly population between the same periods rose by 2.9 percent. Even the older elderly population of 85 years and over grew faster than the national growth rate by 2.72 percent between 1996 and 2001. This is in line with the global average growth rate of the older population of 1.9 percent, which was also significantly higher than that of the global total population's growth rate of 1.2 percent in 2000 (United Nations, 2002:11b).

In examining the population ageing dynamics, the ageing index between 1996 and 2001 increased from 21 elderly persons for every 100 people below 15 years to 23 elderly persons for every 100 people below 15 years. In the same period the youth dependency ratio declined from 59 persons below the age of 15 years per 100 working people to 53 persons below the age of 15 years per 100 working people. According to the United Nations (2002:418c), the median age was 22.6 years and by 2025 it would be 25.9 years. This is further evidence that South Africa's population is gradually ageing.

However, a rising elderly population has serious socio-economic implications for the national government in the form of social welfare provisions. Many of the elderly people are solely dependent on the pension system or social welfare offered by the government since a lot of pensioners still don not get any pensions from their former employers, particularly Blacks, compared to Whites, which could be attributed to the apartheid legacy of discrimination. As a result of the growing number of elderly people, taxpayers will have to pay more to keep up with the rising costs of social security since it's the key in helping to alleviate poverty, particularly of the elderly poor in the rural areas.

The high unemployment rate in the country estimated at 28% in 2006 has meant that the elderly have to maintain extended families with the pension that they receive from the national government (Dasnois, 2005). This, coupled with rising inflation which stands at 13.6%, has put a lot of pressure on the ability of elderly pensioners to purchase basics like food that have become more expensive.

The HIV/AIDS pandemic is also likely to impact on the population, particularly the working age group that are most vulnerable to the pandemic. This suggests that there will be fewer people to look after the elderly and children (Samson, 2004:4). Dorrington et al (2004) further highlighted the impact of the pandemic on the age structure in which the economically active populations were smaller than they should otherwise have been.[12]

Several population projections have already been done in trying to predict the direction of the South African population more especially taking into account the HIV/AIDS pandemic, which has had a profound effect on the demographic structure of the population. However, the various population projections have yielded mixed results with regard to the effect of the pandemic on the size and age-sex composition of the population (Anderson and Van Zyl, 2002). It has been assumed that the pandemic will lead to a decline in the overall population growth particularly in those areas hardest hit.

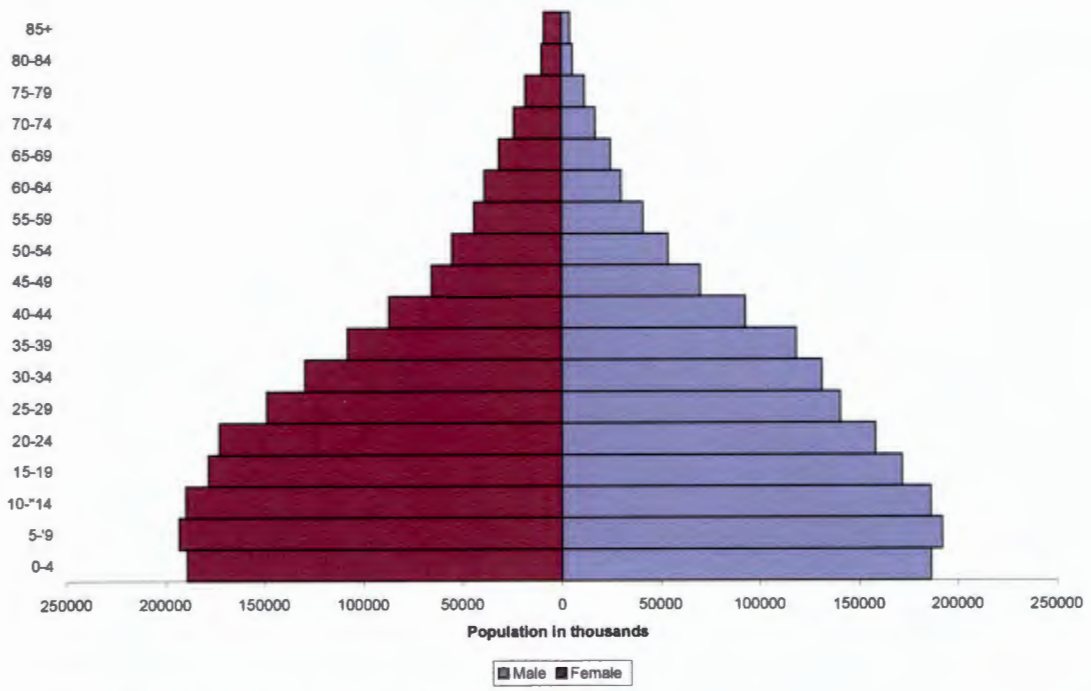
It is known that the pandemic has mainly affected the economically active populations of between 20-49 years of age, which means that the elderly population may not necessarily be affected by the HIV/AIDS virus as much as the 20-49 year age groups. For example, according to the 1992 census, the proportion of the Zimbabwean population aged 60 and above stood at 5 percent of the total population, evenly distributed between males and females (WHO, 2002). Population projections of the elderly revealed a steady increase in their population, particularly women; with life expectancy at age 55 to be 18 years for men and 21 years for women (WHO, 2002). This suggests that regardless of the pandemic the elderly population will continue to rise[13].

[12] According to Dorrington et al (2004) just over 5 million people were HIV positive in 2004.
[13] People aged 60 years and above were reported to constitute 1.48% of all reported cases, during the 1989-1992 periods.

3.3.4 Ageing Trends in the North West Province of South Africa

In the North West Province, the elderly population grew by nearly 4 percent compared to the overall population growth rate of 2 percent. However, given the nature of the province, which is predominantly rural, it is possible that most of the younger population might have migrated to other provinces for better job opportunities. Figure 3.1 indicates that fertility levels are declining, which is depicted by fewer births in the first age group compared to the 5 to 9 year age group. According to Statistics South Africa, the total fertility rate of the province was 3.1 births per woman in 2006, slightly down from the 1998 Demographic and Health Survey estimate of 3.3 births per woman (Zuberi et al., 2005:33), which may be supported by the following population pyramid of the Northwest province.

Figure 3.1 Population pyramid of the North West Province of South Africa



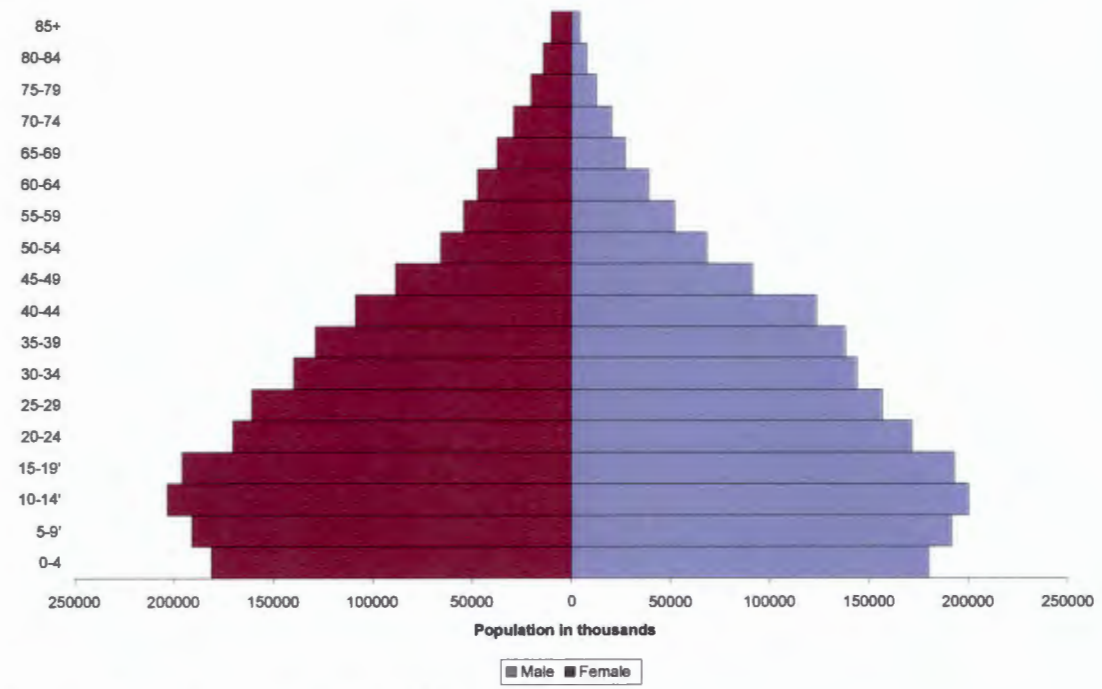
Source: Statistics South Africa; 1996

In general the population of the North West increased from 3.32 million people in 1996 to 3.67 million people in 2001[14](Statistics South Africa, 2001a), an annual growth rate of 1.95 percent. In the same period, however, the elderly population grew from 224006 in 1996 to 269500 in

[14] According to the current mid year population estimates the North West's population stands at 3.37 million taking into consideration the new demarcations (Statistics South Africa, 2006:10).

2001, an annual growth rate of 3.7 percent, which was much higher than the national growth rate. Between the two periods, in 1996, the elderly population constituted 6.7% of the overall population and increased to 7.3% of the overall population in 2001[15].

Figure 3.2 Population pyramid of North West Province (Census 2001)



Source: Statistics South Africa; 2001

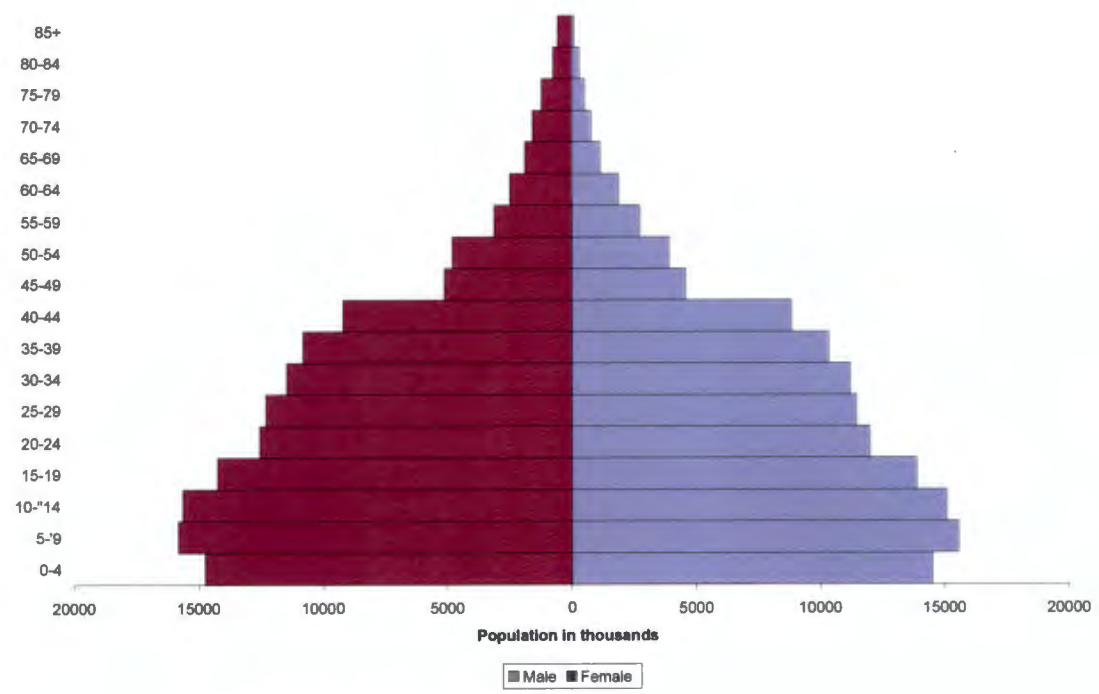
In contrast to the 1996 population pyramid of the North West (Figure 3.3), the above pyramid of the same province in 2001 shows a marked decline in the infant and childhood age groups. This is an indication that fertility was already declining. The recent community survey of 2007 further indicates that the elderly population grew by 7.6% of the overall population.

3.3.5 Ageing Trends in the Mafikeng Local Municipality

[15] The above estimates don't take into consideration the new demarcations as of 2005 where population declined by 0.8 percent from 3.32 million to 3.19 million while the elderly grew by 0.8 percent.

The Mafikeng Local Municipality is one of 22 local municipalities in the North West Province and is also the capital of the province. It is situated on the border with Botswana and is mainly semi arid with the predominant Tswana ethnic group in the area being the Barolong-Boora-Tshidi. Much of the local municipality is mainly rural (Statistics South Africa, 2001a) with its industrial and administrative heart situated in the capital (Mafikeng Local Gazette, 2007).

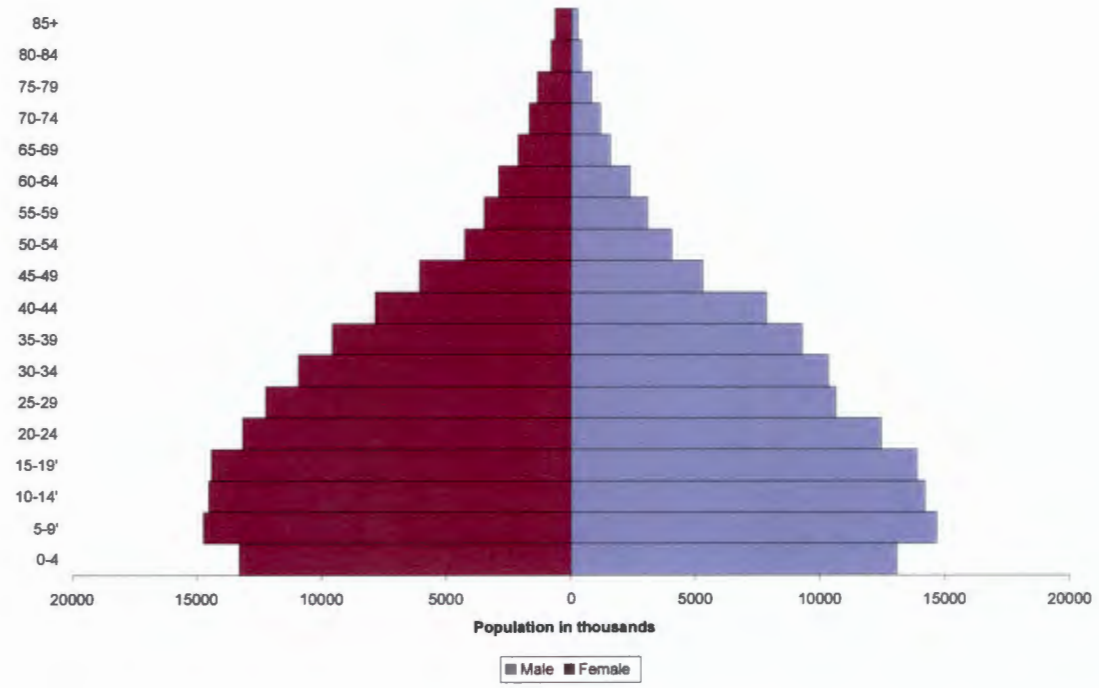
Figure 3.3 **Population Pyramid of Mafikeng Local Municipality of the North West Province of South Africa Census 1996**



Source: Statistics South Africa; 1996

Figure 3.3 above shows the population pyramid of The Mafikeng Local Municipality which indicates that there is a reduction in the number of infants in the first age group compared to the next age groups, which is similar to the 2001 population pyramid seen below. The above figures may not necessarily show any significant demographic changes, but do indicate from the calculations that the elderly population is rising. This may be due to returned migrants who had retired.

Figure 3.4 Population pyramid of the Mafikeng Local Municipality (Census 2001)



Source: Statistics South Africa; 2001.

With reference to the Mafikeng Local Municipality, using the census 2001 statistics, the ageing index was 19 elderly persons 60 years and over for every 100 persons under the age of 15 years. This is compared to the census 1996 statistics where the ageing index was 15 elderly persons 60 years and over for every 100 persons under the age of 15 years.

The youth dependency ratio of the local municipality indicated that for every 1 person below the age of 15 years, there were 2 people in their economically active years (51:100), while the dependency ratio showed that there were 7 elderly people 65 years and over for every 100 working people (15-64) in 2001. In 1996 there were 5 elderly people 65 years and over for every 100 working people (15-64). The proportion of the elderly in relation to the entire population was 4% in 1996 and increased to 6.2% in 2001 in the Mafikeng Local Municipality (Statistics South Africa, 2001b). With reference to the community survey of 2007, the data

shows that the elderly population in relation to the overall population stood at 6.7%, a slight increase from 6.2% in 2001 (Statistics South Africa, 2007).

The above Population pyramid is of the Mafikeng Local municipality that has the same characteristics as the National and Provincial population pyramids. The first age group of 0-4 has considerably fewer births than the previous age groups, indicating that fertility decline has started taking place. However it is also possible that due to outward migration, there are fewer infants in the ages below four years.

3.2 ISSUES AFFECTING THE ELDERLY POPULATIONS

3.2.1 Economic concerns

Poverty is one of the biggest concerns that older people face and is therefore a serious threat to their overall well being (UNFPA, 2002: 29b). Most of them reside in rural areas (Stloukal, 2001:1; Madzingira, 1998:140) where there is less development and thus less opportunity to try and make a positive contribution to their societies. Their needs are seldom acknowledged in poverty reduction initiatives and most people in most developing countries enter old age without any formal social security thus having to rely on their own and their family's ability to meet their needs (Help Age International, 2003:11c). It is thus imperative that the Millennium Development Goals initiative addresses the needs of those living in extreme poverty, which includes the most vulnerable: elderly people, especially women, with further emphasis on how to break the poverty cycle that runs from one generation to another (UNFPA, 2002:29a)[16].

In Africa many of the elderly work in the informal sector, with very few having access to regular income and benefiting from social security (Kazeze, 2002). This suggests that once they leave work, their living standards deteriorate since working in the informal sector provides very few opportunities to save.

Only a few sub-Saharan African countries like South Africa, Namibia and Botswana, offer a pension to their elder citizens which, however, is not enough, given the fact that this pension is shared among extended family members most of whom are unemployed (Economic

[16] Most of the 400 million people in developing nations are living below the poverty line.

Commission for Africa, 2001:2). A case in point is South Africa where one in three households are headed by elderly people and in 66 percent of these households older people care for grandchildren (Help Age International, 2004:3).

In Eastern Europe, the elderly people rely heavily on the pension system, now that state social structures that in the past helped them with basic provisions like housing have collapsed. However, like their counterparts in sub-Saharan Africa, the pension received is so small that it has become nearly impossible to sustain themselves and their immediate families particularly those in rural areas. Furthermore, high inflationary pressures have also added to their woes, to the extent that most of the elderly opt to go hungry since they are unable to purchase enough basics like food (Help Age International, 2002:7c; Madzingira, 1998:143). Essential items like medicines and winter heating are often very expensive given the fact that the prices of essentials rise faster than the increase in the pension.

Consequently, as a result of inadequate pensions, the elderly often have to borrow money and pay off their debts to loan sharks at pension payout points. These money lenders would charge the elderly higher interest rates leaving them with little money to take home to their extended families. In the Eastern Cape, almost a quarter of the rural elderly population in the rural areas reported taking a loan from a micro lender compared to less than 10% of urban black pensioners (Moller and Ferreira, 2003:23). This was common in the rural areas due to the high levels of unemployment among the adult children who had to be supported by their elderly parents, while those in the urban areas did not have to support their adult children as much as their rural elderly counterparts.

It is worth noting that, regardless of how inadequate the pension were, pensioners were still able to sustain the pensioner's children and grandchildren who would cluster around the elderly for survival (Charlton, 2000:3) [17]especially with regard to basic necessities like food and clothing. For instance, the vast majority of the Blacks interviewed in the Eastern Cape Province indicated that their pension was shared amongst family members while at the same time spending very little on their own needs (Moller and Ferreira, 2003:25).

[17] The Pension accorded the elderly with respect and independence in the community which is in line with the activity theory since they play the role of supporting their communities..

As a result, several of the elderly had to do some work to supplement their pensions. For example, in Limpopo Province older women often did supplementary work that included working in the nearby farms to add to their pensions while older men contributed by carving plates, spoons and sculptures to sell (Global Action on Ageing, 2002.).

Exclusion and isolation were identified as being the defining features of poverty in South Africa (May, 2003:vib) with many of the elderly left alone in rural areas and sometimes living in isolated areas. The loss of family support is becoming a feature of ageing, based on the fact that their children migrate to urban areas in search of jobs leaving them vulnerable to the elements, and due to the high cost of living in the urban areas, those adult children who are working may not be able to send any remittances to their elderly parents in the rural areas (Moller and Ferreira, 2003:24).

Skeldon (1999) indicates that migration is age-selective, with the youngest and the brightest leaving the rural areas for the towns and cities. This not only exacerbates the ageing effects of fertility decline by removing the youthful and most energetic cohorts, but also removes those with development initiatives who are most likely to improve the conditions of rural populations and the elderly poor. This indicates that migration is negative for development and is likely to worsen the situation of those left behind especially the elderly, since rural production is eroded thus affecting their welfare.

It should be noted that migration does not just influence the age structure through the exodus of the young adult cohorts but also through the return movements of those who have spent several years away, either abroad or in the urban sector. This may have the potential of aggravating the support problems of the older populations in villages by local sources of labour (Skeldon, 1999;Mckeever,2004). One may only hope that the returning elderly migrants have come with financial resources to invest in businesses or land development which may ultimately contribute to the development of rural communities (Skeldon, 1999).

In some countries the pressures of having a youthful population may force the elderly into early retirement, leading them and those they support into poverty (Kazeze, 2002:3), and because they no longer worked, it may be difficult for the elderly to have access to credit since they no longer get any form of income that could guarantee payments back (Kazeze, 2002:1).

This limits their ability to invest in any form of business that would sustain their livelihood, which may partly be the reason why many of them fall into a state of poverty after retirement. HIV/AIDS is now worsening their situation, since they have to provide support to the sick without any form of assistance. For many people the death of an older relative may imply the loss of income from the pension of the deceased, leading to abject poverty. Even the death of a spouse who happened to be the sole provider can lead to the rapid deterioration of the basic living standards (Global Action on Ageing, 2006).

In a study done in Mpumalanga, South Africa (Makiwane et al. 2004), the pandemic had already begun to stretch the financial resources of the elderly population in terms of the provision of the basics and funeral costs. The study found that 72 percent of the older people in the province are the main breadwinners in multi-generational households, spending much of their income on household necessities and the education of grandchildren. It must be highlighted that pension sharing was also necessary for social integration of the elderly pensioners with their communities (Global Action for Ageing, 2002). However, regardless of the pandemic, the elderly still have to look after their grand children with little support from the parents of children resulting from unwanted / unplanned pregnancies (Global Action for Ageing, 2002).

According to Help Age International (2000), development analysts and policy makers do not take into consideration the role of the elderly during poverty debates, regarding them as economically unproductive. Yet in many rural areas of sub-Saharan Africa, they are responsible for cultivating and looking after the households. This undermines poverty-alleviation strategies, suggesting therefore that the elderly and their families will continue to live in poverty since they are ignored as role players in society. This clearly represents a failure to give equal status to older people's basic human rights based on their age and status relative to their communities (Van Niekerk & Roos, 2008). A lack of assets further compounds their already difficult situation. Elderly women in particular, were not entitled to property and would lose their status especially in countries like Northern India and some parts of Africa as a result of widowhood. In extreme cases they are ejected from their deceased husbands' homes, leaving them hopelessly destitute and even susceptible to sexual exploitation (UNFPA, 2002:31b).

Poverty today is not just a lack of physical necessities, income and material assets, but physical weakness, isolation, powerlessness and low self-esteem are all factors profoundly interlinked with age (Help Age International, 2003a).Poverty among any given community has a direct impact on the elderly since they rely heavily on the community for socio-economic support particularly from the young adults (Help age International, 2000:2).

In some areas like Bangladesh, respect for the elderly is somewhat linked to their ability to provide for their families, such that an older person would have respect based on his/her contribution of land and money (help Age International, 2002a). This again highlights how poverty can impact on the elderly not just in terms of their living standards but also their social status amongst the community. This means that the elderly would rather continue working until they are no longer in a position to do physically work. This may be in line with the exchange theory where the elderly have to do something in exchange for societal acknowledgement. (Nilsson et al 2005:365). However, the economic contribution to overall development by the few that are engaged in some form of employment is not acknowledged, yet they help provide employment opportunities for the youth through rural projects (Kazeze, 2002:2).

As previously highlighted, South Africa is one of the few nations in the developing world that offers the elderly a pension. However, there are problems or concerns raised by the elderly when it came to actually receiving their pension. Long queues are common to such an extent that the elderly have to line up the whole day during pension payouts. This situation has degenerated to the extent that some pensioners have had to queue from the early hours of the morning, braving the elements like rain and cold, just to get their pension money as early as possible to avoid standing in the queue for long hours till late. This seriously jeopardises their health. As Altenroxel (2001) put it, some pensioners referred to pension day as the worst day of their lives - the day they queue for hours to receive their "meagre "R540[18], making them exhausted and even becoming traumatized (Moller and Ferreira, 2003:25). Other issues that they have to contend with include a lack of facilities at payout points like toilets, shelter from the sun or rain, seating and water which most provinces did not provide.

[18] As of 2005, pensioners were to receive R780 and in 2010 it rose to R1080.

Secondly, security at pay points is also a major problem because it puts the elderly population directly at risk of being robbed or shot at (UNFPA, 2002:29a). In some cases they are robbed after collecting their pensions or targeted by moneylenders and unscrupulous burial societies (Help Age International, 2002:5c). The National government has tried to appoint private contractors to help speed up the process of providing pensions to the elderly. However, this has not necessarily alleviated the problem because of frequent pension stoppages without warning, creating arrears, which are not accounted for (Moller and Ferreira, 2003; 26).

The introduction of a new payout system in the rural Eastern Cape Province ended up confusing the pensioners further, with some missing out on their payments since their names didn't appear on the payment records (Moller and Ferreira, 2003; 25). Such delays put the elderly population in a desperate situation for survival and together with their extended families that rely on their pension for day-to-day upkeep; the chances of poverty become almost a reality. It must be noted that while pension payments cover all the provinces in South Africa, some provinces may have exceeded their budgetary provision, which could partly explain some of the delays in cash payments to the elderly (Ferreira and Charlton, 2004:53, Triegaardt,2004).

Related to the above, are the complaints that some of the pensioners still had not received their Identity Document (ID) book or social grants, despite applying for them years ago. These Identity Documents are important if any South African Citizen is to access social services. In a recent case, a distraught 62-year-old woman from Durban had been waiting for her grant for the last 2 years and had still not received it, putting herself and her grandchildren that she supported at risk of being destitute because she did not have an ID book. There were many other elderly people in similar positions throughout the country that were unable to get social grants on account of not having ID books, or because their applications had not yet been processed. Even accessing other grants is proving to be difficult, with one elderly woman lamenting the fact that she still had not received a grant for her disabled grandson despite applying for one a year ago (Help Age International, 2000).

Another related concern affecting the elderly is corruption within the system of pension payouts where officials devise means of stealing pension cheques by creating duplicates of

recipient elderly people, assuming that the elderly recipients were deceased and also suggesting that the elderly recipients had emigrated.

In the Eastern Cape the pension system was dogged by corrupt officials (Ferreira and Charlton, 2004:53) depriving the elderly and their extended families of much needed income to buy necessities. It has been estimated that the National government spends a significant proportion of the national budget on social security and loses at least R1.billion on fraud, theft and inefficiency (Ferreira and Charlton, 2004:53). An example in question was an administrator from the Government Employees' Pension Fund (GEPF) that had been arrested for an alleged pension fraud scam believed to involve more than 20 million Rands (Gifford, 2003). Other cases involved a couple facing more than 800 counts of fraud involving theft of government pension cheques (Mzimba, 2000).

In essence, fraud and corruption may have very serious implications for poverty alleviation since government's efforts are being undermined by officials who have no regard for the elderly population's needs. At times the elderly have found themselves being the victims of circumstances where they are either injured or are killed especially where armed robbers attempt to steal money from the pension payouts. Three elderly women were critically injured, one fatally while trying to hide from armed robbers who fired gunshots, ordering the pensioners to lie down before speeding off with R 500 000 of the pensioners' cash. The deceased, a 66-year-old woman had looked after five orphaned grandchildren. In other parts of Africa, like Zambia, poor management was blamed for the loss of social security (Madzingira, 1998: 143), since there were no proper structures in place to ensure that social security was distributed on time and to the right recipients

Finally, poor or inadequate transport facilities, especially in rural areas, were still a major concern which may be linked to developmental policies. In most African countries, socio-economic development is one sided mainly in the urban areas, suggesting that infrastructure, like roads or telecommunications in the rural areas, is either non-existent or poor and yet existing literature shows that many of the elderly reside in the rural areas (United Nations, 2002:1a; Stloukal, 2001:1; Charlton, 2000:2). This makes their travel extremely difficult, in addition to their limited mobility resulting from their old age. Due to low incomes or

inadequate pension, transport fares are too expensive for them to travel since much of it goes to supporting their extended families as is the case with those elderly in the Eastern Cape who have to travel long distances for health and welfare services (Ferreira and Van Dongen 2004:17). This means access to basic social services and participating in local activities becomes a real problem for them. Even when they do have access to transport they are usually shoved and pushed by other passengers (Help Age International, 2002:1a).

In other instances, overcrowded transport systems may also discourage them from using public transport as a result of their frail nature and even seeking directions to their destination may be difficult on overcrowded transport systems since they are unable to speak loudly in a crowded environment.(Help Age international,2002:2d).

Again in South Africa, transport in a fast, youth oriented society is particularly problematic for older people. Not only are they frequently required to board public transport at a pace which doesn't suit them, but the collapse of public transport systems in the countryside means they have to pay far more to reach pension pay-points, hospitals and clinics (Help Age international,2002:2d)

It has always been assumed that formal income security for the elderly is only possible and sustainable in countries whose economies are better equipped to maintain a formal social security system. However social security for the elderly can be substantially enhanced by measures taken to strengthen older people's abilities to contribute to and be included in the process of development (Help Age International, 2000:3). This may require supporting the informal income security that can build older people's security since a substantial number of elderly have worked in the informal sector, but after retirement they have no form of social security. This would go a long way in improving their own and families' living conditions.

3.2.2 Health concerns

Having proper health is an integral part of every able-bodied person; to be able to function or carry out one's responsibility properly, he/she must be healthy. For the elderly getting or having access to health facilities/services has become a challenge because all health attention is focused on the very young, maternal and reproductive health issues in many sub-Saharan

countries (Charlton and Rose, 2001:1;Kazeze, 2002:3). In the majority of less developed countries, governments provide only limited health services or medical care so that the health needs: preventive, curative, restorative and rehabilitative- of the elderly people, especially the poor, remain largely unmet (UNFPA, 2002:39a).

A report by Joubert and Bradshaw (2003) further indicated that about 145 115 deaths occurred among the elderly population of which 71 641 were male and 73 474 were female.[19] Non-communicable diseases (NCDs) were responsible for 84% of deaths amongst the elderly population (Joubert and Bradshaw, 2003: 154).

Heart disease and stroke were the two major killers among the elderly population with older females dying of stroke and heart disease than males.

The lifestyles' among elderly South Africans also contribute to their ill health, with a significant number of elderly men smoking compared to women at 35 percent to 7 percent respectively. Even with regards to alcohol consumption, over 20 percent of both elderly men and women were engaged in risky drinking (Joubert and Bradshaw, 2003:157). With regard to their eating habits, the elderly people face different health issues like lack of natural teeth, changes in taste and reduced mobility brought about by food deficiencies, which most general practitioners/nurses are unaware of. Degenerative conditions are seldom explicitly diagnosed and the individuals and their families alike tend to accept this process as a normal stage in the course of life. That is why it is necessary that nutritionists and trained geriatric specialists are in place to help provide advice to the elderly on improving their health diets. However, in many developing countries, particularly in Sub-Saharan Africa, trained nutritionists and geriatric specialists are scarce (Kazeze, 2002:3; UNFPA, 2002:40a)

Those who live in rural areas had a poorer health status than those who live in urban areas, a discrepancy which may be attributed to poor health facilities that may also be far from their own homes (Global Action on Ageing, 2002). This is clearly illustrated by the elderly who migrated from the Eastern Cape to the Western Cape particularly to the city of Cape Town

[19] The above figures were extracted from the South African National Burden of disease study.

where health facilities were adequate and clinics easily accessible and better care given to them compared to their former homes in the Eastern Cape (Ferreira and Van Dongen, 2004:16).

In some instances the elderly people expressed dissatisfaction about inefficient appointment systems, long waiting times and understaffed facilities at clinics and hospitals, so much so that some would prefer buying drugs from local shops[20] (Waweru et al., 2003:1). In addition, the negative attitude of some health workers towards the elderly has also affected the quality of health care services provided to older persons.

Some of the reasons given by health workers in Tete, Mozambique, for not treating the elderly people were that, they were too dirty or they had not combed their hair; or they were old and could not take their medicine (Help Age International, 2002:36a). Like their elderly counterparts in Africa, the elderly people in East and Central Europe also complained of poor treatment by health workers who preferred to treat the younger people than them. As a result, there persists a rationing of services that prioritized the young and middle aged. In the past, health care was mostly in the hands of family members who were tasked with the duty of treating the sick on behalf of medical practitioners. But with the advent of the new political systems, younger family members opted to migrate for work in the urban areas and once the large state enterprises collapsed, the elderly people started receiving inadequate health care (Help Age International, 2002:9c).

The 1995 Western Cape Community Housing Trust survey indicated that the most elderly were dissatisfied with state health care facilities, with most preferring to spend their little money to go to a private health care system. Numerous nurses that catered for geriatric services in state hospitals were now used to assist with immunization programmes for children (Charlton, 2000:4; Joubert and Bradshaw, 2003:157). This has resulted in the sick elderly having to wait in long queues to receive treatment, together with everybody else. In the same survey most of the elderly in newly settled areas around Cape Town had chronic diseases like diabetes and hypertension that were undetected and medically untreated.

[20] In Dagoreti, Kenya 62 percent of the elderly indicated that they were buying drugs from kiosks because of poor health facilities in the area.

The cost of medicines or health care is also another related concern raised by the elderly because when they are unable to pay they leave the clinics or health centres without any help or treatment. Most of them have resorted to traditional healers who are not necessarily equipped to solve some of their health problems. In most cases the traditional healers are nearer to their place of residence and are cheaper in terms of costs (Help Age International, 2002:36d). Madzingira (1998:143) quoted Wong who pointed out that the elderly population in Singapore consumed a large proportion of health care resources, which placed a burden on the state, communities and families. Most of the elderly depended on their adult children to pay for their healthcare, but due to economic hardships some of the adult children were unable to send any remittances to their elderly parents and grandparents.

A related study done in Ghana (Mba, 2007:23), found that about 18 percent of older people were unable to pay for their health care because, as a result of migration they had lost contact with their adult children who used to pay their medical bills. In Zimbabwe, only 35 percent of the elderly acknowledged that their adult children were good providers and supported them with their health care needs (Madzingira, 1998:144). In Eastern Europe, the collapse of the communist system meant that most state hospitals are now unable to provide proper health care for the elderly population, with many of the elderly people lamenting the death of their peers. Again the high cost of medical care has also contributed to more deaths of the elderly in this region simply because the social systems that supported them have also ceased to exist with the new political dispensation (Help Age International, 2002d).

The above concern is linked to the fact that most of the elderly in developing nations have no medical insurance that is targeted at the affluent sections of society, making it very difficult to have access to medical care (UNFPA, 2002:40a). In South Africa in 2005, only 13% of the elderly people had access to a medical aid fund (MRC News, 2005:1) suggesting that a vast majority may go untreated by health centres because of escalating costs. The current provincial government is having to battle with the HIV/AIDS pandemic that primarily affects children and the young adult population with negative repercussions for elderly health care attention. It is imperative that the elderly are also advised to change their lifestyles to prevent chronic diseases. Despite the shortcomings of the health care system, elderly South Africans can access

free primary health care at over 3500 primary health care clinics, including prevention, care and treatment of diseases of elderly people (Department of Health, 2006:4).

In addition, it is important that information regarding better living, healthy ageing, as well as details of the risks and illnesses common to their age group is easily accessible (UNFPA, 2002:41a).

Another health concern of the elderly is malnutrition and starvation which may be linked to socio-economic difficulties (Collier, 2005:1). Some of the factors affecting malnutrition among the elderly could be:

- Oral factors which include swallowing problems from a previous stroke, worsening dentition;
- Socio-economic factors like isolation, bereavement of spouse and the all too common aspect of poverty;
- And general health risk like drugs and alcohol as well as chronic disease and disability

In the more developed nations the general assumption is that the populations as a whole, including the elderly, should not suffer from malnutrition because of better standards of living. However, Azad, Murphy, Amos and Toppan (1999:512) suggest that malnutrition of elderly patients in institutions is becoming a major concern and yet it remains largely unrecognized. A study done in Canada from a sample of 160 elderly patients, shows that over 55 percent were either at risk of malnutrition or were malnourished (Azad et al., 1999:513). This may have resulted from neglect of elderly people living in such institutions.

In the case of sub-Saharan Africa, malnutrition among the elderly population may be caused by insufficient food stocks resulting from adverse weather conditions, as has been the case in Ethiopia where observable malnutrition in older people were seen by administrative and agency officials (IRIN, 2005). Currently, East Africa has a food crisis resulting from a severe drought exposing the elderly people to severe hunger especially those who are too frail to

travel to other villages in search of food. Consequently, many of the elderly pastoralists in Southern Ethiopia have lost their cattle to the drought (Help Age International, 2006:1a)[21].

Other causes may be devastating conflicts, such as those that happened in the Democratic Republic of Congo and Eritrea where high malnutrition rates among the elderly have been seen (World Food Programme, 2005:2). Even in periods of emergencies the elderly find it difficult to cope with new strategies that may require them to maintain a healthy diet by adapting to new and unfamiliar foods.

In some rural areas wild foods are an important source of micronutrients and contribute to household food availability but access to these wild foods became more difficult, and often unavailable as a result of displacement (Help Age International, 2001:9)

The decline in food production in Southern Africa may be linked to the fact that HIV/AIDS has already started taking its toll on the agricultural sector where many of the economically active people responsible for cultivating the lands especially in rural areas are dead, leaving the elderly and the very young vulnerable to malnutrition (Drimie, 2002:15). Crops that are more labour intensive are severely affected leading to a switch to crops that are less labour intensive resulting in less land being cultivated. As a result, income from the sale of food stocks will decline and the quality of food supplies may also be affected raising the prospects of malnutrition and starvation.

Most assumptions made are that nutritional deficiencies are inevitable consequences of ageing and disease and the intervention for these deficiencies are only minimally effective. The logic behind this may suggest that elderly people need not waste time going to the clinic or hospital regardless of whether the ailment they are suffering from is curable or not. However, there may be both individual as well as general factors that may put the elderly at risk of becoming malnourished. These may stem from disability, reduced access to food, emotional and functional ability that may lead to decreased food intake (Help Age international, 2001:13). Stressful events and loss of support structures on the other hand may also disrupt food intake leading to poor diet of the elderly (Help Age international, 2001:13). Visvanathan (2003)

[21] It is estimated that nearly a million older people are at risk of starvation in East Africa, according to Help Age International field assessments. As of 2008 the food crisis had worsened due to drought.

points out in his abstract on under-nutrition among the elderly that the same effort put in addressing child nutrition is required to combat under-nutrition in our elders.

In South Africa, most of the elderly are landless (an apartheid legacy) which made it impossible in the past for any form of agriculture because of racial discrimination in land distribution patterns. As Evans (2005:4) points out, malnutrition and unintentional weight loss contribute to progressive decline in health, reduced physical and cognitive functional status, increased utilization of health care services, premature institutionalization and increased mortality. Charlton and Rose (2001:6) pointed out that 43 percent of South African households experienced food poverty in 1995, which was slightly higher for elderly headed households at 50 percent[22]. It can only be assumed that this was a period when South Africa had just undergone a political change and that the situation might since have improved as more of the elderly people now receive pension and most of the population have equal opportunity for social services. It is however imperative that effective nutrition interventions take account of the differences in social and demographic factors like household size, urbanization and race.

A report released recently by the Ministerial Committee on abuse, neglect and ill-treatment of older persons indicated that many elderly people suffered from under nutrition (Republic of South Africa, 2002:1), which was also highlighted by the former Premier of the North West Province when hosting a function for elderly and disabled people. This event was sponsored by Pick and Pay in Taung and the nearby villages in the North West Province where food parcels were provided to the elderly with a reminder to the nearby communities of the role they, the elderly and disabled, still played (Republic of South Africa, 2002:1).

It is possible that malnutrition may result from poverty where most elderly households do not have sufficient funds or no funds at all to purchase basics like food. Such existing conditions can be particularly difficult for the elderly population living in the rural areas where the level of unemployment is high and the meagre pension they receive is absorbed in provisions for their extended families. The relationship between poverty and malnutrition has been well

[22] Food poverty was at 40 percent for the younger households who, to some extent, could do some odd jobs to try and survive compared to the elderly households.

documented with the 1995 World Summit for Social Development and The South Asian Association for Regional Co-operation Inter-ministerial Conference in 1996 linking poverty to malnutrition (United Nations, 2002a). This therefore suggests that tackling poverty would directly reduce the levels of malnutrition, not just for the elderly population but also the very young population.[23] Even those elderly people who are housed in institutions that provide sub-standard food must be aided by governments and civil society to help stem under-nutrition (Altenroxel, 2001:5).

Arguably, the presence of a grandmother in the household reduces infant mortality and improves nutritional status and child development, contrary to the commonly-held belief that grandparents and their old fashioned ideas were a deterrent to improvement in child feeding practices (Help Age International, 2001:8). But it is imperative that further support is given to them in their efforts to provide proper care to these children and this is where the establishment of local networks with the communities is of paramount importance.

3.2.3 Social concerns

Personal security is every individual's right regardless of his or her age. Physical abuse and crime against the elderly is mainly as a result of lack of respect and tolerance for older citizens with older women often being victims of abuse and rape. In a survey done in the Cape Town Metropolitan area, violence and fear of crime inhibited mobility and also affected access to health care facilities (Charlton, 2000:4). Those living in the Cape Flats were particularly vulnerable to gunshots from rival gangs and were powerless to do anything, living in constant fear (Ferreira and Charlton, 2004:85)

In the past years white farmers have been the targets of armed robberies particularly those living in isolated areas. Elderly farmers have not been spared in this regard with a 66 year old man shot in Mpumalanga. All the above examples illustrate the current situation of the elderly people who are either caught in violent situations or are themselves the targets of violence. There is a general perception that the elderly people do not deserve to be part of society and

[23] Poverty alleviation programmes will have to incorporate the features of health and care if they are to positively impact on nutrition

that could be part of the reason why they live in isolated areas away from the general community.

It is also unfortunate that very often the violence against the elderly comes from amongst some family members who take advantage of the frail nature of the elderly to go as far as stealing their pension money (Ferreira and Charlton, 2004:53). For instance, a 13-year old grandson of an elderly woman in Soweto would take all her pension money leaving her destitute. Other such incidences against the elderly have been reported, but the elderly would rather keep quiet for fear of being persecuted by family members (Ferreira and Charlton, 2004:23; Joubert and Bradshaw, 2003:158). This violence against the elderly emanates from dire poverty in households whose members would go as far as inflicting physical harm on the elderly to get their pensions from them and in the process marginalizing them (UNFPA, 2002:30b). Other instances of abuse of the elderly include abusive behaviour by public services or service providers, which might be a reflection of society's negative attitudes to vulnerable people (Help Age International, 2002c; Age Ways, 2002:5a)

The role of the elderly in society is rarely acknowledged or recognized by communities which may explain the violence against them. In Eastern and Central Europe, the elderly peoples' contribution to society is grossly underestimated and they are seen just as a group of people who have outlived their usefulness. Most youth are generally unfriendly towards the elderly people to such an extent that they have become violent (Help Age International, 2002:10c). Yet the elderly have actually helped the younger people through small cash transfers from their pensions, suggesting that they can rely on the elderly for assistance. Today, the elderly have become child minders in many parts of Eastern Europe, which used to be subsidized during the communist era, but has since ceased due to political changes (Help Age International, 2002: 11c).

In the Eastern Cape Province of South Africa, a fun day was held to restore the elderly population's sense of belonging to their communities. This was organized by the Premier's office to honour the contribution made by the elderly and also help facilitate their full participation in their communities (Nini,2003:3). However, these kinds of events are held without the community being reminded about the role of the elderly. This is necessary to dispel

any negative perceptions their communities may have particularly in a youth oriented society that views the elderly as a burden because of their frailty. A multi-pronged programme is necessary to highlight the enormous contributions made by the older South Africans to their society.

Another social concern is the lack of proper housing for the rural and urban elderly people. They do not have the means to rehabilitate their shelter and thus live in poorly constructed houses with leaking roofs, collapsing walls and poorly done floors, which limit their mobility (Tewdoros, 2004:13; Ferreira and Charlton, 2004:16) and expose them to the harsh environment like rain or cold weather (Kazeze, 2002:3). This may, as a result, have serious implications for their overall well being particularly their health. This is further highlighted by the plight of an elderly woman who was staying in a three room shack on the West Rand with a leaking roof and one toilet that she and her husband shared with 10 other people, which had not been working for as long as she could remember, and because of lack of sufficient funds, they were unable to repair their homes or build better houses or repair sanitation facilities in their homes (Kazeze, 2002:4).

In the Western Cape, most of the elderly in Cape Town lived in shacks or informal settlements and semi-detached houses which, among other things, were susceptible to fires that led to destruction of property and loss of lives (Ferreira and Charlton, 2004; 17). Many of those that live in urban areas live in high rise housing structures that are not user friendly in terms of easy mobility, which may be detrimental to their physical well-being, as they may fall causing serious physical damage to their bodies (UNFPA, 2002:31b; Global Action for Aging, 2002). This may be due to the rapid influx of in-migrants from rural areas to cities which suggests that there is a high demand for housing as well as services that cannot be met by city officials. This has led to the mushrooming of informal settlements that have housed the poor, including the elderly.

In the North West Province of South Africa, 87 percent had access to piped water and only 5 percent had no toilet facilities indicating that most elderly live in proper formal housing (Joubert and Bradshaw, 2003:154). However, they may be sharing with their adult children

and grandchildren leading to congestion, creating situations conducive to the spread of diseases due to overcrowding.

Related to the above situation, those living in residential homes for the elderly are equally vulnerable with no uniform standards of cleanliness, resulting in poor living conditions. Most of these residential homes are still dominated by whites with little or no transformation in this particular area (UNFPA, 2002:27b). Most elderly blacks live in the rural areas and are heavily relied upon by their extended families for provision of proper shelter, such that it may be difficult for them to stay without their families. Also traditionally, elderly Blacks stay with their families for support and the idea of staying in old age homes has never been an option as a result of cultural norms where it is expected that society looks after its own (UNFPA, 2002:28b). In situations where there is no formal housing, there is lack of basic facilities such as water and sanitation (Joubert and Bradshaw, 2003:153) and if they do exist they are in poor working condition as highlighted by Kazeze's (2002) anecdotal example of the elderly woman in the West Rand, where toilet facilities had not been working for a long time

In many African societies customary law may govern land ownership. Property disputes affect older persons as family and community members always fight to take control, more especially after the death of the head of household. In most instances, it is the women who bear the brunt of these laws where again discrimination comes into play (Kazeze, 2002:4; Tewdoros, 2004:13). This indicates that property such as houses may be taken away from them after the loss of their husbands, leaving them and their extended families with no shelter and therefore destitute.

During periods of conflict or emergencies, the elderly are usually overlooked, with more emphasis placed on children and women (Help Age International, 2006:1b; Help Age International, 2001:10). According to Charlton and Rose (2001:7), the United Nations High Commission for Refugees estimated that on average 10 percent of refugees are over 60 years old and because of their physical limitations resulting from old age, many of them end up losing their lives during civil wars or are even left behind (Help Age International, 2005:1a). The Sudan crisis, involving particularly the Darfur region, is considered to be the world's worst ongoing humanitarian crisis with approximately 8% of the total population displaced

being the elderly (Help Age International, 2006:1b). Almost a third of the elderly living in those camps are looking after orphaned children and require urgent assistance in supporting their grandchildren in terms of food and clothing. Those that do survive face food shortages and yet, during relief operations their health and nutritional status is overlooked, while children and women are targeted (Charlton and Rose, 2001:6).

Similarly, the Rwanda and Angola conflicts in the 1993-1994 periods highlighted the plight of the elderly who had to take care of their grandchildren after the death of their parents. In some cases, parents would leave their children with the elderly for several days as they looked for food in periods of famine as was the case for those who lived in the Rwandan refuge camps in Tanzania (Help age International, 2001:11). As a result of being displaced, food production was non-existent with many of the refugees' health, including the elderly, at risk of malnutrition.

Even when it comes to the receiving of materials or food parcels during periods of emergencies, the elderly are, in most cases, either ignored or overlooked. During Help Age International's work in a refugee camp for Mozambican refugees in Zimbabwe, it was found that although the younger population groups were given poles to construct huts, no poles were given to older people (Tewdoros, 2004:6). Food distribution centres are not considerate to older people's limited mobility and food rations are often unsuitable for their digestive and dental conditions. The contribution of older people in maintaining some sense of community identity goes unrecognized especially after displacement. Most activities focus on younger people and the role of the elderly is neglected giving them the impression that they are ignored by society.

In Eastern Europe, the collapse of the Communist system of support that provided most of the basic services have left many people, including the elderly, disillusioned since now all services must be paid for. With no social security systems in place, there has been a steady rise in destitute households (Help Age International, 2002:3c). It is generally assumed that when they retired, older people would live in peaceful co-existence with close family and benefit from state support. This, however, has not been the case. The situation in Eastern Europe is particularly serious for the elderly people because unlike their counterparts in Western Europe

where the economies are strong, they get very little support from their governments, which are still trying to grapple with the adjustment from a communist to a capitalist system of governance. Previously, all provisions were provided by the state under the communist "Slogan" of support, where its entire people were provided with most of the important necessities like heavily state subsidized education and housing. However in the late 1980's and 1990s elderly people have seen their income security being wiped out due to inflationary pressures, leading to disillusionment that has now became a major aspect of their lives (Help Age International,2002:4c).

In addition, the political changes that have swept through this region (Eastern Europe) have not benefited the elderly people since they have been left out of the new economic opportunities brought about by political changes. Only the younger people have benefited from these new opportunities since current employers preferred younger people with only a handful of elderly people being trained (Help Age International, 2002:5c). In some instances, the elderly would go to great lengths and sacrifice their jobs for their children. This suggests that older peoples' experiences counted for nothing and with new political systems sweeping most of eastern Europe, come new systems of work that require training of people to be in a position to work under these new systems. Given the age of the elderly people, it would seem logical for employers to invest their resources in younger people who would work longer for their employers.

In the case of South Africa, most of the elderly people living in the Cape Flats lamented the fact that very few things had changed since the advent of a new democratic state where crime, violence and the deterioration of community life have become the norm of everyday life (Ferreira and Charlton, 2004:84). Most of these elderly people indicated that they had to stay barricaded in their homes for fear of being shot. After the demise of the old apartheid system that prevented blacks from moving freely from one area to another, many of these elderly migrated from the Eastern Cape, a predominantly rural area, to the Western Cape in search of a better life. Contrary to their expectations, many lamented the slow pace of development like the continued lack of proper housing and the high crime rates where they lived. Residents of Gugulethu in the Western Cape, including the elderly, have accused the government of not investing in the area, but developing affluent suburbs and newer townships. The socio-

economic development that the residents had hoped for has not been achieved. An elderly man who moved to Gugulethu lamented the fact that crime had not dropped after democracy but instead had increased (Ferreira and Charlton, 2004:49).

Another social elderly concern is the lack of information which is an integral part of everyday life, because it is necessary for access to basic services and the provision of knowledge about important aspects of society in terms of its progress and challenges faced. Elderly people also need information to enable them access to basic services and to be part and parcel of any decision making process; they need to know what activities are taking place in their communities since they are the ones that helped create and establish such communities. The opposite however, is the case, with many elderly people bemoaning the fact that they lack access to information regarding their rights and benefits as elderly people. In Eastern Europe, the elderly complained of being neglected and unaware of their rights partly because they lacked the necessary information that would enable them to access some basic services like health care (Help Age International, 2002:5c). This was partly due to the fact that their communities had also neglected to take care of their own elderly people, whom they saw as a burden. This had ultimately resulted in violence against the elderly (Help Age International, 2002:5c)

In the former Soviet Union, work structures bonded older people up to their retirement when they could still receive some form of benefits and services. But today, the elderly people are no longer bonded to their work place leaving them to fend for themselves with no social and cultural opportunities. This isolates the elderly people from the rest of society, which may expose them to the elements of hunger and poverty.

In South Africa, the 1995 Western Cape Community Housing Trust survey highlighted the fact that most elderly people lacked information on where to obtain health care facilities (Charlton, 2000:5). As a result of the apartheid legacy, many elderly people (about 43%) have no formal education leading to low literacy and education levels. In terms of racial groups 58 percent of Africans had no formal education compared to just 2 percent of whites (Joubert and Bradshaw, 2003:152)[24]. A lack of formal education may partly explain why most of the elderly are unable

[24] The statistical information on education by race was obtained from Statistics South Africa: Census 2001.

to access information regarding meeting their needs. In the North West Province about 45 percent of the elderly population had no formal education compared to the national total of 43 percent. In Tanzania and Cambodia, Help Age International Research (2006:1a) has shown that older women and men prioritized verbal and informal information sources over written ones.[25] This gives a clear indication of the difficulties the elderly have in accessing written information in regards to health, social services and even their rights as senior citizens of the country.

Finally, the representation of the elderly in government or non-governmental organizations is almost non-existent particularly in most developing nations. This could hold true for those regions where the proportion of the elderly is not significant to warrant any form of representation, particularly in areas regarding their own wellbeing. Society in general regards the elderly as pensioners, a title used to distinguish people that have reached an age of retirement and who receive social grant or assistance of some sort.

In the case of South Africa, however, they belong to a social group that is viewed as old, poor and deserving (Ferreira and Charlton, 2004:54). But it has helped them in regaining some form of respect because of the role they play through the support of their extended families. But without any form of institutional representativeness as a group, the extent of their plight in society can never be fully explained with many of their concerns being explained by gerontologists and researchers who try to act as spokespeople for the elderly (Ferreira and Charlton, 2004:55). However human rights organizations and international organizations that place special emphasis on the needs of the elderly are slowly encouraging them to speak out.

3.2.4 Psychological concerns

To some extent, elderly people may also have psychological concerns that may lead to depression. Some of the socio-economic concerns already highlighted like physical and emotional abuse coupled with inadequate support systems have led the oldest elderly to fall into a state of depression (Woolf, 2009; Evans et al., 2002:382).

[25] The verbal and informal sources included peer educators, home-care visitors, the radio and television.

As already pointed out, some of the elderly that are abused are too scared to report this injustice because the perpetrators of abuse are mainly family members that are supposed to provide care to them (Nkuna, 2008:1).

There are a growing number of elderly people who are seeking refuge in old age homes but due to the acute shortage of old age homes, the few homes are unable to cope with the large numbers of the elderly that need such help. The loss of a loved one, particularly a spouse, may have devastating effects making the widow or widower losing all interest in life and even illnesses that were under control would reappear because of neglect in taking medication required to keep the illness under control(Segal et al., 2007:1; Franklin, 2003:5). This, to some extent, has led to suicide as a result of loss of a spouse. Suicide, amongst the elderly, is on the rise as a result of depression, with 17% adults over the age of 65 committing suicide (Rand, 2005:2). Other causes of depression may be the loss of purpose in life due to retirement, the fear of death, particularly with the advancement of age leading to anxiety and ill health like physical disability that may limit participation in daily activities (Segal et al., 2007:2; Rand, 2005:2). This is why it may be imperative to recognize the signs and symptoms of depression like sadness, fatigue, loss of interest and increased use of alcohol and other drugs which are common amongst elderly people.

Gusmano and Rodwin (2006:1), have indicated that isolated elderly people are only found when there is a crisis like the situation in Chicago in 1995 and in Paris of 2003 when, due to heat waves, there were excessive deaths and the majority of which were among the elderly. Most isolated elderly people have higher mortality rates than those who live with their adult children or have someone nearby to look after them. Most of the isolated elderly were women in their advanced years most of whom have poor health as a result of their poor situation. In most developed nations like the United States, they are institutionalized and end up losing their independent life styles. Kaasa (1998:195) established that there were correlations between loneliness of the elderly and low vision, poor hearing, low activity of daily life, loss of spouse and low social networking. For instance, poor hearing may cause concerns in social settings where there are many people present and yet it becomes increasingly difficult to follow or participate in conversations. This may result in a feeling of isolation from one's surroundings and increases the risk of loneliness.

Mental health affects most of the elderly in their advanced ages with the common form being Alzheimer's dementia which may last between 5 to 20 years. The common symptoms may be Delirium, Delusions, Depressed moods and behavioural disturbances. Some of the early stages of mental illness may be memory loss, language difficulties, failures to identify objects and disturbances in planning, yet some of these stages are confused with normal ageing or depression. As a result, most cases are not adequately treated since these deficiencies are masked by the compensation of loved ones (Estronaut, 1999:1). Some of the causes of mental health may be socio-economic hardships faced by the elderly in terms of care-giving, social dislocation and disorganization. Again, elderly women were prone to mental health stress since the burden of these problems is their responsibility. For instance, 40% of the elderly women in Khayelitsha, Cape Town, were found to have symptoms of depression due to difficult socio-economic conditions leading, in some cases, to suicide (Charlton, 2000).South Africa is the only African country with a section that addresses psychiatry for the elderly in the national psychiatric association and the national association of geriatrics or gerontology (Lima et al., 2008:24). However, more mental health resources must be geared to the rural elderly who face numerous socio-economic challenges.

3.3 **THE IMPACT OF HIV/AIDS PANDEMIC ON THE ELDERLY**

3.3.0 Introduction

The most devastating consequences of the HIV/AIDS pandemic arise not simply because many people will die but because the deaths will occur mainly among adults between the ages of 25 and 45 years. These are the same people who are most productive economically and are expected to support families including the elderly. In most developing nations the pandemic is reversing the developmental gains made in the past decades, deepening poverty and eroding the ability of governments to maintain essential services (Drimie, 2002:21). It was expected that the elderly would at this stage assume less of a care-giving role since they had already done this role in the past.

In sub- Saharan Africa, more than five million grandparents are estimated to be taking care of orphaned grand children and a large number of people living with HIV/AIDS. This is an added task that is surely going to impact on their physical and mental abilities[26] (Help Age International, 2003a; 2006b). Across Africa, which has been hardest hit by the pandemic, (UNAIDS, 2003,2008), the elderly now care for up to eight million children orphaned by the pandemic (Plus News, 2002:2) and by the end of 2010 this number would have tripled to about 24 million (Help Age International, 2005:1b). Some of the elderly people indicated that they headed a very big household since they looked after the sick and the children of the sick. For instance, an 80 year old Malawian woman in Zimbabwe reported heading a household of 22 persons comprising five children aged 30 years or older and 16 grand children aged between one and twenty six years (WHO, 2002: 14). Similarly, a study in Thailand found that 70 percent of people living with HIV were in the care of older parents or relatives before their death. Some of the care-givers were over 70 years old and themselves in need of care (Help Age International, 2003d).

3.3.1 Financial Impact

One of the biggest impacts of the pandemic has been the financial implications on the elderly who have taken up the role of providing for the children of their deceased children, in addition to any other financial roles that their adult children had played when they were alive. This includes the provision of basic necessities like clothing, shelter and housing as well as education. According to Nhongo (2004:3), the elderly still remain one of the poorest groups in every community in Africa with available data in relation to the poor and vulnerable groups showing that 64% of the elderly fall below the poverty datum line (Help Age International, 2005b). Much of their savings did not cater for this full time role of providing financially since much of their finances had to be redirected to the needs of the sick and orphans. A clear example is the situation in Zimbabwe, where most of the households interviewed had a shortage of essential and basic household items such as food, money, clothes, blankets and soap (WHO, 2002:6; Nhongo, 2004:6). In some cases the elderly would rather sacrifice the little they got to feed the family, especially the children, as was the case of an elderly Durban

[26] 90% of AIDS care is provided at home, often by older women.

woman whose pension money was not enough to buy enough food and electricity for the home (Help Age International, 2002:3a; 2007:1c).

It is estimated that household income falls by between 48% and 78% when a household member dies from HIV/AIDS, and this excludes the cost of funerals (Drimie, 2002:11). As previously seen, social pensions are a lifeline to the millions of older-headed households with children orphaned by the pandemic, as it provides some relief through the ability to purchase basics like food. In South Africa, over a hundred older headed households rely on pensions to support children orphaned by the pandemic (Help Age International, 2004:6; Booysen et al., 2004:5; Munthree and Maharaj, 2010:167). In addition to pensions, elderly caregivers also rely on child support and foster care grants to support orphans and to some extent private transfers especially from elderly caregivers who are financially better off (Ardington et al, 2010:113). Without it, their situation would be one of abject poverty (Help Age International, 2007:1b; Ardington et al, 2010:111).

The needs of people living with AIDS (PWA) tend to be difficult to meet because they require nutritious food, drugs and money for regular hospital visits and medical care, which are very expensive, especially medicine. Other demands include clean water to regularly wash and dress their wounds, which in some regions may not be easily accessible due to its scarcity, especially for those living in rural areas.

The costs associated with transportation to the health centres, in addition to providing daily provisions, are too high for the elderly to sustain, putting the lives of the sick in jeopardy (Help Age International, 2004:11,Age Ways, 2004). The daily tasks of the elderly have become more difficult to do because with no one to help. They have to travel several kilometres to the next water source in search of water, and in the process straining their own overall physical health[27]. In Tanzania, the average daily cost of providing basic care for a person with AIDS was estimated by respondents to be over five times what an older person could, on average, expect to earn in a day's work (Help Age International, 2004:11; Knodel et al., 2003:160). This simply means that all the savings the elderly might have accumulated during their

[27] In the case of elderly women, they would engage in transactional sex to enable men help them with water.

economically active periods are eroded much faster than expected and yet looking after a person living with AIDS could take from a few months to years.

It is believed that affected households on average saved approximately 40% less than non-affected households on a monthly basis (Booysen et al, 2004:6). In Mozambique the cost of caring for someone with HIV/AIDS was 30 US dollars compared to 12 US dollars which was an older person's average monthly income in rural Mozambique (Help Age International, 2005:2b). This monthly income came from such activities as agriculture, keeping of animals and selling of traditional beer (Help Age International, 2005:2b).

The situation is even worse for those countries where the elderly do not receive any pension from their governments, plunging them further into financial ruin and resulting in the elderly having to find other means of supporting themselves and their families. Thus in Tanzania, the elderly have resorted to small scale trading in vegetables and to the brewing and selling of alcohol. Selling of family assets is another option to sustain those that are sick, as was the case in a recent study done in Welkom and Qwaqwa where nearly 20% of elderly households sold their property to survive (Help Age International, 2002a, Booysen et al., 2004:5). At this level, the elderly people are in a state of sheer desperation to try and support their families, which may even lead them into illegal activities.

Even after the death of the sick, the burden of finances continues in the form of support offered to the orphans and vulnerable children. Clothes, bedding and education are some of the needs that the elderly were unable to adequately provide due to lack of funding, leaving most of the young to drop out of school and end up providing care to those that are terminally ill (Help Age International, 2002a).

In some developing countries, primary education is free, suggesting that at least the basic level of education like reading and writing is accessed by all. But the provision of scholastic materials like pens, pencils and books and transportation is the sole responsibility of the parent or guardian. These, however small, require funds more so if they have to be bought for several children. Again in Tanga, Tanzania, it was noted that about six to seven orphans in a class had

no pencils, pens or textbooks, resulting from a lack of funds from their guardians (Help Age International, 2004:13). In some instances the elderly people would not have to pay for anything since the deceased had left an education policy that covered all education expenses, as was the case in Zimbabwe where several elderly people were fortunate that their grandchildren had an education and health policy (WHO, 2002:15).

In many situations, it is the elderly women who bear the price of care-giving with many of them severely financially handicapped with no economic support resulting from AIDS-related deaths and illness (UNFPA 2002a; Munthree and Maharaj, 2010:164). In Zimbabwe it was reported that two-thirds of care-givers were women who could barely provide for those who were under their care (IRIN Plus news, 2005:1; WHO, 2002).

In cases where there are financial resources to help orphaned children, accessing these resources has proved difficult due to discrimination by social workers who deem many older people "too old" to be the carers of the children, despite the fact that they are already undertaking this role. Nhongo (2004:14), points out that accessing services provided by non-governmental organizations is often equally difficult because of the misguided beliefs and ageist attitudes that serve to exclude older people from development programmes that could help support themselves and their orphans. As a result of their age, older people were routinely excluded from credit programmes with the assumption that they would not be in a position to pay back.

Despite these economic hardships, older people and their families do manage to survive through a precarious reliance on the community and survival strategies that would ultimately depend on the existing environment, the skills they have and access to natural resources. For instance, orphaned children would provide support through performing daily chores like cleaning, cooking and farming, in addition to handouts of cash assistance from close relatives, which unfortunately, is irregular. In Kenya, the government made primary school free for all. Children attending publicly funded schools minimise the impact of care-giving for the elderly grandparents (Ice et al, 2010:59).

3.3.2 Psychological Impact

The psychological impact of the pandemic on the elderly has also compounded their existing socio-economic problems. Providing care to people with AIDS (PWA) can be very stressful for several reasons: the unpredictability of HIV/AIDS; uncontrollability of the HIV/AIDS symptoms, the debilitating or disfiguring effects of the disease (WHO, 2002:15). This activity can be a 24-hour shift, requiring the care-giver to fulfil roles of confidante, chauffeur, and housekeeper and in the case of the elderly, a parent (UNFPA: 2002:43a) This kind of care led many elder caregivers feeling physically exhausted and over whelmed by their circumstances (Munthree and Maharaj: 2010; 171).

However, in as far as the pandemic is concerned, the elderly lament the fact that they watch their adult children physically deteriorate until they die. The loss of a child as the main source of support and the inability to care for their grandchildren can lead to increased stress levels, depression and sadness, which has been compounded by stigmatization by the community (Help Age International ,2004:14;2007:8b). This has affected the health of the elderly people to such an extent that incidences of Tuberculosis, Stomach Ulcers and Hypertension start to arise due to the strain of caring for and watching their children pass away (Essop, 2006:1)

Thoughts of what will happen to their grandchildren when they themselves die is also another contributing factor to their stress levels because there would be nobody left who could support their grandchildren, either because those who should assume that responsibility refuse out of fear of what the community might say brought about by stigmatization or they are already dead (Help Age International 2004:15; WHO, 2002:14).

Another related concern for the elderly people was the fact that health workers that were supposed to be providing the elderly with support with regard to the care given to their sick children and grandchildren, had negative attitudes towards them because of their old age, thus hindering the older people's ability to provide adequate care (IRIN Plus news, 2005:2). Their efforts and the difficulties they encounter with care-giving activities are rarely recognized, leaving them frustrated and as a result very little support is given to them (Help Age International, 2007:7b).

3.3.3 Social Impact

In African traditional society, co-operation between people within the communities is a common occurrence especially regarding issues of community building and farming. The assumption here is that one's problem is also the communities' problem and as such it is the responsibility of all in the community to seek ways of overcoming whatever challenges they have as a group (Help Age International, 2004:13). But in sub-Saharan Africa, the sheer magnitude of the pandemic has stretched these social networks to such an extent that in nearly all households there may be at least one person that is ill with HIV/AIDS (Help Age International, 2004:14). This makes it virtually impossible for these social networks to provide any help, in addition to the stigma and stereotypes related to AIDS. All kinds of social gatherings held by the community that may require the elderly input have been set aside due to the increased time and resources spent on caring for the sick(Help Age International.2006c). In some cases they are ashamed of even attending such gatherings because of having AIDS patients in their family, leading to further loneliness and isolation (Help Age International, 2004:14; 2002b).

In addition to the above, the mother in a family has the main responsibility for bringing up the family and for their behaviour. Therefore having a child or family member suffering from AIDS brings shame on that family as it indicates that he/she is promiscuous and irresponsible signifying bad upbringing by the family (May, 2003:19a; Help Age International, 2007:7a). For example, in Tanzania, older people spoke of diminishing trust and the ability of families to co-operate (Help Age International, 2004:15). This again arises from the fear of stigmatization from the community that will have serious ramifications for social support and the fact that there is a general lack of awareness of the pandemic. In Cambodia, some of the elderly indicated that community members avoided social contact with those living with HIV/AIDS and their families largely because of fears of infection (Knodel et al, 2010:133). This is a clear indication of a general lack of awareness of how HIV/AIDS was spread in developing countries, including South Africa.

3.3.4 Health Impact

The impact of the pandemic has also further worsened the health of the elderly population because of the added tasks of looking after their sick adult children and their grand children. The lack of easy access to health facilities, particularly in the rural areas, coupled with infrequent transport can make their task of care-giving more difficult if not impossible. Older people seldom have access to HIV/AIDS information and when they do it's usually not complete (Help Age International, 2006c; 2007:9b). In Kwa-Zulu-natal, most of the caregivers reported having health ailments as a result of constant care giving activities to such an extent that their sick children felt sorry for the constant care they received from their elderly parents (Munthree and Maharaj, 2010:168).

Prevention campaigns are focused on the Young and "High risk groups" like commercial sex workers, drug users and pregnant mothers but excludes the elderly, who may still be sexually active and today play a leading role of care-giving (Help Age International, 2004:8; Plus News, 2002:2). A study in South Africa found that the oldest age group (aged 50 and over) had the highest level of incorrect answers to questions about HIV/AIDS (Help Age International,2006c), a clear and very disturbing sign that our elderly citizens have been left out of information dissemination regarding HIV/AIDS.

Similarly in Tanzania, the main source of information on HIV/AIDS comes from the radio, newspapers, posters, workshops, village health educators and local non-governmental organizations. However, most of these messages do not take into consideration that many elderly people are illiterate and any form of written information regarding HIV/AIDS is meaningless to them. This greatly hampers their efforts in providing adequate care to those who are terminally ill and in the process they put themselves at great risk of contracting the virus (Help Age International, 2006a).

There are misconceptions about the sexuality of elderly people because the assumption is that most elderly people are no longer sexually active, with most research efforts geared at the young "reproductive" people (Help Age International, 2002a; 2006a). This is part of the reason why very little information exists about the HIV prevalence rate among elderly people (Help Age International, 2004:8). Contrary to expectations, they are equally at risk of contracting the

deadly virus because of inadequate information on risks and preventive measures. In Tanzania for instance, older men after their daily chores would go and mingle with their peers and, in the process, get drunk leading them to get involved with young women with whom they would have unprotected sex (Help Age International, 2004:9). This exposes their spouses to the risk of contracting the virus through these extra marital relationships. A study in South Africa showed that infection rates for the over 50s were 12 percent and 15 percent for women and men respectively and in Uganda 24 percent of women and 18 percent of men that went for voluntary counselling and testing were reported to be HIV positive[28] (Help Age International, 2006:2b), similarly the risk of infection through care-giving activities may also be high through contact with infected bodily fluids (Munthree and Maharaj, 2010:162). Several elderly care givers in a study done in Kwa-Zulu natal were aware of the dangers of infection through contact of infected bodily fluids, but financial constraints prevented them from having protective gloves. (Munthree and Maharaj, 2010:162)

It is well documented that poverty is one of the leading socio-economic concerns that the elderly people face, particularly where countries do not have a proper social security system. Consequently, the elderly women in Tanzania and Zimbabwe would engage in transactional sex in exchange for food, in a desperate effort to survive, especially in situations where they were unable to find work. Other women in Tanzania had to resort to the above methods to get fish and water that was scarce, especially in rural areas (United Nations, 2002:15d; Help Age International, 2004:9). Sexual transactions that are poverty-driven are likely to foster behaviours that are risk-taking, which may also lead to unprotected sex (Drimie, 2002:10; Cohen, 2009). In this regard, elderly women also put their spouses at risk of contracting the HIV/AIDS virus all because of the need to survive the harsh realities of surviving and care-giving.

Culture has always been and is still an integral part of life for many people, particularly in Africa, since it is used to promote unity through norms and values that are passed on from generation to generation. However, the HIV/AIDS pandemic is threatening this very foundation of African culture through polygamous marriages and wife inheritance that will put

[28] In Ahero (Kenya), Juba (Sudan) and two towns in Zimbabwe, a significant number of elderly people tested HIV positive at selected voluntary counselling and testing centres

all the concerned parties at risk of infection (Help Age International, 2004:9) While the custom of wife inheritance has the noble intention of keeping the widow and children together with the assets within the clan, it can have a negative effect of spreading HIV if the deceased husband was HIV positive. In this case it's not the custom that is spreading the HIV but the unprotected sex between spouses, which is something widely accepted in traditional customs.

The illness and death of a patient has been shown to take its toll on the care-givers particularly the elderly who have experienced physical illness like fatigue, insomnia and anxiety resulting from the care-giving activities (Knodel et al., 2003b: 160). Most care-givers are more concerned with the illness of their children and grandchildren and would eat less and not engage in any community activities. A recent study in North-Western Tanzania and Zimbabwe shows that the poor and non-poor households experienced a significant drop in body mass index (BMI) after an adult death (Knodel et al., 2003b:161; WHO, 2002:41). However, in a study done in Kenya care-giving activities had no impact on elderly health which was affected overtime by other factors such as age (Ice et al:2010;56). It is plausible that varying methodologies may account for the differences in findings (Ice et al: 2010; 57).

3.3.5 Stigma and Discrimination

One of the most serious impacts of the pandemic on those tasked with the role of care-giving is stigma and discrimination. Most people still do not understand what HIV/AIDS is all about and, as a result, would rather not say what the sick are suffering from for fear of being alienated (Help Age International, 2002a,Du Guerny,2002:18). This may jeopardize any hope of job opportunities or any form of assistance from the community (Plus news, 2002:2). This stigma extends to children, parents and other family members including friends of persons living with AIDS. An old woman who washes the wounds of her adult son may be considered to be in need of cleansing. People visiting the home of a family with somebody living with HIV/AIDS may not accept any food or drink offered, believing it to be contaminated. This refusal of hospitality may be offensive to the elderly host (Help Age International, 2007:8a). In this regard older people were forced to ensure that whatever they did, did not suggest that they were caring for an HIV positive person. In a study done in Tanzania, an elderly woman had to

conceal the fact that she was looking after her sick daughter by not wearing gloves, which in itself is a risk to the care-giver (Help Age International, 2004:9).

Most people, including the elderly would rather say that their children were ill as a result of bad luck or misfortune than face total isolation from the community that they so much rely on in times of critical need. Some communities in Ethiopia are still unwilling to accept that there is a pandemic (Plus News, 2002:2) which may be due to lack of awareness of HIV/AIDS. In some instances older people were even accused of witchcraft as a result of the deaths of the young people they looked after, with some of the elderly being physically abused or chased away from the community (Help Age International, 2002a).

In Kwa-Zulu Natal, South Africa, Help Age International (2007:11a) highlighted the stigma still attached to the pandemic in rural areas where the sick preferred to die secretly in the privacy of their homes because they were afraid of being stigmatized by their community and relatives. As already pointed out it is not just the sick that are afraid of being stigmatized but the care-givers who happen to be the elderly also risk being alienated from the community if found to be looking after somebody with HIV/AIDS.

There is an urgent need for intervention in trying to solve the HIV/AIDS pandemic more especially in sub-Saharan Africa, which, apart from the pandemic has a host of socio-economic problems, one of which is abject poverty. The linkages between the pandemic and some of the socio economic problems are slowly emerging, with some studies indicating the linkage between poverty and HIV/AIDS especially in the less affluent areas.

3.3.6 Family and community support

The community and, more especially, the family have and still play a key role in supporting elderly people particularly in developing countries (Mba, 2007:154; Nilsson et al; 2005:366). As indicated, the lack on an established social security system in most developing countries means that support for the elderly must come from the community (Mba, 2007:155; Velkoff, 2008:2). This is their only hope of survival where the traditional welfare system generally involves not just financial support but also social interactions with members of the family,

where elderly people can still play the role of giving valuable advice to the younger generation (Nilsson et al; 2005: 367). This is important in the sense that most elderly people do not want to be perceived as burdens to their adult children, which is why in a typical traditional family set up the elderly people are accustomed to looking after their grand children. This may be in line with the role theory which suggests that the roles of individuals change with age (Corttrell, 1942:618). That is why sometimes the preferred choice of grandparent may be the grandmother as is the case in rural Ghana and most African traditional settings (Mba, 2007:155).[29]

It should be noted that elderly people may not necessarily co-reside with their adult children but stay in close proximity for the sake of privacy and yet continue to have close family ties with their adult children and grandchildren. This is the case in Greece where elderly parents stay in their own homes but live near their adult children for their support (Karagiannaki, 2005:3).

In the case of South Africa, the presence of children of all ages, siblings, other relatives together with the dependants of the elderly in African, Asian and coloured households demonstrates these groups' cultural preference for multi-generational living (Amoateng et al., 2007:56; Kinsella and Ferreira, 1997:5) while according to Kinsella and Ferreira (1997) less than 20% of whites lived in multi-generational households

Support for the elderly may also come from the local community especially if individual families are unable to provide the required support. This may be in the form of community based organizations, funded privately and assisted by the government in providing the elderly with care. PUNSAKA in Indonesia was established solely to provide social and health care activities, including spiritual guidance and physical fitness programmes to elderly people (Dole and Rajaro, 2002:13). In addition, collaboration with local clinics and community health centres has enabled the elderly to get basic health care. This has impacted positively on elderly people that are able to live in a dignified way and in a way lessening the burden of support on their families. Similarly, in Cambodia most of the community members visited the sick

[29] However, elderly women moved to the extended family when their husbands had died.

offering fruits and food, which is an indication that communities did provide some support to the elderly care givers (Knodel et al, 2010:133).

The South African government has created proper guidelines safeguarding the care of the elderly in community based organizations. These include their rights to reside at home; pursue opportunities to their full potential and benefit from family and community care (Republic of South Africa, 2003:12). In addition all community based care and support services must be registered and all those persons providing home-based care must go through prescribed training to maintain a recognized code of conduct.

In developed countries, the elderly people are in a better situation as far as supporting themselves than their elderly counterparts in the developing countries. The differences are quite significant by gender, with elderly unmarried women more likely to stay alone than the elderly men (Karagiannaki, 2005:2; Nilsson et al, 2005:371; Mba, 2007:155). This scenario is highly prevalent in Western and Northern Europe where proportions of elders living alone ranges from 75 to 95 percent, with the Southern European nations have lower proportions of between 55 to 70 percent. There are several reasons that could explain this phenomenon which include low fertility rates, leading to fewer children able to look after their elderly parents; rise in female labour force participation reducing the potential for elderly support and rural to urban migration where most elderly people may not wish to move to the cities (Karagiannaki, 2005:3, Mba, 2007: 157). The existing literature shows that a rise in the incomes of the elderly has meant more privacy in the form of independent living which has coincided with social security coverage and benefits[30]

Some of the above factors, however, have begun to filter through to the developing countries like rural – urban migration gradually eroding the traditional extended family system and thus affecting the customary source of support for the elderly (Mba, 2007:154). However, the modernization phenomena in much of Asia have not necessarily led to any major changes in the traditional system of support for elderly, which may be due to strong cultural family ties (Mba, 2007:155).

[30] Other studies however indicate that demographic or cultural changes are more relevant in explaining the trend of independent living of elderly

3.4 SUMMARY

In conclusion, this chapter has reviewed the existing literature affecting elderly people, covering issues like their fast growth in numbers particularly in areas where the demographic transition is shifting towards lower population growth rates resulting from falling births. Issues affecting them are socio-economic, health and psychological in nature and the added burden of the HIV/AIDS pandemic could not have come at a worse time when they are supposed to be looked after by their adult children. Instead, they have had to take up that role of care-giving again, as the pandemic affects their economically active children.

This has had a major socio-financial and health impact on their already over stretched lives.

However, there is support for the elderly coming from the family and the community especially with the growing number of elderly people throughout the world. This support is in the form of socio-economic and health assistance. In turn, the community can benefit from a healthy elderly population who may provide help at home or even spiritual guidance as is the case in most Asian countries.

Furthermore, existing support systems are generally inadequate due to a lack of proper facilities for health, and there is a need for proper mechanisms that may help to alleviate their socio-economic plight as high unemployment rate among their adult children's generation, particularly in the rural areas, exacerbates their poverty levels.

In examing ageing trends South Africa and, in particular in the North West province and the Mafikeng Local Municipality where this study was done, there is a significant proportion of the elderly people in relation to the general population. This, as already indicated, will create a new set of socio-economic challenges for those developing countries that are still grappling with low levels of socio-economic development. It must be noted that this study was started before the 2007 community survey was conducted; however, attempts have been made to incorporate some of the community survey results, which have shown that there are increases in the elderly proportions at provincial and municipality level.

Having examined the ageing trends of the elderly and some of the socio-economic, health and psychological concerns affecting the elderly together with their plight as care-givers due to the HIV/AIDS pandemic, the next chapter looks at the methodological issues of how the elderly respondents have been selected and the forms of analytical techniques used to interpret the results.

CHAPTER FOUR

METHODS AND SOURCES OF DATA

4.0 INTRODUCTION

This chapter describes the study methodology and data sources, what sampling techniques have been used to get the sample population for this study in the Mafikeng Local Municipality of the North West province of South Africa, and how they have been interviewed. In addition, an examination of the statistical techniques applied in the study and constraints or limitations of this study are also presented.

According to the 2001 Census data, the distribution of the elderly population in the North West province is summarized in Table 4.1.

Table 4.1- Elderly Population Distribution of the North West Province by District

Area	Total	Percent
Bojanala(East)	89,266	33
Central	58,126	21
Southern	42,616	16
Bophirima	35,489	13
Bojanala(West)	44,006	17
Total	269,503	100

Source: Statistics South Africa, 2006

The above figures highlight the relative percentage numbers of the elderly throughout the district municipalities. Bojanala (East), being the biggest municipality, has the highest percentage number of elderly people. In general, they show a sufficiently significant proportion

of the population that requires local governments to be concerned about development issues which involve elderly needs. Mafikeng Local Municipality where this study was done is situated in the Central District Municipality of the North West province

4.1 SURVEY DESIGN AND IMPLEMENTATION

This study uses primary data collected from the Mafikeng Local Municipality which is one of 22 local municipalities of the North West Province of South Africa.

4.1.1 Sources of data and Methods of Data Collection

There are two commonly used sources of data namely, primary and secondary sources of data collection. For this study, the primary and secondary sources of data were employed. Information pertaining to a particular issue was sought using data collection instruments. Existing Secondary data sources like the Censuses 1996 and 2001 were found inadequate in providing the necessary information for the study of this nature. They were only used to make comparisons in showing the percentage growth of the elderly populations in the province and local municipalities between the two census periods.

Several studies have tended to use both qualitative and quantitative methods in trying to understand the socio-economic issues related to the elderly. For instance, May (2003a:10) used both methods in investigating chronic poverty in South Africa. The World Health Organization (2002:3) also used both methods in Zimbabwe to study the impact of AIDS on older people. The use of both quantitative and qualitative methods in this study therefore was intended to enrich the information from both approaches and create a set of good policy recommendations. Some of the socio-economic issues that required the use of the quantitative approach are sources and levels of income and sustainability of the elderly; their main sources of cooking, heating and lighting, access to public transportation facilities, their health issues and their access to health facilities; the level of education, their employment status and HIV/AIDS awareness, age, gender, marital status and race of the elderly population.

There are five qualitative approaches commonly used for research which are Narrative, Phenomenological, grounded, ethnographic and the case study. For this study, focus group discussions, a qualitative method of data collection was used to study the attitudes or

perceptions of the elderly and the extent of care-giving and the impact of HIV/AIDS on their financial and health situations and issues of stigma and discrimination resulting from care-giving. Furthermore, socio-economic questions were asked of the elderly respondents using this approach so as to further understand their situation. This method was used because it does not require much financial resources to organise the participants to be interviewed. Also it can be used particularly if the respondents are relatively illiterate, as may be the case for the elderly respondents. The study made use of tape recorders so that the information sought was recorded, later translated and transcribed. Also local interviewers who were conversant with the local language were used to help in the discussion of the socio-economic issues affecting respondents.

There are four categories of data collection, but the most common methods used in fieldwork operations are personal surveys or door-to-door administered surveys where an enumerator asks questions from a questionnaire to the respondent. This has the major advantage of removing any ambiguity arising from the questions asked and therefore minimizing any misinterpretations. It also provides for the opportunity for explanations. However, the major disadvantage is the high expenses associated with these surveys that involve travelling, subsistence and remuneration (Connor-Linton, 2003).Despite its limitations, the personal survey method is appropriate given the fact that the area under study is convenient enough for the researcher and would inevitably minimize some of the costs associated with travelling and subsistence. In this regard, a questionnaire containing socio-economic, health and HIV/AIDS issues affecting the elderly was administered to the elderly.

4.1.2 Sample identification

For this study, elderly people 60 years and over were interviewed. The definition of elderly is in line with the South African Older Person's Bill that looks at the elderly as 60 years and over. It should be noted that only the elderly head of the household was eligible to be interviewed in case he/she happened to be present at the time of the interview. In case the head was unavailable the elderly spouse or representative of the household was interviewed to give the required information.

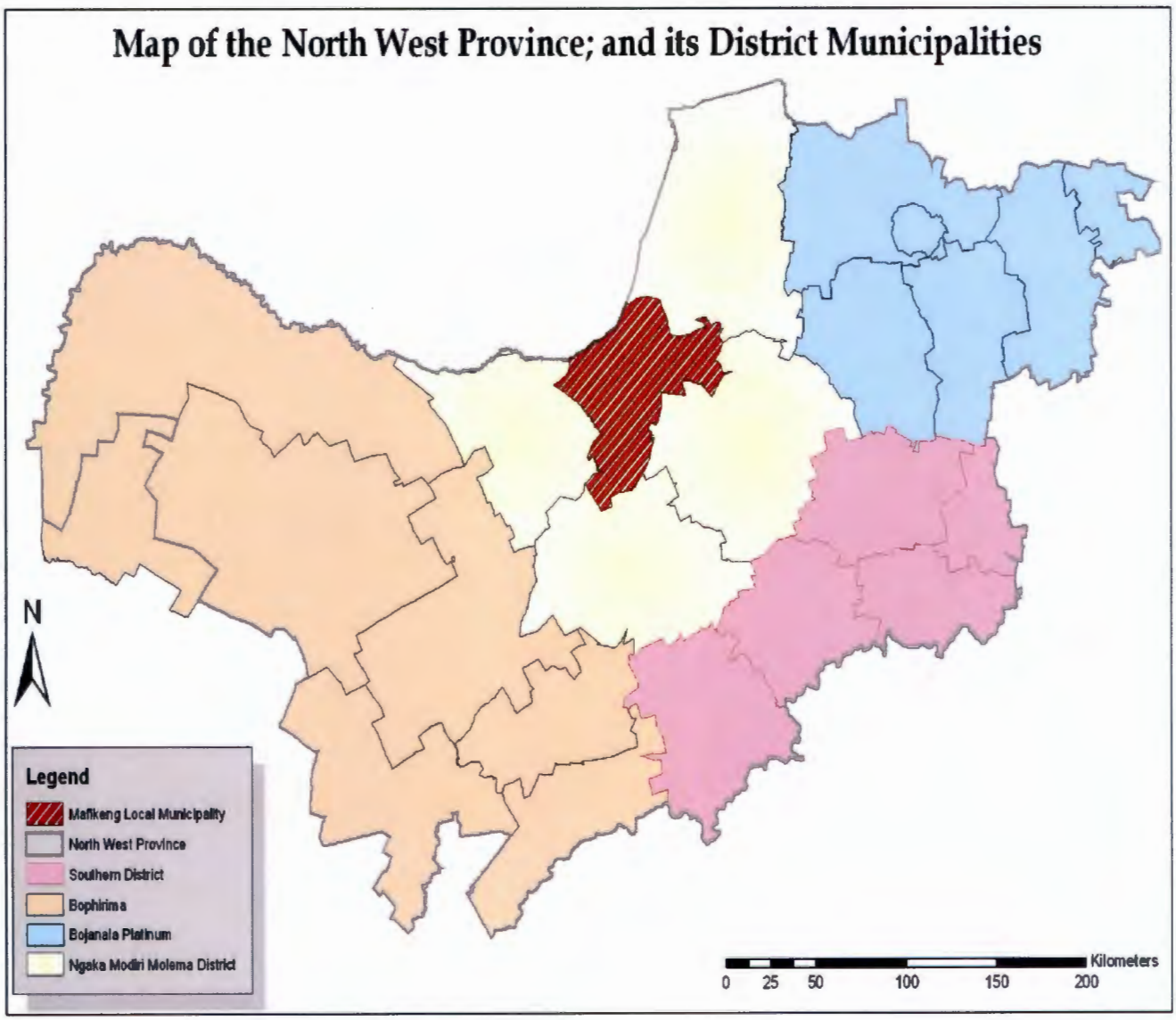
4.1.3 Sampling frame

The focus of the study area was the Mafikeng Local Municipality in the Modiri Molema District Municipality,(formerly called Central District Municipality) with an elderly population of 16 110, one of the five municipalities of the Central District Council and also where the capital of the North West Province of South Africa is located. The other municipalities are: Ditsobotla (12 000 elderly), Tswaing (10 500 elderly), Zeerust (8 700 elderly) and Setlakgobi (12 250 elderly).

The Mafikeng Local Municipality was chosen because of its proximity to the North West University and hence cost consideration and easy supervision of field activities in the area were taken into account. It is made up of 28 wards and 421 enumeration areas, classified by tribal, urban and informal settlements; recreational, industrial areas, farms and sparsely populated areas (Space-Time Research, 2005). Rural areas constitute tribal and informal settlements together with sparsely populated areas and farms, while urban settlements, recreational, institutional and hostel areas fall under urban areas (Space-Time Research, 2005:1). Mafikeng Local Municipality is rural and comprises 18 wards and only two urban wards. The other eight wards are classified as a mixture of rural and urban or peri-urban settlements.

Figure 4.1 shows the shaded area which is the Mafikeng Local Municipality where this study was undertaken.

Figure 4.1



According to the United Nations(2003), older persons are those aged 60 years and above which is in line with the definitions adopted in South Africa and most African nations and thus eligible for pension (Republic of South Africa, 2003:2).This is a standard definition that is used to define the elderly worldwide and is thus used in the study. However, there may be several

definitions of whom or what is termed as an elderly person, which could be based on cultural norms. For instance, a person who is most senior in the community may be considered an elder or the physical signs of age in an individual, like grey hair (particularly in rural areas), may confer the position of an elder regardless of age (Du Tlessis, 1999:3). A study done in Zimbabwe on the impact of HIV and AIDS, focused on the social roles played by the elderly 50 years and above in society: for example in African settings, being a grandparent conferred such a title and the added respectability, regardless of the chronological age. In most countries where economies are poor, the burden of survival puts people at a greater disadvantage than in rich countries, making them age prematurely (WHO, 2005:5).

4.1.4 Sample size

According to Census 2001, Mafikeng Local Municipality had a total population of 259 482 with 67 580 Households. Of this population, 16 110 were elderly, which constituted about 6.2 percent of the overall population (Statistics South Africa, 2005). It is from this total elderly population that a sample unit was drawn to provide relevant information with regard to the socio-economic challenges facing the elderly population in the Mafikeng Local Municipality using a quantitative and qualitative questionnaire. The rationale of getting a sample unit is to get a representative population with respect to the elderly concerns. Ageing affects everybody that is why this study looks at both males and females. Socio-economic, demographic and health - related issues among the elderly have been investigated especially in relation to their problems and the impact of the HIV/AIDS pandemic on their lives. It is necessary to draw a sample that is representative of the elderly population because whatever results are achieved may shed some light on the overall elderly situation in the Mafikeng Local Municipality of the North West Province.

4.1.5 Sampling Techniques

There are various methods of sampling that could be used to get a sample population relevant to this study. These range from sampling methods that are less representative to those that involve the random selection of study units by chance. In this case, we have non-probability sampling methods and probability sampling methods (Sampling Techniques, 2005:1). For this study a multi-stage sampling technique was used in which several samples were drawn until

individuals were finally selected for the study. This was used since sample wards had to be randomly selected before elderly households were selected from the sample wards.

As previously pointed out, the Mafikeng Local Municipality is made up of 28 wards that are divided into 421 enumeration areas.[31] According to Statistics South Africa (2006), there are about 67,580 households in the municipality. This means that on average each enumeration area has about 153 households. However, in census 2001, not all enumeration areas had sample units since the area of focus for this study is the elderly population. This resulted in the use of purposive sampling to select the Enumeration Areas (EA's) that had the sample units or the elderly population. This sampling method was selected in order to avoid selecting Enumeration Areas which may be out of reach of the researcher and also those that did not have any significant number constituting an elderly cohort. During the undertaking of the population census in 2001, all enumeration areas and wards were listed with a unique code number for identification purposes. These code numbers were used for identification purposes of the wards and enumeration areas giving the sample units for this study. Simple random sampling was used to select three (3) sample wards from the total of 28 wards and a total of fifteen (15) enumeration areas from the randomly selected wards. Of these selected wards one was an urban area, the other was a rural area, while the third ward was both an urban and rural area. With respect to the wards six were in the urban areas, while 8 were in the rural areas. With the help of the local councillors in the selected Enumeration areas all the elderly households were identified for the study and listed. Then systematic random sampling was used to select a total sample of 560 elderly households from the selected Enumeration Areas. This sample was statistically calculated at a 95 percent confidence level which is commonly used by researchers and represents the true percentage of an answer being picked by the population within a confidence interval.

In addition, maps were used to clearly identify the selected Enumeration Area boundaries to avoid getting sample units from a wrong enumeration area.

[31] According to Statistics South Africa, the enumeration area is the smallest geographic unit and can be aggregated up to municipal, district and provincial level.

4.1.6 Pilot study

A small pilot study was conducted in order to identify any potential problems with the questionnaire design and sampling. This was undertaken three weeks before the main field work. Two enumeration areas were randomly selected, one urban and the other rural and a total of 50 elderly respondents, 25 rural elderly and 25 urban elderly were interviewed within a week. The majority interviewed were elderly black, followed by the elderly coloured since they were easily approachable. There were more females (40) than males (10) especially in the rural areas that headed their households

One of the main problems encountered by the enumerators was that the selected enumeration areas had very few elderly respondents compared to what the Census 2001 database had indicated. This may be due to the fact that the elderly might have migrated or died leading to a low response rate. For the main study, it was therefore necessary to first identify those wards and enumeration areas that had elderly households.

Secondly, enumerators indicated that the questionnaires were too long, with most elderly respondents complaining of too many questions. As a result a revised questionnaire was created focusing on shortening the various sections and also removing certain sub-sections. Furthermore some of the questions asked were not clearly understood by the respondents. This meant rephrasing them to make understanding of the questionnaire clear.

The pilot study provided a clear idea of how long the main study would take, given that the average duration of interviewing an elderly respondent was about 45 minutes and it also gave an indication of where more emphasis was needed with regard to the questionnaire design.

4.1.7 Instruments used in Data Collection/questionnaire

As indicated earlier, a questionnaire containing socio-economic and health issues related to HIV and AIDS was administered to the elderly respondents. Two instruments were used in the pilot study and later in the main study namely, the Household questionnaire and the individual elderly questionnaire. Most of the contents of the questionnaires were based on the model

questionnaires done from a recent survey on the needs of the elderly carried out in Mpumalanga Province by Makiwane, Scheider and Gopane (2004) with the help of the Department of Health, Mpumalanga Province and another economic survey done in Soweto on Income and Expenditure by Naidu (2006) with the help of the Economic Policy Research Institute.

The Household questionnaire was used to list all the usual members and visitors in the selected households. The main purpose of the household questionnaire was to identify elderly women and men aged 60 years and over who were eligible for the individual interview and to collect basic information on the characteristics of each person listed, such as their age, sex, race, education, relationship to the head of the household and the type of government grants received by various members of the household members. In addition a question was asked of who was or were the main care-givers of children under the age of 18 years.

The individual questionnaire for the elderly was used to collect information from all elderly respondents aged 60 years and over. Only the head of the household who happened to be an elderly person was permitted/ allowed to provide answers to both the household and individual questionnaire. In cases where there was no household head, a representative who was an elderly person was allowed to answer both questionnaires. The elderly were asked questions on the following topics: income, expenditure and household assets; demographic issues of fertility, mortality and migration; education; employment; media access; health status, which included disability and services needed and received; nutrition; perceptions of HIV/AIDS including care-giving of the sick and orphans.

4.1.8 Training and fieldwork

The administration of the instruments was done by the researcher with the assistance of managerial staff and enumerators from Statistics South Africa office in Mmabatho. There were 7 enumerators that were selected to carry out the field work process. These enumerators were selected on the basis that they lived near most of the selected enumeration areas for the study. This meant that they could easily walk to and from their homes to the respondents' areas. All the enumerators were taken through all the sections of the questionnaire to find out if there were any questions from the research instruments that were not clear.

On the first day of the fieldwork, each enumerator was given 80 questionnaires and was expected to visit about two enumeration areas. Subsequently the researcher, with the help of two managerial staff that provided transportation, visited all the locations of the enumerators to establish if there were any problems in the actual field operations and also to collect the questionnaires that had been completed. In those enumeration areas that were far, the enumerators were provided with funds to travel and if necessary, to sleep over until the entire selected elderly households had been interviewed.

At the end of each day all the enumerators went through all the questionnaires they had completed that day to ensure that the responses were consistent. If there were doubts, they would first revisit that household to get more clarity on the question.

After the completion of the enumeration area, each enumerator was required to indicate the number of questionnaires completed. This would help ascertain the overall response and completion rates.

One problem encountered by all enumerators was that some elderly respondents could not complete the interview due to tiredness or irritation at the length of the questionnaire. The decision taken by the researcher and the managerial staff from Statistics South Africa was to discard those questionnaires that were less than half completed. In all, out of the total sample of 560 questionnaires originally envisaged, 54 questionnaires were incomplete and therefore discarded. In some cases there were no elderly household heads in some of the selected households. It was suggested and agreed that a representative of the household who was an elderly person could answer both questionnaires. In all situations this representative happened to be the wife or partner.

The fieldwork process lasted 6 weeks, with 506 elderly households interviewed from the selected enumeration areas.

With regard to the qualitative study, a questionnaire was used to provide an in depth analysis of elderly care givers activities. Two enumerators were selected, one that resided in the rural area and the other in the urban area. This was done since the enumerators were familiar with the communities they lived in and make it easier to interview the elderly respondents. With the

help of Statistics South Africa, the enumerators were trained on how to conduct a focus group discussion. This required introducing oneself to the participants and giving a brief introduction of what the discussions were all about. Each question had to be introduced by the enumerator who ensured that all participants gave their own views on the questions. In addition, the enumerators were shown how to operate the Dictaphones for the recording of the conversations.

During the focus group discussions, 10 elderly respondents were each randomly selected from the urban and rural areas each from the selected ward's EAs used to select the sample of the elderly. All the participants were encouraged to provide their views on the discussion questions. In most socio-economic questions the elderly mostly agreed with each other in relation to answers given by one of the respondents. However, respondents were also encouraged to provide any other views apart from accepting the general perception. The focus group discussion done in the rural area took longer than expected because most elderly respondents took more time discussing each question. But during the discussions the respondents were reminded of time limits for each question.

4.1.9 Response rate

The response rate looks at the number of questionnaires not completed by the elderly respondents. In this study we eliminated or discarded those questionnaires that had less than half of the sections completed. This was because substantial information was still missing from questionnaires that were not completed and it would therefore not serve any purpose capturing information from them.

Table 4.2 Response rates of the sample wards

Ward	Total questionnaires A	Returned Completed B	Returned Not completed C	Completion Rate B/A (%)
1	155	134	21	86.5
8	264	241	23	91.3
28	141	131	10	92.9
Total	560	506	54	90.3

The overall completion rate of 90.3% is high, indicating that most questionnaires were completed. This was expected, mainly because the personal survey has the advantage of ensuring that the questionnaires were completed with the proper supervision of enumerators. This means that the balance of 9.7% of the questionnaires was not completed due to tiredness of the respondents. Ward 1, an urban area had a lower response rate mainly because most elderly respondents at the time of the field survey were not in their homes. Ward 8, which is a rural area, had the highest response rate, most respondents were not in a position to complete the questionnaire because it was too long. In all situations there was a general willingness by the elderly respondents to participate in the study, with no refusals, but the length of the questionnaire resulted in a few elderly not completing the questionnaire due to tiredness or according to some, too many questions.

4.1.10 Data Verification

Coding and capturing of the data was done at the North West University; Mafikeng Campus using the Statistical Package for Social Sciences (SPSS). A database using SPSS was created in relation to the 12 sections of the questionnaire. The first section comprised the household questions and the other 11 sections were the individual questions for the elderly respondents.

All answers to the closed questions were entered as numeral codes, with the chosen responses captured in the database. With the open-ended questions only the common responses were given numeral codes and the responses from the elderly respondents captured. In cases where the open-ended responses could not be coded, all the responses such as the names of the people that usually lived in the household were captured.

In addition, all responses by the elderly from the focus group discussions were transcribed and translated from the local language into English and a summary of all the responses were written. In some situations direct quotes of ad verbatim words spoken by the elderly respondents were used to give a clearer idea of their experiences. This also required the creation of themes for particular issues affecting the elderly, based on the questions asked.

The data cleaning process took place simultaneously with data capturing. This was done with the use of SPSS. Duplicate or incomplete records were corrected by referring to the original questionnaire, while incomplete questionnaires were removed. The final dataset was visually inspected by running frequencies of all items to ensure the accuracy of results.

4.1.11 limitations of this study

Funding for research undertaking is often a major constraint. As a result, this study has had to focus on the Central District Council of the North West Province with particular emphasis on the Mafikeng Local Municipality, which also had a negative impact in determining the appropriate sample size of the population[32]. Also due to time constraints it was not possible to have a large sample size, which thus necessitated the use of a sample of 560 elderly people. This may lead to selection bias(Williams et al, 2010:11), especially on HIV/AIDS related issues which had very few responses Secondly, the study focused on the elderly i.e. those sixty years and over, which might be a problem on its own because most of them usually reside in the rural areas which may not be easily accessible. It was also important that the questionnaire be translated into the local dialect because most of the sample units could only respond in the local dialect. The local municipality was originally a homestead for black Africans that were resettled here due to the apartheid policies of relocation of many Africans to homelands.

[32] Mafikeng municipality covers about 3 700square km.

As a result, most of the elderly respondents were black Africans which caused the study highly skewed in that it reflected mainly one race. This suggests that any analysis based on race can not give any meaningful results

During the data collection process, some of the selected enumeration areas were far from the enumerators' homes, which was offset by them having to stay in their work locations until all the sampled elderly had been interviewed. There were long distances between homesteads, particularly in the rural areas which meant that only a small number of elderly respondents could be interviewed per day and, as already indicated, this greatly limited the ability to increase the sample size. Also some of the elderly respondents from the selected enumeration areas were reluctant to respond to the questionnaires because they had already been interviewed on some of the issues affecting them by other researchers. Their argument was that they had already been interviewed several times and to date nothing had been done by the local authorities. This, to some extent, was overcome through reassurance that this study was purely for academic purposes and that the enumeration team did not belong to any government department or agency.

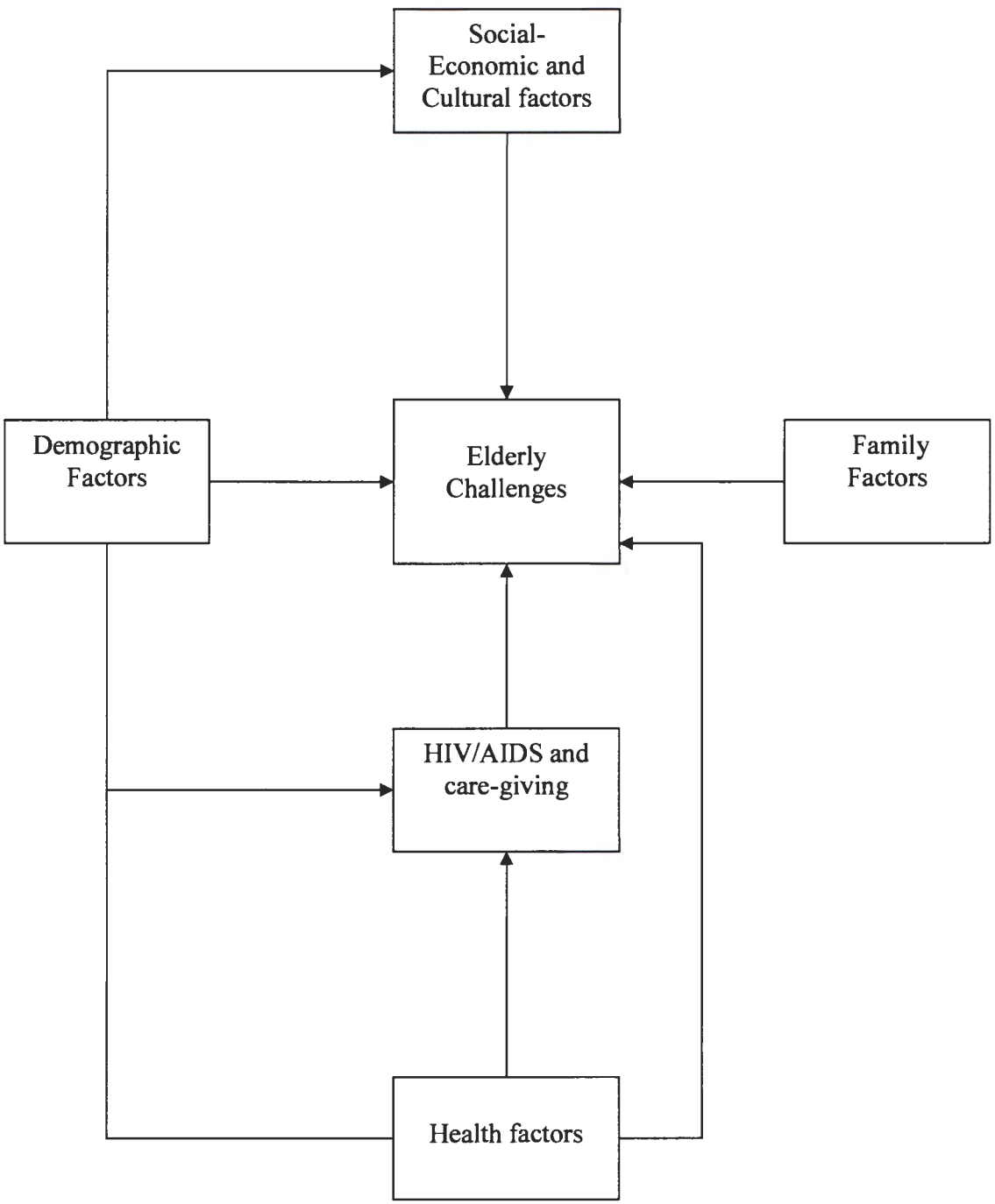
Furthermore most elderly respondents were reluctant to answer issues related to HIV/AIDS, which according to some was still something that was not easily discussed, with most preferring to say that natural causes were responsible for the death of a loved one. The reason behind this was that losing a child to HIV/AIDS implied that the deceased was promiscuous resulting from bad upbringing which was a reflection on the elderly parents. As a result, several questions on HIV/AIDS related issues were not answered leading to response Bias (Williams et al, 2010:12). Also, during the focus group discussions, most of the elderly did not want to answer questions related to HIV/AIDS such as whether they knew of anyone in their communities that had lost a child, friend of relative to the pandemic. Only a few respondents participated in such discussions. Even the answers given by those elderly respondents in relation to HIV/AIDS were not clear, an indication that the elderly respondents generally did not wish to discuss HIV/AIDS issues openly. This may suggest that issues of stigma attached to the disease and discrimination from society do exist. Furthermore, there was no way of validating their responses to the questions asked which is a limitation to self reported data. Responses to certain questions may be skewed to present a very bad situation In this regard,

this study on HIV/AIDS related issues does not present clear responses that may assist to highlighting the extent of the problem elderly caregivers face.

4.2 CONCEPTUAL FRAMEWORK

The general framework of ageing and its social-economic problems is shown in the figure.

Figure 4.2: Ageing and its challenges



The above framework is derived from establishing the linkages between elderly challenges and the socio-economic and health issues affecting them. The elderly population is affected by several challenges which may impact negatively in their efforts to live a meaningful life. For instance, social economic factors such as community intolerance of the elderly which has led to their abuse and ultimately losing respect has led to most elderly being marginalised. This may be due to their relatively smaller population in relation to the overall population. Most elderly respondents live in the rural areas especially after they have reached retirement age. In the context of South Africa, most rely on government pension given the fact that they were not able to get formal employment which would have boosted their savings and their retirement pensions. However, due to the high unemployment rates, especially in the rural areas, most are compelled to support their adult children and their children on a state pension that is totally inadequate to provide all the basic necessitates such as clothing, food and education. This has led to their inability to save as a result of the burden of having to support their extended families. Despite this, the pension they receive has enabled them to provide some form of support which would have led to most families being destitute.

Demographic factors such as age may also be a challenge especially if a significant number of elderly live to advanced ages, requiring constant care. In general, females live longer than males and as a result live to advanced ages compared to their male counterparts. This has led most to live lonely lives as a result of the death of their spouses and with no support face an array of socio-economic and possibly health challenges.

The HIV/AIDS pandemic has created unprecedented suffering to those who care for the sick and who have lost loved ones (World Health Organization, 2002). In most cases, it's the elderly females who bear the brunt of having to care for the sick with no support. Care giving activities requires constant watch over the sick which may be laborious, given their frail nature.

The overall health of the elderly may be influenced by their ability to eat regularly which is important for them to retain their strength, given the role they have to play which includes supporting their immediate families. However, as already indicated, the burden of supporting their immediate families due to lack of employment opportunities means that the elderly can

not save and may not be in a position to attain access to proper health care. Most socio-economic development is skewed towards the urban areas, which suggests that health facilities may not be easily accessible by the elderly as a result of poor road networks. There is also a need to cater for elderly health care needs given that there health needs are different from the general health needs of the community especially in regard to child, maternal and reproductive issues (Medical Research Council, 2005).

Family support is vital particularly for those elderly in their advanced ages. Physical assistance would be urgently required of the elderly if they are to do part of their daily chores. However due to the high unemployment rates in the rural areas, most of the young economically active members of the family have opted to leave the rural areas to go to the urban areas in such for jobs (Samson, 2004:10). In addition, HIV/AIDS pandemic has taken the lives of most of the adult children of the elderly, leaving them with grand children to support, an activity they are ill prepared to do.

The above figure also highlights several linkages between the above factors that lead to the elderly challenges. For instance the health problems may be as a result of the elderly inability to access health facilities in the rural areas, a socio-economic factor. These socio-economic and health factors are discussed below.

In conclusion the above factors have led to the elderly challenges and would therefore require urgent action to ensure that relevant mechanisms are in place to safeguard their livelihood.

4.3 DESCRIPTION OF VARIABLES

4.3.1 Selection of Variables

The variables that were investigated in this study consist of the dependent variables namely social and health problems affecting the elderly respondents. These variables are dependent on or influenced by a number of factors that may impact on the overall well-being of the elderly. These factors which this study termed as independent variables/predictors include:

1) Background characteristics of the elderly respondent like age, place of residence, marital status, gender and household type

2) Demographic characteristics like number of children ever had and number of children dead
3) Their general nutritional status like number of meals had everyday together with members of their household
4) Their general living conditions like their source of heating, condition of their homes, access to services like roads, whether they had ever been employed, level of education and involvement in community activities.
5) Their experiences of being older like whether they are respected, their safety from the neighbourhoods and whether crime has affected them.
6) HIV/AIDS related issues like their experience as care-givers, knowledge of HIV/AIDS, support received for care-giving and access to health care services

4.3.2 Operationalisation of the variables used in the study

The survey had incorporated questions that attempted to operationalise socio-economic problems facing the elderly in the era of HIV/AIDS. These include;

4.3.2.1 Health and Nutritional Status

Information about the health and nutritional status of the elderly respondents that was collected include;

- *Disability status of elderly*

(1) Yes (2) No

- *Have meals per day*

(1) Yes, often (2) No

- *Average meals per day*

(1) One (2) two (3) three or more

4.3.2.2 Perceptions/experience of being older

Regarding perceptions, information about elderly respect, abuse by the community and safety were asked from the elderly respondents. These include;

- *Elderly abuse*

(1) Strongly agree (2) agree (3) neutral (4) Disagree (5) strongly disagree

- *Elderly needs not addressed*

(1) Strongly agree (2) agree (3) neutral (4) Disagree (5) strongly disagree

- *Elderly respect*

(1) More respect (2) less respect

- *Elderly crime*

(1) Very safe (2) Not safe at all

- *Elderly save money*

(1) Yes (2) No

- *Safe during pension collection*

(1) Very safe (2) Not safe at all

4.3.2.3 HIV/AIDS and care-giving

Questions on HIV/AIDS and care-giving which were asked of the elderly respondents include:

- *Heard about HIVAIDS*

(1) Yes (2) No

- *Main care provider of orphans*

(1) Yes (2) No

4.3.2.4 Education and income

To determine the level of education, housing condition and their income amongst the elderly respondents, the following questions were asked

- Level of education

(1) No education (2) Primary education (3) secondary and higher education

- Monthly total income

(1) less than R1000 (2) between R1000 to R1500 (3) between R1501 to R3000

(4) Over R3000

-Condition of House

(1)good (2) bad

- Source of heating

(1) Electricity (2) paraffin (3) wood

- Source of lighting

(1) Electricity (2) paraffin (3) wood

- Source of cooking

(1) Electricity (2) paraffin (3) wood

4.3.2.5 **Importance of the above variables**

The above questions were included in the questionnaire in order to help establish some of the socio-economic concerns generally faced by the elderly. For instance, it is necessary to ascertain the health status of the elderly together with their disability status as it will have an influence on their ability to support their families and also participate in their communities.

This is also depicted by the number of meals they have per day since this is vital to maintaining their overall health.

4.3.2.5.1 Perceptions of the elderly

Questions on crime, respect and their safety were asked to understand their general perceptions of their communities. Existing literature (Global Action on Ageing, 2002, Ferreira and Charlton, 2004:84, Help Age International, 2002b:10) shows that because of their old age, elderly people are either neglected or not taken seriously. As a result this study tried to establish whether this was also the case with the elderly in the Mafikeng Local Municipality. This has the potential of alienating the elderly if they have negative perceptions about their communities and their families.

4.3.2.5.2 General living conditions of the elderly

Questions on their educational background were asked since this is an important indicator in reflecting the opportunities that the elderly may have had before retiring and also their ability to perform any form of activity that requires reading and writing. A higher level of education often reflects a higher income and usually, higher standards of living. That is why issues like their housing conditions, the sources of water, heating and electricity were asked in order to clearly understand their living conditions, particularly of those in the rural areas where most of the elderly reside (Stloukal, 2001:1; Madzingira, 1998:140).

4.3.2.6 Background variables

The following background variables were used in most of the bivariate and multivariate analyses.

4.3.2.6.1 Age

Age is an important factor in the demographic process and a key marker of socio-economic issues affecting elderly respondents. For this reason it was included in all analytical models. It is used for univariate and bivariate as well as multivariate analyses. In the multivariate analysis it is used as one of the predictors to determine its effect on the dependent variables. The question asked with regard to their age was:

How old are you? *Exact age (in years)*

4.3.2.6.2 Place of residence

In most developing countries, there are disparities in the level of socio-economic development between rural and urban areas. In this regard it was important to ask the respondents their place of residence. Place of residence was coded as *(i) Urban (ii) Rural*

4.3.2.6.3 Sex

The sex of the respondent was important because in most cases there are disparities in the level of socio-economic issues that affect sex differently. Also with regard to care-giving activities, there are differences in terms of who actually is directly involved. Sex was coded as *(i) male (ii) female*

There were two dependent variables that were used to understand the challenges faced by the elderly. They were health problems and social problems of the elderly. The dependent variable on health of the elderly had two responses which were;

(1) Good *(2) bad*

This means that, depending on their responses, the elderly were either in good or bad health.

The second dependent variable, social problems, was created by combining some of the existing variables in the questionnaire which looked at:

- whether the elderly respondents were respected by their communities,
- whether they felt safe in their neighbourhoods

The above variables were selected since they encompassed issues that affect the elderly and indirectly impact on other issues such as their ability to support their families to receive services that suit their needs. Given that the above two variables have similar responses, they were collapsed to form agree or disagree. These responses formed the basis for the dependent variable.

Table 4.3 Summary description of Variables

Variable name	Coding categories	Type
Any Health problems	(i) Yes (ii) No	Dependent
Disability Status	(i) Yes (ii) No	Independent
Eat regularly	(i) Yes (ii) No	Independent
Number of meals per day	(i) One (ii) Two (iii) Three	Independent
Elderly abuse	(i) Agree (ii) Disagree	Independent
Elderly needs not addressed	(i) Agree (ii) Disagree	Independent
Elderly Respect	(i) Agree (ii) Disagree	Independent
Elderly crime	(i) Very safe (ii) Not safe	Independent
Save money	(i) Yes (ii) No	Independent
Safe during pension collection	(i) Very safe (ii) Not safe	Independent
Heard of HIV/AIDS	(i) Yes (ii) No	Independent
Place of Residence	(i) Urban (ii) Rural	Independent
Education level	(i) No (ii) Primary (iii) Secondary	Independent
Monthly income	(i) < R1000 (ii) R1000 to R1500 (iii) R1501 to R3000 (iv) Over R3000	Independent
Condition of house	(i) Good (ii) Bad	Independent
Source of heating	(i) Electricity (ii) Paraffin (iii) wood	Independent
Social problems	(i) Yes (ii) No	Dependent
Sex	(i) Male (ii) Female	Independent

4.4 METHODS OF ANALYSIS

The analysis was carried out at three levels, namely, the univariate, bivariate and multivariate levels

4.4.1 Univariate analysis

Univariate analysis is concerned with the description of individual variables and their patterns of response. For this study it was done to show the percentage distribution of background, socio-economic and health characteristics of the elderly respondents.

4.4.2 Bivariate analysis

The Chi-square test is a test of association among different categorical variables (Bless and Kathuria, 1993:186). It is one example of bivariate analysis which simply tests whether the observed or actual frequency of a phenomenon corresponds to the expected frequency. In this case, several hypotheses were established and tested. For a null hypothesis that is not rejected, the X^2 has a distribution with K-1 degrees of freedom. The existence of associations between dependent and independent factors is tested by comparing the significance level calculated for each pair of factors (dependent and independent) with that from a standard X^2 distribution to reach decisions about whether to or not to reject null hypotheses for factors measured at this level.

Its drawback, however, lies in the fact that there is no degree of association between the variables (Bless and Kathuria, 1993:255). It is a rough estimate in that it accepts weaker or less accurate data, which may not necessarily give the right picture of the existing situation (Connor-Linton, 2003).

4.4.3 Multivariate analysis

This examines several variables at the sametime to get an understanding of the relationships between them. For the multivariate analysis, logistic regression was used. One of the basic concepts of using logistic regression is to predict whether an event will occur or not (Ama,

2007: 140). The models allow many independent variables to be included in a convenient framework. They allow for investigation of both additive relationships and interactions between independent variables. The relationships among the dependent and independent factors were examined for statistical significance using the Wald Statistic which has a chi-square(X^2) distribution.

The parameters were estimated using the maximum likelihood method. The method is represented by:

$$P_s = \frac{1}{1 + e^{-z}}$$

Where $P_{(s)}$ is the probability of the event of interest, e is the natural logarithm and z represents the linear combination, $B_0 + B_1X_1 + \ldots\ldots + B_KX_K$ for K number of predictor variables (X).

In Interpreting logistic regression coefficients; the coefficient (B) can be interpreted as the change in the log odds associated with a one –unit change in the independent variable. If B_K is positive, the value of Exp (B) will be greater than 1, indicating that a one-unit change in the independent variable means that the odds are increased that the event will occur. If B_K is negative, the value of Exp (B) will be less than 1, indicating that a one –unit change in the independent variable means that the odds are decreased that an event will occur. If B_K is zero, the value of Exp (B) is 1, indicating that the odds are unchanged for a one – unit change in the independent variable.

4.5 ETHICAL CONSIDERATIONS

Permission to conduct this study was sought from the Department of Social Development (Mmabatho) which is directly responsible for the welfare of the aged population and the North West University in which this study was done. The local Councillors and chiefs in the respective wards that house the sample enumerations were consulted for the sake of legality and any help that might be required from them during the data collection process. Permission was also requested from the sample elderly respondents to be interviewed, with the clear

indication that their responses to the questions were confidential and strictly for academic purposes.

4.6 SUMMARY

Having looked at how data for this study was collected, the next chapter examines the socio-economic characteristics of the elderly respondents. This shall give an insight into the issues affecting them. Their level of knowledge of HIV/AIDS shall be examined together with challenges of care-giving.

CHAPTER FIVE

SOCIO-ECONOMIC PATTERNS AND DIFFERENTIALS IN THE ELDERLY POPULATION

5.0 INTRODUCTION

In the previous chapter, we examined the ways in which data on the sample population for this study was collected and the operationalisation of variables together with sampling techniques used for analysis. This chapter examines the general socio-economic and demographic differentials in the elderly population under study using cross-tabulation analysis. In addition, multivariate analysis has been used to examine factors that are significantly related to social issues affecting the elderly.

The socio-economic and demographic variables discussed in the chapter include: education; place of residence; marital status; age; gender; children ever born; children dead; migration status; general living conditions namely house conditions, source of drinking water, source of energy used for cooking, heating and lighting; source of income; standard of living before 1994; whether or not the elderly saved moved; information source; main bread winner. It also examines the perceptions of the elderly with respect to their gender, age and place of residence. Some of the above variables have also been used for the multi-variate analysis. The existing literature suggests that differences in some of the above characteristics may result from or be due to variations in the level of development or the opportunities accorded to either male or female elderly (Mba, 2007; Marcoux, 2001; Madzingira, 1998).

5.1 SOCIO-ECONOMIC AND BACKGROUND CHARACTERISTICS OF THE ELDERLY RESPONDENTS

This section examines the background characteristics of the elderly population. These characteristics include age, sex, number of children ever had by the respondents, death of any children, place of residence, migration status, marital status, whether they got a pension, household type and whether or not they ever attended any literacy classes. The analysis aims to get a clear understanding of elderly socio-economic and health characteristics and support

existing literature. For instance females live longer than their male counterparts since they have a higher standard of living (United Nations, 2002:1). The results are presented in Table 5.1

Most of the elderly respondents were in the younger age groups of 60-69 years (51.2%) making up over half the total number of elderly respondents. This is followed by those in the 70-79 years (29.2%).

It is evident from the table most of the elderly respondents were female by nearly twice the percentage number which is due to the fact that women had a higher life expectancy than their male counterparts.

From table 5.1 below most of the elderly respondents had between 4-6 children(38.2%) followed by 1-3 children(32.4%).It is possible that most elderly respondents, as is seen on Table 5.2 had no education and therefore might have started having children at an early age.

Table 5.1 shows that the majority of elderly respondents had lost children by nearly have the percentage number (66%) which may have been due to the difficult socio-economic conditions which affects mostly the infants. In addition the majority of elderly respondents had never attended any literacy classes which may suggest that most elderly are unable to read and write which have impact negatively on their ability understand written information or do any form of transactions

Existing literature suggests that most elderly respondents live in rural areas after they have retired from their formal occupations (Stloukal, 2001; Madzingira,1998). The table shows that the majority of respondents lived in the rural areas which may be due to the fact that the North West province was mainly rural.

Table5.1 shows that the majority of the elderly respondents had never moved from their current place of residence. It is plausible that most of these elderly respondents were actually born in their current place of residence. Given that Mafikeng was the capital of a former homeland which had relative autonomy from the South African government, there might have been no

reason for them to leave elsewhere. While about 22 percent of indicated that they had move to their current place of residence but from within the North West province.

In relation to marital status, half the percentage number of elderly respondents where either widowed or divorced compared to about 37% that were married or living together. It is possible that those elderly still married or living together were still relatively young. This is clearly shown from the table were most of the elderly respondents were between the ages of 60-69 years.

As expected, nearly all elderly respondents indicated that they received a pension from government. This is mainly due the fact that most elderly had never worked before, with only 9% of elderly respondents indicating that they did not earn a pension.

Interestingly the majority of elderly respondents indicated that they lived with nuclear families (63.2%). Given the fact that most lived in the rural areas where the unemployment rate was high; they were expected to live with their adult children and their children who would lie on them for support.

Finally, only 5% of elderly respondents had taken literacy classes which clearly suggests that the majority of elderly respondents were illiterate. This would be detrimental in their efforts to do any form of transaction or even participate in community activities that would involve reading and writing.

Table 5.1 Background characteristics of elderly respondents

Characteristics	Frequencies	Percent
Elderly Age		
60-69	261	51.6
70-79	148	29.2
80+	97	19.2
Sex		
Male	171	33.8
Female	335	66.2
CEB		
0	25	4.9
1-3	164	32.4
4-6	193	38.2
7	124	24.5
Death of any children		
No	168	33.2
Yes	338	66.8
Place of Residence		
Urban	134	26.5
Rural	372	73.5
Previous place of residence		
Within the North West	116	22.9
Other provinces	44	8.7
Another country	18	3.6
Never Moved	328	64.8
Marital status		
Married/living together	186	36.8
Divorced/widow	255	50.4
Never married	65	12.8
Get pension		
Yes	465	91.9
No	41	9.1
Household type		
Nuclear	320	63.2
Extended	186	36.8
Attended literacy classes		
No	479	94.7
Yes	27	5.3
Total	**506**	**100.0**

Table 5.2 presents some of the socio-economic characteristics of the elderly respondents which include education, source of income, whether or not the elderly were able to save money, house condition, home ownership, source of information and whether elderly ever worked.
It is evident from the table that the majority having no education. It is plausible that most of these elderly respondents did not have the opportunity to get education which might have impacted on their overall current standard of living. It is no wonder that the majority of the elderly respondents indicated that they did get a state pension which, to a larger extent, has helped in alleviating poverty especially for those elderly who have to support their extended families.

Related to the above, most elderly respondents indicated that their source of income was from government pensions compared to those that received a salary and had a private pension at 7.3 and 8.1 % respectively. In addition about 5 % of the elderly respondents indicated that they had other sources of income which could come from their adult working children or they might own private businesses that they rely on as a source of income.

Table 5.2 clearly highlights the fact that the majority of the elderly respondents indicated that they were unable to save (78%). This inability may be related to the fact that they earned a government pension which was not enough particularly for those that had extended families to provide the basics such as food, clothing and possibly education. Such was the nature of information shared in the focus group discussions by care givers who blamed the high unemployment especially in the rural areas such that their adult children had to rely on their pensions to survive. As an elderly man put it:

> *I have three adult children who are unemployed and they are dependant on me for sustenance together with their children. It is extremely difficult for me to support them with the pension money I get.*
> *They are supposed to be supporting us by now, added an elderly woman in support of her male counterpart, "we can not be providing for them forever.*

Furthermore, data in table 5.2 indicates that the majority of the elderly respondents did not own a house which may suggest that they may be living with their adult children who own houses which may partly explain why a significant percentage number of them relied on family for information (45%) compared to 25% that relied on the media.

Table 5.2 Socio-economic characteristics of elderly respondents

Characteristics	Frequencies	Percent
Level of education		
No Education	226	44.7
Primary	192	37.9
Secondary and Higher	88	17.4
Main source of income		
Salaries	37	7.3
Gov't pension	403	79.6
Private pension	41	8.1
Other	25	4.9
Save Money		
No	353	77.9
Yes	112	22.1
Condition of House		
Good	290	57.3
Bad	216	42.7
Ownership of House		
Yes	491	97.0
No	15	3.0
Source of information		
Radio	95	19.0
TV	125	25.0
Family	227	45.0
None	59	11.0
Ever worked before		
Yes	355	70.2
No	151	29.8
Total	**506**	**100.0**

Table 5.2 above also shows that 57% of elderly responderts owned a house compared to 43% that did not. However, maintaining these houses may be a problem given their limited financial resources. This is clearly highlighted in the qualitative results where the majority of the elderly

care givers in the rural areas indicated that despite owning a house, they were in dire need of repairs particularly leaking roofs.

Regarding work, the data suggests that majority of the respondents indicated that they had never worked before which may be due to the fact most were unable to find jobs. Given the fact that most had no education, this may also explain why most had not worked before as shown by the majority of those with no education.

5.2 SOCIO-ECONOMIC CHARACTERISTICS BY SOCIAL PROBLEMS OF ELDERLY RESPONDENTS

This section examines the socio-economic issues affecting the elderly by health and social problems. These include safety during pension collection, Household type, source of heating, level of education, source of cooking, monthly income, whether they were safe from crime, whether they were shown respect, whether their needs were being addressed and whether they were being abused. The aim would be to ascertain any association between selected elderly perceptions and their living conditions in relation to their social problems.

Table 5.3 presents the percentage distribution of selected living conditions and perceptions of the elderly by social problems. Most elderly respondents with social problems indicated that they felt safe during pension collection (83.9%) compared to those who did not feel safe at all. It is possible that most elderly when to the pension pay points with their family members. Interestingly those who lived in a nuclear family had mores social problems (61%) compared to those who lived in extended families. It is plausible that that those who lived with extended families got some form of support from their family members which could be physical and emotional support compared to those who lived in nuclear families. However the chi-square results were statistically insignificant suggesting no association between social problems and Household type of elderly respondents.

The table also indicates that most elderly respondents used paraffin and a source of cooking and heating particularly more so for heating purposes (76.5%). The cost of electricity given their relatively low incomes may explain why most elderly preferred using paraffin for both heating and cooking compared to electricity. The chi-square results were statistically significant suggesting that there is an association between source of heating and cooking and social problems of the elderly.

5.3 Percent distribution of elderly respondents in relation to their socio-economic challenges

Characteristics	Social problems		Total	
	Yes	No	%	N
Safety during Pension collection (*)				
Very Safe	83.9	75.0	81.9	381
Not safe at all	16.1	25.0	18.1	84
Household type (NS)				
Nuclear	61.3	69.5	63.2	320
Extended	38.7	30.5	36.8	186
Elderly source of heating (**)				
Electricity	23.5	34.7	26.1	132
Paraffin	76.5	65.3	73.9	374
Level of education (NS)				
No Education	44.8	44.1	44.7	226
Primary	38.1	37.3	37.9	192
Secondary and higher	17.1	18.6	17.4	88
Elderly source of cooking (*)				
Electricity	54.9	45.8	52.8	267
Paraffin	45.1	54.2	47.2	239
Elderly monthly Income (**)				
Less than R1000	65.7	79.7	69.0	349
More than R1000	34.3	20.3	31.0	157
Safety from crime (***)				
Very safe	37.9	12.7	32	162
Not safe at all	62.1	87.3	68	344
Elderly shown Respect (***)				
Yes	30.9	50.0	35.4	179
No	69.1	50.0	64.6	327
Elderly needs not addressed (***)				
Agree	15.2	31.4	19.0	96
Disagree	84.8	68.6	81.0	410
Elderly face abuse (***)				
Agree	72.4	36.4	64.0	324
Disagree	27.6	63.6	36.0	182
Total	**100.0**	**100.0**	**100.0**	**506**

Note: *** = p<0.001; ** = p< 0.01; * = p < 0.05; ns = Not Significant

Looking at the level of education of the elderly respondents, most of the respondents with social problems had no education (44.8%) compared to those with secondary or higher education (17.1%). This could be linked to the amount of income received by elderly respondents where as the table above shows, most elderly respondents earned less than R1000 which may have been insufficient to fully provide for their families, especially those elderly that headed extended families.

With regard to elderly perceptions, table 5.3 clearly shows that the majority of the elderly respondents were affected by crime, respect, abuse and their needs were not being addressed which may suggest that communities they lived in needed to be more tolerant to the elderly people who still played a significant role in society. The chi-square results clearly show statistically significant variations of the perceptions of the elderly with regard to social problems. However in the focus group discussions, there were variations in the responses given buy rural elderly care givers who indicated that they were respected by the communities as a result of the support they rendered while their urban counterparts indicated that most people were not patient with them especially when using public services such as transport. An urban elderly woman describes the situation she and her colleagues go through;

> *Every time we take this route to our homes, we are yelled at and called funny names. I don't know what has become of today's children*
> *They should set up queues for us so that we don't have to get pushed around. I don't know why everybody thinks that we still have the same strength like them.*

Table 5.4 presents percentage distribution of selected living conditions of the elderly respondents by elderly social problems. Social problems include issues such as crime and no respect of the community towards the elderly. Most of the elderly respondents with social problems indicated that they lived in houses that were still in good condition. This means that their homes did not have any leaking roofs or homes with cracked walls that would be detrimental to their overall health and those they lived with. In general irrespective of whether the elderly had social problems or not, most elderly living in houses that were in good condition.

Table 5.4 Percent distribution of elderly respondents in relation to their socio-economic challenges

Characteristics	Social problems		Total	
	Yes	No	%	N
Housing condition (NS)				
Good	59.3	50.8	57.3	280
Bad	40.7	49.2	42.7	216
Whether they save (NS)				
Yes	24.7	22.1	24.1	112
No	75.3	77.9	75.9	353
Reasons for not saving (NS)				
Pension too little	24.6	28.4	25.5	90
Debts to pay	27.9	23.5	26.9	95
Extended family	47.4	48.1	47.6	168
Place of Residence (NS)				
Urban	26.6	22.9	26.5	134
Rural	72.4	77.1	72.5	372
Main source of water (*)				
Piped water in Yard	29.9	36.4	31.4	159
Communal tap	39.7	43.2	40.5	205
Borehole	30.4	20.3	28.1	142
Total	**100.0**	**100.0**	**100.0**	**506**

Note: *** = p<0.001; ** = p< 0.01; * = p < 0.05; ns = Not Significant

The table above also shows that irrespective of whether the elderly saved or not, the majority of the elderly respondents did not save. As already indicated most respondents as seen in the table 5.3 received less than R1000 which was not enough to fully meet their needs and those of their families. This may partly explain why the chi-square results were statistically insignificant suggesting no association between whether the elderly saved or not and social problems.

Place of residence and reasons for not saving further show that there were very small variations between elderly with social problems and those with no social problems, which may partly

explain why the chi-square results were statistically insignificant suggesting no association between whether the elderly saved or not and social problems.

Finally in regard to their main source of water most of the elderly respondents with social problems used the communal tape (39.7%) followed by those that used the Borehole (20.3%). In contrast those with no social problems more respondents used the communal tape (43%) followed by piped water in the yard (36.4%). The results show statistically significant variations between the source of water by the elderly respondents by whether they had social problems or not.

5.3 LOGISTIC REGRESSION OF ELDERLY SOCIO-ECONOMIC CHARACTERISTICS BY THEIR SOCIAL PROBLEMS.

This section examines some of the selected independent variables that may explain social issues affecting the elderly using logistic regression. One of the conditions for the use of logistic regression is that the dependent variable is dichotomous with responses showing either yes or no. There are several assumptions of logistic regression. These, according to Ama (2007:134), include:

- It does not assume a linear relationship between the dependent and independent variables;
- The independent variables need not be interval, nor normally distributed, and
- The dependent variables must be a dichotomy

The responses to the selected variables and their frequencies are shown together with the reference group for each of the variables. For instance, for the place of residence, the reference group is the elderly who lived in the rural area.

For this study the dependent variable which is whether elderly are affected by social problems such as crime and no respect for the elderly is dichotomous with elderly respondents either saying yes or no to the questions.

The model on table 5.6 looks at social issues that affect the elderly particularly amongst the communities they live in. Some of the selected variables used to explain social issues of the

elderly include, their involvement in community activities which is important since they can still provide guidance to their communities, the communities' ability to consult the elderly particularly on issues that directly affect them(May, 2003:vi), their general safety both at pension points (ANC Today, 2001:1; Pick'n Pay, 2003:1; Help Age International, 2002:5c) and place of residence which may also directly affect their physical health, the amount of income they receive which has direct implications for their general sustenance and the families they look after (Help Age International, 2002:7c; Madzingira, 1998:143). This is also linked to their ability to save based on the family size or type of household. The place of residence of the elderly may also determine what opportunities and level of services that exist.

Rural areas are plagued with inadequate basic services and limited job opportunities for the younger generation leading to social ills such as crime (Moller and Ferreira, 2003:25). Indirectly, it can also lead to physical and emotional abuse by immediate family members who may want to steal the pension of the elderly (The Sunday Times Metro, 2006:8; Ferreira and Charlton, 2004:53). Their sharing of the pension they received in the form of basic services like food and clothing for their families may plunge them into poverty, given the fact that it can not fully provide all the required needs of the family (Moller and Ferreira, 2003:25).

5.3.1 **Description of Social variables**

Table 5.5 provides the independent variables that were used for the multivariate analysis with regards to social problems of the elderly. A total of eleven explanatory variables were identified that may explain social issues of the elderly. With the exception of the place of residence, whether the elderly were in a position to save money and if they shared their pension, most of the responses of the other independent variables in the summary above were collapsed to form just two responses based on how the elderly responded. For instance with regards to consultation of the elderly regarding their needs, most responses were that the elderly agreed and/or disagreed with the statement. The last category of each variable is always zero which indicates omitted values for a set of dummy variables.

Table 5.5 **Summary of variables: Social problems**

variables	Coding categories	Frequency	Parameter coding
Elderly not involved in communities	Agree Disagree	156 350	1.000 .000
Safe collecting pension	Very safe Not safe at all	381 124	1.000 .000
Elderly consulted	Agree Disagree	187 319	1.000 .000
Elderly abused	Disagree Agree	294 171	1.000 .000
Place of residence	Urban Rural	134 372	1.000 .000
Elderly share pension	Yes No	95 370	1.000 .000
Able to save money	Yes No	153 353	1.000 .000
Monthly income	Less than R1000 More than R1000	349 157	1.000 .000
Elderly needs not addressed	Agree Disagree	130 376	1.000 .000
Elderly safe from crime	More Safe Less Safe	163 302	1.000 .000
Pension stolen	No Yes	123 342	1.000 .000

5.3.2 Results of the factors associated with social problems affecting the elderly

Table 5.6 below shows the results of the logistic regression model. The 5% level is used to determine the level of significance of the independent variables in relation to the dependent variable and any value below that level indicates that the results are significant. The beta coefficient provides the direction of the response in which a positive coefficient suggests the higher the chances of an event occurring.

Table 5.6 **Results of the Parsimonious Logistic Regression Model: Social problems**

Independent variables	categories	B	df	Significance level at 5%	Exp(B)	95% C.I Lower	95% C.I Higher
Monthly Income	< R1000	RC					
	>R1000	0.974	1	0.003	2.647	1.121	4.086
Share your pension	Yes	RC					
	No	0.753	1	0.027	2.123	0.991	4.240
Pension stolen	No	RC					
	Yes	1.681	1	0.000	5.372	0.768	7.612
Elderly safe from crime	More safe	RC					
	Less safe	-1.392	1	0.000	0.248	0.075	0.766
Elderly needs not addressed	Agree	RC					
	Disagree	1.056	1	0.001	2.874	1.087	4.836
	Yes	RC					
Elderly Respected	No	2.117	1	0.000	8.308	5.867	25.499
Constant		-3.137	1	0.000	0.043		

- RC = Reference Category

The above table presents the logistic regression results for the elderly with regard to their social concerns. Of the eleven explanatory variables selected, respect for the elderly, whether their needs were addressed, the amount of monthly income they received, whether their pension was stolen from them, whether they shared their pension and crime were statistically significant at 5% level. For instance, the elderly respondents who indicated that they were not respected by their communities were 8 times more likely to have social problems than those who felt respected. Interestingly elderly respondents that earned more than R1000 were 2.6 times more likely to have social problems, while those elderly who disagreed with the statement that their needs were not being addressed were 2.8 times more likely to have social problems. Similarly those elderly respondents who did not share their pension were 2 times more likely to have social problems. The Adjusted R-square indicates that 32.9% of the variables included in the above regression model explain the variations in the dependent variable while the overall model was statistically significant.

The variables not included in the model were, place of residence, abuse of the elderly, whether the elderly were consulted, their involvement in community activities and whether they saved money since they were statistically insignificant at 5%.

5.3.3 **Discussion of Results: Social problems**

The social concerns of the elderly may emanate from the society in which they live, showing that intolerance towards them, especially from the younger generation, varies from bad to good. This may partly explain why most of the elderly who felt that they were not respected were more likely to have social problems, but this may also be linked to the limited employment opportunities where communities may resort to illegal activities such as crime. From the Parsimonious logistic regression model above, it is interesting to note that the elderly respondents who did not share their pension were more likely to have social problems. This may be linked to the fact that they did not support any member of the community and were thus susceptible to crime.

In addition, the above regression results in regard to the social problems of the elderly, suggest that elderly respondents who did not feel safe from crime were less likely to have social problems. It is possible that those elderly respondents who felt less safe from crime had a negative perception of the community they lived in. Similarly, the elderly respondents that earned more than R1000 were more likely to have social problems. It is plausible that other factors may contribute to their likelihood of having social problems like having to take care of extended family members particularly their adult children who may be unemployed or sick. Also, the fact that they may have extra money to spend, may encourage them to spend leading them into unforeseen debt. Most of the elderly rely on their pensions to support themselves and their families, without it they would be plunged into abject poverty. As a result, the elderly respondents who indicated that their pension was stolen would have to source funds from elsewhere to buy the basic necessities in supporting their families, and in the event that they failed to get funds would affect them psychologically.

Finally, crime affects everybody, but it is the young and the elderly that are most vulnerable because of their physical nature. However, the above logistic regression model (Table 5.6) suggests that those who felt less safe were less likely to be affected by crime. The perception

that crime exists in the area, yet in actual fact it might not, may partly explain why some of the elderly may not feel safe.

5.4 SUMMARY

In summary, data in this chapter have shown that the low income levels among the elderly, their inability to save and the negative perceptions of their communities are some of the socio-economic challenges facing the elderly. For instance, the bi-variate and multi-variate results (tables 5.3 and 5.6) have shown that most elderly that earned less than R1000 would be affected by social problems. In addition, Issues of crime, respect and abuse by the communities were mostly reported by the majority of respondents as being some of the challenges they faced, this despite the fact that they played a role in the support of their communities and families.

CHAPTER SIX

HEALTH PATTERNS AND DIFFERENTIALS IN THE ELDERLY POPULATION

6.0 INTRODUCTION

In the previous chapter, we examined the socio-economic and demographic characteristics of the elderly respondents. In addition, Bi-variate and multi-variate analysis were used to ascertain the socio-economic characteristics of the elderly by their social problems.

This present chapter explores some of the health characteristics of the elderly respondents and also examines some of the socio-economic characteristics of the elderly using bi-variate and multi-variate analysis by their health problems. The health variables discussed in this chapter include: elderly disability status; health status; whether they ate regularly; their vegetable intake; any difficulty doing household activities and whether they experienced body pains. Elderly age; their monthly income; type of household; place of residence; marital status and source of heating were the variables used in the multi-variate analysis in relation to their health problems.

6.1 HEALTH AND BACKGROUND CHARACTERISTICS OF ELDERLY RESPONDENTS

This section examines the background characteristics of the elderly population. These characteristics include Disability status, whether they starved, experienced body pains, had difficulty doing household activities, the number of times they had vegetables, their health status and place of residence. As in the previous chapter, the analysis aims to get a clear understanding of elderly health characteristics and also ascertain whether these characteristics support existing literature about their health.

Table 6.1 presents the health characteristics of the elderly respondents. The majority of respondents interviewed indicated that they had no disability which bodes well in their efforts to contribute to their communities' development and support for their families.

Observations from the table indicate that the majority of elderly respondents did not eat regularly or often starved which would have a negative impact on their health (Charlton and Rose, 2001) and therefore their ability to perform their daily chores. It is plausible that there is not enough to eat at their homes such that the elderly thought of their families first at the expense of their own health.

In response to body pains, most elderly respondents indicated that they did not have any body pains. This may be due to the fact that most elderly respondents were in the younger age bracket and thus still able to perform daily chores. It is expected that as one grew older, one would become more frail and degenerative diseases would begin to rise. In the same light most elderly respondents indicated that they did not have any difficulties doing household activities as most were still in the younger elderly age bracket as seen in the previous chapter (Table 5.1). Another explanation for this may be due to the fact that they have support from family members to do the household chores or even stay alone such that there is not much household chores to do.

Similarly, over 80% of the elderly respondents indicated that they were in good health which was mainly due to the fact that most elderly were in the younger age bracket and were thus still active within their communities. It would be expected that the older elderly in the 80 plus age bracket to have health problems depending on their lifestyle.

The intake of vegetables for elderly would enable their bowels to stay in peak condition and at the same time it protects against intestinal problems (Putatunda, 2010). Over 50% of interviewed elderly respondents indicated that they had vegetables 4-7 days a week which bodes well for ability to remain health and possibly live longer. Only 13.2% indicated that they had vegetables once a week.

Finally, most elderly lived in the rural areas as is depicted in the table below, which shows that 75% of the elderly respondents resided in the rural areas compared to 25% that lived in the urban areas. Existing literature shows that most elderly retired at their place of residence which happened to be in the rural areas after their economically active years (United Nations, 2002:1a: Stloukal, 2001:1: Charlton, 2000:2).

Table 6.1 Health characteristics of elderly respondents

Characteristics	Frequencies	Percent
Disability Status		
No	440	87.0
Yes	66	13.0
Eat regularly		
Yes, often	391	77.3
No	115	22.7
Experience body pains		
None	388	75.4
Severe	118	24.6
Difficulty doing HH activities		
None	296	58.5
Severe	210	41.5
Vegetable in-take		
4-7 days	268	53.0
2-3 days	171	33.8
Once a week	67	13.2
Health Status		
Good	408	80.6
Bad	98	19.4
Place of Residence		
Urban	134	26.5
Rural	372	73.5
Total	**506**	**100.0**

6.2 ELDERLY HEALTH AND BACKGROUND CHARACTERISTICS BY THEIR HEALTH STATUS

This section examines the socio-economic issues affecting the elderly by health problems. The aim would be to ascertain any association between selected elderly perceptions and their living conditions in relation to their health problems

Table 6.2 presents percentage distribution of the elderly respondents in relation to their living conditions by their health problems. As in previous tables most elderly respondents lived in the rural areas as shown by the higher percentage numbers of the respondents irrespective of whether they had health problems or not. There were very small variations between elderly respondents who had health problems and those who did not in both urban and rural areas, which may partly explain why the chi-square results were statistically insignificant.

The table further shows that most elderly respondents with health problems were in the younger elderly age group of between 60-74 years (62.2%) compared to those in the older age group of 75 years and over. It is plausible that most of the younger elderly respondents are responsible for the welfare of their families which presents itself with a set of challenges from a physical and emotional perspective. The chi-square results were statistically significant indicating variations between elderly age and health problems

Interestingly, there were variations between elderly respondents who felt lonely in regards to whether they had health problems or not with 66.3% with health problems compared to 49.3% with no health problems. It is plausible that those with health problems and lonely may need physical support particularly those in the older age groups.

Furthermore, very few elderly respondents (2%) with a disability had health problems compared to those with no health problems (15%).It is possible that most of the disabled elderly with no health problems might be disabled physically but were still able to perform their daily chores

Table 6.2 Percent distribution of elderly respondents in relation to their health challenges

Characteristics	Health problems		Total	
	No	Yes	%	N
Place of Residence (NS)				
Urban	25.5	30.6	26.5	134
Rural	74.5	69.4	73.6	372
Elderly Age (**)				
60 - 74	52.2	62.2	54.2	274
75+	47.8	37.8	45.8	232
Find yourself lonely (**)				
Yes	49.8	66.3	53.0	268
No	50.2	33.7	47.0	238
Disability Status (***)				
Yes	15.7	02	13.0	066
No	84.3	98.0	87.0	440
Doing Household activities (***)				
None	34.3	75.5	42.3	214
Severe	65.7	24.5	57.7	292
Elderly eat regularly (NS)				
Yes	23.5	19.4	22.7	115
No	76.5	80.6	77.3	391
Source of cooking (**)				
Electricity	50.0	64.3	52.8	267
Paraffin/wood	50.0	35.7	47.2	239
Household type (**)				
Nuclear	60.5	74.5	63.2	320
Extended	39.5	25.5	36.8	186
Marital status (**)				
Married	33.8	49.0	36.8	186
Divorced/widowed	53.8	35.7	50.4	255
Never married	12.3	15.3	12.8	65
In-take of vegetables (***)				
4-7 days	49.3	68.4	53.0	268
2 -3 days	36.5	22.4	33.8	171
Once a week	14.2	9.2	13.2	67
Experience Body pains (***)				
None	2.2	21.4	5.9	30
Severe	97.8	78.6	94.1	476
Source of heating (***)				
Electricity	21.1	46.9	26.1	132
Paraffin/wood	78.9	53.1	73.9	374
Total	**100.0**	**100.0**	**100.0**	**506**

Note: *** = p<0.001; ** = p< 0.01; * = p < 0.05; ns = Not Significant

From table 6.2, it is evident that there were very significant variations between elderly respondents with who had health problems and therefore had difficulty doing household activities (24.5%) and those with no health problems in the same category (65.7%). It is possible that the elderly with no problems but with difficulty doing household activities may have a physical disability but do not suffer from any degenerative diseases such as heart problems. The results of the chi-square show highly significant variations between elderly respondents being able to do household activities or not by their health status.

Similarly there were differences between elderly respondents who experienced body pains or not in relation to their health status with 2.2% with health problems but with no body pains compared to 21.4% of elderly respondents in the same category. It is possible that other health issues that are not physical in nature may be affecting the elderly with no body pains.

Finally in relation to source of heating and their health status, the majority of elderly respondents that used paraffin/wood did have health problems which may be respiratory in nature such as asthma, as a result of inhaling the smoke from the burning fuels. The chi-square results show significant variations between those elderly respondents' source of heating and their health.

6.3 LOGISTIC REGRESSION OF ELDERLY SOCIO-ECONOMIC CHARACTERISTICS BY THEIR HEALTH PROBLEMS

The existing literature does suggest that health issues affect many elderly people and, as such, there are factors which impact on the health aspects of their lives. In this regard several independent variables from this study have been selected to examine their impact on the health of the elderly. They include: whether the elderly have regular meals since accessibility to food is vital for their strength and ability to carry on with their daily activities, their place of residence where rural areas have no proper health facilities as a result of underdevelopment (Global Action on Aging, 2002:10), the amount of disposable income which is inadequate to sustain themselves and their extended families particularly in the era of HIV/AIDS where grand parents have sole responsibility for looking after their sick adult children and their

children, affecting the elderly psychologically(Woolf, 2009; Evans et al., 2002). The source of heating that they use in their homes may also impact negatively on their overall health to the extent that those who use wood have a higher chance of inhaling fumes which may lead to respiratory illnesses such as asthma. In addition, whether their homes are in good condition or not to prevent them from getting cold in winter or rain from getting into their homes, their age especially those advanced in years and who may need physical assistance, their disability status may also influence their overall health conditions.

The type of household may also impact on their health and make it impossible for the elderly living or heading extended households to cope with the physical challenges of supporting such a big family (Help Age International, 2004:3). Finally, those elderly who are divorced or widowed may need assistance especially the older elderly whose overall health may be affected without any form of assistance.

For this study, the respondents were asked about their health status for which the responses were either good or bad. This forms the basis of the dependent variable and, given that it has only two responses, led to the use of the logistic regression as a statistic technique to predict the outcome of the independent variables.

6.3.1 Description of health variables

This section examines some of the selected independent variables that may explain health issues affecting the elderly. The responses to the selected variables and their frequencies are shown together with the reference group of the variables. For instance, the reference group for age is those elderly 75 years and over.

Table 6.3 provides the independent variables that were used for the multivariate analysis with regard to the health problems of the elderly. A total of ten explanatory variables were identified. Most of the responses of the variables had at least four responses. However, responses from the respondents are currently shown in the table with the exception of the condition of the house, disability status of the elderly respondents and place of residence which have their original responses shown table 6.3. For instance, the original responses for whether the elderly would ever go without any meal during the day or not were;

(1) Yes, often (ii) Yes, sometimes (iii) never

Table 6.3 **Summary of variables: health problems**

variables	Coding categories	Frequency	Parameter coding
Marital Status	Married/living together	186	1.000
	Divorced/widowed	320	.000
Place of Residence	Urban	134	1.000
	Rural	372	.000
Type of household	Nuclear	186	1.000
	Extended	320	.000
Elderly eat regularly	Yes, often	115	1.000
	No	391	.000
Disability status	Yes	66	1.000
	No	440	.000
Elderly age	60-74	349	1.000
	75+	157	.000
Monthly income	Less than R1000	349	1.000
	More than R1000	157	.000
Condition of house	Yes	290	1.000
	No	216	.000
Source of heating	Electricity	132	1.000
	Paraffin/wood	374	.000
Access to main road	Easy	346	1.000
	Difficult	160	.000

However, since most of the responses were either "yes", "often" or "never", the third response was incorporated into "yes", often leading to the creation of the two responses, "yes, often" and "never". Most variables have been collapsed along the same lines and the final version of the variables is presented in Table 6.1. The last category of each variable is always zero which indicates omitted values for a set of dummy variables.

6.3.2 Results of the factors associated with health problems affecting the elderly

Table 6.4 shows the results of the logistic regression model. The 5% level is traditionally used to determine the level of significance of the independent variables in relation to the dependent variable such that any value below the 5% level indicates that the results are statistically significant. The beta coefficient provides the direction of the response such that a positive coefficient suggests the higher the chances of an event occurring.

Table 6.4 **Results of the Parsimonious Logistic Regression Model: health problems**

Independent variables	Categories	B	Df	Significance level at 5%	Exp(B)	95% C.I Lower	95% C.I Higher
Disability Status	Yes	RC					
	No	-2.375	1	0.001	0.093	0.019	0.369
Elderly age	60-74	RC					
	75+	0.615	1	0.040	1.849	1.082	3.591
Marital status	Married/living together	RC					
	Widowed/divorced	0.508	1	0.045	1.662	0.962	2.712
Household type	Nuclear	RC					
	Extended	0.556	1	0.046	1.744	0.991	3.751
Source of heating	Electricity	RC					
	Paraffin/wood	0.955	1	0.000	2.509	1.553	4.634
Access to main road	Easy	RC					
	Difficult	2.421	1	0.000	11.256	3.980	31.837
Constant		-2.747	1	0.000	0.064		

- RC = Reference Category

The above table shows the logistic regression model with regard to the health problems of the elderly. Source of heating, marital status, age of the elderly, disability status, type of household that the elderly respondents headed and whether the elderly respondents had access to the main road were statistically significant at 5 % level. The problems regarding the health of the elderly may range from mental to physical problems that impede their ability to do their daily chores. For instance, a negative and statistically significant effect of the disability of the elderly suggests that the elderly respondents who were not disabled were 9.3 times less likely to have health problems, while the elderly respondents who used paraffin or wood for heating were 2.5 times more likely to have health problems compared to those who used electricity. Elderly respondents who were 75 years of age and over were 1.8 times more likely to have health problems while the elderly respondents that found it difficult to access the main road were 11 times more likely to have health problems. The Adjusted R-square indicates that the variables included in the regression model explain the variations in the health problems by 29%.

6.3.3 Discussion of Results: health problems

The variables that were not significant include place of residence, condition of the house of the elderly, whether the elderly respondents ate regularly and their monthly income.

The logistics regression results based on health and social issues of the elderly support the existing literature and the bi-variate results in the previous chapters. For instance the disabled elderly may be suffering from mental and physical illnesses that may lead to health challenges and may prevent them from fully doing their daily chores. This, to a certain extent, may be linked to the advanced age of the older elderly because their physical and mental aspects of their bodies deteriorate as they get older. However, this maybe countered by continuous healthy living such as physical exercises and proper diet. The respondents who are widowed/separated or divorced may live lonely lives without any companionship, particularly for support may be affected mentally and restricted physically especially at advanced ages. This may explain why they are likely to have health problems. The respondents who live with their extended families may also be affected by health problems resulting from the day-to-day physical challenges of doing the daily household chores especially for those elderly in advanced ages. In addition, the socio-economic challenges of the community such as unemployment are a burden to the elderly who have to support their extended families with their meagre pension. This may lead to mental stress as they try to ensure that they take care of their families with the limited financial resources at their disposal. Heating is very important especially during the winter season when night and, occasionally, day temperatures fall. However, other sources can also contribute to respiratory illnesses especially if wood or paraffin is used, which arises from inhalation of smoke fumes. Electricity is the most preferred source because it doesn't have the disadvantages of producing smoke; however, it is an expensive means of heating for most of the elderly who opt to use wood or paraffin. This is why the regression results, with regard to health, show that the elderly respondents who used wood or paraffin as their source of heating were more likely to have health problems.

Furthermore, accessibility to basic services like healthcare may be dependent on the distance of place of residence of the elderly respondents such that those who stay further from the main

road where transport can be sought may have less of a chance of accessing basic services (Ferreira and Van Dongen, 2004:16). However, other factors like whether the elderly is staying a lone or not, their age may also influence their ability to access the main road.

6.4 SUMMARY

This chapter has highlighted the fact that most elderly respondents did not have enough to eat which may have a negative impact on their overall health status. However, most did not have a disability status which bodes well for their ability to participate in community activities. Elderly source of heating, cooking, whether they had body pains and doing household activities are some of the characteristics that impacted on elderly health care according to the bi-variate and multi-variate results(see table 6.2), while those respondents that used paraffin as a source of heating were more likely to have health problems.

The next chapter examines the HIV/AIDS awareness of elderly respondents

CHAPTER SEVEN

CHALLENGES AND NEEDS OF ELDERLY CAREGIVERS

7.0 INTRODUCTION

In the previous chapter, we examined the health characteristics of the elderly respondents. As was the case in chapter 5, bi-variate and multi-variate analyses were used to ascertain the socio-economic characteristics of the elderly by their health problems in the previous chapter.

This chapter examines the characteristics of elderly respondents in relation to HIV/AIDS awareness, background characteristics of elderly care-givers and their needs in regard to their care giving activities. Some of the care-givers' characteristics include their age; whether they got support for their care; orphans needs; affordability of care; mode of transport used to transport the sick; services used to treat the sick; state of healthcare facilities and cost of health care. In addition responses on issues of care giving from the focus group discussion are included to highlight some of the needs and challenges of elderly caregivers.

7.1 HIV/AIDS AWARENESS OF THE ELDERLY RESPONDENTS

This section of the chapter examines HIV/AIDS awareness among the elderly respondents and characteristics of the elderly caregivers. Some of the variables used include knowledge about HIV/AIDS, their source of knowledge about HIV/AIDS, and how the knowledge was transmitted, whether any household member had been lost to HIV/AIDS and issues related to care-giving. This is important to find out if elderly respondents are aware of the pandemic to aid in the efforts in controlling its spread. It also provides some insight into the needs of the elderly care givers as they try to provide proper care for the sick and orphaned.

Table 7.1 presents Elderly respondents' awareness and Knowledge of HIV/AIDS. It is evident from the table that awareness of the disease is generally very high with about 93% of the respondents having heard of it. This is probably as a result of vigorous campaigns on raising awareness of the HIV/AIDS pandemic.

This is mirrored by the majority of responses on how the pandemic is transmitted; more elderly respondents indicating that unprotected sex was one way in which a person could get HIV/AIDS. The focus group discussions showed that most respondents knew about HIV/AIDS

albeit that was more the case for urban elderly caregivers than their rural counterparts. In addition, most elderly caregivers indicated that the most common ways of stopping the spread of the virus was through the use of the condom and abstinence.

Unexpectedly, there were significant variations with regard to where the elderly respondents had heard about HIV/AIDS, with most elderly indicating that the media (40.5%) was where they had heard about the pandemic in contrast to those that had heard about the pandemic from family and friends (35.3%).This was followed by 21.4% that heard about HIV/AIDS transmission from clinics and Hospitals. This clearly highlights the importance of the media and family in creating awareness of the pandemic given the fact that most elderly respondents were not literate.

Interestingly, the majority of the elderly respondents (about 75%) said they have not had any members of their households lost to the disease. In a society stigmatized by the disease, people are reluctant to admit that their loved ones are suffering from the disease (Munthree and Maharaj: 2010; 170). HIV/AIDS testing is avoided by the majority of the population; and the immediate cause of death is often if not always recorded as TB or pneumonia and not the underlying cause of HIV/AIDS. The focus group discussions on the above topic further showed that most elderly were unwilling to discuss the issue of death resulting from HIV/AIDS. As 69 year older elderly woman who was identified as ID No2, commented.

I can not answer that question. It is a very sensitive one.

Similarly, the table indicates that over 80% of the elderly respondents were not the main care providers and 75% of elderly respondents indicated that they had not lost anyone to the HIV/AIDS pandemic. Given that South Africa is one of the countries in sub-Saharan Africa with one of the highest prevalence rates, it is plausible that there are more elderly respondents who may be caregivers and are not willing to openly say that they are for fear of stigmatization. The loss of a member of the household to HIV/AIDS is seen as a sign that the deceased were promiscuous and therefore blame the parents for poor upbringing, which is why most deaths may not be recorded as due to HIV/AIDS but natural causes.

Table 7.1 Elderly respondents' knowledge and awareness of HIV/AIDS

Characteristics	Frequencies	Percent
Ever heard of HIV/AIDS		
Yes	471	93.1
No	35	6.9
Total	**506**	**100.0**
If yes Where		
Media	191	40.5
Friends	166	35.3
Hospitals & clinics	101	21.4
Don't Know	13	2.8
Total	**471**	**100.0**
HIV/AIDS transmission		
Unprotected sex with infected	335	71.1
Kissing	008	1.7
Don't know	128	27.2
Total	**471**	**100.0**
Elderly care provider		
No	409	80.8
Yes	97	19.2
Total	**506**	**100.0**
Any HH member lost to HIV/AIDS		
No	353	74.9
YES	118	25.1
Total	**471**	**100.0**

Table 7.2 presents the background characteristics of elderly caregivers with the majority being in the younger age bracket 60 -69 years. Given the challenges of care giving which include providing constant care to the sick in the form of feeding etc, one would require all the energy to fully perform this task which the older elderly, due to their frail nature would not adequate do.

Interestingly, the data in the table below shows variations in the marital status of the caregivers with 40% indicating that they were married or lived together. This bodes well for the caregiver who would share the daily activities involved in providing care, unlike the 43% and 17% of elderly caregivers who indicated that they were divorced and never married respectively who have to provide care on their on.

Table 7.2 Background Characteristics for elderly care givers

Characteristics	Frequencies	Percent
Elderly Age		
60-69	54	55.7
70-79	32	33.0
80+	11	11.3
Marital Status		
Married/Living together	39	40.2
Divorced/widowed	42	43.3
Never married	16	16.5
Place of Residence		
Rural	79	81.4
Urban	18	18.6
Health status		
Good	17	17.5
Bad	80	82.5
Household type		
Nuclear	51	52.6
Extended	46	47.4
Sex		
Female	68	70.1
Male	29	29.9
Attended adult education		
Yes	07	7.2
No	90	92.8
Monthly income		
Less than R1000	55	56.7
More than R1000	42	43.3
Total	**97**	**100.0**

As already indicated, providing care may have a negative impact on the caregivers' health, both physically and emotionally, particularly if this is being done with no support. This may

explain why from the table above the majority of caregivers had bad health as a result of the constant care provided to the sick. The focus group discussions of the caregivers further illustrates the problem with most suffering from back and breathing complications. An 81 year old rural elderly woman identified as ID No 4 commented:

> *I get tired too often having to clean the house and watch my four grand children at the same time. As a result I get back pains because I have to clean up the mess they cause.*

The table further shows that the majority of elderly caregivers lived in the rural areas (81.4%) compared to those who lived in the urban areas (18.6%). This is because most elderly were found in the rural areas were they retired from formal employment. Similarly, most of the care givers were female who were expected to look after the sick and orphans from a cultural perspective. It is also possible that more elderly females than males were available given the fact that women lived longer than men.

Furthermore, Table 7.2 shows that most elderly caregivers earned less than R1000 (56.7%) compared to those that earned more than R1000 (43.3%). This may have serious implications in providing proper care to the sick and/or orphans especially in terms of healthcare and proper nutrition which may be expensive. Most of the elderly care givers in the focus group discussions lamented the fact that the cost of living was too high especially in regard to food and private care. Most urban elderly opted for private health care since they got the attention they needed and thus avoided the long queues in public hospitals.

> *"I cannot afford waking up so early in the morning to go and line up at Boipelong (main public Hospital). I would rather save to see a private doctor where I shall get his full attention," said* a 65 year old urban elderly man identified as ID No6.

Table 7.3 **Elderly caregivers' perceptions and selected living conditions**

Characteristics	Frequencies	Percent
Elderly needs addressed		
Agree	16	16.5
Disagree	81	83.5
Elderly Shown Respect		
More respect	36	37.1
Less respect	61	62.9
Safe from Crime		
Very Safe	28	28.9
Not safe at all	69	71.1
Source of cooking		
Electricity	36	37.1
Paraffin/wood	61	62.9
Source of heating		
Electricity	14	14.4
Paraffin	83	85.6
Main source of water		
Pipe water in Yard	23	23.7
Communal tap	50	51.5
Borehole	24	24.7
Source of Information		
Radio	58	59.8
Family	18	18.6
Television	21	21.6
Doing Household activities		
None	33	34.0
Severe	64	66.0
Total	**97**	**100.0**

Table 7.3 above presents data on the elderly caregivers' perceptions and selected living conditions. The data reveal that most elderly caregivers indicated that their needs are not addressed. Such needs may be in the form of financial and moral support in their efforts of care giving. This may be due to the fact that they are not represented in any capacity in local

government affairs as was clearly stated by all the respondents during the focus group discussions.

> "*I have never heard of anyone representing us at national or provincial level, if there is somebody then he is not doing a good job*," commented an urban elderly lady identified as ID No3.

In most cases, the elderly caregivers discussed ways of solving the problem at hand, yet they were severely handicapped by a lack of support from their communities.

All elderly respondents in the focus group discussions were of the view that it was necessary to have elderly representation in order to have a voice on issues affecting them. This would go a long way in trying to make services conducive to their needs, like specialized health care and support structures that can make their overall lives better. It is, therefore, necessary to have elderly representation at local municipality, provincial and national level for their issues to be effectively dealt with.

"*It is important that we are heard so that we can be part of any changes affecting us*," was the response of a 76 year old man identified as ID No7.

Data in table 7.3 further shows that the majority of elderly care givers felt that they were not respected (62.9%) and were affected by crime (71%). This, despite the fact, that they provided care to the sick who are members of the community. Most urban elderly care givers from the focus group discussions were affected by crime especially those that lived alone. One elderly respondent identified as ID No 4 commented:

> *I have been robbed twice at my home and I live alone with no one to assist me.*

The sources of cooking and heating directly affect the health of the caregivers and those that they take care of. Yet the majority of the care-givers indicated that they relied on paraffin for heating (61%) and cooking (83%). The breathing problems experienced by most of the elderly care givers in the focus group discussions may be as a result of inhaling the smoke from the use of paraffin, which they used as a source of heating. In addition, most elderly relied on their pension to support their sick and orphaned family members which was inadequate, this necessitated the care-givers to resort to energy sources that were affordable, this despite their health hazards.

Related to the above, half of the elderly caregivers used the communal tap (51.5%) as their main source of water, followed by 24.7% that used the borehole as their source of water. In most cases, communal taps are centrally located and it is plausible that such taps may be quite distant from their homes making it difficult to access water needed for household activities. The rural elderly care-givers in the focus group discussions indicated that water had to be fetched kilometres away from their homes, or in some cases had to stand in long queues for water from a communal tap. Given their frail nature, it would be virtually impossible for them to fetch water as a result of the distance of the communal tap. It would also be impossible for them to leave the sick unattended at home.

The source of information is vital for caregivers in their efforts of providing the best care to their sick. Surprisingly, however table 7.3 reveals that most elderly caregivers relied on their radio, followed by the television as their source of information. This maybe due to the fact that most elderly caregivers were divorced or widowed as seen in the previous table and thus stayed alone. However, from the focus group discussions, most rural elderly care givers bemoaned the fact that there was still insufficient information especially in relation to their personal needs, for instance, how to remain in good health. There was no proper diagnosis of their ill health with the result that most respondents preferring to stay at home in the hope that the illness would go away. As one rural elderly woman identified as ID No 8 summed it up:

> *"There is no need for me to go to the clinic if they can not properly tell me what I am sick of so I would rather stay at home."*

Finally, data in table 7.3 show that most elderly caregivers (64%) had severe difficulties doing household activities which included constant care of the sick. It is possible that most caregivers provided care and also did household chores without any assistance. Table 7.2 has already shown that most elderly caregivers were either divorced or widowed and thus might have lived with no adult family members to provide assistance with daily household activities especially that of looking after the sick. In the focus group discussions, having back problems was a common illness of most elderly care givers which resulted from having to constantly watch their energetic grandchildren. However, most of the elderly, despite this drawback, enjoyed

seeing their grandchildren play with so much energy. As one 71 year old rural elderly woman identified as ID no 6 put it:

> *"They give me a hard time running up and down in the house which has worsened my back pains. But I would rather they continued because I was once like them."*

7.2 ELDERLY CARE GIVERS NEEDS

This section examines elderly care givers needs in respect to providing care for the sick. The variables to be examined below give an indication of how elderly care givers support the sick given the living conditions of the area.

Table 7.4 presents the frequency distribution of caregivers in accordance with their needs. Receiving support for the care of the orphans may go a long way in helping care-givers to cope with the challenges of care-giving. Unfortunately, about 75% of the elderly care-givers received no support, making their efforts in providing proper care to orphans extremely difficult. The focus group discussions clearly highlighted the difficulties the care-givers experienced when looking after orphans with the majority indicating that limited financial resources was one of the biggest hurdles to providing proper care. This situation is not unique to the South African situation but also in other developing countries severely affected by the pandemic. Elderly care givers in Zimbabwe indicated that financial constraints were the single major factor that hindered their ability to provide proper care (WHO, 2002:16).

Caring for orphans by the elderly has its challenges since they have to play the role of being parents again. Basic necessities like food and clothing were the most expensive items in providing proper care to orphans according to the elderly care-givers. Elderly care-givers in the urban areas, according to the focus group discussions found it extremely difficult to support themselves and their households since they had additional expenses such as rent. This was followed by education and healthcare respectively (23.5%). Depending on the number of orphans that they have to provide care for, elderly caregivers may struggle to fully support them and given the fact that the majority received support, it is very difficult to meet all the proper requirements of providing proper care as is mirrored by the response to whether the family could afford providing proper care.

Table 7.4 Elderly caregivers required needs

Characteristics	Frequencies	Percent
Barriers to services		
Financial	41	42.3
Attitude of staff	17	17.5
Transport	39	40.5
Elderly get support for care		
Yes	24	24.7
No	73	75.3
Orphans needs		
Education	24	23.5
Health	24	23.5
Basic necessities	40	41.2
All the above	12	11.8
Affordable to family		
Yes	26	26.8
No	71	73.2
Services used to cure The sick		
Formal	46	47.4
Community based	51	52.6
Distance to nearest health Centre		
Less than 5 km	9	9.3
More than 5 km	88	90.7
Mode of transport to Health centre		
Walk	12	12.4
Car/Bus	85	87.6
Cost of health care		
Less than R100	23	23.7
Over R100	74	76.3
State of healthcare in The area		
Good	27	27.8
Bad	70	72.2
Total	**97**	**100.0**

Furthermore table 7.4 indicates that lack of finances and transport were the main barriers to access to services according to over 40% of elderly caregivers. As already seen, most elderly caregivers rely entirely on their pension and do not receive any form of support making it very difficult to adequately provide for the sick and orphans. Most elderly respondents leave in the rural areas with limited development which includes inadequate transport facilities, making it more difficult for the caregivers to access health care facilities and shops.

The kind of services used by the elderly care-givers may impact on the overall health of those that they are caring for. The table above shows that about 52.6% of the elderly care-givers used community-based services to care for the terminally ill and orphans compared to 47.3% that used formal services. It is possible that community based services were easily accessible and affordable compared to the formal services. This may partly explain why most elderly care givers indicated that the cost of health care was over R100 which depending on the number of orphans that need care would be too costly.

Finally, from table 7.4, the majority elderly care-givers described health care services as bad (72.2%) with only 27.8% giving a positive response to health care services. The current state of affairs can only make their efforts more difficult and may lessen the chances of survival of the sick. The urban elderly care givers in the focus group discussions have alluded to the fact that they opted for private health care which was more expensive but more effective in providing treatment compared to the long queues of government hospitals.

In as far as other issues related to care-giving is concerned, most care givers, from the focus group discussions indicated that that lots of exercise together with cleanliness was important in maintaining the proper health of children with HIV/AIDS. Staying positive about life was also important because it would enable them to go on with life as normally as possible. As one 71 year old female care-giver identified as ID No 9 suggested

> *"It is important that they don't think too much about their HIV status. This helps them to continue with their lives like before. "*

It is worth noting that, from the focus group discussions, none of the elderly care-givers had faced any discrimination due to their care-giving activities. This may be due to the fact that

most communities where the elderly care givers lived were well conversant with how HIV/AIDS was spread, thus minimizing the stigma surrounding HIV/AIDS. Also, they got community support for their efforts in taking care of their sick adult children and orphaned children and in all situations they were the only ones that could look after the children on behalf of their deceased adult children. It is a known fact that grandchildren are usually left in the hands of their grandparents particularly those staying in rural areas, while their adult children go to the urban areas in search of employment prospects.

7.3 SUMMARY

This chapter has highlighted the fact that most elderly respondents had knowledge of how HIV/AIDS was spread as well as its prevention. The media has played a significant role in creating awareness about the pandemic followed by family members.

Most elderly caregivers were in the younger elderly age group with the majority of them living in the rural areas. It is therefore not surprising that the majority of elderly caregivers were female, given their higher life expectancy than the males.

A significant percentage number of elderly caregivers earned less than R1000, which was not adequate to provide basic necessitates that, include health care and education to the orphans.

Respect and crime were the some of the main concerns of the elderly care givers, a similar concern raised by most elderly that urgently needs to be addressed. Most elderly care givers relied on paraffin as a source of heating and cooking which had a negative impact on their health especially in regard to breathing as a result of inhaling of the smoke.

The majority of elderly care givers got no support for their efforts, yet they were expected to provide basic necessities to those they are taking care off. Financial support was urgently needed to fully support orphans, not just in regard to food but also to send the orphans to school and provide proper health care for the sick.

Of great concern was that most elderly care givers indicated that health facilities were bad which did not bode well for their efforts for the sick to get proper health care. This is compounded by the fact that most elderly caregivers had to travel more than 5 kilometres to get to the nearest health centre. This may partly explain why most elderly relied on community based care to treat the sick.

CHAPTER EIGHT

DISCUSSIONS AND RECOMMENDATIONS

8.0 INTRODUCTION

The existing literature suggests that the ageing phenomenon is set to rise due to sustained declines in fertility, resulting from low infant, child and maternal mortality which is in line with the Demographic and epidemiological transition theories that indicated that a decline in pestilence would lead to the fall in mortality levels leading to a rise in fertility contributing to population growth. Further improvements in health would have led to more decline in mortality leading to a fall in fertility levels. This has contributed to the current rise in the global elderly population. However, the pace of the growth of the ageing population is set to be higher in the developing world as a result of the faster reduction in fertility rates over a shorter period of time than in to the developed countries. In the context of Africa, particularly sub-Saharan Africa, fertility and mortality levels are moderately high in comparison with global standards (Kinsella and Philips, 2005:16) indicating that more children are born each year leading to a greater younger population. But a few sub-Saharan nations like South Africa already have lower fertility and mortality levels which have led to the rise in the proportions of the elderly population such that by 2030, South Africa's elderly population is set to rise to 11%.

Population ageing is seen as one of the world's greatest achievements in the sphere of public health, medical advancement and economic development over illnesses of the elderly and injuries that had prevented the rise in the life expectancy for millennia. But the growth in the ageing population has also brought many challenges regarding the wellbeing of the elderly particularly in developing countries and who are faced with low levels of socio-economic development characterized by poor infrastructure and low per capita income. The HIV/AIDS pandemic has brought an added burden for the elderly in the form of care-giving at a time when they are ill equipped to assume such a role due to limited resources, thus putting them at a greater risk of themselves contracting the virus.

Consequently, the aim of this study was to analyse the socio-economic and demographic needs and concerns of the elderly in the era of HIV/AIDS in the Mafikeng Local Municipality of the

North West Province of South Africa. It was imperative that this study clearly understood the concerns of the elderly in the face of a growing threat of HIV/AIDS that is threatening to plunge them further into poverty. This chapter therefore, presents the summary of the findings developed from the data collected from the elderly respondents. Based on the findings of this study, relevant criteria are outlined as recommendations for the improvement of the living conditions of the elderly and those they take care of.

8.1 GROWTH OF THE ELDERLY POPULATION IN THE MAFIKENG LOCAL MUNICIPALITY OF THE NORTH WEST PROVINCE

The first objective of the study was to examine the growth of the population of the elderly in the Mafikeng Local Municipality. This was done by looking at the growth of the population of the elderly in relation to the overall population between the 1996 and 2001 censuses. The results did not yield any significant growth in the population of the elderly between the two censuses, however the ageing index between the two censuses rose from 15 persons 60 years and over for every 100 persons under the age of 15 years to 19 persons 60 years and over for every 100 persons under 15 years in 2001. In the same period the dependency ratio had risen, an indication of the growth of the population of the elderly between the same periods. Using the community survey of 2007, the results show that the elderly population in relation to the overall population grew, albeit by just 0.5% from 6.2% in 2001 to 6.7% in 2007. This does indicate that the Mafikeng Local Municipality is in the fourth stage of the demographic transition theory which indicates that fertility levels are declining due to further declines in the mortality levels. There was also an initial increase in the life expectancy of the population of the Mafikeng Local Municipality before the rise in the HIV/AIDS prevalence rates.

8.2. THE SOCIO-ECONOMIC AND DEMOGRAPHIC CONCERNS OF THE ELDELY

The second objective of this study was to examine the socio-economic, health and demographic concerns of the elderly. From a demographic point of view, the results revealed that there were more elderly female respondents than male elderly respondents (66% versus 34%), which is in line with most studies that show that there are more elderly females as a result of a higher life expectancy at birth (Help Age international 2002:8a; Velkoff and Lawson, 1998:2; Kinsella and Philips,2005:23). Because they live longer than their elderly

male counterparts, females carry the burden of providing care to the sick and the very old family members.

Most elderly respondents were in the younger elderly age bracket of 60-69 years (52%) which bodes well for overall care of the infants and possibly the sick. However the majority of them indicated that they had lost a child / children, possibly to the pandemic, given its high prevalence rate. The majority relied on government pension (92%) which to a large extent enabled them to support their families given the high unemployment rates. This explains why the majority of the interviewed respondents indicated that they did not save (78%) simply because of the burden of support they had to their families. This was further supported from the responses from the focus group discussions were caregivers blamed high unemployment especially in the rural areas for their inability to save. In this regard it can be argued that development is polarized towards the urban areas (Ledent, 1982:509). It is no wonder that the majority of elderly who earned less than R1000 had social problems since they have to spend on food, clothing and education.

In addition, the use of paraffin/wood for heating and cooking was a common occurrence amongst the elderly. This may have negative implications for their health and that of those they live with. Because of insufficient funds most of the elderly people may not be in a position to repair their homes

It is often believed that traditional family structures and norms of respect mean that elderly people are well supported and protected by their communities and their immediate families play an active role to ensure that they do receive the necessary attention that can make their overall participation in communal activities as simple as possible. Unfortunately, the results have shown that most of the elderly people (69%) were more likely to have social problems. A lack of respect may suggest that the elderly respondents might be subjected to physical and emotional abuse which the results in this study have supported. Most of the elderly, due to their frail nature, may not be in a position to protect themselves and have to turn for help to the very community that does not show them respect.

Similarly, the results indicate that most of the elderly were affected by crime and where not respected by their communities (62% and 69%).It is no wonder that those elderly who were

less respected were 25 times more likely to have social problems. However, it may not just be the elderly that are affected by crime, but the community in general. The high unemployment rates may lead to the rise in social ills such as theft that may ultimately affect the elderly.

8.3 HEALTH ISSUES AFFECTING THE ELDERLY

The majority of elderly respondents did not have any disability status which may be due to the fact most elderly were still in the younger elderly age bracket as already seen (51%) this would enable them to continue with their daily household chores. This is supported by the fact that those most elderly respondents did not have any difficulty doing household chores (59%), with a bigger percentage number not having any body pains (75%). The general indication is that most elderly were in good health, supported by the results of 80.6%.

Older peoples' ability to remain healthy may be influenced by the existing health facilities at their place of residence, which may also determine their accessibility and whether they are affordable. As a result most elderly respondents who live in the rural areas had health problems (75%) which may be due to any of the above factors.

Several other aspects of their living conditions that may also impact negatively on their health include the use of wood/paraffin for cooking and heating. This unfortunately, was a common occurrence, as the results show that the elderly respondents who used electricity for heating had better health compared to those using wood/paraffin. In addition, the multivariate results have shown that the elderly respondents that used paraffin or wood as a source of heating are 4.6 times more likely to have health problems. Furthermore elderly respondents who were either widowed or divorced were 2.7 times more likely to have health problems which may be due to be related to the fact that they live alone and may require some form of support especially those who are in their advanced ages.

8.4 HIV/AIDS AND CARE-GIVING

The third objective was to investigate the effect of HIV/AIDS on the elderly as care-givers in the selected areas of the Mafikeng Local Municipality. The HIV/AIDS pandemic has affected nearly all families with the death of at least one family member, particularly in sub-Saharan Africa where the prevalence rates are relatively high compared to other regions. Therefore, in

attempts to stem the spread of the pandemic, efforts have been made by local and National Governments together with non-governmental organizations to inform the general public through various media sources about ways of protecting themselves from contracting the virus. Consequently, the results from this study show that irrespective of place of residence, the majority of the elderly had heard of HIV/AIDS (93% versus 7%), particularly from the media such as the radio and also from family members.

Providing care for the sick and the orphaned children requires a lot of socio-economic and moral support, yet the results in this study show that the elderly, the primary care-givers, receive no support (75% versus 25%) at a time when they themselves need care and support. This support which includes constant physical and emotional care of the sick, provision of health care, feeding and provision of education to the orphaned children require, amongst others, financial assistance which was what most elderly care-givers indicated was essential in sustaining the overall wellbeing of the sick and the orphaned children.

In addition, basic necessities like food, clothing etc (41%), according to the results, were mostly required care-givers to adequately take care of the sick. However, the meagre pension received by the care-givers was already stretched to the limit through support of extended kin and this may lead to the elderly households becoming destitute. This may lead to orphaned children dropping out of school and reducing their survival chances in life. The recent rise in basic food prices and other commodities may have worsened the elderly care-givers' situation such that they now got less for the same amount of money spent on items like food.

Apart from the need to have sound financial backing, other aspects like access to health care is critical if the sick have any chance of maintaining their good health. The results indicate that the majority of elderly caregivers (91%) had to travel more than 5 kms to the nearest healthcare centre. The inadequate road networks in the rural areas also suggests that public transport was either too expensive or unreliable which may lead to care-givers taking extreme measures of having to walk to the nearest health centre in an effort to get urgently needed medication for their sick. This may be influenced by the age of the elderly care-giver and the distance to the nearest health centre from their households. The older cohort of elderly care-givers may not be

in a position to walk due to their frail nature which may thus reduce the chances of survival of the sick who are totally dependent on them for care.

In dealing with the concerns of the elderly, the government proposed an Elderly Bill in 1998 which was finally amended and passed in 2006 to safeguard elderly rights and spelled out obligations of those departments and non-governmental organizations that provide services to them. However, when zooming into the issues that emerged from the findings it is evident that there is still a lot of work that lies ahead to further improve the livelihoods of the elderly particularly those elderly care-givers who need urgent help. The pandemic continues to plunge their livelihoods into further poverty with no support, poor road networks, particularly in the rural areas and total neglect from government and non-governmental organisations in including them in preventative measures.

Taking into consideration the findings in this study, recommendations are made that try to provide some way forward in tackling these issues concerning the elderly.

8.5 RECOMMENDATIONS REGARDING ISSUES AFFECTING THE ELDERLY

This study has shown that the elderly respondents in the Mafikeng Local Municipality face several challenges with their plight further burdened by the current HIV/AIDS pandemic that has elevated by default the elderly to become parents again with little or no support. Based on these findings, this study makes recommendations that are discussed below.

8.5.1 Further understanding of the implications of being an elderly person

There is a great need to embrace the ageing population in the way developed countries have done. This means, amongst others, critically examining the general living conditions of the elderly people and the local government providing subsidized services like housing so that the elderly may be in a position to live in proper homes. This may keep them warm particularly in the winter periods, but they must also be suitable for their needs in terms of mobility. Overcrowding which is a common occurrence, particularly in the rural areas, may be eased by providing adequate housing suitable for the extended kin.

8.5.2 Poverty alleviation

Elderly people are consistently among the poorest of the poor in most local communities. But in the context of a few developing countries like South Africa, the elderly have social security provided by the national government which has prevented them from facing socio-economic hardships. This has helped in achieving the first Millennium Development Goal which is eradicating extreme poverty and hunger. However, this pension grant is meant to provide for the immediate needs of the elderly and does not take into account the various indirect needs that face them, especially those related to caring for an undetermined number of sick or unemployed dependants. These factors need to be examined and addressed. There needs to be a concerted effort to create policies and programmes that may lead to job opportunities for their unemployed adult children who, up until now, rely on their elderly parents' pension for support. This has made saving very difficult for the elderly since all their pension goes into providing for their households. All forms of socio-economic development must place more emphasis on rural development where most of the elderly households live. This will give a chance for their adult children to be employed and lessen the support burden on the elderly. Also, opportunities for employment must target the younger old, especially local community projects created and sponsored by non-governmental organizations and community based organizations that may help supplement their pension. In addition, the recent rise in prices of basic commodities like food means that low income earners are adversely affected in such a way that they have to spend more for less. Therefore, there is need for low income groups like the elderly to be exempted from taxation on such basic commodities like food. This may help cushion the high prices placed on such commodities. The informal sector which does not have any social security systems must be urgently looked into since a significant number of people work in this sector, yet they do not have any guaranteed income security after retirement, leading them to be solely dependent on national government for support.

8.5.3 Respect and Abuse

Today, as a result of the existing challenges placed on communities, elderly people play a significant role in supporting their families. Yet it is unfortunate that they are subjected to abuse and lack of respect from their communities. These situations of disrespect and abuse

arise because the elderly people are portrayed as a liability to society and a drain on government and family resources. A more balanced view of ageing (one that gives attention to their authority, knowledge, dignity and caution that comes with a lifetime of experience) is needed both to increase the self-esteem of the elderly and to improve their contribution to development. The Older Persons Bill of the Republic of South Africa was promulgated in 1999 and amended in 2006 to, amongst others, safeguard the rights of elderly people and together with the Madrid International Plan of Action on Ageing clearly states that all governments, National and Local, with the collaboration of Non-Governmental Organizations and Community-Based Organizations must ensure that their rights are upheld. This means that communities must be sensitized about the rights of the elderly as members of society which may help do away with stereotypes about them. This may be partly achieved by involving the elderly in community activities and decision making which may show their potential in helping to build their communities, even at their advanced ages.

Similarly, there is a need for tougher legislation by local government against abuse of the elderly, which may go along way in safeguarding the dignity of the elderly. This may also necessitate the improvement of channels for older people to have access to legal service through public education. Elderly people must be encouraged to speak out about issues of abuse amongst them and make sure that they are respected by their communities as enshrined in the South African Constitution.

8.5.4 Elderly representation

The local government together with the assistance of International and national agencies must create an elderly body that will represent their concerns or experiences of being elderly in their communities. Such a body would help provide first hand information of their needs thus ensuring the participation of the elderly in community development issues. It would also help communities understand the role of the elderly and how they can contribute to societal issues through dialogue with the communities they reside in. This can only make their conditions better in relation to their community.

8.5.5 Health for the elderly

The demand for health services is bound to increase substantially with a demographic transition marked by the continued rise of the elderly, especially in the rural areas where they reside after retirement. The elderly are usually prone to diseases resulting from the natural physiological and biological deterioration of their bodies and mind. This will require a drastic rise in the provision of services best suitable for their conditions. Policy options need to address these emerging health needs geared at serving the elderly, hand in hand with health education on how to maintain a healthy lifestyle like eating healthy foods, doing physical activity and prevention of unhealthy and risky behaviour. This would go a long way in prolonging the life of the elderly and also reduce health costs to a minimum. The World Health Organization estimates that by 2020, chronic diseases, along with mental health and injuries will make up three quarters of health care needs in developing and newly industrialized nations(Help Age International 2002:8c), hence the above policy options need an urgent rethink. The above can only be realized if local governments provide the necessary health infrastructure which today is either too far from the residences of the elderly or non existent and together with civic society they can help monitor the health progress of the elderly to ensure that they maintain proper health care.

In supporting civil society and local governments' efforts to keep the elderly healthy, communities must be empowered with resources and technical expertise on how to care for the older persons in the community, especially the next of kin who could also assist the elderly by encouraging them to be physically active. All these are strategies to prevent disease and disability.

8.5.6 HIV/AIDS and care-giving

There is a plethora of information showing that the elderly people are the last defence of hope in caring for the sick and orphaned children. This means that there is an urgent need to involve the elderly in HIV/AIDS campaigns on how to adequately take care of the sick and at the same time protect themselves from infection during the provision of care to those that are sick. With the help of agencies, programmes must be designed to enable the elderly people to access HIV/AIDS information through public meetings and community health workers. In addition

the myth that the elderly are no longer sexually active because of their age must be discarded and HIV/AIDS campaigns must also involve the elderly people through various media organs using appropriate local languages so that the elderly can understand the importance of protecting themselves.

One of the targets of the Millennium Development Goals is to reverse the spread of HIV/AIDS by the year 2015. This means recognizing the role that older women and men play in supporting the achievement of this goal through several local and international organisations like Help Age International that have placed their efforts in Africa to create income generating projects that help the elderly and also to advise older carers of orphans and the sick. Such initiatives must reach the rural areas so that all elderly carers can benefit from those projects that will go a long way in providing some form of comfort to them. All HIV/AIDS programmes must involve the input of the elderly care-givers so that policies created will take their experiences in care-giving into consideration and therefore lead to better understanding of what the care-givers face during their daily activities of providing care. Elderly care-givers must be educated about medication such as Anti Retrovirals and provided with any other information relevant to their use.

Similarly, the local governments need to factor in financial support structures for elderly care-givers in their budgets since such finances would be able to cover medical costs of those that are sick, while non governmental organizations and community-based organizations can partner local government efforts by monitoring elderly care-givers in their efforts in trying to provide adequate care to their households. The child support grant may go some way in providing some relief for orphans in the form of clothing; however, these orphaned children also need to have an education which the child support grant does not cater for. This is why there is the need for free educational concessions for orphaned children at least up to a post-primary certificate level.

8.6 **Areas for Future research**

This study has highlighted some of the socio-economic issues affecting the elderly and the disturbing situation of those care-givers who have the additional task of providing for the sick and orphans with socio-financial implications.

8.6.1Understanding coping mechanisms in socio-economic situations

There is a need to critically understand the coping mechanisms of elderly households particularly in situations where there are inadequate basic commodities like food in the home. This situation may arise due to lack of funds that have been exhausted mainly due to the reliance on one source of income, the pension, to sustain large extended families particularly in the rural areas. Rising costs of staple foods and other basic commodities are making the situation more difficult with the current pension for the elderly which buys less than it used to, meaning that more is spent for the same basket of commodities. It is hoped that this would help to shed more light on the survival strategies of the elderly households and possibly help provide ways of safeguarding the livelihoods of such households in difficult situations.

8.6.2 Understanding the roles of elderly and their needs as care-givers

The roles of the elderly and their needs as care-givers in the fight against HIV/AIDS pandemic are not recognized and as such they do not receive any form of support, yet they are the last hope for those infected by the HIV/AIDS virus. There is an urgent need to involve their experiences in HIV/AIDS interventions that may ultimately lead to proper guidelines on how to properly take care of the sick. This may be achieved if further research is done to fully understand elderly experiences in providing care and hopefully adequate attention shall be provided to not only the elderly but also those relatives or friends who are care-givers. In addition to prevent selection bias, a reasonably representative sample on issues related to care-giving and HIV/AIDS must be gathered that would provide a clear insight and signpost proper and realistic policy designs.

8.6.3 Elderly affected and infected by the HIV/AIDS pandemic

Very little research seems to have been done on the prevalence rates of the elderly who are infected with the HIV/AIDS virus, mainly because the focus has been on the very young that get infected from "mother to child blood transmission" and those in their reproductive years. Such is the case that all forms of prevention strategies are focused on the above population groups with an overwhelming assumption that most of the elderly are no longer sexually active. Already, the literature on HIV/AIDS prevalence amongst the elderly in the developed countries suggests that there are significant numbers of the elderly being exposed to secondary infection by the HIV/AIDS virus, which strongly indicates that enough data on their plight needs to be sought to get a clearer understanding of their situation, which may also help dispel any myths about their non sexual involvement because of old age.

8.6.4 Understanding community perceptions of the elderly

It has been assumed that since the elderly are the most senior people in society and because of their vast life experiences, they are treated with respect and all members of society have an obligation to safeguard their rights. However, this is not the case since this study has highlighted that most of the elderly, irrespective of place of residence, are not respected. There is a need to understand what the factors/ reasons are behind the disrespect for the elderly amongst the communities they live in given their frail nature. Current socio-economic hardships amongst communities leading to social ills like crime may contribute to the lack of tolerance of the elderly. However, given the fact that most of the elderly provide support to their immediate families, there is a need to have a deeper understanding of why there is a general lack of respect which may boost the need for policy interventions.

8.7 SUMMARY

In conclusion, the above recommendations may go a long way in making the elderly live better lives with the support of the community and recognition of their efforts in the form of care-giving to the young and the sick. However, governments must encourage more research on the question of the elderly which would possibly lead to informed policies to adequately support them.

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Definition of terms

1. **Older person,** according to the South African Older Persons Bill (2003), is a person who, in the case of a male, is 65 years of age or older and, in the case of a female, is 60 years of age or older (Republic of South Africa,2003:3).
2. **Developing countries:** – Countries that are generally characterized by low levels of industrialization, personal incomes, educational attainments and health standards.
3. **Developed countries:** – Countries that are generally characterized by high levels of industrialization, personal incomes, educational attainments and health standards.
4. **Life expectancy:** – The average number of years that a person in a given country may expect to live or the additional years a person could expect to live at the current mortality trends. The average life expectancy for people in a developing country is 61 and for developed countries is 74(Wikipedia,2008:1)
5. **Household**: – This is a group of persons who live together and provide themselves jointly with food and/ or other essentials for living. It can also be defined as one or more persons occupying a housing unit (Statistics South Africa, 2004a:10).
6. **Sampling methods**: – tools used to select a sample population for a study. They are classified as either probability where each member of a population has an equal chance of being selected or non-probability sampling methods where members are selected from the population in some non-random manner (Bless and Kathuria,1993:23)
7. **HIV/AIDS** :– According to the Web, HIV/AIDS is Acquired Immune Deficiency Syndrome or acquired immunodeficiency syndrome (AIDS or Aids), a collection of symptoms and infections brought about through destruction to the immune system by the immunodeficiency virus (Wikipedia,2007:1).
8. **Demographic Transition Theory:** – This is the historical shift of birth and death rates from high levels to low levels. The decline in death rates begins before the drop in birth rates leading to explosive growth in population, as is the case in many developing countries (Weeks,1999).
9. **Epidemiological Transition Theory**: – This shows the long-term changes in health and disease patterns as mortality moves from high levels to low levels. The changes vary from developed to developing countries (Omran, 1971:21).

10. **Urban area**: – This is a place or area with a specified minimum number of people or population density. In this case densely populated fringes around towns or municipalities may be classified as urban. A population of 2000 or more is considered urban (Statistics South Africa, 2004a:20).
11. **Rural area:** - This is any area that is not classified as urban. It may be sub-divided into tribal areas and commercial farms as is the case in South Africa (Statistics South Africa, 2004a:17).
12. **Enumeration area**: – The smallest geographical unit or piece of land into which the country is divided for census or survey enumeration, of a size able to be effectively enumerated. According to Statistics South Africa Enumeration areas contain between 100 and 150 households (Statistics South Africa, 2004a:7).
13. **Wards:** – An area or areas containing several enumeration areas.
14. **Young population:** – A population with a relatively high proportion of children, adolescents, and young adults; a low median age; and thus a high growth potential.
15. **Ageing population:** – A population with a relatively high proportion of middle-age and elderly persons, a high median age, and thus a lower growth potential.
16. **Social security**: – A wide variety of public and private measures that provide cash or in-kind benefits paid out at low cost to people in an effort to avoid poverty and maintain the household.(Wikipedia,2010:1)
17. **Care-giving**: – This is giving assistance to other people or infants who because of physical disability, chronic illness or cognitive impairment are not able to do day-to-day activities without any kind of help. Caring for others can take three forms: Instrumental, informational and emotional.(Drentea, P.2007:1)
18. **Population pyramid:** – A population pyramid is a graphical representation of a population's age and sex composition. By showing the numbers of males and females in each age group, the pyramid displays a clear picture of the populations' characteristics (Wikipedia, 2007:1)
19. **Mortality**: – These are deaths that occur within a population. There are several forms of mortality based on the age category of the population, which include infant mortality rate, child mortality rates and maternal mortality rates (Weeks, 1999:23)

20. **Fertility:** – This refers to the number of live births occurring in a population. The average number of children that would be born to a woman during her lifetime is referred to as the total fertility rate (Weeks, 1999:36).

Appendix 1

AGEING AND ITS SOCIO-ECONOMIC PROBLEMS IN THE ERA OF HIV/AIDS

INSTRUCTIONS

Dear participant, I am a student at the North West University, Mafikeng Campus. I am conducting a study that examines the socio-economic problems of the elderly in the era of HIV/AIDS in the Mafikeng Local Municipality. I am kindly requesting you to take part in this study which is optional. Your response will be strictly kept confidential and will be used for academic purposes only and will not be given to any other person. You can refuse to answer any question and may stop the interview at any time. May I continue?

IDENTIFICATION

2.1 Household No. | | | |

2.2 Zone Number and/or name of residential area : _____

2.3 Household street address/house or dwelling number: _____

2.4 Name of the respondent : _____ Telephone No.: | | | |

2.5 Number of people living in household : | | |

2.7 Type of household | 1 | Nuclear | 2 | Single | 3 | Extended Family | 4 | Co-habit

INTERVIEWER VISITS

		First visit	Second visit	Third visit
Date: YY/MM/DD				
Interviewer's name				
Result*				
Next visit:	Date			
	Time			

Total No. of visits: | |

* Result codes:	
1	Completed
2	Partly completed
3	Refused (specify reason if any)
4	Postponed
5	Other (specify)

EDITING AND CODING INFORMATION

Field edited:	
Date:	
Coded by:	
Date:	
Captured by:	
Date:	

Section 1: COMPOSITIONS OF HOUSEHOLD

	Usual residents	Relationship to respondent	Sex	Age	Govt grants	Education level	Employment Status	Ask for children under 18 years	
ID no	Names of the people who usually live in this Household	What is the relationship of (names) to you? 1=Self 2=Spouse 3=Son/daughter 4=Grandchild 5=Mother/father 6=Grandparent 7=Son/daughter in law 8=Other relative 9=Not related	Is (name) male or female?	How old she/he?	Does (name) receive any grants from Govt? 1=Old age pension 2=Disability grant 3=care dependency Grant 4=Child support grant 5=Foster grant 6=Other 7=No grant	What is the highest level of education 1= No Education 2=primary 3=Secondary 4=Tertiary	What is (name)'s current employment status?	Main Caregiver for (name)? Use same codes as in (3)	Does (name) attend a crèche or school? 1= No 2= Crèche 3= School
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
01									
02									
03									
04									
05									
06									
07									
08									
09									
10									
11									
12									
13									
14									

Section 2: Income, Expenditures and Household assets

2.1 Note name and ID code number from Household list of respondent for this section. Kindly circle or tick the codes/numbers that represent the responses of the participants

Name:	ID code number:

2.2 What is the main source of income in your Household?

Source type	Main Source
Salaries and wages	01
Remittances from outside HH	02
Government Old age pension	03
Private old age pension	04
Government Disability grant	05
Care dependency grant for disabled children	06

Source type	Main Source
Child support grant	07
Foster care grant	08
Grant in Aid	09
War veteran's grant	10
Loan from family	11
Other	12

2.3 How consistent is this source of income? By consistent I mean do you get this income monthly?

Consistent	01
Not consistent	02
Don't know	03

2.4 Who is the main breadwinner in your Household?

Son	01
Daughter	02
Son-in-Law	03
Daughter-in-law	04

Grandchildren	05
Spouse/partner	06
Self	07
More than one person	08

2.5 Who makes the decisions about how to spend the money in the Household?

Everyone makes decisions about their own money	01
I make them because I am the household Head	02
I make the decisions but am not the head	03

The Household head makes the decisions not me	04
The younger members make the decisions	05
We discuss together	06

2.6 What do you mainly spend your income/money on?

Household necessities like food, groceries	01
Clothing	02
Rent/accommodation	03
Other	07

Transport	04
Education	05
Water and Electricity	06

2.7 Do you own a house?

Yes	1
No, live in a rented house by government	2
No, live in a rented house by private individual	3
I do not know	4

2.8 Do you own agricultural land?

Yes	1
Yes, but leased it out	2
No, hired in	3
No	4

I do not know	5

2.9 Do you own any of the following (Circle any of the following options)

Motor vehicle	1
Bicycle	2
Motor bike	3
None of the above	4

Section 3: General information on the respondent and his/her household

Instructions

Interviewer: The following sections are to be completed by the each elderly person in this household. In this case an elderly person is one who is 60 years and older. Kindly circle or tick the codes/numbers that represent the responses of the participants. Each section must be read out to the elderly respondent.

3.1 Note name and ID code number from Household list of respondent for this section. Kindly circle or tick the codes/numbers that represent the responses of the participants

Name:	ID code number:

3.2 Gender of Respondent

Male	1
Female	2

3.3 Race

Black African	1	Indian	3
Coloured	2	White	4

3.4 Area type. By Area type I mean areas classified according to characteristics of a residential population in terms of urban and rural.

Urban	1
Rural	2

Migration

3.5 Have you lived in the North West (Mafikeng area) since birth?

Yes	1	No	2	**IF 'NO', GO TO QN3.9**

3.6 If you have not lived here since birth, where did you live before you came to live in your current home? In what province did you previously live?

Within the North west	1
Other provinces in South Africa, specify	2
Another country	3
Don't know	4
Never moved	5

3.7 What was the main reason for moving? **(CIRCLE 1 OPTION)**

Removal by Government/municipality	1	Moved for better services/housing	4
Got married /divorced	2	Family/ community feud	5
Job related	3	Crime	6
Other (specify)	7		

3.8 What type of area was the place where you lived?

Urban- Town/City	Formal	1
	Informal	2
Rural	Traditional (e.g. ex-homelands; villages)	3
	Formal (e.g. commercial farms	4

Fertility

3.9 **a)** How many of your biological children are still alive, living with you or are staying somewhere else? ☐☐

b) How many of them are currently employed? ☐☐

3.10 **a)** How many daughters or sons-in-law are still alive, living with you or are staying somewhere else? ☐☐

b) How many of them are currently employed? ☐☐

Mortality

3.11 **a)** Have you ever had a boy or girl child who was born alive but later died?

Yes	1	No (Skip to question 3.12)	2

b) If yes how many of your children have died? ☐☐

c) What was the cause of death? (Circle one option)

Diabetes	1
TB	2
HIV/AIDS	3
Cancer	4
Accidental injury	5
Injury through assault	6

3.12 How many son or daughters in law have died? ☐☐

3.13 What kind of toilet does this household use/have?

Flush toilet in dwelling	1	Flush toilet communal	3
Flush toilet in yard	2	None	4
Others (specify)	5		

3.14 What is the most often used source of drinking water by this household?

Piped water in dwelling/yard	1	Dam	5
Public or communal tap	2	Spring	6
Water carrier/tanker	3	Well	7
Borehole	4	Other, specify	8

3.15 What fuel do you mainly use for cooking and heating?

Electricity	1	Coal / charcoal	4
Gas	2	Wood and coal	5
Wood	3	Paraffin	6
Other (specify)	7		

3.16 What do you mainly use for lighting?

Electricity	1
Gas	2
Candles	3
Paraffin	4
Other (specify)	5

3.17 How was your standard of living before 1994?

Okay/Fine	1
Better than Today	2 (skip next two questions)
Very Bad	3
Don't know / Can not say	4

3.18 Has your situation improved, got worse or remain the same in the last 10 years since 1994?

Improved	1
Stayed the same	2 (skip next question)
Got worse	3

3.19 You told me that your situation has (worsened / improved). Can you tell me why this has happened?

Retired, no longer earning	1
Receiving Old age pension	2
My children looking after me	3
My children have forgotten me	4
My children have died	5

My spouse who was earning has died	6
I am receiving a CSG	7
Lost my home	8
Other (specify)	9
Don't know	10

3.20 What is your age? (Or note down from Household listing)

3.21 What is your current marital status? ('With Children 'refers to children who are alive. If all children have died then use 'without children')

Married	With children	1
	Without children	2
Live together	With children	3
	Without children	4
Divorced	With children	5
	Without children	6
Widower / widow	With children	7
	Without children	8
Never married	With children	9
	Without children	10
Other (specify)		11

Section 4: Education

Instructions

Interviewer: This section examines the educational background of the elderly person in this household

4.1 Have you ever attended adult education classes to learn to read and write?

Yes	1	No	2	Don't know	3

4.2 How many years of schooling do you have?

4.3 What is your highest level of Education?

No Education	1	Primary	2	Secondary	3	Tertiary	4

Section 5: Employment

Instructions

Interviewer: This section examines the employment status of the elderly person in this household

5.1 Have you ever had a job?

Yes	1	No	2

5.2 What is your current employment status?

Unemployed, not looking for work	1
Unemployed, actively looking for work	2
Work in informal sector, not looking for permanent work	3
Work in informal sector, permanent looking for work	4
Social grant recipient	5
Housewife, not working at all, not looking for work	6
Housewife, not looking for work	7

Student/learner	8
Self-employed-fulltime	9
Self employed-part-time	10
Volunteer	11
Other (specify)	12
Employed part-time	13
Employed full-time	14

5.3 If you are married or have a partner (living with you or not), what is his/her employment status? (Skip this question if the respondent is a widow or widowed)

Unemployed, not looking for work	1
Unemployed, actively looking for work	2
Work in informal sector, not looking for permanent work	3
Work in informal sector, looking for permanent work	4
Social Grant Recipient	5
Housewife, not working at all, not looking for work	6
Housewife, looking for work	7

Student/learner	8
Self-employed – full time	9
Self-employed part time	10
Employed part time(if none of the above)	11
Employed full time	12
Volunteer	13
Other (specify)	14

Section 6: Media Access

Instructions

Interviewer: This section looks at the accessibility of the media by the elderly respondent in the Household

6.1 What is your main source of information about events, news, and things like that, etc? (Circle 1 Option)

Radio	1
TV	2
Family members	3
Other (specify)	7

Pamphlets or posters	4
Newspaper	5
Community meetings	6

6.2 What TWO (2) radio stations do you listen to most? (GIVE 2 OPTIONS)

a) _____

b) _____

6.3 Which TWO (2) TV stations/channels do you watch most often? (GIVE 2 OPTIONS)

a) _____

b) _____

6.4 Which TWO newspapers/ magazines/books do you read most often? (GIVE 2 OPTIONS)

a) _____

b) _____

6.5. Can you easily get or access information you need to carry out your activities?

Section 7: Health Status

Instructions

Interviewer: This section examines the health status of the elderly person, including those with disabilities.

READ OUT: I want to ask you about your overall health, which includes your physical and mental state.

7.1 In general, how would you rate your health today?

Very good	1	Good	2	Moderate	3	Bad	4	Very Bad	5

7.2 When you get ill/sick how do you pay for your medical expenses?

Medical aid	1
Cash/pension money	2
In kind	3

The following questions look at the elderly person's health in the last 30 days. The responses to the questions range from no difficulty to extreme difficulty. They include; 1) no difficulty; 2) mild difficulty; 3) moderate difficulty, 4) severe difficulty or 5) extreme difficulty or an inability to do the activity.

Do you find any difficulty doing the following;		None	Mild	Moderate	Severe	Extreme/ Cannot do
7.3	Doing work or household activities?	1	2	3	4	5
7.4	Moving around the house or outside?	1	2	3	4	5
7.5	Providing self-care, such as washing or dressing yourself?	1	2	3	4	5
7.6	Have bodily aches or pains?	1	2	3	4	5
7.7	Concentrating or remembering things?	1	2	3	4	5
7.8	Having personal relationship?	1	2	3	4	5
7.9	Participation in the community?	1	2	3	4	5

7.10. Have you got any injuries due to movement within the house in the past 12 months?

Yes	1	No **(Skip to question 7.13)**	2	I don't know**(Skip to question 7.13)**	3

7.11. If yes did you go for any medical treatment for your injuries?

Yes	1	No	2

7.12. Who took you to hospital for medical treatment?

Spouse/partner	1
Children	2
Grand children	3
Friends/neighbours	4
Relatives	5

Disability

Interviewer: This sub section examines those elderly people with disabilities in each household. Those elderly with no disability or who don't know may skip this sub-section

7.13 Do you have a disability?

Yes	1	No	2	Don't know (Skip to next question	3

7.14 If yes, what is your main disability?

Physical	1
Mental/ psychological	2
Hearing	3
Other (specify)	7

Vision	4
Communicating	5
Cognitive (memory, thinking)	6

7.15 How old were you when this disability started?

_____

7.16 Do you use any assistive devices such as walking sticks, wheelchair, magnifying glass, etc?

Yes, all the time	1	Yes, Sometimes	2	No	3

7.17 If yes, please specify what device you use.

_____

7.18 How satisfied are you with your health?

Very satisfied	1
Satisfied	2
Very unsatisfied	5

Neither satisfied nor unsatisfied	3
Unsatisfied	4

Section 8: Services needed and received

Instructions

Interviewer: This section examines the needs of disabled elderly people in this household.

Services		Have you Needed any of the following services during the past six months?		If yes Did you receive the services you needed?		Quality of service 1= very good, 2= good; 3= not good or poor; 4= poor; 5= very poor
		Yes	No	Yes	No	
8.1	Regular health care (clinic or GP)	1	2	1	2	
8.2	Emergency Health care (hospital and ambulance)	1	2	1	2	
8.3	Community or institutional care for elderly	1	2	1	2	
8.4	Rehabilitation and/or assistive devices	1	2	1	2	
8.5	Welfare services-e.g. care, food parcels, counselling etc.	1	2	1	2	
8.6	Social grant services (OAP, DG, CSG, CDG, Foster Care Grant)	1	2	1	2	
8.7	Recreational	1	2	1	2	
8.8	Transport	1	2	1	2	
8.9	Religious	1	2	1	2	
8.10	Employment/labour	1	2	1	2	
8.11	Housing	1	2	1	2	
8.12	Legal	1	2	1	2	
8.13	Other	1	2	1	2	

8.14 Which of these services would you select that are good in general (select up to three options)?

Pension pay out service	1
Health care	2
Public Transport	3
Municipal service	4
Other (specify)	9

Security	5
Infrastructure	6
Good housing	7
Old age homes	8

8.15 Which of the services listed below do you think need to be improved (select up to three options)?

Pension pay out service	1
Health care	2
Public transport	3
Bad/ poor Municipal services	4
Other (specify)	9

Poor/ lack of physical Infrastructure	5
Security	6
Lack of old age home	7
Lack of/ poor housing	8

I want to ask you about how accessible different places are for you. By accessible I mean how easy it is for you to reach them and get into them.

Place		Accessible	Accessible With difficulty	Not accessible	There are none	Don't use
8.16	Own dwelling, toilet	1	2	3	4	5
8.17	Water source	1	2	3	4	5
8.18	GP or Clinic	1	2	3	4	5
8.19	Place of worship	1	2	3	4	5
8.20	Post office or Bank	1	2	3	4	5
8.21	Pension pay point	1	2	3	4	5
8.22	Shops, community facilities	1	2	3	4	5
8.23	Welfare office	1	2	3	4	5
8.24	Other govt offices	1	2	3	4	5
8.25	Other (specify)	1	2	3	4	5

8.26 What mode of transport do you use to get around?

Bus	1
Taxi/minibus	2
I walk	3 **(Skip next question)**
Other	4

8.27 Is the mode of transport you have mentioned above easily accessible from your home?

8.28 How long does it take you to go to the clinic or anywhere else using your usual mode of transport (e.g. car, bus, taxi or walking)?

Less than 30 minutes	1	More than 2 hours	4
30 to 60 minutes	2	Never go	5
1 to 2 hours	3	Don't know	6

8.29 How long does it take you to go to the nearest Social Security office or anywhere else using your usual mode of transport (e.g. car, bus, taxi, or walking)?

Less than 30 minutes	1	More than 2 hours	4
30 to 60 minutes	2	Never go	5
1 to 2 hours	3	Don't know	6

8.30 How much does your transport cost to get to the Clinic/GP or Social Security office or anywhere else?

Nothing (walk, get a free lift or never go)	1	R11 – R15	4
Less than R5	2	More than R15	5
R5-R10	3	Don't know	6

Section 9: Care giving and receiving (including assistance)

READ OUT: This section examines the elderly role in care giving activities to the members of this household. I would like to ask you about the care that you are giving to your children and grandchildren. By care I mean physical and emotional needs, not just financially First I will ask about any care that you give and then I will ask about any care that you need and receive.

9.1 Do you provide care for any adults because of an illness or impairment?

Yes, in the HH	1	Yes, out of HH but locally	2	No	3 **(go to question 9.4)**

9.2 If yes (to responses1 or 2), is this care giving.....

Full time	1	Part-time but daily	2	Occasionally	3

9.3 How many of the adults are helping you

Full time	1	Part-time but daily	2	Occasionally	3	None	4

9.4 Do you provide care to any children?

Yes, in the HH	1	YES, out of HH but locally	2	No	3 **(go to question 9.7)**

9.5 If yes (to responses1 or 2), is this care giving .....

Full time	1	Part-time but daily	2	Occasionally	3

9.6 How many of the children are helping you

Full time	1	Part-time but daily	2	Occasionally	3	None	4

(If the respondent does not provide any care then go to question 9.9)

9.7 Do you receive any payment, money or in kind, for this care giving?

Yes	1	Sometimes	2	No	3

9.7a If **'YES'** or sometimes who provides you with money or something in kind

Community Based organizations	1	Non-Governmental organizations	3
Local Government	2	Others (specify)	4

9.8 How much difficulty do you have with providing the care?

None	1	Mild	2	Moderate	3	Severe	4	Extreme/cannot manage	5

Instructions

Interviewer: The reminder of this section examines the caring needs of the elderly person of each household

9.9 Do you need any assistance to do the activities you need and want to do in everyday life?

Yes, generally	1	Yes, for specific activities (e.g. going to the bank or shops)	2	No	3 **(Go to next section)**

What type of assistance do you usually need, and how often do you receive it when you need it?

Assistance type		Needed		Receive		
		Yes	No	Yes	Sometimes	No
9.10	Care for self (Bathing, toilet, dressing, etc)	1	2	1	2	3
9.11	Domestic work (cleaning, cooking, etc)	1	2	1	2	3
9.12	Fetching water	1	2	1	2	3
9.13	Collecting firewood	1	2	1	2	3
9.14	Transport	1	2	1	2	3
9.15	Undertaking transactions (e.g. Collecting grant, etc)	1	2	1	2	3
9.16	Going to clinic, church, etc	1	2	1	2	3
9.17	Care for children and grand children	1	2	1	2	3
9.18	Care for sick HH members	1	2	1	2	3
9.19	Other (specify)	1	2	1	2	3

9.20 Who mainly or most often provides the care or assistance you need? (Circle all applicable options)

Son/daughter	1
Son/daughter in law	2
Grandchild(ren)	3
Other relative	4

Non-relative (excluding health workers)	5
Health worker	6
Social worker	7
Other	8

9.21 Do you pay the person, money or in kind, to take care of you or assist?

Yes	1	Sometimes	2	No	3

Section 10: Nutrition

Interviewer: This section looks at the Nutritional status of each elderly person in this household

10.1 On average how many meals do you have every day?

One	1	Two	2	Three or more	3

10.2 Do you ever go without any meal during the day because you do not have food?

Yes, often	1	Yes, sometimes	2	Never	3

10.3 Do any children in this HH ever go without any meal during the day because there is no food available?

Yes, often	1	Yes, sometimes	2	Never	3

10.4 Do any other adults in this HH ever go without any meal during the day because there is no food available?

Yes, often	1	Yes, sometimes	2	Never	3

On average how often do you eat the following? (Circle one of each)

Item eaten		Everyday	4-6 days	2-3 days	Once a week	Never eaten them
10.5	Meat or eggs	1	2	3	4	5
10.6	Vegetables	1	2	3	4	5
10.7	Fruits	1	2	3	4	5

Section 11: Experience of being older

Instructions

Interviewer: This section examines elderly perceptions on being an older person

I am going to read you things on what people have said it means to be an 'older person'. Tell me if you think these are necessary for being an 'older person' or not necessary. (Read each option out)

Perceptions		Necessary for being 'older'	Not necessary for being 'older'
11.1	Reaching a specific age	1	2
11.2	Having authority in one's family and household	1	2
11.3	Having children to look after oneself	1	2
11.4	Needing care	1	2
11.5	Being respected	1	2
11.6	Being frail	1	2
11.7	Taking on senior roles in the community, e.g. advising younger people	1	2
11.8	Being retired	1	2
11.9	Receiving a pension	1	2
11.10	Other (specify)	1	2

11.11 Would you like to get out of your house more often or are you satisfied with how much you get out of your house?

Would like to get out more often	1	
Satisfied with how often get out	2	**Skip next question**
Don't know	3	**Skip next question**
No response	4	**Skip next question**

11.12 Kindly state why you do not get out more often? (Select two options)

Reason	
Health problem	1
Lack of transportation	2
Feeling unsafe	3
Lack of assistance	4
No events to go to	5

Reason	
Not asked to participate/ not invited	6
Have to take care of the house	7
Have to take care of HH members	8
Other (specify)	9
Don't know	10

11.13 Do you find yourself feeling lonely?

Quite often	1
Sometimes	2

Almost	3
Don't know	4

11.14 Do you have someone you can trust and confide in?

Yes	1	No	2	Don't know	3

11.15 How much respect would you say young people show older persons these days compared to when were a child?

Much more respect	1
More respect	2
About the same respect	3

Less respect	4
Much less respect/ no respect	5
Don't know	6

11.16 In general, how safe from crime do you feel in your neighbourhood?

Completely safe	1	Slightly safe	4
Very safe	2	Not safe at all	5
Moderately safe	3	Don't know	6

11.17 Do you know any elderly person who has been affected by crime?

Yes	1	No	2 **(Skip next question)**

11.18 If **'YES'**, how? _____

11.19 Do you receive an old age pension?

Yes	1	No	2 **(Go to question 11.22)**

11.20 How safe do you feel when you collect your pension?

Completely safe	1	Slightly safe	4
Very safe	2	Not safe at all	5
Moderate safe	3	Don't know	6
Pension is paid into bank account	7		

11.21 Do you have to share your pension with others (family or not)?

Yes	1	No	2

11.22 Are you in a position to save money?

Yes	1 **(Skip next question)**	No	2

11.23 If no to the above question what is the main reason?

Pension I get is too little	1	Looking after extended family	3
I have to pay my debts	2	Basics like health, food too expensive	4

11.24 Who decides how to spend your pension money?

Myself	1	Younger members of the Household	4
Myself together with others	2	Children not living with me	5
Head of Household(not me)	3	Other (specify)	6

11.25 How long do you have to wait in a queue to get your pension?

Less than 1 hour	1	A whole day (7 –12 hours)	4
Between 1 and 3 hours	2	Sometimes I have to come back the next day	5
Between 4 and 6 hours	3	Pension is paid into bank account	6

11.26 Have you ever heard of someone whose pension has been stolen from him or her?

Yes	1	No	2 **(Skip next question)**

11.27 If **'YES'**, where was it stolen?

At the pension pay point	1	At home	3
Between the pay point and home	2	Other, specify	4

11.28 What do you do if you need extra money? (CIRCLE 1 OPTION FOR EVERY ROW)

	Yes	No
a) Borrow from family	1	2
b) Borrow from friends	1	2
c) Borrow from a loan shark/ Mashonisa	1	2
d) Sell assets e.g. furniture, clothes, radio, live stock	1	2

Tell me whether you agree or disagree with the following statements

		Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
11.29	Older people in my community experience a lot of abuse	1	2	3	4	5
11.30	I feel the provincial government consults with older people to find out what their needs are.	1	2	3	4	5
11.31	The provincial government is not addressing the needs of older people in the North West	1	2	3	4	5
11.32	I feel included in the decision making process	1	2	3	4	5
11.33	I feel that my community does not include older people in their activities	1	2	3	4	5

11.34 Have you ever experienced any abuse in the last 5 years?

Yes	1	No	2 **(Skip next question)**	Don't know / can't remember	3 **(Skip next question)**

11.35 If yes, has this abuse been…..

	Type of abuse	**Yes**	**No**
a)	Physical? (not including sexual)	1	2
b)	Sexual?	1	2
c)	Financial (e.g. your grant or other money taken away)?	1	2
d)	Emotional (e.g. being shouted at and not made to feel part of the household)?	1	2
e)	Combination of two or three of the above?	1	2

11.36. Is the house you live in proper condition?

Yes	1	No	2	I don't know	3

11.37. How easy is it for you to access the main road from your house or home?

Very easy	1	easy	2	difficult	3	Very difficult	4

11.38 List **THREE (3)** positive things that the North West Government has done for older people.

1._____

2._____

3._____

11.39 List **THREE (3)** things that the North West Government should do but has not done for older people.

1._____

2._____

3._____

Section12: HIV/AIDS and care giving

Instructions

Interviewer: This section is to be answered by an elderly respondent in charge of care giving in each household. Only the main care giver should be asked these questions.

12.1 Are there any household members lost to AIDS related illness and death?

Yes	1	No	2

12.2 If **'YES'** how has it affected your household finances?

Still the same as before	1
Made it worse	2
Don't Know	3

Please tell me whether:

		Yes	No
12.3	Are you part of an NGO/community programme supporting your terminally ill children or their orphaned children?	1	2
12.4	Have there been any court cases resulting from ownership of property after the death of one of your children	1	2
12.5	Do you have access to medication to treat those children who are sick of AIDS?	1	2
12.6	If yes are they easily accessible	1	2

Caring for orphans

Interviewer: The following questions look at the impact of caring for orphans by an elderly person in each household.

12.7 Is the older person the main care provider of orphans?

Yes	1	No	2

If 'YES' why? _____

12.8 Which of the items below is the most expensive in terms of caring for orphans?

Clothing	1	Education	2	Health	3	Food	4	Other	5

12.9 Do you get any support?

Yes	1	No	2 **(Skip next question)**

12.10 If **'YES'**, where do you and other caregivers get this support?

Type of support	Source of support
Financial/economic	
Social	
Emotional	
Spiritual	
Physical caring	

12.11 What are your health needs in caring for the terminally ill person?

a) _____

b) _____

c) _____

12.12 How would you rate your health?

Very good	1	Good	2	Fair	3	Bad	4	Very bad	5

12.13 If in poor health, would you attribute it to the caring activities you perform?

Yes	1	No	2

Access to health care services

Interviewer: The next set of questions examines the accessibility of health care services by the elderly in this household

12.14 Which of the main services below are used in the care of the terminally ill and orphans in this household?

Formal	1	Informal	2	Private	3	Community based	4

12.15 Which of the barriers below limit access to and utilization of services?

Financial	1	Attitude of staff	2	Transport	3	Stigma and discrimination	4	Other	5

12.16 How far is it to the nearest health centre?

Less than 5 kilometres	1	Between 5 and 10 kilometres	2	More than 10 kilometres	3

12.17 What is the main mode of transport?

Walk	1	Wheel barrow	2	Scotch cart	3	Car/bus	4

12.18 How much do you pay for transport to and from the health centre?

None	1	Less than R10	2	Between R10 and R25	3	More than R25 / 50	4

12.19 How much do you pay for Health-care services?

None	1	Less than R100	2	Between R100 to R250	3	Over R250	4

12.20 Is this affordable to the family?

Yes	1	No	2

12.21 How would you describe Health provision and services in your area?

Very good	1	Good	2	Fair	3	Bad	4	Very bad	5

Violence and abuse related to HIV/AIDS

Interviewer: This sub section examines violence and abuse related to HIV/AIDS against the elderly in this household.

12.22 Have you experienced incidence of any of the following stigma, violence, abuse, witchcraft accusation in this family due to your association with AIDS?

	Type of abuse	Yes	No
a)	Violence	1	2
b)	Sexual abuse?	1	2
c)	Physical abuse?	1	2
d)	Witchcraft accusation	1	2
e)	Stigma	1	2

THANK YOU

Appendix 2

Qualitative Instrument

Instructions

Dear participant, I am a student at the North West University, Mafikeng Campus. I am conducting a study that examines the socio-economic problems of the elderly in the era of HIV/AIDS in the Mafikeng Local Municipality. I am kindly requesting you to take part in this study which is optional. Some of the questions are related to HIV/AIDS and care giving. Your response will be strictly kept confidential and will be used for academic purposes only and will not be given to any other person. May I continue?

Participants were allowed to introduce themselves before questions were asked. Each question should not take more than 10 minutes.

1. You have lived with your communities for a long time, some of you since birth; do you think you are respected?
2. Can you describe some of the challenges you face as elderly people in your communities?
3. Apart from the challenges you have indicated previously, what are the personal challenges you face as elderly people?
4. As elderly people in your communities, have you had anyone that represents you in local government?
5. Are there any health concerns that you have, if yes what are they?
6. How would you describe the health care services in your areas?

The Following questions are related to HIV/AIDS

1. Have you heard of HIV/AIDS, if yes how is it spread?
2. Do you have any idea as to how you can prevent it from spreading?
3. Do you know of any one in your communities that had lost a child or relative, friend to HIV/AIDS?
4. What are the difficulties you face in looking after orphans?
5. What kind of support do you urgently need to take care of the orphans?
6. In your opinion what do you think is necessary in taking care of those who are sick?
7. Have you ever faced discrimination from anyone because of your role as a care giver?

Thank You