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RESEARCH

Understanding the challenges and opportunities encountered by the elderly in urban KwaZulu-Natal, South Africa

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Background: This article is based on research conducted by students at the University of KwaZulu-Natal as part of the course-work requirements in the research module in social work in students' final year of study.
Although each student conducted only one interview, when combined, the rich data allowed students and lecturers (the authors of this article) to glean significant understandings pertaining to the needs and problems of the elderly in KwaZulu-Natal, South Africa.
Methodology: Qualitative paradigm using exploratory and descriptive designs and an interview guide.
Results and conclusion: The findings highlight the insecurity and vulnerability of the elderly, specifically pointing to their social and emotional neglect, with family members taking advantage of these positions of want; their living circumstances where they were exposed to crime and/or living in cramped conditions because of accommodating family members who did not have their own homes; uninvited grandparenting responsibilities; poverty and food insecurity suffered by them as well as unresolved health concerns. Finally, the article concludes with recommendations for both future research and services.

Keywords: elderly vulnerability, grandparenting, health care, poverty

Introduction and context

'Growing old, just like running at the dawn of the longest day into a wall made of bullets, requires luck and often a quiet heroism.'[1]

This quote aptly describes elderly living and provides the context of this study.

The socio-political and economic context of the elderly in South Africa is recognised as being one where unemployment, poverty and illness render the elderly a vulnerable group.[2] Vulnerability may be too mild a term to describe atrocities that the elderly are exposed to, with Ntshobane[3] and Ferreira and Lindgren[4] using the term elderly 'abuse', exploitation and, of late, rape of elderly women in South Africa. Other concerns include becoming targets of crime. All of this points to the need to research why this is occurring and how to address this. In spite of these challenges, the elderly perform key functions that promote family survival and togetherness e.g. 'grandparenting' in an era of HIV/AIDS[5] with this role being on the increase in sub-Saharan Africa,[6] suggesting that research into the lived experiences of South Africa's elderly is important from both a policy and practice point of view. Considering the aforementioned context and expressed concerns, in 2013 final-year social work students and lecturers at the University of KwaZulu-Natal felt it appropriate to research the needs of the urban elderly in KwaZulu-Natal.

Research aim and objectives

The overall aim of the study was to understand how the elderly experienced life in KwaZulu-Natal, South Africa. The objectives were to explore:

- living circumstances of the elderly in urban KwaZulu-Natal, South Africa;
- challenges and opportunities encountered by the elderly;
- elderly persons' current needs for care;
- elderly persons' recommendations for improved living.

These objectives were general enough to allow students to research any aspect of or context in which the elderly lived in urban KZN, enabling thick descriptions of themes pertinent to the elderly.

Research methodology

Research design

The overall research paradigm was qualitative, and exploratory and descriptive designs were chosen with a view to anticipating rich and novel data pertaining to the elderly in KZN.[7] Given that many elderly are inclined to and often feel the need to talk at length, it was necessary to adopt an 'insider' perspective, with these designs being well suited to the research, researchers and participants.

Sample and sampling process

Two aspects need to be noted with regard to the study's sample. First, regarding the overall sample, all students were required to interview only *one* elderly person who was available, over 60 years old, in full *compos mentis*, and not a direct relative of the student. Students selected participants from urban KwaZulu-Natal as this was the location of the university and allowed easy access to participants from the same locale. Thus convenience, purposive and criterion sampling methods were employed. Second, only 30 of 140 reports of students' research reports were selected for this article. The reason for this is that, as in all student endeavours, there are always those students who perform well and who take their work seriously. The authors were able to select 30 clearly written reports from a total of 140 reports. These student reports were ones where the assessed mark was 60% and above. Furthermore, the reports included appendices with

all raw data clearly displayed for the purpose of further systematic[8] analysis by the authors, should this have been deemed necessary.

Data collection and collation

The research instrument used in the study was the semi-structured interview as it allowed for optimal connection with and adjustment of questions to suit participants.[9] Each instrument was carefully developed and sanctioned by the lecturers before the interview could take place. The steps of content analysis[7] were diligently applied by students whilst lecturers used document analysis.

Ethics

Ethical considerations were afforded much importance during the conduct of the study with permission being sought and granted from the University of KwaZulu-Natal's Research Ethics Committee. Accordingly, issues of anonymity, confidentiality and iterative consent[10] were deeply respected. Further, the numerous life challenges, concerns and problems raised by the elderly were addressed either directly by the students, or referrals were made for ongoing services. Where required, gatekeeper permission was secured.

Trustworthiness

This being a qualitative study, the dimensions of trustworthiness[7,9] were afforded significant importance. Credibility was achieved through prolonged engagement with participants, this being stressed during lectures and supervision of the research project; transferability was assured by students thickly describing the context of each study; dependability was reached by sample triangulation using various different elderly persons from different contexts; and confirmability was achieved by employing an audit trail where students were required to present all transcripts, and during the assessment and examination of the project.

Limitations

Sampling bias could possibly have affected this project both in relation to the selection of each research participant by the student and lecturers selecting only the 'best' reports. Notwithstanding this possible bias, it is believed that the new and interesting data that this research has generated will promote further rigorous research that heeds the need for generalisation.

There was a risk of researcher bias in data collection in that student researchers were in training and could have interviewed in ways that might have yielded biased results, as well as reporting results incorrectly. Both these concerns were addressed via regular lecturer input, alongside monitoring and supervision of the research. A fully transcribed interview with highlights of emerging themes was supplied (as a requirement by all students) at the end of each report to value the research's dependability and credibility.

Each student interviewed only one participant. This requirement was mainly to ensure manageability of the research project and did not allow students to fully appreciate general trends. Although students were apprised of the possibility of lecturers synthesising the data for a publication, the findings below are presented without any claim to generalisability.

Results and discussion

There are two main aspects to the findings in this article. First, the living circumstances of participants need to be appreciated and second, the nature of the needs and problems experienced by the elderly requires to be understood better than we currently do. It was clear that the overall living circumstances straddled findings on challenges and the few opportunities discussed by participants. Hence a degree of 'overlap' is inevitable, although the authors describe themes discretely. Participants were also invited to share ideas for improved living as per the last objective. This latter 'theme' is conflated with author recommendations at the conclusion of the article, in view of similarities in both parties' suggestions, but where the authors provide more depth pertaining to some of the ideas.

There will be limited reference to quantitative data as not only was this a qualitative study but we also do not make any claims to generalisability. Notwithstanding this, the following identifying sample details are discussed to provide a context for appreciating the findings.

Sample details

All 30 elderly participants were over the age of 60, with some of them being unable to verify their exact age. They all resided in urban KwaZulu-Natal and were generally known but not related to the researcher-students. Of the 30, only one participant was male and 29 were female. In relation to race, 28 were African, one Coloured and one White. In this qualitative study, these sample details may not be regarded as skewed as in the case of quantitative research.

The living circumstances of the elderly were first explored as per the first objective. It was found that the elderly in this study were mainly grandmothers who were heading households, their own children having died of HIV/AIDS, or who were working far away from home. Other elderly participants lived with family or at an institution and a few lived alone.

Themes identified in the study, as per the research objectives were:

Living circumstances: grandparents heading households

Grandparents were sad to report that they had no control over their own children's life circumstances and the consequent decision to care for their grandchildren. This concern of having no power to make a decision on caregiving is also discussed by Strom and Strom.[11] A major contributing factor to the experience of powerlessness and loss of control was financial insecurity, which occurred whether or not there was some state aid. In particular, there was sadness at not being able to adequately feed the children they cared for. Food insecurity and poverty are core concerns of grandparent-headed households. Some of the responses reflecting these concerns were:

'The grant is not enough. Groceries do not last the whole month, so sometimes we go to bed on an empty stomach … the church helps where they can….'

'I receive small money … cannot provide nutritious food.'

These findings are not unique to this study, with Raniga and Simpson[12] and others[13,14] similarly establishing that the elderly cannot maintain a home financially using their pensions and/or social grants alone. What was of interest in this study was appreciating the emotional distress accompanying the inability to provide for their grandchildren. This distress is manifested as follows.

For many, the physical and emotional burden of parenting was overwhelming. In some instances this burden was exacerbated by other problems presented by the children such as substance use or having AIDS, as depicted in the following quotes:

'It is worse when children abuse substances … then they steal my pension money.'

'I wait in queues for long for her ARV medicine while she is at school … exhausting.'

In the example above on having an HIV-positive child, the participant said that she cannot afford private medical care, so going to a state clinic was her only option. Engstrom,[15] too, expresses a similar sentiment, adding that often the elderly person's own health is compromised when attending to the needs of dependants. Poverty and financial concerns feature again, appearing to cut across several themes in the study.

Being a grandparent also meant providing for the scholastic needs of children under their care. Not being able to assist with schoolwork was an expressed concern of participants as depicted in the following quote:

'I feel so sad when I can't help — the neighbour's children in matric help them….'

Despite the inability of grandparents to directly assist their grandchildren, it is noteworthy that the spirit of *ubuntu* prevails in the community and that there is a vested interest in the educational welfare of the children. Ferrer-Chancy et al.[16] similarly found that neighbours who were able to do so helped with attending to the educational needs of the children. It must be noted that the neighbours could not assist financially, this being established in a different study on financial distress preventing the practice of *ubuntu* in the area of mental health.[17]

Many participants experienced a combination of anger, stress and hopelessness as evidenced in the following:

'It stresses me to see them sleeping … without eating anything.'

We see yet again how strongly poverty and, in this instance, food insecurity influences the mental health and emotional state of the elderly. Mudananhu[18] also discusses how anger and hopelessness accompany stress, these emotions likely having a bearing on those whom they are caring for. Herein we note the pervasive hold of poverty, needing multiple stakeholder engagement in the hope of spurring intervention. The following quote captures the sentiment of one participant's pain and how easily depression can result in the face of multiple loss, unresolved grief and inability to manage everyday responsibilities.

'It is painful to watch my children die…it hurts.'

Many related their emotional state to being lonely, inactive, overburdened with responsibilities or dealing with family problems. Ssengozi[19] similarly outlines the helplessness experienced by caregivers who have to witness death and dying despite one's best nursing efforts. In the present study, the problem was exacerbated by limited or no family and/or social support offered to the elderly. Poor mental health and stress often led to substance use by the elderly as mentioned by one participant:

'I numb the hurt [of loss to AIDS] and stress [of caregiving] by drinking too much and taking pills to sleep.'

Of concern was that several participants either stated explicitly that they were depressed or described symptoms indicating that indeed they were suffering depression. Hence, left untreated/unattended, some participants may graduate, or may have already graduated, from being stressed to becoming depressed. Left unattended, the consequence of this downward spiral is inevitable.

Only one participant indicated that she was happy to care for her grandchildren saying:

'I loved my daughters [who died from AIDS] … it is not a burden to care for their children — it is tradition.'

The self-sacrifice of the grandparent, putting the needs of the grandchildren above their own,[20] is noteworthy, given the aforementioned problems we uncovered related to health, illness, finances etc. Indeed, quite a few participants were appreciative of the experience of grandparenting, but generally discussed this alongside discussing some of the previously noted concerns. They valued their grandchildren's companionship and the help some of them offered with chores. Later, we establish how painful it is to experience isolation and loneliness, as well as not being given any acknowledgement by family members — so this finding relates to a forthcoming finding on social life that will be discussed later. Furthermore, the debility brought about by failing health, illness and immobility predictably led some of the participants to express appreciation in receiving support from their grandchildren. What may be of interest is for further research to be undertaken into the correlation between enjoying and valuing this grandparenting function and failing health, financial support and loneliness. In addition, it will be worthwhile to establish whether any grandparents were satisfied with their grandparenting role *without* these being linked to additional complaints or concerns.

Challenges: health and illness

Predictably, the elderly experienced many health concerns as they aged. Several sub-themes were apparent within this theme, two of which are discussed below in detail with supporting quotations.

Suffering poverty again provided the context/reason for ill health and poor access to medical services. Several participants reported how costly it was to address their health concerns, with many complaining about immobility and inactivity at a time when both were regarded as essential.[21] Concerns over the debility and immobility accompanying their illness and their limited finances are captured in the quotations from two different participants below:

'I can't go out or play bowls, my leg aches … medical help [is] too costly.'

'I have diabetes, arthritis and pressure.'

In another instance, the participant referred to costly medical help that made her seek alternative care from a traditional healer as follows:

'I go to the sangoma because the clinic is too costly.'

It is clear that medical needs increase with age,[21] as do multiple illnesses suffered by the elderly,[22] but this study shows that the elderly cannot afford to address their health needs or attend to their illnesses. There are several implications arising from this concern, which should be explored in further studies: the emotional and financial drain of elderly ill health on families; the need for preventive care; ill grandparents who cannot cope with parenting

responsibilities; and the need for access to one-stop services with a team of professionals to name but a few.

In some instances, the inevitable decline in health necessitated institutionalisation as discussed by Petrov.[23] Said one participant in this regard:

'I sometimes passed out so my daughter put me here [institution] … [I had] no choice.'

With failing health comes inability to care for others as the elderly person him/herself becomes unable to care for him/herself. One wonders at the costly implication of such a development in the life of an elderly person — to the family, the individual and the state. The elderly need care and hence, from a certain point onwards, cannot give care, a concern for all those who appear to rely on their free-of-charge child care services. In one instance, the elderly person was extra careful in pre-empting health-related problems that come with advancing age and taking care of themselves, as stated in the following quote:

'I fear not being healthy, so I eat well & look after myself … I am all they [grandchildren] have.'

This approach might postpone but not prevent ill health that accompanies ageing. Another finding related to why some elderly folk took care of themselves was fear of being a burden to their children. Hence some elderly folk performed tasks that were potentially dangerous as seen in the quote below:

'I rather do things myself … even if it is hard for me.'

Schatz,[24] too, discusses caretakers' preoccupation with dependent care, but in this study we see the focus shift to caring for oneself in order to better provide and take care of dependants and/or not to be a burden to others. Such an attitude is laudable, even heroic, given that for many old age is considered a time when family-related responsibilities are limited and/or not stressful. Yet, it has also been demonstrated that the elderly may be forced to care for themselves even when they cannot really do so properly on their own. Notwithstanding this, the advantage of self-care that accompanies the sense of responsibility towards dependants may be an interesting future research focus that may guide planning for elderly health when there is some purpose (including being better able to care for dependants) to living.

Challenge/opportunity: family relationships and social life

Relationships with family were closely tied to the elderly person's social life and social isolation. Many participants complained about not having any real family contact or support, evident in the following quotes from two different participants:

'Most of my family are deceased.'

'…only [have a] niece and nephew left — there is not more than a hello from them — they have their own lives.'

Family appear to be absorbed in their own lives and have little energy or time for their elderly relatives/parents even though the need to be remembered and cared for is strong (compare Mazikwane and Kwizera[25]). One participant expressed gratitude at the recognition and support she received from family as follows:

'I am grateful that they [sons in law] accept me and have me in their house.'

These words may reflect knowledge and understanding that such a living arrangement is not commonplace, but hearing this appreciation along with the obvious benefits of being with family may stimulate government-sanctioned programmes for home-based support of the elderly.

The quality of social life among the elderly was also explored and, unsurprisingly, this was often found to be related to family support. For example, there was sadness at not being able to participate in community activities because of the elderly person's own ill health, having to care for younger family members with AIDS, and not having family who could take them to the activity. The following quotes refer to the need for acknowledgement and support by the community and, thus, the isolating consequence of AIDS in families:

'I am excluded…. I am not recognised by the community.'

'Some of the neighbours isolate me because of the AIDS in my home.'

However, not all participants waited for others to take the initiative in ensuring a meaningful social life. One widower took charge of his social life, thus flouting claims by Ahmed and Hafeez[26] that widowhood increases isolation:

'… friends are important when you have lost so much family … they make the days go faster.'

Other participants expressed how they actively sought the support of the church and other community structures to ensure social inclusion as follows:

'I go to church with my grandchildren and community members who come to pray for us at my house.'

Finally, it was found, yet again, that finances dictated the social living of the elderly as one participant succinctly explained:

'If I have resources, I can maintain a social life; I go to the pensioners' group every Tuesday, we dance, sing, exercise.'

The need to belong to a larger unit as opposed to suffering isolation is clear from these findings, adding to those of Hawkley et al.[27] who warn that isolation may increase vulnerability to health risk and needs to be heeded, especially among the elderly who already suffer ailing health.

In sum, then, this study suggests the need for further exploration into what factors contribute to the experience of a meaningful social life even in the face of AIDS, widowhood and other stigma, and how this could be strengthened in the face of the financial hardship faced by so many of the elderly in South Africa. This could go a long way in guiding policy and service intervention towards improving their general quality of life.

Need for care: crime

Several concerns were raised regarding crime, foremost among these being vulnerability to crimes that are related to isolation: many of the elderly participants in this study feared becoming victims of crime and tended to be housebound. One, for example, said:

'Crime is bad in SA, that's why I don't go anywhere, luckily for me the bar is next door.'

So many of the elderly referred to the need for social inclusion by family and community (discussed earlier as a challenge), but there is also an inclination to isolate themselves because of crime. Yet this tendency appears to be a double-edged sword, in that the reason behind self-imposed isolation in itself may also result in becoming victims of crime. Unfortunately, some participants became victims of crime at the hands of their own grandchildren who were involved in crime themselves. Said one:

'My grandchild … even steals my pension money and some of the house appliances [to sell for her drug habit].'

Such theft was often also accompanied by disrespect and sometimes assault. The violence meted out to the elderly in this study fortunately did not find any of the elderly to be victims of rape, a growing crime targeting elderly women[3] in the country.

The elderly volunteered information on how best the problem of crimes against the elderly could be addressed, offering ideas for what would and would not work, given their particular circumstances. A simple strategy not to fall victim to crime was not possessing or keeping valuables at home, evidenced in the following words:

'I have nothing here to attract criminals.'

Keeping valuables such as money and appliances out of the home, however, appears to be more than just an inconvenience but, rather, a form of self-deprivation akin to staying at home to avoid crime. As such, it seems to be a stopgap in the face of high levels of vulnerability and hardly addresses the vulnerability experienced by the elderly in this study. Regardless, an innovative method suggested by one participant was to blow a whistle when faced with danger. However, this was not sustainable as it was used to address family-related dramas rather than crime, as follows:

'We were once given a whistle to blow … but this didn't work because when our children were drunk and disorderly, we blew [whistle] although there was no crime.'

Conclusions and participant/author recommendations

The findings in the study highlight the context of structural problems experienced by South Africans where poverty, HIV/AIDS, unemployment and crime abound. As a consequence, grandparenting, ill health and exclusion by family and community were pervasive. Of note in the study is that the elderly participants experienced forms of vulnerability in which structural social problems at once required them to provide care for others, such as grandchildren in need of care, yet also indicated limited, inadequate or no support where they require to be cared for themselves. The participants and researchers/authors offer the following suggestions to address some of the problems identified in this study:

- Addressing poverty, unemployment and food insecurity: 'Food gardens' for consumption and profit discussed by Makadzange and Dolamo[28] appear necessary. Along with this, suggestions by participants for budgeting advice, increasing social security grants to cover grandparenting over and above the regular old-age pension, extending the foster care grant age limit to beyond 18 years and financial support from family need noting.
- Addressing physical, emotional and social problems: The authors endorse the suggestion of participants that government, welfare, health and education should mainstream elderly concerns. Based on the findings, such service and support could include: support groups for needs such as delayed grief or grandparenting sick and/or drug-dependent children; volunteer initiatives to supervise and support the elderly; support from the community could include formalising the mentoring of school-going children and assistance with homework. To address food insecurity and isolation, the community together with the welfare sector could also organise lunch and social programmes for the elderly. In addition, education and awareness regarding neglect of the elderly could receive attention.
- Increasing access to services: both participants and authors recognise the need for de-centralising services, having more mobile clinics and one-stop service centres.

These suggestions along with dedicated research on the elderly, as discussed in the results section of this article, will surely pave the way for better care of a vulnerable and, sadly, voiceless but important population group, the elderly.

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