Study to Understand and Foster the Functioning and Involvement of Contributive Elders (SUFFICE)

Report on a pilot study towards a health intervention

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Printed by

University Documentation Management Services
Lower Main Road
Observatory, Cape Town
South Africa

Foreword

The pilot study (n = 55) of the Study to Understand and Foster the Functioning and Involvement of Contributive Elders (SUFFICE) was conducted in the older population of historically black townships of the Western Cape metropole in 2006. SUFFICE is a joint project of The Albertina and Walter Sisulu Institute of Ageing in Africa (IAA) at the University of Cape Town, the Stroud Center for Study of Quality of Life at Columbia University (New York, USA), International Longevity Centre–South Africa (ILCSA) (affiliated to the IAA) and International Longevity Center–USA (ILC–USA) (New York). Collaborators at each of the organisations participated in the pilot study and contributed to this report. Associate Professor Sinfree Makoni in the Department of Linguistics and Applied Language Studies at Pennsylvania State University in the USA contributed to developmental work on the project and in the early stages of the pilot study.

This report is intended as a pilot test of hypotheses that i) elders' helping activities contribute crucial benefits to children, other family and their community; ii) the activities are often maintained despite major chronic disabilities and considerable personal distress; and iii) the activities could be enhanced considerably through attention given to their unmet health care needs. The pilot results are consistent with the hypotheses and present a strong case for an expansion of the SUFFICE programme to cover representation of communities throughout South Africa and in other African countries. Better understanding of the connections between the well-being of persons of all ages in the community, the pivotal helping roles initiated and sustained by elders, and the ways in which the health of contributive elders can be ensured could lead to a profound re-evaluation of hidden costs to communities stemming from a neglect of older persons in accessing minimally adequate health services.

Zameka Ndzotyana, a technical assistant at the IAA, managed field data collection, captured the data, and undertook translations from English into isiXhosa and *vice versa*. Nokuthula Kulati, Nobubele Mpetsheni and Nomava Ngxangxeni conducted interviews with the 55 subjects. Jackie Stoffels at the IAA rendered typing assistance to the project. The authors wish to thank the interviewers for data collection; the managers of three NGO sites for access to recruit and interview subjects; IAA staff members who worked on the project; and the 55 elders who provided information and shared their experience with us.

Support of the pre-pilot and pilot phases of the SUFFICE project by the Stroud Center is acknowledged gratefully.

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Cape Town
June 2007

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1 Background, aims and hypotheses

The Study to Understand and Foster the Functioning and Involvement of Contributive Elders (SUFFICE), a multi-centre collaborative project conducted in Cape Town and Durban (South Africa), aims to i) document help that elders give to family and community; ii) evaluate whether health impairments limit elders' capacity to be helpful, or impose unnecessary distress in their continuing to help; and iii) provide evidence for redesigning health services to support elders' helping activities. The project is based on a notion that South Africa's public health system should aim to support elders to fulfil the valuable roles they play and the substantial contributions they make, through appropriate and targeted health services, and thereby enhance their health status as well as their well-being, and that of their family and community. The project's approach calls for a paradigm shift, from one of treating elders as if their health problems are a personal matter and a drain on scarce national resources, to one where proactive steps are taken to minimise the progression of functional impairment in order to maximise remaining functional and contributive capacity, and to reduce elders' distress in making those contributions.

The conceptualisation and relevance of the project relate partly to a realisation and evidence of the multiple roles that elders play in South Africa in supporting family, socialising and caring for grandchildren, and contributing to community development, especially in disadvantaged residential settings and where children have been rendered vulnerable or orphaned by HIV/AIDS. A key consideration that shaped the project is the internal and external environment of townships in which the target population resides, which present specific challenges to older residents' functioning. Conditions of township life with which elders must deal, roles and responsibilities that they assume, and services that they contribute to family and community in this context therefore warranted investigation. Such conditions include extreme poverty, high unemployment of adult kin, poor urban infrastructure, poor access to health care, high levels of crime and violence, changing family structures, and a heavy burden placed on older women, in particular, as carers to family members infected with or affected by HIV/AIDS.

Yet another consideration was the inadequacy of geriatric services provided by the country's public health system, which for a variety of reasons may be less accessible and effectively targeted to older clients than desirable. Public health services are offered at three levels of care: primary, secondary and tertiary; approximately 92 per cent of clients of all ages are served at primary clinics, 6 per cent at secondary hospitals, and only 2 per cent are referred to a tertiary hospital. Management of health conditions is dependent on decisions made at primary level; referral of clients through levels of care is far from seamless. Health professionals at primary and secondary care levels have virtually no training in geriatric care. Only eight registered geriatricians are available, at tertiary level, to serve a population of 3.3 million persons age 60 years and over. Primary care clinics are overcrowded, operate a poor appointment system, entail long waits for clients to see a health professional and experience chronic shortages of medications. Such exigencies of the system are non-conducive to the provision of quality health care for older clients. Levels of dissatisfaction among clients and health professionals are high.

Since 1994, public health policy has moreover prioritised maternal and child health care, and the health care needs of older clients have been marginalised. Dedicated geriatrics clinics and community nursing services operated previously were withdrawn in the mid 1990s and health professionals trained in geriatric care were redeployed to child immunisation programmes. Only two universities affiliated to a tertiary hospital, the universities of Cape Town and Kwazulu-Natal (Durban), have a chair of geriatrics; the chair at the University of Cape Town has been frozen since 2000. Geriatrics is hardly included in the teaching curricula of any of the medical schools. Multidisciplinary health care programmes for older clients are lacking generally. Clearly, geriatric clinical services and education and training in Geriatric Medicine are under developed and in need of improvement and expansion – all of which provided additional motivation for the conceptualisation and implementation of the SUFFICE project.

Assumptions of the project, which is ongoing, are that i) elders' contributions to the strengths and well-being of family and others in their community should be sustained; ii) impaired functioning has a negative impact on their capacity to care and contribute adequately and without excessive difficulty and distress; and iii) elders' health competency therefore needs to be enhanced. Hence, a determination of health (and environmental) limitations on older persons' functional capacity, in addition to documentation of the contributions they make, could help to identify how they may be enabled and supported as a valuable and critical resource to sustain those contributions. Thus, the findings could have implications for the provision of appropriate health services and social services, and therefore multisectoral responses to the conditions and needs of this population.

Pre-pilot studies conducted in 2003/4 constructed and tested a structured interview schedule to evaluate the health and functioning of residents aged 65 and older of Khayelitsha and Gugulethu, historically disadvantaged townships outside Cape Town. The data collection instrument used in the pre-pilot phase was supplemented and used to conduct interviews with 55 elders in the pilot study conducted in 2006, which study findings are reported here.

Hypotheses of the pilot study were:

- Elders in disadvantaged communities play a major role in preserving the health and well-being of their children, family and community.

- The elders sustain this contributive role despite health imposed functional limitations and physical and emotional distress.

- Health services could be redesigned to support their contributive roles, and hence enhance their health and well-being, as well as that of their family and community.

2 Method

Cross-sectional data were gathered from sampled elders age 65 and over who were isiXhosa speaking, resided in the targeted communities and could be identified as

potentially “contributive.” “Potentially contributive” elders were defined as persons who are ambulatory and attend a seniors’ centre.

2.1 *Sample*

A non-random convenience sample of 55 “potentially contributive” elders was drawn at the sites of three non-governmental organisations (NGOs) that serve older persons in the townships: 1) The Cape Peninsula Organisation for the Aged (CPOA) Senior Centre in Gugulethu; 2) Grandmothers Against Poverty and AIDS (GAPA) in Khayelitsha; and 3) the Students Health and Welfare Community Organisation (SHAWCO) Senior Centre in Khayelitsha. The two senior centres (CPOA and SHAWCO) have large memberships, while GAPA operates as a support and empowerment group to a physically and emotionally vulnerable but highly contributive female older population. A decision to draw a sample at senior centre sites, rather than to use a house-to-house random sampling technique, was based on clientele at the centres being ambulatory and thus potentially able to engage in contributive activities.

The managers of the NGO sites were informed of the aims of the project and invited to help the interviewers to identify “potentially or likely contributive” elders, both male and female – although the gender distribution was unspecified, among members who could be interviewed for the purpose of data collection. Some subjects were identified by snowballing with the help of other interviewees. The realised sample is shown by NGO site subgroup and gender in Table 1.

2.2 *Interview schedule*

The interview schedule used to collect data covered precoded responses for indicators of elders’ actual or potential contributions and their enabling and restrictive contexts (see Figure 1), grouped broadly as follows: *Contributive actions*: especially cooking, supervision and socialisation of grandchildren, giving advice and financial support, caring for family members, pension sharing and a diverse range of culturally conditioned actions. *Beneficiaries:* especially family members, particularly children and grandchildren, other members of the community. *Health problems:* self-perceived health, activities of daily living, symptom syndromes, cognitively controlled functions, depressed mood, fears and worries, chronic pain, effort intolerance, critical stresses and accidents, hearing, vision, and attribution of problems. *Service use:* medications, health life-style. *Personal and household information:* demographics, housing facilities and conditions. *Affiliations:* membership of organisations and volunteering.

Open-ended items in the schedule required an interviewer to enter a narrative under the following guideline headings (see Figure 1 again): *Basic contributive actions*: e.g. cooks for others. *Complex contributive actions:* e.g. sets standards for children.

Table 1
Realised sample, by NGO site and gender (percentage distribution and frequencies) (n=55)

Organisation	Male		Female		Total	
	%	n	%	n	%	n
CPOA[1]	17.4	4	82.6	19	41.8	23
GAPA[2]	8.3	1[4]	91.7	11	21.8	12
SHAWCO[3]	35.0	7	65.0	13	36.4	20
Total	21.8	12	78.2	43	100.0	55

1 Cape Peninsula Organisation for the Aged Senior Centre (Gugulethu).
2 Grandmothers Against Poverty and AIDS (Khayelitsha).
3 Students Health and Welfare Community Organisation Senior Centre (Khayelitsha).
4 Male security officer and gardener at GAPA site (66 years). All members of GAPA are grandmothers.

Beneficiaries of the action: e.g. serves breakfast and dinner, and prepares grandchildren for school. *Context:* e.g. mother of the grandchildren works long hours, father is sickly. Household consists of these members and the elder. *Enablers:* e.g. the stove and kitchen are in good condition. The dwelling has inside piped water. Mother (the midldle generation mother of the grandchildren) shops for groceries. *Restraints:* e.g. none at present, but pain in joints and limitation of mobility are looming threats. *Health and social service implications:* e.g. evaluation of secondary preventive intervention to maintain mobility and relieve pain. *Estimate of contribution to the community:* e.g. grandchildren are able to go to school, mother can continue to work and earn income for the household and to care for her sickly husband.

2.3 *Data collection*

As the interview schedule was supplemented with items not used previously, it was field tested and reliability between raters established on four subjects in the study population. Responses of these subjects are not included in the pilot study analyses.

Three experienced interviewers of the same ethnic group as the targeted elders, but not socially connected to the elders, were recruited and trained intensively in the administration of the schedule. Before interviewing, all subjects were informed fully of the aims of the study, the confidentiality of the information they would provide, and their right to withdraw from the study at any time during an interview; all signed an informed consent form affirming their willingness to participate in the study. All interviews were conducted privately at the study sites or in subjects' homes,

Figure 1
Indicators of actual or potential contributions and enabling and restrictive contexts, by action and example

	Action	Example
1	Basic contributive action	Cooks for others
2	Complex contributive actions	Sets a standard of behaviour for the family
3	Beneficiaries of the action	Serves breakfast and dinner and prepares grandchildren for school
4	Context	Mother of grandchildren works long hours, father is sickly. Household consists of these members and the elder
5	Enablers	Stove and kitchen are in good condition. The dwelling has inside piped water. Mother shops for groceries
6	Restraints	None at present, but pain in joints and limitation of mobility are looming threats
7	Health and social service implications	Evaluation of secondary preventive intervention to maintain mobility and relieve pain
8	Estimate of contribution to the community	Grandchildren are able to go to school, mother can continue to work and earn income for the household and to care for her sickly husband.

and in isiXhosa, one of South Africa's eleven official languages and the language spoken mainly in the targeted communities. The duration of the interviews ranged from 60 to 80 minutes.

Completed schedules were cross-checked with interviewers by the fieldwork manager at the Institute of Ageing in Africa (IAA), who also captured the data and translated the open-ended responses from isiXhosa into English. Quantitative data were tabulated and qualitative data were translated and content analysed. Statistical analyses were carried out using SPSS statistical programmes.

3 Findings

Main findings of analyses of the data and cross-tabulations of specific data pertaining to functional limitations and symptoms of distress as potential restraints on

elders' contributive actions are given in subsections below. Selected open-ended data are shown as narrative in the text.

3.1 *Socio-demographic profile of the sample*

Socio-demographic characteristics of the sample are shown in Table 2. Broadly, almost four-fifths of the sample (78.2 %) was female; the mean age was 73.1 years (range 65–88 years); seven in ten subjects (70.8 %) had six or more years of schooling (seven subjects had no formal education); almost two-thirds (63.6 %) had no spouse; the majority (65.4 %) had been employed in the service sector; and the majority (94.5 %) received a social pension (the remainder had applied for a pension).

Table 2
Socio-demographic characteristics of the sample (percentage distribution)[1]
(n = 55)

Characteristic	%	Characteristic	%
Total	100.0	Total	100.0
Gender		**Marital status**	
Male	21.8	Married	36.4
Female	78.2	Widowed	45.5
		Divorced/separated	9.1
Age group (years)		Never married	9.1
65–74	61.8		
75–84	27.3	**Occupational sector**	
85+	10.9	(for main part of working life)	
Mean age 73.1		Service	65.4
Range 65–88		Industry	10.8
		Clerical	7.2
Level of education		Professional	7.2
No formal schooling	12.8	Other	3.6
< 6 years	16.4	None	5.5
6–7 years	21.8		
8–9 years	29.1	**Social pension beneficiary**	
10–11 years	14.5	Yes	94.5
Matriculation	3.6		
Diploma	1.8		

[1] Percentages may not add up to 100.0 in this table and other tables due to rounding off.

3.2 *Household characteristics*

Household characteristics of the sample are shown in Table 3. The majority of the households (92.7 %) were headed by a subject or the spouse (the remainder were headed by another family member); the mean number of persons in a household was 5.3 (range 1–12); and of a total of 290 persons resident in the 55 households, 20.3 per cent (n = 59) were elders (persons age 65 and over), 61 per cent were age 16–64 years and 18.6 per cent were children (< 16 years).

Table 3
Characteristics of the sample households (percentage distribution) (n = 55)

Characteristic	%	Characteristic	%
Total	100.0	Total	100.0
Head of household		**Main source of water**	
Subject	83.6	Piped water inside dwelling	63.6
Spouse	9.1	Piped water in yard/on site	34.5
Child/-in-law	3.6	Communal tap	1.8
Sibling/-in-law	3.6		
		Type of toilet facility	
Number of persons in household		Flush toilet inside dwelling	49.1
		Flush toilet in yard/on site	49.1
One	1.8	Other (unspecified)	1.8
Two	21.8		
Three	9.1	**Household items** (in working order) (multiple responses)	
4–7	52.7		
8–12	14.5	Telephone/cell-phone	58.2
Mean 5.3 persons		Stove/burner (electricity/gas)	89.1
		Electricity	98.2
Total number of persons by age group in households		Television set	87.3
		Radio/hi fi	81.8
65+ years	20.3	Refrigerator/deep freeze	78.2
16 – 64 years	61.0	Washing machine	30.9
< 16 years	18.6	Car	10.9
		Mean index score 5.3 (maximum score 8)	
Type of dwelling			
Brick house	92.7		
Shack	5.5		
Room/shack in backyard	1.8		

Structural and material features of the dwellings were as follows: In nine in ten cases (92.7 %) subjects lived in a brick house (the remainder lived in an informal structure); the majority had piped water either in the dwelling (63.6 %) or in the yard/on site (34.5 %); and less than half (49.1 %) had a flush toilet inside the dwelling (a similar percentage had the facility on site). The mean number of household items (an index of 8 items – see Table 3) of the households was 5.3.

3.3 *Health and functional status*

Selected items on self-reported health and functional status of the sample are shown in Tables 4 and 5. Regarding **general health**: almost three-quarters rated their health as fair or poor (72.7 %); compared to that of peers, three-fifths (60 %) rated their health as fair or poor. Nine in ten subjects (90.9 %) reported chronic health conditions. Chronic health conditions that impaired function reported spontaneously by the sample were mainly hypertension, musculoskeletal problems, the effects of stroke and diabetes. (Note: Not all data on the subjects' health conditions are tabulated or indicated in this report, but are available from the authors; see the Addendum.)

Table 4
Selected items on self-reported health status and emotional status of the sample (percentage distribution) (n = 55)

Item	%	Item	%
Total	100.0	Total	100.0
General health		**Happy with things**	
		Very happy	54.5
Self-rated health		Fairly happy	36.4
Good	27.3	Not very happy	7.3
Fair	63.6	Not happy at all	1.8
Poor	9.1		
		Worries about things	
Peer comparison		Yes	61.8
Good	40.0		
Fair	45.5	**Feels sad/depressed**	
Poor	14.5	Yes, a lot	14.5
		Yes, sometimes	58.2
Has chronic condition/s		No	27.3
Yes	90.9		
		Feels frightened/anxious	
Has difficulty walking		Yes, a lot	14.5
Yes	54.5	Yes, sometimes	34.5
		No	50.9
Subjective suffering		**Thinks life is not worth living**	
Experiences pain		Yes, a lot	5.5
Yes, a lot	14.5	Yes, sometimes	45.5
Yes, sometimes	63.6	No	49.1
No	21.8		
		Has trouble sleeping	
Pain limits activities		Yes	43.6
Yes, a lot	7.3		
Yes, sometimes	52.7	**Has difficulty with memory**	
No	40.0	Yes	61.8

Table 5
Health effects on sample elders' level of ability to perform selected activities of daily living (ADLs) (percentage distribution) (n = 55)

Activity	Extent of health effects on ability to perform activity			Total
	A lot %	Sometimes %	None %	%
Health effect on performance of activity				
Light housework	34.5	50.9	14.5	100.0
Heavy housework	29.1	30.9	40.0	100.0
Getting around	49.1	41.8	9.1	100.0
Carrying heavy packages	23.6	23.6	52.7	100.0
Travelling outside neighbourhood	47.3	36.4	16.4	100.0
Social activities	36.4	34.5	29.1	100.0
Extent of cooking/preparation of meals (in past month)	%			
Has never cooked/cannot cook	5.5			
Has cooked/can cook	3.6			
Can no longer cook	9.1			
Someone else cooks	43.6			
Some of the cooking	18.2			
A lot of the cooking	5.5			
Cooked all meals	14.5			
Difficulty handling money/doing personal business by self				
Yes	45.5			

Regarding **function**: Of the 55 sample elders, 50 had difficulty getting around; 47 had difficulty doing light housework; 46 had difficulty travelling; 39 with engaging in social activities; 33 with doing heavy housework; and 30 with walking (see Table 4). The subjects had greatest difficulty performing activities that required physical strength or stamina, and least difficulty getting around, doing light housework and travelling outside the neighbourhood. A third of the total sample (33.2%) had done some, a lot or all of the cooking in the past month (Table 5).

Regarding **cognition**: Three-fifths of the sample reported difficulty with memory, which they described as forgetfulness (Table 4). Almost half the subjects (45.5%) reported difficulty in handling money and/or conducting personal business on their own (Table 5).

Regarding **emotional problems**: Subjects mainly reported depression and anxiety as such problems. More than half felt life was not worth living, either a lot or

sometimes, which suggests low morale and possibly depression. Half (49.1%) admitted to anxiety (they "get frightened/feel anxious"); symptoms that accompanied feelings of anxiety in 27 elders (sweating 33.3%, trembling 22.2%, heart palpitations 63%) indicate that anxiety is often severe (Table 4).

Almost four-fifths of the sample experience **pain** and in three-fifths, pain limits usual activities (Table 4).

Some elders described how health conditions limit their function as follows: *I have a leg problem… it is not easy to walk long distances. I have swollen legs. I had a hip operation. My right arm is painful and I can't handle anything. Cooking is a problem. Blood pressure makes me dizzy. I can't cope with daily work. I had a stroke and now have paralysis on one side. I become tired and lack energy. I get dizzy. I am unable to do things as before. I can't do my chores*.

Examples of elders' descriptions of pain were: *Ulcers. My legs are painful. My arms hurt. I have pain in my eyes. Arthritis.* Some described how pain limits their activities as follows: *Sometimes the pains in my legs stop me from going to other people and doing things. If I didn't have these pains in my legs and in my body I would do much more for myself as well as other people.*

Reasons given by more than half the sample for limitation of activities relating to their health and/or functional status were: *General weakness. Paralysis in part of body. Poor balance. Falling. Pain in legs, feet. Stiffness. Swelling in joints. Backaches. Headaches. Cost, unaffordability. Tiredness, fatigue*.

Examples of elders' descriptions of emotional problems were: *Sometimes I can't cope with my daily work. I can't cope with anything. I have nerves. I am diabetic and nervous. I have difficulty walking and I don't sleep sometimes. Arthritis and stress. I cannot work and have sleepless nights.*

3.4 *Elders' contributions*

Specific ways in which elders help others and thereby contribute to others' well-being are shown in Table 6. Raising children, looking after grandchildren, advising on home care and child care, keeping house for the family, helping with money and helping with big decisions are common ways in which these elders help.

Among elders who have living (adult) children (n = 37), all but three are involved in a nurturing role. In 28 of the 37 elders with living children, the elder is the main (primary) caregiver. The total number of family members being cared for, rather than helped – as reported by the 55 elders, was: Adult children 45, grandchildren 76 and great-grandchildren 4. Twenty-eight subjects reported that they are mainly responsible for raising co-resident grandchildren, while six shared the responsibility. In sum, 44 of the 55 elders kept house for co-resident family; 43 helped with money; 38 helped when someone is ill; 38 looked after grandchildren; 34 gave advice; 30 fixed things; and 14 shopped or ran errands. The caregiving role of the majority of the elders is thus prominent. More than half have a major care responsibility for one

or more family members, setting aside spousal care; day-time responsibility is added when

Table 6
Ways in which sample elders help others (percentage distribution) (multiple responses) (n = 55)

Nature of help	Response			Total
	Yes %	No %	N.A. %	%
Raises children	61.8	5.5	32.7	100.0
- has main responsibility	50.9			
- shares responsibility	10.9			
Helps when someone is ill	69.1	25.5	5.4	100.0
Looks after grandchildren	69.1	25.5	5.5	100.0
Gives advice on home/children	61.8	32.7	5.5	100.0
Shops, runs errands	25.5	69.1	5.5	100.0
Gives gifts	54.5	40.0	5.5	100.0
Helps with money	78.2	16.4	5.5	100.0
Fixes things	54.5	40.0	5.5	100.0
Gives advice on jobs/business	50.9	43.6	5.5	100.0
Helps with big decisions	78.2	16.4	5.5	100.0
Keeps house for adult children	80.0	14.5	5.5	100.0
Cares for a person with a health need	14.5	83.6	5.5	100.0
Assists a dependent person	10.9	87.3	1.8	100.0

parents are at work. The caring role of these elders is active, varied and demanding moreover, in that it goes far beyond mere giving of advice from an armchair or as a spectator. Implicit in much of the caregiving is elders' expenditure of pension money to benefit family members.

Elders described ways in which they help others as follows*:* **Help others*:*** *Share our problems. Give advice to others.* **Help the community*:*** *Advise about problems we are facing in the community. Help people to vote, educate the youth about HIV/AIDS and what they face in life. Give lessons about HIV to neighbours. Teach one how to behave. Learn about our human rights. Attend community meetings about persons who do wrong. Teach youth to get involved in sport. Work as a secretary at a not-for-profit organisation that helps others. Pray for people who have HIV/AIDS. I am involved in group discussions about how to handle our problems. We advise each other that we must unite, have peace and pray for people who have HIV/AIDS. We help people to vote – take them to the lines and make sure they are in the right line to vote. I take part in a street committee, solving people's problems. We aim to keep order in the community. I do bereavement workshops and discussion on social life. I do youth groups, help them to do some activities so they can stop crime.*

Help grandchildren*:* *Help my grandchildren to know what affects youth. Give a lesson about HIV to my grandchildren. Help my grandchild and educate him about HIV. Help my grandchildren to know about things.* **Help individuals in need*:*** *Visit*

those that are left alone in their houses. Help in old age homes. Lend them money or do their washing. Clean the houses of those who can't do anything for themselves. Small shopping and washing. Provide sugar and teabags. I just listen to them. Make sure that all the families have food. Look after HIV children. Help solve domestic problems, maybe with their children that don't want to listen. **Group activities and mutual support groups***: Sewing and knitting group – discussion and sharing views. We sew pillow cases and cushions and sell them to the public. We share our differences. We learn to sew, do exercises, share our problems with others and give each other advice. We learn to communicate with others. We volunteer to do bazaars.*

3.5 *Overlap of health problems and contributive activities*

Cross-tabulations of the elders' health limitations and types of helping activities provide insight into the health burden under which elders continue these activities. This overlap indicates the extent to which the elders may suffer physical and emotional distress in the course of helping others, and a possibility that health limitations may limit the scope of the activities. Table 7 shows health problems as indicated by self-rated level of health ("good," "fair" or "poor," by peer comparison) reported by elders who help others in specific ways. Table 8 shows the severity of health imposed limitations on a set of common daily activities (excluding helping contributions).

Table 7
Help activities of sample elders who help, by self-rated level of health (peer comparison) (percentages) (n = 55)

Help activity	Self-rated level of health (peer comparison)		
	Good %	Fair %	Poor %
Raises grandchildren (main or shared responsibility)	63.6	60.0	62.5
Helps someone ill	63.6	72.0	75.0
Looks after grandchildren	72.7	68.0	62.5
Gives advice on home/children	72.7	56.0	50.0
Shops, runs errands	40.9	12.0	25.0
Gives gifts	54.5	64.0	25.0
Helps with money	77.3	80.0	75.0
Fixes things	54.5	56.0	50.0
Gives advice on jobs/business	59.1	44.0	50.0
Helps with big decisions	86.4	72.0	75.0
Keeps house for adult children	77.3	80.0	87.5
Cares for a person with a health need	13.6	16.0	12.5
Assists a dependent person	13.6	8.0	12.5

Table 8
Severity of health limitations versus numbers of helping activities[1] (percentages) (n = 55)

		Number of helping activities											
		No helping %	1.00 %	2.00 %	3.00 %	4.00 %	5.00 %	6.00 %	7.00 %	8.00 %	9.00 %	Most helping	Total %
Health limits	Most limited	25.5	28.2	11.8	15.5	6.4	4.5	3.6	4.5	–	–	–	100.0
		21.2	18.2	15.2	13.6	13.6	10.6	4.5	3.0	–	–	–	100.0
		20.3	21.6	18.9	12.2	10.8	8.1	2.7	1.4	4.1	–	–	100.0
		11.9	14.9	22.4	19.4	10.4	6.0	4.5	6.0	1.5	1.5	1.5	100.0
	Moderate	9.5	13.1	16.7	23.8	8.3	14.3	4.8	3.6	–	6.0	–	100.0
		9.5	17.5	14.6	15.3	13.1	13.1	5.8	6.6	3.6	3.6	.7	100.0
		5.6	19.3	16.8	13.7	9.9	14.3	8.1	6.8	3.1	1.9	.6	100.0
		5.9	9.1	17.6	24.6	8.6	9.6	12.8	4.3	4.8	2.7	–	100.0
	Least limited	7.2	11.7	14.0	14.3	13.0	12.4	8.5	9.8	5.2	2.6	1.3	100.0
Total		10.7	15.8	15.8	16.8	10.7	11.0	7.3	6.1	3.3	1.9	.5	100.0

1 Horizontal rows show percentages of subjects with a given severity of health limitation who perform a given number of helping actions.

Cross-tabulations of **health problems** and **contributive activities***:* Elders in this sample, who were ambulatory and active, help others despite considerable health problems represented by fair and poor self-perceived health. Helping activities are particularly inhibited where they demand physical exertion (see "shops, runs errands"). The scale of health limitations shows a gradient of greater inhibition of helping with more severe health limitations, though the majority of the group of elders who are most limited by their health still engage in contributive actions. Inferences must be qualified by the selection of this sample and the cross-sectional data collection, but the two sets of findings are fairly robust: elders contribute while coping with their own ill-health and the ill-health inhibits the full extent to which they can contribute.

Difficulty with **walking***:* Of the 38 of 52 elders who look after grandchildren, 20 (52.6 %) have difficulty walking; hence, helping to raise grandchildren occurs regardless of functional problems such as difficulty with walking. Of 14 of 52 elders who help others by shopping, eight (57.1 %) have difficulty walking. Of 38 elders who do not shop, 55.3 % notably have difficulty walking. Of 30 of 52 elders who fix things for others, half have difficulty walking; 22 elders do not do this activity – 14 of whom (63.6 %) have difficulty walking. Of 44 of 52 elders who keep house for adult children, 27 (61 %) have difficulty walking, but notably the difficulty does not inhibit performance of this activity.

Pain accompanying elders' contributions*:* Pain severe enough to make elders think "a lot" about pain or to stop activities "a lot" occurred across all ways of helping at more or less the same rate: 10–20 % for thinking a lot about pain and 6–10 % for pain stopping activities (disregarding the outlier). For elders who "sometimes" think about pain or pain stops activities "sometimes," the frequency accompanying contributory actions is much higher: above 50 % and 35–55 %, respectively. Of 38 elders who look after grandchildren, 25 (66 %) are stopped (or limited) in this activity by pain. Of 14 elders who do not look after grandchildren, half are stopped by pain; notably, elders continue to look after grandchildren even though the majority endure pain. Of 14 elders who shop for others, six suffer pain. Of 33 elders with pain, six (18 %) shop for others. Of 22 elders without pain, eight (36 %) shop for others; pain may inhibit this activity. Thus, contributions continue despite pain, but suffering may be entailed in the contributory activities and may inhibit the level of contributions.

Sadness*:* Of 38 elders who look after grandchildren, seven (18.4 %) reported that they are "sad all day." Of 34 elders who participate in raising grandchildren (they are mainly responsible or share responsibility for doing so), six (17.6 %) are "sad all day." The latter item can act as a rough proxy for depressed mood. Depression is a painful illness and may also undermine the nurturing effect of this relationship. Thus, elders who raise or help to raise grandchildren often need attention for depression

Self-report (**attribution**) of specific inhibiting health conditions*:* The proportion of elders who claimed a particular condition inhibits their contributory activities "a lot" (as opposed to only "sometimes" or "never") was greatest where they suffered pain in their legs and forgetfulness (both over 40 %), with paralysis, general weakness, poor balance, stiff joints, headaches and tiredness all being reported by over 20 % of the subjects. This finding contrasts with that for non-health conditions (cost, crime, interference by others, and a lack of convenient facilities (these data are not

tabulated in this report; see the Addendum), which were reported by 15 % of subjects.

Examples of narrative statements of elders relating to health limitations on their contributive activities are as follows: *There's nothing I can do now as my health situation is not pleasing at all. There's nothing I can do because I can't walk. I was helping but not now. I can't help, I only go to church. I can't talk properly and I can't help no-one with anything nor educate them about whatsoever they want. I no longer do any kind of work for my community because I am too old; the only thing I am able to do is lend money or do washing for those who are looking for help.*

3.6 *Use of formal and informal services*

Fifty subjects indicated that they had sought medical treatment for a chronic condition (or multiple conditions) in the past year. The majority had visited a primary care clinic (72 %) and/or a hospital (50 %), while almost two fifths (38 %) had consulted a private doctor (some subjects had sought treatment at multiple types of facilities). Examples of elders' descriptions of health disorders that require treatment are: *Diabetes. Heart problems. High blood pressure. Chest problems. Diarrhoea.*

Forty-five of these 50 elders indicated where they obtain medications for their chronic condition/s (multiple agencies could be indicated): The majority (91.1 %) obtain them at a primary clinic or hospital (where the medications are supplied free to social pensioners – but supplies are erratic). Almost two-fifths (37.8 %) obtain medication from a private doctor when they consult one and 35.6 per cent purchase over-the-counter preparations.

Only seven of the 50 subjects (14 %) reported experiencing difficulties at the facilities or agencies where they sought treatment or obtained medications. Some described these difficulties as follows: *Sometimes there is a lack of service. They don't give enough pills [patients must return to the clinic/hospital frequently to have their prescription refilled]. Waiting for long to see the doctor. I was given the wrong medication and had a swollen mouth and eyes.*

4 **Summary of findings and discussion**

The SUFFICE pilot study provides evidence that stereotypical roles of targeted elders are often reversed: elders are care providers rather than care recipients. A wide range of elders' contributive actions and recipients who benefit from these actions were identified. The findings demonstrate that the sampled elders make considerable contributions to the well-being of their family and community, but which overlap with substantial health problems and impose functional limitations and distressing symptoms. The findings must be interpreted narrowly, as the sample is small and the elders selected are ambulatory and socially interactive; thus, it may be expected that health impairments will be even more marked and restricting in a less select population.

For the most part the sampled elders are in touch with available services, especially a primary clinic and a hospital. Thus, an important avenue is available for the introduction of interventions to relieve the health problems that cause limitations and suffering, with continuing contributory activities of elders as outcome goals. Clinics and hospitals are venues moreover for links to social and community services that share these outcome goals. Physical or mental distress and/or functional difficulties and limitations in the subjects may be surmised to have propelled their interaction with formal health care services in the first place. However, these data do not explore the motivation or effectiveness of the treatment encounter in improving an elder's ability to continue contributory actions and relieving accompanying pain and other distress.

The potentially strong messages yielded by the study for the planners and providers of health and social services to the older population may thus serve to frame a case – and to plan a next phase of SUFFICE – for an appropriate health and social service intervention. The intervention should be implemented through local services, founded on an awareness of how the potentially productive role of elders, when enhanced, can be beneficial to all members of the community. In sum, the pilot study outcome – and the SUFFICE programme thus far – have presented a targeted challenge to geriatric services in the public sector in South Africa and a guide to the design of an appropriate health intervention. (See the Addendum.)

Sources

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Addendum

This report on the pilot study of the SUFFICE project is an abridged version of a full report which presents the complete data set as well as an outline of a proposed health intervention. The full report is available electronically from *instituteofageing@uct.ac.za*. Enquiries: *Sebastiana.Kalula@uct.ac.za* or *Monica.Ferreira@uct.ac.za*

The intervention proposed in the full report is intended to redesign geriatric services in the public sector to enhance elders' health and functioning and thereby support their contributory activities. A key aim of the intervention will be to demonstrate that changes and innovations introduced in service procedures and standards can benefit clients and others – when clinicians inquire into the contributive roles of older patients and designate the preservation and enhancement of these roles as targets for intervention. A next step of the SUFFICE project is to detail protocols for such an intervention; no such protocol exists in the literature or in geriatric and allied professional training curricula.

Cardinal elements of the proposed intervention (demonstration study) are presented as stages and steps in Figure 2 overleaf.

Two sites with existing strong geriatric infrastructure and a large volume of older clients, geographically distant from one another, have been identified provisionally for the intervention. These sites are 1) the Division of Geriatric Medicine within The Albertina and Walter Sisulu Institute of Ageing in Africa at the University of Cape Town and the affiliated International Longevity Centre–South Africa, in Cape Town; and 2) the Department of Geriatric Medicine in the Nelson Mandela School of Medicine at the University of KwaZulu Natal, in Durban.

The Stroud Center made grants available to the IAA for the pre-pilot and pilot phases of SUFFICE. Funds are now required to support an intervention at the two provisionally identified sites: specifically, to design and implement training packages and to test the feasibility and acceptability of the intervention informally. (See Figure 2.)

Figure 2
Outline of stages and steps in the proposed health intervention at two geriatric sites

Stage/step	Action
Stage 1	
Step 1:	Selection of two conventional ambulatory clinical sites with a high volume of older patients
Step 2:	Independent inventorying of the presence and frequency of contributive roles and chronic health problems among older patients
Step 3:	Noting the degree of awareness by service providers of these roles, and a relationship between patients' health problems and their performance of contributive roles
Step 4:	Recording the rationale, type, frequency and distribution of service interventions
Stage 2	
	A training programme offered of selected service(s), based on lessons learned in Stage 1, including a technique for brief systematic inquiry into the contributive roles and interacting chronic health problems of each elder, as well as specification of procedures and standards for a clinical response aimed at preserving and enhancing their contributions. It is envisaged that the training programme will be designed, supplemented and co-ordinated by a geriatrician with extensive experience, including the initiation of similar training programmes in other developing countries (Dr Bloom at ILC–USA), and a multidisciplinary services research team that was involved in the pilot study.
	Steps 3 and 4 in Stage 1 will then be repeated to note changes and innovations in clinical practices by this service after the training module has been implemented.
Stage 3	
	After Stages 1 and 2 are completed and have led to appropriate revision in the training programme, the ground will be prepared for Stage 3: A controlled trial of routine versus trained intervention with extended outcome evaluation. The stage will cover i) a continuance and expansion of elders' contributive roles; and ii) relief of such distress as may accompany the performance of those roles. Selection of comparable control and intervention sites will depend on availability of sites in a particular region.

Notes: A fourth stage could be envisaged in which the benefit side of the cost–benefit equation is measured, in order to take account of benefits to older patients and benefits to individuals and groups that are mediated through the primary recipient and beneficiary of the health and allied services.