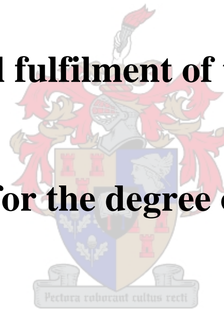
THE SOCIAL SUPPORT SYSTEMS AND QUALITY OF LIFE INDICATORS OF JEWISH SENIORS LIVING IN MILNERTON AND SURROUNDS

S. PARTON

Thesis in partial fulfilment of the requirements

for the degree of



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DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and has not previously in its entirety or in part been submitted at any University for a degree.

....

Signature **Date**

(Mrs S Parton)

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SUMMARY

The motivation for this research study was the lack of available literature on Jewish seniors and the social support systems which enabled independent living. The aim of this research study is to provide guidelines for social work intervention with Jewish seniors by gaining a better understanding of the social support systems which promote the quality of their lives and independent living.

To this end, both quantitative and qualitative research approaches were used. The research design was a non-experimental design using a survey research strategy. The knowledge purpose of the research design was exploratory/descriptive.

The literature study gives an overview of demographic trends with special emphasis on population ageing and its influence on social policy and legislation within the South African context. In addition to describing the quality of life indicators and well-being in the older person, the literature study seeks to identify and describe the function of social support systems from a systems theory approach.

This small scale social survey used a simple random sample of 30 Jewish seniors who were aged 60 years and above. The response rate was 80%. All were members of a volunteer-based community centre, Cape Jewish Seniors Association, Milnerton. The research instrument was a face to face interview using both closed and open ended questions. All but one interview took place in the participants' homes.

The results of the survey showed that the majority of Jewish seniors have matriculated and were financially independent. Most owned their own homes and were satisfied with their living arrangements. The majority of seniors lived independently and did not want to live with their children. Business/financial reasons and traumatic events were reasons for moving from an area while family and downsizing were reasons for moving to an area (push/pull factors). Most aged in place.

Women outnumbered men and change in marital status was linked to increasing age. The majority of the participants enjoyed a high degree of social contact with, family and

friends. The primary and secondary support systems of Jewish seniors and types of social support, showed few disparities to findings in the literature study. Most seniors did not use formal support systems.

Financial independence, involvement in community organisations and having good health were perceived as enabling older persons to live independently within the community. Being very active in organisations, ageing in place and ownership of property are determinants of a very good quality of life. Having a state pension, widowhood and advancing age are factors that have the most negative impact on the older person's quality of life.

In light of the above, it is recommended that social work interventions with older persons take cognisance of the following: social participation in civic organisations vs. social isolation; ageing in place vs. long distance migration; financial independence vs. state pension grant; the marital status and age of the older person.

As there is limited data on Jewish seniors, it is recommended that a national social survey of the Jewish senior population is undertaken.

OPSOMMING

Die motivering vir hierdie studie was die gebrek aan beskikbare literatuur aangaande Joodse senior burgers en die maatskaplike ondersteuningsisteme wat 'n onafhanklike bestaan moontlik maak. Hierdie studie poog om riglyne vir maatskaplike werk intervensie by Joodse seniors daar te stel deur 'n beter begrip vir hulle maatskaplike ondersteuningsisteme te ontwikkel en om hierdeur die kwaliteit van hul onafhanklike bestaan te verbeter.

Beide kwalitatiewe en kwantitatiewe navorsingsbenaderings is gebruik. Die navorsingsprojek was nie-eksperimenteel en het 'n verkennende strategie gevolg. Die kennisdoel van die navorsingsprojek was eksploratief/beskrywend.

Die literatuurstudie gee 'n oorsig oor die demografiese tendense met spesiale klem op bevolkingveroudering en die invloed hiervan op maatskaplike beleid en wetgewing binne die Suid-Afrikaanse konteks. Tesame met die beskrywing van die kwaliteit van lewensindikatore en die welstand van die ouer persoon, poog die literatuurstudie ook om die maatskaplike ondersteuningsisteme te identifiseer en om dit uit 'n sisteem-teoretiese oogpunt te beskryf.

Hierdie klein-skaalse maatskaplike ondersoek het 'n lukrake monster van 30 Joodse seniors van 60 jaar en ouer gebruik. Die reaksiekoers was 80%. Die monster was almal lede van die vrywillig-gebaseerde gemeenskapsentrum, Cape Jewish Senior Association te Milnerton. Die navorsingsinstrument was 'n een-tot-een onderhoud waar van sowel geslote - as oopeinde vrae gebruik gemaak is. Behalwe in een geval, het al die onderhoude in die betrokke groeplede se huise plaasgevind.

Die uitslag van die ondersoek dui daarop dat die meerderheid Joodse seniors gematrikuleerd is en finansieel onafhanklik is. Meeste besit hulle eie huise en is tevrede met hulle lewensomstandighede. Die meerderheid seniors woon onafhanklik en het ook nie die begeerte om by hul kinders te woon nie. Besigheids-/finansiële redes, traumatiese gebeure, familie en afskaling was die rede dat hulle na 'n ander area getrek het (stoot-/trekfaktore). Meeste het in een plek oud geword.

Vrouens is meer as mans, die verandering in huwelikstatus is gekoppel aan groeiende ouderdom. Die meerderheid van die deelnemers geniet 'n hoë mate van sosiale kontak met familie en vriende. Die primêre en sekondêre ondersteuningsisteme, en ook die tipes sosiale ondersteuning van Joodse seniors, dui op weinig van die teenstrydighede wat in die literatuur

gevind is. Die meeste van die seniors maak nie van formele ondersteuningsisteme gebruik nie.

Finansiële onafhanklikheid, betrokkenheid in gemeenskaporganisasies en goeie gesondheid stel ouer persone in staat om suksesvol binne 'n gemeenskap te woon. Om aktief in organisasies te wees en om in jou eie huis oud te word, is determinante van 'n baie goeie lewenskwaliteit. 'n Staatspensioen, weduwee- (wewenaar-) skap en ouderdom is die faktore wat die mees negatiewe invloed op 'n ouer persoon se lewenskwaliteit kan uitoefen.

In die lig van bogenoemde, word dit aanbeveel dat maatskaplike werk intervensies met ouer persone onderneem word, met die klem op: maatskaplike deelname aan siviele organisasies vs. sosiale afsondering; veroudering in eie woonplek vs. langafstand migrasie; finansiële onafhanklikheid vs. staatspensioen; die huwelikstatus en ouderdom van ouer persone.

Aangesien daar beperkte data oor Joodse seniors beskikbaar is, word dit aanbeveel dat 'n nasionale maatskaplike opname oor hierdie groep gedoen word.

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CHAPTER 1

INTRODUCTION

1.1 MOTIVATION FOR STUDY

The title of this research took inspiration from an old Dutch-Jewish saying, that loosely translates, means "Oh God, what is my lot in life? Hard work and then death?" (O God, wat is myn lot, hard werk en dan kapot?"). This research sets out to explore the social support systems of Jewish seniors as well as the quality of life indices that enable Jewish seniors to remain living in the community and who are members of Cape Jewish Seniors Association, Milnerton.

Cape Jewish Seniors Association (CJSA) has been operating for 21 years and was established in response to the social needs of the Jewish older person (Stein, 1986). CJSA is a volunteer-based service organisation for Jewish seniors with four branches in the Cape Peninsula. The parent branch is found in Seapoint, followed by Wynberg, Muizenberg and lastly, Milnerton. CJSA, Milnerton was formally launched in January 2002 as a consequence to the increasing numbers of Jewish seniors moving to the area.

In South Africa, the Jewish population has experienced an overall decline of some 36% since the 1970's and at present has an estimated total population of 85,500 (Kaplan, 2006). This decline in absolute numbers is attributed in large part to emigration and interfaith marriage (Dubb, 1994). Nationally, Jews account for less than 0,2% of the total population of the country's estimated 48 million people and as such constitute an ethnic minority (Statistics SA, 2001a & b). Three surveys undertaken in 1991, 1998 and 2005 point towards an ethnic minority who are highly assimilated and who view themselves as being both Jewish and South African (Dubb, 1994; Kaplan, 2006; Kosmin, Goldberg, Shain & Bruk, 1999). The unique demographic character of Jewish seniors thus lends itself to further exploration.

Of interest to this study is that national figures show that in South Africa, older persons aged 60 and over, make up 7,3% of the total population. Provincial figures show that in the Western Province, 10,8% of all race groups, are aged sixty and over while 18,7% of the white population are aged 60 and over (Dept of Social Development, n.d.:8-9). However, 27,6% of the Jewish population living in the Western Province are aged 60 and over, double the

provincial norm for all race groups, 10% higher than the white population and almost four times the national average. (Statistics SA, 2001a, b & c). The rates of migration of older Jewish persons into the Milnerton area and surrounds, could not be substantiated by the 2001 South African Census. However, what can be ascertained is that in the Milnerton area, the Jewish faith ranks second to Catholicism (Erasmus & Mans, 2004:6).

The aforementioned gives rise to two areas of concern in relation to the social support for seniors. Firstly, while the South African Jewish population has steadily declined, the rate of population ageing of the Jewish population is not known. What is known is that the population of older persons across all race groups in the Western Cape has increased 3% between 1996 and 2001 (Dept of Social Development, n.d.:7). Certainly, the population of Jewish seniors in the Western Cape is considerably higher than comparable age cohorts across the various race groups (Statistics SA, 2001a & f). In the long term, this may have implications with respect to old age dependency and parent support ratios. Secondly, commenting on the most recent survey of South African Jewry, Kaplan (2006:19)[1] noted that the perception has grown that the Jewish community is not an ageing population. This perception may well have an impact on two fronts: (i) it may inadvertently diminish the importance of the role (and future role) that social service organisations play in the lives of Jewish seniors and (ii) as a consequence, hamper access to adequate and equitable funding.

The growing number of people over the age of sixty is fast becoming a matter of international concern with projected population growth reaching unprecedented levels by the year 2050 (Legare, Ibrahima, Sossa & Smuga, 2003; WHO, 2002). By 2050, older persons in both the developed and developing nations will comprise an estimated 33% of their total populations or a total of two billion (Kinsella & Velkoff, 2001; UN, 2006). The UN (2006) predicts that by mid century, both the young and the old populations will be made up of equal numbers which has major implications for both the old age dependency and parent support ratios. With this in mind, the UN felt it imperative that social policies were put in place in order to forestall a socio-economic crisis in both the developed and developing regions of the world as was evidenced by the implementation of the Madrid International Plan of Action on Ageing, 2002.

Subsequently, the South African government policy on older persons drew on international guidelines that were laid down in the Second World Assembly on Ageing, viz. the Madrid

[1] In 1998 65% agreed and 2005, 46% agreed that the Jewish population is not an ageing population.

International Plan of Action on Ageing, 2002. One of the stipulated priorities mentioned is the need to ensure enabling and supportive environments for the older person by means of developing support systems that would "enhance … self reliance of older women and men and create conditions that promote quality of life and enable them to work and live independently in their own communities for as long as possible and desired". In other words, not to move, but to age in place (Harrigan & Farmer, 2000:45; Ramashala, 2001:373; UN, 2002:29).

A similar theme was carried forward in the Older Persons Bill (2003) which recognised inter alia, the access of older persons to "health, welfare and other care and support systems" in order for them to "live with dignity within the community" (South Africa, 2003). Once more, emphasis is placed firmly on the recognition that care for the older person within the community is of paramount importance, albeit through the function of either formal or informal support structures. While a paradigm shift from the macro to the micro level is all too evident, what needs to be explored, is the social capacity of seniors to age in place and to live in the community for as long as possible.

According to literature, social support in old age is one of the most important domains as it serves not only as a buffering effect against associated losses but also has positive effects across a wide range of outcomes such as well-being, quality of life, health, morbidity and mortality rates (Antonucci, 1985; Bowling, 2005:102; Carroll & Whelan, 1994:4; Gabriel & Bowling, 2004; Harrigan & Farmer, 2000:51; Qureshi, 1990:32-39; Siebert, Mutran & Reitzes, 2000:101). However, amongst the Jewish seniors living in the Milnerton area, these are the very factors that are unknown and require statistical verification viz. the social support systems of the seniors as well as their quality of life indices.

Questions that need further exploration are:

- What social supports are in place to sustain the older person within the community?
- What are the push/pull factors that account for the members' migration?
- What is the kin availability?
- What are their preferred living arrangements? Are the seniors equipped to live independently within the community? If so, what are the enabling factors?

- Finally, what, if any, are the gaps in the formal and informal support systems and what can be done to meet these needs?

In the light of limited available literature and data sets pertaining to (South African) Jewish seniors, the central thrust of this research would be the identification of the social support systems of the members of CJSA, Milnerton. The next level purpose of this study would be to better impact the medium to long term planning of the organisation in question where such planning is age and need-specific. It is further hoped that the findings of this research would have wider implications in terms of policy decisions by other Jewish service organizations committed to the aged in Cape Town.

1.2 PROBLEM STATEMENT

The government's contention that "there is … an inappropriate emphasis on the Government's responsibility for the care for the aged" shifts the burden of support from central government to community support services and local authority and by extension, to the informal sector. Thus while the South African government shares the concern of population ageing[2] with the rest of the world, as is evidenced by its formulation of the Older persons Bill, there still remains a critical lack of information pertaining to both informal service providers and issues surrounding older persons (South Africa, 1997; WHO, 2002:7). This critical lack of information is extended to the Jewish population and in particular Jewish seniors aged 60 and over.

1.3 AIM AND OBJECTIVES OF THE STUDY

Following from the above, the overall **aim** of this research is to gain a better understanding of the social support systems of Jewish seniors that promote the quality of their lives and enable them to live independently in their own community in order to provide guidelines for social work intervention with Jewish seniors.

The specific **objectives** of this research are as follows:

- To describe population ageing and how this has influenced social policy and legislation pertaining to older persons living in South Africa.

[2] The White Paper on Social Welfare sounds a warning that the projected population of senior citizens in South Africa will total 3,4 million by the year 2015 (South Africa, 1997:86).

- To explore the quality of life indicators and well being in the older person.
- To identify and describe the function of social support systems from a systems theory approach.
- To identify and discuss the quality of life indicators and types of social support of Jewish Seniors.
- To identify and explain the social support systems of the Jewish seniors.
- To present guidelines for social workers dealing with Jewish seniors.

1.4 CLARIFICATION OF KEY CONCEPTS

For the aim of this study the following key concepts are clarified.

1.4.1 Jewish

For the purpose of this research, Jewish would pertain to any one who professes to be Jewish either through birthright or religious conversion, and who considers themselves Jewish, irrespective of their frequency of attendance at a place of worship. It also pertains to any person of Hebrew descent (Barnhart & Barnhart, 1987:1132; Lamm in Donin, 1991:8).

1.4.2 Older persons/Seniors/Aged

According to the Older Persons Act, South Africa, older persons are women and men aged 60 and 65 respectively (South Africa, 2003:3). Usually the terms of reference are country-specific and relate to ages of retirement (Legare *et al*., 2003; WHO, 2000:10). However, for the purpose of this study, the terms older person, seniors and aged, will be used interchangeably and will be used to denote people aged 60 and over. This has largely been determined by the fact that both males and females from the age of 60 can become members of Cape Jewish Seniors Association.

1.4.3 Jewish seniors

Jewish seniors in Chapters Five and Six will refer to Jewish seniors who live in the Milnerton area and surrounds and who are members of Cape Jewish Seniors Association, Milnerton.

1.4.4 Social support system

Social support systems, as distinct from social networks, is defined by the Social Work Dictionary as "an interrelated group of people, resources and organisations that provide individuals with emotional, informational, material and affectionate sustenance. Members of

a social support system may include the individuals closest friends, family members, key members of the peer group, fellow employees, member organisations and institutions that can be called for help in time of need" (Barker, 1999:474).

1.5 RESEARCH METHODOLOGY

1.5.1 Research approach

More and more social scientists are using mixed research approaches to better understand the research topic at hand. Both approaches are complementary and both add value to the other and together, achieve a deeper meaning and understanding of the research topic. In order therefore to better understand the social context plus the quantitative nature of the research topic under study, both qualitative and quantitative research approaches were used (Grinnell, 1985:121, 263; Grinnell, Tutty & Williams, 2005:86-87; Rubin & Babbie, 1993:30; Terre Blanche & Durrheim, 2002:40). It is can be further stated that the judicial use of both these research approaches serve to increase both the effectiveness and expertise of social workers in the field of gerontology (Sheridon & Kisor, 2000:98).

1.5.2 Research design

Sheridan and Kisor (2000:104) state that the two factors that determine the choice of research design are the purpose of the research as well as the timing of the data collection. The research design employed for the purpose of this study is a non-experimental design using a survey research strategy.

The three main characteristics of survey research are:

- It aims to gather data about a situation that already exists (Williams, Tutty & Grinnell, 1995:241).
- It gives a quantitative description of the population under study (Pinsonneault & Kramer, 1992:5).
- It is a systematic fact gathering method "… in which a specific series of questions is asked, through written or oral questionnaires, of a representative sample of the group being studied" (Barker, 1987:161).

Survey research is also best suited to studies where the unit of analysis is the individual; in this case the unit of analysis would be the individual members of CJSA, Milnerton. The research design is a cross-sectional survey design as data was collected only once, as opposed

to a longitudinal study that is carried out over a period of time and on successive occasions (Grinnell *et al.*, 2005:331; Williams *et al.,* 1995:244-245). The express purpose of such a design is to extrapolate findings to the population at "the point in time the survey was conducted" (Pinsonneault & Kramer, 1992:9). The knowledge purpose of this design is exploratory/descriptive as it answers "what" as well "how and why" questions (Fouche & De Vos, 2005:106). It must be noted that exploratory studies are employed in bringing to the fore new insights into phenomenon of which very little is known about which is the case with regard to the social support systems of the Jewish seniors who are members of CJSA, Milnerton. (Fouche & De Vos, 2005:106; Rubin & Babbie, 1993:106; Terre Blanche & Durrheim, 2002:39; Yegidis & Weinbach, 1991:76). This study is also descriptive in nature as it serves to describe the characteristics of a population through the use of quantitative data (Fouche & De Vos, 2005:106).

1.5.3 Research method

1.5.3.1 Literature study

Fouche & Delport (2005:84) states that the literature review helps to elucidate the problem being researched and as such, lays a solid foundation for the rest of the research process and most importantly, provides a framework that allows "for the research results to be interpreted in relation to existing theory". Thus this research will be informed by a literature review which examines the following three areas: (a) population ageing; (b) quality of life indicators of the older person and (c) social support networks as related to systems theory.

1.5.3.2 The sampling process

Strydom (2005a) citing a 1983 study by Arkava and Lane states that a sample is made up of elements of the population that are to be considered for inclusion in the study. In other words, by studying the sample, the researcher will be able to extrapolate the results to the population (Strydom, 2005a:193).

There are three steps in the sampling process viz. defining the population, developing the sample frame and the choice of a sampling technique (Sheridan & Kisor, 2000:105-108).

Defining the population

The term population is synonymous to universe and in the area of social research, refers to "all people or cases that could theoretically be available for an investigation" (Barker, 1987:122). For the purpose of this social work research, all those who make up the 2006

membership list of Cape Jewish Seniors Association, Milnerton, define the population as these subjects possess the attributes in which the researcher is interested (Mark, 1996:104; Strydom, 2005a:193).

The population is made up of 134 such members and is drawn from the following area: Bloubergrant, Bloubergrands, Bothasig, Brooklyn, Century City, Century View, Edgemead, Greenpoint, Lagoon Beach, Milnerton, Oranjezicht, Parow (including Parow East and North), Rugby, Sunningdale, Tableview, Tygerhof, West Beach, Woodbridge Island and Woodstock. It must be noted that members that attend from Greenpoint, Oranjezicht, and Woodstock are the exception rather than the rule, as CJSA has a branch in Sea Point.

Developing the sample frame

A sampling frame is defined as a "listing of units (people, objects or events) in a population from which a sample is selected" (Grinnell, 1997:448). McCauley (1987:126) observed that in a sampling frame: (a) each person must have a unique identifier in other words assign each person in the frame a number; (b) There must be no duplications and (c) non-population members are to be excluded from the sample frame (in Sheridan & Kisor, 2000:106).

The sample frame will thus be made up of:

- Jewish Seniors who have paid their annual 2006 membership fees to CJSA, Milnerton irrespective of their area of residence.
- Jewish seniors who are 60 years and older (i.e. born during or before 1946).

The sample frame excludes:

- Members who are younger than 60 years of age (i.e. born after 1946).
- Seniors who are physically too ill to participate in an interview and who are mentally/intellectually incapacitated due to any one of the dementias. In other words, only the functionally well are included in the sample frame.
- Non-Jewish members as this study seeks to describe the social support systems of a subsection of the Jewish population.

As a result of the above conditions, the sample frame consists of 112 Jewish seniors aged 60 and over who have paid their 2006 membership fees and who are considered by the researcher to be both physically and mentally competent to participate in an interview.

An important issue at this juncture is the selection of the **sample size**. Large sample sizes have the advantage of reducing sampling error (Rubin & Babbie, 1993:243). To this end Stoker (1985) suggested for a population of 100, the sample size should be 45% or 45 participants. However time constraints and lack of available resources mitigate against the use of such a large sample size.[3] Other authors suggest that an adequate sample size is 10% of the research population while yet others regard 30 respondents as the minimum sample size (in Strydom, 2005a:195; Williams *et al.,* 1995:233). It is significant to note that Williams *et al.* (1995:233) state that a sample size of 10% will "provide reasonable control over sampling error".

Given that the research population is relatively small (113), and to reduce sampling error as far as possible, the sample size of 10% was rejected in favour of a larger sample. On balance, the researcher chose a sample size of 30 respondents or 27% of the research population. The fact that the research population is fairly homogenous[4] not only allows for a smaller sample size but also lends itself to smaller sampling error and thus greater representivity. As will be seen in the following section on sampling procedure, simple random sampling was used in order to increase both representativeness and external validity, thus decreasing the probability of sampling error (Rubin & Babbie, 1993:243; Terre Blanche & Durrheim, 2002:316-317).

Sampling procedure

The sampling procedure that was chosen for this study is a probability sampling using a simple random sampling technique. Probability sampling as defined in the social work dictionary (Barker, 1999:125) and Williams *et al.* (1995:337) is the "systematic selection of cases in a way that allows the researcher to calculate the likelihood, or level of probability, that any given case/every member would be selected from the population". Probability sampling also allows for the sample to have a higher degree of representation of the population from which it was drawn (Barker, 1999:126; Mark, 1996:106; Strydom, 2005a:196). The findings can also be generalised to the population thus allowing for a high degree of external validity (Reamer, 1998:136). Furthermore, because probability sampling employs a random selection method, it is also the procedure least likely to result in selection bias (Reamer, 1998:73; Strydom, 2005a:196; Terre Blanche & Durrheim, 2002:276).

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[3] This alone translates into 45 hours interviewing time.
[4] In as much as the research population all belong to the same ethnic minority group and are all aged 60 years and older.

A simple random sampling technique was used in this research mainly for the fact that it allows for the possibility for everyone on the sample frame having an equal chance of being chosen for the sample (Strydom, 2005a:197). Systematic and interval sampling were ruled out as suitable methods as there existed a high probability of selection bias due to the make up and ordering of the sampling frame.[5] The research population is made up of the membership list.

The steps taken to draw the simple random sample are based on Strydom (2005a:197-198). The steps are:

1. Those persons listed on the CJSA, Milnerton membership list were identified as the research population.
2. The sampling frame was developed by including only Jewish seniors aged 60 and over who had paid their 2006 membership and were considered by the researcher to be mentally competent and physically able to complete the interview.
3. Each person on the sampling frame was assigned a number from 01–113.
4. The sample size of 30 was selected. The sample size was based on Grinnell and Williams (1990) assertion that this number is sufficiently large enough, the research population is small, fairly homogenous (all belong to the same ethnic minority, all consider themselves Jewish, all belong to CJSA Milnerton, and all are aged 60 and over) and that the instrument was pre-tested to ensure reliability (in Strydom, 2005b:210-211).
5. A computer generated sample was rejected in favour of a table of random numbers given in Rubin and Babbie (1993:601-602). The random number table has been used extensively in social science research and therefore lends credibility to the scientific nature of this research. The researcher had no means of verifying the scientific validity of the computer generated sample.
6. Each column was numbered, from left to right (1) through to (14). The numbers were written on a piece of folded paper in a container and the researcher drew one number out. This was the column chosen. Reading down this column, the first three digits on the right hand side were used. The columns were read top to bottom, left to right. Every number

[5] The sampling frame is drawn from the membership list which is in alphabetical order listing husbands first and then wives. The danger then lay in more men being chosen than women or vise versa resulting in an over representation of either the male or female gender.

that was as large as the research population or smaller was chosen and marked (Strydom, 2005a:203). The first 30 such numbers made up the sample.

1.5.4 Method of data collection

1.5.4.1 Preparation for data collection

As considerable time had elapsed from the time that consent was first asked of the organisation to proceed with the research, the researcher again verified consent and forwarded a copy of the questionnaire to the Chairperson and Director of CJSA as well as her colleagues and work associates who sit on a Professional Sub-Committee of Cape Jewish Seniors Association.[6]

According to Strydom (2005a:195), in order to ensure reliability when working with small populations, it is advisable to pre-test the instrument several times against a similar population. As the research population is relatively small and reliability had to be ensured, preparation for data collection entailed the following:

1. The researcher first requested her colleagues to pre-test the questionnaires in order to limit error (Babbie & Mouton, 2001:244; Reamer, 1998:73). The rationale is that being Jewish and professional social scientists, they are competent in identifying any cultural bias or content ambiguity.
2. The questionnaire was then pre-tested on a male committee member from Milnerton who also met the selection criterion.
3. Thereafter, a colleague who was not present during the first pre-testing, was asked to vet the questionnaire for any inconsistencies or bias.
4. The final pre-test was with a male committee member from the Wynberg branch who also met the selection criterion.
5. After each pre-test, the questionnaire was adjusted accordingly.

It must be noted that while all seven individuals who assisted in pre-testing the questionnaire were Jewish, five met all the criteria of the research population: they were Jewish, 60 and over, paid up members for 2006, and were both mentally and physically competent to complete the questionnaire.

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[6] CJSA Professional Sub-Committee is drawn from the Management Committee, Executive Committees of CJSA and the three social workers employed by CJSA. Those that sit on this committee have a psycho/social work background.

Once the sample was drawn, the researcher approached the would-be participants and requested their permission to be interviewed. The matter of informed consent was explained. All but one interview took place in the participants' homes. One interview was an office interview as the participant could not be assured of privacy in their home.

1.5.4.2 Research instrument

The research instrument that was used was an interview as interviews took place on a face to face basis. Before the interviews took place, the researcher first obtained the participants informed consent (Addendum A). The interview schedule was structured and used both closed as well as open ended questions.

The key component in face to face interviews is the level of interpersonal communication that takes place which improves the response rate (Babbie & Mouton, 2001:250). The higher the response rate the greater the probability that the results will be representative of the population under study. The opposite holds true in mailed surveys. (Sheridan & Kisor, 2000:112-113). Care was taken that in dealing with the older old and the very old that the questionnaires would be readily understood and that the duration/length of the interview was not too onerous.

Care was taken that the format of the questionnaire adhered to the following guidelines (Mark, 1996:250-256; Reamer, 1998:231-244):

- As this is an exploratory/descriptive study, a broad range of questions were posed.
- The use of ordinary, clear and concise language was used. As far as possible social work terminology was avoided.
- Both open ended and closed questions were used in order to illicit the appropriate responses. This also served to minimise ambiguity.
- Filter questions were also used as these serve to identify which questions were appropriate thus ensuring that only the relevant questions are answered and in the correct sequence.
- All personal questions which are considered sensitive were asked at the end of the questionnaire. This increased the likelihood of the questionnaire being completed in an honest manner.

- The questionnaire was structured in such a way that questions were ordered by question and content format in order to prevent confusion and decrease the likelihood of non-responses.

1.5.4.3 Method of data analysis

The study started in January 2005 and finished in August 2007. According to Babbie and Mouton (2003:101) data analysis is the method by which the collected data is analysed. The data collected is descriptive as it sets out to describe and summarize the variables under examination (Grinnell *et* al., 2005:357). As this research approach is primarily quantitative, all the responses were given a numerical value or coded. Where responses from open-ended questions were qualitative in nature, the responses were categorised into themes and coded (Franklin & Ballan, 2005:445). The raw data was entered into Excel and tabulated. The levels of measurement that were used to measure the data were nominal, ordinal, interval and ratio measurement.

Once the data was entered into Excel and collated, the data was grouped and presented in various tables and charts (Chapters Five and Six). Examples of tables used to illustrate the nominal data are contingency tables, grouped frequency distribution tables and percentage distribution tables. Charts that were used to illustrate the nominal and discrete data were simple and horizontal bar charts. Histograms were also used when continuous data needed to be illustrated in a meaningful way. Pie charts and exploded pie charts were also used to analyse data (Denscombe, 1998:177-190).

1.6 ETHICS

Due regard must be given to ethical concerns while undertaking social research, central to which are the three guiding principles of autonomy, nonmaleficence and beneficence (Reamer, 1998:111-120; Rubin & Babbie, 1993:57-61; Terre Blanche & Durrheim, 2002:66).

In order to ensure the **autonomy** of the participants, the researcher had an ethical responsibility to first of all of obtain informed consent of the respective participants. However, the participants were also being made aware that while the contents of the research paper belong in the public domain; their identity would remain strictly confidential (Babbie, 1989; Grinnell, 1985; Mouton, 2004; Sheridan & Kisor, 2000). Key to the concept of autonomy is the understanding that the participant could withdraw his/her consents to

participate in the research at any time without fear of consequence (Terre Blanche & Durrheim, 2002:66).

The code of ethics governing research practice in the field of gerontology does not differ widely from other fields of research. However, as the population is made up of Jewish seniors, a proportion of who may have experienced the Holocaust, special consideration had to be given to the avoiding emotional distress and harm (Sheridan & Kisor, 2000:122). Thus the principle of **nonmaleficence** was applied (Terre Blanche & Durrheim, 2002:66).

A key component is accountability to one's peers and the effect that the research process may have on both the participants and the community (Babbie, 1989:477; Mouton, 2004:242). Permission to proceed with this research was granted by the Executive Committee of Cape Jewish Seniors Association who employs the researcher. Professional etiquette also necessitated that the researcher inform the respective Jewish religious leaders in the community i.e. both Orthodox and Reform, that a research study was to be undertaken, the results of which were to be disclosed. Finally, the principal of **beneficence** can be seen to be in place with the reciprocal agreement that research findings would be used by the Cape Jewish Seniors Association (Terre Blanche & Durrheim, 2002:66).

It must be further noted that: (1) The limitations of the research process would also be made known to both the organisation and to the researcher's peers and social science community; (2) The researcher is registered as a social worker with the South African Council for Social Service Professions and as such has adhered to the ethical code of that profession.

1.7 LIMITATIONS OF THE STUDY

A stated limitation of this study is the limited availability of literature and data sets dealing with Jewish seniors within the South African context. To this end, numerous international journals were referred to that dealt with issues pertaining to the older person.

The researcher was also hard - pressed to find relevant research from the field of Social Work in South Africa. This research paper has therefore drawn from other bodies of knowledge such as medicine, sociology, psychology and in some instances, anthropology.

The demographic profile of Jewish seniors living in Milnerton and surrounds, gleamed from SA Statistics 2001 census, is not a true reflection of the present-day Jewish population living in these areas. Firstly, the Census no longer requires respondents to denote their religion. The researcher also suspects a reluctance to denote one's religious affiliation in a government

census, with members of the Jewish population giving preference to registering with the central register (for the Jewish Community). A very similar occurrence is found amongst English Jewry in a study undertaken in 2003 (Leeson, 2003). Secondly, inaccurate calculations of the 2001 census data by SA Statistics. The latter contention is borne out by a letter from Mendal Kaplan[7] which states, amongst other things, that the religious count was "understated by at least 20%" (Kaplan, 2006). Thus data from the respective Jewish registers would give a truer reflection of the demographics although these figures are also incomplete as mentioned in a telephonic interview with a member of the Jewish Board of Deputies, Cape Town. The researcher did not over-sample. There were six refusals thus the number of participants was reduced from 30 to 24. However, it was felt that to maintain the integrity of the research study it was preferable to state this as a limitation of the study rather than compensate with the sample frame. Attention is drawn to the exceptionally good response rate of 80%, which is indicative of the representativeness of the sample (Babbie & Mouton, 2003:261).

The questionnaire did not include "sms" as a means of telecommunication under Social Contact question 3b. Should this have been included, there would have been a higher number of recorded contacts between the respondents and their support system. This omission was pointed out to the researcher by one of the respondents.

The researcher did not ask the participants who were living independently how easy it had been to make friends, therefore no comparison could be made with those who lived in retirement villages.

During the course of the research study, a participant's spouse died. The subsequent change in the participant's marital status was recorded.

1.8 PRESENTATION

This research study is made up of seven chapters. Chapters Two, Three and Four are literature reviews.

Chapter One, the introductory chapter, spells out the motivation for the study, the problem statement, the aims and objectives of the study, the research approach as well as the research

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[7] Note that this letter was used as an insert to the booklet "The future of South African Jewry. Comments and observations" M. Kaplan. 31 July 2006.

design and the research methodology. Ethical issues as well as limitations of the research study are examined.

Chapter Two gives an overview of demographic trends with special emphasis on population ageing. The social policies and legislation, both international and national, which were promulgated in response to the demographic trends of the aged, are also examined. The aforementioned provides the backdrop against which the demographic trends, lifestyle and concomitant needs of the Jewish seniors belonging to CJSA, Milnerton. As information is drawn from census data, secondary data analysis is used in this chapter.

Chapter Three discusses the quality of life indicators and well being of the older person living in the community while chapter four looks specifically at the social support systems, more notably the informal support systems of the older person as applied by systems theory.

Both Chapters Five and Six report on the results of the collated data. These results are also linked back to findings in the chapters dealing with the literature reviews (Chapters Two, Three and Four). Chapter Five gives the results of the self reported quality of life indices and the types of social support that Jewish seniors living in the community experience. Chapter Six gives the results of the social support systems of Jewish seniors living in the community as well as their perceptions of service delivery from the Government sector.

Chapter Seven deals with the findings of Chapters Five and Six. The conclusions and recommendations which are presented in this chapter are based on these findings. Recommendations for further research are also given.

CHAPTER 2

OVERVIEW OF POPULATION AGEING TRENDS, SOCIAL POLICY AND LEGISLATION

2.1 INTRODUCTION

The first objective of this research study is to describe population ageing and how this has influenced social policy and legislation pertaining to older persons living in South Africa. This chapter gradually narrows its focus from first examining trends on a global level and then looks at Africa, South Africa and finally the Jewish population under study, namely the Jewish seniors residing in the Milnerton areas. In short, this chapter sets out to examine the Jewish senior population group against the background of current demographic trends, social policy and legislation.

Central to the importance of demographic trends is the direct bearing they have on social policy and, ultimately, legislation. Mirkin and Weinberger (2001:52) state that this is the very challenge that policy makers are faced with, the challenge to provide conditions that are conducive to the promotion of a quality of life that will "enhance the ability of the older persons to work and live independently (and for) as long as possible". A synopsis of the United Nations policy documents on the aged is also covered in this chapter and mention is made on how they have effected policy revision and legislation in South Africa.

Attention is drawn to the following: (1) The statistical discrepancies that are found in the different source documents with regard to demographic and statistical trends and (2) Policy documents and statistics pertain to the period ending July 2006.

2.2 WORLD DEMOGRAPHIC TRENDS

Some of more important and easily identifiable demographic trends are population ageing, life expectancy rates, replacement levels at birth and the increase of older persons against younger cohorts. Significant socio-demographic trends are the migration and urbanisation patterns of the older person and their preferred living arrangements.

2.2.1 Population ageing

Population ageing is one of the most important demographic trends to emerge in recent times and while characteristic of the developed nations of the world, demographers have predicted that in the not too distant future, this too will be cause for concern in developing nations. The phenomenon of population ageing is brought about when countries experience an ever increasing ageing population with a corresponding decline in the numbers of younger cohorts, and has been defined in the United Nations policy framework on active ageing as simply "the decline of children and young people and an increase in the proportion of people aged 60 and over" (WHO, 2002:6). Moreover, population ageing is most heavily influenced by low levels of fertility together with decreased rates of adult mortality (Kinsella & Velkoff, 2001:17).

Important contributing factors have been the decrease of infectious diseases, the introduction and implementation of birth control measures and the entry of women into the labour market. Initially, improved health led to lower mortality rates in both the young and old alike which led to a higher life expectancy. Ramashala (2001:363), views population ageing as the long term consequence of socio-economic development.

As previously mentioned in the opening chapter, by 2050 older persons in both the developed and developing nations will comprise an estimated 33% of their total populations or a total of two billion (Kinsella & Velkoff, 2001). In real terms, one in five persons worldwide will be aged 60 and over. By the following century, however, more than a quarter of the world's population (28%), will fall into this age category (Mirkin & Weinberger, 2001:41).

Figure 2.1 illustrates how from 1900 to 2100, the population of older persons will have increased fourfold, from 6,9% to 28,1%. However the increase of some 18% between 2000 and 2100 is considerably higher an equivalent time span between the years 1900 and 2000, an increase of a mere 3,1%. The conclusion to be drawn, is that population ageing will happen at a far faster pace than hitherto experienced, particularly within the developing countries of the world (Figure 2.1).

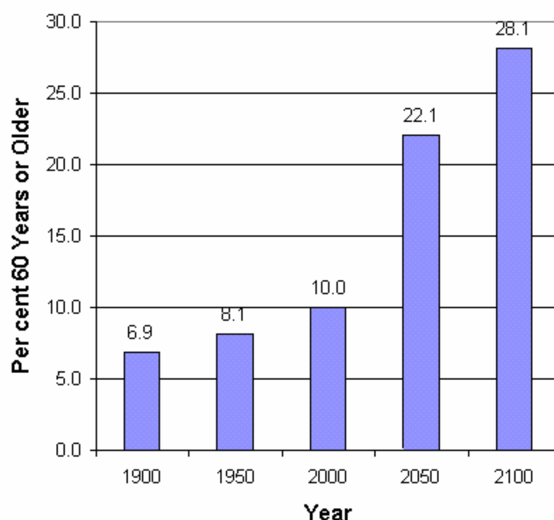

Figure 2.1: Three Centuries of World Population Ageing
(Source: Long-Range World Population Projections: Based on the 1998 Revision. The Population Division, Department of Economic and Social Affairs, United Nations Secretariat)

The worldwide total population of those aged 60 and over will more than double between the years 2000 and 2050 as will the populations in Africa, Asia and Latin America and the Caribean (Figure 2.2).

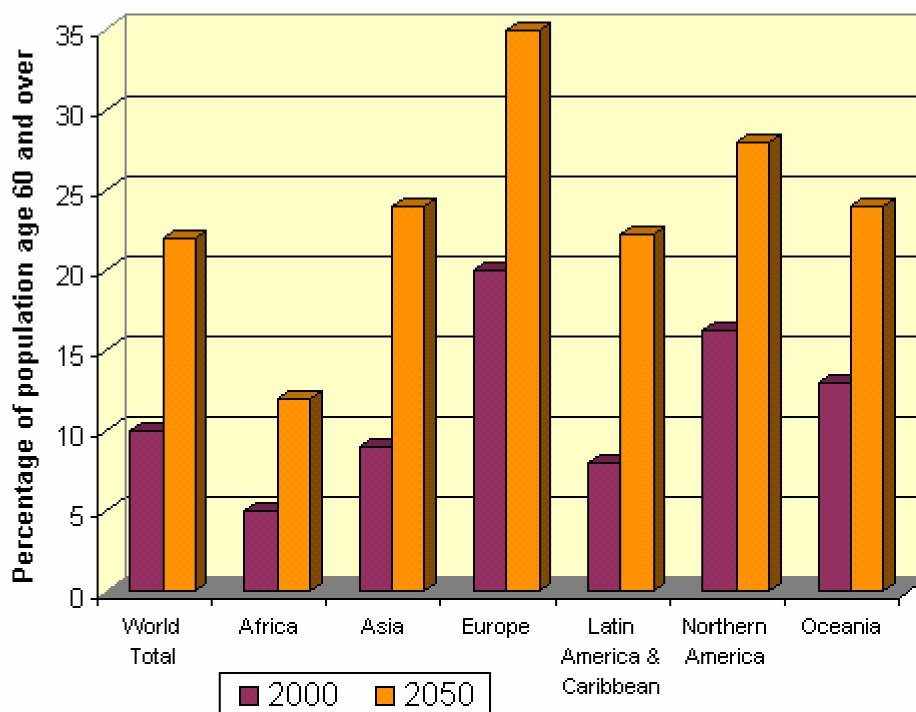

Figure 2.2: Percentage increase in age 60 and over by region
(Source: World Population Prospects, The 1998 Revision, Volume II: Sex and Age. The Population Division, Department of Economic and Social Affairs, United Nations Secretariat)

In 2002, the number of older persons (in absolute numbers) living in developing nations of the world stood at 400 million. However, by 2025 this figure will have more than doubled to 840 million, representing 70% of all older people worldwide (WHO, 2002:9). To better illustrate this trend, the increase in the number of older persons in developed countries will increase 65% between the years 1996 to 2030 as compared to 200% for the same period in the developing nations (HelpAge International, 2002:21).

Furthermore, by 2030, three-quarters of the world's elderly population will be living in the developing nations of the world and only one quarter in the industrialised nations, a decrease of 15% over a 30 year period (Table 2.1).

Table 2.1: Absolute numbers and percentage of people over 60 in the developing world

Year	Absolute numbers aged 60+	Percent of world's older population
2000	374 million	60%
2008	493 million	65%
2030	1 billion plus	75%

(Source: State of the World's older people 2002, HelpAge International)

As can be seen in Table 2.1, by the year 2030, the numbers of people aged 60 and over will increase from 374 million to one billion, an increase of 15%. During 2000 the world's elderly population aged 60 and over grew at an unprecedented 795 000 persons per month and was estimated to total 605 million people, or 10% of total of the world's population. Of this, 20% occurred in the developed regions of the world, 8% in the less developed and 5% in the least developed parts of the world. By the year 2050, it is estimated that in the developed and developing regions of the world, these figures would have increased 33,2% and 12% (Rand Organisation, 2005). After 2010, it is foreseen that this accelerated population ageing will be at its most rapid as the large number of "baby boomers" begin to reach age 65.

The median age can also be used as an indicator for ageing populations and has been defined as "the age that divides a population into numerically equal parts of younger and older people" (Kinsella & Velkoff, 2001:16). Similarly, the median age can also be used to gauge the shifts in age distribution especially within populations. Between 1999 and 2050, the greatest variances in median ages will occur in Latin America and the Caribbean, followed equally by Africa and Asia (Figure 2.3).

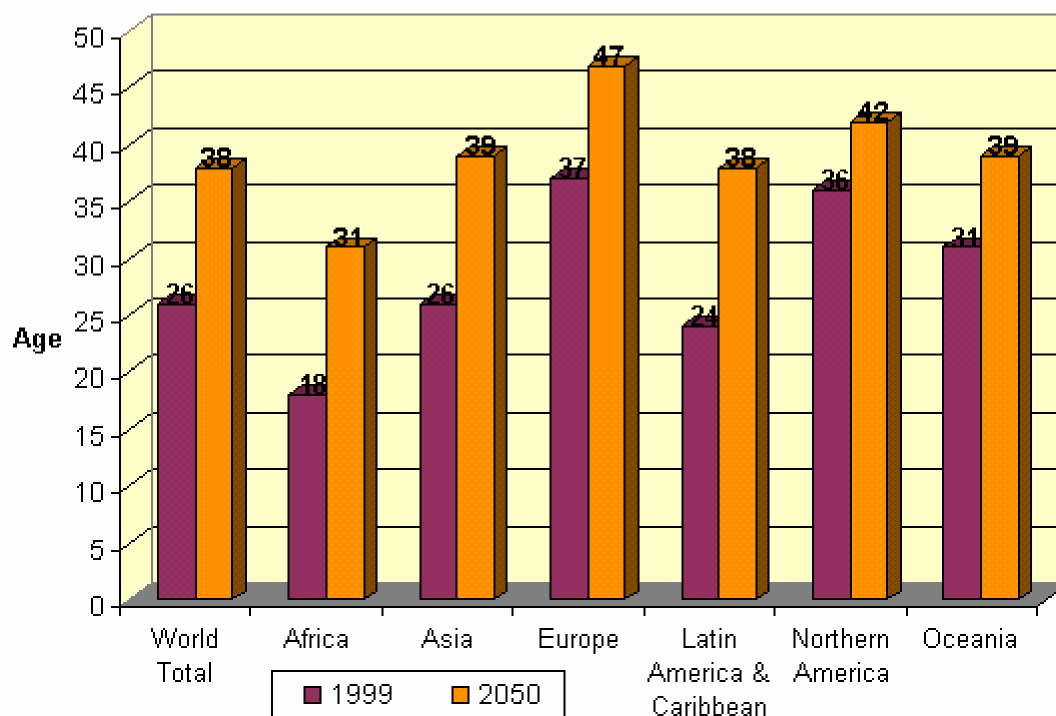

Figure 2.3: Median Age by Region, 1999-2050.
(Source: World Population Prospects, The 1998 Revision, Volume II: Sex and Age. The Population Division, Department of Economic)

The spectre of a burgeoning ageing population should lend impetus for social agencies, at all levels, to plan for the future needs of the elderly. This is especially important in the developing regions of the world where the needs of the older person are often overshadowed by more immediate socio-political issues.

2.2.2 Life expectancy

In this section, the role that life expectancy plays in population ageing will be discussed. Life expectancy at birth has seen an increase throughout the world bar for some parts of Latin America and more notably, Sub-Saharan Africa, where the life expectancy has been dramatically cut to 45 years due to the AIDS pandemic. By 2010, it has been projected that in countries such as Botswana, Namibia, South Africa and Zimbabwe, life expectancy will be reduced by thirty years (Kinsella & Velkoff, 2001:27). The life expectancy for those born in the developed nations of the world currently stands at over 74 years of age (Japan and Singapore stand at 80). Table 2.2 shows a significant difference of 26 years in the life expectancy at birth between North America and Africa. In East Asia the life expectancy at birth rose sharply from less than 45 years in 1950 to 72 years of age in 2001(Kinsella & Velkoff, 2001:23).

Generally speaking, over a period of a hundred years i.e. between 1950 and 2050, life expectancy rates are expected to increase by 30 years. Table 2.2. highlights the global figures of life expectancy and ageing for the years 1950, 2000 and projections for the year 2050.

Table 2.2: Global figures of life expectation and ageing: 1950, 2000 and 2050

Indices	1950	2000	2050
Life expectancy at birth	46 years	65 years	76 years
Age of 50% of world's population	24+ years	27+ years	36+ years
Percentage of children	34%	30%	21%
Percentage of 60+	8%	10%	21%
Total number aged 80+	14 million	61 million	314 million
Total number aged 90+	Not given	8 million	61 million
Total number aged 100+	Not given	180 000	3.2 million
% of women aged 65+	Not given	56%	55%
% of women aged 80+	Not given	64%	61%

(Source: State of the world's older people 2002, HelpAge International)

Significantly, by 2050 the percentage of children will equal the percentage of people aged 60 and over while the numbers of people aged over 80 will have increased five fold and those aged 90 years of age, eight fold. By 2050, those aged 100 and over will increase 18 fold. Moreover, throughout the world, females live longer than their male counterparts. This higher male morbidity rate results in a gender imbalance which is carried through to old age.

From as early as 30-40 years of age, females begin to outnumber men, irrespective of the regions' socio-economic development. While the proportion of elderly women is higher than men in the developed nations of the world, in the developing regions, in terms of absolute numbers, women far outweigh the number of men (UNFPA, 1998:4). In both Europe and North America it has been shown that women usually outlive their male counterparts by up to seven years.[8] Furthermore, between the ages of 60-70, those who are married are more likely to be men.[9] In other words, men in this age group are more than twice as likely to be married as their female counterparts of the same age (75% and 35% respectively). However, as the incidence of male mortality is also higher in this age group, so too is there a correspondingly high incidence of widowed females (Kinsella & Velkoff, 2001).

[8] In Russia women outlive their men folk by 12 years, the conjecture being that the high incidence of alcohol and homicide accounts for the high mortality rate amongst Russian males (Kinsella & Velkoff, 2001).
[9] Because men normally marry women younger than themselves.

It is unclear why women not only live longer than their male counterparts but also outnumber males in every age group bar for the 0-9 age group and this apparent ‘gender advantage" generally holds true for both the developing and developed regions of the world (Kinsella & Velkoff, 2001:29). For women, the death of a spouse normally means a lowering of living standards and in some cases, poverty (Kinsella & Phillips, 2005:26). The death of a spouse affects men and women differently in as much as men are more likely to remarry, but in the absence of remarriage (which becomes increasingly improbable with advancing years), they are more likely than women to lose their social support network (Kinsella & Phillips, 2005:25).

It can thus bee seen that increased life expectancy, decreased adult mortality, coupled with low fertility rates, have been the primary reasons for population ageing. Furthermore, the phenomenal global upsurge in the life expectancy rates is also an indicator of socio-economic development and can be viewed as a demographic "revolution" (HelpAge International, 2002). Furthermore, programmes and social policies designed to address the needs of the older person should take cognisance of the fact that older women outlive older men and should therefore be age and gender specific.

2.2.3 Low replacement levels

Critical to our understanding of population ageing is the relationship between the average age of a given population, low replacement levels and fertility rates. Population ageing is exacerbated by low replacement levels and is indicative of societies in transition i.e. when societies change from high fertility and high mortality rates to correspondingly low fertility and low mortality rates. Generally speaking, the average age of a population will rise when the fertility rates decrease (Mirkin & Weinberger, 2001:47).

As increasing numbers of women entered the labour market, fertility rates declined as did replacement levels and the size of a population stabilises when the replacement levels of births per woman equals 2.1. Below that figure, the population size in the younger age groups decreases, leaving a higher incidence of older persons. In 1975 there were only 22 countries worldwide that had birth-rates either below or equal to the replacement level. By 2002, the number of countries that were experiencing low replacement levels had risen to 70 while the projected increase in 2025 is said to be 120, a fivefold increase over a span of fifty years (Kinsella & Velkoff, 2001:7).

Of significance is Mirkin and Weinberger's (2001) contention that the rate of demographic transition taking place in developing nations is more rapid than that of the developed countries of the world. Moreover it is the rate at which the fertility decline is taking place which is effecting population ageing or what the United Nation terms the "unprecedented speed of the ageing process" (UNFPA, 1998). An example of this rapid population ageing can be found in Azerbaijan where it will take only 41 years (from 2000-2041) for the percentage of the population of those aged 60, to double from 7% to 14% (Kinsella & Phillips, 2005:15). France, on the other hand, took 115 years to double its population that was aged 65 and over. A consequence of the rapid rise of population ageing is the need to recognise that these developing nations are in a state of transition and whether they will have available resources to meet the demand of public pensions and healthcare.

2.2.4 Increase of older age population against younger cohorts

One of the consequences of population ageing, is that by 2050, for the first time in history, the number of older persons aged 60 and over will equal the number of children aged 0–14 (Figure 2.4). However, while this is not a universal phenomenon, it will be experienced by many nations throughout the world (Mirkin & Weinberger, 2001:37).

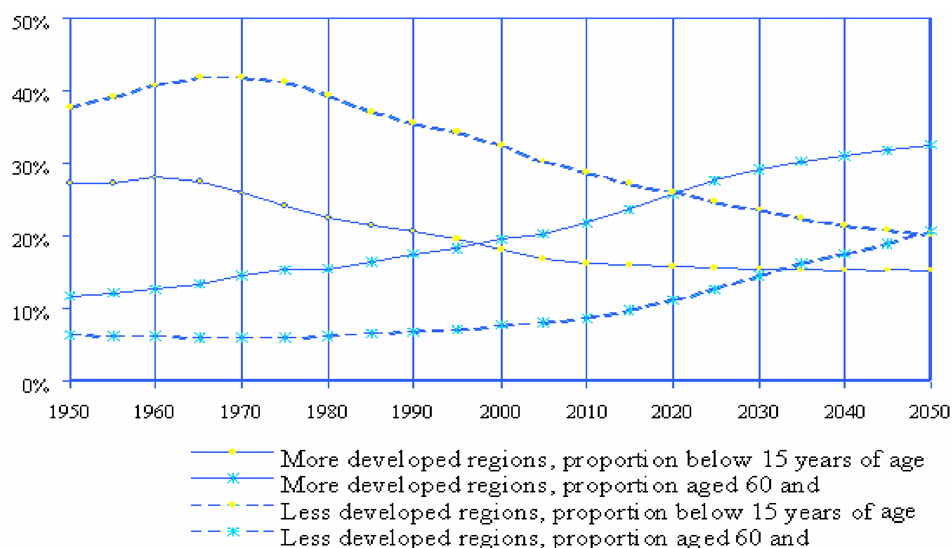

Figure 2.4: Proportion of total population aged 0-14 and 60 and over. More and less developed regions, 1950-2050 (medium variant projections).
(Source: World Population Prospects, The 1998 Revision, Volume II: Sex and Age. The Population Division, Department of Economic and Social Affairs, United Nations Secretariat).

It can be seen from figure 2.4 that there will be an increase of older persons over that of the younger cohorts (HelpAge International, 2002; World Population Prospects, 2004). Moreover, it is expected that the developed nations of the world will experience this trend at least 30 years before the less developed nations

2.2.5 Old age dependency ratios

The elderly support ratio can be defined as "the number of people aged 65 and over per 100 people aged between 20-64" (Kinsella & Velkoff, 2001:73). The elderly support ratio is also sometimes known as the elderly dependency ratio and has to do with potential social support in a given population (Kinsella & Velkoff, 2001:73). When there has been an increase of an older population against younger cohorts due to population aging, the elderly support ratio is also weakened which negatively impacts financial resources for social pensions and care giving.

It is well documented that in Sub-Saharan African countries with high rates of HIV grandparents are having to care for their grandchildren and orphaned children. An example is found in Ahero, Kenya, where 81% of the orphans in that community are cared for by older persons (Helpage International, 2007:8). These so-called skip-generation[10] families have replaced the traditional extended family with the result that the older persons' traditional support base has been eroded and is a clear example of a weakened elderly support ratio (Kinsella & Velkoff, 2001:83-84).

Finally, the fastest growing age group are those aged 80 and over (also termed the oldest old). In 2002 this age group constituted 17% of the world's elderly or 1% of the world's population. However, this age group is projected to increase 70%, from 17% to 87%, by 2020 (Kinsella & Phillips, 2005:9). Twenty two percent (22%) of this age group live in the developed world and 13% in the developing world. Between the years 1887-2000 this age group increased by 24%. In 1991 it was projected that by 2005 over a third of the elderly population in the USA would fall into this age category (UN, 1991a:10).[11] The parent support ratio[12] of this 80 plus age group is presently sustained by the high number of baby boomers, i.e. children born after

[10] Skip-generation families occur when orphaned children are cared for by their grandparents and also as a result of young parents' out-migration whilst seeking employment (Kinsella & Velkoff, 2001:83).
[11] Unprecedented in history are the numbers of people living beyond 100 years especially in the developed nations of the world. Studies indicate that in 1950, only 200 centenarians lived in France as compared to the projected 41 000 by 2050.
[12] Number of people aged 80+ per 100 people aged 50-60 (Kinsella & Velkoff, 2001:79).

The concern arises that through low replacement levels, in the coming years, the parent support ratio of the oldest old will weaken considerably.

2.2.6 Migration and urbanisation trends of the older person

This section will deal with the migration and urbanisation trends of older persons. Long term projections indicate that worldwide there will be increased rates of urbanisation as well as population ageing and that the underlying causal factors are markedly different. Urbanisation is caused by increased influx of populations from rural to urban settings while population ageing, on the other hand, is caused by changes in fertility and mortality rates. While there is a clearly observable relationship between urbanisation and population ageing, they do not necessarily develop at the same pace and have a tendency to differ from region to region. The three patterns that have emerged are: (1) Africa and Latin America with more rapid rate of urbanisation than population ageing; (2) Europe and South Asia where the rate of urbanisation and population ageing is the same while (3) North America, East Asia and Oceania experience high population ageing and low urbanisation (UN, 1991b:55-81).

By 2015, 80% of older persons in the developed world will be living in urban areas while in the developing regions, the incidence will have significantly increased from 34% in 1990 to just over 50% by 2015, a gain of 12%. The rate of urbanisation in the less developed regions of the world is almost double that of the developed regions who will experience a rate of only 7% for the same period (UN, 1991b). Most of those who live in the rural area are elderly and are more likely to be men. Conversely, more women are more likely live in urban areas than their male counterparts (Kinsella & Velkoff, 2001:51). A contributing factor to the sex differential in the urban areas is the high incidence of recent - widowed older persons who return to an urban area in search of family support.

Serow (1991) cites a 1998 study by Rogers, who identified two patterns of migration in the elderly: (1) long distance and amenity motivated and (2) short-distance and assistance motivated (Kinsella & Velkoff, 2001:55; Serow, 1991:197). In the first instance, those who were more likely to be motivated by amenity determined migration would be in their early to mid 60's, be married and enjoy a healthy and affluent lifestyle. They would prefer to live apart from their children, a concept described as "intimacy at a distance" (Palloni, 2001:5). It has also been shown that there is an increasing tendency for couples to move on retirement, i.e. from large urban settings to either a suburban or rural area. The assistance motivated

migrants, on the other hand, would be in their 70's and 80's, would be less healthy or wealthy than the first group, and would seek the support of their children or move to a long term facility. This group would also prefer to move to the periphery of a metropolitan area whereas the oldest old prefer a medium sized municipality.

The migratory trends that are most characteristic of the older person in developed countries are out-migration from urban to rural areas followed in latter years, by a return migration to an urban area, normally precipitated by changes in living circumstances. An example of this trend is that one in three Parisians moved to their place of birth after retirement (UN, 1991a:10). In Australia the pattern of out-migration is almost as great as the return migration. Thus while "ageing in place" typified many older persons, there is increasing evidence that the older person is experiencing higher mobility or "the retirement effect" especially in the United Kingdom and the United States of America (UN, 1991a:5).

Very little is known about the migrant patterns, both out-migration and return migration, of the older person in less developed countries although there is some evidence to suggest that increasing numbers of the elderly are moving to urban areas. What has been suggested is that inherent to the migrant patterns of the aged in these regions, is the associated transfer of resources, albeit financial or social. Migration is thus seen as a "strategic family decision ... to the extent that (it) raises family incomes and the ability to reunite members" (Kinsella & Velkoff, 2001:55).

2.2.7 Preferred living arrangements of the aged

The preferred living arrangements of the elderly differ greatly between developed and developing nations and are influenced by socio-cultural factors. In developed countries, characterised by the nuclear family, women prefer independent living and are more likely to live alone. Males, on the other hand, prefer to live with family members. Significantly, in Germany and USA the highest percentage of those living independently were in the oldest age groups (Germany, 1999, 66% of 75+ and USA 60% of 85+ in 1995 lived by themselves). In the United Kingdom, one in four households comprised of pensioner only households.

Quite a different picture emerges in developing regions where both male and female elderly live with family members in two to three generational households, in other words, in extended families. Multi-generational families are still the norm in many countries although urbanisation has affected intra-familial structures in as much as the extended family has given

way to the nuclear family. The change in family structure has implications for kin availability and the subsequent care and support for the aged. It can be argued however that pivotal to intergenerational transfer and care for the aged, is the strength of interfamilial relationships as this, more than anything, determines the willingness to care for the aged. That said, those that are most at risk are older women who have never married, or older widowed women who are childless and live in the less developed regions of the world (Apt, 2001; Kinsella & Phillips, 2005; Kinsella & Velkoff, 2001).

2.3 THE SITUATION IN AFRICA

While traditionally, familial care for the aged in Africa has ranked high, ageing per se, was not considered an important socio-political issue. The African Union, however, has sought to redress this with the publication of its policy framework and plan of action on ageing (African Union, 2002:5; Kinsella & Phillips, 2005:16).

Kinsella and Phillips (2005:16) make a distinction between the proportional increase of older people in Africa and absolute numbers by arguing that although the proportion increase will be moderate, absolute numbers will increase markedly over the next few decades. In 2000, Africa had a population of 30 million that were older than sixty. By 2050, this figure will increase fourfold to 130 million (WHO, 2000). The numbers of people aged 80 and over were estimated at three million in 2002 and in line with global demographic trends, set to increase to 22 million by 2050. Figures given by Apt (2001) highlight the severity of the problem that Africa will be faced with in coming years (Table 2.3).

Table 2.3: Percentage increase of population aged 75+ by region: 1980-2050

Region	Percentage Increase
Western Africa	526
Eastern Africa	434
Northern Africa	427
Middle Africa	385

(Source: Population Bulletin of the United Nations, Nos. 42/43-2001 (Apt, 2001:288)

As can be seen from Table 2.3, the Western African region will experience a percentage increase of 526% in its population aged 75 years and over a 70 year period. The region that

has the second highest percentage increase over the same period of time, for the same population age group, is Eastern Africa with a percentage increase of 434.

The "lowest" is the middle African region, at 385%.

The AIDS pandemic, civil wars and declining fertility rates are the major influences that determine the median age for Africa. In 1999 Africa was the "youngest" region in the world. Of the six world regions, Africa has the highest population below the age of 15, the lowest aged population of 65+, the lowest median age (18) and the lowest life expectancy at birth: 52 years of age. Although the average life expectancy at birth stands at 52 years of age,[13] the range within the African continent is significant, 76 years in Libya to a low 35 in Zambia (Population Reference Bureau, 2004).

Not only is Africa the youngest region in the world, in terms of population age, it also has one of the highest levels of rural elderly (Apt, 2001; Kinsella & Velkoff, 2001). Unlike the more developed regions of the world where up to 76% of the population will live in an urban setting, the elderly in Africa are three times more likely to live in rural areas (African Union, 2002; Kinsella & Velkoff, 2001; Population Data Sheet, 2004). Of concern is that by the year 2020 the majority of their younger cohorts will be residing in urban areas leaving the elderly to fend for themselves.

This out-migration of the young to urban areas has effectively altered the structure of the family system from an extended family entity to that of a nuclear family system. In the absence of return migration of the young, the elderly may in some instances be forced by economic pressures to join their children in the urban areas. This is what Apt refers to as a "conflict of loyalties between the urbanised conjugal family and the extended traditional family" (Apt, 2001:296). However, studies have indicated that in Africa, when the elderly move to urban areas, it is normally to impoverished slum dwellings (Apt, 2001). Furthermore, the elderly in Africa, in the absence of formal social relief, are the most likely to work beyond the age of 65 (Apt, 2001:305; Ramashala, 2001:367).

[13] Fifty one years of age for males and 54 years for females.

In Africa, the older generation of grandmothers are increasingly becoming the primary care givers due to the high mortality rates in their younger cohorts due to AIDS or death during childbirth (one in sixteen according to the August 2004, UNFPA Report). Studies undertaken in Africa showed that in Zimbabwe, just over one third of rural households were skip-generation households and similarly in Kinshasa, 35% of the caregivers for AIDS orphans were grandparent(s) (Kinsella & Velkoff, 2001:84). Of increasing concern to policy makers, is the plight of elderly refugees who along with children, are the least able to care for themselves (African Union, 2002).

According to Ramashala (2001), in many parts of Africa, the family still remains the primary source of care for the aged. However, the deeply embedded cultural construct of filial obligation has tended to detract from the need to develop minimum data sets pertaining to the aged which in turn has hampers development policies that adequately address caring for the older person (Apt, 2001; WHO, 2000).

2.4 THE SITUATION IN SOUTH AFRICA

While South Africa has one of the more robust economies in Southern Africa, it is also a country that is very much in transition and one that still bears the legacy of the apartheid system (Ramashala, 2001:368). This becomes most evident when viewing the population age structure of the various race groups. The demographic makeup especially of the black and white populations mirror trends found in the developed and the developing regions of the world (Figures 2.5 and 2.6).

When comparing the population pyramids in Figures 2.5 and 2.6 it can be seen that the age structures within the black population group most resemble the age structures characteristic of the less developed regions of the world viz. the preponderance of younger cohorts over the older age groups. It must be noted that South Africa is very much a country in transition where there are fairly low fertility rates (of three births per mother) but a contrastingly high mortality rate, and where life expectancy, within the black population, has fallen to 45 years of age (Kinsella & Ferreira, 1997).

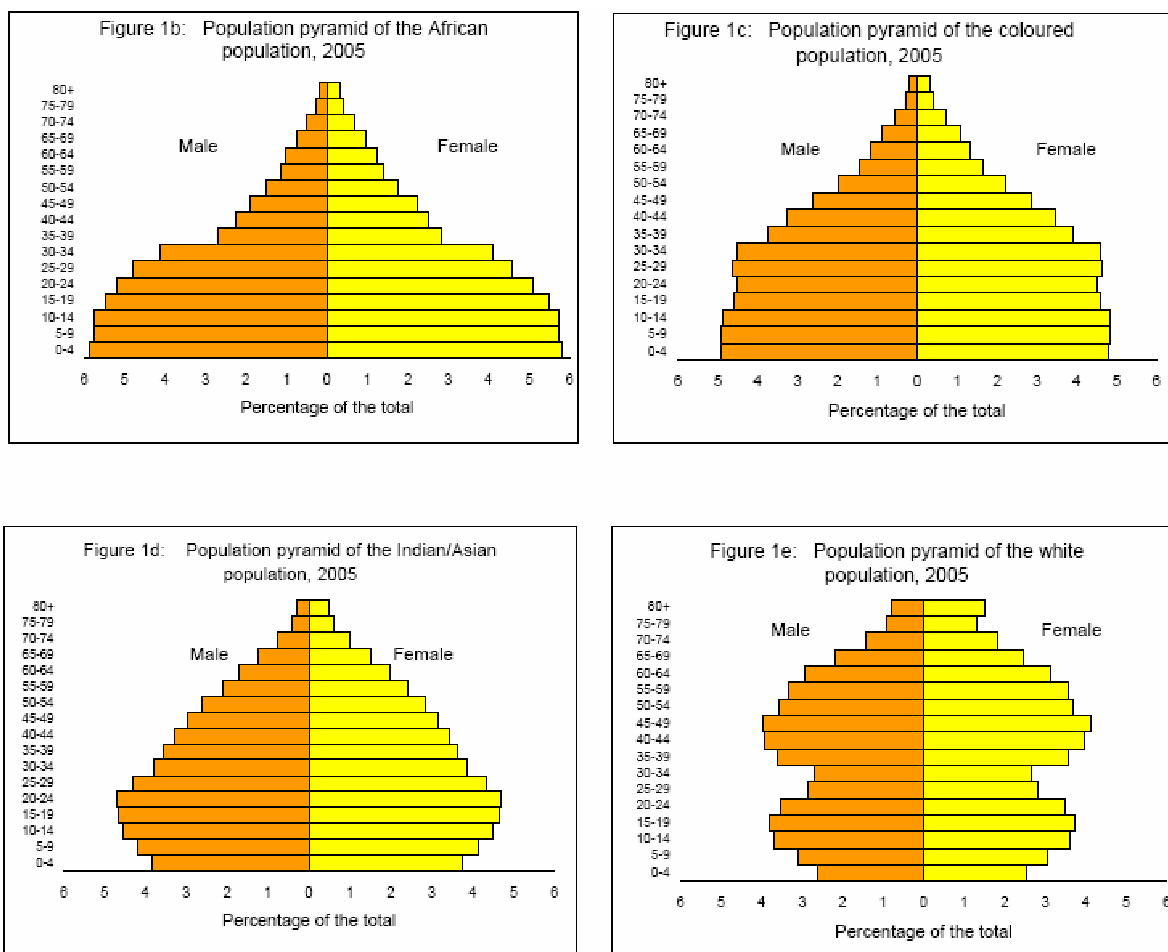

Figure 2.5: Population pyramids based on age and race.
(Source: Statistics South Africa, 2005a. Midyear population estimates.)

Conversely the demographic trend within the white population group is fairly similar to what would be found in a more developed region. The typical pyramid shape gives way to something more bulbous in appearance. Tellingly, within the 0-59 age range, the only age structures that are less than 3% of the total population are the 0-4 and the 25-30 age groups. Of significance is the large number of those aged 80 and over: almost 3% of the total white population. One of the more disturbing facts to emerge is the difference in life expectancy at birth between these two groups: white women will outlive black woman by 22 years and men by 18 although, should they live beyond the age of 60, the sharp differences diminish (Kinsella & Ferreira, 1997).

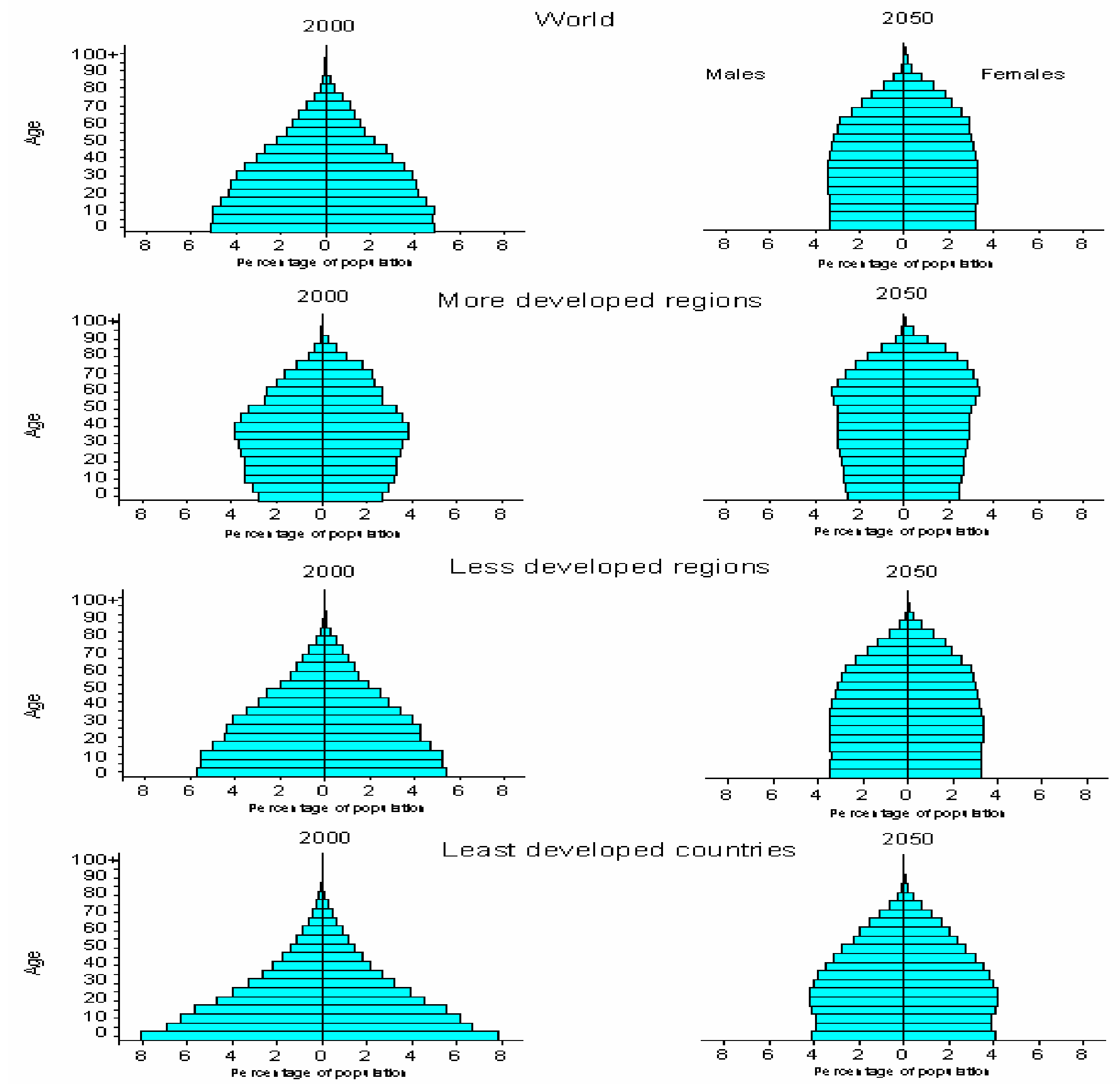

Figure 2.6: Population pyramids: age and sex distribution, 2000 and 2050 (Source: The Sex and Age Distribution of the World Populations: 1998 Revision, Volume II: Sex and Age (United Nations publication, Sales No. E.99.XIII.8), medium variant projections)

The largest racial group in South Africa is the black population which comprises of 79% of the total population, followed by whites (4,4 million), Coloured (4,1 million) and Indian/Asian (1,1 million) (Statistics South Africa, 2005a). Of the nine provinces, the following five have the highest populations, ranked in descending order: KwaZulu-Natal (20,6%), Gauteng (19,2%), Eastern Cape (15%), Limpopo (12%) and Western Cape (9,9%). Significantly are migration patterns, both in and out, of the provinces. Gauteng has the highest in-migration, at 853 400 with a net migration of 519 900 and the Western Cape has an in-migration of 337 300 with a net migration 224 400, the second highest in the country (Statistics South Africa, 2005b).

Migration patterns, both in and out of the provinces are given in Table 2.4.

Table 2.4: Ranking of migrant patterns per province

Province	Rank* of total in-migration	Rank of total out-migration	Rank of net migration	Rank % of 60+
Eastern Cape	6	1	9	2
Free State	8	7	7	7
Gauteng	1	3	1	3
KwaZulu-Natal	3	5	3	1
Limpopo	7	2	8	4
Mpumalanga	5	6	5	8
Northern Cape	9	9	4	9
North West	4	4	6	6
Western Cape	2	8	2	5

*1 is highest, 9 is lowest.
(Source: Statistics South Africa, 2005a)

What needs to be established is whether there is a casual link between migrant patterns and the incidence of older persons living in different provinces and establishing the push-pull factors. It is with this in mind that the importance of establishing minimum data sets becomes apparent.

Table 2.5 gives a breakdown of the population estimates in South Africa of older persons according to age cohort and race.

Table 2.5: Population estimates by age and race

Age group	Blacks N=37 205 700	%	Coloureds N=4 488 800	%	Indian/Asian N=1 153 900	%	Whites N=4 379 800	%	Total
60-69	1 472 300	4	183 900	4	74 100	6	469 800	11	2 200 100
70-79	689 000	2	84 500	2	32 600	3	240 700	6	1 046 800
80+	192 000	1	22 600	1	9 100	1	101 000	2	324 700
Total	2 353 300	7	291 000	7	115,800	10	811 500	19	3 571 600

(Source: Statistics South Africa, 2005a)

It can be seen that currently the population of the older age group is three times higher amongst whites than blacks, and this is attributed to the differences in life expectancy and fertility rates, the precursors of population ageing (Kinsella & Ferreira, 1997; Statistics South Africa, 2005a).

The indicators for South Africa for the period 1950-2050 are illustrated in Table 2.6.

Table 2.6: Indicators for South Africa: 1950, 2000 and 2050

	1950	2000	2050
Total fertility rates	6,5	2,95	1,85
Life expectancy at birth	45	58,4	59,4
Median years	20,9	23,1	30,2
% of population aged 60+	6	5,9	13,1

Source: United Nations population division. World population prospects: the 2004 revision).

It can be seen from Table 2.6 that South Africa is still a young country (compared to Europe) having a median age of 23 in the year 2000 and increasing to 30,2 by the year 2050. The percentage of those aged sixty and over will have more than doubled between the years 1950 and 2050, from 6% to 13,1% in 2050. In absolute numbers, South Africa has at present three and a half million people aged sixty and over with the largest contingent falling into the 60-69 age category (Statistics South Africa, 2005b; UN, 2004). As with the rest of Africa, it has been predicted that the rate of population ageing will increase at a far quicker pace than previously experienced in the developed regions of the world (Kinsella & Ferreira, 1997).

Since the 2001 government census, South Africa's population has declined from 48 819 770 to 46 888 200, a decrease of just over 2 million people or 4,6% of the total population. Due to the high incidence of HIV in the country, and declining fertility rates,[14] it has been projected that by 2050, South Africa will experience a negative population growth of 11% (Population Reference Bureau, 2004). Evidence of this decline is given in the midyear population estimates of 2005. From 2001 to mid 2005, the population declined by 2 068 430 or 4,6%. In 1997, South Africa had more persons aged 60 and over than any other country in Southern Africa and by mid 2005 they accounted for 8% (3 571 600 people) of the total population (Statistics South Africa, 2005a; Kinsella & Ferreira, 1997). Unlike many other parts of Africa where the rural population is 64%, South Africa has a percent urban of 53% with most of the resources being concentrated in the urban areas (2005 Database).

Of the nine provinces, KwaZulu-Natal has the largest number of 60-69 year olds while the Eastern Cape has the highest number of 70-79 year olds. KwaZulu-Natal has the largest

[14] Fertility Rates: 15% over a 10 year period: 1985-1995 UN 2002b, and Statistics SA, 2005:PO302. Overall incidence rate of HIV is 10% (Statistics South Africa, 2005).

number of senior citizens living within its borders yet it also has the highest unemployment in the country (Table 2.7).

Table 2.7: Distribution of older persons per age group and province

Province	60-69 age group	70-79 age group	80+ age group
Eastern Cape	327,969	177,271	73,315
Free State	114,346	56,548	26,893
Gauteng	338,747	162,684	67,752
KwaZulu-Natal	377,331	208,456	79,210
Limpopo	195,849	127,880	67,401
Mpumalanga	115,328	65,519	31,295
Northern Cape	46,695	23,328	10,157
North West	130,313	71,630	31,611
Western Cape	206,642	105,691	40,652
Total	1,853,220	999,007	428,286

N =3,280,513
(Source: Statistics South Africa: 2005b)

As can be seen from Table 2.7 the Eastern Cape has the third highest number of older persons and is ranked the third highest unemployed or not economically active province in the country (Department of Social Development, n.d:15). Most of the oldest old also live in the Eastern Cape. Although the Northern Cape is the least populated province in South Africa and has the smallest number of aged persons living within its borders, its aged population constitutes 9% of the province's population which is statistically significant.

In their article on ageing trends in South Africa, Kinsella and Ferreira (1997) maintain that in the long term, the growth rate of the older person will surpass that of the total population, with those older than 70 becoming the fastest growing age group. They further contend that this trend is unlikely to reverse. Although it has been shown that there a high degree of poverty in the provinces with the greatest concentration of older persons, it is unknown to the researcher (and beyond the scope of this thesis), whether there exists a positive correlation between the two. Nevertheless, the problem of unemployment and poverty remains a grave concern especially amongst the most vulnerable, namely the young and the old.

2.5 THE JEWISH POPULATION

Although Jewish settlers arrived in South Africa in the early 1800's, the main influx was between 1880 and 1930 and was by and large drawn from Lithuania. Two other periods in history saw an influx of Jews into South Africa. The first was just prior to WWII, when many Jews immigrated to South Africa from England and Germany, and then again in the mid 1970's, when many came from Israel and Zimbabwe. It was during this period that the Jewish population enjoyed its highest number, a peak of some 118 000.

In 1936, the Jewish population accounted for 4,5% of the total white population but gradually declined to its present level of 1,4% (Dubb, 1991:7; Kosmin *et al*., 1999; Statistics South Africa, 2001b). The Jewish population has declined to its present total of just over 75 500 people of which approximately 74% living in Johannesburg, 20% in Cape Town and the remaining 6% in smaller communities such as Port Elizabeth, Pretoria and Durban.

Dubb, in his 1991 survey, predicted a fairly rapid decline of Jewish older persons during the 1990s with migrant shifts to larger cities such as Johannesburg and Cape Town. The 1991 survey also identified, for the first time, demographic trends in the older population. In all three of the age categories 65+, 65-74 and 75+ females outnumbered their male counterparts, which is similar to worldwide trends. Significantly, amongst the 65-74 age groups the proportion of those born in South Africa grew to just under 62% which intimated a higher degree of assimilation than previous generations. In terms of marital status, there were a greater percentage of men than women in all age groups who never married and who had married then latter divorced. Women rather than men, in the 65-74 age groups, were more likely to lose a spouse but in the 75+ age group, women are more likely to be divorced. Most older persons lived either in a private home or apartment and most expressed a preference for housing that would provide care along a continuum.

According to the 2001 census, the Jewish population is drawn in the main from the white population and totals 61 673 people. Additionally, a further 13 876 people from other population groups consider themselves Jewish.[15] Thus 82% of the Jewish population in South Africa is drawn from the white population group while the remaining 18% is from the other population groups.

[15] The Lemba Tribe consider themselves direct descendants of an ancient Yemenite tribe.

Table 2.8: Total number of Jewish population by gender and race

	Black/African	Coloured	Indian/Asian	White	Total
Male	5 529	649	306	29 399	35 883
Female	6 449	635	308	32 274	39 666
Total	11 978	1 284	614	61 673	75 549

(Source: Statistics South Africa, 2001a Census.)

The area under study is the immediate feeder areas for CJSA, Milnerton. There are a total of 1303 people who regard themselves as Jewish who live in these areas. From Table 2.9 it can be seen that Milnerton, Tijgerhof and Woodbridge Island have the greatest numbers of Jewish people, including seniors, living in these areas (Table 2.9).

Table 2.9: Geography by age group for person weighted, Judaism

Area	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+	Total
Brooklyn	0	0	0	0	0	0	3	0	0	3
Milnerton Central	0	6	0	3	0	3	6	3	0	21
Milnerton Ridge	6	6	6	9	3	6	0	0	0	36
Milnerton SP	112	102	57	93	103	97	46	22	18	650
Rugby	0	0	9	3	3	0	3	0	0	18
Sanddrift	0	3	0	0	6	3	0	0	0	12
Tijgerhof	103	78	46	68	94	41	33	19	4	486
Woodbridge Island	4	9	0	9	9	14	20	12	0	77
Total	225	204	118	185	218	164	111	44	22	1303

(Source: Statistics South Africa, 2001d Census (Space–Time Research Web Page Report produced by Erasmus & Mans, 2004; Mostert, 2007).

The three highest areas of concentration of Jewish seniors are Milnerton (50%), Tijgerhof (37%) and Woodbridge Island (6%). Older people aged 60 and over account for 14% of the total Jewish population living in these areas. Furthermore, 92% of these Jewish seniors are aged between 60-69, 38% are aged between 70-79 and 12% of older persons are aged 80 and over. The distribution of the Jewish population per gender and area is given in Table 2.10.

Table 2.10: Distribution of Jewish population per area and gender

Suburb	Male	Female
Brooklyn	3	0
Milnerton Central	3	18
Milnerton Ridge	21	15
Milnerton SP	338	311
Rugby	15	3
Sanddrift	6	6
Tijgerhof	222	266
Woodbridge Island	39	37
Total	**647**	**655**

(Source: Statistics South Africa, 2001e Census (Space–Time Research Web Page. Report produced by Erasmus &Mans, 2004; Mostert, 2007).

There are only marginally more Jewish females than males living in the areas listed in Table 2.10.

Care and respect for the aged is an intrinsic part of the Jewish faith and is deeply rooted in its Talmudic and rabbinical teachings. This ideological mindset can best be illustrated by A.J. Herschel's observation that "… the true test of a people is how it behaves towards the old. It is easy to love children. Even tyrants and dictators make a point of being fond of children. But the affection and the care for the old, the incurable, the helpless are the true goldmines of a culture" (Rappaport, 1982:59). While anecdotal evidence seemingly supports the notion of large numbers of seniors being left without their children's support (due to emigration), this is simply not the case. Only 15% of those interviewed in the 2005 survey reported having no children living in South Africa (Kaplan, 2006:17).

2.6 POLICIES

As governments became aware of the problems associated with population ageing, the United Nations took the lead in focusing on an often marginalised sector of society, the aged. The First World Assembly on Ageing took place in 1982 but concerned itself in the main with demographic issues. The first International Day of the Older Person was announced on 1 October 1990 by the United Nations General Assembly. It took a further nine years before a properly constituted declaration on the rights of the elderly was drawn up, viz. the United Nations Principles for Older Persons (16 December 1999). As concern grew over population

ageing and its attendant problems, a Second World Assembly on Ageing was convened in April 2002 out of which emerged the Madrid International Plan of Action on Ageing.

The declaration of the rights of the elderly focused on five main areas. Broadly speaking they are the right to independence both economically and in choice of residence; participation in the community and in policy decisions; care and protection, both legal and civil; self-fulfilment through the pursuit of opportunities and access to resources and that all older persons are assured of dignity and security, free of all forms of abuse and discrimination (UN, 1991c). Of particular importance is the implication that economic participation by the older person should be self-determined and based on competency levels.

The Second United Nations World Assembly on Ageing in April 2002, was a proactive response to the anticipated ageing issues facing the 21st century. Moreover, it was the first time that member states agreed to work together, at all levels of society, in promoting the rights of the aged. As a direct consequence the Madrid International Plan of Action on Ageing, was adopted. This policy framework viewed the older person as an integral and interconnected part of society and was considered an inclusive rather than exclusive policy, that sought to integrate the older person into the mainstream of society and which identified three priority concerns: (1) older people and economic development, (2) advancing health and wellbeing in old age, and (3) ensuring enabling and supportive environments (Kinsella & Phillips, 2005). Underpinning this policy is the concept of active ageing which is defined as "the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age" (UN, 2002:12).

The Madrid International Plan of Action was the first United Nations policy document that sought to create a framework for international initiatives and joint cooperation that would meet the challenges of population ageing, and as such highlighted the shift away from ageing as merely a demographic issue to an integrated approach in improving the quality of life for the older person. It also provides the basis for a United Nations policy framework on active ageing and is the benchmark against which the present Older Person Bill, South Africa (2003), is measured. In short, it has helped influence policy decisions on regional and national levels as well as encouraged research on ageing (WHO, 2004). The African Union, in conjunction with HelpAge International, formulated a policy framework and plan of action that was approved of by member states in July 2002. In its Foreword, the interim chairperson for the Commission of the African Union, Amara Issy, states that the Madrid Plan drew

heavily on the African Union policy document. South Africa is one of the few member states that have drawn upon this document to help guide it in formulating its policy on older persons. Of significance to this research paper is the contention that while the problems of the aged must be tackled in order to improve their quality of life, this can only be done against a background of proven (academic) research of which there is very little. The resultant lack of information impacts upon the equitable distribution of resources to the aged (African Union, 2002:9).

The political arena has changed markedly since the South African Charter for the Aged was published in 1977 in which it was stated that the retired and elderly were not seen as a social problem.[16] Twenty years later, the White Paper on Social Welfare (1997) sought to redress the imbalances and inequalities of the Nationalist Government by recognising the vulnerability and discriminatory practices meted out to the aged. During 1993 it was estimated that over 7,5 million people lived in households that were in receipt of a state grant and that in impoverished households, which were typically three generational, the grant helped up to five people other than the pensioner (White Paper on Social Welfare, 1997). The White Paper on Social Welfare promoted community based care for the older person over institutional care and saw the family as the core support system and as such shifted the burden of care from government.[17] Its approach was very much in line with the concept of active ageing, seeing ageing as part of a life course and enabling the older person to live an independent life for as long a possible. It also saw the need for an integrated, intersectoral approach to caring for the aged.

Taking its lead from the White Paper on Social Welfare, the Older Persons Bill (2003), sought to redress the imbalances of the past by addressing the fundamental human rights of the older person. The Older Persons Bill was loosely based on the Madrid Plan's priority directions for action on ageing but omits altogether the second tenant, namely, advancing health and wellbeing into old age, although it does expand its focus to include protection and residential facilities. Furthermore its overemphasis on residential care is at odds with the White Paper's ethos of care within the community. Broadly speaking, contentious issues that required further review were:

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[16] A charter for the aged in South Africa: US Administration on Ageing, Washington, DC, 2001 http://www.aoa.gov/prof/international/resources/resources_rights_nat_05.asp.

[17] Except in the case of the frail elderly, the destitute and the disadvantaged who require full-time care. Ch. 8.82c, White Paper.

(1) the undue attention given to residential facilities with scant regard given to the enabling mechanisms that would maintain the older persons in their communities for as long as possible. At present less than 1% of total vulnerable older persons are in residential care;

(2) the gender differences given in the definition of older person (60 for female and 65 for male), and

(3) a register for elder abuse and the implementation of best practice principles with regard to elder abuse. Under further review, these issues were addressed and in November 2006, the Older Persons Act 2006 came into being pending the finalisation of the regulations.

2.7 CONCLUSION

This chapter has dealt with the underlying causes of population ageing and how it has determined the course of policy and legislation for the older person. The older Jewish person is very much part of the make up of the communities where they live and have a high degree of assimilation into the local community. Both African and Jewish cultural mores emphasise the care and respect for the aged. Kenya's former president Jomo Kenyatta's view of the older person best sums up the traditional view held on the importance of caring for the aged and illustrates the interconnectedness not only between the individual but by implication, between systems. "Nobody is an isolated person. First and foremost, he is several people's relative and several people's contemporary" (Apt, 2001:296).

CHAPTER 3

QUALITY OF LIFE INDICATORS AND WELLBEING IN THE OLDER PERSON

3.1 INTRODUCTION

"Senescence begins and middle age ends the day your descendants outnumber your friends"[18] is how the ageing process is described by *The New Yorker*. While this view of old age may be held by many today, the pressing concerns of population ageing is forcing academics and public alike to rethink this perception of the ageing process. Theoretical perspectives have evolved from initially viewing the older person as disengaging from society to the present day focus of the older person actively engaged and experiencing a sense of wellbeing and quality of life, far into their old age.

In a sense, too, as our understanding of this age cohort has grown, stereotypes depicting the aged are also slowly changing. More and more we are coming to realise that many older persons are entering their "third age" with zest and gusto. What are it then that determines one's quality of life?

The main objective of this chapter is to describe not only the quality of life indicators that lead to successful ageing and wellbeing in the older person, but also the psychosocial needs of the aged.

3.2 THE MEANING OF OLD AGE

Old age conjures up many images, most of them stereotypical. As old age has different meanings, a brief outline will be given of the meaning of old age from different perspectives.

Not only does the ageing proceed along a continuum but it is made up of three different processes, viz. primary, secondary and tertiary ageing. Primary ageing refers to the normal, inevitable and common/universal changes that take place during the ageing process such as menopause and loss. Secondary ageing, e.g. dementia, refers to developmental changes that

[18] Senescence is the fact or condition of growing old.

are unpredictable and influenced by disease, lifestyle and the environment. Tertiary ageing and terminal drop are characterised by a marked decline in cognitive and functional ability in the period before death. It has been argued that an example of successful ageing would be someone who never experiences the hardships of secondary ageing but successfully moves from primary through to tertiary ageing (Cavanaugh, 1997:13; Perlmutter & Hall, 1992:78-79).

However, ageing and getting old are two entirely different concepts. Whereas ageing is normally attributed to physical changes that take place over a lifetime, the concept of "getting old" is social, in as much as it has a subjective bias and is culturally determined (Harrigan & Farmer, 2000). An example of culturally determined "old age" is the Mesakin of Sudan, who enter eldership during their 30's (Kieth, 1985). An other example can be found in industrialised countries where retirement at 65 may be considered a rite of passage that signals the onset of old age and where chronological age is used as the sole marker of "old age". The inherent danger, in adopting such a viewpoint, is the tendency to perpetuate the stereotype of the older person as being unable to engage in society in a meaningful way.

The ageing process on the other hand takes into account environmental influences and lifestyle forces which influence behaviour and tends to look at the importance of age cohorts (Maddox & Campbell, 1985). It tends to view the older person as being able to engage in a meaningful way within their social and cultural milieu. This is clearly the case when one views the importance of intergenerational transfer as examined by various researchers (Bezrukov & Foigt, 2004; Palloni, 2001:85). A good example of intergenerational transfer is found in the Akwe-Shavante of Brazil, where the old are "recycled" or reassigned to the younger age cohort in a mentoring capacity and work alongside the young in showing them how to build huts (Kieth, 1985:231).

What is apparent but not readily understood, is why some people do not show the normal patterns of ageing and continue to experience robust health and a sense of wellbeing throughout their life course. This is not to detract, however, from the impact of socio-environmental experiences on a particular age cohort as, for example, being brought up during WWII or the hippie movement in the 1960's. While it is now understood that genetics and socio-economic influences are important determinants in the health of the aged, the question posed is, why do some people, irrespective of their level of functioning, enjoy a sense of wellbeing?

3.3 THEORETICAL FRAMEWORKS DEALING WITH OLD AGE

The current emphasis on community living, driven by economic necessity, is supported by WHO's policy framework on active ageing. According to the World Health Organisation's policy framework, active ageing is seen as the optimisation of opportunities in order to enhance one's quality of life and includes both the concept of successful and healthy ageing (Kinsella & Phillips, 2005:36; WHO, 2002). Active ageing indicates a paradigm shift away from the biomedical model of successful ageing that sees ageing solely in terms of cognitive and physiological functioning in the absence of disease. Active ageing is thus an inclusive rather than an exclusive framework, in much the same way that Rowe and Kahn endeavoured to distinguish between usual and successful ageing, when they incorporated the principle of active engagement into their understanding of the ageing process. Complementing this viewpoint was the development of psycho-sociological models which looked at successful ageing in terms of (1) life satisfaction throughout one's life course; (2) social participation and functioning, and (3) inner resources (Bowling & Dieppe, 2005:1549).

However, the active ageing/successful ageing models failed to take into account the subjective views and objective reality of the older person. Subsequently social scientists began to view these models as limiting in that there was a tendency to negate the very real problems associated with age such as frailty and suffering, especially in the oldest old (Baltes & Mayer, 2001; Cavanaugh, 1997; Lloyd-Sherlock, 2004:6).

More recently, researches have begun to move away from active ageing and to focus on quality of life indicators in the older person. Walker suggests that the terms successful ageing, positive ageing and healthy ageing are interchangeable and can be used to describe the quality of life of older persons. However, the study further emphasises that quality of life per se can only be measured by one of two methods: (1) the effect of health on one's quality of life, and (2) subjective interpretation of quality of life (Kennedy & Hamilton, 2005:36). It is with this latter measurement that this chapter will concern itself.

Work undertaken by GO,[19] the University of Sheffield's programme on the study of quality of life in the older person, has proposed a quality of life model based on subjective responses from a survey of older people. The themes that came out of this research are in line with the rights and principles of the aged which underpin the policy framework of active ageing

[19] GO is an acronym for the Growing Old Programme.

(WHO, 2002:13). As in any new field of study, theoretical models abound. Suffice to say; as awareness grows around the issues of population ageing, it becomes increasingly evident that old age has become very much a development issue in the socio-political arena with a strong emphasis being placed upon the rights of the aged and their active participation in determining their life course (Kinsella & Phillips, 2005:37; Peng & Phillips, 2004:112; WHO, 2002).[20]

It can be seen from the above that the ageing process encompasses a multiplicity of experiences in an age group that is rather complex and diverse and, as such, far from homogenous (Lloyd-Sherlock, 2004:6). Moreover, ageing cannot be seen in isolation but only as part of a continuum that is played out along one's life course and can be defined as "... the process of progressive change in the biological, psychological and social structure(s) and lifestyle forces of individuals" (Beaumont & Kenealy, 2004:756; Cavanaugh, 1997:5; Kinsella & Phillips, 2005; WHO, 1999:4).

3.4 QUALITY OF LIFE INDICATORS

3.4.1 Introduction

In this section the definitions of quality of life, independence and autonomy will be given as well as a description of the quality of life indicators and the bearing they have on the wellbeing of older people. Attention too will be given to the close link between the psycho-social needs of the aged and quality of life indices.

3.4.2 Definitions

Just over a decade ago, the World Health Organisation defined quality of life as "an individual's perception of his or her position in life in the context of the culture and value systems where they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept incorporating … a person's physical health, psychological state, level of independence, social relationships, personal beliefs and relationship to salient features in the environment" (WHO, 2002:13).

[20] As, for example, older people interviewed in a survey undertaken by the Beijing Ageing Study Centre stated that the government's protection of their legal rights should be of a high priority.

The quality of life in the older person is further determined by levels of autonomy and independence, where autonomy refers to the daily and personal decisions one makes about one's life whilst independence refers to the ability of the individual to undertake daily tasks with the minimum interference or help from others (WHO, 2002:13). Broadly speaking, autonomy is linked to cognitive ability while independence is linked to functional ability.

3.4.3 Self selected quality of life indicators in the older person

"Constructing a collective, inclusive, dignity-affirming meaning for the latter part of life, will come when the voices of older people, speaking for themselves, are salient" (Witkin, 2000).

Self selected quality of life indicators that have been identified in several studies can be equated with five of the most identifiable basic needs of the older person (Beaumont & Kenealy, 2004; Blazer, Sachs-Ericson & Hybels, 2005). They are:

(1) Good social relationships – social support.

(2) Good home – adequate housing.

(3) A good neighbourhood – a safe environment.

(4) Good health and functionality – health.

(5) Adequate income – economic security.

In addition to the five basic needs of the older person, other quality of life indicators that are worth mentioning are having: a positive outlook, social activities and hobbies (Beaumont & Kenealy, 2004:760, 1-14; Blazer *et al.*, 2005:299).

The following section will deal with each of the salient points individually by way of describing the quality of life indicators of older persons.

3.4.4 Good social relationships and social support

Meaningful social relationships, where the older person felt cared for and emotionally supported, ranked high in terms of adding to the older person's quality of life, which ties in with Maslow's needs of love and belonging (Maslow, 1943:6). Social relationships, as described by Bowling and Gabriel and Beaumont and Kenealy , included relationships not only with family members but also with friends and neighbours (Beaumont & Kenealy, 2004; Gabriel & Bowling, 2004). In earlier studies it was shown that the strongest indicator to

satisfaction was derived from family life and that these relationships often cushioned the impact of loss so often experienced by the aged. An example of this buffeting effect is found in literature which highlight the importance of the positive parent/adult child relationship in countering the devastating effects of widowhood (Berg, 1996:332; Lauer, 1989:280).

It is evident that positive intra-familial relationships have an important role to play in terms of life satisfaction. The importance of the emotional bond and reciprocity between grandparent and grandchild cannot be underestimated. It has been shown that the birth of grandchildren can offset much of the loss that is experienced during this period of one's life course (Clarke & Roberts, 2004:192). The sense of renewal and continuity derived from the grandparent-grandchild relationship is much the same as Eriksson's theory of generativity.

Significantly, Blane, Wiggins, Higgs and Hyde (2004) found that the frequency of contact[21] was not as important as quality and density of relationships which is borne out by Holmen's study on loneliness among elderly people living in Stockholm. Counter-intuitively, it was found that parents who lived with their children had the highest scores of loneliness (Hall & Havens, 2002). Put more succinctly, the older person is apt to have a higher quality of life if they have lots of good friends, and while the immediate family is most often the primary source of wellbeing in the aged, this is not necessarily always the case.

Although migration of adult children is a characteristic of modern society, it is a myth to suggest that contact between the family members and the elderly is on the wane as modern forms of telecommunication allow for regular contact (Harrigan & Farmer, 2000:44). Furthermore, literature tends to suggest that friendships, and particularly those of long standing, can be as important as family relationships in contributing to the quality of life of the aged (Bowling & Gabriel, 2004; Carroll & Whelan, 1994:4; Siebert, Mutran & Reitzes., 2000:101). It has also been argued that the formation of close friendship ties are a consequence of a lack of kin availability and that these close friendships, known as fictive kin, often become the primary source for emotional support (Stubb, 1982:143).[22]

[21] Amongst those aged between 65-75.

[22] In some African cultures longstanding friends will take on the status of a relative with all the responsibilities that this entails. Another example is found amongst the orphans in refugee camps where they organise themselves into substitute family structures. A more common example is the practice in Christianity of appointing a godparent.

According to Gabriel and Bowling (2004:22) having positive relationships with one's neighbours is termed neighbourhood resource capital and that in the absence of family, neighbours often act as surrogate families. In such an instance, friendship ties would be formed and neighbours would take on supportive roles and give assistance where needed (such as a lift to the shops or hospital). This is important amongst the aged as it lends itself to feelings of security, particularly in cases of emergencies. It must be said, however, that reciprocity is the key to these relationships as this ensures the older person's sense of independence.

While positive social relationships are strong determinates of quality of life in the older person, it could be argued that in the absence of meaningful social relationships, a high degree of social isolation and a concomitant lowering of quality of life would be experienced (Victor, Scambler, Bond & Bowling, 2004:123). Thus, for example, poor social support has been identified as a precursor to depression (Harris, Cook, Victor & Beighton, 2005).

Moreover, the strong association between social isolation and ill health is heightened by the fact that ill health in itself may lead to social isolation and a cycle of social disengagement is put into motion. Thus an individual's level of social integration plays a pivotal role in the wellbeing of the older person and is borne out by evidence showing that married people, those who attend religious places of worship (as opposed to being religious) and those who are visited often by friends, all enjoy a positive quality of life (Rowe, 2005:2). Thus Aristotle's statement that "a life without friends is not worth living" is as true today as it was during his lifetime.

3.4.5 Good home and adequate housing

Beaumont and Kenealy's 2004 study on quality of life and comparisons in old age found that the most important domains listed by the subjects were family, health and home (Beaumont & Kenealy, 2004). The UK government described the importance of housing as being "... much more than just the bricks and mortar. It determines people's identity, their privacy, space and the place where they express their individuality. It is one of the determining factors in promoting the independence of older people, wherever they choose to live" (Gilroy, Kellett & Jackson, 2004). This section will deal with the importance of the home in determining quality of life in the older person.

Adequate (and affordable) housing has been cited as one of the five basic needs of older persons as well as being seen as one of the main determinants in quality of life in older persons as it allows for security, independence and autonomy (Beaumont & Kenealy, 2004:764; Windle & Woods, 2004:584). Furthermore, as our homes not only determine how we live but how we are viewed by society, the meaning of home becomes a central issue in influencing the older person's level of wellbeing, more so than any other age group due to the simple fact that older people are more likely to spend more time at home (Gilroy *et al.*, 2004).

People who owned their own homes had higher quality of life scores and were less likely to suffer from depression than those who rented, which is borne out by the fact that a significant number of participants reported deriving a "great deal of pleasure" from having their own homes as well as giving them happy memories (Gabriel & Bowling, 2004; Windle & Woods, 2004:585). By the same token, those who moved to residential care or nursing homes experienced a diminished sense of security with no emotional affinity to their new residence with a concomitant lower sense of wellbeing (Clough, Bright, Leamy, Miller & Brooks, 2003).

Home ownership during the course of one's life did not play an important role; it was rather the immediacy of ownership that contributed to wellbeing. It was also found that owning one's home allowed the older person greater control over their own lives both in their decision making and activities of daily living. Of utmost importance, home ownership was seen to afford the older person emotional security (Blane *et al.,* 2002; Clough *et al.*, 2003; Windle & Woods, 2004:584).

In much the same way as living in a socio-economically deprived neighbourhood negatively affects one's social relationships, so too does inadequate housing. The effects are one and the same; they both result in diminished social relationships and heightened stress with associated raised levels of morbidity (Blazer *et al.*, 2005; Bowling, 2005). The Baltimore longitudinal study undertaken in 1982 suggests that a sense of wellbeing, as a result of social support, better equips the older person to deal with "environmental contingencies" such as maintenance (Wan, Odell & Lewis, 1982:37). Be that as it may, the realities of diminished capabilities and finances can impede the older person's abilities to maintain and repair their homes, as has been found in Wales where 50% of all houses owned were built prior 1930.

Furthermore, it is worth noting that a quarter of all old age pensioners in the UK have only the government pension as their only source of income.[23]

Other factors that need to be considered when looking at the importance of one's home in optimising wellbeing in older age are: the home must be able to accommodate reduced mobility and take into account both safety and security measures as well as comfort and pleasure. Ideally, the home should have a second bedroom in order to accommodate visitors or to use as a hobby room. The home must also be near to local facilities and services, and preferably within walking distance. Thus locality or where one's home is situated, is seen to be important component of wellbeing amongst the aged (Clough *et al.*, 2003; Gabriel & Bowling, 2004).

3.4.6 A good neighbourhood and a safe environment

The importance of living in a "good" neighbourhood was emphasised as being integral to the wellbeing of older persons. Literature indicates that older people want to live in a neighbourhood that they feel is safe and secure enough to leave their homes to visit friends and go to the shops if need be. In other words, being able to live in an area that was free of crime and gangs (Clough *et al.*, 2003; Gabriel & Bowling, 2004). They also wanted the character of the neighbourhood to look and "feel" friendly as well as to be pleasing to the eye such as having green belts (Clough *et al.*, 2003; Gabriel & Bowling, 2004; Gilroy *et al.*, 2004).

The participants felt that not only was a sense of community important but that, on a more practical level, the infrastructure and public amenities needed to be more than adequate. The importance of having affordable and accessible public transport that was user friendly was cited, as this ensured continued independence and access to amenities, both for leisure and non-leisure purposes.

Another important component in terms of living in "a good" neighbourhood, is that the community had a sound infrastructure that afforded them, amongst other things, community based activity centres and a reliable public transport. The availability of resources is an important factor in being able to tap into extended social support networks beyond the borders of one's neighbourhood. Thus the use of neighbours and the wider community as a

[23] Accessed from www.ageallaincewales.org.uk/lay%20issues.htm#6 on 26 February 2006.

resource ties in with the right of the older person to participate as well as a basic need for security (Maslow, 1943; WHO, 2002).

While a good home and neighbourhood lends itself to a good quality of life and sense of wellbeing, it is equally true to say that living in a deprived neighbourhood will result in a poor quality of life. Poverty, together with poor health, was found to rank highest in terms of dissatisfaction with one's quality of life (Blane *et al.*, 2002).[24] Furthermore, deprived neighbourhoods are synonymous with social and economic exclusion, and for those from an ethnic minority this experience can be seen as a "double jeopardy" as they face discrimination on two fronts – racial and economic. The lack of social amenities impacts on social networks which, in turn, has a negative influence on the quality of life of the aged (Scharf, Phillipson & Smith, 2004:103). To highlight the plight of the older person living in such communities, it has been shown that high levels of crime are often linked to both low social economic status and high levels of mortality (Blazer *et al.*, 2005).[25]

Older people's sense of isolation is further exacerbated by their inability to participate in normal social activities that are characteristic of a cohesive community. Other effects of living in high density, poor socio-economic areas are lowered morale, poor home management and poor body care, which have further implications for morbidity (Breeze, Fletcher, Wilkinson & Grundy, 2002).[26] Moreover, people living in under-resourced neighbourhoods are unable, due to the lack of public transport, to make use of services not found in their neighbourhood, unlike their more wealthy counterparts. Transport is seen to be central in helping the aged maintain their sense of independence and dignity (Gabriel & Bowling, 2004:23-24).

From the above the important role that neighbourhood and home play in the quality of life of the older person can be seen. Each domain impacts the other. Living in a good neighbourhood leads to stronger social networks with correspondingly higher levels of wellbeing. On the other hand, living in a deprived neighbourhood leads to weakened social networks, isolation and declining health, and low ranking of quality of life. Thus not only is the social milieu of the older person important in determining their sense of wellbeing and

[24] That is, in early old age, 65-75 years of age. This tends to change in older aged (80+).
[25] There is a positive correlation between rundown buildings and a high incidence of crime.
[26] In older persons aged 75+.

life satisfaction, but the community in which they live has to have a sound infrastructure with effective public services and effective service delivery.

3.4.7 Good health and functionality

The World Health Organisation's Second World Assembly on Ageing, 2002, stated that 59% of all deaths worldwide are caused by non-communicable diseases which were directly attributed to the lifestyle effects throughout one's life course (WHO, 2004). To counteract what was seen as an unnecessary economic health burden, the United Nations put forward a plan of action that advocated a healthy lifestyle throughout one's life course as general consensus pointed towards health as being one of the key quality of life indices. Furthermore, many proponents of successful ageing see good health and functionality as the key indicator to wellbeing in the aged (Kahana, Kahana & Kercher, 2003:156; Rowe, 2005). This section will deal with the link between good health and functionality with regard to wellbeing and quality of life in the older person.

Gabriel and Bowling (2004) found that good health predicated quality of life and wellbeing. Good health, they found, was essential in allowing people to function well in their activities of daily living (IADL), where IADL is determined by the ability of the older person to be mobile, bath, dress, feed, level of continence and ability to perform social roles(Wan *et al.*, 1982). Factors directly linked to wellbeing and good health were education, vision, hearing and the absence of depression. In addition, strong social and family ties, were directly linked to the well being of the older person with social participation being the strongest indicator of well being (Welsh-Bohmer, 2006:207).

The importance of health during one's life course in determining healthy wellbeing in old age cannot be underestimated. It is thought that most older persons will suffer at least one chronic illness during their latter years. However, literature has indicated that although chronic pain accompanied by chronic illness has a strong negative impact on wellbeing, health education does lead to both longevity and quality of life. It stands to reason that sound health habits lead to good health which in turn staves off age related diseases.

Furthermore, healthy well-being during one's life course lowers the incidence of disabilities in old age as well as countering the effects of the disability cascade. The disability cascade can best be described as the knock-on effect that chronic illness has on an individual's overall wellbeing (Kahana *et al.*, 2003). It has been argued that disability in itself does not lead to the

lowering of wellbeing but rather the impact that disability has on other domains (Ozawa & Hong, 2003). Consequently, chronic illness left unchecked leads to physical impairment and functional limitations with decreased psychological wellbeing and associated decline in social functioning. By the same token, poor or deteriorating health in a significant other had a marked impact on an older person's sense of wellbeing (Gabriel & Bowling, 2004:28-29).

It was further found that there is a strong link between subjective health and life satisfaction (Beckett & Dungee-Anderson, 2000:277; Kennedy & Hamilton, 2005; Lauer, 1989). However in a study undertaken by Newman and Newman in 1987, it was found that 80% of independent living 85 year olds in their target group performed ably in their activities for daily living. This gives some indication of the level of healthy wellbeing amongst the aged, given that wellbeing is linked to functionality and the ability to fulfil social roles.

It can thus be seen that longevity is not to be confused with successful ageing but it is rather age together with functionality and self reported perceptions of health that gives rise to wellbeing amongst the aged. It follows that healthy wellbeing in old age is nothing more than an expression of a healthy lifestyle throughout one's life course. However, the success of active ageing is contingent upon government will, economic growth and a manageable disease burden. It must be noted that the economic growth of a country does not necessarily reflect that country's ability to overcome health problems should the disease burden be overwhelming (Cutler, Deaton & Lleras-Murray, 2005).

3.4.8 Adequate income and economic security

This section will deal with the influence of adequate income and economic security in determining wellbeing and quality of life in old age. There is no doubt that in a cash economy, income security is one of the most important needs of the older person for without adequate income, the basic needs of the older person lie beyond their grasp. Economic security allows for good health, living in a good home and good neighbourhood which in turn determines the ability of the older person to enjoy good social relationships. This is borne out by self reported quality of life indices where participants stated that having adequate finances was seen to be an important factor in determining a sense of wellbeing in old age. Not only is it essential in meeting one's basic needs but it also ensures a modicum of independence and allays fears of not being able to fend for oneself in an emergency (Gabriel & Bowling, 2004).

Age, education, gender, marital status and race all play an important role in determining the economic wellbeing of the aged (Ozawa & Hong, 2003). Thus the oldest old are more likely to be poorer than the younger old. Furthermore, one's level of education will in large part determine one's economic status throughout one's life and therefore will have a direct bearing on the older person's economic wellbeing in latter years.

Older men are more likely to be economically better off than women while married older persons enjoy the highest rate of economic wellbeing. It was also found that although there is a direct link between widowhood and poverty in old age, this is only true for women and not men. Men's economic status after widowhood is unlikely to change, unlike that of their female counterparts who will continue to experience a downturn in their economic wellbeing. Moreover, older women from minority groups will be subject to the double jeopardy effect; impoverished due to both race and gender.

In America and the UK, older people from ethnic minorities experience the greatest level of poverty which can be directly attributed to early life discriminatory practices, particularly in education, with desultory effects in latter life and old age (Blazer *et al.*, 2005; Nazroo, Bajekal, Blane & Grewal, 2004). Furthermore, economic exclusion experienced by ethnic minorities as well as perceived economic inadequacy is predictors of higher mortality in older people (Blazer *et al.*, 2005; Cutler *et al.*, 2005). The latter also postulates that low status and rank over protracted periods of time lead to states of "fear or flight" and hence an increased probability of cardiovascular disease (Cutler *et al.,* 2005:28) An important finding in his study on the determinants of mortality was that poor health led to a lowered financial status and not vice versa. Cutler (2005) cites Smith's 1999 and 2005 findings that ill health was the leading cause of retirement (Cutler *et al.*, 2005:28).

Retirement is a fairly new concept, having only been introduced in 1935 in the USA[27] as a direct consequence to the high rate of unemployment. The introduction of state pension schemes at time of retirement or reaching pensionable age was also seen as a means of maintaining a standard of living and reducing poverty in old age. Certainly in the developed countries of the world, poverty levels amongst the aged are far lower than in developing countries where little or no economic provision has been made for people of pensionable age (Moller & Ferreira, 2003:1).

[27] By the introduction of the Social Security Act.

It could be said that the introduction of mandatory retirement was a form of social engineering, of forced disengagement as it were, whereby men aged 65 and older were retired in order to make way for their younger counterparts (Lauer, 1989:272). Leisure time associated with retirement is a relatively new concept as prior to the Depression years, the older person, as long as they were capable and functional, worked well into their latter years. This belies the current belief held in Western society, that after the age of 40, productivity declines in the workplace and has perhaps perpetuated one of the most harmful myths of old age. While ageism has become commonplace in the workplace, as evidenced by mandatory retirement, population ageing and the resultant shortfalls of retirement funding, is forcing governments to consider extending the age of retirement.[28]

It has been found that forced early retirement, whatever the cause, has a strong negative effect on the wellbeing of the retiree (Blane *et al.*, 2004). Further consideration must be given to the fact that in the United Kingdom it is estimated that only a third of all retirees do so of their own volition (Lloyd-Sherlock, 2004). Moreover, retirement as a rite of passage is a misnomer based solely on the fact that a rite of passage is contingent upon three stages, viz. separation, marginality and reincorporation. Kieth argues that in the old, there is no reincorporation and that the retirees are left "stranded" (Kieth, 1985). It would seem that while retirement should be experienced as a time of renewal, for many older person it is fact not. The inference that is drawn, is given the high rate of enforced retirement, retirement as such may impact negatively on the older persons level of wellbeing.

The issues surrounding retirement and pensions are too numerous to mention and are beyond the scope of this paper. Suffice to say, if the elderly are to be assisted in their quest for independent living, if they to are to experience a decent quality of life and sense of wellbeing which affords them dignity, as encapsulated by United Nations principles, efforts must be made on all levels of society, to ensure the adequate financial provision of the aged.

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[28] UK News: "Warning of £150bn black hole in pensions," by Norma Cohen (*Financial Times*, 9 January 2006). Available: http://news.ft.com/cms/s/d7446f2c-80b4-11da-8f9d-0000779e2340.html.
UK News: "Retirement at 67 to be considered by Ministers," by Ben Hall (*Financial Times*, 19 September 2005).
Britain's Turner Commission recommends retirement age be raised to 68 – The Economist Global Agenda, 30 November 2005. http://news.ft.com/cms/s/1bfed8ae-28aa-11da-97c7-00000e2511c8.html.
Malaysia News: "Raising the retirement age," by Elayne Yee Siew Lin (*The Star* [Kuala Lumpur], 19 September 2005). Note: This article is a commentary. Available: http://biz.thestar.com.my/news/story.asp?file=/2005/9/19/business/12034421&sec=business.

While access to resources has increased in South Africa, there is no doubt that poverty levels for the majority of the aged remain a pressing and urgent problem. In a South African study it was found that basic needs such as food, water and shelter were not available to many rural and peri-urban elderly and that most of the participants had an inadequate standard of living, identifying a lack of financial resources as the main stressor (Braithwaite, Mogotlane, Rodrigues, Dorsey, Mangongo & Matlakala, 2002). Implicit in this finding is that elderly rural South Africans are experiencing unacceptably high levels of economic hardship to the detriment of their wellbeing.[29]

3.4.9 Positive outlook

"Cancer can bite my body – but it can't bite my spirit" (Guttman, 2001:125). Having a positive outlook on life and a sense of psychological wellbeing is perhaps one of the most important factors that enable older persons to adapt to the vagaries and many changes associated with old age such as bereavement, declining health, mobility, relocation and retirement, to name a few. Ryff's 1991 model of psychological wellbeing points to the following as enabling mechanisms: being on good terms with others, having a sense of self and a sense of purpose in life, environmental mastery, personal growth and autonomy. All of these factors have to deal with the inner strength of the person and closely match life stage development theories on self actualisation and integrity.

In Gabriel and Bowling's 2004 study, it was found that personality, life events and one's subjective interpretation of those experiences, play a large part in determining one's level of quality of life and sense of wellbeing. Furthermore, important coping mechanisms that were identified as ensuring a state of homeostasis and a fairly high degree of quality of life, were acceptance and downward contrasts.[30] Acceptance would be reflected in statements such as "It could be worse" while downward contrast could be illustrated in such a statement as "Well, there are people far worse off than me" (Beaumont & Kenealy, 2004; Gabriel & Bowling, 2004).

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[29] Research conducted by Oxford University in Khayelitsha township is examining the relationship between the high incidence of dementia amongst the aged and their extreme social deprivation and poverty. Interview with Professor Monica Ferreira, November 2005.

[30] Downward contrast used as a social comparison strategy and defined as seeing others as having a poorer quality of life, being worse off or less fortunate (Beaumont & Kenealy, 2004:755).

It could be argued that downward contrasts together with acceptance are adaptive and functional strategies in enhancing quality of life and are rooted in relative and not absolute measures. For example, people living in an economically deprived community may not perceive themselves as being "poor" or worse off than anyone else but may, in fact, consider others worse off than themselves. Thus the role that perception plays in determining quality of life cannot be underestimated. Significantly, in terms of emotional and health related indices, it was found that the older person's *perceptions* of their health, despite evidence of chronic disease, was a strong indicator of life satisfaction (Fakourie & Lyon, 2005).

Fakourie and Lyon (2005) citing Aldwin's 1996 study, observe that people aged 85-89 worried less than their younger cohorts and those aged 90 and older, complained the least about their physical discomforts although they were arguably the most physically compromised.[31] Carstens also holds the view that this is an adaptive response to old age and is seen as "energy conservation" (Filipp, 1995:223). In other words, the low levels of worry in the oldest old could be explained as the "decrease in future extension" which implies an apathetic acceptance, and not a sense of achievement and integrity, as espoused by Maslow and other developmental theorists.

Self efficacy is another adaptive mechanism that helps explain why some people, given the same set of circumstances, are better able to cope than others. Self efficacy may in fact be the most important factor in determining levels of quality of life in as much as it allows the person to have a sense of control over their lives or environmental mastery (Bowling & Dieppe, 2005). The Berlin Aging Study concluded that high ratings of wellbeing amongst their subjects, despite negative life circumstances, were attributed to three other adaptive mechanisms, viz. gradual adaptation, change of comparison standards and lowered aspirations (Baltes & Mayer, 2001:468).

Just as a positive outlook on life helps to determine a sense of wellbeing, anxiety, worry and depression, what Frankl says are the result of an "existential vacuum", will equally play a negative role in the older person's perception of quality of life. It has also been documented that negative perceptions pertaining to unmet basic needs, poor health and weak social support systems and low self esteem are all predictors of higher mortality among the aged (Berg, 1996:328-334; Blazer *et al.*, 2005:6). Contrary to common belief, a lower perception

[31] In a study undertaken by Aldwin, 1996 (Fakouri & Lyon, 2005).

of quality of life does not lead to depression but rather the reverse. Depression and other psychosocial stressors led not only to a lower perception of quality of life but also increased levels of morbidity (Beaumont & Kenealy, 2004; Davidson & Arber, 2004:137; Lauer, 1989:301).

It can be seen from the above how important psychological adaptive mechanisms are in maintaining a sense of wellbeing in later life as they allow the older person to cope with the many problems associated with this life stage.

3.4.10 Social activities and hobbies

While keeping oneself busy or occupied was seen as an important component to wellbeing in the aged, it was often the meaning derived from these activities that lent credence and weight to them. Thus volunteering takes on a deeper meaning as it provides continuity from the workplace (be it home or workforce) at the same time allowing for social contact and reciprocal engagement to take place (Gabriel & Bowling, 2004).

A study on community profiling of the aged in Baltimore, found that the younger seniors (60-74 years of age) were more likely to volunteer than older seniors (Wan *et al.,* 1982). Gender played no mediating role in this instance. Furthermore, although the single status (i.e. divorced or separated) indicated the willingness to volunteer, in practice they were the least likely to do so. Significantly, single status people enjoyed solitary activities more than their married counterparts while widowed persons preferred to get involved in leisure activities at the club.

In order for the older person to pursue leisure activities in a meaningful way four variables are considered: available time; activities or interaction with others; preference which infers choice and lastly, competence which is the level of functionality needed to participate (Harrigan & Farmer, 2000). The Baltimore Longitudinal Study indicated that their participants preferred to spend their "free-time" in activities that can be done alone such as reading, gardening and hobbies (Wan *et al*., 1982).

The pursuit of adult education during this period of one's life time was seen to be important as it afforded older persons the experience to develop their intellectual capacity, an important aspect of active ageing. The American concept of Elderhostel and U3A are good examples of

older people continuing to grow and develop and to seek out new experiences in the latter years (Moody, 2004).

3.5 CONCLUSION

In conclusion it can be seen that life course influences and proximate factors are largely responsible for determining the quality of life in the older person as do their subjective and objective experiences. Of the five basic needs of older persons, it is felt that income adequacy is the most important determinant of wellbeing in the aged, followed by health. Underpinning the determinants of quality of life in the elderly, are the adaptive mechanisms together with the right to autonomy, independence and dignity all of which enable older people to have a sense of wellbeing despite their circumstances.

CHAPTER 4

THE SOCIAL SUPPORT SYSTEMS OF THE OLDER PERSON

4.1 INTRODUCTION

The old adage of "no man is an island unto himself" holds true and places the individual, irrespective of age, gender and culture, firmly within the boundaries of several mutually dependent systems. Whereas the previous chapter dealt in large part with the self reported quality of life indicators and wellbeing of the older person, this chapter will look at the mechanisms and systems that allow older persons to function within their communities.

Thus the objective of this chapter will be to describe the function of the informal support systems of the older person from a systems theory approach by looking at social support per se, the theoretical framework of informal systems as well as a more detailed analysis of the informal support system of the older person. Central to understanding the full dimension of this support system is the importance of intergenerational transfer or exchange. Finally, care for one's family as a basic tenant of the Jewish faith will also be looked at.

4.2 THE IMPORTANCE OF SOCIAL SUPPORT SYSTEMS OF THE OLDER PERSON

For decades now, literature has been documenting the importance of meaningful and trusting relationships throughout one's lifespan as a determinate to wellbeing in later life. The importance of social support on the wellbeing of the elderly has been well documented (Antonucci, Lansford & Akiyama, 1985; Carroll & Whelan, 1994:4; Gabriel & Bowling, 2004; Siebert *et al.*, 2000:101).

Research has shown the positive impact that social support systems have on older persons in terms of mental and physical health and wellbeing in addition to lowering the levels of morbidity (Antonucci *et al.*, 2001; Markides & Black, 1996). The point must be made, however, that inherent to the relationships within the social support framework lies the

propensity for a sense of wellbeing and conflict to coexist (as a result of dependency feelings) (Antonucci *et al*., 2001; Cimarolli, Reinhardt, Horowitz, 2006).

The previous chapter highlighted some of the deleterious effects that an impoverished social support system has on the wellbeing of the older person: increased levels of stress, diminished health with associated high rates of morbidity, to name a few. It has also been noted that the absence of informal support systems predisposes the institutionalisation of the aged (Schroder-Butterfill & Marianli, 2006:19; Smith, 2001:13; Wenger, 1995).[32]

Such is the importance of social support systems that one of the stated objectives of the International Conference on Population and Development in Cairo is the development of both formal and informal support systems which would enable families to care for their elderly within the family home and with the assistance of all significant role players, both in government and civil society (UNFPA, 1994). It could also be argued that the success of implementing the United Nations Plan on Active Ageing centres on the development of social support systems.

4.2.1 Definition of social support and social networks

While the focus of this chapter is on the informal support systems of the aged, it is best to look at support systems of the older person in their entirety in order to place the older person at the foci of these interdependent and dynamic systems. To better understand both the formal and informal support systems of the aged, it is best to look at a few definitions pertaining to social support and social networks. At times the terms social networks and social support have been used interchangeably. Social networks refer to the total number of people one has contact with and with whom one has a bond – what Pearlin and others referred to as the "totality of an individual's attachments" (Moriarty & Butt, 2004; Pearlin, Aneshensel, Mullan & Whitlash, 1997).

[32] Significantly, Stephens (1977), in a study on ageing, social support and social policy found that older people living in large households tended to have smaller informal support systems than those who had only one child or who were childless. It is not known if this is due to the fact that older childless people must make more of a concerted effort to build a network than those with larger families.

Social support, as defined by Bowling in 1991, is the "interactive process through which assistance is obtained through one's (selected) network" and has more do with one's intra- and interpersonal relationships and by its implicit assumption, mutual exchange (Bowling, 2005). The Baltimore Longitudinal Study expands this definition by including the self rated perceptions of the older person. Thus social supports are seen as "*enduring* personal ties to a group of people who can be relied upon to provide emotional sustenance, assistance and resources in a time of need" (Wan *et al*., 1982:21). This definition has made provision for the living arrangements of the older person and included in its understanding, perceived assistance and social networks as indicators of social support.

Furthermore, underpinning Wan *et al*.'s (1982) definition of social support and the emphasis placed on the nature of the personal ties, is Antonucci's postulation that the support engendered during one's latter years is the product of relationships that have been build up over a lifespan – what Antonucci refers to as the convoy model of social support (Antonucci *et al*., 1985).[33] It can safely be said then that social support means nothing more than an exchange process where assistance is given by one party and received by another and includes care along a continuum which serves to enhance the wellbeing of the older person, be it psychosocial or physical.

Mention must be made that out of the study of social systems and networks has emerged a field of study that focuses on social capital as defined as "networks of social relations which are characterised by norms of trust and reciprocity which leads to outcomes of mutual benefit" (Stone, 2003). To highlight the overarching concept of social capital is a quote given by an Asian immigrant to the United Kingdom: "My roots are there, but my branches are here".

Before more is said about the theoretical framework of social support systems of the aged, something needs to be written about intergenerational transfer and exchange that takes place between the older person and their social support system.

4.2.2 Intergenerational transfer and exchange

As has already been mentioned, family networks are important vehicles through which intergenerational exchanges take place. These exchanges may be material, practical and

[33] Model of Convoy.

emotional and are essential components to the wellbeing of the elderly and are largely determined by the living arrangements, the stage of development of the country, and the ability of family members to access resources (Schroder-Butterfill & Marianli, 2006). Not surprisingly, Stone (2003) found that those older people from lower socio-economic status had the least social support available. She also found that intergenerational exchange was very much part of one's cultural heritage and very much determined by one's family structure (such as in filial obligation as practised in China and in Thailand or the Judaic biblical injunction to care for the aged). However, in the absence of intergenerational transfer or reciprocity, the care for the older person then becomes dependent on the strength and meaningfulness of the relationship between the carer and the cared for (Pearlin *et al.,* 1997:298).

When looking at intergenerational transfer it is important to note the important role that grandparents play in the lives of their adult children and grandchildren. According to the 2000 US census, 2,3 million grandparents have grandchildren living within the same household, of which, 30% were cared for by the grandparents (Simmons & Dye, 2003). In some African countries, such as Botswana and Zimbabwe, this figure is easily exceeded as the AIDS pandemic decimates countless young parents. Consequently, a high percentage of children in these countries find themselves being cared for by their elderly (and in most cases) impoverished older grandparents (Kinsella & Velkoff, 2001:27, 84). In a study undertaken in Australia it was found that those excluded from intergenerational support were divorced fathers, the childless, those whose families lived a distance away, recent migrants, and those with poor health and low income (Stone, 2003).

De Vaus' 1996 study in the same paper points out that support given is not always unconditional and is tempered by available (access) to resources (Stone, 2003). Apt sounded a warning in 1998, that the lack of a resource base created the danger of the aged becoming marginalised as they were perceived as being a burden to their families (Apt, 1998). Of equal concern in Africa is the plight of the older person with no support base. Tellingly, a quote from an elder Ghanaian serves to highlight the importance of intergenerational transfer in Africa and the precarious position in which childless older persons finds themselves: "… ageing in Ghana is a serious problem at least to us who do not have children; even how to get food is a problem."[34]

[34] HelpAge International Pamphlet, 1997.

4.2.3 A theoretical overview of social support systems according to systems theory

In this section, a brief theoretical overview will be given of social support systems of the older person as conceptualised by systems theory. Support systems have been described as being informal, quasi-formal and formal, and when applied to the elderly, are largely defined by the proximity of the affective relationships to the older person as well as the "degree of bureaucracy of those relationships" (Cantor & Little, 1985).[35]

Central to this theory is the model of substitution whereby the older person would seek help first from his/her informal social network and only then turn to the formal network in what Cantor has termed the "hierarchal compensatory theory of social support" (Cantor & Little, 1985:746; Zodikoff, 2003). An important criticism of this is the contention that while this is the ideal, often support is dependent on what and who is available (Segrin, 2003).

The informal support systems are made up of three subsystems and are defined by the primacy of their relationship to the older person. Thus the primary informal support system consists of kin (family); secondary is friends and neighbours while tertiary informal support systems (also quasi-formal) are described as being mediating support elements such as religious or cultural organisations (see Table 4.1 below).

Table 4.1: The informal support system of the older person

Informal Support Systems	Subsystems	Comment
Primary	1. Spouse 2. Children 3. Other relatives	Also referred to as kin.
Secondary	1. Close friends 2. Neighbours	
Tertiary	1. Religious affiliations 2. Community centres	Also referred to as quasi-formal support systems.

The formal support system, on the other hand, is made up of two broad categories or subsystems, viz. (1) political and economic institutions, and (2) voluntary and government organisations (Table 4.2).

[35] A model put forward by Cantor, M. in 1977, in **Ageing and Social Care**, p.748.

Table 4.2: The Formal Support Systems of the Older Person

Formal support systems	Comment
Political and Economic	Would determine policies and legislation pertaining to the aged as per e.g. social security
Voluntary and Government organisations	Concerned with legislative and policy interventions pertaining to the aged

Moreover, this model takes into consideration the bi-directional interaction that takes place between the macro and micro systems and the effect that these systems have upon one another. Both formal and informal social support networks should be seen as complementary systems, each with their characteristic functions, providing best practice in serving the needs of the older person or what has become known as a task-specific model, or principle of substitution, as conceptualised by Litwak (Cantor & Little, 1985; Wenger, 1984:195). It must be stated at this point that this research will only be looking at the informal and quasi-formal support systems as they are the most likely to be used by the older person as enabling and adjustment mechanisms in helping them live in the community as long as is feasible.

4.3 INFORMAL SUPPORT SYSTEMS

4.3.1 The importance of informal support systems

One of the important consequences of an informal support system is that it lessens the burden on the taxpayer and state. Thus, for example, it has been estimated that in Britain, informal carers saved the country just under £34 billion per annum, which is also indicative of the large role informal support systems play within society (Brown & Matthews, 2006; Neno, 2004). Much has been written about caregiver strain, the overburden of caring for an older person who has diminishing cognitive and physical abilities. However, this is a vast topic in itself and beyond the scope of this paper.

What needs to be taken into consideration when discussing the informal support systems of the aged is that in many countries, irrespective of their stage of transition, the family structure is undergoing unprecedented change due to population ageing and the changing face of marriage as we know it.

Thus, for the first time in the industrialised nations of the world we have increased incidences of childless marriages, divorces and the never-married. These factors all have a bearing on

the dependency ratio added to which, as in the case of the South African Jewish community, one finds a high rate of emigration in addition to which is a substantially high rate of interfaith marriage (Dubb, 1994). This, in turn, begs the question, to whom does the older person turn to in time of need?

4.3.2 The definition of informal support systems

Informal support systems can be defined as a "series of linkages along which information, emotional reassurances and services flow to and from a person and which includes, inter alia, his and/or her exchange relationships" (Kropf, 2000). It must be noted that these exchanges are not only social and economic but also emotional (or expressive) in nature. Thus, more than anything else, it is the emotional component that differentiates informal social support networks from the formal social support systems (Kropf, 2000:171; Moriarty & Butt, 2004; Qureshi, 1990; Siebert *et al.*, 2000; Taylor, Sylvestre & Botchner, 1998; Wan *et al.*, 1982; Wenger, 1984).

4.3.3 A brief theoretical overview of informal social support systems

In this section a brief theoretical overview will be given of the informal social support systems of older people as well as the subsystems and the processes peculiar to each subset.

At this point it must be emphasised that research findings have highlighted the fact that it is neither the frequency of contact nor the cohabitation between adult children and parents that determine the level of support given to an older person. Indeed, the main determinant of meaningful social support of the older person lies in the strength and depth of the relationship between the adult children and their aged parent(s). Additionally, a study by Kieth as cited by (Pearlin *et al.*, 1997) points out that underlying these relationships of caregiver to care receiver is an informal contractual relationship which he termed "voluntary principles of individual agreement" which is quite distinct from the formalised contractual relationship found in formal support systems (De Jong Gierveld, De Valk & Blommesteijn, 2001; Lam, 2006; Leeson, 2003; Pearlin *et al.*, 1997).

Informal support systems for the older person fall roughly into two broad categories: informal support for the functional well elderly, and support for the moderately severely impaired (Cantor & Little, 1985). Support for the functionally well will mainly be drawn from family, friends and neighbours with a high degree of reciprocity taking place. The relationships here

are predominately affective, with the older person taking an active part in the family life. Characteristically, a high degree of intergenerational interchange takes place, be it advice, monetary gifts or assisting adult children with child rearing. Table 4.3 below best illustrates this process.

Table 4.3: The informal support system of the older person

Informal support systems	Type of care	Subsystems	Comment
1. Primary	• Affective • Instrumental • Personal care	• Spouse • Children • Other relatives	• Also referred to as kin. • High incidence of intergenerational transfer.
2. Secondary	• Affective • Instrumental	• Close friends • Neighbours	• Exchange does take place but more practical and to a lesser degree.
3. Tertiary	• Affective • Spiritual • Instrumental	• Religious affiliations • Community centres	• Also referred to as quasi-formal support systems.

As can be seen from Table 4.3, three subsystems have been identified as making up informal support systems. They are primary, secondary and tertiary social support systems of the older person and operate in descending order of preference and importance.

However, as the older person becomes increasingly frail, due to age and or illness, this relationship undergoes a marked shift. The relationship between the older person and family support becomes increasingly unidirectional, i.e. support comes mainly from the family members, and the exchange of resources also diminishes (Cantor & Little, 1985; De Jong Gierveld *et al.*, 2001). It can be seen then, that in terms of a continuum of care, the older person first draws on support from their primary and secondary informal support systems. However, with increased ageing and associated decline in size of the informal support system, the older person will look towards more formalised systems for care support (Cranswick & Thomas, 2005; Smith, 2001).

4.4 PRIMARY INFORMAL SUPPORT SYSTEMS

According to Cantor's theory of hierarchical compensatory model of social support within the primary informal support system, the preferred carers of the older person would be made up of family or kin (Cantor & Little, 1985). Within this subsystem there exists a preferential and hierarchical caregiver support, viz. spouse, children followed by siblings, cousins and other

relatives such as grandchildren, nephews or nieces. For the purpose of this study the spouse and children will be dealt with in detail.

Several authors have stated that support given by family members share the following characteristics (Fromme, Drach, Tolle, Ebert, Miller, Perrin & Tilden, 2005; Pearlin *et al.*, 1997). Naleppa and Reid (2003:31) state that typically, the support given is:

- **Emotional or expressive**. Significantly, expressive support in such an instance has a greater propensity to stave off depression than instrumental support (Pearlin *et al.,* 1997:298).
- **Instrumental**. Instrumental support is described as assistance with such instrumental activities of daily living as cooking, housecleaning, laundry, shopping and transport.
- **Personal**. Care in this instance would involve assistance with activities of personal care such as bathing, washing hair, use of the bathroom, dressing and mobility. Personal care is quite distinct from social care.
- **Managing money, decision making**.
- **Liaising** with formal and quasi-formal care services, where needed.
- **Financial assistance**.

The defining characteristic of the informal support system is that the relationships are ongoing, as opposed to the contractual relationships found in formal support systems (Pearlin *et al.*, 1997). Furthermore, it has been postulated that the availability of informal care is very much dependent upon prevailing culturally determined attitudes (De Jong Geirveldt *et al.*, 2001; Markides & Black, 1996). Thus, within the Jewish community there is not only a strong religious and cultural sanction for care of the aged and until recently in Israel, also legislative (Dorff, 2005; Israel, 2006; Rappaport, 1982).[36]

[36] Israel is one of a few countries (like Ireland and Greece) where care for the aged by their families is legislated for. Myers-JDC Brookdale Institute, Centre for Research on Ageing. Family Caregiving, needs and programme initiatives in Israel. Ageing sub-committee meeting, 10 October 2005. Accessed on 8/6/06 from http://brookdale-en1.pionet.com/default.

Studies in the early 1990s, found that in certain ethnic minority groups such as the African-American, the care recipient is more likely to be cared for by members of their extended family and network (such as neighbours and friends) (Naleppa & Reid, 2003:207).

It can be seen from the aforegoing that the older person who receives care from their primary social support system will derive a strong sense of emotional wellbeing, life satisfaction and will subsequently be better equipped to make the necessary psychological adjustments associated with old age (DuPertuis *et al.*, 2001; Stephens, Blau, Oser & Millar, 1979).

4.4.1 Spouse

This section will deal with the function of the spouse as a primary caregiver within the informal social support system of the older person. Research has indicated, contrary to popular belief, that within the primary support system, the most important source of support for the married older person, is the spouse, and not the oldest adult daughter (Cantor & Little, 1985; Naleppa & Reid, 2003). Furthermore, the spousal caregiver will in all likelihood see their role as an extension of their marital role which, to a certain degree, does lessen the care burden load (Li, 2004).

Most literature in the past has focused on the wife as the spousal caregiver and not men, which belies the important role that male carers play in the supportive system either as spousal caregivers or as adult sons (Fromme *et al.*, 2005).[37] The spouse is more often the person best suited to offering emotional, social and instrumental support and is seen as the first "line of defence" (Cantor & Little, 1985; Naleppa & Reid, 2003). Of interest is the fact that older spousal caregivers are less likely to receive support themselves as compared to a younger caregiver, which serves to heighten a sense of isolation, thus adding to the caregiver's burden (Li, 2004). It must be remembered that younger cohorts would in any event have a wider informal support system than their older counterparts and would thus draw their support from this source. The older person, by contrast, will have a far smaller support system due to the rate of attrition experienced during this period of their lives.

Furthermore, Li's research findings can lead one to question whether there exists a tension between the adaptive psychological mechanism that takes place in the first instance and the

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[37] This is also indicative of gender bias, in this instance towards men as caregivers.

reality of carrying the burden of care under the strain of diminishing resources, be they physical, emotional or financial.

Due to population ageing, the spousal carer will in all likelihood be the wife (Kropf, 2000). Most telling of all is the "widower effect" where the spouse dies soon after their partner's death. The bereaved older person is said to be at risk anywhere from between 30 days until two years after the death of their partner and this is directly attributed in large part to the widowed partner suffering from multiple loss (of support) including social, emotional and financial support (Kornblum, 2006). This seems to contradict a study Singer, cited by Segrin (2003), into the effects of social support over the lifespan which found that older people were not as dependent on spousal support for their wellbeing as their younger cohorts (Segrin, 2003:331).

Be that as it may, it is only once the spouse feels that they have depleted their recourses that they will turn to the formal social support system for additional help (Antonucci *et al.*, 1985; Cantor & Little, 1985; Naleppa & Reid, 2003). Cantor and Little (1985) make the contention that those most at risk are older people who never married and those who are childless. In a comparative study between elderly Jewish people in Russia and Ukraine it was found that, common to other literature, the unmarried and childless elderly showed the highest levels of loneliness (Lecovich, Bareasch, Mirsky & Kaufman, 2004). There is no doubt that a lack of formal support systems in such countries would also exacerbate an already tenuous situation and place the older person at further risk.

From the above one can see the valuable function that the spouse plays as a primary caregiver. Not only does spousal support, both instrumental and affective, lead to a sense of wellbeing of the care recipient, but it enables the older person to remain at home and age in place for as long as is practicable. It must also be remembered that personal care, such as bathing and personal cleanliness, is the function of the primary and not the secondary support group.

4.4.2 Children

A Ghanaian proverb best illustrates the sense of relational obligation that adult children experience in terms of providing support and care for their ageing parents: "Since your elders take care of you when you cut your teeth, you must in turn take care of them while they are losing theirs" (Apt, 1998).

Contrary to common belief, it is not the children that are the primary caregivers of their ageing parent(s), it is only in the absence of a spouse that children take on this role. It stands to reason then that as more older women experience widowhood than men at the same age, that older females are more likely to be cared for by their children (Cantor & Little, 1985; Neno, 2004). Furthermore, while the spouse is still alive, adult children will play more of a secondary caregiving role and assist with respite care for the caregiving parent (Cantor & Little, 1985). What follows is a description of the function that adult children play in the primary support system of the older person.

As already has been mentioned, it is only once the ageing parent has been widowed, that the adult children adopt the function of a primary support system. Mention must be made of the fact that adult daughters still make up the majority of caregivers for ageing parents and are often conflicted by what has become known as the "sandwich generation", i.e. caring for both older parents and their own children (Li, 2004). With population ageing however, it is becoming less uncommon for adult daughters to be caring not only for their aging parent and younger children, but also for their aged grandparent.

While in the past focus was placed on older daughters as caregivers, it is worth noting that recent literature has shown that sons account for up to a third of all caregiving roles (Naleppa & Reid, 2003). In instances where adult brothers and sisters care for their older parent(s), support normally follows traditional lines; the daughter will assist primarily with instrumental help while the son will manage financial matters (Cantor & Little, 1985). Furthermore, Peters-Davis, Moss and Pruchno (as cited in Naleppa & Reid, 2003) suggest that an often overlooked category of the informal social support group is children-in-law who often offer the same degree of care as the care recipient's adult children.

Another source of social support worth mentioning is that of adult siblings co-operating with each other to best meet the needs of their aged parent(s) in what has been described as "the most important developmental task of early and middle adulthood" (Ingersol-Dayton, Neal & Hammer, 2003). One of the greatest advantages of siblings caring together as a team is that they share the caregiving load thus minimising the over burden on one person. However, the changing family structure is having a profound effect on the degree to which informal care can remain the main source of support. According to the US census report, currently, 7% of older men and 8,6% of older women are divorced (Gardiner, 2006).

The current divorce statistic amongst American seniors has vast implication for children as informal caregivers. Firstly, as has been stated by B.S. Schone,[38] divorced elderly parents are less likely to receive care from their children than their widowed counterparts and as such are the least likely to receive informal care from their children. Thirdly, there is inordinate strain placed on a child caring for both elderly parents that are divorced, what has become known as the caring triangle. Fourthly, this caring triangle presupposes a filial obligation to the estranged parent where one does not exist or is tenuous at best. Thus the effects of divorce in terms of informal care support for the elderly are long term and certainly can serve to undermine the moral obligation as stated above (De Jong Gierveld *et al.*, 2001).

Finally, with ever increasing numbers of women entering the workplace coupled to the high incidence of divorce, it becomes increasingly difficult for single women to care for an ageing parent (Brown & Mathews, 2006; Gardiner, 2006). It can safely be argued that the informal care by family members (and as such, the informal support system) is not only linked to kin availability but also subsumes and carries with it the weight of moral obligation which again is dependent on one's relationships developed over the lifespan. A quotation from the Director of Gerontology at Towson University illustrates the importance and veracity of Antonucci's convoy model of support: "The relationships we have with our family members when we're younger are often predictive of the support we have available to us in old age" (Gardiner, 2006).

In societies undergoing socio-economic transition, the family has also undergone a structural shift from one of multi-generational households to that of the nuclear family. Such shifts are usually accompanied by changes in traditional values. Thus, for example, in traditional Chinese families where filial piety, based on Confucian principles was the norm, adult children were economically dependent on the parents until such time as the parents died. With industrialisation, however, adult children have tended to migrate and live apart from their older parents. Findings suggested that while filial piety is still upheld as a value there is an increased probability that caring will be influenced more by socio-economic determinants such as the living arrangements, the economic status of the adult child and the depth of their relationship with their aged parents (Lam, 2006). Certainly within the Jewish community with the reality of emigration and increased intermarriage altering family structure and kin availability, the principle of the family as an informal support system still holds sway

[38] Senior economist at the Agency for Health Care Research and quality, Rockville, USA.

(Brodsky & Berg-Warman, 2006; Leeson, 2003).[39] In a South African survey undertaken of the Jewish community, older people cited, alongside family members, the domestic workers as one of the main sources of instrumental support (Dubb, 1994).

Findings from the National Survey in Mexico suggest that the amount of care received by the aged from their children in the urban areas is more than that in the rural areas (Da Conceicao & De Oca Zavalia, 2004:237). This seems inconsistent with studies by Isaacs in 1972, and Townsend in 1957 (cited by Wenger, 1984), which showed that care for the elderly held equal importance in both urban and rural areas. What is open to conjecture is the perception that informal support systems are stronger in a rural setting than in an urban area. The reasoning behind this argument is that in urban areas adult children have a higher degree of access to economic resources. That being the inference, it would seem that intergenerational exchanges are in large part not only determined by the economic development of the country but also the ability to access economic resources. However, according to a study set in Korea of rural elderly who were aged 70 and over and who lived apart from their adult children, a strong determinant to the receipt of both instrumental and affective care, was the frequency of contact between parent and child (Lee, 2004).

Da Conceicao and De Oca Zavalia (2004) further found that in the face of a lack of formal support systems within a community, complex informal networks, such as family, friends and neighbours emerge and that informal support systems include both intra- and interfamilial intergenerational exchange. Such developments are to found in Zimbabwe and other parts of Sub-Saharan Africa where, due to the AIDS pandemic, grandparents, and particularly grandmothers, have been forced into a prolonged care relationship of their grandchildren with little or no support from the formal government sector. The AIDS pandemic has also given rise to the emergence of fictive kin and older siblings as alternative caring networks .

4.4.3 The older person's siblings

While other relatives do and can play an important role in the primary support system of the aged, this research will focus on the older person's siblings as part of this support system.

[39] Seventy six percent of the Jewish elderly in Israel still live in the community (Brodsky & Berg-Warman, 2006:3).

Literature has shown that informal care by the older person's siblings is likely to take place when the older person is widowed and childless or never married. Furthermore, while the primary informal support system is functional, the relationship between the siblings is more likely to be affective in nature. It is only on the death of a spouse and in the absence of other primary support that the care support received from older siblings will change from affective to that of instrumental support (Canter & Little, 1985; Naleppa & Reid, 2003).

While it has been stated that a positive correlation exits between close sibling relationships in early adulthood and old age, it has also been found that siblings who did not enjoy a close bond in early adulthood often draw closer during old age (Bengstin, Rosenthal & Burton, 1997; Naleppa & Reid, 2003). It would seem then that support received by a sibling is of paramount importance to the wellbeing of the older person and that with continued low fertility and replacement rates, there is every likelihood that care by siblings may well become commonplace in years to come.

4.5 SECONDARY INFORMAL SUPPORT SYSTEM

Secondary support systems are mainly made up of friends and neighbours and exclude family and relatives.

4.5.1 Friends and neighbours

This section will discuss the important function that friends and neighbours have in providing secondary social support to the older person. There is some conjecture over whether or not the social network of the older person diminishes over time, but what is clear, is that the depth of the remaining relationships and social support is sustained and are considered important not only to the wellbeing of the older person but also to the older person's "continuity" of identity (Antonucci *et al*., 2001; Siebert *et al.*, 2000; Stephens *et al*., 1979; Stone, 2003).

A vast amount of research into the importance of friendship in ones latter years has pointed towards the positive influence friends have on both the psychological and physical well-being of the older person. Arling (cited in Kropf, 2000) has stated that friends and neighbours often play a more important supportive role in the life of the widow, in terms of morale, than do her children. This is especially true in the case where adult children do not live in close proximity to their older parents. Notably, friends who tend to live in closer proximity, can respond more

quickly in a time of crisis. Literature also tends to suggest that age-segregated housing such as retirement villages, or age heterogeneous neighbourhoods, followed by religious institution and work, is where friendships are most often formed (Liebler & Sandefur, 1998; Stephens *et al.*, 1979).

In an Australian study undertaken in 2003 by Stone, it was found that neighbourhood exchanges were the least demanding or obligatory and tended to be instrumental in nature. Furthermore it was found that neighbourhood ties, given low rates of community mobility and migration, were more likely cemented in one's early 40's and that these ties would persist well into old age. By the same token, it was observed that the relationship between the two domains of social support, viz. family and friends, differ in quite unique ways and are not, in fact, interchangeable.

In this Australian study it was found that spousal support was a greater predictor of wellbeing for the older person but that having a greater number of friends in one's supportive network tended to lessen loneliness during widowhood (Stone, 2003).[40] In other words, friendship has a buffering effect of the loneliness experienced by widowhood, especially in the case of women (Antonnuci *et al.*, 2001; Caputo, 1999; Du Pertuis, Aldwin & Bosse, 2001; Liebler & Sandefur, 1998). Research has also shown that widows spent more time than married women giving instrumental support and, conversely, received more emotional support (Liebler & Sandefur, 1998). The reason for this is quite self-evident; married women have less spare time than their single counterparts. Moreover, their emotional support would, all things being equal, be sought from their spouse. Owing to the fact that neighbours and friends are often in a better position than the older person to know what community resources are available it has been noted that friends and neighbours are often the interface between the elderly person and community resources.

A further observation has been that neighbours tend to build an informal support system with the elderly that is inclined to be instrumental in nature as, for example, giving an older person a lift to the shops or to the doctor (Li, 2004). Li (2004) noted that elders who use secondary support systems (as well as those being cared for by their daughters) are more apt to use community based services. This is very much in line with Cantor's model of hierarchical support whereby the older person would look first towards family and kin before turning to

[40] Significantly, it was also found that "having a best friend that got on your nerves" was also positively associated with life satisfaction!

friends for support and lastly to formal or quasi-formal support systems (Cantor & Little, 1985). Significantly, it was noted that friendships were important in terms of social support and not personal care support.

Another point of interest underlying the old adage "you can chose your friends but not your family" is that both choice and reciprocity lie at the heart of friendship, without the sense of obligation which is so characteristic in the primary social support system (Du Pertuis *et al.*, 2001). However, from the care recipient's perspective, the inability to reciprocate instrumental support (from friends) can inadvertently lead to lowered levels of wellbeing due to perceptions of dependency. In the main the exchanges between friends can be both similar and complementary and the support in secondary support systems tends to be more expressive than instrumental (Liebler & Sandefur, 1998).

Literature is studded with the positive effects that friendships have on the overall wellbeing of the older person. The presence of friends in the secondary support systems of the older person thus lends itself to greater morale, lowered levels of loneliness, increased self worth and emotional support with respect to disease (Du Pertuis *et al*, 2001; Liebler & Sandefur, 1998).

4.6 TERTIARY SUPPORT SYSTEMS

Tertiary support systems of the older person are also called quasi-formal support systems as the support that is garnered at this juncture is extra-familial and is drawn from community resources such as religious institutions and community organisations, examples of which are faith-based/secular volunteer and community centres, congregate meal programmes and so on.

4.6.1 Religious and community resources

The importance of religious and community resources and their interplay between the older person and their wellbeing is only now beginning to be fully understood and measured by social scientists within the field of gerontology. As religious belief lies at the heart of the Jewish culture and identity it is felt that for the purposes of this research focus needs to be placed on the important function that religion plays in the formation of a tertiary support system for the older person, particularly for those adherents to the Jewish faith.

Religious observance and attendance at a place of worship ranks high in importance in the lives of older people, particularly with the present generation of older cohorts who were brought up in an era where religion played an important role (Cnaan, Boddie & Kang, 2005; Nelson-Becker, 2005). Subsequently, in the USA today, 79% of older persons aged between 65 and 74 rank religion as very important (Cnaan *et al*., 2005). Several studies have shown that taking an active role in religious and civil activities, leads to lower levels of stress and higher levels of health. Coupled to this is the fact that in both instances involvement in these institutions offers a potentially wider network of social support (Cranswick & Derric, 2005; Stone, 2003).

Studies, in particular Huttman (1985), have also shown that civic and religious involvement, especially with churches and synagogues, served to "expand the opportunities for social support" and give greater levels of life satisfaction in the older person (Cnaan *et al*., 2005; Kropf, 2000; Liebler & Sandefur, 1998; Stephens *et al.*, 1979). Judaism, alongside the other Mosaic religions, holds the older person in high esteem by virtue of their standing in the community and the value they add in terms of wisdom and experience. Of utmost importance is the biblical injunction to honour one's mother and father and not to cast aside the older person. Thus religious and filial obligation towards the care for the aged in the community become inexorably intertwined and bound up in memory of religious ritual and family obligation (Leeson, 2003).

Older people who were well integrated into the religious fabric of their community experienced the following outcomes: less depression, less substance abuse, lower mortality and morbidity rates, and stronger adaptive processes to change such as disability and bereavement (Cnaan *et al*., 2005). Places of worship are also vehicles through which more formal services can be introduced to the older person in conjunction with their other informal networks so that both affective and instrumental support is given.

In a study undertaken in the USA it was found that among African-American churchgoers the relationships formed in these settings tended to be closer than those in a secular setting and acted as a buffer against financial stress and perceived levels of health (Krause, 2006). Voluntary organisations can also be a place where the older person can make friends and be a place for receiving both affective and instrumental support. Community centres, social clubs, volunteer organisations and political organisations are all places where older persons can develop their social networks and so supplement and enhance their social support base

(Leeson, 2003; Naleppa & Reid, 2003). Thus they are often the link between informal support systems and formal support systems of the older person. Furthermore, it could also be argued that faith based community organisations, in the face of changing family structure, serve to further maintain the older person within their communities and social milieu far better than their secular counterparts, especially when the maintenance and continuation of one's faith and culture are so inextricably bound up in the wellbeing of the older person.

4.7 FORMAL SUPPORT SYSTEMS

Although the thrust of this research is based on the informal support systems of the aged, some mention must be made of the function of formal support systems and the important complementary role they play in enabling the older person to live in the community for as long as possible.

Broadly speaking, formal support systems are those systems that can best be described as instrumental/practical and comprised of "services and agencies which are established to meet the needs of the older person" (Kropf, 2000). In other words, formal support services are rendered by formalised institutions to meet the needs of the aged and include: (1) government agencies, (2) NPO's, (3) community care services, (4) congregate meal programmes, (5) senior service centres, (6) adult education, and (7) volunteer services.

Again, when referring back to the continuum of care, formal social support services will, according to Cantor and Little (1985), best serve the older person in the following ways:

- In the younger well elderly, the main focus of formal support services is on activities and socialisation.
- In the moderately frail elderly, the main focus of formal support systems will be as above but with formal assistance for some daily living activities such as shopping and transport.
- With the frail old-old, the main focus of formal support service would be the assumption of "surrogate family responsibility through the provision of in-home services or institutional care" (Cantro & Little, 1985:763).

The 2001 Canadian census brought to light some noteworthy trends in the use of formal support systems by the older person. Formal services were more likely to be employed by females who lived alone, were educated, were homeowners and had a wide circle of female

friends (Cranswick & Thomas, 2005). Although there is some overlap, formal social support systems are very much linked to the socio-economic development of a country as well as their societal mores on caring for the aged. Greece, Italy, Ireland and Israel have legislated care of the aged by the family, which is further entrenched by religious doctrine. This is in sharp contrast to some Northern European countries (e.g. Denmark and Norway) where the state has taken over the care burden of the aged. However, while the level of formal care is to a great extent linked to a country's access to resources, it must be noted that it is greatly dependent on the stated country's willingness to introduce social security measures that would protect the aged.

4.8 CONCLUSION

From the above it can be seen that, at times, aspects of both informal and formal support systems are employed by the older person in order to enable them to "age in place". Moreover, the interplay between the informal and the formal support systems are at one at the same time, interdependent and dynamic, operating from the micro to the macro level and working together to hold the older person in a position of stasis. There is no doubt that informal support systems play an enormous role in the care for the aged and create untold financial savings for governments. However, this should not detract either from the individual's responsibility to embark on an active ageing policy throughout their life course, or from governments ensuring that their fiscal policies are such that adequate provision is allowed for one of the most vulnerable sectors of the population – the aged.

CHAPTER 5

EXPLORATION OF THE QUALITY OF LIFE INDICATORS AND TYPES OF SOCIAL SUPPORT OF JEWISH SENIORS LIVING IN THE COMMUNITY

5.1 INTRODUCTION

The self selected quality of life indicators in the older person, as earlier discussed in Chapter Three, are the key concepts that are explored in this chapter together with the fourth objective of this research, viz. to identify and describe the quality of life indicators and types of social support systems of the Jewish seniors who are living in the community.

The researcher is of the opinion that by looking at the social support systems within the context of quality of life indictors, a fuller and richer picture of the participants lives will be brought to the fore and to this end both qualitative and quantitative research methods have been used. It is can be further stated that the judicial use of both qualitative and quantitative methods can serve to increase both the effectiveness and expertise of social workers in the field of gerontology (Sheridan & Kisor, 2000:98).

The main thrust of this study is the exploration of the support systems of the participants. While both formal and informal support systems will be explored, the main focus is on the informal support system. The perceived gaps in service delivery and suggested solutions as well as factors that influence and have a bearing on the support systems will also be explored with specific focus placed on the quality of life indicators in the older person. It is of equal importance to examine the demographics of the participants and the interrelatedness of gender, age and marital status as well as kin availability.

Areas being examined are:

- Demographics identifying details, gender, age and marital status. Also included will be number of children and area of residence as these points towards kin availability.
- Informal social support systems viz. primary, secondary and tertiary support systems.
- Selected quality of life indicators in the aged such as a good home/type of accommodation, a good neighbourhood, good health and functionality, adequate income and self reported quality of life and outlook.

- Perceived gaps in social services and factors that enable members to continue living in the community.

5.2 RESULTS OF THE INVESTIGATION

5.2.1 Demographics

5.2.1.1 Introduction

In this section, areas such as highest level of education, migration factors, ageing in place, gender and age will be explored.

Attention is drawn to the fact that after the interview took place, one of the participant's spouse died. For the purposes of this research, only the marital status of this participant has changed – all other recorded responses of this participant remain the same.

5.2.1.2 Highest level of education and source of income

As the researcher felt that it was too sensitive a matter to ask the participants about their estimated annual income, they were asked to state their highest level of education. It was the researcher's expectation that this would be indicative of the participants' current financial situation. A study undertaken by Ozawa and Hong (2003) showed a positive correlation between the level of one's education and one's economic well being in old age. Significantly, it was found that only 4% (1) of the participants held a degree, 42% had attended college and 50% had matriculated (Table 5.1).

Table 5.1: Distribution of highest level of education

Level of education	f	%
University Degree	1	4
College	10	42
Matric	12	50
Std 9	1	4
Total	**24**	**100**

N=24

A far stronger indicator of the financial health of the participants would be whether or not they drew a government pension plan. It was found that only 12,5% (3) of the participants drew a government pension while a quarter (6) of the participants had private pension

schemes. Just under two thirds (15) were reliant on investments/properties (other) (Table 5.2).

Table 5.2: Main source of income during retirement

Source of income	F	%
Govt pension	3	12.5
Private pension	6	25
Other	15	62.5
Total	**24**	**100**

N=24

A total of 21% (5) of the participants, including the three that drew a government pension plan, received financial assistance from their adult children.

- "I don't know what it will be like in a few years time. I am being assisted by my family. Your children support you - according to Jewish Law, they are obliged to help you. I always worry about something – when I was younger, I didn't have time to think".
- "I hate depending on them. I prefer to give."

Only 21% (6) of the participants were employed but only on a part-time/flexi time basis, two of whom worked for adult children due to of the expertise that they could offer. Those participants who worked, found that the money supplemented their income, kept them occupied and kept their "brains active". Eight percent (2) of the participants had spouses that were still actively employed. The remaining 46% (11) of the participants relied solely on their investments/pensions.

The quotes given above serve to highlight the need for adequate finances in not only meeting one's basic needs but also for ensuring a modicum of independence. Moreover, financial independence also allows one to fend for oneself in an emergency (Gabriel & Bowling, 2004).

5.2.1.3 Push/pull factors to current place of residence

In order to ascertain what were the push/pull factors or migration to the present place of residence, the interviewer asked the participants where they had lived previously, and the reasons for them leaving. In order to cross reference and verify the responses, similar questions were again asked towards the end of the interview schedule. Where the questions

were open-ended and the data qualitative in nature, the researcher searched for themes, coded them accordingly and then interpreted the results (De Vos, 2005:338).

(a) Push factors

Push factors refer to reasons for leaving the area and which result in out-migration. Fifty percent (12) of the participants said they left their previous place of residence to live in the Milnerton area either due to business or financial reasons. Of these twelve, 8% (2) participants retired, 13% (3) had spouses who retired and 4% (1) participant was retrenched. The remaining six participants cited various financial reasons, either it was too expensive to live by themselves – 8% (2), or businesses ventures did not go according to plan 13% (3) or downsizing 4% (1).

A participant who was retrenched unexpectedly stated "They gave me the needle. It was a shock. I thought I could go on". Another participant said:

- "My spouse was retrenched … the whites in the 60-65 age bracket … were top heavy ... thought they would work until 65. My spouse was 62. It was a terrible shock … my spouse went into deep depression. I lost my hair".

The remaining 12 participants cited the following as primary reasons for moving to their current place of residence: Children leaving home totalled 13% (3); loss of a spouse totalled 13% (3); health of a spouse/partner totalled % (3); stress totalled 8% (2) and finally, security scored 8% (2).

The stress of running a business was such that it precipitated relocation to Cape Town, is illustrated in the statement given by a participant.

- "The stress of work became too much. So I sold the business and came to live in Cape Town …."

Of the 24 participants, 50% (12) of the participants experienced varying degrees of trauma accompanying their relocation. Eight percent (2) moved as a direct result of their spouse's death while one participant moved in anticipation of their spouse's death. Four percent (1) of the participants moved due to a debilitating disease. Thirteen percent (3) of the participants cited financial reasons while a further 13% (3) said it was a result of their children emigrating. Eight percent (2) of the participants who had been mugged said this had a direct bearing on their decision to move to a retirement village.

Twenty nine percent (7) of the participants relocated from Johannesburg and for some of these members, the relocation was a particularly trying and harrowing time. Four percent (1) of the participants were hijacked whilst living in Johannesburg and this precipitated the decision to move to Cape Town.

- "My daughter emigrated and I was left completely alone."

And from another:

- "My spouse knew he was going to die, so we came to Cape Town to be with the children."
- "… it was a terrible wrench".

This participant who made the last statement, later stated "Having a new grandchild in Cape Town has filled a void in our lives" which highlights the buffeting effect that the birth of a grandchild has in the face of multiple loss in old age (Clarke & Roberts, 2004:192).

(b) Pull factors

Pull factors refer to reasons for moving into an area and which result in in-migration. The main reason that the participants gave for moving into their current place of residence was to be near family i.e. 42% (10) of the participants. It is significant that 90% (9 of 10 participants) of this group, relocated from Johannesburg to Cape Town which translates to 42% of the total target group. Of these ten, 40% (4) were widows who moved to be near family and as already mentioned, one of the participants moved in anticipation of their spouse's death. Three participants were married and two were living with partners.

A further 21% (5) of the participants moved in order to live in a retirement village. Two of these five participants moved specifically to a retirement village for feelings of safety as a direct result of being mugged. Other reasons given by participants for moving was financial/ downsizing 17% (4); to be near the sea 13% (3), and to be near friends 8% (2).

- "My aim was always to live in Cape Town. I wanted to live close to my son."
- "… I came to Cape Town … to be near the sea and have a view of the sea!"

While it can be observed that there are two very obvious migration patterns, they do not adhere strictly to the trends observed by a 1988 study by Rogers as cited by Kinsella and Velkoff (2001:55) and United Nations (1991b:197). The two migration patterns cited in literature are: (1) long-distance and amenity motivated and (2) short-distance and assistance

motivated. Although 42% of the target group migrated from Johannesburg, it was not amenity motivated but rather to be with family. Moreover, those 14 participants that migrated a short distance i.e. from within Cape Town, were not necessarily assistance motivated. Just over a third of this group 36% (5), the highest score, were amenity motivated which contradicts Roger's observation. Furthermore there was no evidence to back the observation that the two migration patterns were age-specific i.e. long distance migration takes place in ones early 60's while short distance migration takes place in the 70-80 plus age bands.

5.2.1.4 Ageing in place

According to a United Nations report (1991a:5), there is increasing evidence to suggest that older persons are experiencing higher degrees of migration, also described as the "retirement effect". The same report postulates that ageing in place may also be on the decline. However, this research study showed that 46% (11) of the participants were born in Cape Town and at present live in Cape Town. Sixty three percent (15) of the participants have spent most of their adult years in Cape Town, although one of these has spent twenty years on the West Coast and just over twenty years in Milnerton. Although 38% (9) of the participants spent their adult years in Johannesburg, only a third was born in Johannesburg and spent most of their adult life in that city.

Of interest is the fact that all of the participants that fell into the 80 plus age cohort were born in Eastern Europe, either in Lithuania (3) or Latvia (2). One other participant was born in London and was a child evacuee during WW11. Some of the narrative is worth recording:

- "We left in 1932. We managed to get out because we didn't have anything. They were only interested in the wealthy."
- "My parents left in early 1920 … my uncle was the first person to be shot in the shtetl" (Yiddish for small village – term used in Eastern Europe and Russia).

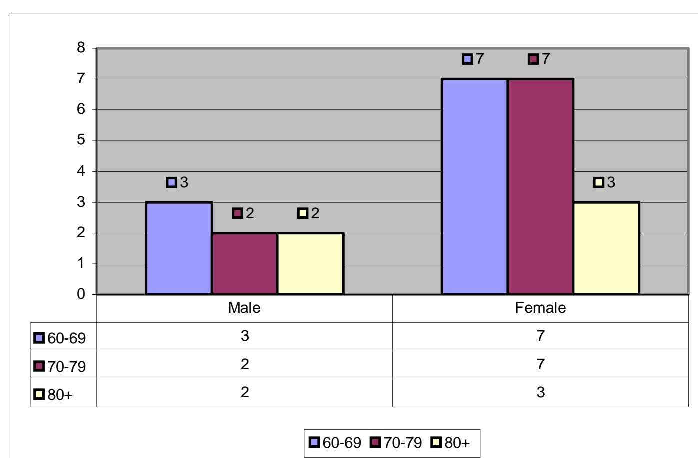
The research has found no collaborating evidence to support the suggestion that out migration in early old age is followed by return migration at a later stage[41] (United Nations, 1991a:10). Furthermore, the above figures would seem to suggest that ageing in place is not in decline but something that has been enjoyed by just under two thirds of the participants.

[41] As was evidenced in Paris, France, where one in three Parisians moved to there place of birth.

5.2.1.5 Gender

This section will look at gender as well as compare the age cohorts according to gender. It has been put forward in literature that not only do females outnumber males but also outlive them, a phenomenon known as gender advantage (Kinsella & Velkoff, 2001:29; UNFPA, 1998:4).

The results of this study showed that gender advantage held true for the target group (Figure 5.1). Of the 24 people who took part of the research, seven were male and 17 were female. There were three men in the 60-69 age band and two each in the 70-79 and 80+ age groups. Of the 17 females, there were seven in both the 60-69 and 70-79 age band and three in the 80+ group (Figure 5.1).



N=24

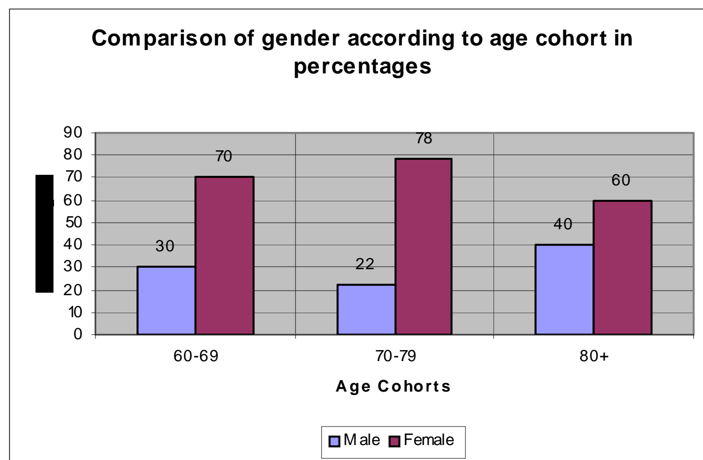
Figure 5.1: Comparison of age cohorts according to gender

5.2.1.6 Age

The terms "older persons" and "seniors" usually refer to those people who have reached retirement age and draw on a government pension. The age determinates differ from country to country and in South Africa, the government pensionable age is 60 for women and 65 for men (South Africa, 2003:3; WHO, 2000:10). For the purpose of this study, the participants, both male and female, were all aged 60 and over.

There were 24 participants and their ages fell into the following three age cohorts 60-69, 70-79 and those aged 80 and over (80+). In all three age cohorts it was found that there were more females than males, with the highest number of females found in the 70-79 age group (Figure 5.2). Percentage wise, this age group showed the greatest difference between gender.

There were 56% more female participants than male participants in this age cohort. In the 60-69 age group, females were represented 40% more than males and 20% more in the 80+ age band.



N=24

Figure 5.2: Comparison of gender according to age cohorts in percentages

Of interest is the observation that the percentage of males across the three age groups appear to be the inverse of the females (Table 5.3).

Table 5.3: Comparison of percentage differences according to age-cohort and gender showing inverse relationship

Age cohort	% Difference Female	% Difference Male
Btw 60-69 & 70-79	+18	-18
Btw 70-79 & 80+	-18	+18

In other words, there is 18% more females and 18% less males in the 70-79 age groups than in the 60-69 age group. In the 80+ age group there is 18% less females and 18% more males than the 70-79 ages. The reason for this inverse relationship cannot be established.

5.3 LIVING ARRANGEMENTS

5.3.1 Preferred choice of partner

Of the 24 participants, 12 were married i.e. 50% of the total target group.[42] All of those that were married said that they were satisfied with their living arrangements and all of those who

[42] During the time that the interviews took place to the writing up of the results, one of the participant's spouses died. The statistics were altered accordingly.

were married picked their spouses as the preferred choice of partner and were asked to explain their response. Three quotes are worth mentioning here:

- "My spouse comes first and then my friends."
- "Because we are devoted to one another."
- "What's more important than your spouse?"

Of the remaining 12 participants, eight are widowed, three are living with partners and one is widowed but in a LAT (living apart but together) relationship. The majority of the participants (83% or 20 participants) were satisfied with their living arrangements, with two people stating that they were undecided. Just 42% (10) of the participants said that given the choice, they would live with their spouse ("He was such an important part of my life, he was my soul mate"). Seventeen percent (4) of the participants said that a partner was their first choice. One of the four who responded this way was a widow and when asked to explain the choice responded:

- "The loneliness. (And) for the companionship and to share some of the financial burden. I no longer have the earning power".

All of those that were living with a partner cited their partners as their first choice for a living companion. Two people said they preferred to be alone:

- "I am completely Ok by myself. I would like a partner – not to live with - I wouldn't like having to wash his dirty socks!"
- "I am level headed and know where I am going. I can look after myself."

From the above it can be seen that those who had marriage partners and partners were satisfied with their choice of partner.

5.3.2 Preferred living arrangements

There is strong evidence to suggest that the target group preferred independent living in as much as 92% (22) lived independently of their children and 83% (20) said they would not like to live with their children. Of 24 participants taking place in the study, only two participants (8%) lived with their children.

"I don't want to stay with my children – they have their own years. I don't want to be dictated to by my children. Rather the devil you know than the devil you don't."

Just over two thirds or 16 of the participants reported being very happy with their present living arrangements and 25% (6) said they were content. Only 8% (2) of the participants said that they were uncertain. Other results from this exploratory study showed that fifty percent (12) said they do not want to live in a retirement village with frail care while 8 (33%), said they were undecided. Ninety two percent (22) of the participants said they would not like to live in an old age home. Some of the comments recorded are:

- "Live in an old age home? Never!"
- "Pull the plug!"
- "Are you kidding?"

It can be seen from the foregoing responses that the participants valued their independence highly with only 8% (2 participants) living in intergenerational households. So while daughters ranked high in terms of a meaningful relationship, it could not be in any way be construed that the participants would like to live with their daughters. Yet another consideration is the impact that out-migration of the younger generation has on some of the participants. Of the nine participants that relocated from Johannesburg, the precipitating event was their children's emigration from South Africa. In total, 17% (4) of the target group relocated as a result of this out-migration. However, being independent does not negate the need for strong intra-familial ties.

5.3.3 Most meaningful relationship

In this section the most meaningful social relationships of the participants were explored. Meaningful social relationships deal with both inter and extra - familial relationships (neighbours and friends), and are an indicator of good quality of life (Beaumont & Kenealy, 2004; Gabriel & Bowling, 2004). Furthermore, the meaningfulness attached to such relationships has more to do with the quality of the relationship as distinct from the frequency of contact (Blane *et al*., 2004).

5.3.3.1 Most meaningful relationship of married participants

The participants self-reported responses to the question "Who do have the most meaningful relationship with" was explored. While all of the married participants, 12 in total, were happy with their choice of partner and were satisfied with their living relationships, 50% (6) said that their most meaningful relationship was with their spouse. Of this number, 83% (5) were men. Only one woman said that her most meaningful relationship was with her spouse. The

remaining four married women, cited having a friend as the most meaningful relationship (Table 5.4 where n = 12).

Table 5.4: Most meaningful relationship of married participants

Gender	Spouse	Friend	Sibling	Neighbour
Male	5	0	0	0
Female	1	4	1	1
Total	**6**	**4**	**1**	**1**

n = 12

A significant observation is that men chose their spouses irrespective of their spouse's health status while women were more apt to turn to their friends.

5.3.3.2 Most meaningful relationship of unmarried participants

For unmarried participants, daughters and partners have the highest and equal score (4). There was one non - response. All those that had partners, whether living together or apart, named their partners as being the person they had the most meaningful relationship with. For widows not in a relationship, daughters scored the highest (Table 5.5).

Table 5.5: Most meaningful relationship of unmarried participants

Marital status	Partner	Daughter	Friend	Sibling	N.R.
Widow	0	4	2	1	1
LWP	3	0	0	0	0
LAT	1	0	0	0	0
	4	4	2	1	1

n = 12

From the above it can be seen that daughters play an important role in the lives of their widowed parents. While instrumental support is of great import, implicit in this relationship is affective support found in the primary support system.

5.4 GOOD HOME AND ADEQUATE HOUSING

The need for secure living accommodation ranked high amongst the participants as evidenced by the type of accommodation in which they live.

5.4.1 Type of accommodation

Literature has shown that living in a good neighbourhood that feels safe and secure is an important component of well being in the older person (Clough *et al.,* 2003; Gabriel & Bowling, 2004).

Most of the participants were in some way living in communal living quarters, be it a retirement village, gated community, flats, townhouse or a room in a house. Only two participants lived in independent housing. Mention is made of the type of accommodation one lives in as this has a bearing on one's contact with neighbours and the ability to make friends with one's neighbours (Table 5.6).

Table 5.6: Type of accommodation

Type of accommodation	f	%
Retirement village	9	38
Flat	5	21
Gated community	5	21
Room	2	8
House	2	8
Townhouse	1	4
Total	**24**	**100**

N=24

According to literature (Gabriel & Bowling, 2004; Windle & Woods, 2004:584-585), people who owned their own homes experienced a higher degree of quality of life than those who did not, as it was seen to offer the older person a higher degree of emotional security. It has also been observed that it is the immediacy of own ownership that has a bearing on one's quality of life and not prior ownership. This is amply illustrated by one participant who now rents "I feel I've come down in the world. I'm now renting when (once) I owned two comfortable homes".

5.4.2 Home ownership

As already stated, home ownership has a good deal to do with emotional control over one's environment and thus has a direct bearing on ones quality of life. The participants were asked if they owned their own homes to which they could respond yes or no. However it became apparent that there was a third category and that was partial ownership.

To the question "Do you own your own home?", 16 of the 24 participants said that they currently owned the homes in which they were living. This accounted for two thirds of the

target group. Twenty one percent (5) rented while 12,5% (3) had part ownership of their homes (Table 5.7). It was found that for all those that had part-ownership of their properties, the other party was the participant's adult children. All those that presently rent have been home owners in the past.

Table 5.7: Number of participants who own their own homes

Home ownership	**f**	**%**
Yes	16	66.7
No	5	20.8
Other	3	12.5
Total	**24**	**100**

N=24

5.4.3 Home ownership and quality of life

Adequate and affordable housing, together with health, security, independence and autonomy, is seen as the main determinates of a good quality of life in the older person. (Beaumont & Kenealy, 2004:764; Windle & Woods, 2004:584). To the question, how do you rank your quality of life, the participants were given the option of answering: very good, fair or poor. The participants self reported ranking of their quality of life is recorded in Table 5.8.

Table 5.8: Self reported QOL ranking

Quality of life ranking	**f**	**%**
Very Good	15	62.5
Fair	9	37.5
Poor	0	0
Total	**24**	**100**

N=24

Just over 62% (5) of the participants reported that they had a good quality of life while just over a 37% (9) reported that their quality of life was fair. None of the participants felt that their quality of life was poor. The quality of life of the participants was also ranked against their type of property ownership (Table 5.9).

Table 5.9: QOL ranking and property ownership

Quality of life ranking	**Own Home**	**Rent Home**	**Part Ownership**	**Total**
Very Good	12	3	0	15
Fair	4	2	3	9
Poor	0	0	0	0
Total	**16**	**5**	**3**	**24**

N=24

It can be seen from Table 5.9 that 75% (12 out of 16 participants) of home owners and 60% of renters (3 out of 5) rated their quality of life as good. Some responses from the participants who own their own homes and ranked themselves as having a good quality of life are:

- "We're blessed to have our health and house and cars and our own house. We don't have to pay rent. We are financially secure."
- "I have a lovely home. I am socially active… and can afford to see my children oversees."
- "I am short of nothing: food, a paid up home. I have family, community and nice people to talk to."

However, none of those that had part ownership said that their quality of life was very good but rather "fair". All three of the participants cited poor health as affecting their quality of life. One participant said:

- "Because I feel I would still like to drive a car but medically I can't. And be independent and do my own thing."

The above comment serves to highlight the importance of health in the elderly and how ill health negatively impacts such domains as independence and the sense of control over the environment.

5.5 ADEQUATE INCOME AND ECONOMIC SECURITY

The highest percentage of participants who felt that they had a good quality of life, owned their own homes. Home owners also experienced the highest sense of financial security and felt the least worried about their financial future than those who rented or partially owned their properties. This latter category was the most vulnerable in as much as they scored the lowest across all three domains: they had the lowest QOL score, they felt almost 30% less financially secure than owners and were worried twice as more than owners about their financial future (Table 5.10).

Table 5.10: Financial security according to property ownership

Ownership	Good QOL	Financially secure	Not worried about financial future
Own	12 (75%)	15 (94%)	11 (69%)
Rent	3 (60%)	4 (80%)	2 (40%)
Part ownership	0	2 (67%)	1 (33%)

It cannot be ascertained why those that have part ownership are those that feel the least financially secure and show the lowest ranking for quality of life. The common denominator is that all three share ownership with an adult child but it is not known if this in anyway impedes not only their sense of financial independence but also their sense of control over their own financial future and as such their sense of autonomy.

5.6 LIVING IN A GOOD NEIGHBOURHOOD AND A SAFE ENVIRONMENT

This section sets out to explore two areas. One has to do with the neighbourhood per se and the other has to do with relationships. In the first instance, areas under discussion are whether or not the participants feel they live in a good neighbourhood, if they feel safe where they live, if they feel that their neighbourhood is suitable for older persons and if they feel attached to their neighbourhood. Secondly, the relationship that the participants have with their neighbours will be explored.

A significantly high number of the participants said that they lived in a good neighbourhood that was suitable for older people and in which they felt safe. Only one person felt that they did not live in a good neighbourhood, two were undecided on the matters of safety and a further two participants felt that their neighbourhood was not suitable for older people. Of significance is that the participant who said they did not live in a good neighbourhood also ranked their QOL as fair, as well as saying that the neighbours could not be regarded as friends.

- "The neighbourhood. I wish I had more money. It's not like when I had my two businesses. Now I have to watch every cent."

Another participant who rented a room in a communal house did not regard the neighbours as friends. In this instance the QOL was also ranked fair.

- "Sometimes I feel I don't want to go on. Loneliness has a great deal to do with QOL. There are many days when I feel very alone. I feel much better after Bible Study. I hate being alone over weekends."

From the above quotations it can be seen the impact that neighbours have on the older persons quality of life. A comparison of the participants attitudes towards the neighbourhoods in which they reside is given in Table 5.11.

Table 5.11: Comparative attitudes of participants towards the neighbourhood in which they live

	Yes	No	Undecided	Total
Live in a good neighbourhood	23	1	0	24
Feel safe	22	0	2	24
Suitable for older people	21	2	1	24
Good relationship with neighbours	22	0	2	24
I can depend on my neighbours	21	1	2	24
My neighbours can depend on me	23	0	1	24
I regard my neighbours as friends	20	3	1	24

N=24

As can be seen from Table 5.11, the majority of the participants stated they enjoyed a good relationship with their neighbours whom they regarded as their friends. "We go walking, to movies and plays together. All phone me to ask me if I'm OK." While most of the participants felt that they could be depended upon should their neighbours need help and vice versa (between 88% - 97%), a third of the participants either did not respond or said they had not given help recently to a neighbour "We have just moved here, so haven't had the opportunity".

When asked how either they had helped a neighbour or a neighbour had helped them, most of the participants said it was instrumental in nature such as fixing a car, giving a lift, shopping and so on.

Most of the participants found that the public amenities such as shopping and medical facilities were easily accessible. However for those who did not drive, shopping posed a problem. All but four of the participants (83%) still drove their own cars. Three of those participants who relied on other people/public transport to get around were in the 80+ age group. Of these four who did not drive, three found getting to the shops troublesome:

- "It's very difficult, if there is no bus, you have to wait for someone to take you, if you can't walk because of the rain."
- "Medical isn't bad but the shopping is lousy – they (the shops) are too far away."

- "I don't use the bus service because it's too high off the ground and I'm afraid I'll fall … I need to buy in bulk. I need to think ahead for my medicine and two weeks (ahead) for my groceries."

It would seem from the above mentioned results, that there is a strong dichotomy between the majority of participants who enjoy a good quality of life and a small but needy minority whose experience is very different and harsher. On the one hand a majority of the participants enjoy not only affable relationships with their neighbours in an environment that is both safe and secure with easily accessible amenities but also a higher degree (or sense) of financial security. On the other hand, there is a small minority, who have a lower self reported QOL ranking, with weaker social ties and less access to public amenities.

5.7 TYPES OF SUPPORT IN THE INFORMAL SUPPORT SYSTEMS

5.7.1 Introduction

According to literature, support is drawn in the main from family, friends and neighbours (Cantor & Little, 1985). This section bridges the research done on the primary and secondary support systems of the participants and focuses on the different types of support found in the informal support systems. The types of support that will be examined are instrumental support, personal support and affective support which looks at different types of advice that older persons often seek out from people within their social networks.

The responses divided equally into two groups of 12 participants each viz. those who were married and those who were not and were reflected in the tables as n = 12 where N (the target group) equalled 24. This latter group includes those who are in a relationship be it either living together or apart. For the sake of brevity, only the top three scores of each domain will be reported on. Where the participants have given more than one answer to a question, the first choice was accepted and the others rejected.

5.7.2 Instrumental support

Instrumental support refers to assistance one receives with activities of daily living (ADL) such as cooking, house cleaning, laundry, shopping and transport. This section looks at those that are most likely to assist the participants with their ADL and those people the participants would prefer to assist them with the activities outlined above.

5.7.2.1 Most likely to assist

There are two broad categories found in instrumental assistance. The first comprises giving lifts and help with the shopping. The second, has more to do with housework and deals with cleaning, cooking and laundry.

1) Married

The spouses were cited as the person most likely to render assistance across all four domains. Eight said that their spouses would help with lifts and shopping but that the domestic worker would more than likely do the house cleaning. Most spouses would assist with the cooking and laundry. After the spouse, a friend and neighbour would be the ones most likely to assist with shopping and this was in large part due to the fact that in these instances the spouses were chronically ill (Table 5.12).

Table 5.12: Responses from married persons as to who would most likely render instrumental support

	Lifts	Shopping	House cleaning	Cooking	Laundry	Frequency of choice
Spouse	8	8	3	6	7	32
Son	1	0	0	0	0	1
Daughter	1	0	0	1	0	2
Friend	1	2	0	2	0	5
Neighbour	1	2	0	0	0	3
Domestic Worker	0	0	9	3	5	17
Sub total	**12**	**12**	**12**	**12**	**12**	

n =12

2) Not married

For those 12 participants that were not married, the daughter was the person most likely to assist across all domains, with an overall score of 20. This is in sharp contrast to those who were married, where the daughter had a score of just two (Table 5.13). Following on from the daughter, the partner and son were the persons most likely to render instrumental assistance. None of the participants cited their neighbour as the person most likely to render instrumental assistance.

Table 5.13: Responses from persons not married as to who would most likely render instrumental support

	Lifts	Shopping	House cleaning	Cooking	Laundry	Frequency of choice
Partner	2	2	0	1	2	7
Son	2	1	1	2	0	6
Daughter	4	5	3	4	4	20
Friend	3	2	0	0	0	5
Neighbour	0	0	0	0	0	0
Domestic Worker	0	0	7	4	5	16
Non-response	1	1	1	1	1	5
Sub total	**12**	**12**	**12**	**12**	**12**	

n = 12

It would seem from the above results, that in the absence of a spouse, the participant is more liable to turn to the next of kin for assistance namely, the children and more particularly the daughter.

5.7.2.2 Preferred choice for instrumental support

1) Married

There was no significant difference between the "most likely to" and "preferred" person to render assistance. The same participants who said that their spouses would more than likely give them instrumental support across all domains, also cited their spouses as those from whom they would most preferred to receive instrumental assistance. Again four people cited that their spouses would help with lifts and shopping but that their domestic worker would assist with the house work. The differences only become significant for those with chronically ill spouses in as much one person indicated they would prefer a nurse aid to assist with all activities (Table 5.14).

Table 5.14: Preferred instrumental assistance support: responses from participants that are married

	Lifts	Shopping	House cleaning	Cooking	Laundry	Frequency of choice
Spouse	7	7	5	6	6	31
Son	0	0	0	0	0	0
Daughter	1	2	0	0	0	3
Friend	2	2	0	1	1	6
Neighbour	1	0	0	0	0	1
Domestic Worker	0	0	6	4	4	14
Nurse aid	1	1	1	1	1	5
Sub total	**12**	**12**	**12**	**12**	**12**	

n = 12

Overall, the preferred choice for instrumental support, is the spouse. In terms of lifts and shopping, the preferred person remains the spouse followed by friends, then daughter and lastly neighbour.

2) Not married

It was found that when there is no husband, the daughter is the most preferred person to render instrumental support across most domains. The domestic worker scores only one point higher for house work than the daughter, that is 12 and 11 respectively (Table 5.15).

Table 5.15: Preferred instrumental assistance support: responses from participants that are not married

	Lifts	Shopping	House cleaning	Cooking	Laundry	Frequency of choice
Partner	1	1	1	1	2	6
Son	2	2	1	2	0	7
Daughter	6	6	3	4	4	23
Friend	1	1	0	0	0	2
Neighbour	0	0	0	0	0	0
Domestic Worker	0	0	5	3	4	12
Nurse aid	2	2	2	2	2	10
Sub total	**12**	**12**	**12**	**12**	**12**	

n = 12

Significantly, of those participants with partners, only one participant stated that they would prefer their partner to render instrumental support.

5.7.3 Personal support

Personal care has to do with such activities as bathing, washing, hair, use of the toilet, dressing and walking/mobility.

5.7.3.1 Most likely to assist with personal care

1) Married

Seven of the 12 married (i.e. 58%) participants replied that their spouses would more than likely be the one to assist with all the activities related to personal care. When the spouse was suffering from chronic illness and had there were no children living in Cape Town, friends, neighbours and nursing aids were cited as the ones more likely to help (Table 5.16). This is very much in line with Segrin's (2003) critique of the compensatory model which states that support is often dependant on who is available.

Table 5.16: Persons who are most likely to render personal care to married participants

	Walking	Dressing	Bathing	Washing hair	Use of toilet	Frequency of choice
Spouse	8	8	8	8	8	32
Son	0	0	0	0	0	0
Daughter	0	0	0	0	0	0
Friend	2	0	0	0	0	2
Neighbour	1	2	2	2	2	9
Domestic Worker	0	1	1	1	1	4
Nurse aid	1	1	2	2	2	8
Total	**12**	**12**	**12**	**12**	**12**	

n = 12

Only one married person said that the domestic worker in their employ would be more than likely help with the more personnel aspects such as bathing, washing and use of the toilet. Again in this instance, the spouse suffered from chronic illness.

2) Not married

The daughter is the person who is most likely to help the parent who is not married with activities of personal care bar for walking where the son is more than likely to be the person to assist. Just half of those with partners reported that the partners would help with dressing, bathing and the use of the toilet. One person who has a partner felt that their partner would help in all areas of personal care (Table 5.17).

Table 5.17: Persons who are most likely to render personal care to participants that are "not married"

	Walking	Dressing	Bathing	Washing hair	Use of toilet	Frequency of choice
Partner	1	2	2	1	2	8
Son	3	1	1	1	1	7
Daughter	2	6	6	7	6	27
Friend	2	0	0	0	0	2
Neighbour	0	0	0	0	0	0
Domestic Worker	1	1	1	1	1	5
Nurse aid	2	1	1	1	1	6
Non-response	1	1	1	1	1	5
Total	**12**	**12**	**12**	**12**	**12**	

n = 12

It can be seen from the above results that the three persons who are most likely to help in descending order are the daughter, a partner followed closely by the son.

5.7.3.2 Preferred person to assist with personal care

1) Married

The spouse had the highest overall score, 32, as the person most preferred person to assist with personal care. The nurse aid was the second most preferred person with a score of ten. One of the participants stated "If my son was here, he would be my first choice. But I would use a nurse aid, as I wouldn't want to be a burden to the family".

From this comment it can be seen, yet again, that support is often dependant on who is available. The daughter and the friend each scored five. None of the participants chose a neighbour or domestic worker as the preferred person to assist with personal care (Table 5.18).

Table 5.18: Preferred personal carers for married participants

	Walking	**Dressing**	**Bathing**	**Washing hair**	**Use of toilet**	**Frequency of choice**
Spouse	8	8	8	8	8	32
Son	0	0	0	0	0	0
Daughter	1	1	1	1	1	5
Friend	1	1	1	1	1	5
Neighbour	0	0	0	0	0	0
Domestic Worker	0	0	0	0	0	0
Nurse aid	2	2	2	2	2	10
Total	**12**	**12**	**12**	**12**	**12**	

n = 12

It can be seen from Table 5.18 that the spouse remains the person of choice in assisting with personal care, followed by the use of a nurse aid, and then equally by daughter and friend.

2) Not married

For those participants that are not married, the daughter scored the highest, 33, as the person most preferred to render personal care (Table 5.19). Two participants also commented that they would also turn to their daughters – in-law for assistance. Two participants stated that they would prefer their partner and a nursing aid to assist with their more personal needs. One of the participants who preferred the use of a nursing aid has no family living in Cape Town

and is a widow. The use of the domestic worker for personal care only occurs once and that is for assistance with walking.

Table 5.19: Preferred personal carers for the not married

	Walking	Dressing	Bathing	Washing hair	Use of toilet	Frequency of choice
Partner	2	2	2	1	2	9
Son	1	1	1	1	1	5
Daughter	4	7	7	8	7	33
Friend	1	0	0	0	0	1
Neighbour	0	0	0	0	0	0
Domestic Worker	1	0	0	0	0	1
Nurse aid	3	2	2	2	2	11
Total	**12**	**12**	**12**	**12**	**12**	

n = 12

From the above results it can be seen that for those participants who are not married, the daughter is the person who is preferred the most to assist with personal care.

5.7.4 Other types of support

Types of support that are typified in the primary informal support systems, other than instrumental and personal, is emotional support, managing money, decision making, liasing with formal or quasi-formal systems and financial assistance (Naleppa & Reid, 2003:31).

In this section the response to the questions "Who would you turn to for emotional, financial, medical advice or if you needed advice on moving to an old age home?" In keeping with the rest of this chapter, the responses were divided into two groups viz. those who were married (n=12) and those who were not (n=12). This latter group includes those who are in a relationship, be it either living together or apart. For the sake of brevity, only the top three scores of each domain will be reported on. Where the participants have given more than one answer to a question, the first choice was accepted and the others rejected.

5.7.4.1 Emotional support

Two thirds (8) of the married participants said that they would turn to their spouse for emotional support. This was the highest percentage in favour of the spouse in all of the domains. The son was the preferred choice of two of the participants while only one person

said they would turn to a friend for emotional advice.[43] For the not married, one third chose their daughter as the person they would most likely turn to for emotional support while a quarter preferred their partner.

5.7.4.2 Financial advice

For married participants, the spouse was the most frequently chosen person that the participant would turn to for financial advice. The son and "other" scored at 2 each while friend, daughter and sibling were chosen once each. Those participants who were not married, chose their son as the person they would most prefer to seek financial advice from. In fact, for the non married, this was the only area in which the son ranked higher than the daughter.

5.7.4.3 Medical advice

For married participants, the spouse was the most frequently chosen person from whom they would seek medical advice (7) followed by a friend (3) and then equally between son and daughter (1 each). For those participants who were not married, daughters (4) scored the highest followed closely by friends (3) and then partners (2). Significantly, friends ranked second overall and were chosen an equal number of times by both married and unmarried participants. It has been noted that friends are often best placed to offer insight to the needs of the older person (Naleppa & Reid, 2003:33-34).

5.7.4.4 Advice on moving to an old age home

Fifty percent (6) of the married participants said they would chose their spouses for advice on moving to an old age home while 33% (4) said they would ask their sons. Third in line was "other". There was one non response in this category. This was the only domain that elicited non-responses. One from a married participant and two from unmarried participants. For those that were not married, the daughter was the preferred choice 42% (5), followed by the son at 25% (3) and a sibling, 17% (2).

Overall, the three people that were most likely give emotional support and advice were the spouse, the son and the daughter. However these figures tend to be misleading as on closer inspection it was observed that there were differences in the choices that were made by those that were married and those that were not. For the unmarried participants, the choice of the daughter across three of the four domains was higher than for the married participants (with

[43] The spouse suffers from dementia.

the exception of financial advice). The difference in the overall score was 13. Those that were not married had as their third choice, a sibling (7). Only one married participant said they would seek any advice from a sibling and that was for financial advice. The "neighbour" failed to score in any of the domains which agrees with literature (Naleppa & Reid, 2003:34).

In summary, for those who are married, the top three persons that the participants would most likely turn to for advice in descending order are: the spouse (27), the son (9) and friend (5). In contrast, the unmarried participants had their children as their first choice with daughters scoring 15 and sons 11. The third choice was a sibling (7).

5.8 COMPARISON OF SUBJECTIVE QUALITY OF LIFE INDICATORS ACROSS DOMAINS

5.8.1 Introduction

In this section the researcher set out to explore what factors impacted the quality of life of the participants. When asked to rank their quality of life, the participants were given three options: Very good, fair or poor. Fifty eight percent (14) ranked their quality of life as very good while 42% (10) of the participants ranked their quality of life as fair. No one ranked their quality of life as poor. As the researcher wanted to explore which factors had influenced the participants choice in ranking their QOL, the researcher cross referenced responses across various domains. While the central focus of this research paper is to explore the social support systems of the older person, the domains mentioned below all serve to anchor the older person within their social milieu.

5.8.2 Results

All of the participants (100%) stated that being healthy, being financially secure and being independent were necessary to having a good quality of life (Table 5.20) Two thirds of the participants felt that leading an active life was necessary to a good quality of life while just under two thirds (62,5%) felt having hobbies was also important. Of some significance is that five out of seven participants who had no children living in Cape Town, ranked their QOL as very good. This would point to literature studies that stated that the depth relationships is not dependant upon proximity or frequency of contact but on the quality and density of the relationship (Blane *et al.*, 2004; Hall & Havens, 2002). Moreover the use of modern telecommunications also allows for intimacy at a distance (Harrigan & Farmer, 2000).

Table 5.20: Factors influencing a good quality of life

	Yes	No	Undecided
Leading an active life	16	8	0
Having hobbies	15	7	2
Being healthy	24	0	0
Being financially secure	24	0	0
Being independent	24	0	0

N = 24

The factors that were found to have the highest level of influence in determining a very good quality of life and ranked in decreasing order of importance is illustrated in Tables 5.21(a).

Table 5.21(a): Comparison between self reported "Very Good" and "Fair" quality of life ranking across domains where very good = n14 and fair = n10

Quality of life indices		Description	Very Good QOL	Fair QOL
Quality of life		Self reported quality of life	n =14	N = 10
1	Finance	Private pension & investments	13	7
2	Belonging	Have a strong sense of belonging	12	7
3	Home ownership	100% ownership of property	12	4
4	Age in place	Lived in Cape Town most of adult life	11	3
5	Active involvement	Very active in at least one organisation	10	1
6	Health	Participants who ranked their healt as good	10	4
7	Marital status	Being married	9	2
8	Age	Age cohort: 60-69	8	2
9	Loneliness	Never lonely	8	3
10	Religion	Religion more important with age	8	4
11	Kin availability	No children living in Cape Town	5	2
12	Marital status	Number of widows	5	6
13	Age	Age cohort: 70-79	4	5
14	Age	Age cohort: 80 +	2	3
15	Finances	State Pension	1	4

From the above it can be seen that the three most important determinants for a very good quality of life in the older person is having a private pension and investments; having a strong sense of belonging and owning your own property (100% ownership).

In order to establish a clearer picture between the self reported "Very Good" and "Fair" quality of life ranking across domains, the researcher examined the percentage makeup of each domain and then ranked the percentage difference, where very good QOL = 14 participants and fair QOL = 10 participants (Table 5.21(b)).

Table 5.21(b): Comparison between self reported "Very Good" and "Fair" quality of life ranking across domains according to percentage and ranked in percentage difference where very good QOL = n14 and fair QOL = n10

Rank		Very Good % n=14	Fair % n=10	% Difference
1	Very active in organisations	71	10	61
2	Aged in place	79	30	49
3	100% ownership of property	86	40	46
4	Being married	64	20	44
5	Age cohort: 60-69	57	20	37
6	Private pension/Investments	93	60	33
7	Self ranked perception of health: good	71	40	31
8	Never lonely	57	30	27
9	Religion more important with age	57	40	17
10	Have a strong sense of belonging	86	70	16
11	No children living in Cape Town	36	20	16
12	Aged cohort: 80 +	14	30	-16
13	Age cohort: 70-79	29	50	-21
14	Percentage of widows	36	60	-24
15	Percentage of State pensions	7	40	-33

The factors that were found to have the highest level of influence in determining a very good quality of life and ranked in accordance to the highest percentage difference are reported as follows:

1. Being very active in at least one organisation be it a community centre, religious activities, sports, volunteer organisation or political body (Naleppa & Reid, 2003).
2. Living most of your adult life in the same city as well as retiring in the same city in other words, ageing in place. Ageing in place has been seen as typifying many older person (UN, 1991:5).
3. Having 100% ownership of ones current residential property as opposed to part ownership or renting. This is supported by studies that have shown that home ownership contributed to the older persons sense of well being (Blane *et al*., 2002; Gabriel & Bowling, 2004). Furthermore, home ownership allows for a sense of control over ones environment and is associated in turn with feelings of security, independence and autonomy (Beaumont & Kenealy, 2004; Windel & Woods, 2004).
4. Being married. 64% of the participants (i.e. 9 out of 14) ranked their quality of life as very good were married while only 20% (2 of the 10) participants who ranked their quality of life as fair, were married. Being married implies both the availability of a primary support system as well as a higher degree of economic well being than for the single or widowed older person (Kinsella & Velkoff, 2001).
5. Being between the age of 60-69 in other words, young-old. The supposition here is that younger-old tend to be more financially secure than the older old (Ozawa & Hong, 2003) The conjecture too is that the younger old have a higher level of functionality than their older counterparts. Younger seniors also tend to volunteer more than their older counterparts and volunteerism in turn, has a positive influence on QOL ranking (Wan *et al*., 1982). However, this study did not show any real significant age differential with regard to volunteering and QOL ranking (57% very good QOL vs 50% fair QOL ranking).
6. Having either a private pension and/ investments as opposed to a state pension grant in other words, being financially independent. Economic security allows for good health. Living in a good home and a good neighbourhood which also determines the ability to enjoy good social relationships (Gabriel & Bowling, 2004).
7. Having the perception of good health. It is not only good health and functionality that influences the older persons quality of life but also the fact that there exists a strong link between subjective health and life satisfaction (Kennedy & Hamilton, 2005; Lauer,

1989). Seventy one percent (10/14) of the participants who ranked themselves as having a very good quality of life, ranked themselves as having good health.

8. Never being lonely. There were almost twice as many participants who stated that they were never lonely and who ranked their QOL as very good (57% compared to 30% who gave a fair QOL ranking). The link between having a sense of belonging and the strength of one's adaptive mechanisms needs further exploration.
9. Have the sense that religion has become more important with ageing.
10. Have a strong sense of belonging.

By the same token, less satisfaction with one's quality of life can be attributed to the following:

1. Lack of involvement in civic and religious activities.
2. Migration from one city to the another near to or at the time of retirement as has been evidenced by those participants who relocated from Johannesburg to Cape Town. This higher rate of mobility (or retirement effect) has been noted in the UK and USA (UN, 1991:5). While Kinsella and Velkoff (2001:55) see migration patterns of older persons as a means of reuniting family members, the multiple losses that are associated with moving may well cancel any positive effects of being closer to family members.
3. Renting and not owning one's home 100% i.e. only having partial ownership.
4. Being in the 70-79 age cohort.
5. Not being financially independent.
6. Having the perception of poor health.
7. Feelings of loneliness.
8. Having the sense that religion has become less important with ageing.
9. Not having a strong sense of belonging.

Factors that were found to have the most negative impact on the participants quality of life are:

1. **Advancing age**. The majority of the participants who ranked their quality of life as fair were between 70-79. However, the fact that the 80+ ranked marginally higher than their

70-79 age cohort (Table 5.21(a)) gives credence to the observation that the oldest old are less likely to complain than their younger counterparts (Fakourie & Lyon, 2005:6).

2. **Widowhood**. One and a half times more participants who ranked their QOL as fair were widowed. In other words 6 out of the 10 participants who ranked their QOL as fair were widowed i.e. 60%. For those that ranked their QOL as very good, only five out of the 14 participants were widowed i.e. 36% (Table 5.21(a) & Table 5.21(b) respectively).

3. **State pension grant**. Four out of the ten participants who ranked their QOL as fair were state pensioners while only one in 14 with a very good QOL had a government pension fund (Table 5.21(a)). Thus being financially compromised has a deleterious effect on one's self reported quality of life ranking. It could be argued that government restrictions imposed on state pensioners is a form of economic exclusion. A study by Blazer *et al.* (2005) showed that economic exclusion over protracted periods of time led to higher rates of mortality amongst ethnic minorities. It is not known if the same principle would apply to the older person who receives a state pension which could be a matter of further research.

5.9 CONCLUSION

From the above it can be concluded that the older persons' sense of security is of paramount importance to their quality of life and sense of wellbeing. Inextricable linked to the feelings of security is financial independence and an intact primary support system. These two factors in turn enable the older person to have a greater degree of mastery over their environment. The fact that the younger old are more likely to be married, also provides an explanation as to why this age group tend to experience a higher quality of life than their counterparts in the 70-79 age bracket.

CHAPTER 6

EXPLORATION OF THE SOCIAL SUPPORT SYSTEMS OF JEWISH SENIORS LIVING IN THE COMMUNITY

6.1 INTRODUCTION

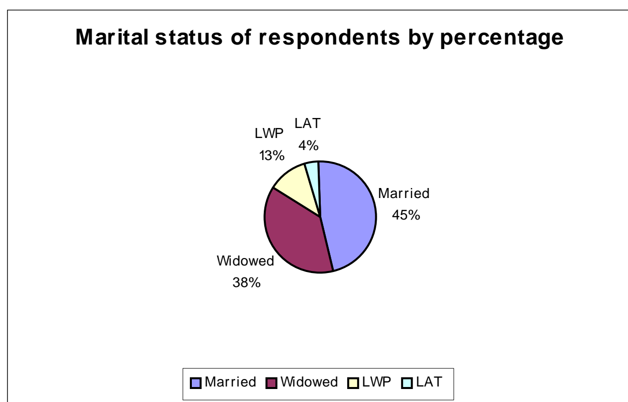
In Africa, the family remains the primary source of care for the elderly (Apt, 2001:296). What follows is an exploration of the primary informal support systems of Jewish seniors living in the community with focus being placed mainly on the spouse and children as the main sub systems. The objective of this chapter is thus to identify and describe the social support systems of Jewish systems who are still living in the community. It must be stated that the participants can be deemed to be the functionally well.

6.2 THE PRIMARY INFORMAL SUPPORT SYSTEM AND KIN AVAILABILITY

6.2.1 Marital status

There is a close association between marital status and age which is spoken of in literature and borne out in this research. The marital status of individuals is an important component of social support. The spouse is one of the foremost subsystems which make up the primary informal support system mentioned in Cantor's hierarchical compensatory theory of social support (Cantor & Little, 1985:746).

There were 11 individuals that were married, 10 who were widowed, three who were living with a partner (LWP) and one person who was living apart from their partner, but together, termed a LAT relationship. A percentage breakdown of the marital status of the participants is given in Figure 6.1.



N=24

Figure 6.1: Marital status of participants by percentage

While it would seem that there is only a 7% difference between those that are married and those that are widowed, closer inspection shows that more men are married than women, by a factor of two, i.e. 72% of men as compared to 35% women (Figure 6.2). (Significantly, this was the figure put forward by Kinsella and Velkoff (2001) but in relation to the 60-70 age group.) Conversely, more women are widowed than men, by a factor of three i.e. 47% of women compared to 14% of men.

The results of this exploratory study show that male participants between the ages of 60-79 i.e. across two of the three age groups, were all married. However this picture changes sharply in the 80+ age group where none of the participants were married although two within this group were living with partners. Furthermore, in the 60-79 age bracket, men were almost twice (1,75%) as likely to be married than woman. Thus the marital status for men, only changed in the 80+ group (Table 6.1(a) where n=7 for males).

Table 6.1(a): Marital status according to gender and age cohort in percentages

	Gender	Marital Status				
Age Cohort	**Male**	**Married**	**Widowed**	**LWP**	**LAT**	**Total**
60-69	3	100%	0%	0%	0%	100%
70-79	2	100%	0%	0%	0%	100%
80+	2	0%	50%	50%	0%	100%

The female participants on the other hand experienced change in their marital status across all three age domains. Between 60 and 80 years of age, there was a significant decrease in the percentage of married women (58%). (Table 6.1(b) where n=17 for females).

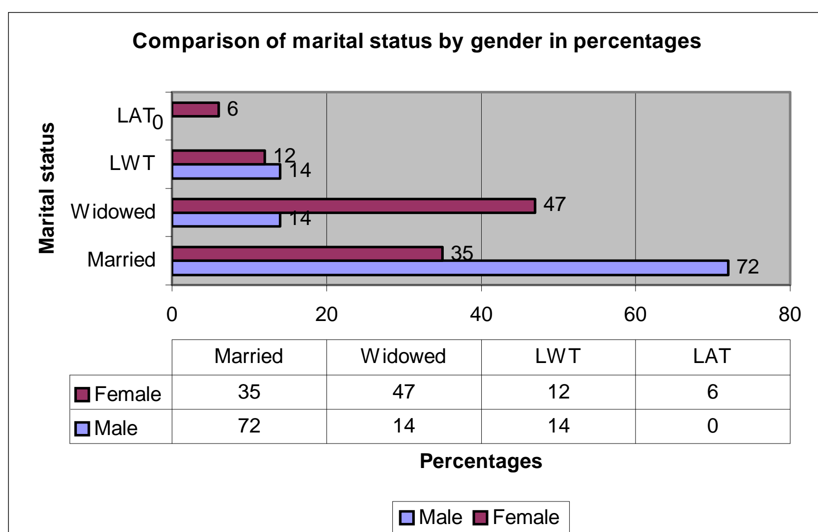
Table 6.1(b): Marital status according to gender and age cohort in percentages

	Gender	Marital Status				Total
Age Cohort	Female	Married	Widowed	LWP	LAT	
60-69	7	58%	14%	14%	14%	100%
70-79	7	29%	71%	0%	0%	100%
80+	3	0%	67%	33%	0%	100%

n=17

It can be seen that both males and females experienced their greatest change in marital status in the 80+ age group.

The researcher then made a percentage comparison of the marital status and gender of the participants (Figure 6.2).



N=24

Figure 6.2: Comparison of marital status by gender in percentages

According to literature between the ages of 60 and 70 those who are married are more than likely to be men. Additionally, male mortality is also highest in this age group, so too is there an associated high incidence of widowhood amongst females. (Kinsella & Velkoff, 2001). However according to these results, it was shown that men in the 70-79 age group were more likely to be married than their female counterparts. Moreover, it was this age group that showed the greatest levels of mortality at 71% (Table 6.1(b)).

For women the death of a spouse often means the loss of income and in some instances poverty. Moreover, men are more likely to remarry, and if they do not, they are more at risk than women, as they tend to lose their support network (Kinsella & Phillips, 2005:25-26). Significantly, out of the 24 participants interviewed, two were living with a partner and one was in a LAT relationship.

6.2.2 Number of children

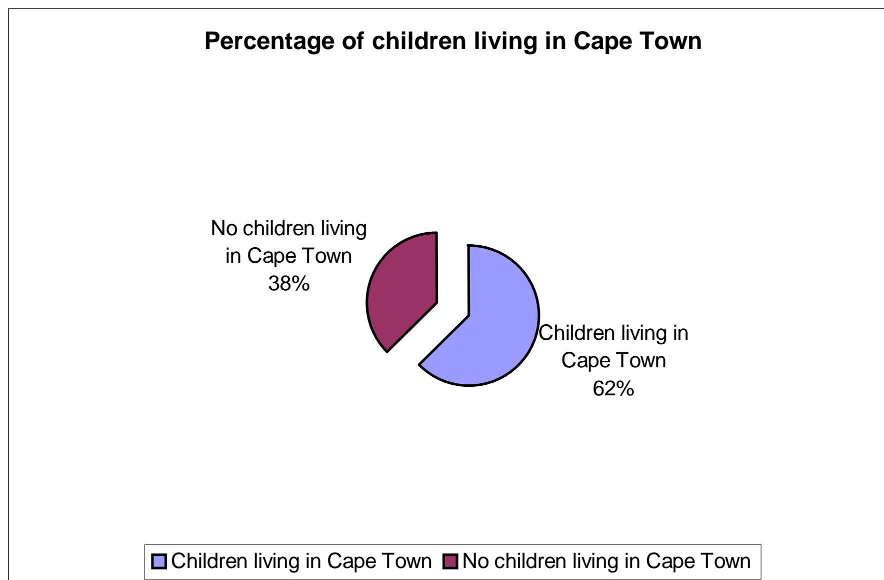
In sociological terms, having children increases the chances of being cared for in one's old age and is often referred to as the adult dependency ratio. Conversely, those older people who are childless and widowed are seen to be the most vulnerable. Moreover, adult children are an integral part of the primary support system for the older widowed person. The number of offspring per participant ranged from nil to five, with an equal number of participants having two and three children. Only two other participants have more than three children and only one participant was childless. Of the 24 participants, four had children that had died. All four of these participants included their deceased children in the question "How many children have you?" which indicates a continuing relationship with their children irrespective of the time lapse since their child's death.

The average number of children per participant is 2,5 which is above the standard rate of replacement and therefore allows for a healthier adult dependency ratio. Of those listed, one participant has adult children living in three different continents and one participant has adult children living in two different continents. Three participants have no children living in South Africa with all of their children either living in the USA or Australia. Of these three, one is a widow.

- "I miss my children and grandchildren. When my son had an op, I wish I could have been there."
- "The world is going by and I'm left behind. I miss my son and grandchildren."

Twelve participants had children living in Cape Town (50%) and of these twelve, four had all of their children living in Cape Town. Thirty eight percent had children living in Johannesburg while four participants (17%) had no children resident in South Africa at all (Figure 6.3). One participant was childless but considered their partner's children as surrogate

family. It could be argued in this instance that this is a form of fictive kin as described by Stubb (1982:143).[44]



N=24

Figure 6.3: Percentage of participants' children residing in Cape Town

Hall and Havens (2002) found that older parents who lived with their children had the highest scores of loneliness. However, this was found only to be partially true of the participants. Only two of the participants lived with their children, in both cases, daughters and in both cases the participants were over eighty years of age. The one participant stated that they never feel lonely while the other one replied "sometimes" and that they "felt alone". Another two participants had children that were living with them but this was a transient arrangement. In this situation, the participants fell into the 70-80 age group and both said that they never felt lonely.

6.2.3 Contact with adult children

This section will deal with the amount of contact that the parents had with their children in the week prior to the parents participating in the research. Contact meant both visits and by means of telecommunication. An average was taken of both scores. It must be reiterated that a limitation of this research was the omission of sms' from the question "How many times last week did you communicate via letter, telephone or email?"

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[44] Fictive kin relationships develop in the absence of kin availability.

Harrigan and Farmer (2000:44) have stated that it is an erroneous assumption that contact decreases between parents and their emigrant children. On the contrary, modern telecommunication allows for frequent contact and this was found to be the case in this research. Just under three quarters, 71%, of the total target group communicated with their children at least once per week with 29% having contact with their children on a daily basis (Table 6.2).

Table 6.2: Frequency of contact with adult children during the previous week

Frequency of contact	Number of visits	Frequency of telecommunication	Average %
Every day	4	10	29
Few times/week	5	7	25
Once per week	4	4	17
No contact	6	2	17
Non response	5	1	13
Total	**24**	**24**	**101%**

N=24

The frequency of contact that is evidenced in the above results is what Apt (2001:5) refers to as "intimacy at a distance" and is an important component when looking at the emotional support of the older person and their need for love and sense of belonging.

6.2.4 Contact with other family members living in Cape Town

This section will deal with the frequency of social contact that the participants had with other family members living in Cape Town.

Fourteen (58%) out of the twenty four participants have family living in the same suburb as themselves, the vast majority being their children (13). The remaining ten participants had cited other family (6) siblings (5), and children (4) living in Cape Town. Two still had fathers that were still alive. It was noted that during the week prior to the interview, 38% of the participants had not made any form of contact with any of their relatives (other than their children). As can be seen from Table 6.3 there is a higher frequency of contact via telecommunication than face to face visits.

Table 6.3: Frequency of contact with other relatives during the previous week

Frequency of contact	Number of visits	Frequency of telecommunication	Average %
Every day	0	3	6
Few times/week	2	8	21
Once per week	7	6	27
No contact	13	5	38
Non response	2	2	8
Total	**24**	**24**	**100%**

N=24

It is significant to note that studies have shown that in the absence of formal support systems within the community, complex networks of informal social relationships and support systems which include family, friends and neighbours develop (Da Conceicao & De Oca Zavalia, 2004). It can be seen from the above that while over a third of the participants had made no contact with their relatives in the week preceding the interview, fifty four percent had made contact at least once.

6.3 SECONDARY INFORMAL SUPPORT SYSTEM

6.3.1 Introduction

The following section will explore the secondary support system of the participants which are made up of close friends and neighbours. It is in this area that the phenomenon of "fictive kin" may occur i.e. in the absence of primary support, the older person may turn to their friends or neighbours to fulfil this role.

6.3.2 Contact with friends

To the question "Are friendships important to you", 83% (20) of the participants replied that friendships were important to them. Thirteen percent (3) of the participants said that friendships were not important to them. One person was undecided. On average, each participant said they had four special or close friends. The range of the number of friends was from nil (0) to six (6) friends per participant. Seventy one percent (17) of the participants had friends that lived near by.

On average, 31% of the participants had contact with their friends at least once per week while 15% had had no contact at all with their friends in the week prior to the interview (Table 6.4).

Table 6.4: Frequency of contact with friends during the previous week

Frequency of contact	Number of visits	Frequency of telecommunication	Average %
Every day	2	5	15
Few times/week	6	11	35
Once per week	12	3	31
No contact	4	3	15
Non response	0	2	4
Total	**24**	**24**	**100**

N=24

The importance of enduring friendships is highlighted by a widow's response:

- "I like to spend most time with my partner but I also like to keep my circle of girlfriends."

According to literature, living in a retirement village is conducive to making friends (Liebler & Sandefur, 1998; Stephens *et al.,* 1979). This study showed that 67% that lived in a retirement village found it very easy to make friends:

- "People are very friendly. It's up to you to make friends."
- "It is one happy family. Jews and non-Jews alike."
- "People are very supportive and kind. If you are ill, they will come and help."

One participant who said they were uncertain as to how easy it had been to make friends said:

- "It wasn't easy to start off with. When we came here my husband was ill, so I spent most of the time with him and the children. I couldn't socialise."

The researcher did not ask the participants who were living independently how easy it had been to make friends.

6.3.3 Contact with neighbours

In the older person, who is functionally well, support is said to be drawn from neighbours with a high degree of reciprocity taking place (Cantor & Little, 1985). Furthermore, in the absence of a primary support system, neighbourhood ties become more important to the older person thus strengthening these ties even further. It can be said then that the frequency of one's contact with one's neighbours points towards building and maintaining an informal social network. Certainly in age segregated housing, contact with one's neighbours is synonymous with making friends.

While over a quarter of the participants had no contact with their neighbours during the week prior to the interview taking place, 23% had contact with their neighbours at least once during the same period. Seventeen percent of the participants had daily contact with their neighbours (Table 6.5). However, when one splits the type of accommodation it can be seen that those participants who lived in a retirement village had the highest daily contact with neighbours, between three and four times higher than the other housing types.

Table 6.5: Frequency of contact with neighbours during the previous week

Frequency of contact	Number of visits	Frequency of telecommunication	Average %
Every day	4	4	17
Few times/week	8	7	31
Once per week	6	5	23
No contact	6	7	27
Non response	0	1	2
Total	**24**	**24**	**100**

N=24

A quarter of the participants who lived in a retirement village visited with their neighbours everyday. Only those living in flats (20%) had a similar score. None of the participants who lived in a room, a house or a town house, made contact with their neighbours on a daily basis. It was also found that those participants who lived in retirement villages scored the lowest in terms of "no contact" during the week (Table 6.6).

Table 6.6: Frequency of contact in percentages with neighbours as per accommodation type

Frequency of contact	Retirement village n=8	Gated community n=6	Flat n=5	Room n = 2	Independent housing n=2	Town house n=1
Every day	37,5	8,33	10	0	0	0
Few times/week	43,75	33,33	20	0	0	100
Once per week	12,5	16,67	50	0	50	0
No contact	6,25	33,33	20	100	50	0
Non response	0	8,33	0	0		0
Total	**100**	**100**	**100**	**100**	**100**	**100**

N=24

It can be seen from the above that two thirds of the participants had contact with their neighbours at least once per week with those living in a retirement village had the highest degree of contact with their neighbours on a daily basis.

It can thus be seen that neighbours form an integral part of the older person's social support system. It is evident that the majority of the participants do have secondary support systems to help sustain them within the community and furthermore, their social network has not diminished. More importantly, studies have also shown that friendships have a buffeting effect against loneliness especially for the widow and that central to friendship, lies choice and reciprocity (Stone, 2003).

6.3.3.1 Neighbours as friends

In this section under neighbourhood, the participants were asked if they regarded their neighbours as friends. Participants were asked to respond yes, no or undecided. Twenty of the participants said that they regarded their neighbours as friends, three said no and one participant was undecided (Table 6.7).

Table 6.7: Distribution of participants who regard their neighbours as friends in percentages

Reply	f	%
Yes	20	83
No	3	13
Undecided	1	4
Total	**24**	**100**

N=24

It can be seen that 83% (20) of the participants considered their neighbours as friends while 13% (3) said that they did not regard their neighbours as friends. One participant was undecided. When examining if accommodation type was in any way associated with the participants' replies, it was found that all of those participants who lived in a retirement village, townhouse or independent houses, reported that they regarded their neighbours as friends (Table 6.8).

Table 6.8: Distribution of participants in percentages who regard their neighbours as friends as per accommodation type

Accommodation type	f/accommodation type N = 24	Neighbours as friends n = 20	%
Retirement village	7	7	100
Independent homes	2	2	100
Townhouse	1	1	100
Flat	5	4	80
Gated community	7	5	71
Rooms	2	1	50
Total	**24**	**20**	

Those participants who least regarded their neighbours as friends were those who lived in rooms, followed by participants living in gated communities and finally by those who lived in flats.

6.3.3.2 Domestic workers as a source of support

From findings in the section dealing with the persons most likely to and most preferred persons to render social support, it is apparent that the domestic worker plays an important role in the lives of the older person. In this section the participants were asked if they employed a domestic worker and to what degree they were dependent upon the domestic worker in their employ. The participants had to answer: very dependent, dependent, not at all dependent, other and N/A for those who did not employ a domestic worker.

It was found that 75% (18) of the participants employed a domestic worker, 21% (5) did not and 4% (1) participant was undecided. Fifty four percent (13) of the participants stated they were not at all dependant upon the domestic worker in their employ (Table 6.9).

Table 6.9: Level of dependency in percentages upon domestic workers in older persons employ

Description of dependency	f	%
Very dependant	1	4
Dependant	2	8
Not at all dependant	13	54
Other	3	13
N/A	5	21
Total	**24**	**100**

N=24

From the above it can be seen that that 13% (3) of the participants were dependant of the domestic worker in their employ. A further 13% (3) stated other and for 21% (5) participants this was not applicable. Of those that were most dependant, one participant had a debilitating disease, one had a chronically ill spouse and one was widowed and in the older-old age group.

Dubb in his 1995 survey of Jewish South Africans, talks about the supportive role of the domestic workers in South African's homes. While the above results show that the dependency upon domestic workers is at present low, should the health status of the participants change, the domestic workers role in the lives of the participants will certainly increase.

6.4 TERTIARY/QUASI SUPPORT SYSTEMS

6.4.1 Introduction

As was previously mentioned in Chapter 4 (paragraph 4.6), tertiary support systems or quasi-formal support systems, are characterised by two features. Firstly, they are extra-familial and secondly, they are drawn from community resources. For the purpose of this research, only involvement in the community centre (CJSA, Milnerton) and the members' respective places of worship were examined. According to studies it has been shown that civic and religious involvement, as opposed to affiliation, serves to increase the chances of social support (Kropf, 2000:173).

6.4.2 Cape Jewish Seniors Association, Milnerton

In this section the members were asked about the frequency of attendance at the centre, how long they had been members for, if they volunteered and if so, in what capacity. The members were also asked to respond to the statement "CJSA, Milnerton is important to me: Agree, Disagree or Undecided". If they agreed with the statement they were asked to explain why the community centre was important to them.

6.4.2.1 Period of membership

The average length of membership at CJSA, Milnerton was three years and the length of membership ranged from six months at the lower end of the scale to 4,5 years at the upper end (Table 6.10(a)).

Table 6.10(a): Range of length of membership to CJSA, Milnerton

Length of membership	4,5 years	4 years	3 years	2,5 years	2 years	1 year	0,5 years	Total
No of members	5	6	4	1	6	1	1	24

N=24

In one instance, a member had been a member at a previous branch and their total length of membership at CJSA was eight and a half years.[45] In Table 6.10(b) presented below, the period of membership in years per member is given.

Table 6.10(b): Period of membership in years

Length of membership in years	f
0.5 years – 2 years	8
2.5 years – 3 years	5
3.5 years – 4 years	6
4.5 years	5
Total	**24**

N=24

According to Table 6.10(b) above, it can be seen that a third (8) of the participants have become members within the last two years while 21% (5) have been members since the centre's inception**.** It would appear that membership to the organisation has been maintained and that new members are being added.

6.4.2.2 Frequency of attendance

In this section the participants were asked how frequently they attended functions at the centre: more than once per week, once per week, once a month, never and other (Table 6.11). One quarter of the participants (6) attended the centre more than once per week while eight percent (2) attended once a week. A further 38% (9) of participants attended functions only once per month i.e. the supper.

[45] Membership to CJSA, Milnerton opened in June 2002. Activities were held at the Milnerton Hebrew Congregation. In January 2003, CJSA Milnerton opened their own community centre.

Table 6.11: Frequency of attendance according to percentage

Frequency of attendance	f	%
More than once per week	6	25
Once per week	2	8
Once per month	9	38
Never	2	8
Other	5	21
Total	**24**	**100**

N=24

Of the five participants that cited "other", only 4% (1) attended twice a month. It is important to note that the remaining 17% (4) of the participants hardly ever attended functions either due to their own ill health or they were caring for spouses who were chronically ill.

6.4.2.3 The importance of CJSA, Milnerton

In this section the importance of being a member of CJSA, Milnerton will be explored. The participants were asked to respond to the statement "CJSA, Milnerton is important to me" and to explain why they felt that way if they answered in the affirmative.

Eighty three percent of the participants (20) stated that CJSA, Milnerton was important to them while 13% (3) said that it was not. Only one participant was undecided**.** Sixty three percent (15) of the participants volunteered their services at CJSA, Milnerton**.**

For those that stated that CJSA, Milnerton was important, some of their explanations are given below:

- "It's been a life-saver for me. (I) meet wonderful people, it gives me something to do and somewhere to go."
- "It gives me a place to meet people and to socialise. Something to do. It's very important to me."
- "It brings quality of life. (I) mix with other people outside the family and meet other people."

Significantly, 83% (20) of the participants who stated that CJSA, Milnerton was important to them, 25% (6) of this number, felt that the community centre was more important for other people than for themselves. The following comment aptly describes this situation:

- "I believe it's important for other people but it's not (important) for me".

However their view did not in any way impinge on their commitment to CJSA, Milnerton as all are active volunteers.

- "I enjoy being a volunteer. It gives me a place where I feel at home, it gives me a purpose."

Another significant observation was that only three participants mentioned the cultural importance of the centre.

- "It's important to me because it's Jewish".
- "I am realising more and more it's a place to meet Jewish people."
- "It keeps the Jewish people together. It keeps loneliness away".

The above comments serve to highlight past studies that indicate community centres, social clubs and volunteer organisations are not only where the older person develop their social networks and their social support base, extraneous to the family but also receive (and give) affective and instrumental support (Leeson, 2003; Naleppa & Reid, 2003).

6.4.3 Religion

In this study, the role that religion plays in the life of the participants was explored for two reasons. Firstly, studies have shown that in the elderly, religious involvement leads to greater opportunities for making new friends and associated increased levels of life satisfaction (Cnaan, 2005; Kropf, 2000; Liebler & Sandefur, 1998; Stephens *et al.*, 1979). Secondly, is the influence of religion on the adaptive mechanisms of the seniors and as such, their quality of life (Nelson-Becker, 2005:55).

6.4.3.1 Religious affiliation and frequency of attendance

The majority of the participants i.e. 75% (18) are Orthodox, while 17% (4) belong to Reform. Four percent (1) consider themselves secular and the remaining 4% (1) cited their religious affiliation as "other".

According to the results, it was shown that 21% (5) of the participants attended shul[46] more than once per week and a third (8) attended only once per week. In other words, 54% (13) of the participants attended shul at least once per week. Thirteen percent (3) of the participants attended shul only on High Holy Holidays i.e. the most important religious days in the Jewish

[46] Shul is the place of worship as in synagogue.

calendar. A further third (8) of the participants fell into "other" category. It can thus be seen from the above figures that 54% of the participants attended shul at least once per week.

6.4.3.2 The importance of religion

In this section the participants were asked to respond to two questions "What role does religion play in your life" and "Has religion become more or less important to you as you have become older and why?"

6.4.3.3 The role of religion

Fifty eight percent (14) of the participants said that religion played an important role in their lives while 21% (5) said that it did not. Two responses were along the lines of spirituality as opposed to religion and there were three non-responses. Examples of the respective responses given are:

- "Yes, very much so. I think a person without a G-d (God) or without a belief is without a rudder."
- "No. I am a Zionist. I have a very strong belief in Israel."
- "I have a lot of faith in G-d. When I need help, I talk to G-d. So G-d is very important. But I don't know about religion."

It can therefore be said that most of the participants felt that religion played an important part of their lives while a minority felt that religion played no role at all. Yet others, made a distinction between institutionalised religion per se and spirituality.

6.4.3.4 The increase in importance of religion with ageing

Sixty three percent (15) of the participants stated that religion had become increasingly important to them as they have become older. Twenty one percent (5) of the participants stated that religion had become less important with ageing while the remaining 17% (4) maintained that there had been no change in the importance of religion in their lives, that it had remained unchanged throughout their life span.

Of those that felt that religion had become more important, 26% (four of the 15 participants) felt that this period of their lives afforded them the opportunity to explore religion in a deeper and more meaningful way. Some of the comments are:

- "With the children gone, I can concentrate more on religion and not just on traditions."

- "I am getting an opportunity to know more about the characters of the Bible because of Bible Study. In the War (WW11), all I knew (about) was Moses."
- "Not because I'm coming to an end but I have more time now that I'm not in business."
- "It's important at this age. I want to learn more. Not because I have to, like when I was younger, but because I want to. It's deeper. I want to learn more and increase my knowledge."

The results also indicated that a third (8) of those who said that religion had played an increasingly important role in their lives, also said that religion helped them to cope with trauma such as illness and bereavement as well as giving them a sense of belonging. For one participant who cared for a spouse with dementia, attending religious services not only offered respite but was seen as spiritually comforting.

- "Very important in my life. It's a break from the daily routine and spiritually uplifting."

Other comments were:

- "More important because of my illness (cancer)…without it, I wouldn't have gotten through my illness. You understand it (religion) more."
- "I turn to G-d to help me through my dilemmas."
- "It's important. I like to belong to a community. It helped me to cope when my spouse died. I was always there (shul). It seemed to help. Now I take my grandchildren."
- "It gives me a sense of belonging. (You) must have a belief, otherwise you float."

Of the seven participants quoted in this section, five attended services at least once a week. A significant observation is that of the 14 participants that ranked their quality of life as " very good", 57% (8) said that religion had become more important as they aged. In comparison, those that ranked their quality of life as "fair", only 40% (4) of the ten participants, felt that religion had become more important with advancing years.

It can be seen that for most of the participants, religion offered a means of gradually coming to terms with the changes associated with old age. These adaptive mechanisms have been described by Baltes and Mayer (2001:468) as well as Beaumont and Kenealy (2004:755).

6.5 FORMAL SUPPORT SYSTEMS

6.5.1 Introduction

Formal support systems are formalised institutions that render instrumental support along a continuum of care that is dependant on the older persons level of functionality (Cantor & Little, 1985; Kropf, 2000). In this section, three areas will be explored. Firstly, the participants' use of formal support systems will be explored as well as their perceptions of the Government's service delivery to older persons, the inference being that the participants would respond to what they saw as shortfalls in service delivery. In the latter instance the question was put to the participants: "If you were in Government, what services would you introduce to help senior citizens?". Secondly, the participants were asked what they thought made it possible for seniors to live in the community. Thirdly, the participants were asked if there was a need to establish, in Milnerton, a Jewish retirement village with frail care facilities.

6.5.2 The use of formal support systems and perceived gaps in social services to the older person

6.5.2.1 Use of formal support systems

In this section the researcher sought to explore the extent to which participants had used formal support services. In this instance formal support services are the registered social support services which serve the Jewish community. The participants were asked if they had used any of the services within the last year for counselling or advice viz. Jewish Community Services (statutory and short term counselling), Nechama (bereavement counselling), Highlands House (Old Age Home) and Glendale (sheltered care for the mentally challenged). They were also asked if they had received counselling or advice from either a Rabbi or CJSA, Milnerton or had attended any support group or any other form of counselling service. The participants were asked to rank the services they received and were also asked if they felt there was a need for a retirement village with frail care that catered specifically for Jewish seniors.

A third of the participants (8) stated that during the previous year they had used formal support services in the community. However this figure is under-reported and is possibly due to fear of disclosure. The researcher felt compelled by ethical constraints not to pursue this matter as the participants have a right to non-disclosure i.e. the right not to answer the question. There was one non response.

Of the eight participants that used formal support services, 63% (5) ranked the service as good, 25% (2) ranked the service as fair and 13% (1) ranked the service as poor. Fifty percent (4) of these participants had used CJSA, Milnerton and 13% (3) had sought the advice or been counselled a Rabbi. Seventy nine percent (19) of the target group felt that all of the formal support services offered by the Jewish community were easily accessible if you had transport. Fifty four percent (13) of the participants felt that there was a need for a Jewish retirement village with frail care in Milnerton while 33% (8) opposed the idea.

6.5.2.2 Perceived gaps within the formal support system

In order for the researcher to explore the participants perceived gaps within the formal support system they were asked what systems they would put in place to assist seniors if they were in government. The responses were recorded and then put into themes. It must be noted that the participants gave more than one suggestion. The results are given in Table 6.12.

Table 6.12: Suggested government services that should be offered to older persons

Suggested services	**f**	%
Pension	11	25
Health care	10	23
Transport	9	21
Accommodation	5	11
Employment opportunities	4	9
Increased support for the disadvantaged	2	5
Acceptance by general public	1	2
More community centres	1	2
More concessions	1	2
Total	**44**	**100**

N=24

The three main themes that emerged from the responses were better pension, followed by improved health care and transport services for the older person. Although only three of the participants receive a government pension, eleven participants stated that the government pension grant needed to be increased. Some of the comments are:

- "A better pension. Can't come out on a government pension."
- "Increase the government pension and scrap the means test. Everyone should be entitled to a government pension. You should not be penalised for having worked."
- "Higher pensions. Some are battling but have to pay the same prices as everyone else."

- "Seniors are not looked after. They need a better pension scheme."

The other area that drew the second greatest response was the need for an improved health care service for the aged. Ten participants felt that the health care system needed to be improved. Often the suggestions are drawn from the participants own experiences with the health system as illustrated by the following statements:

- "Better health facilities – they need better than what they are getting. The clinics are shocking. The doctor said to me "Look, get to the point, I haven't much time." I know he sees many people but they need more Doctors to care for us better. You're a number not a person."
- "The attitudes of the nurses in frail care need to be studied. In 1995 my mother was left naked on the bed because the nurse went and had her tea. There was no spoon given for her soup and there was theft. There needs to be more supervision of wards. The government needs to look into the abuse and subtle abuse of the elderly, as well as the attitude of the nurses. I am terrified of the same thing happening to me."
- "Improve clinics and hospitals and have access to decent systems. You have to wait five to six hours. Sometimes my spouse has been there from 7.30 am until 3 pm at the hospital. Thank goodness my spouse can (also) go to the clinic, but it's soul destroying."

The area that drew the third highest response (9) was to do with the need for improved transport system that was more suited to the physical and financial needs of the seniors. The sense of independence that a suitable transport system can afford the older person is best illustrated by the following comment:

- "The transport system is horrific. There is no infrastructure here. In Australia you can be independent (i.e. pensioners). Here in South Africa, if you haven't got a car, it's horrific."
- "Transport – if you haven't got a car it's very difficult to get to Groote Schuur – it's pathetic."
- "The bus service should be free for seniors. I have to catch a buss for the clinic at 6 (a.m.) which is peak time and pay R6,90. There is no concession. There should be no restrictions. It costs R9 from Milnerton to town one way."
- "Better transport system, safer and more secure. There should be a railway station at Milnerton to take you into the centre of town. There should also be transport concessions based on age, not means."

- "There should be subsidised transport for seniors. Dial –a- Ride costs R16 a round trip."

It can be seen that adequate finances, together with improved health care and affordable and accessible transports services, are key concerns of the participants, irrespective of their present socio-economic status.

6.6 PARTICIPANTS' PERCEPTIONS ON WHAT ENABLES SENIORS TO REMAIN LIVING IN THE COMMUNITY

6.6.1 Introduction

In this section the researcher set out to explore what the participants saw as the key enabling factors that allowed them to remain living in the community as opposed to going into residential care. The question "What makes it possible for seniors to live in the community?" was put to the participants. The question was open ended as this allowed for qualitative data to be recorded. There was one non –response to this question. The researcher transcribed their responses, and collated the responses according to themes (Franklin & Ballan, 2005:445).

6.6.2 Results

Five themes were identified from the responses and are ranked in descending order according to the number of responses (Table 6.13). Where participants gave more than one response, this was recorded (Table 6.13). Only the top five themes were recorded. The top five factors that the participants felt enabled older persons to live in the community for as long as possible were financial independence (10), tertiary social support i.e. involvement with the CJSA, Milnerton (6) and thirdly, good health, together with primary and secondary social support were ranked all in third place (Table 6.13).

Table 6.13: Perceived enabling factors that allow for community living according to frequency of response

Ranking	Identified enabling factors	f	%
1	Financial independence	10	36
2	Tertiary social support	6	24
3	Having good health	4	16
3	Primary social support	4	12
3	Secondary social support	4	12
	Total	**28**	**100**

The above results are supported by findings in literature which state that finances and good health are two of the key indicators that determine quality of life in the older person (Gabriel & Bowling, 2004; Kahana *et al.*, 2003:156; Rowe, 2005). What is an anomaly, is that

involvement in the community centre was cited more frequently than primary and secondary support systems as being an enabling factor in living in the community. Perhaps the aforementioned finding can be attributed to the assertion that community and volunteer associations (of which CJSA Milnerton shares both attributes) are often the interface between formal and informal support systems (Naleppa & Reid, 2003:34).

The response that best sums up the need for financial independence is illustrated by the following comment:

- "If you've been provided for you can live in your own home. If you haven't been provided for then you must rely on your children. Otherwise, the Jewish community."

One of the participants commented on the important role that CJSA, Milnerton has played in their life:
"... I couldn't bear coming back to an empty house if something happened to my spouse – what would happen to me? I wouldn't want to live overseas (with the children). I don't know if I could handle the climate. They have their own lives to lead. You lose what you have here. CJSA has been a life saver for me once my mother passed away."

It is evident that within the South African context, in order to remain living independently in the community, financial independence as well as good health, is of paramount importance. It also becomes evident that the interaction of the social support systems anchor the older person in the community.

6.7 CONCLUSION

It can be seen that in order for the older person to be able to live in the community for as long as possible, many systems and subsystems come into play. The interaction of the informal and the formal systems are of vital importance to the maintaining of the elderly in the community, key to which is good health, strong social and family ties alongside social participation (Welsh-Bohmer, 2006). Not to be overlooked is the concept of self efficacy together with the use of adaptive mechanisms as factors which enable the older person to maintain control and mastery of their environment. It would seem too that the older persons level of quality of life determines whether or not the aged are able to remain living in the community. Further study is needed to determine the relationship between the quality of life and community living: it is not known if a decrease in quality of life linked to the point of admission to institutional care can be quantified.

CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

In the previous chapter the social support systems and quality of life indices which help sustain Jewish seniors within the community were identified. In accordance with the final objective, this chapter sets out to present guidelines, based upon the conclusions and recommendations, for social workers dealing with the Jewish elderly.

7.2 CONCLUSIONS AND RECOMMENDATIONS

The following conclusions and recommendations are based upon the results of the exploratory research into the social support systems of Jewish seniors who are members of Cape Jewish Seniors Association, Milnerton. The term Jewish seniors refers to Jewish older persons who residents of Milnerton and surrounds.

7.2.1 Demographics

The percentage of Jewish older persons over the total Jewish population living in Milnerton and surrounds is 15% while the total population of older people, across all race groups in South Africa is 7%. Older people make up 19% of the total white population of South Africa.

All of the participants were white, aged 60 and over, included both genders, were Jewish, and were members of CJSA, Milnerton. Most of the participants lived in Milnerton and surrounds. The two main areas where Jewish seniors live are in Milnerton Central (47%) and Tijgerhof (30%). Milnerton Central and Tijgerhof are the areas closest to the Orthodox synagogue, the largest of the four Jewish places of worship (shuls) found in these areas.

From the above findings it can be **concluded** that the Jewish community in the Milnerton area and surrounds is an ageing community, when compared against national figures, which contradicts the general perception within the Jewish population that the Jewish population is **not** an ageing population. CJSA, Milnerton is a faith based organisation that caters for Jewish male and female older persons aged 60 and over. It can also be **concluded** that the organisation caters for a small urban ethnic minority drawn in the main from the white

population. It can also be **concluded** that the Jewish elderly prefer to live in close proximity to their synagogue or shul.

Recommendations

Social work tasks related to prevention:

- Awareness programmes aimed at the larger Jewish community need to dispel the myth that the Jewish community is **not** an ageing community. Educational programmes need to be developed to highlight the issues of population ageing.
- Social workers need to introduce outreach programme to Jewish seniors, both male and female.
- Social workers need to network with other organisations rendering services to older persons in order to strengthen its working base.

Social work tasks related to assessment:

- Social workers need to be aware of the need to be flexible and that membership is often based on the psycho-social needs of the potential member and not on rigid set paradigms of faith and age.
- Social workers should, if asked, be able to advise Jewish seniors who are looking for accommodation, where the synagogues and shuls are located.

7.2.1.1 Highest level of education and source of income

Several members indicated at the outset of the investigation that a condition of participating in the study was that they would not be asked questions that were considered too personal. The majority of the participants held either a matric or college qualification as their highest level of education. Only one participant did *not* have a matriculation certificate and only one participant had a university degree. The majority of the participants did not work and the greater majority had as their main source of income, investments and/property as opposed to having either a state pension or private pension. Only a minority of the participants were financially disadvantaged. However, those that were the most financially disadvantaged were those that received a state pension and were reliant on their adult children for financial support.

From these findings it can be **concluded that** while the majority of Jewish seniors are financially advantaged, there is a small sector that experience financial hardship which in all

instances, are those who draw a government pension. The conclusion drawn is the government pension is not sufficient to meet the financial needs of older person living in the Milnerton area. Counter-intuitively, the standard of education of the older person is not an indication of a higher level of income. What is clearly evident is that a Jewish senior who draws a state pension will be experience financial hardship.

Recommendations

Social work tasks related to the assessment or intake phase:

- Social workers need to be aware that an older person who is receiving a government pension will in all probability require financial assistance in order to remain living in the community.
- Social workers must take cognisance of the fact that for the older person, the question of income is a sensitive matter. Social workers must also be aware of any value judgements they may place on the relationship between the older person's level of education and their level of income.

7.2.1.2 Push/pull factors to current place of residence

Push factors

Half of all the participants moved to their current place of residence either due to business or financial reasons. Half of all the participants also experienced traumatic events linked to their relocation. The traumatic events that were spoken of were death/anticipated death of spouse, debilitating or life threatening disease, financial reasons, emigration of children and being mugged by an assailant. Twenty nine percent of the participants relocated from Johannesburg. Over half of those who moved from Johannesburg to Cape Town moved due to traumatic events in their lives. The trauma mirrored those events cited above.

Pull factors

The three main reasons for moving to the current place of residence were to be with family, to live in a retirement village and for financial downsizing. The vast majority of those participants, who wanted to be with family, were those that had lived in Johannesburg and 40% of this group were widows. For those that wanted to live in a retirement village, 40% cited security reasons.

From these findings it can be **concluded** that the migration patterns of the participants did not reflect those found in literature in as much as the long distance migration was not amenity

motivated but rather family motivated. Moreover, long distance migration was often precipitated by traumatic life events. Furthermore, those participants who migrated short-distance, were not assistance motivated, but amenity motivated. In addition, the migration patterns of the participants were not age-specific. Finally, the most vulnerable would be those who migrated long-distance and suffered multiple loss.

Recommendations

Social work tasks related to assessment or intake phase:

- Social workers need to be aware of the issues surrounding the migration of the older person especially in the case of long-distance migration where trauma and multiple loss often accompany such a move.
- Where the migration of the older person is amenity related, social workers need to be aware of the available resources in the community. Social workers need to make this information available to the older person in order for informed decision-making to take place.

7.2.1.3 Aging in place

Just under half of all the participants were born in Cape Town while just under two thirds of the participants spent most of their adult years in Cape Town and just under one third spent their adult years in Johannesburg.

All of those participants, who fell into the 80+ age group, immigrated to South Africa in their childhood, most of them having their origins in Eastern Europe. The underlying reason for their family's migration was anti-Semitism and fear of persecution as evidenced by the narrative "… we managed to get out …" and "… My uncle was the first to be shot …".

From the findings it can be **concluded** that the majority of the participants are ageing in place and that the retirement effect spoken about in literature is not characteristic of this group. Furthermore, there is no indication to suggest that out migration in early old age was followed by return migration at a later stage. It can also be **concluded** that those in the 80+ age group have a stronger likelihood of being born in Eastern Europe and to have immigrated as children to South Africa, for reasons of personal safety.

Recommendations

Social work tasks related to assessment or intake phase:

- Social workers need to be aware that seniors falling into the oldest-old age group of 80 years and over, may have either themselves, or their families and relatives, experienced first hand, the ravages of WWII (and in some instances WWI). In the case of Jewish seniors where participants as children fled before war broke out, the participants may carry with them the traumatic memories of their parents.

Social work tasks related to intervention:

- Social workers need to be aware that memories of past traumatic events experienced during WWII may be triggered by present day crisis. Social workers need to refer such older persons to professionals who specialise in Post Traumatic Stress Syndrome.

7.2.1.4 Gender and age

All of the participants were aged 60 and over and there were more females than men across all three age groups of 60-69, 70-79 and 80+. In the 70-79 age cohorts there were almost three and a half times more females than males. This age group also had the most number of female participants than any other age cohort. Most of the males that were participants fell into the 80+ age group. It was also found that the percentage difference of male participants across the three age groups were the inverse to the percentage difference of the female participants across the same age groups.

From the findings it can be **concluded** that the phenomenon of gender advantage is a characteristic of older persons aged 60 and over, and is at its most predominant in the 70-79 age group. It can be further **concluded** that community centres that cater for older persons, most appeals to females between the ages of 70-79 and for men, from the age of 80. There is insufficient data to establish whether or not the low percentage of male participants in the 70-79 age cohorts is due to higher mortality or morbidity rates or if males in this age group simply elect not to become members of a senior community centre. Although there appears to be an inverse relationship between male and female participants across the three age cohorts, this has not been statistically proven and the significance of any potential relationship needs further research.

Recommendations

Social work tasks related to the assessment phase:

- Social workers should be aware of the gender advantage of females in the older age groups and the implications this has for group dynamics in a community/social service setting.

7.2.2 Living arrangements

Under living arrangements, there were three main areas of focus, namely, preferred choice of partner, preferred living arrangements and most meaningful relationship. All of the married participants were satisfied with their living arrangements and all chose their respective spouses as their preferred choice of partner and the person with whom they have the most meaningful relationship. The majority of those participants who were not married were satisfied with their living arrangements and gave equal weight to daughters and partners as the person with whom they had the most meaningful relationship. Only a very small percentage of the participants said that they would prefer to be alone.

The vast majority of the participants lived independently of their children in single generation households while a very small percentage lived in intergenerational households. Most of the participants said they would not like to live with their adult children. The vast majority of the participants were vehemently opposed to living in an old age home and half felt they would not like to live in a retirement village with frail care.

From the above findings it can be **concluded** that the participants place a high value on independent living and are generally satisfied with their living arrangements and choice of partner. Their partners, including spouses, are also the people with whom they have the most meaningful relationship. However, for widows, daughters are the people with whom they have the most meaningful relationship.

Recommendation

Social work tasks related at prevention:

- Awareness programmes need to dispel the stereotype of the older person as dependant and needy, more especially so with the elderly who are functionally well. In the same vein, it is recommended that awareness programmes highlight the high value the older person themselves place on independent living.

Social work tasks related to the intervention phase:

- Social workers need to be aware that placement in old age homes or residential care is not a first option but should only be chosen as a last resort when all other options have been explored.
- Social workers need to inform the older person of available resources within the community which will enable them to remain in the community as long as is viable.
- Social workers need to be aware that for most older persons, living with an adult child will impact on their sense of independence and this aspect of intergenerational living needs to be discussed in-depth with the client system.

7.2.3 Good home and neighbourhood, adequate housing, safe environment and economic security

In the main, the participants lived either in a retirement village, gated communities or in flats. Only two participants lived in stand-alone houses and these participants fell into the 60-69 age cohort. Two other participants lived in a room and one in a townhouse. Most of the participants felt that the neighbourhood in which they lived was suitable for the older person and those they felt safe. Most of the participants were on good terms with their neighbours and considered them as friends and felt that they (the participants) could be relied upon to render instrumental support if the need arose. The majority of the participants felt that public amenities were accessible. However this did not hold true for those that did not drive, who were mostly in the 80+ age group. Just over two thirds of the participants owned their own property. The remainder either rented or had part ownership. Those that owned their own property had the highest self reported quality of life score, followed by those who rented. Those who had part ownership scored the lowest. Furthermore, participants that owned their own property felt the most financially secure and the least concerned about their financial future than those who rented or part owned, and in that order.

It can be **concluded** from the above findings that there are two distinct groups: the majority of the participants who own their own properties, are on good terms with their neighbours and live in a neighbourhood that is both safe and secure. This group also has a high degree of financial security and a high self reported quality of life ranking. In sharp contrast to this group, is a minority of seniors, that do not own their own property who have a lower self reported quality of life ranking, who have weaker social ties and less access to public amenities. These findings are in line with studies that state that the immediacy of home

ownership lends itself to a higher ranking of quality of life and that financial security is a strong indicator for well being in the older person. It is not known why the participants who part-owned their property had the lowest quality of life scores.

Furthermore, most of the participants preferred living in secure complexes and participants who lived in stand-alone homes are in the young-old age group. Those participants who are 80 years old and older are the individuals who are no longer able to drive and who will have the most difficulty accessing public amenities and would feel the decline in independence most keenly.

Recommendations

Social work tasks related to prevention:

- Awareness programmes focusing on effective retirement planning need to be aimed at young adults.
- In instances where older persons form extra-marital partnerships, social workers need to advice seniors to protect personal income and property wherever possible.

Social work tasks related to assessment:

- Social workers need to be aware that the older person who rent or part-own their property, are economically vulnerable and are the most concerned about their financial future.
- Social workers also need to be aware that those older persons who rent or part own their homes are those that tend to have weaker social ties within the neighbourhood.
- Social workers need to ascertain if there is a need for social relief. The financial assessment needs to conduct with sensitivity so as to protect the dignity and sense of self worth of the older person as is enshrined in the principles of Human Rights.
- Social workers need to ascertain whether or not the older person is still permitted to drive.

Social work tasks related to intervention:

- Social workers need to know what resources are available in the both the Jewish community and the community at large so as to best meet the older persons economic needs in terms of providing social relief.

- Social workers need to assist the older person integrate into community centres and or relevant religious bodies so as to strengthen social ties other than what may be provided within the neighbourhood.
- The social welfare sector needs to lobby for public transport that is suitable for older persons and especially for those aged 80 and over. In other words, public transport that is user-friendly, economic and easily accessible.

7.2.4 Comparison of subjective quality of life indicators across the domains

The participants unanimously stated that being independent, being financially secure and being healthy, were all factors that determined a "good" quality of life. The factors that were found to have the highest influence in determining a "very good" quality of life were having a private pension and investments, having a strong sense of belonging and having 100% ownership of property. However, closer examination found that in addition to 100% ownership of property, being very active in organisations as well as aging in place was the factors that most determined having a "very good" quality of life, as opposed to "fair".

From the above finding it can be **concluded** that the determinates of a very good quality of life for older persons are inter-dependant for two reason. Firstly, financial security allows independence and increases the chances of healthy well being. Secondly, ageing in place and active involvement in a civic or religious organisation enhances the older person's sense of belonging.

Recommendation

Social work tasks related to prevention:

- Social workers who deal with the older person in the Jewish community must be aware that older persons, who are at risk and are the most vulnerable, will be those who have a self reported *poor* quality of life and are financially compromised. Further considerations should focus on seniors who have migrated long-distance and do not participate in any community organisation be it secular or religious.

7.2.5 The primary support system and kin availability

7.2.5.1 Marital status and number of children

Marital status

Forty five percent of the participants were married and 38% were widowed. The remaining percentage of those either living together with partners or in a relationship but living apart, consisted of less than 20% of the total target group. Seventy two percent of the male participants were married in contrast to 35% of their female counterparts. Forty seven percent of the women who participated were widowed as opposed to 14% of males. The percentage difference between the number of participants who were married and those that were widowed is less than ten percent. All of the men who participated in this research who were between the ages of 60-79, were married. This percentage decreased by 50% in the 80+ age group. Just under 60% of women in the 60-69 age group were married as opposed to 29% in the 70-79 age group. None of the women age 80 and over were married.

From the above findings it can be **concluded** that older men aged between 60-79 are more than likely to be married than older women of the same age, by a factor of two. This finding is partially in line with literature that found that there was a higher incidence of married older men than older women between the ages of 60-70. It can also be concluded that as a whole, older women are three times more likely to be widowed than older men. The marital status of the older male alters sharply in the 80+ age where evidence points towards an equal probability of either being widowed or living with a partner. Older women in the 80+ age group are less likely to live with a partner than their male counterpart. Of significance is that almost three out of four older women in the 70-79 age group, and two out of three in the 80+ age group are widowed which in effect, for this group, leaves adult children as the main source of primary support.

Recommendations

Social work tasks related to assessment:

- Social workers need to be aware of the impact of gender advantage in older women and the consequences thereof, namely that the older woman will in all likelihood have a diminished primary support system.

- Social workers will need to assess the persons who make up the constellations in the client systems primary support system and where necessary, attempt to strengthen secondary support and tertiary support systems.

7.2.5.2 Number of children and contact with children

There was an average of 2,5 children per participant with the frequency distribution ranging from 0-5 children per participant. In the main adult children lived overseas (63%), in Cape Town (62%) or Johannesburg (41%). Thirty eight percent had no children living in Cape Town of which 17% had no children living in South Africa at all. However, just over half of the participants i.e. 58% have adult children living in the same suburb as themselves. Seventeen percent of the participants had children that had died. Three of the participants were widowed, one of these was childless, and two had no children living in South Africa and one was both widowed, had no children living in South Africa and who had child that had died. Only two of the participants lived with their adult children and both of these respondents fell into the 80+ age group.

Just under three quarters of the participants had contact with their children at least once a week, a quarter had contact with their children more than once per week and just under a third had daily contact, irrespective of the children's country or place of residence. Contact was either visit to the home, telephonic or by email. A limitation of this study, as previously stated, is that contact by sms was omitted from the questionnaire. Seventeen percent had had no contact with their children and there was a reported 13% non-response.

From the above findings it can be **concluded** that the number of children per participant is above the replacement rate which lends itself to a stable adult dependency ratio, emigration not withstanding. Just under two thirds of the older persons have children who live in Cape Town. Half of the seniors have children who live in the same suburb as them and therefore, have recourse to a primary support system. It can also be concluded that the participants also enjoyed a high degree of contact with their adult children irrespective of where they lived. It is the researcher's belief that had sms' been included in the research instrument, the reported rate of contact between the older persons and their children, would have been far higher. Finally, there is a small group of older persons (13%) who are have no recourse to any immediate primary support group be it spousal support or with adult children and as such can be deemed to be the most vulnerable.

Recommendations

Social work tasks related to intervention:

- Intervention by social workers must be aimed at the most vulnerable older person i.e. those who have no primary support system in Cape Town. Social workers need to be knowledgeable about systems theory approach. The older persons must be helped to develop alternative support systems that will help sustain them in the community.
- Social workers need to be aware of the resources in the community that will assist the older person to participate and integrate into the larger community.
- Social workers need to be skilled in dealing with issues of loss and loneliness.

7.2.5.3 Contact with other family members living in Cape Town

Family members, other than children that lived in Cape Town and not in the same suburb as the participants, were fathers (2), siblings (6) and other relatives (6). On average, 54% of the respondents had contact with other family members at least once a week with 21% making contact a few times per week. On average, 6% of the participants contacted other family members daily. Thirty eight percent made no contact with their family members. There were two participants who made non responses. Contact was either by means of visits or telecommunication. Nine of the respondents had visited other family members at least once during the week while 17 of the participants had made contact (telecommunications) with these family members during the same period.

From the above findings it can be **concluded** that there were more older persons who visited their relatives than did not and that the preferred method of contact was telephonic. It can also be **concluded** that older people contact their adult children twice as much as they do other family members.

Recommendations

Social work tasks related to assessment:

- Social workers need to be aware of the complex network of informal support systems within the older person's social milieu.

7.2.5.4 Types of social support in primary support systems

The types of social support that were examined were instrumental support, personal support and affective support and the person who was most likely to or who was the most preferred

person(s) to render such support. Instrumental support looked at lifts, shopping, house cleaning, cooking and laundry while personal support looked at assistance related to activities of daily living such as walking, dressing, bathing, washing hair and the use of the toilet. Other types of advice looked at were emotional support and advice on a number of topics related to older persons such as medical advice and advice on moving to an old age home. The target group divided naturally into two evenly numbered groups, one group of older persons who were married and one group that was not. Included in this latter group, were those older persons who were involved in relationships, either living with or apart from their respective partners. Each sub-group comprised of twelve participants.

- **Married older persons**

For those older participants who were married, the spouse scored the highest across all domains, be it as the person most likely to render specific support or as the person most preferred to render a specific type of support. In instrumental support, the spouse scored 32 and 31 respectively in the categories "most likely to" and "most preferred". Adult children scored 28 and 30 points lower in both categories. A similar range of scores was evidenced in personal care support. In the "most likely" group, the spouse scored 32 and significantly, adult children scored nil – as opposed to neighbour (9) and nurse aid (8). In the "preferred" category, the spouse had the same score while the daughter scored marginally higher at three. The adult son had no score.

For those participants who were married, the three persons to whom they would approach for emotional support and various types' advice would be the spouse, the son and then a friend. The corresponding scores are 27, nine and five.

- **Not married older persons**

For those older persons who were not married, daughters scored the highest across all of the domains with the exception of seeking financial advice, where sons took preference over daughters. In instrumental support, the person who was most likely to render support was the daughter with a score of 20, followed by the partner, scoring seven and then the son with a score of six. The person most preferred to render instrumental support is the daughter with a score of 23 followed by the son with a score of seven and then the partner who scored six. On examining personal support it was found that the rankings were the same for both most likely and preferred. The ranking order was daughters, followed by partners and then sons. Of significance is the high scoring the daughters received in both the "most likely to" and

"preferred" categories, scoring 27 and 33 respectively. The choice of the daughter also surpassed that of the son as the person who would render emotional support with partners ranked as second. The only instance where the son is ranked higher than the daughter is for financial advice. The ranking for medical advice was daughter, friend, partner and son. On seeking advice to move to an old age home, the daughter advice would be sought the most followed by the son and then a sibling. Overall, for older persons who are not married, advice is sought from the daughter, sons and siblings.

From the above findings it can be **concluded** that for those older persons who are **married,** the spouse is the primary person who is likely to render support and is also the person most preferred to render support. Adult children play a limited role in both instrumental and personal support and across the remaining domains. Where spousal support is not forthcoming due to chronic illness, and where children are not available, instrumental and emotional support is sought from neighbours and friends. The above findings are thus supported by Segrin's (2003) critique of the compensatory model which states that support is often dependant on who is available. For older persons who are **not married**, adult daughters play a pivotal role and are the ones who are most likely to render instrumental and personal support, followed by partners and then adult sons. In all instances, bar for financial advice, daughters are the person to whom they would most prefer to turn for support and advice. Sons play a more important role in an advisory capacity than they do in either instrumental or personal support.

Recommendations

Social work tasks related to assessment:

- Social workers need to asses the extent and availability of the older persons primary social support subsystems.
- Social workers need to be aware that the older persons who are most vulnerable are those older persons who have no children living in the same city as themselves and who care for spouses who are chronically ill.
- Social workers also need to be aware of the pressures brought to bear on adult children, particularly daughters, when either parent is widowed. Often adult children are caught between coping with their own family and work demands, at the same time, giving support to their aged parent. This becomes particularly onerous during times of crisis and it is often at this point, that social workers will be introduced to the older persons' adult

children for the first time. Social workers therefore need to be able to interpret family dynamics and act as mediator between family members.

7.2.6 Secondary support systems

7.2.6.1 Contact with friends and neighbours

The majority of the participants, 83%, said that friendships were important to them with 81% having contact with friends **at least** once per week. Just over 80% of the participants regarded their neighbours as their friends. Fifteen percent of the participants contacted their friends on a daily basis and 35% had contact a few times per week. Friends were visited 20 times in one week and neighbours 18 times. Overall, contact was highest with friends (81%), followed by neighbours and children (71% each) and 54% for relatives. A large percentage, 71%, of the participants had contact with their neighbours at least once per week with 31% contacting their neighbours a few times a week and 17% contacting them every day. Of those respondents who lived in a retirement village 67% found it easy to make friends and had the highest contact with their neighbours than those participants who lived in other types of housing. Respondents who lived in rooms had no contact at all with their neighbours during the week while participants who lived in houses and thought of their neighbours as friends, made contact once per week. However, those that lived in independent housing also regarded their neighbours as friends as did all of those living in a retirement village and in a townhouse. Only two of the participants who moved from Johannesburg to Cape Town, moved directly into a retirement village.

From the above findings it can be **concluded** that most older people feel it is important to have friends. Most older people regard their neighbours as friends despite the fact that they will not seek certain types of support from them. Older people also have more contact with friends than with their adult children and neighbours and the least contact with relatives who are not members of their immediate family. It can also be concluded that older people who live in retirement villages have the highest degree of social contact and are the least socially isolated. These results are supported by research studies cited in literature. It can also be **concluded** that for older people who migrate long-distance and who move directly into a retirement village, the associated losses are off set by the social friendships forged in a retirement village. In other words, the social milieu of retirement villages has a buffering effect against the loss of social networks when older persons migrate long distance. It can also be **concluded** that older persons who live in retirement villages, independent homes and

townhouses have a higher regard for their neighbours as friends than those older persons who live in flats, gated communities or rooms. Frequency of contact cannot be used exclusively to measure friendship or the meaningfulness of a relationship. This finding too is borne out by research. Finally, it can be **concluded** that older persons still enjoy a secondary support system with neighbours and friends and that their social network is far from diminished.

Recommendations

Social work tasks related to prevention:

- Awareness campaigns by social workers which focus on retirement planning should include the advantages of living in retirement villages.

Social work tasks related to intervention:

- Should the older person be seeking accommodation, social workers need to advise older persons of the advantages of living in retirement villages.
- Social workers need to be knowledgeable about the different types of residential facilities that are available in the community in order to assist the older person make informed decisions when deciding to move to alternative accommodation. At the same time social workers must not infringe the older persons right to self determination and must respect the older person's choice of residence.

7.2.6.2 Types of support in secondary support systems

The types of support received from the secondary support system was explored. Types of support are the same as for the primary support systems as is the division of married and not married participants. In this section it also became apparent that the role of the domestic worker and nurse aid were important to the functioning of the older person and were thus included in the secondary support system.

- **Married**

For participants that are married, the people that are *most likely* to render **instrumental support**, in ranked order, are as follows: the domestic worker, friend and neighbour with corresponding scores of 17, five and three. Both friends and neighbours would help with lifts and shopping but friends would also cook. The ranking for the persons *most preferred* to render instrumental support is identical to those that are *most likely* to render instrumental support. While the domestic worker scored 14, the scores for friends and neighbours were

two and one respectively. These scores are deemed to be insignificant. For **personal support**, married participants cited their neighbours and their nurse aids as the people who would *most likely* to render personal support across all domains. They scored nine and eight respectively. It must be noted that the score of nine for neighbours is the only time that neighbours as a source of secondary support feature with any significance. The domestic worker and the friend both scored below five. The nurse aid was also the *most preferred* person to assist with personal care. The neighbour got a nil score. For **other types of support**, friends ranked third in giving advice for married participants. Neighbours, domestic workers or nurse aids were given no mention.

- **Not married**

For participants that are not married the person who was *most likely* to render **instrumental support** was the domestic worker who scored the highest at 16. The domestic worker would be involved in support related to housework duties alone. Friends, with a score of five, would assist with lifts and shopping. The person *most preferred* to render instrumental support for those who were not married are the domestic worker and the nurse aid with a score of 12 and 10 respectively. The score of two for friends is insignificant. Neighbours got a nil score. The ranking for **personal care** and those *most likely* to help were identical to those *most preferre*d to render instrumental support, although the scores were different. (The nurse aid scored six and while the domestic worker scored five). The nurse aid ranked the highest in terms of the *most preferred* person to render personal support with a score of 11. Friends and domestic worker were both ranked second last with scores of one. Neighbours received a nil score. The only time that any person from the secondary support system was called upon to render **affective support** or give advice from friends and that was to seek **medical advice**. No mention was made of the neighbour.

When adding up the total scores for each of the persons rendering secondary social support to the older person across all the domains, the scores were: domestic worker 69; nurse aid 45; friends 28 and neighbours 13. The domestic worker had the highest score out of all those who were most likely to render support while for the "most preferred", it was the nurse aid.

From the above findings it can be **concluded** that in the secondary social support systems of the older married person, the people that are most likely to render support in descending rank order is the domestic worker, neighbours, a nurse aid and lastly, friends. The most likely, as well as preferred, source of instrumental support for the older person is the domestic worker.

Neighbours, then nurse aids, are the most likely source of personal care support for the older person whereas friends are more likely to be involved in instrumental support but on a very limited basis. However, married older persons would prefer to have friends, rather than neighbours, render personal care. Older persons give the same weight to nurse aids in terms of most likely to and preferred sources of personal care.

It can be further **concluded** that for the older person who is not married, those people who will most likely render secondary social support are, ranked in descending order, the domestic worker, friends and nurse aids. The domestic worker will be the "most likely" to render instrumental support. Nurse aids also play a role in rendering personal care support albeit in a very limited way. Friends will only be involved in a very limited way in giving lifts, shopping cooking and walking. For those older persons who are not married, the person they would most prefer to render personal care is a nurse aid while for instrumental support, it is the domestic worker. Again, friends play a very limited role as the preferred person to render any form of support other than to seek medical advice. Married older persons would also seek emotional support from their friends, as well as medical and financial advice. However, older persons who are not married, will only ask their friends for medical advice. Older persons, in the absence of a spouse, prefer the use of nurse aids twice as more as those who are married. The final **conclusion** is that within the South African context, domestic workers and nurse aids make up a sub-system of the secondary social support system of the older person.

Recommendations

Social work tasks related to prevention:

- Social workers need to educate the community about available care giving resources within that community.
- Social workers who work in community centres are ideally placed to use the community centre as a resource centre for the use of the broader community.

Social work tasks related to assessment:

- Social workers need to establish who the older person turns to for support in their secondary support system.
- Social workers also need to assess the strengths and weaknesses of the older persons secondary social support system.

Social work tasks related to intervention:

- Social workers need to be aware of available care giving and nurse aid resources within the community in order to enable the older person make an informed decision about their care needs.

7.2.7 Tertiary support systems

7.2.7.1 Cape Jewish Seniors Association, Milnerton

The average length of membership at CJSA, Milnerton is three years with a third of the participants becoming members within the last two years. Membership has been steady since the launch of CJSA, Milnerton in January 2003. Just under three quarters of the participants attended the centre at least once a month, while a third attends once per week. A quarter of all the participants attended functions more than once a week. A very small percentage of the participants never attended the centre due to either their own ill health or that of their spouse. The remaining 21% of the members attended the centre between two to three times per month.

Just over eighty percent of the participants felt that CJSA was important to them. For over half the participants, the centre was an important part of their lives. Their narrative gave some indication of the depth of meaning that the participants ascribed to being members of CJSA, Milnerton "It's been a life saver", "It's very important to me" "It gives me purpose". A quarter of the participants, while stating that CJSA was important, qualified this by stating that it was more important for other people. Although many of this group did not readily attend the functions at the centre, they all volunteered their services. A small minority said that CJSA, Milnerton was not important to them. Two thirds of the all the participants volunteered at the centre. Very few of the participants mentioned that cultural importance of the centre.

From the above findings it can be **concluded** that most of the members of CJSA, Milnerton feel that it is important to belong to a community centre and this in turn is supported by studies which show that community centres are effective in extending the social support base of older persons. Membership intake has been fairly evenly distributed since the Centre was opened in 2003. The status of the membership is healthy in as much as long standing members have remained while new members have been drawn in. It can also be **concluded** that most members volunteer their services.

There are two distinct groups of members. The first and larger group, enjoys membership because of the sense of belonging and purpose that such membership brings. Older persons in this group tend to attend functions on a more frequent basis as well as volunteer their services. The second and smaller group, also volunteer, but do not feel the need to attend functions although they recognise the importance of the centre for other seniors. Members that never attend and do not volunteer, usually do so because of ill health, either their own or that of their spouse. The fact that so few participants commented on the Jewish identity of the centre is of no consequence as no direct question to this effect had been posed.

Recommendations

Social work tasks related to prevention:

- Social workers need to develop awareness programmes aimed at the larger community which focus on the psycho-social benefits of belonging to community centres.
- While Social workers need to encourage older persons to become members at community centres, they must take cognisance of the motivation for joining and at all times must accept the older persons right to self determination.

7.2.7.2 Religion

Three quarters of the participants are Orthodox, 17% of the participants are Reform while the remaining eight percent of the participants stated they were either secular or "other". Just over half of all the participants attended a place of worship at least once per week, 13% only attended on special religious days and the remaining 33% cited "other".

Over half of the participants felt that religion played an important role in their lives and a third of these participants felt that religion was a buffer against trauma such as illness and bereavement. This group also reported that religion had given them a sense of belonging. Twenty one percent of the participants felt that religion had not played an increasingly important role as they grew older while 17% felt that the importance of religion in their lives had remained unchanged. Thirteen percent made the distinction between institutionalised religion and spirituality and there was an 8% non-response.

Just under two thirds of all the participants found that religion had become increasingly important to them as they had got older. Over half of the participants who rated their quality of life as very good also said that religion became more important to them as they aged.

Twice as many participants fell into this category than participants who rated their quality of life as fair.

From the above it can be **concluded** that older persons are more apt to be adherents of Jewish Orthodoxy than Reform and this reflects the larger Jewish community. Not only do most older Jewish persons attend religious services on a regular basis, they have also found that as they have aged, religion has played an increasingly important role in their lives. It can also be **concluded** that the role of religion is a key determinate in the quality of life for many older people and for some, it is an adaptive mechanism as it enables older persons to cope with traumatic life issues.

Recommendations

Social work tasks related in assessment:

- Social workers must assess the older persons belief system and where applicable, encourage the older person to participate in religious activities. To this end, social workers needs to develop working relationships with the respective Rabbis in the community and to refer older persons who may benefit from religious counsel.

7.2.8 Formal support systems

7.2.8.1 The use of formal support services and perceived gaps within the formal support system

During 2006, a third of all the participants turned to formal support services for help with just over half of this group using CJSA, Milnerton, 29% used other formal support systems and 17% turned to a Rabbi for counselling. Just under two thirds of those who had used the formal support services ranked the services as good, a quarter said they were fair and 13% reported receiving poor service. Just under 80% of the participants found that formal community agencies were easily accessible and just over half of all participants felt that there was a need for a Jewish retirement village, with frail care, in the Milnerton area. A further finding was that participants felt that the three main areas of neglect in terms of service delivery in the formal sector were pensions (25%), health care (23%) and transport (21%).

From the above findings it can be **concluded** that one in three members will make use of formal support services. Should the time limit of counselling within the last year be extended, this figure would increase substantially from to one in two members seeking support from the formal support services. In both cases, it can be assumed that the informal relationships that

were developed in the community centre paved the way for older people to seek help from the formal sector which is consistent with studies found in literature.

However, the continued use of the formal support services is entirely dependant on the participants perception and experience of formal intervention and support as well as their accessibility. The formal support services are accessible to most Jewish seniors who live in Milnerton and surrounds bar for a few who cannot drive. Jewish seniors are divided as to whether or not there is a need for a Jewish retirement village with frail care to be built in Milnerton. A final **conclusion** that can be drawn is that Milnerton Jewish seniors, irrespective of their socio-economic status, see pensions, health care and transport as the three areas that most need attention from the Government sector.

Recommendations

Social work tasks related to intervention:

- Social workers in community centres need to be aware that they are the interface between the older person's informal and formal support systems and that it is the development of the informal or casual relationships that will enable the older person to seek assistance or help from the formal social support systems.
- Social workers in community or social service settings that serve older persons need to be devise programmes that help develop informal relationships amongst the older persons' peers.
- Social workers need to be aware that a lack of transport will hinder the older person seeking intervention from the formal support systems. To this end, social workers, together with other agents, need to be advocates for the needs of the elderly and motivate relevant authorities to provide accessible, affordable and user friendly public transport.
- Social workers also need to advocate for the rights and the needs of the elderly at Government level in order to significantly improve both the social pension grants and health services.

7.2.9 Participants' perceptions of what enables seniors to remain living in the community

Respondents identified the three enabling factors that most determined senior's ability to continue living independently within the community. The areas, ranked in descending order, are financial independence (36%), involvement in CJSA, Milnerton (24%) and good health

(16%). Furthermore, the qualitative statements of the respondent serve to highlight the depth of their feelings. Thus the statement "I couldn't bear to living in an empty house … CJSA has been a lifesaver for me" and the more poignant statement of a respondent who in their eighties stated "If you've been provided for you can live in your own home" lends weight to the respondents perceptions that financial independence and belonging to CJSA, Milnerton, enable older persons to remain living in the community.

From the above findings it can be **concluded** that financial independence, involvement in a senior service centres /community centres and good health are the three main determinants of older persons being able to remain living in the community. It can be further **concluded** that this finding is supported by studies in literature.

Recommendations

Social work tasks related to prevention:

Social workers need to act as advocates on behalf of seniors by motivating for:

- Awareness campaigns from both the Government and private sector which focus on retirement planning and that target young adults to judicially plan for their retirement years.
- Awareness campaigns targeting 50-60 year olds need to be developed in order to encourage seniors to become involved in community centres or volunteer organisations.
- Awareness programmes which encourage active ageing throughout one's life span and that ensure optimum health in old age.

7.2.10 Research

Areas for further research include the following:

Further research is needed to study the combined effects that out migration and decreased replacement levels will have upon the adult dependency ratio within the Jewish community as this has relevance for long-term planning and policy decisions for Jewish welfare organisations in terms of its older population.

A national survey of the Jewish senior population should be undertaken in order to establish patterns of population growth/decline against the worldwide phenomenon of population ageing. However this cannot be undertaken unless an accurate census of South Africa's Jewish population is undertaken.

The comparison between retirement villages and gated communities, in terms of the friendship-neighbour axis requires further research as well as the supposition that age segregated communities have a stronger communal identity for older persons than those living in a gated communities is true.

Further research is needed to establish if there is a need to build a Jewish retirement village with frail care within the Milnerton area.

BIBLIOGRAPHY

AFRICAN UNION. 2002. **AU policy framework and plan of action on ageing.** HelpAge InternationalAfrica Regional Development Centre, Nairobi. Retrieved from http:/www.helpage.org/images/pdfs/AUFrameworkBook.pdf on 15/08/2005.

ANTONUCCI, T.C., LANSFORD, J.E. & AKIYAMA, H. 1985. Personal characteristics, social support and social behaviour. In: BINSTOCK, R.H. & SHANAS, E. (Eds.). **Handbook of ageing and the social science** (2nd ed.). New York: Van Nostrand Reinhold Company.

ANTONUCCI, T.C., LANSFORD, J.E. & AKIYAMA, H. 2001. Impact of positive and negative aspects of marital relationships and friendships on well-being of older adults. **Applied Developmental Science**, 10888691, 5(2).

APT, N. 1998. Multigenerational relationships. **Bulletin on Ageing**. Bulletin No. 2/3 Part 5/8 UN Division for Social Policy and Development. Accessed on 05/07/2006.

APT, N.A. 2001. Rapid urbanization and living arrangements of older persons in Africa. In Living Arrangements of older persons: critical issues and policy responses. **Population Bulletin of the United Nations** (Special Issues) 42/43. New York: United Nations Publications.

BABBIE, E. & MOUTON, J. 2001. **The practice of social research**. Cape Town: Oxford University Press.

BABBIE, E. & MOUTON, J. 2003. **The practice of social research**. Cape Town: Oxford University Press.

BABBIE, E. 1989. **The practice of social research** (5th ed.). USA: Wadsworth Inc.

BALTES, P.B. & MAYER, U.K. 2001. **The ageing Berlin study**. Ageing from 70 to 100. UK: Cambridge University Press.

BARKER, R.L. 1987. **The Social Work Dictionary**. National Association of social workers. Maryland, USA.

BARKER R.L. 1999. **The social work dictionary** (4th ed.). Washington DC.: NASW Press.

BARNHART, C.L. & BARNHART, R.K. 1987. **The world book dictionary** (vol 1). Chicago: World Book Inc.

BEAUMONT, J.G. & KENEALY, P.M. 2004. Quality of life perceptions and social comparisons in healthy old age. **Ageing & Society**, 24:755-769.

BECKETT, J.O. & DUNGEE-ANDERSON, D. 2000. Older persons of colour. In: SCHNEIDER, R.L; KROPF, N.P. & KISOR, A.J. (Eds.). **Gerontological social work** (2nd ed.). Wadsworth: Brooks/Cole.

BENGSTIN, V., ROSENTHAL, C. & BURTON, L. 1997. Paradoxes of families. In: BINSTOCK, R.H. & GEORGE, L.K. **Handbook of ageing and the social sciences** (4th ed.). London: Academic Press.

BERG, S. 1996. Ageing, behaviour and terminal decline. In: BIRREN, J.E. (Ed.). **Handbook of the psychology of ageing** (4th ed.). USA: Academic Press.

BEZRUKOV, V.V. & FOIGT, N.A. 2004. The impact of transition on older people in Ukraine: Looking to the future with hope. In: LLOYD-SHERLOCK, P. (Ed.). **Ageing, development and social protection: generalisations, myths and stereotypes in living longer. Ageing, development and social protection**. UK: UNRISD Zed Books Ltd.

BLANE, D., WIGGINS, R., HIGGS, P. & HYDE, M. 2002. **Inequalities in quality of life in early old age.** Research Findings, 9. From the Growing Older Programme. Economic and Social Research Council. November 2002. Accessed from http://www.shef.ac.uk/ uni/projects/gop/ Blane_F9pdf on 13/12/2005.

BLANE, D., WIGGINS, R., HIGGS, P. & HYDE, M. 2004. Life course influences on quality of life in early old age. **Social Science & Medicine**, 58:2171-2179.

BLAZER, D.G., SACHS-ERICSON, N. & HYBELS, C.F. 2005. Perception of unmet basic needs a s a predictor of mortality among community dwelling older adults. **American Journal of Public Health**, 95(2):299–304.

BOWLING, A. & DIEPPE, P. 2005. What is successful ageing and who should define it? **British Medical Journal**, 331:1548–1551.

BOWLING, A. 2005. **Measuring health**. **A review of quality of life measurement scales** (3rd ed.). Berkshire: Open University Press.

BRAITHWAITE, D., MOGOTLANE, S., RODRIGUEZ, H., DORSEY, S., MANGONGO, R. & MATLAKALA, M. 2002. Elderly citizens perception of their health and care provided in a rural South African community. **ABNF Journal**, 13(2):37-40.

BREEZE, E., FLETCHER, A., WILKINSON, P. & GRUNDY, C. 2002. **Inequalities in Quality of life among people aged 75 and over**. Research findings 1. From the Growing older programme. Accessed from http:/wwwshef.ac.uk/uni/projects/gop/elisabethbreeze.htm on 13/12/2005.

BRODSKY, J. & BERG-WARMAN, A. 2006. **The supportive community: a programme to enhance the quality of life of the elderly in Israel**. (Article in press).

BROWN, K. & MATTHEWS, E. 2006. Careworn country. **Community Care**, 1617:34-35.

CANTOR, M. & LITTLE, V. 1985. Aging and social care**.** In: BINSTOCK, R.H. & SHANAS, E. (Eds.). **Handbook of ageing and the social science** (2nd ed.). New York: Van Nostrand Reinhold Company.

CARROLL, B. & WHELAN, T. 1994. Reflections on the Round Table. Positive ageing - the way forward. In: **Proceedings of Round Table. Theories of ageing and attitudes to ageing in Ireland.** Dr Stevens' Hospital, Dublin. 25th March, 1994. National Council for the Elderly. Publication No. 33.

CAVANAUGH, J.C. 1997. **Adult development and ageing** (3rd ed.). USA: Brooks/Cole Publishing Company.

CIMAROLLI, V.R., REINHARDT, J.P. & HOROWITZ, A. 2006. Perceived overprotection: support gone bad. **The Journals of Gerontology: Series B: Psychological Science and Social Sciences**, 61B(1):18.

CLARKE, L. & ROBERTS, C. 2004. The meaning of grandparenthood and its contribution to the quality of life of older people. In: WALKER, A. & HENNESSY, C.H. (Eds.). **Growing older. Quality of life in old age**. Berkshire: Open University Press.

CLOUGH, R., BRIGHT, L., LEAMY, M., MILLER, V. & BROOKS, L. 2003. **Housing decisions in old age. Briefing Paper 1**. Lancaster University, Dept of Applied Social Science in conjunction with Council Care. Retrieved from http://www.Counsiland care.org.uk/pdf/briefingpaper1.pdf on 26/02/2006.

CNAAN, R.A., BODDIE, S.C. & KANG, J.J. 2005. Religious congregations as social service providers for older adults. **Journal of Gerontological Social Work**, 45(1-20):105-130.

CRANSWICK, K. & THOMAS, D. 2005. Elder care and the complexities of social networks. **Canadian Social Trends**. Statistics Canada. Catalogue No. 11.008.

CUTLER, D., DEATON, A. & LLERAS-MURRAY, A. 2005. **The determinates of mortality.** Paper presented at workshop at Princeton, July 16, 2004. Accessed from http://www.princeton.edu/~rpds/downloads/cutler_deaton_lleras-muney_determinants_mortalitynberdec05.pdf on 22/06/2007.

DA CONCEICAO, C.G. & DE OCA ZAVALIA, V.M. 2004. Ageing in Mexico: families, informal care and reciprocity. In: LLOYD-SHERLOCK, P. (Ed.). **Living longer. Ageing, development and social protection**. UK: UNRISD. Zed Books.

DAVIDSON, K. & ARBER, S. 2004. Older men: Their health behaviours and partnership status. In: WALKER, A. & HENNESSY, C.H. (Eds.). **Growing older. Quality of life in old age**. Berkshire: Open University Press.

DE JONG GIERVELD, J., DE VALK, H. & BLOMMESTEIJN, M. 2001. Living arrangements of older persons and family support in more developed countries. In: **Living arrangements of older person. Special issue No's 42/43. United Nations Population Bulletin.** New York: United Nations Publication: 193-217.

DE VOS, A.S. 2005. **Qualitative data analysis and interpretation**. In: DE VOS, A.S., STRYDOM, H., FOUCHÉ, C.B. & DELPORT, C.S.L. 2005. **Research at grass roots - for the social sciences and human service professions** (3rd ed.). Pretoria: Van Schaik Publishers.

DENSCOMBE, M. 1999. **The good research guide for small-scale social research projec**ts. Buckingham: Open University Press.

DEPARTMENT OF SOCIAL DEVELOPMENT. n.d. **South African policy for older persons**. Department of Social Development. Republic of South Africa: 6-15

DEPARTMENT OF WELFARE AND POPULATION DEVELOPMENT. 1997. **White Paper on Social Welfare.** Government notice no. 1108, Government Gazette 386 (18166), 8 August, Pretoria: Government Printer.

DEPARTMENT OF WELFARE AND POPULATION DEVELOPMENT. 2003. **Older Persons' Bill.** Government Gazette No. 25347, 13 August, Pretoria: Government Printer.

DE VAUS, D.A. 1994. **Surveys in social research** (3rd ed.). Australia: Allen & Unwin Pty Ltd.

DONIN, H.H. 1991. **To be a Jew. A guide to Jewish observance in contemporary life**. Canada: Harper Collins.

DORFF, E.N. 2005. End of life: Jewish perspectives. **The Lancet**, 366(9488):862-865. Accessed from http://www.asu.edu/clubs/bioethics/jewish.pdf on 01/07/2006.

DUBB, A.A. 1994. **The Jewish Population of South Africa. The 1991 Socio-demographic survey**. Cape Town: Jewish Publications.

DUPERTUIS, L., ALDWIN, C.M. & BOSSE, R. 2001. Does the source of support matter for different health outcomes? Findings from the normative aging study. **Journal of Ageing Health**, 13(4):499-510. Accessed from http://www.hcd.ucdavis.edu/faculty/aldwin/support.pdf on 25/05/2006.

ERASMUS, J. & MANS, G. 2004. **Reports on the Demographic Profiles of Milnerton and Surrounds.** Unit for Religion and Developmental Research, University of Stellenbosch.

FAKOURI, C. & LYON, B. 2005. Perceived health and life satisfaction among older adults. The effects of worry and personal variables. **Journal of Gerontological Nursing**, 31(10):17-24.

FILIPP, S.-H. 1995. Motivation and emotion. In: BIRREN, J.E. & SCHAIE, K.W. (Eds.). **Handbook of the psychology of ageing** (4th ed.). San Diego: Academic Press: 218-315.

FOUCHE, C.B. & DELPORT C.S.L. 2005. **Introduction to the research process**. In: DE VOS, A.S., STRYDOM, H., FOUCHÉ, C.B. & DELPORT, C.S.L. 2005. **Research at grass roots - for the social sciences and human service professions** (3rd ed.). Pretoria: Van Schaik Publishers.

FOUCHE, C.B. & DE VOS, A.S. 2005. **Problem formulation**. In: DE VOS, A.S., STRYDOM, H., FOUCHÉ, C.B. & DELPORT, C.S.L. 2005. **Research at grass roots - for the social sciences and human service professions** (3rd ed.). Pretoria: Van Schaik Publishers.

FRANKLIN, C. & BALLAN, M. 2005. Reliability and validity in qualitative research. In: GRINNELL, R.M. Jr. & UNRAU, Y.M. (Eds.). **Social work research and evaluation. Quantitative and qualitative approaches** (7th ed.). Oxford: Oxford University Press: 445.

FROMME, E.K., DRACH, L., TOLLE, S.W., EBERT, P., MILLER, P., PERRIN, N. & TILDEN, V.P. 2005. Men as caregivers at the end of life. **Journal of Palliative Medicine**, 8(6):1167-1175.

GABRIEL, Z. & BOWLING, A. 2004. Quality of life in old age from the perspectives of older people**.** In: WALKER, A. & HENNESSY, C.H. (Eds.). **Growing older. Quality of life in old age**. Berkshire: Open University Press.

GARDINER, M. 2006. Divorce's shadow: when older parents need help. **Christian Science Monitor**, 98(95):13-14.

GILROY, R., KELLETT, P. & JACKSON, S. 2004. **Contrasting living arrangements for older people**. Paper presented at the ENHR Conference 2-6 July 2004, Cambridge: University of Cambridge.

GRINNELL, R.M. Jr. 1985. **Social work research and evaluation** (2nd ed.). Australia: FE Peacock Publishers.

GRINNELL, R.M. Jr. 1997. **Social work research and evaluation** (4th ed.). Australia: FE Peacock Publishers.

GRINNELL, R.M. Jr., TUTTY, L. & WILLIAMS, M. 2005. The quantitative research approach In: GRINNELL, R.M. Jr. & UNRAU, Y.M. (Eds.). **Social work research and evaluation. Quantitative and qualitative approaches** (7th ed.). Oxford: Oxford University Press: 354-360.

GUTTMANN, D. 2001. A logotherapeutic approach to the quest for meaningful old age. **Social Thought**, 20(3/4):117-128.

HALL, I. & HALL, D. 2004. **Evaluation and social research**. **Introducing small-scale practice.** New York: Palgrave Macmillan.

HALL, M. & HAVENS, B. 2002. Social isolation and social loneliness. In Writings in Gerontology (18) **Mental Health and Ageing.** Oct 2002. National Advisory Council on Ageing. Canada. Retrieved from http://www.naca-centa.ca/writings_gerontology/writ18/writ18_e.htm on 04/02/2006.

HARRIGAN, M.P. & FARMER, R.L. 2000. The myths and facts of ageing. In: SCHNEIDER, R.L., KROPF, N.P. & KISOR, A.J. (Eds.). **Gerontological social work** (2nd ed.). Canada: Wadsworth. Brooks/Cole.

HARRIS, T., COOK, D.G., VICTOR, C., DeWILDE, S. & BEIGHTON, C. 2005. Onset and persistence of depression in older people – results from a 2-year community follow-up study. **Age and Ageing**, 35(1):25-32.

HELPAGE INTERNATIONAL. 2002. **State of the world's older people 2002.** HelpAge International, London.

HELPAGE INTERNATIONAL. 2007. **Opening eyes to AIDS care in Africa.** Till C & Scobie J. Ageways (Eds.). Issue 68. February 2007. HelpAge International, London.

HIRST, J. 2000. **And who will wipe your bottom?** New Statesman. 06 March 2000. Kampfner J. (Ed.). Accessed http://www.newstatesman.com/200003060012 on 29/06/2007

INGERSOL-DAYTON, B., NEAL, M.B. & HAMMER, L.B. 2003. Collaboration among siblings providing care for older parents. **Journal of Gerontological Social Work**, 40(3):51-66.

ISRAEL, S. n.d. **The ageing process: Late life questions.** In: The Jewish Life Cycle. The Pedagogic Centre. The Dept for Jewish Zionist Education. The Jewish Agency for Israel. Jerusalem, 2002-4. http://www.jewishagency.org/JewishAgency/English+Education/Compelling+Content/Jewish+Time/Life+Cycle/Jlc/06-17.html+31.htm#16 on 01/07/2006

KAHANA, B., KAHANA, E. & KERCHER, K. 2003. Emerging lifestyles and proactive options for successful ageing. **Ageing International**, 28(2):155-180.

KAPLAN, M. 2006. **The future of South African Jewry – Comments and observations.** Cape Town: University of Cape Town.

KENNEDY, A. & HAMILTON, S. 2005. The evidence on quality of life for older people. **Nursing Times**, 10(42):36-37.

KIETH, J. 1985. Age in anthropological research in Handbook of ageing and the social sciences. In: BINSTOCK, R.H. & SHANAS, E. (Eds.). **Handbook of ageing and the social science** (2nd ed.). New York: Van Nostrand Reinhold Company.

KINSELLA, K. & FERREIRA, M. 1997. **Ageing trends: South Africa.** Bureau of the Census, USA. 1B/97-2 Washington, DC: US Government Printing Office.

KINSELLA, K. & PHILLIPS, D.R. 2005. Global ageing: the challenge of success. United Nations. **Population Bulletin**, 60(1):3-40.

KINSELLA, K. & VELKOFF, V. 2001. **An Ageing World: 2001**. Bureau of the Census, USA. Series p95/01-1. Washington, DC.: US Government Printing Office.

KIRK, A.B. & ALESSI, H.D. 2000. Senior service centres: A comparison of affiliated and non-affiliated participants. **Adultspan**, 2(2):89-100.

KORNBLUM, J. 2006. Ill spouse can hasten death. **USA Today**, 02/16/2006.

KOSMIN, B.A., GOLDBERG, J., SHAIN, M. & BRUK, S. 1999. **Jews of the 'new South Africa': highlights of the 1998 national survey of South African Jews**. JPR Report No 3 September 1999. Institute for Jewish Policy Research, London.

KRAUSE, N. 2006. Exploring the stress buffering effects of church-based and secular social support on self related health in later life. **Journal of Gerontology Social Sciences**, 61b(1):35-43.

KROPF, N.P. 2000. Home health and community services. In: SCHNEIDER, R.L., KROPF, N.P. & KISOR, A.J. (Eds.). **Gerontological Social Work** (2nd ed.). Canada: Wadsworth. Brooks/Cole.

LAM, R.C. 2006. Contradictions between traditional Chinese values and the actual performance: a study of the caregiving roles of the modern sandwich generation in Hong Kong. **Journal of Comparative Family Studies**, 37(2):299-313.

LAUER, R.H. 1989. **Social problems and the quality of life** (4th ed). USA: Wim C. Brown.

LECOVICH, E., BAREASCH, M., MIRSKY, J. & KAUFMAN, R. 2004. Social support networks and loneliness among elderly Jews in Russia and Ukraine**. Journal of Marriage and Family**, 166(2):306. Accessed from http://proquest.umi.com.ez.sun.ac.za/pqdweb?index=6&did= 63797 on 5/16/2006.

LEE, H. 2004. Age group differences in the effect of intergenerational relationships on social support exchanges with adult children among older adults. **The Gerontologist**, 44(1):182.

LEESON, G.W. 2003. **Changing families as societies age: care, independence and ethnicity**. Working Paper Number WP503. Oxford Institute of Ageing, University of Oxford. August 2003. Oxford Institute of Ageing Working Papers. Available: www.ageing.ox.ac.uk.

LEGARE, J., IBRAHIMA, M., SOSSA, O. & SMUGA, O. 2003. **Population ageing: a challenge for developing countries**. International Federation on ageing. University of Montreal. Retrieved from www.ifa-fw.org/docs/PopulationAgeing20021.doc on 9/10/2006.

LI, L.W. 2004. Caregiving network compositions and use of supportive services by community – dwelling dependant elders. **Journal of Gerontological Social Work**, 43(2/3):147-164.

LIEBLER, C.A. & SANDEFUR, G.D. 1998. **Exchanging social support with friends, neighbours and co-workers.** Center for Demography and Ecology. University of Wisconsin-Madison. CDE Working Paper No. 98-19. USA.

LLOYD-SHERLOCK, P. 2004. Ageing, development and social protection: generalisations, myths and stereotypes**.** In: LLOYD-SHERLOCK, P. (Ed.). **Living longer. Ageing, development and social protection**. UK: UNRISD Zed Books Ltd.

MADDOX, G.L. & CAMPBELL, R.T. 1985. Scope, concepts, and methods in the study of ageing. In: BINSTOCK, R.H. & SHANAS, E. (Eds.). **Handbook of ageing and the social science** (2nd ed.). New York: Van Nostrand Reinhold Company.

MALAYSIA NEWS: "**Raising the retirement age**," by Elayne Yee Siew Lin (_The Star_ [Kuala Lumpur], September 19, 2005). Note: This article is a commentary. http://biz.thestar. com.my/news/story.asp?file=/2005/9/19/business/12034421&sec=business.

MARK, R. 1996. **Research made simple. A handbook for social workers**. USA: Sage Publications.

MARKIDES, K.S. & BLACK, S.A. 1996. Race, ethnicity and ageing. In: BINSTOCK, R.H. & GEORGE, L.K. **Handbook of ageing and the social sciences** (4th ed.). London: Academic Press.

MASLOW, A.H. 1943. A theory of human motivation. Originally published in **Psychological Review**, 50:370-396. In: **Classics in the history of psychology**. An internet resource developed by Green C.D. Toronto: York University. Retrieved from http://psycho classicas.yoku.ca/ Maslow/motivation.htm on 30/01/2006.

MIRKIN, B. & WEINBERGER, M.B. 2001. The demography of population ageing. In Living Arrangements of older persons: critical issues and policy responses. **Population Bulletin of the United Nations** (Special Issues) 42/43. New York: United Nations Publications.

MOLLER, V. & FERREIRA, M. 2003. **Getting by ... Benefits of non-contributory pension income for older South African households**. Institute of Ageing in Africa, University of Cape Town.

MOODY, H.R. 2004. Structure and agency in late-life learning. In: TULLE, E. (Ed.). **Old age and agency**. New York: Nova Science Publishers.

MORIARTY, J. & BUTT, J. 2004. Social support and ethnicity in old age. In: WALKER, A. & HENNESSY, C.H. (Eds.). **Growing older. Quality of life in old age**. Berkshire: Open University Press: 168.

MOUTON, J. 2004. **How to succeed in your masters' and doctoral studies. A South African Guide and resource guide**. Pretoria: Van Schaik Publishers.

MUTRAN, E.J. & REITZES, D.C. 2000. Friendship and social support. The importance of role identity to ageing adults. In: KEIGHER, S.M., FORTUNE, A.E. & WITKIN, S.L. (Eds.). **Ageing and social work. The challenging landscapes**. Washington DC: NASW Press.

NALEPPA, M.J. & REID, W.J. 2003. **Gerontological social work. A task-centred approach**. New York: Columbia University Press.

NAZROO, J., BAJEKAL, M., BLANE, D. & GREWAL, I. 2004. Ethnic inequalities. In: WALKER, A. & HENNESSY, C.H. (Eds.). **Growing older. Quality of life in old age**. Berkshire: Open University Press.

NELSON–BECKER, H. 2005. Religion and coping in older adults: a social work perspective. **Journal of Gerontological Social Work**, 45(1/2):55-67.

NENO, R. 2004. Spouse caregivers and the support they receive: a literature review. **Nursing Older People**, 16(5):14-15.

OZAWA, M.N. & HONG, B.-E. 2003. Disability and economic well being in old age. **Journal of Disability Studies**, 13(4):231-243.

PALLONI, A. 2001. Living arrangements in older persons. In Living arrangements of older persons. **Population Bulletin of the UN**, 42/43. New York.

PALMORE ERDMAN, B. (Ed.). 1993. **Developments and research on ageing**. An International Handbook. London: Greenwood Press.

PEARLIN, L.I., ANESHENSEL, J.T., MULLAN, J.T. & WHITLASH, C.J. 1997. Caregiving and its social support. In: BINSTOCK, R.H. & GEORGE, L.K. (Eds.). **Handbook of ageing and the social sciences** (4th ed.). London: Academic Press: 283-302.

PENG, D. & PHILLIPS, D.R. 2004. Potential consequences of population ageing for social development in China. In: LLOYD-SHERLOCK, P. (Ed.). **Living longer. Ageing, development and social protection**. UK: UNRISD Zed Books Ltd.

PERLMUTTER, M. & HALL, E. 1992. **Adult development and ageing** (2nd ed.). New York: John Wiley and Sons.

POPULATION DATA SHEET. 2004. Population Reference Bureau. Retrieved from www.prb.org/pdf04/04WorldDataSheet_eng.pdf on 11/08/2005.

POPULATION REFERENCE BUREAU. 2004. Retrieved from http://www.prb.org/TemplateTop.cfm?section=PRB_Country_Profiles+template/source/countryprofile/countryprofile display. cfmCountry=337 on 28/08/2005.

QURESHI, H. 1990. Social support. In: PEACE, S.M. (Ed.). **Researching social gerontology. Concepts, methods and issues.** London: Sage Publications: 32-45.

RAMASHALA, M.F. 2001. Living Arrangements, poverty and the health of older persons in Africa. In Living Arrangements of older persons: critical issues and policy responses. **Population Bulletin of the United Nations** (Special Issues) 42/43. New York: United Nations Publications.

RAND ORGANISATION. 2005. **Preparing for an ageing world**. Retrieved from hhttp://www.rand.org/publications/RB/RB5058?index.html on 23/07/2005.

RAPPAPORT, S. 1982. **Some Jewish thoughts on old age**. Jewish Affairs. South African Board of Deputies, Johannesburg.

REAMER, F.G. 1998. **Social work research and evaluation skills**. A case based, user-friendly approach. New York: Columbia University Press.

ROWE, J.W. 2005. **The new gerontology: implications and strategies for an ageing society**. 2005 Annual meeting of the Gerontology Society of America. Accessed from www.geron.org/AnnualMeeting/OpeningTalk,2005.pdf on 12.05.2005.

RUBIN, A. & BABBIE, E. 1993. **Research methods for social work** (2nd ed.). Pacific Grove, California: Brooks-Cole.

SCHARF, T., PHILLIPSON, C. & SMITH, A.E. 2004. Poverty and social exclusion – growing older in deprived urban neighbourhoods. In: WALKER, A. & HENNESSY, C.H. (Eds.). **Growing older. Quality of life in old age**. Berkshire, UK: Open University Press.

SCHNEIDER, R.L., KROPF, N.P. & KISOR, A.J. (Eds.). **Gerontological social work** (2nd ed.). Canada: Wadsworth: Brooks/Cole.

SCHRODER-BUTTERFILL, E. & MARIANLI, R. 2006. A framework for understanding old–age vulnerabilities. **Ageing and Society**, 26(1):9-35.

SEGRIN, C. 2003. Age moderates the relationship between social support and psychosocial problems. **Human Communication Research**, 29(3):317-342.

SEROW, W.J. 1991. Patterns of rural-urban migration among the elderly. In: UNITED NATIONS **Ageing and Urbanisation**. Proceedings of the United Nations International Conference on Ageing Populations in the context of Urbanisation. Sendai (Japan), 12-16 September 1988. New York: 186-202.

SHEAFOR, R.W., HOREJSI, C.R. & HOREJSI, G.A. 2000. **Techniques and guidelines for social work practice**. London: Allyn & Bacon.

SHERIDAN, M.J. & KISOR, A.J. 2000. The research process and the elderly. In: SCHNEIDER, R.L; KROPF, N.P. & KISOR, A.J. (Eds.). **Gerontological social work** (2nd ed.). Wadsworth: Brooks/Cole.

SIEBERT, D.C., MUTRAN, E.J. & REITZES, D. 2000. Friendship and social support. The importance of role identity to ageing adults. In: KEIGHER, S.M., FORTUNE, A.E. & WITKIN, S.L. (Eds.). **Age and social work. The changing landscapes**. Washington, DC: NSAW Press.

SIMMONS, T. & DYE, J.L. 2003. **Grandparents living with grandchildren: 2000 Census.** Brief C2KBR-31, U.S. Census Bureau: Washington, DC. 10p. Accessed from http://www.census.gov/prod/2003pubs/c2kbr-31.pdf on 23/06/2007.

SMITH, J.A. 2000. **Ontario family councils programme. Research on family councils**. Retrieved from http://www.familycouncils.net/2000lit.html on 17/5/2006.

STATISTICS SOUTH AFRICA. 1996. Population **Census 1996 by province, gender, religion and population group.** Retrieved from http://www.statssa.gov.za/census01/Census96/HTML/default.htm on 06/07/2007.

STATISTICS SOUTH AFRICA. 2001a. **Census 2001: Age, gender, and population per province**. Retrieved from http://www.statssa.gov.za/extract.htm on 25/05/2005.

STATISTICS SOUTH AFRICA. 2001b. **Census 2001: Gender, religion and population as per province and district council. Judaism**. Retrieved from http://www.statssa.gov.za/extract.htm on 27/05/2005.

STATISTICS SOUTH AFRICA. 2001c. **Census 2001 Geography by age for person weighted, Judaism**. Space–Time Research Web Page. (Reports produced by Mans, G. 2004 and Mostert, V. 2007).

STATISTICS SOUTH AFRICA. 2001d. **Census 2001 Geography by age group for person weighted, Judaism.** Space–Time Research Web Page. (Reports produced by Mans, G. 2004 and Mostert, V. 2007).

STATISTICS SOUTH AFRICA. 2001e. **Census 2001 Geography by gender for person weighted, Judaism.** Space–Time Research Web Page. (Reports produced by Mans, G. 2004 and Mostert, V. 2007).

STATISTICS SOUTH AFRICA. 2001f. **Census 2001: For Jewish faith/Hebrew, person weighted per province per age**. Retrieved from http://www.statssa. gov.za/extract.htm on 18.06.2007.

STATISTICS SOUTH AFRICA. 2004. **Bulletin of Statistics** 38(2). Statistics SA, Pretoria.

STATISTICS SOUTH AFRICA. 2005a. **Mid-year population estimates, South Africa 2005**. Retrieved from http://www.statssa.gov.za on 24/08/2005.

STATISTICS SOUTH AFRICA. 2005b. **Census 2001. By province, age groups, population group and gender. New demarcation. December 2005**. Retrieved from http://www.statssa.gov.za on 24/07/2007.

STEIN, Y. 1986. **The challenges of meeting the future needs of the elderly in an aging and shrinking Jewish community**. Cape Town: South Africa. Rough Draft.

STEPHENS, R.C., BLAU, Z.S., OSER, G.T. & MILLAR, M.D. 1979. Ageing, social support systems and social policy. **Journal of Gerontological Social Work**, 1(1):33-45.

STONE, W. 2003. **Ageing, social capital and social support. Submission to the House of Representatives Committee on Ageing. Inquiry into long term strategies to address the ageing of the Australian population.** Australian Institute of Family Studies.

STRYDOM, H. 2005a. **Sampling and sampling methods**. In: DE VOS, A.S., STRYDOM, H., FOUCHÉ, C.B. & DELPORT, C.S.L. **Research at grass roots - for the social sciences and human service professions** (3rd ed.). Pretoria: Van Schaik Publishers.

STRYDOM, H. 2005b. **The pilot study**. In: DE VOS, A.S., STRYDOM, H., FOUCHÉ, C.B. & DELPORT, C.S.L. **Research at grass roots - for the social sciences and human service professions** (3rd ed.). Pretoria: Van Schaik Publishers.

STUBB, H.R. 1982. **The social consequence of long life.** Springfield, Illinois: Charles C. Thomas.

TAYLOR, A.R., SYLVESTRE, J.C. & BOTCHNER, J.V. 1998. Social support is something you do, not something you provide: implications for linking formal and informal support. **Journal of Leisurability**, 25(4). Accessed from http://www.lin.ca/resource/html/Vol25/V25N4A2.htm on 29/4/06.

TERRE BLANCHE, M. & DURRHEIM, K. (Eds.). 2002. **Research in practice. Applied methods for the social sciences**. Cape Town: University of Cape Town Press.

UK NEWS. 2005. "**Retirement at 67 to be considered by ministers**," by Ben Hall (Financial Times, September 19). Available: http://news.ft.com/cms/s/1bfed8ae-28aa-11da-97c7-00000 e2511c8.html.

UK NEWS. 2006. **"Warning of £150bn black hole in pensions**," by Norma Cohen Financial Times, January 9). Available: http://news.ft.com/cms/s/d7446f2c-80b4-11da-8f9d-0000779 e2340.html.

UNFPA. 1994. **Population growth and structure – elderly people. Programme of action of the international conference on population and development.** Cairo. Paragraph 6.16-6.20. Accessed from http://www.unfpa.org/ icpd/icpd_poa.htm#ch6c on 21/05/06.

UNFPA. 1998. UN report on **Population Ageing: Background Review.** Retrieved from http://www.unfpa.org/icpd5/meetings/brussels_ageing/reports/ageing.pdf on 26/08/2005.

UNITED NATIONS (UN). 1991a. **Ageing and Urbanisation**. Proceedings of the United Nations International Conference on Ageing Populations in the context of Urbanisation. Sendai (Japan), 12-16 September 1988. New York: 10.

UNITED NATIONS (UN). 1991b. UN Secretariat, Population division, Dept of international Economic and Social Affairs **Global perspective on population ageing in the context of**

urbanisation. In Ageing and Urbanisation. Proceedings of the United Nations International Conference on Ageing Populations in the context of Urbanisation. Sendai (Japan), 12-16 September 1988. New York: 55-80.

UNITED NATIONS (UN). 1991c. **United Nations principles for older persons**. Division for social policy and development. Retrieved from www.un.org/esa/socdev/iyop/ yoppop.htm on 19/09/2005.

UNITED NATIONS (UN). 2002. **Madrid plan of action on ageing**. Report on the Second World Assembly on Ageing 2002. Retrieved from www:http//file://A:\Report of the Second World Assembly on Ageing.htm on February 10, 2005.

UNITED NATIONS (UN). 2005. **World Population Prospects**. The 2004 revision population database. UN population division. Retrieved from http://esa.un.org/unpp/ p2k0data.asp on 11/08/2005.

UNITED NATIONS (UN). 2006. International day of older persons. 1 October 2006. A/CONF.197/9. Retrieved from http://www.un.org/events/olderpersons/2006/ background. html on 10/10/2006.

UNITED NATIONS RESEARCH INSTITUTE FOR SOCIAL DEVELOPMENT. 2004. **Living longer. Ageing, development and social protection**. (Ed.). UK: Zed Books Ltd.

VICTOR, C.R., SCAMBLER, S.J., BOND, J & BOWLING, A. 2004. Loneliness in later life. In: WALKER, A. & HENNESSY, C.H. (Eds.). **Growing older. Quality of life in old age**. Berkshire: Open University Press: 107-126.

WAN, T.T.H., ODELL, B.G. & LEWIS, D.T. 1982. **Promotion of well being in the elderly. A community diagnosis.** New York: Hawthorne Press.

WELSH-BOHMER, K. 2006. Ten dimensions of health and their relationships with overall self-reported health and survival in a predominately religiously active elderly population: the Cache County memory study. **Journal of American Geriatric Society**, 54:199-209.

WENGER, C.G. 1984. **The supportive network. Coping with old age**. London: George Allen & Unwin.

WENGER C.G. 1995. A comparison of urban and rural networks: Liverpool and Northwales. **Ageing and Society**, 15(1):59-81.

WILLIAMS, M., TUTTY, L.M. & GRINNELL, R.M. 1995. **Research in social work: an introduction** (2nd ed.). Itasca, Ill.: Peacock.

WINDLE, G. & WOODS, R.T. 2004. Variations in subjective wellbeing: the mediating role of psychological resource**. Ageing and Society**, 24:583-602.

WITKIN, S.L. 2000. How ripened are you. In**:** KEIGHER, S.M., FORTUNE, A.E. & WITKIN, S.L. (Eds.). **Aging and social work**. Washington, DC: NASW Press: 24.

WORLD HEALTH ORGANISATION (WHO). 1999. **A life course perspective of maintaining independence in old age**. Geneva.

WORLD HEALTH ORGANISATION (WHO). 2000. **Information needs for research, policy and action on ageing and older adults in Africa.** Report of a workshop on creating a minimum data set for research, policy and action on ageing and the aged in Africa. Harare, Zimbabwe 20-22 January 2002. HelpAge International.

WORLD HEALTH ORGANISATION (WHO). 2002. **Active ageing: A policy framework**. A Contribution to the 2nd UN World Assembly on Ageing, Madrid, Spain, April 2002. Geneva.

WORLD HEALTH ORGANISATION (WHO). 2004. **International Plan of Action on Ageing: report on implementation**. Executive Board, 115th Session.

WORLD POPULATION PROSPECTS. 2004. **The 2004 revision population database.** Table 5. Retrieved from http://esa.un.org/unpp/p2k0data.asp on 28/08/2005.

YEGIDIS, B.L. & WEINBACH, R.W. 1991. **Research methods for social workers**. New York: Longman.

ZODIKOFF, B. 2003. Understanding older spousal dyads attitudes towards community service use: An analysis of applied theoretical models. **Journal of Gerontological Social Work**, 39(3):3-31.

ADDENDUM A

CONSENT FORM

Research project: a survey of the social support systems and quality of life indicators of Jewish senior citizens in Milnerton and surrounds.

Statement by member

I, the undersigned, ____

(ID___________________________) of____________________________________

____(address)

A I confirm that:

1. I was invited to take part in the above mentioned research project that is being conducted by the Department of Social Work of the University of Stellenbosch in co-operation with Cape Jewish Seniors Association, Milnerton and with permission of the Executive of Cape Jewish Seniors Association.

2. It has been explained to me that:

   2.1 The purpose of the study is to collect information regarding the social support systems of Jewish seniors who were members of CJSA, Milnerton during 2006 in order to provide guidelines for social work intervention.

   2.2 The information will be collected through the completion of a questionnaire by the researcher during an interview conducted with me.

   2.3 Thirty members will be included in the study and that only one interview will be necessary.

3. The collected information will be treated as confidential, but that the findings will be presented in a thesis and as such will be in the public domain.

4. I can obtain the results of this research from the researcher after the project has been concluded.

5. I have been informed of my right to refuse participation in the study and that participation in the project may be terminated at any time without penalty or prejudice to myself. I also understand that the researcher may cancel my participation in the study if he/she considers it to be in my own interest.

6. The above-mentioned information was explained to me and I have been presented with the opportunity to ask questions and that the questions were answered to my satisfaction.

B Please contact Sue Parton, Tel: 555 1736/ 797 4278, if you have any questions about this research project or your participation in it.

C Your signature below indicates:

1. That you have agreed to participate in the above-mentioned study.
2. That you have read this information provided in this form and understood the contents.
3. A copy of this signed consent form will be given to you for your own keeping.

Signed by ____________________________on ____________________________2007

____
Signature

STATEMENT BY RESEARCHER

I, ____, declare that I have:

1. Explained the information contained in this document to ________________
2. Requested him/her to ask for further explanation if anything was unclear.
3. Conducted this discussion in English.

Signed by ____________________________on ____________________________2007

____
Signature

ADDENDUM B

UNIVERSITY OF STELLENBOSCH

DEPARTMENT OF SOCIAL WORK

QUESTIONNAIRE

THE SOCIAL SUPPORT SYSTEMS AND QUALITY OF LIFE INDICATORS OF JEWISH SENIORS LIVING IN MILNERTON AND SURROUNDS

All the information recorded in the questionnaire will be regarded as confidential and respondents names will not be made known. However, the results of this research will be in the public domain.

IDENTIFYING INFORMATION

Questionnaire number: ____________________

Place of interview: ____________________

Date of interview: ____________________

Time of interview: ____________________

Name of interviewee: (optional) ____

(The appropriate boxes are to be ticked where required)

DEMOGRAPHICS

1. Gender

Male	
Female	

2. What is your current marital status?

Never married	
Married	
Widowed	
Divorced	
Living with a partner	
In a relationship but not living with the partner (LAT)	

3. Does your age fall between?

60-69	
70-79	
80+	
If 80+ please give your age	

4. Where were you born? ______________________________

5. Where did spend your childhood years? ______________________

6. Where did you spend most of your adult years? ________________

7. How many children do you have? ___________________________

8. Where do your children live? ______________________________

____

9. What is your highest level of education?

CJSA

1. How long have you been a member of CJSA, Milnerton? ____________

2. How often do you attend CJSAM?

More than once per week	
Once a week	
Once a month	
Never	

3. Do you volunteer at CJSA? ______

4. If so in what capacity?

____

____

5. CJSA, Milnerton important is to me.

Agree	
Disagree	
Uncertain	

6. If "AGREE", can you explain why CJSAM is important to you?

____

RELIGION

1. What is your religious affiliation?

Orthodox	
Reform	
Secular	
Other	
None	

2. How often do you attend services?

More than once per week	
Once a week	
Only on High Holy Days	
Never	

3. What role does religion play in your life?

____

____

____

4. Has your faith become more or less important to you as you have become older? Why? (write which one)

____

____

____

____

____

3. Other than the spiritual aspect of attending Shul, do you consider Shul as a place where you can meet new friends?

Yes	
No	
Uncertain	

4. If “YES”, have you made meaningful friendships at the Shul you attend?

Yes	
No	
Uncertain	

AREA OF RESIDENCE

1. Which suburb do you live in? ____

2. How long have you lived in this suburb? ________________________________

3. How long have you lived in your current place of residence? _______________

4. Do you have family members that live in the same suburb as you? If "YES" which family members live in the same suburb as you?

Mother					
Father					
Children		How many		Position in family	
Siblings		Brothers		Sisters	
Other					

If "NO" which family members live in Cape Town?

Mother					
Father					
Children		How many		Position in family	
Siblings		Brothers		Sisters	
Other					

5. Why did you move to this suburb?

____

____

____

____

6. Where did you live immediately before moving to this suburb?

____

Why did you leave?

____

____

____

ACCOMMODATION

1. Do you live in a retirement village?

Yes	
No	

2. If "YES", how easy was it to make friends?

Very easy	
Easy	
Difficult	
Very difficult	
Uncertain	

3. Why do you think it was like this?

____

____

____

4. In what type of accommodation do you live?

Flat	
House	
Room	

Other ______________________

5. Do you RENT or OWN the residence where you are currently living?

Rent	
Own	

6. If you "RENT", have you ever owned your own property?

Yes	
No	

7. Are you happy living where you are at present?

1	Very happy	
2	Content	
3	Very unhappy	
4	Uncertain	

8. In response to the statements below, please answer Strongly Agree = SA, Agree = A, Disagree = D, Strongly Disagree = SD, Undecided = U.

If I had a choice …

	SA	A	D	SD	U
I would prefer to live in a house by myself					
I would prefer to live in a house with a partner					
I would prefer to live with my children & family					
I would prefer live with friends					
I would prefer to live with strangers					
I would prefer to live in a retirement village with frail care					
I would prefer to live in an old age home					

LIVING ARRANGEMENTS

1. Who do you live with?

Alone	
Spouse	
Partner	
Adult son/daughter	
Grandchildren (stipulate gender)	
Friend	

Other ______________________________

2. Who is head of the household? ______________________________

3. If you share accommodation with someone other than your spouse, who

- pays for the groceries? ______________________________
- pays the bond/rent? ______________________________
- does the housework? ______________________________
- does the cooking? ______________________________
- keeps you company the most? ______________________________

4. If you share accommodation with an adult child and/or your grandchildren, do you:

	OFTEN	SOMETIMES	NEVER
Help take the grandchildren to school			
Supervise their homework			
"Babysit" the grandchildren			
Pay for groceries			
Cook meals for the family			

Other ______________________________

5. I am satisfied with my present living arrangements?

Agree	
Disagree	
Uncertain	

6. What do you most like about sharing accommodation with your adult child and grandchild(ren)?

____

____

7. What do you like least about sharing accommodation with your adult child and grandchild(ren)?

____

____

8. If you had a choice, who would you live with?

Spouse	
Alone	
Adult son/daughter and/ grandchildren	
Partner	
Friend	

Other ____

9. What is the reason for your choice

____

____

NEIGHBOURHOOD

1. In response to the statements below, please answer Strongly Agree = SA, Agree = A, Disagree = D, Strongly Disagree = SD, Undecided (U).

	SA	A	D	SD	U
I live in a good neighbourhood					

____

____

	SA	A	D	SD	U
I feel safe where I live					

____

____

	SA	A	D	SD	U
The neighbourhood is suitable for older people					

____

____

	SA	A	D	SD	U
I am very attached to my neighbourhood					

____

____

2. What is your main means of transport?

I drive my own car	
I use public transport	
Someone drives me	

Other ____

3. If you do not drive, is the buss stop within walking distance?

Yes	
No	

Comment ____

____

4. How accessible are public amenities such as the shops and medical facilities?

____

____

____

____

5. If you do not drive, how safe do you feel walking to the bus stop?

Very safe	
Safe	
Not at all safe	
Undecided	

6. I have a good relationship with my neighbours.

Agree	
Disagree	
Undecided	

7. I can depend on my neighbours when I need help.

Agree	
Disagree	
Undecided	

8. My neighbours can depend on me when they need help.

Agree	
Disagree	
Undecided	

9. I think of my neighbours as friends.

Agree	
Disagree	
Undecided	

10. Give an example of how you recently helped a neighbour.

____

____

11 Give an example of how a neighbour recently helped you.

____

____

____

QUALITY OF LIFE

1. How would you rank your quality of life?

1	Very good	
2	Fair	
3	Poor	

2. Why do you feel this way?

____

____

____

____

3. Please respond to the following statements A = Agree, D= Disagree U = Uncertain.

Please comment on your answer.

	A	D	U
Leading an active social life is important to my QOL			

____

	A	D	U
Having hobbies is important to my QOL			

____

	A	D	U
Having good health is important to my QOL			

____

	A	D	U
Being financially secure is important to my QOL			

____

	A	D	U
Being independent is important to my QOL			

____

4. What has helped you to face the negative changes of ageing (e.g. any form of loss such as health, bereavement, finances etc.)?

____

____

5. If you no longer drive, can you describe how this effects you?

____

____

____

SOCIAL SUPPORT

1. My friendships are very important to me.

Agree	
Disagree	
Undecided	

2. How many very close/special friends have you? ____________________________

3. How many times did you contact them during the last week?

Once a week	
2-3 times per week	
Every day	

4. Is your closest friend a relative?

Yes	
No	

5. If "YES" state relationship ___________________________

6. If someone other than your spouse, how many times have you had contact with them this week?

____

7. If "NO" have you got a close friend that lives near by?

Yes	
No	

8. Who do you have the most meaningful relationship with?

____

____

9. Who do you consider your closest confidant?

____

10a. If you ever need help or needed help with any activities of daily living, who do you think is MOST LIKELY to help you?

	Spouse	Son	Daughter	Neighbour	Friend	Other (State)
Lift						
Shopping						
House cleaning						
Cooking						
Laundry						
Walking						
Dressing yourself						
Bathing						
Washing your hair						
Use of the toilet						

10b. Asking the same question, who would you PREFER to help you with activities of daily living?

	Spouse	Son	Daughter	Neighbour	Friend	Other (State)
Lift						
Shopping						
Cleaning the house						
Cooking						
Laundry						
Walking						
Dressing yourself						
Bathing						
Washing your hair						
Use of the toilet						

10c. Do you employ a domestic worker?

Yes	
No	

10d. If "YES", to what extent are you dependant on her assistance?

Very dependant	
Dependant	
Not at all dependant	

Other ____

11. Who would you most likely turn to for the following?

	Spouse	Son	Daughter	Neighbour	Friend	Other (State)
Emotional support						
Financial advice						
Advice on medical matters						
Advice on moving to a home						

12. During the last year, have you made use of any of the following social welfare services for advice or counselling?

	Y	N
CJSA, Milnerton		
Jewish Community Services		
Nechama		
Highlands House		
Glendale		
Rabbi		

Any support groups ____

____

Other ____

____

13. If "YES" to any of the above, please rank how successful they were in helping you.

1	Good	
2	Fair	
3	Poor	

14. Generally speaking, if you needed to use any of the social services offered in the Jewish community, would you find it easy to get to these organisations?

Yes	
No	
Uncertain	

SOCIAL CONTACT

1. I have a strong sense of belonging.

Agree	
Disagree	
Uncertain	

2. How many times in the last week have you visited: (ED = Every Day; FT = Few Times)?

	ED	FT	1	0	NA
Neighbours					
Shul					
Friends					
Adult children					
Other relatives					
CJSA					

3a. Are you computer literate?

Yes	
No	

3b. How many times last week did you communicate via letter, telephone or email to your:

	ED	FT	1	0	NA
Neighbours					
Shul					
Friends					
Adult children					
Other relatives					
CJSA					

4. If your children live outside of Cape Town, how often do you see them in a year?

- Child 1 _____________
- Child 2 _____________
- Child 3 _____________
- Child 4 _____________
- NA ________________

5. Out of your entire network of family and friends, with whom do you spend the most time?

____

____

____

6. Out of your entire network of family and friends, who do you LIKE to spend time with the most?

____

____

____

7. How active are you in the following: 1= very; 2= fairly; 3= not at all

Religious activities	1	2	3

____

____

Politics	1	2	3

____

____

Social clubs	1	2	3

____

____

Sports	1	2	3

____

____

Volunteer Organisations	1	2	3

____

____

8. I feel lonely

1 Often	
2 Sometimes	
3 Never	

Comment ____

____

____

HEALTH

1. How would you rank your health on a scale 1 – 3?

1 Good	
2 Fair	
3 Poor	

Comment ____

____

____

2a. During the last year have you been treated for any of the following?

Heart	
Diabetes type 1 or type 2	
Macular degeneration/ glaucoma/cataracts	
Cancer	
High blood pressure	
High Cholesterol	
High Cholesterol	
Arthritis	
Hip Replacement	
Parkinsons	
Insomnia	
Depression	
Any other psychological conditions that require medication	
Are you on any repeat medication	

____

____

____

2b. If you experienced any of the above, who in your network of family and friends helped you the most?

____

____

____

____

3. In the past year, have you had to care for anyone suffering from any one of the above conditions?

Yes	
No	

4. Are any close family relatives in institutional care?

Yes	
No	

5. If "YES**",** please state

- the relationship ___________________________________
- the type of institution ______________________________
- the reason for their admission _______________________
- how long they have been there _______________________

6. If you have cared for or are caring for a chronically ill person, what services have you used or are using?

____

____

____

____

7. What services would make it easier for you to care for a person in your home who has been /or is chronically ill?

____

____

____

____

FINANCIAL SITUATION

1. Do you still work?

Yes	
No	

2. If "YES" do you work:

Full time	
Part time	

3. I am still working because ____

____

____

4. Are you working for the same company as when you retired?

Yes	
No	

5. I am looking forward to full-time retirement.

Agree	
Disagree	
Uncertain	

6. If "NO" would you like to work?

Agree	
Disagree	
Uncertain	

7. If "YES", why would you like to work?

____

____

8. At present, I feel financially secure.

Agree	
Disagree	
Uncertain	

9. Do you have:

- A government pension fund? _______________
- A private pension fund? ___________________
- Other ____

____

____

10. Do you have:

- A medical aid _________________
- A hospital plan ________________
- None of the above _____________
- Other ____

____

____

11. I am worried about my future financial well being.

Agree	
Disagree	
Uncertain	

RETIREMENT

1. What was your profession the year immediately before your retirement?

____

2. How old were you when you retired? ______________________

3. What was the reason that you retired?

- Reached retirement age ________
- Retrenched ________________
- Early retirement ____________
- Ill health __________________
- Other______________________________________

4. I adjusted easily to retirement.

Agree	
Disagree	
Uncertain	

Explain ____

____

5. Where were you living at the time you retired?

____

____

6. Did you move when you retired?

Yes	
No	

7. If "YES" where did you move to?

____

8. If "YES", why did you move when you retired?

___

___

___

9. Please describe any age discrimination you may have experienced in the work place.

___

___

___

GENERAL

1. If you were in Government, what services would you introduce to help senior citizens?

___

___

___

___

___

___

2. What do you think makes it possible for seniors to live in the community for as long as they can?

___

___

___

___

___

3. Do you think there is a need for a Jewish retirement village with frail care in Milnerton?

Yes	
No	

___

___

___

4. Have you any other comments you would like to make?

____

____

____

____

____

____

Thank you

Sue Parton
Social Worker