Rural Seniors' Access to Health Care: A Review of the Issues in Developing Countries and an Illustration from Grandmothers in Rural South Africa

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Anne Paxton
B.Sc. O.T., University of Cape Town, 1975

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Name:	**Anne Paxton**
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Examining Committee:

Chair: **Name** Dr. S. Corber
BSc., MDCM
Associate Professor, FHS

Name Dr. K. Corbett
MPH, PhD
Senior Supervisor
Professor and Chair, Undergraduate Programs, FHS

Name Dr. M. Joffres
MD, PhD
Supervisor
Professor and Director, Graduate Programs, FHS

Name Dr. N. Berry
MA, PhD
External Examiner
Assistant Professor, FHS

Date Defended/Approved: March 18th, 2008

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ABSTRACT

The number of older people globally is rapidly increasing, as are their health care needs. In developing countries, where governments already struggle to provide adequate health care to their general populations, seniors experience tremendous barriers in accessing health care. This paper explores the concept of access and the challenges older people in developing countries face in obtaining health care.

It also presents research done in a remote rural area of South Africa to identify health access challenges of grandmothers of AIDS orphans. Methods included a survey (N=50) and additional staff interviews. Participants experienced similar barriers to accessing health services as do seniors in other developing countries: distances to health centres, inability or challenges walking due to health conditions that come with ageing, lack of roads, costs of transportation, and lack of time due to household responsibilities. More effort is needed to meet the health needs of this older generation.

Keywords: Older people; aged; health access; barriers; health services; AIDS orphans; South Africa, developing countries

Subject terms: Older people; health access; remote rural; developing countries; health care

DEDICATION

This project is dedicated to the many "grandmothers" throughout Africa who are giving their lives to bring up the children of those who have died of AIDS. May the immense gift they are giving, not only to these children but to society as a whole, be acknowledged by an increased willingness on the parts of governments to ensure that their health needs are met so that they can complete this very important job.

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CHAPTER 1: INTRODUCTION

The population of the world is in the midst of a demographic transition with the number of older people rapidly increasing in all nations, both developed and undeveloped. This aging revolution has been especially evident over the past 50 years due to improvements in water supplies and hygiene, better control of infectious diseases, and improved knowledge and medical technology. According to HelpAge International's "*Ageing and Development Report*", the increase in the proportion of the population over 60 globally is greater than in any previous era. In 1950 there were about 205 million people over the age of 60, in 2000, about 550 million and it is estimated that by 2050, there will be about two billion (The Ageing and Development Report: A Summary, 1999).

In developing countries this phenomenon is also occurring despite the ravages of infectious diseases such as HIV/AIDS, malaria, and tuberculosis (TB). It is expected that the number of people over 60 in these countries will increase by more than 135% between 2005 and 2030 (Zimmer & Martin, 2007). This will amount to 850 million older people, about 12% of the population by 2025 and will increase to about 20% by 2050 (The Ageing and Development Report: A Summary, 1999; Perth Framework for Age-friendly Community-based Primary Health Care, 2008). Unfortunately, in developing countries the economic situation

has not kept abreast of this increase, resulting in severe poverty amongst this older population, a trend that is expected to continue into the foreseeable future (The Ageing and Development Report: A Summary, 1999). In addition, governments are struggling to cope with providing adequate health resources for their general populations, let alone this older generation (Ageing, Poverty and the International Development Agenda, n.d.).

Even in industrialized nations, national health budgets tend to favour the young and middle aged while the older generation, those over 60 years of age, generally have a smaller proportion of the overall budget designated to their needs despite being a growing segment of the population. In developing nations where health budgets are usually very limited, with enormous demands being made to provide basic health care to their populations, there is even more of a discrepancy between per capita spending for older people in comparison to that allocated to children, youth, and the younger employable generation who are the backbone of the economy of these countries. As HelpAge International states: "... older people still remain a neglected group, largely invisible to those who promote economic development, health care and education" (The Ageing and Development Report: A Summary, 1999, p. 3).

In the majority of rural primary care health centres there are no specific programs for older adults. There are no geriatric specialists, no screening programs, and no initiatives targeted specifically to seniors (Kalache, Hoskins, & Mende, 2004). As a result and because seniors have difficulty accessing even

the health services that do exist, older people in developing countries are not receiving the care that they need and have a right to (Forgotten Families: Older People as Carers of Orphans and Vulnerable Children, 2003; Perth Framework for Age-friendly Community-based Primary Health Care, 2008). This problem is further exacerbated by the huge and ongoing migration of trained health professionals from developing countries to industrialized countries, a situation that is not likely to improve in the near future (Mills et al., 2008).

Health Access Defined

Health access is a term that is commonly used in the literature regarding health care, but remains somewhat elusive in terms of definition. There have been many attempts over the years to better define this concept especially in operational terms that can be measured and evaluated. The Concise Oxford Dictionary defines access as "the right or opportunity to reach" – in this case, health services/care. In defining health access, a number of notions have been put forward that further expand upon the concept – accessibility, availability, affordability, adequacy, accountability, accommodation and acceptability (Penshansky, 1981; Puentes-Markides, 1992). What this ultimately amounts to is the degree to which those needing and wanting health care have the right and opportunity to utilize health services. All these dimensions of access are part and parcel of our present day understanding of the term "health access" as it relates to health care/services and as such will be used to further our appreciation of this issue as it pertains to older people in developing countries.

The concept of health access incorporates many different dimensions. The framework I have chosen to use is adapted from Cristina Puentes-Markides' model in order to reflect the factors pertaining to health access of seniors (Puentes-Markides, 1992). As can be seen from Appendix 1, these can be organized into macro-level, institutional-level, and individual-level categories. Each of these contains specific factors which are further described in the narrative below.

The majority of populations in remote rural areas of developing countries have difficulty accessing health care due to multiple factors which are interrelated and fall into three main categories. At the macro-level, factors such as the socio-political values of those in power, the economic state of the country, health and economic policies, the financing of the health system, the employment situation, and even the road infrastructure of a country all influence the extent and type of health systems that are developed. These factors form the basis for availability, adequacy, accountability, and affordability (Penshansky, 1981; Puentes-Markides, 1992).

At the institutional level, inherent in the structure of the health care system, are many factors which affect health access. These include the geographic distribution of health services, the diagnostic and treatment services offered, the range and availability of necessary drugs, the costs of services to patients, the prevalence of western medical culture, staff recruitment, profit orientation of the health care system, and hours of operation amongst others.

This impacts availability, adequacy, accountability, affordability, and physical accessibility of health services (Penshansky, 1981).

At this level too are the training institutions for health care staff and the emphasis (if any) placed on aging issues in the curricula. Adequacy and accountability are affected by the extent of knowledge and understanding staff have about older people and their needs (Puentes-Markides, 1992). At the institutional level also are the attributes of health care workers – their awareness of the living conditions and lifestyles of their patients, their attitudes and feelings towards them, their behaviours such as discrimination based on age, gender, race or class, unwillingness to treat those without insurance and their inability to speak the language of the people they serve. This affects their ability to accommodate particular needs, to provide quality services (adequacy) and the acceptability of their services to the populations they serve (Penshansky, 1981).

At the individual level, many overlapping factors come into play. These can be identified as situational – living in poverty, being unemployed and therefore having no medical insurance, being unable to afford to pay for health services, being homeless, a migrant worker, imprisoned or a refugee or living far away from a health centre and roads. Personal factors impacting health access include level of education, etiological beliefs, ability to speak the language of the country/providers, being mentally ill or physically disabled. These factors impact physical accessibility, affordability, and acceptability (Penshansky, 1981; Puentes-Markides, 1992).

At the individual level, too, is the behaviour of the person – their motivation to seek care based on their perception of the severity of the problem, their reluctance/fear to seek care due to previous negative experiences with the health system, their perceptions regarding the ability of the health services to solve the problem and delayed help seeking. These factors affect acceptability and accommodation (Penshansky, 1981; Puentes-Markides, 1992).

Puentes-Markides' model was originally established to describe the health access needs of women in developing countries. While many of the same factors apply to the elderly, I have expanded the model to include other factors and orient it towards the particular needs of the elderly. At the macro-level, this includes economic status and infrastructure development of the country and the status of the elderly within the cultural value system of the country. At the institutional level, I have oriented the factors to knowledge and awareness of seniors' needs and included range and availability of drugs. At the individual level, I have chosen to identify three streams of factors – characteristics of clients, the situation they find themselves in, and their behaviours and motivation. On this level, Puentes-Markides only identified two streams, "characteristics of clients", and "behaviour of clients". While examining the model and applying it to seniors in developing countries, I felt that these factors needed to be further differentiated to better describe the barriers that the elderly experience in accessing health care.

The concept of access to health care and the many dimensions that are incorporated into our understanding of the term provide a framework to ground these dimensions in practical application and outline the many factors that play a part in access. The next chapters describe the most common barriers that older people in developing countries face in terms of their access to health care and illustrate these issues with an account of personal research done in a remote rural area of South Africa to identify the health access challenges of grandmothers looking after AIDS orphans and other vulnerable children.

CHAPTER 2: THE CHALLENGES EXPERIENCED BY OLDER PEOPLE IN RURAL AREAS OF DEVELOPING COUNTRIES

The above framework for understanding the different dimensions impacting utilization of health services pertains to all populations to one degree or another. In developing countries however, and especially in rural areas, there are significant deficiencies at each and every level resulting in extremely poor access to health services for the populations who live here. Because older people are generally more vulnerable due to physical degeneration the impact on them is even greater and as such will be further explored.

The literature regarding this older generation in developing countries suggests that they are unable or limited in their ability to access health care due to a number of factors which overlap and impact each other, making it difficult to clearly measure the impact of each of them (Kalache et al., 2004). In order to better understand this special population of older people and their specific health needs, I have included information describing their characteristics, the typical health conditions they suffer from, and the challenges they face on a day-to-day basis. This information sets the stage for better understanding the barriers that the elderly in developing countries face in accessing health care, which is described more fully in the pages that follow.

Characteristics of Older People in Developing Countries

Age: While the United Nations defines older persons as those aged 60 and above, in developing countries, because of the harshness of their lives, people tend to age faster than in industrialized nations, where life is considerably easier for people with an infrastructure that provides for most of their basic needs such as safe water supplies, sanitation systems, electricity etc. (Ageing Issues in Africa: A Summary, n.d.). As a result, the definition of what exactly constitutes being an older person is subject to debate. People as young as their 50's can be considered to be amongst this group, as of course are those who have reached the grand age of 90 (State of the World's Older People 2002, 2002). The definition is really based more on physical features such as greying hair and wrinkled faces, the types of health conditions people are experiencing or the number of grandchildren they have rather than the number of years they have been alive (Bock & Johnson, 2008; Ageing Issues in Africa: A Summary, n.d.).

Gender: Worldwide, women generally have a longer life expectancy than men resulting in greater numbers of women than men amongst the older generation (State of the World's Older People 2002, 2002). Currently, worldwide, there are about 70 million more women than men over 60, with a ratio of 82 men per 100 women. This ratio becomes even more extreme amongst the oldest-old, to the point that some authors believe that the issues of the older population should be seen in terms of the issues of older women (Global Action on Aging:

Major Developments and Trends in Population Ageing, 2007). In developing countries this trend is no different. However, living conditions for older women in these countries is very different. Special note will be made in relation to women in the points that follow.

Education: In remote rural areas of developing countries, this generation of people is generally poorly educated. A study done on pensioners by Ferreira in South Africa found that of the black research participants, almost 50% had not had any schooling and a further 30% had attended only primary school (Ferreira, 2006). Not having access to education as children has resulted in large numbers of older people being illiterate. In the report *Major Developments and Trends in Population Ageing*, the data from 80 developing countries found that 53% of those over 65 were illiterate, with the illiteracy rate being higher amongst women than men (Global Action on Aging: Major Developments and Trends in Population Ageing, 2007). This in turn further disadvantages older people in terms of being able to access information and understand their rights (Forgotten Families: Older People as Carers of Orphans and Vulnerable Children, 2003). The impact of this can be seen in older people losing their land and becoming homeless because they are unaware of their rights, not knowing how to protect themselves from infectious diseases (boiling water etc.) and not understanding the importance of seeking health care for illness or continuing to take drugs which have been prescribed even though they may be feeling better (antibiotics, TB drugs).

Living Conditions of Older People in Developing Countries

Household survival: Poverty is rife in remote rural areas of developing countries. Survival is based on one's ability to grow food, forage for wood for cooking, and collect water from the closest water source – rivers, streams and springs, often many miles away. All these tasks are considered "women's work". According to *The Ageing and Development Report*, older people are generally amongst the poorest in rural areas of developing countries (The Ageing and Development Report, 1999). Most women living in rural areas are not formally employed and survive by growing their own food, raising animals and subsisting on the land (State of the World's Older People, 2002). These tasks continue well into old age. Men in these areas are more likely to be employed in the formal sector but often there is little work to be had, resulting in high unemployment with subsequent lack of income for the household (Khan & Lee, 2007). As men grow older, they must make way for younger men with more strength and stamina, so that they can support their young families. As people grow older, their physical strength diminishes, as does their health, resulting in an inability to work and to undertake all the tasks involved in day-to-day survival Forgotten Families: Older People as Carers of Orphans and Vulnerable Children, 2003).

A number of seniors engage in small informal endeavours such as mat weaving and selling vegetables to help increase their household incomes, but are often unfairly discriminated against in terms of obtaining micro loans to pursue

more lucrative projects. This is especially true for women who are doubly discriminated against based on both gender and age. (Forgotten Families: Older People as Carers of Orphans and Vulnerable Children, 2003; Ageing Issues in Africa: A Summary, n.d.).

Infrastructure: The infrastructure in remote areas of developing countries is usually minimal. Often there are no roads, just walking paths, and occasionally tracks that expensive 4-wheel vehicles can drive on. Utilities that are taken for granted in the developed world simply do not exist here – electricity, a secure and safe water supply, sanitation systems, fuel for cooking and even food security.

To summarize, life is very difficult for those who live in these remote, rural areas. Women bear the brunt of this as they are the ones who do the work to keep the household afloat – fetch the water and wood, till the fields, tend the animals, look after the sick and take care of the children – cooking, cleaning, washing and many other household tasks. Research has found that the majority of the poorest poor are made up of the elderly who struggle with day-to-day survival, are often excluded socially within their communities and are frequently discriminated against because of their age (Ageing, Poverty and the International Development Agenda, n.d.).

Health Conditions

The epidemiologic transition is having a huge impact on seniors in developing countries (Global Action on Aging: Major Developments in Health and Ageing, 2007). Not only do they suffer from many infectious diseases such as respiratory infections, gastro-intestinal disease, TB, malaria and AIDS which can incapacitate them and often lead to disability but, due to an increase in life expectancy, older people here suffer many of the same chronic health conditions as those in industrialized nations (The Ageing and Development Report: A Summary, 1999; Zimmer & Martin, 2007). These include hypertension, stroke, heart disease, diabetes, arthritis, cancers, chronic respiratory diseases and visual and hearing loss (Preventing Chronic Diseases: A Vital Investment: WHO Global Report, 2005; Yach, Kellogg, & Voute, 2005). According to WHO, of the chronic disease deaths worldwide, 80% occur in middle and low-income countries and half of these occur in women (Preventing Chronic Diseases: A Vital Investment: WHO Global Report, 2005). They thus experience the double burden of disease, both infectious and chronic. Add to this older people's vulnerability to violence and abuse, and they can be considered to be carrying a triple burden.

Not all of the conditions mentioned above affect access to health care so I will briefly describe only those that have been found to particularly impact health access.

Bone and joint conditions: Because their bodies have huge demands made on them from a very early age (multiple pregnancies and hard physical work), the majority of older women living in remote rural areas suffer enormously from joint pain throughout their bodies due to degeneration of the joints, cartilage damage, osteoporosis and arthritis (Yach et al., 2005).

Respiratory diseases: Because they cook on wood fires, often inside their small, poorly ventilated homes, and also use toxic fuels like paraffin, older women especially, develop respiratory diseases such as obstructive pulmonary disease, asthma and lung cancer and are prone to infections such as tuberculosis and pneumonia (Preventing Chronic Diseases: A Vital Investment: WHO Global Report, 2005).

Cardiovascular disease: As with any aging population, high blood pressure is common and if left untreated, this can lead to strokes rendering them hemiplegic and often disabled and dependent on others to take care of them. While historically heart disease and diabetes have not been major problems in this population, in recent years, with the advent of western influences and greater life expectancy, the prevalence in both these conditions is growing (Hossain, Kawar, & El Nahas, 2007; Reddy, 2002).

HIV/AIDS: It has recently come to light that many older people also suffer from AIDS. Because countries only report statistics for those aged up to 49, this has not been documented leaving a huge number of potentially infected older people out of the estimates thus denying them the opportunity for testing,

counseling and treatment (Khan & Lee, 2007; Knodel, Watkins, & VanLandingham, 2003). Given that AIDS has been known for over 20 years, it is not surprising that the numbers amongst this population would be significant - according to UNAIDS estimate, 2.8 million older people worldwide (King, 2000).

Mental illness: A condition that has been identified in recent years and is having serious consequences is the widespread depression that is occurring as a result of the loss of sons and daughters and friends and members of their communities which has and continues to occur as a result of HIV/AIDS epidemic which has been sweeping through many developing countries since the late 80's (Khan & Lee, 2007; Knodel et al., 2003; Ssengonzi, 2007). Whole communities are having their parent generation decimated resulting in those impacted feeling overwhelmed by the huge burden of taking care of those with the disease, many of whom are in the process of dying. This burden, borne mostly by women creates immense stress that is exacerbated by the responsibility of taking care of the children of those with disease. Entire communities are reeling from the impact and barely able to cope, resulting in widespread depression and also a sense of apathy that comes with feeling overwhelmed. The resulting changes in family structure as a result of the deaths of those with AIDS have a huge emotional impact on grandparents and often lead to further isolation and loneliness (Madhavan, 2004).

CHAPTER 3: BARRIERS TO ACCESSING HEALTH CARE FOR RURAL SENIORS

Using the health access framework described above, one can see at the macro-level that older people's needs and rights do not even make it on to Global agenda. Within the Millennium Development goals, children and mothers needs are addressed but there is no mention of the needs of the older generation. The same goes for the International Development Targets. As *State of the World's Older People 2002* comments: "The detachment of ageing issues from development debates means that policy initiatives, which not only assist older people but also have wider benefits across generations, have been ignored by the development mainstream." (State of the World's Older People, 2002, p.12).

In terms of nations' infrastructures, it is clear at the macro-level, that the majority of developing countries simply do not have the funds needed to establish a viable health system. According to Carrin, approximately one third of countries in the world have less than the US$40-45 required to provide basic health services to their populations (Carrin, 2007). In sub-Saharan Africa, per capita spending on healthcare for many countries is under US$10 per year, and this is usually skewed to the urban areas. Instead, patients needing health services must pay out of pocket. This cost prevents many people from seeking care. For those that do, it is often catastrophic, leading to households selling

everything they own to cover costs and eventually becoming poverty stricken (Carrin, 2007; Khan & Lee, 2007). Annually, about 25 million households worldwide, 100 million individuals, are pushed into poverty by such health costs (Carrin, 2007). The older generation, especially in developing countries, is impacted even more by this as they are more vulnerable to illness due to their age and cannot afford health services as many already live below the poverty line (Abegunde, Mathers, Adam, Ortegon, & Strong, 2007).

Numbers And Locations Of Health Centres

At the institutional level of health access, due to health financing shortfalls as mentioned above, there is a paucity of health centres in developing countries and particularly in rural areas (Kalache et al., 2004; Puentes-Markides, 1992). The few health care centres that are built tend to be in urban areas thus largely inaccessible to those living in remote rural areas (Forgotten Families: Older People as Carers of Orphans and Vulnerable Children, 2003; Knodel et al., 2003). Health centres in rural areas tend to be broadly dispersed and often have difficulty attracting staff resulting in lower quality of care.

Despite national strategies in some developing countries to bring health care closer to the people by increasing the numbers of clinics in rural areas, it can still take people many hours to walk or travel to the nearest clinic (Ageing Issues in Africa: A Summary, n.d.). The lack of mobile health centres which go into remote communities to provide health services to people within their

communities, are sorely lacking as are programs designed specifically to meet the needs of this special group of older people (Kalache et al., 2004). Mehrortra et al. comment that those nations which have prioritized making only very basic levels of health care universally available, financed from government revenues, have made great inroads to the public health of their people, even though they function at the most basic level in terms of health systems. This has made a huge impact on population health, especially in relation to the health of the poor (Mehrotra, 2002).

Physical Access

Due to the lack of road infrastructure, transportation to health centres is often non-existent. Even when roads do exist, the costs of taking a bus or taxi are prohibitive, especially for older people who are likely unemployed and living in poverty (Kalache et al., 2004; Ageing Issues in Africa: A Summary, n.d.). The most common way for this generation to physically access health services is to walk or if lucky, to take a donkey or ox-cart. Many seniors are incapacitated by chronic diseases which inflict them as they grow older and prevent them from being able to walk any distance at all. In rural areas, households are usually some distance from roads (if an infrastructure of roads even exists) and the sheer effort of getting to the road, even if there is a taxi or bus to provide transportation (at great expense), is often not feasible. It is not uncommon to see old people being brought to the clinics in wheelbarrows when they are not able to make the journey independently.

Drugs

Accessing suitable drugs and maintaining secure supplies is extremely difficult for developing countries. This results in older people often not being able to get the drugs that they need, either because they cannot get to a health centre to pick them up, or because there are no supplies to fill prescriptions. In addition, seniors often cannot afford to pay for drugs and instead go without, or take them less often, thus not treating their health conditions effectively (Kalache et al., 2004; Ageing Issues in Africa: A Summary, n.d.).

Awareness And Knowledge About Aging

While health professionals in developing countries are trained in the delivery of primary health care, the emphasis tends to be placed upon delivery of services to children, youth and adults in the prime of their lives, based on the WHO indicators that are generally used to evaluate countries' health care outcomes. This means that health programs tend to focus on preventing and controlling infectious childhood diseases, reducing maternal and infant mortality rates and providing primary care to those who are able to get to health centres, usually the younger and middle aged working population who can afford transportation costs, and user fees. Thus, chronic disease management tends to take a back seat when priorities are considered, especially when dealing with a very limited budget, so the elderly in developing countries are often left out of the planning picture.

In addition, few health worker training institutions such as those for doctors and nurses provide curricula focused specifically on the elderly. As a result, health workers awareness and knowledge about elder care is sadly lacking (Kalache et al., 2004; Ageing Issues in Africa: A Summary, n.d.).

Attitudes of Health Care Practitioners Towards the Elderly

In combination with the above, possibly due to this lack of awareness, health care workers often have negative attitudes towards their elderly patients (Kalache et al., 2004). They see them as complaining and attention seeking and tend to minimize and dismiss their complaints. This serves to alienate older people and often discourages them from attending clinics or health centres. When they do finally seek care, it is often already too late for effective treatment, and they are then scolded for not coming earlier (Ageing Issues in Africa: A Summary, n.d.). As well, seniors in developing countries often experience discrimination at the hands of the health care workers due to their association with HIV/AIDS (Forgotten Families: Older People as Carers of Orphans and Vulnerable Children, 2003).

Costs

At the individual level, poverty has a huge impact on health access. Transportation costs to health centres and user fees once there make access prohibitive for those with minimal cash flow (Kalache et al., 2004). In countries where HIV/AIDS is pandemic, grandparents are often the ones taking on the

responsibility of caring for their grandchildren (Bock & Johnson, 2008; Khan & Lee, 2007; Madhavan, 2004). This is an additional drain on household finances – more mouths to feed, clothing to purchase, and school expenses to cover. To receive health services for themselves or the children they care for, grandparents have to pay user fees as well as the costs of any drugs that are prescribed (Ageing Issues in Africa: A Summary, n.d.). Because finances are so tight within households, seniors' decisions to seek care for themselves are often put off until an illness is very serious, even life threatening, making it much more expensive and difficult to treat (Kalache et al., 2004). Seniors, and especially women, are also likely to neglect their own health in favour of ensuring that others in the household get what they need, whether it be food or drugs, all the while continuing to fulfill their responsibilities as household heads and trying to make ends meet (Forgotten Families: Older People as Carers of Orphans and Vulnerable Children, 2003; Puentes-Markides, 1992). In addition, poverty impacts many of the social determinants of health such as education, housing and nutrition leading to a vicious cycle of poor health resulting in even further poverty (Preventing Chronic Diseases: A Vital Investment: WHO Global Report, 2005).

Social Pensions

Over recent years, a few developing countries have implemented universal pension programs for their elderly citizens (Beales & Gorman, 2002; Gorman, 2004; Johnson & Williamson, 2006). These have been shown to keep

families above the poverty line in that they provide a reliable and significant income to seniors, helping maintain household and food security, enable clothing to be purchased, and even enabling children to attend school (Ferreira, 2006). Unfortunately pension schemes have been implemented in very few countries despite evidence that applying only 1% of the GDP, affordable to most developing countries, is able to raise the standard of living for huge numbers of households to above the poverty line (State of the World's Older People 2002, 2002). According to Burns et al, the South African Department of Social Development (2002) estimated that the Old Age Pension reduced the poverty gap by 91% (Burns, Keswell, & Leibbrandt, 2005). Research has shown that social pensions are often used by pensioners to support extended families including grandchildren, especially in areas where unemployment is high (State of the World's Older People 2002, 2002). In addition, pensions serve to bring money into rural areas, and provide a basis for credit at local markets and stores thus stimulating the economy (Johnson & Williamson, 2006). They are also gender sensitive in that women, who make up a greater proportion of older people, are able to access pensions on the same basis as men, not dependent on their past work history.

Health Needs Awareness

The lack of opportunity for formal education among older people in developing countries often translates into a lack of information about health issues such as knowing when to seek care and how to deal with emergencies,

both for themselves and children they may be caring for. Their knowledge of basic food and hygiene safety (boiling water for consumption, storing food safely) is lacking and their ability to deal with health crises such as treating burns and dealing with gastro-intestinal infections is poor (Madhavan, 2004). They also do not understand the effects of smoking, diet and exercise on hypertension, cardiovascular disease and diabetes and thus are unlikely to be taking proactive measures to prevent these diseases. As a result of this lack of information, they are often slow to seek health care. In addition, it is common for older people to deprive themselves of certain things such as food and health care, wanting the financial resources instead, to go to the grandchildren in the household. Older people are also rarely provided with information about HIV/AIDS prevention and are therefore themselves vulnerable to becoming infected. They are also not able to counsel their grandchildren about the importance of prevention, and how to protect themselves (Forgotten Families: Older People as Carers of Orphans and Vulnerable Children, 2003; Khan & Lee, 2007).

Household Duties and Lack of Time

The multiple tasks involved in running a household is a very demanding task and is also very time consuming, especially when such basics as the collection of water from streams and rivers can take a few hours. Add to this excursions into distant areas to forage for wood, taking care of a garden, looking after animals and also the cooking, washing and cleaning, and it is easy to understand why older women do not have the time to go to the health centre.

For those who cannot afford to take a taxi, there is in addition the time taken to walk to the clinic, often a number of hours. Once they get there, they are usually seen on a first come first serve basis, and often have to wait many hours before receiving attention. Health planners do not seem aware of these issues, and little is done to try and remedy the situation. Thus seniors complain that they do not have the time to attend to their own health needs because they are too busy taking care of the household. They already feel physically exhausted from their day-to-day tasks and have little energy left to make the arduous journey to the nearest health centre.

Care Giving Duties

In many households impacted by AIDS, there may be adult children as well as younger children who are sick and dying with HIV/AIDS or other diseases such as malaria, gastro-intestinal infection or tuberculosis. Caring for these individuals is intense and exhausting and becomes a full time job for the remaining family members. There is no time to seek care for oneself in these situations, even when one is barely able to carry on (Khan & Lee, 2007; Knodel et al., 2003).

Child Care Duties

For those women who are the primary caregivers of grandchildren, being able to leave them for the period of time it would take to get to the clinic, wait in line, get medications, etc. is simply not possible. Having other people in the

community to look after the children for this period of time depends on a number of factors. Often, stigma is associated with households who have lost someone to AIDS, despite it being ever more common (Knodel et al., 2003; Madhavan, 2004). Other households do not want to associate with these families for fear of themselves being infected. Thus, community support for families with an AIDS death is usually not forthcoming. As a result, grandmothers tend to neglect their health needs and just get on with the tasks that need to be done (Forgotten Families: Older People as Carers of Orphans and Vulnerable Children, 2003).

Traditional Healers

In developing countries, older people often prefer to first seek help from traditional healers who are more easily accessible and familiar to them. While these healers are often effective at dealing with less serious problems and provide excellent psycho-social support to their patients, they generally do not have the knowledge and tools to treat infections such as AIDS, TB and pneumonia. Education programs in some developing countries are now targeting traditional healers to equip them with the knowledge and skills they need to play a more effective role in the treatment of people in rural settings. This is especially pertinent to older people who generally prefer to seek care from a known entity with whom they are familiar. In addition, in most rural areas where health services are scarce, traditional healers are much more accessible (King, 2000).

Chapter 4: AN ILLUSTRATION FROM A STUDY OF GRANDMOTHERS IN RURAL SOUTH AFRICA

Because little research has been done on the health access needs of the elderly in developing countries, I decided to undertake a research project in a very poor, remote rural area of South Africa.

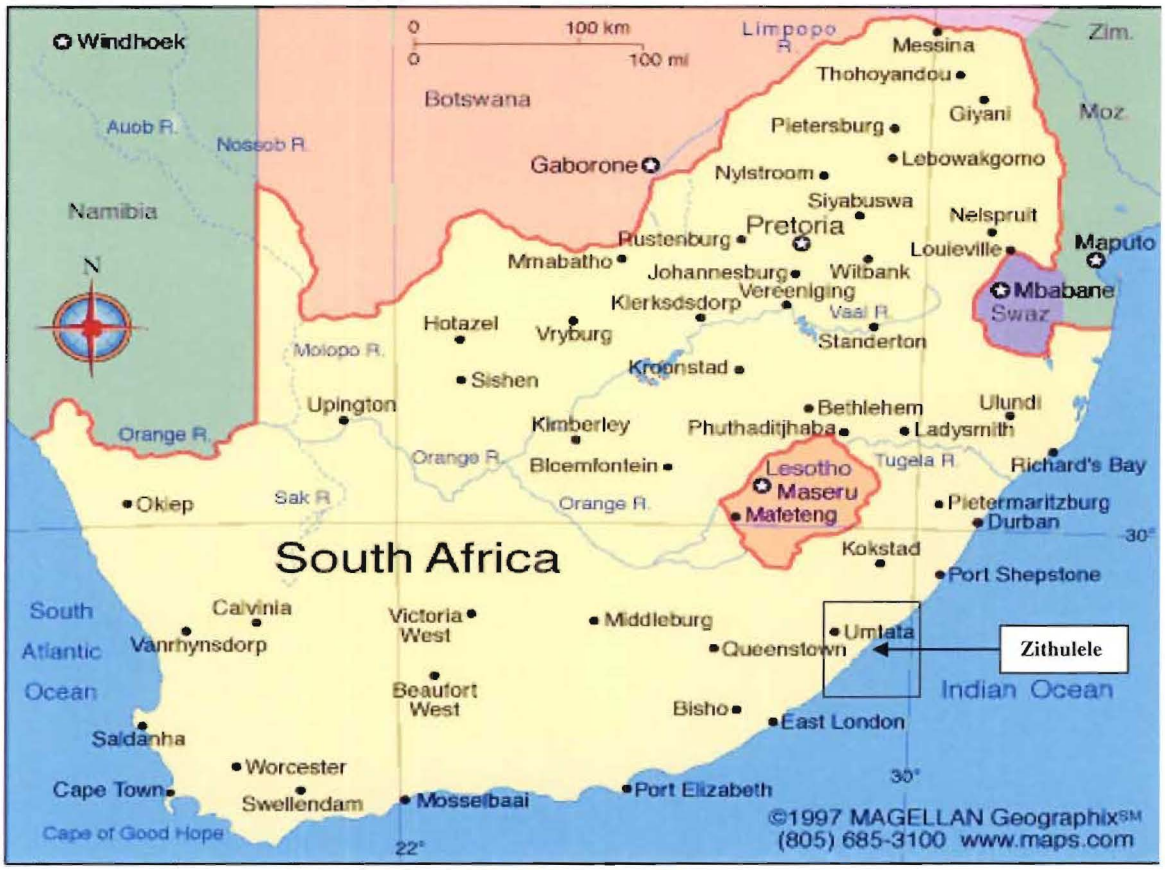

Figure 1: Map of South Africa

Figure 2: Detailed Map of Zithulele Hospital Service Area

The main purpose of this study was to explore the challenges that grandmothers caring for AIDS orphans and other vulnerable children experience in relation to accessing health care. The study was undertaken in an area with minimal infrastructure such as roads, sanitation, and water systems. There was a 146-bed hospital serving a population of about 130,000 Xhosa people, as well as six satellite clinics. Most of South Africa's rural areas are very similar to other developing countries in terms of the difficult conditions that people live in and the extreme poverty that they face. Grandmothers' access to health services here is likely similar to seniors' access in developing countries where the majority of the population live in rural areas.

From the literature review, I thought that grandmothers would face multiple challenges in accessing health services based on the remoteness of the villages and the lack of infrastructure. That they have taken on the additional burden of caring for their dying children and their grandchildren, with all the tasks this involves, might mean that very little time is left to take care of their own health needs.

Research Question

What are the health access challenges of "grandmothers" who take care of orphans and other vulnerable children?

Method

Study Population

This study explored the challenges that 50 grandmothers living in a remote rural area of South Africa faced in terms of accessing health services. A grandmother was defined as an older woman whose grandchildren lived with her. Grandfathers were not included in the sample as there are far fewer of them due to their dying at an earlier age or being away working as migrant labourers. As well, it is generally not part of their culture for men to take care of children.

Sampling and Recruitment

Purposive sampling was employed to recruit 50 subjects for this study. Most (38) of the grandmothers were recruited through the hospital or clinics, where they were either a patient themselves or were accompanying a relative/child to the hospital or were visiting relatives who were inpatients. Other grandmothers were recruited through one of the headman in the district (5), through a local church youth worker (2), through an interested party at a neighbouring village who is involved in aid projects (2), and lastly by approaching older women at the side of the road (3).

Data Collection and Recording

The data for this study were collected from interviews based on a survey (see Appendix 2) that lasted between 40 minutes and an hour. All but five interviews were audio-recorded (those participants being unwilling to be tape recorded). Because very few people in this area speak English, I used the services of a translator who was able to communicate with the grandmothers in

their native tongue, Xhosa. The interviews took place in a variety of settings from a private room on a hospital ward, to the grass outside the hospital, a couple of chairs set up for us outside the headman's house, and even on the grass at the side of the road. Most of the time there was not much privacy and more often than not a crowd would gather to see and enjoy the spectacle.

The interview was composed of a survey of 37 closed questions to establish basic demographic information, living conditions, health access information, health services received, and grandmothers' opinions about these. As well, basic financial information was obtained.

A further five open–ended questions were asked firstly to glean an understanding of the composition of the grandmothers' households and the size and type of housing they had. I asked what grandmothers perceived as their health problems. Lastly, their challenges to accessing health services were explored, as well as their ideas to improve access to health services for themselves and other older people in their communities.

Informal interviews were also conducted with the staff at the hospital and clinics to determine the health conditions they commonly dealt with in older people, the range of diagnostic and health services they were able to provide, the challenges they faced, and the conditions they worked in.

Time Line

Dates	May 21 – 30	June 1 – 30	July 16 – 30	Aug 1 – Sept 30
Orientation and preparation	>>>>>			
Pilot interviews	>>>>>>			
Interviews		>>>>>>>>>>>	>>>>>	
Data input		>>>>>>>>>>>>>>>>>>>>>		
Analysis			>>>>>>>>>>>	
Report preparation and presentation to hospital staff			>>>>>>>>>>>	
Report writing			>>>>>>>>>>>>>>>>>>>>>>	

Data Analysis

Quantitative Analysis

The data from the closed questions were entered into Excel in order to perform descriptive analysis of the demographic information, living conditions of the grandmothers, health service access, health services offered, satisfaction with health services, and financial information.

Qualitative Analysis

The qualitative questions were coded using a priori coding lists for family structure, health conditions, and health access challenges identified by the grandmothers. These were developed prior to the study, and then adapted based on five pilot interviews. Emergent codes were added during the study in order to obtain a complete set of health problems and health access issues.

The ideas that grandmothers had with regard to improving health access were coded using thematic analysis based on emerging themes.

Findings

Demographics

Table 1: Age of Grandmothers (in years)

	n*	%
<50	1	2
50-59	11	22
60-69	28	58
70-79	8	16
80+	2	4

*Sample size = 50

As shown in Table 1, most of the grandmothers interviewed were aged 60 – 69 (56%), with only two percent being under the age of 50, and four percent being older than 80. The remainder were aged 50 to 59 (22%) or 70 to 79 (16%).

Table 2: Description of Grandmothers' Household/Family Situation

	n*	%
Those with Husbands	17	34
Those with Adult Children at Home	36	72
Those who had Lost One or More Adult Children	22	44

*Sample size = 50

Of these grandmothers, 17(34%) had husbands still living at home with them and 36 (72%) had adult children also living in the home. Because the unemployment rate in this region is so high (77%), adult children are often not able to establish their own homes but remain dependent on their parent(s),

especially if the latter are accessing the Old Age Security Grant on which whole families often depend.

Twenty two (44%) of these grandmothers had lost an adult child, though due to the stigma associated with AIDS and the sensitivity of this issue, it was hard to determine exactly how many of these deaths were related to AIDS.

Table 3: Income Sources of Grandmothers

	n*	%
Old age pension	43	86
Handicap pension	5	10
Spouse with pension	11	22
Child care grants	29	58
Other household income	14	28

*Sample size = 50. Many participants had multiple sources of income.

Of the 50 grandmothers interviewed, 43 (86%) were in receipt of the Old Age Pension (R780 per month, about $110), five (10%) of a handicap pension and 11 (22%) had spouses who were also receiving a pension. Twenty-nine (58%) were accessing one or more childcare grants (R200 per month about $30).

Fourteen (28%) of the grandmothers interviewed reported making or supplementing their incomes through either a job (as a domestic, working for neighbours by collecting firewood or thatching grass), making and selling grass mats, or selling vegetables from their gardens. Only three had other family members who worked and helped support the household.

Table 4: Source of Household Water

	n*	%
River	17	34
Spring	30	60
Tank	5	10
Community tap	7	14

*Sample size = 50. Participants had multiple sources of water.

As can be seen in Table 4, 17 (34%) of those interviewed accessed their water from a stream or a river, and 30 (60%) from a spring (the hills in this rural part of South Africa have many natural springs which create a puddle around them, often dug deeper by the people of the area, and used by cattle, goats, sheep and pigs as their drinking source as well. They are rarely fenced off to prevent animal access.) Only seven (14%) accessed their water from a tap which was usually a small water system that had been established for a specific community who would fetch their water daily using buckets which they would then carry home on their heads. Five (10%) grandmothers reported having a tank to collect rainwater that they use in the rainy season (summer). Once this is empty, they have to revert to using the river or spring again.

While distances were difficult to establish accurately, it was clear that the majority of grandmothers had to fetch their water from more than 500 metres away (n =40), usually walking on a rough path over steep hills – this carrying buckets weighing about 5 kilograms on their heads.

Table 5: Purification of Water

	n*	%
Always boil water	11	22
Sometimes boil water	4	8
Never boil water	34	68
Treated at source	1	2

*Sample size = 50.

34 (68%) of the grandmothers reported that they did not boil their water. Only 11 (22%) of the 50 boiled their water regularly, and a further 4 (8%) would boil it if there were an outbreak of diarrhea in the household. One grandmother had treated water piped into her house and therefore did not need to boil it.

Table 6: Types of Sanitation Systems

	n*	%
Outhouse	7	14
"The bushes"	43	86
Flush	0	0

*Sample size = 50.

Forty-three (86%) of the 50 grandmothers had no sanitation system of any sort. Instead they "used the bushes" as they have done forever. The pigs forage through the bushes at night and eat the faeces. In recent years it has been discovered that the pigs are usually infected with tapeworms, of which the human is the intermediary host. The people eat the pig meat, and the tapeworm cysts enter their systems where they lodge in the brain causing epilepsy. There is a very high prevalence of epilepsy in this area.

Table 7: Type of Cooking Fuel Used

Cooking fuel	n*	%
Wood	50	100
Paraffin	43	86
Gas	1	2
Electricity	0	0

*Sample size = 50. Many participants used multiple types of fuel

All the grandmothers interviewed reported that they cooked primarily with wood on an open fire outside their huts. This involves the time consuming and back breaking task of fetching firewood, sometimes from long distances away on a regular basis, in order to be able to cook. It was common to see women and girls carrying large loads of firewood on their heads, over great distances. With the increase in population over the past 50 years, the wood resources are becoming less available and women have to travel further distances in order to be able to forage what they need, often putting themselves at risk of snake bites, falls and even rape.

The secondary type of fuel used for cooking was paraffin. 43 (86%) grandmothers had paraffin stoves though many stated that they used them only for tea or if it was raining out preventing them from cooking on a fire. Many stated that they often did not have money for the paraffin. Studies done in South Africa have shown paraffin used in poorly ventilated setting such as these huts to be very toxic to human health, and the incidence of asthma is thought to have increased due to the use of this as a cooking fuel.

Table 8: Description of Garden Crops

	n*	%
Maize	44	93.6
Green vegetables	34	72.3
Orange vegetables	20	42.6
Potatoes/Sweet Potatoes	20	42.6
Fruit trees	12	25.5

*Sample size = 47.

Of the 50 grandmothers, 47 (94%) reported having a garden where they grew a selection of produce. Forty-four (94%) grew maize which is one of the staples of their diets. The majority also grew vegetables such as spinach, cabbage (winter crop), potatoes, sweet potatoes, pumpkins, carrots, beets, peas and beans. Only 12 (25.5%) of the grandmothers had fruit trees – banana, peach, apricot, and fig, despite this area having an excellent climate for fruit tree growing. This meant that most households were getting some fresh fruits and vegetables to supplement their staple diets of maize and dried red beans.

Health

In response to the question: "Tell me about your health", the grandmothers self reported a number of conditions. This was followed by questions asking what medications they took, and what for. In reports of high blood pressure, it was noted only if the participant was taking hypertensive medications. Of the sample 23 (46%) reported having high blood pressure.

Table 9: Health Conditions of Grandmothers (self-reported)

	n*	%
High Blood Pressure	23	46
Joint Pain (arthritis?)	24	48
TB: Treated	11	22
Not treated	3	6
Asthma	9	18
GOLP**	34	68
Other	19	38

*Sample size = 50. **General Old Ladies Pains

Some participants had multiple conditions

Tuberculosis (TB) is very prevalent in this community, and 16 (32%) of grandmothers reported having been diagnosed at some point in their lives with TB. These grandmothers were further questioned to determine if they had completed their treatment protocol. Of the 14 who reported TB, three had not completed the six-month treatment. This is significant information, as these grandmothers are therefore probably still infectious, suffering the debilitating effects of the illness, and likely to infect grandchildren living in close proximity, sleeping in the same bed and occupying a poorly ventilated hut. This could also contribute to drug resistant TB which is already creating major problems through out South Africa.

Another commonly reported condition was major joint pain, usually knees or shoulders which precluded grandmothers from walking any distance and being able to function well in activities of daily life. The medical system here had also developed an acronym for a generalized condition affecting all the joints of the

body, GOLP, an acronym for General Old Ladies Pains. Because of the continuous physical challenges that girls and women face on a day to day basis to keep a household running, such as fetching water and wood, their bodies take a beating which results in joint deterioration, arthritis and general joint pain throughout the body. This only gets worse as the women age. Of my sample, 68% complained of this problem.

The other fairly significant reporting was that of asthma, 18%. As already discussed, the use of paraffin stoves contributes to respiratory conditions, including asthma.

The other conditions that were reported were: stroke, cancer, heart attack, women's problems, headaches, chest pains, coughing, stomach pain, vomiting blood, fatigue, weakness, weight loss and epilepsy.

Drugs

If someone is diagnosed with a condition that requires medication, it is provided at no cost. However, there are frequently problems of supply, so patients have to return monthly to get their new supplies – a time consuming, expensive trip often taken in vain. Of the 50 grandmothers interviewed, 27(54%) reported taking medications. As already mentioned, 23 (46%) of these take hypertensive medications. The other most commonly prescribed medication was painkillers for GOLP and joint pain (74%). In addition three (6%) grandmothers reported using inhalers for asthma.

Health Services

Six questions were asked regarding the services received at the hospital or clinic. The majority of grandmothers (94%) reported that their blood pressure was taken, 49% confirmed that staff usually explained what was wrong with them, and told them what they needed to do to make it better. I usually followed this answer up by asking what sorts of things they were told. Most of this group had received some education about diet (little salt, lots of vegetables) as well as information about resting joints, taking medications as needed etc. 75% felt satisfied with their treatment at the health center, while 18% were unsure and 7% were dissatisfied with the services. Interestingly, 15% of grandmothers reported seeing a Traditional Healer in addition to attending the health center, while 83% saw a private General Practitioner at great personal expense (about R140 per visit). This begs the question of just how satisfied they really were with the National Health Care system. In terms of being treated with respect, 91% stated that they were treated respectfully, while 9% felt there were times when they were not given respect, and one person was dissatisfied with the respect given.

Physical Access

The grandmothers interviewed reported three main ways to get to the hospital or clinics – walking, taking a taxi or getting a lift. 24% always walked, 46% took a taxi, while 28% did a combination of two of the above. One person stated that she came part way in an ox cart. I saw someone being brought to a clinic in a wheelbarrow.

Costs

Table 10: Hospital User Fees (in rands)

	n*	%
0	27	54
1 – 9	2	4
10 – 19	5	10
20	16	32

*Sample size = 50.

1 rand = C$7.00

In South Africa the user fees for attending hospital is R20 (about C$3), unless the person is a pensioner. Women are eligible for a social pension at age 60, men at age 65. Those on disability pensions or receiving child care grants are also exempt from user fees. Thus the majority of the grandmothers I interviewed should not have been paying user fees. However, during my interviews it came to light that a number 23 (46%) were having to pay user fees and were not receiving receipts for their payments. It appeared that these funds were being pocketed by the reception staff. This matter was brought to the attention of the Chief Medical Officer who took immediate steps to prevent this corrupt practice.

Table 11: Cost of Transportation to Health Services

	n*	%
0 – 9	11	33.3
10 – 19	11	33.3
20 – 29	6	18.2
30 – 39	3	9.1
40 - 49	2	6

*Sample size = 33

1 rand = C$7.00

As can be seen in Table 6, taxi fares in this part of the world are quite expensive, as people have very few other options to travel from one place to another, and the taxi owners take full advantage of this captive audience. Of the 33 grandmothers who did come by taxi, 33% paid under R10, 33%, R10 to R20, 18%, R21 to R30 and 15%, over R30. A R20 taxi fare would be over 2% of their monthly pension.

Time

Table 12: Length of Time taken to get to Health Centre (in hours)

	n*	%
<1	22	44
1 – 2	12	24
2 – 3	7	14
3 – 4	6	12
>4	3	6
Overnight**	2	4

*Sample size = 50. **Also >4 hours

In terms of the length of time grandmothers estimated that it usually took to get to a health centre, 44% took less than an hour, 24% took one to two hours, 14% two to three hours, 12% three to four hours and 6% greater than four hours. Of this 6%, 4% reported that they had to stay overnight with friends on the way, as the distance was so great.

Because a trip to the health centre is very time consuming, not only to get there, but also to wait in line for service, and then again for results if any tests have been done, grandmothers must make arrangements for someone to take care of the grandchildren. For those with other adults in the household (50%), this is relatively simple. However, a number of grandmothers (22%) reported that children took care of themselves, or were left in the charge of the oldest child. 24% reported leaving the children with friends and neighbours, a sign that cooperative communities do exist.

Challenges to Accessing Health Services

Table 13: Barriers to Attending Hospital/Clinic

	n*	%
Too far to walk	9	18
Unable to walk	8	16
No Taxi Money	22	44
User Fees	3	6
No one to take care of grandchildren	10	20
Other	10	20

*Sample size = 50. Participants reported multiple barriers

Given the above information regarding accessing health care, the challenges grandmothers reported as the "things that make it difficult to come to the hospital/clinic" are not surprising. However, only 68% were able to respond to this question, the remainder answering "I don't know". Further comment about this is contained below. 65% of those who did respond commented on the expense of taking a taxi and not having the money for this, 15% found the distances too great to walk. Another 15% stated that their physical conditions prevented them from being able to walk any distance and 32% mentioned problems with finding someone to look after their grandchildren for such a long period of time. Only 6% found the user fee to be a problem (though this has hopefully now been resolved). Other issues that were mentioned included needing to be at home to take care of household tasks (15%)

Ideas for Improvements

As far as presenting their ideas for "making things easier for you and other older people to get health services", 64% of respondents (n=33) felt that having a Health Care Worker come into their community and do home visits to provide basic services and medications would be extremely helpful. This would address the challenges mentioned above – distances to travel, ability to walk, money for taxis, and child and household care. A number of people (18%) suggested that clinics be held in remote areas using local schools (of which there are many, well distributed) or the headmen's houses. Twenty seven percent were interested in having a special hospital bus to provide transportation for those needing to

attend hospital or clinics. Other suggestions included having more doctors and nurses, building more roads for local access and improving the ambulance system so that very sick people could be transported to the hospital. One person felt that the administration should be improved so that wait times at the hospital and clinics could be reduced.

An interesting finding that emerged in relation to the last two questions (what are the challenges, and what ideas they had for solving these) was the striking inability of the majority of the grandmothers to come up with any answers. The most frequent first response was "I don't know". It took a lot of probing and persuasion to get even some of them to come up with any ideas. Eventually my persistence bore fruit and 34 grandmothers were able to give me some ideas regarding their challenges and 33 provided ideas about steps that could improve access. The reasons for this paucity of thought, and their incredible acceptance of things being the way they are, with no apparent thought or motivation to improve the situation can only be guessed at. The majority of these grandmothers were uneducated and had lived a long time under the apartheid system of government where black people's needs were not taken into consideration to any extent. In addition, the majority of black women in rural South Africa have little voice to stand up for themselves, and demand better services.

Limitations

A number of limitations were identified with regard to this study. As primary interviewer, not being of the culture nor speaking the language of the people I was interviewing (Xhosa) limited full understanding of what questions were appropriate for this culture and hidden meanings in the responses. In addition, relying on the services of the interpreter both for phrasing questions appropriately, and relaying the responses accurately and with sensitivity, meant that I was not able to control this aspect of the interviews.

Because of my connection with the hospital, I recruited the majority 38 (76%) of my sample of grandmothers at the hospital or clinics where they were either seeking health care for themselves or a family member, or visiting family in the hospital. Thus they were already aware of how to access services. This led to potential selection bias and may not have been representative of grandmothers in this community as a whole, especially those who are not inclined to seek care from these settings. This also applies to the sample size which was only 50, so findings cannot be generalized to the entire community of grandmothers or older people.

Being "from the hospital" and "white" may have affected certain responses such as to the question, "Who else do you go to for health care?" Some grandmothers may have felt uncomfortable admitting that they visit a traditional healer, thinking I may not have approved.

Discussion

This study set out to identify the challenges that grandmothers face in accessing health care in a remote rural area of South Africa. This objective was sufficiently answered through the descriptive analysis that was done, together with the data garnered from the participants in their responses to the qualitative questions. In summary, the main barriers to accessing health care were: distances grandmothers have to travel to reach health centers, being unable to walk these distances due to health limitations, the costs of taxis (if available), and having someone to care for grandchildren while they attended the health center.

These findings raise important questions with regard to the health care system in this area and how it is able to respond to the special needs of the senior population. While seniors are eligible for health services like everyone else in that area, there are no specific programs targeted to addressing their special needs. The responsibility for this lies at the feet of the national health care system. First of all, there are no funds targeted to seniors which would allow for specialized programs. In addition, training of doctors and nurses with an emphasis on working with seniors is not a priority. Given the epidemics of HIV/AIDS, TB and malaria in South Africa, and the need to address these diseases first, this is not surprising. Nonetheless, given the large number of seniors who are in need of services, and the incredible job that grandmothers are doing in taking care of this generation of children, especially those orphaned by AIDS, I believe that local primary care hospitals could reallocate some of their

funds to improve health services for their senior population (and therefore for the grandchildren's generation). I also believe it is incumbent on the National Health System to provide funds for specialized health programs for seniors and to include, in the health worker curricula, courses with a special focus on the elderly.

Conclusion

As can be seen from my findings, many of the barriers to health access, which were discussed in the earlier parts of this paper, were identified as barriers for the participants of my study. While there was a hospital offering good primary health care, and six clinics scattered throughout the area, there were still problems of physical access to these resulting from poor road infrastructure and high costs of transportation. Walking was the main alternative but was arduous and difficult if not impossible for those with chronic health conditions, especially heart conditions and arthritis. In addition, walking was very time consuming, as were the wait times and many of my study participants found it difficult to take that time away from their household duties, especially caring for grandchildren.

From my interviews with staff, it was clear that there were no special programs for the elderly and none of the staff had undergone special training to develop their knowledge, awareness and skills in working with seniors. It simply was not seen as a priority amongst all the other conditions and issues they are dealing with at the hospital and clinics on a very limited budget.

Future Research

While this study has certainly highlighted the challenges that grandmothers face in accessing health care, much work still needs to be done to determine how to improve health services. Some of the areas are:

Mental Health: One of the areas I chose not to pursue in my interviews was the sensitive issue of mental health amongst these grandmothers. During a few of the interviews participants started to cry as they talked about the loss of their children and of being discriminated against. This topic would therefore be a useful one to further explore, as long as counselling and support could be provided in their own language to the participants who experience emotional challenges.

Outreach Clinics: Conduct a feasibility study to determine the practicality of providing outreach clinics. This would include identifying venues in the areas furthest away from clinics and the hospital, where monthly clinics could be held, assessing the roads and tracks to determine whether a 4-wheel drive vehicle could access these areas, and if not, how staff and supplies could get there (all terrain vehicles).

Health Access: In order to be able to generalize the findings of this study, similar studies should be undertaken in remote rural areas of other developing countries to determine if older people's health access challenges are the same, and what further issues might exist.

CHAPTER 5: IMPLICATIONS AND RECOMMENDATIONS

In light of the broad spectrum of health access challenges facing the elderly in remote rural areas of developing countries, it is clear that more effort must be made to focus attention on the health needs of this particular generation. This must occur at all three levels relating to health access: macro, institutional and individual. At the macro level, multi-lateral organizations, governments, and policy makers need to better understand the issues of health access for seniors so they can develop policies and fund programs which will address the health needs of this vulnerable population.

At this macro level, a network of non-profit organizations called HelpAge International appears to be spearheading this process. This organization focuses on improving the lives of the elderly by linking organizations interested in the well being of seniors throughout the world, sharing resources and ideas, and promoting research. It also develops platforms to voice the need for change and to bring the plight of older people to the attention of policy makers, governments, and multi-lateral organizations. This network has been instrumental in advocating for the human rights of older people to health care at the macro level and has been successful in raising awareness within multilateral organizations such as the United Nations and the World Health Organization. This, in turn, impacts politicians and policy makers at the governmental level.

HelpAge International also helps build partnerships between governments and non-governmental organizations (NGOs) at local, national and international levels, further raising awareness and pressuring for change. This will hopefully ultimately result in improved health policies and better health system structuring, funding and programming for older populations.

At the institutional level, planners and health service administrators also need to be educated about the growing senior population and their particular health needs. They too must focus their attention on ways to improve services to their senior populations, either by applying for further funding from national governments or NGO's or by reorganizing their budgets to allow for special programming for the elderly. In the long run this could prove to be cheaper than providing health services to seniors as part of the general population. By understanding the issues facing this generation, they can make meaningful changes that facilitate health access and improve health services for seniors.

At the same time, medical and nursing schools need to update their curricula so that health workers graduating from their programs are skilled, knowledgeable, aware, and well prepared to deal with the onslaught of a senior generation that is expected to grow exponentially over the next 50 years. It is by educating them at this point in their careers that they will be able to take the knowledge and awareness they have developed out into hospitals and health centers leading to appropriate practices and hopefully also raising awareness amongst their fellow workers.

At the individual level relating to health access, the first issue that needs to be addressed is the extreme poverty that a large proportion of seniors live in. This poverty creates a vicious cycle of ill health leading to inability to take care of self and family, inability to work and get an income, leading even deeper into poverty. Much research has been done on the impact of social pensions on poverty and it seems that the only way to break this vicious cycle is by providing universal social pensions to the elderly. Work needs to be done too to make people more aware of their rights and to help them find their voice. Many NGO's are involved in projects that are seeking to empower the elders of societies so that they can participate by making choices about their lives and not just suffer at the hands of fate.

Outreach programs through schools, churches and community gatherings must be supported so that seniors can receive information on health issues and be given opportunities to receive health services. Here too HelpAge International is active, operating at a more local level through non-profit organizations to ensure that seniors have a voice and are able to participate as much as possible in planning processes that affect them. They provide training to member groups, and support practical grassroots programs particularly in emergency situations where the needs of the elderly are often overlooked.

The Stephen Lewis Foundation has been very effective within Canada at bringing the plight of AIDS orphans and grandmothers to the attention of the public. I believe that great strides could be made in improving health access for

seniors in developing countries if organizations initially focused on the health needs of grandmothers who are looking after AIDS orphans. Not only does this group elicit much media attention throughout the western world, making them the subject of great sympathy, advocacy and support, but they are also playing a very important role in providing for the health and wellbeing of the future generation. Because HIV/AIDS is widespread across many developing countries, grandmothers looking after AIDS orphans can be found all over the world. Ensuring that they have access to health care will start a process that will ultimately have a broader impact. Infrastructure will be developed to provide health services to them, health care workers will receive training to improve their awareness and knowledge of the issues relating to growing old, and programs oriented to grandmothers' needs will be funded. This will set in motion a process that can then be expanded to include all the older generation.

An initiative that could be implemented at the grass roots level in relation to the above scenario is the introduction of mobile health clinics into remote rural areas. These would provide appropriate screening and health services to older people where health centers are not easily accessible. Based both on the research I have read, and on my own study of grandmothers I believe this would make a very positive impact on the lives of many seniors. As Mehrortra et al. explain, even if only the most basic of services was provided, a huge difference would be made to the health of the older generation (Mehrotra, 2002).

This paper has undertaken an exploration of the concept of access to health care as it relates to older populations in rural areas of developing countries. It has also examined the literature on barriers to health access and demonstrated from a personal research project, a strong connection between what the literature has identified as barriers to accessing health care, and the reality of these barriers in the lives of the grandmothers who participated in my study.

A number of recommendations have been made to address future research needs as well as suggest practical initiatives which could be conducted by NGO's, health centers, and governments in order to better meet the health care needs of their older generations.

APPENDICES

Appendix 1: Health Access Framework

Macro Level
Socio-political values
Economic status
Style of development
Macroeconomic policies
Health policies
Infrastructure
Work/employment conditions
Social safety net
Status of seniors within society
Availability, Affordability, Adequacy, Accountability

Institutional Level	
Structure of the Health System	**Staff Attributes**
Location and number of health centres	Awareness of seniors' needs and issues
Diagnostic and treatment services	Knowledge of conditions affecting seniors
Range and availability of drugs	Beliefs about seniors' status
Costs of services	Attitudes towards seniors/poor
Profit orientation	Behaviours towards seniors (discrimination)
Hours of operation	Ability to speak language of clients
Staff recruitment	Cultural understanding and sensitivity
Staff education and training	Unwillingness to treat uninsured patients
Availability, Affordability, Adequacy, Accountability, Acceptability, Accommodation	**Availability, Adequacy, Accountability, Acceptability, Accommodation**

Individual Level		
Characteristics of Clients	**Situation of Clients**	**Behavior/motivation of Clients**
Elderly	Socio-economic status	Perception of severity of situation
Level of education, literacy	Employment or income status	Reluctance/fear to seek care
Etiological beliefs	Lack of health insurance	Delayed help seeking behavior
Ability to speak language of providers	Ability to pay for services	Perception about the ability of health system to solve the problem
Ability to identify health problems as problems	Ill with specific disease - e.g. Arthritis, AIDS	Previous negative experience with health services
Mentally ill, demented, mentally or physically handicapped	Homeless, battered, imprisoned, migrant, refugee, nomad	
	Living far away from health services	
	No roads/transport	
Acceptability	**Availability, Affordability**	**Acceptability, Affordability**

Appendix 2: Grandmothers' Survey

Basic information

1. Please tell me about your family. (husband, sons, daughters, grandchildren, others)

2. Where are your adult children now?

3. Tell me about the g/children who are living with you now and how old they are.

4. Do the children go to school?

5. If not, why not?

6. How old are you?

7. Tell me about your home (kraal) - how many rondawels, flats etc?

8. Who lives close to your kraal? (family, relatives, friends, neighbours)

9. Where do you get your water for cooking?

10. How far away is that from your home?

11. Do you boil your water before drinking it?

12. What type of toilet do you have?

13. Do you have a garden?

14. What do you grow in it?

15. How do you cook your food? (wood, paraffin, gas, electricity).

Health status and treatment

16. Tell me about your health. (TB + Rx)

17. Do you take pills? What for?

18. Do they take your blood pressure when you go to the clinic/hospital?

19. Do they check your urine?

20. Do they check your blood?

21. Do they explain what is wrong with you?

22. Do they explain what you need to do to make it better and/or to stay healthy?

23. Do you feel satisfied with your treatment there? (yes, so-so, no)

Health access

24. What makes it difficult for you to come to the hospital/clinic when you are sick

25. How do you come to the hospital/clinic?

26. How long does it take for you to get here?

27. How long do you have to wait to see someone?

28. Does a health care worker ever visit you in your home?

29. Who looks after the children while you are here?

30. Do the staff treat you with respect?

31. Who else do you go to for health care? (Traditional Healer, GP.)

32. How much does a visit to them usually cost?

33. What would make it easier for you to get health services from the clinic or hospital?

Finances

34. How much does a visit to the hospital/clinic cost you?

35. Have you ever **not** come because you cannot pay?

36. What would transportation cost to get to the clinic/hospital and back home?

37. Do you get a pension? Does your husband?

38. Do you get any grants for the children? How many?

39. Have you received any other grants like food, clothing etc. in the past year?

40. Do you have any other income? From what?

41. Do any of the household members work?

General

42. Is there anything more you could tell me that might make it easier for you and other grandmothers to get health care?

REFERENCE LIST

Abegunde, D. O., Mathers, C. D., Adam, T., Ortegon, M., & Strong, K. (2007). The burden and costs of chronic diseases in low-income and middle-income countries. *The Lancet, 370*(9603), 1929-1938.

The ageing and development report: A summary. (1999). Retrieved November 10, 2007, from http://www.helpage.org/Resources/Policyreports

Ageing issues in Africa: A summary. (n.d.). Retrieved November 10, 2007, from http://www.helpage.org/Resources/Policyreports

Ageing, poverty and the international development agenda. (n.d.). Retrieved January 6, 2008, from http://www.helpage.org/Resources/Policyreports

Ancient remedies, new disease: Involving traditional healers in increasing access to AIDS care and prevention in East Africa. (2002). Retrieved February 20, 2008, from http://search.unaids.org/Results.aspx?c=Publications&l=en&q=traditional

Beales, S., & Gorman, M. (2002). *Population ageing and development: New strategies for social protection*. Retrieved November 10, 2007, from HelpAge International Web site: http://www.helpage.org/Resources/Policyreports

Bock, J., & Johnson, S. E. (2008). Grandmothers' productivity and the HIV/AIDS pandemic in sub-Saharan Africa. *Journal of Cross Cultural Gerontology.* Retrieved January 15, 2008, from http://springerlink.metapress.com.

Burns, J., Keswell, M., & Leibbrandt, M. (2005). Social assistance, gender and the aged in South Africa. *Feminist Economics, 11*(2), 103.

Carrin, G. (2007). Designing health financing policy towards universal coverage. *Bulletin of the World Health Organization, 85*(9), 652.

Ferreira, M. (2006). The differential impact of social-pension income on household poverty alleviation in three South African ethnic groups. *Ageing and Society, 26*, 337-354.

Forgotten families: Older people as carers of orphans and vulnerable children (2003). Retrieved November 11, 2007, from http://www.helpage.org/Resources/Policyreports

Global action on aging: Major developments and trends in population ageing (2007). Retrieved January 4, 2008, from http://www.globalaging.org/pension/world/2007/development.pdf

Global action on aging: Major developments in health and ageing (2007). Retrieved January 6, 2008, from http://www.globalaging.org/health/world/2007/whodevelopments.pdf

Gorman, M. (2004). *Age and security: How social pensions can deliver effective aid to poor older people and their families.* Retrieved November 10, 2007, from HelpAge International Web site: http://www.helpage.org/Resources/Policyreports

Hossain, P., Kawar, B., & El Nahas, M. (2007). Obesity and diabetes in the developing world - a growing challenge. *The New England Journal of Medicine, 356*(3), 213-215.

Johnson, J., & Williamson, J. (2006). Do universal non-contributory old-age pensions make sense for rural areas in low-income countries? *International Social Security Review 59 (4), 47–65.*

Kalache, A., Hoskins, I., & Mende, S. (2004). *Towards age-friendly primary health care.* Retrieved December 5, 2007, from WHO Web site: http://whqlibdoc.who.int/publications/2004/9241592184.pdf

Khan, M., & Lee, M. (2007). *Global action on aging: How does HIV/AIDS affect the elderly in developing countries?* Retrieved January 6, 2008, from Global Action on Ageing Web site: http://www.globalaging.org/health/world/2007/Today.pdf

King, R. (2000). *Collaboration with traditional healers in HIV / AIDS prevention and care in sub-Saharan Africa: A literature review.* Retrieved February 20, 2008, from UNAIDS Web site: http://search.unaids.org/Results.aspx?c=Publications&l=en&q=traditional

Knodel, J., Watkins, S., & VanLandingham, M. (2003). AIDS and older persons: An international perspective. *JAIDS Journal of Acquired Immune Deficiency Syndromes, 33*(Supplement 2), S153-S165.

Madhavan, S. (2004). Fosterage patterns in the age of AIDS: Continuity and change. *Social Science & Medicine, 58*(7), 1443.

Mehrotra, S. (2002). Improving basic health service delivery in low-income countries: 'Voice' to the poor. *Social Science & Medicine (1982), 54*(11), 1685-1690.

Mills, E. J., Schabas, W. A., Volmink, J., Walker, R., Ford, N., Katabira, E., et al. (2008). Should active recruitment of health workers from sub-Saharan Africa be viewed as a crime? *The Lancet, 371*(9613), 685-688.

Penshansky, R. (1981). The concept of access - definition and relationship to consumer satisfaction. *Medical Care, 19*(2), 127-140.

Perth framework for age-friendly community-based primary health care. (2008). Retrieved January 6, 2008, from http://www.who.int/ageing/projects/perth/en/index.html

Preventing chronic diseases: A vital investment: WHO global report. (2005). Retrieved January 4, 2008 from http://www.who.int/chp/chronic_disease_report/contents/en/index.html

Puentes-Markides, C. (1992). Women and access to health care. *Social Science & Medicine, 35*(4), 619.

Reddy, K. S. (2002). Cardiovascular diseases in the developing countries: Dimensions, determinants, dynamics and directions for public health action. *Public Health Nutrition, 5*(1A), 231-237.

Ssengonzi, R. (2007). The plight of older persons as caregivers to people infected/affected by HIV/AIDS: Evidence from Uganda. *Journal of Cross-Cultural Gerontology, 22*(4), 339-353.

State of the world's older people 2002. (2002). Retrieved November10, 2007, from http://www.helpage.org/Resources/Policyreports

Yach, D., Kellogg, M., & Voute, J. (2005). Chronic diseases: An increasing challenge in developing countries. *Transactions of the Royal Society of Tropical Medicine and Hygiene, 99*, 321.

Zimmer, Z., & Martin, L. G. (2007). Key topics in the study of older adult health in developing countries that are experiencing population aging. *Journal of Cross-Cultural Gerontology, 22*(3), 235-241.