SOCIAL PROTECTION OF THE ELDERLY IN SWAZILAND

A RESEARCH REPORT

By

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EXECUTIVE SUMMARY

This study evolved from the Umchumanisi strategy. Among other things, Umchumanisi aims at giving a voice to the marginalized groups. In this regard, the initiative has facilitated poverty dialogues in over 20 constituencies. One of the most recurrent issues during these dialogues has been the plight of the elderly in Swaziland. This study therefore was to investigate the vulnerability of the elderly in Swaziland and highlight the extent to which selected programmes respond to the needs of the elderly.

A combination of qualitative and quantitative methods were used to collect the data for this study. A questionnaire was used to interview 207 elderly people from the four regions. In addition there were community focus group discussions of the elderly and key informant interviews with officials of five organizations that assist the elderly. These included officers from two of the regional offices and one from the Head Office of the Social Welfare Department. Key informants from two NGOs were also interviewed.

The findings of the research reveal that the elderly bear the brunt of unemployment, poverty and HIV/AIDS. At a time in their lives when their economic, social, physical and motional well being is at its lowest, the elderly are expected to shoulder the responsibilities of taking care of families. Irrespective of place of residence, the majority of the elderly care for people within and outside their households. This caring however is not reciprocated as very few of the respondents had other people caring for them in return. While the elderly are faced with many problems, the problems of the disabled elderly are even more acute. Food security is a major problem for the elderly. While land does not seem to be a problem for most of them, lack of access to farming inputs has continued to be a challenge to their food security.

An overview of the programmes designed to assist the elderly shows that support tends to be sporadic, inadequate and reaches very few of the destitute elderly. The elderly do not receive adequate support from any source. To begin with, the knowledge about the available programmes was very low and the criteria used to select the beneficiaries was regarded as not being objective leaving the majority of destitute out. The procedures for accessing the state grant was not considered to be “elderly friendly”, accessing the grant becomes a burden or chore to the elderly, especially to the disabled and the sick.

The study concludes with several recommendations. A policy on the elderly is long overdue, the political rhetoric about concern for the elderly reaches a peak during elections but this has not been translated into the enactment of policies once the politicians are in parliament. The criteria for determining eligibility should be improved and more elderly friendly procedures are needed for accessing the state grant. The role of the elderly in family welfare should be acknowledged in development programming.

The assistance for the elderly should go beyond financial help and include other services such as farming inputs, health care and school fees. Policies and programmes on HIV/AIDS should recognise the role of older persons as care givers to the sick and orphans. Promoting a culture of saving and investing will prevent people from being destitute in their old age. Collaboration of stakeholders is necessary to optimise the limited resources available. Community based efforts to provide food for the elderly and the needy should be supported.

1.0 INTRODUCTION

Poverty is a multi-dimensional phenomenon, which requires multi-faceted approaches tailored to the needs of individuals, communities, countries and the region at large. According to Matsebula V (2003: 4), the response of government to poverty conditions in Swaziland has not been an impressive one. The absence of adequate policies has also been cited as one of the reasons why the country is vulnerable to catastrophes such as drought.

In Swaziland, social protection has been largely neglected or addressed with inadequate tools and insufficient funds. The presupposition is that the elderly in Swaziland are part of the groups that are most vulnerable to poverty as there are no safety nets to safeguard them against all forms of catastrophes. This research therefore seeks to investigate the socio-economic factors determining the vulnerability of the elderly in Swaziland, as well as policies and programmes that are designed to protect the elderly against all forms of vulnerabilities. It also intends to assess the effectiveness of programmes intended to protect the elderly against any vulnerabilities. It is therefore important to understand the socio-economic context influencing the vulnerability of the elderly in order to contribute to formulation of policies designed to improve the situation of the elderly.

1.1 Background

The 1997 Swaziland population and Housing census estimated the population of the country at 929 718 and 53% are females. Those over the age of 55 years accounted for 4.6% of the total population. Swaziland is a lower middle income developing country, it is divided into four administrative regions, namely: Hhohho, Manzini, Shiselweni and Lubombo regions. More than 70% of the Swazi population resides in the rural areas. Only about 31% is employed with more males than females dominating the employment sector. *The dependency ratio of 140 to that 100 economically active people would have to support themselves which places a heavy burden on the economically active population.*

The government of Swaziland is concerned about the welfare of the elderly, as expressed in the National Development Strategy where government pledges its commitment in promoting savings in order to protect the elderly and ensuring that they are provided with basic needs. This facilitates the emergence, maintenance and regulation of old aged homes.

Swaziland is faced with a serious challenge as it is estimated that 66% of the population live below the poverty datum line of $1 per day (less than E71 per month) yet the country is classified as middle income country with a GDP per capita of US $1, 298 (World Bank, 2002). Despite being classified as a middle income country, the wealth of the country is not evenly distributed, leaving the majority of the population poor. The Swaziland Household Income and

Expenditure Survey (SHIES) (1995), shows 10% of the Swazi population control 40% of the total income, whilst the poorest 40% of the population, control only 14% of the total income. World Bank 2002 also indicates that the depth and severity of poverty is worse in the rural areas with the Shiselweni and Lubombo regions being the worst affected by poverty. It is also estimated that 30% of the urban population is poor. The country is also faced with acute food crisis as it is estimated that more than 300 000 people are in need of food aid.

Since Swaziland is a patriarchal society, women bear the brunt of poverty. Most poor families are those that are headed by widows, illiterate adults and to large extent families that are headed by grand parents who have no sources of income and live in abject poverty. The elderly in Swaziland are therefore one of the groups that are most vulnerable to poverty. The Swazi population is being devastated by the HIV / AIDS scourge as it is estimated that 38.6% of the Swazi population are infected by the virus. The whole society is susceptible to the HIV/AIDS, the poor being unable to cope with the challenges that come with this disease as they do not have the coping mechanisms. According to **Ageing and development (issue 13 January 2003: 1),** the rising incidence of HIV/AIDS, drought and displacement have weakened family support for older people. Older people, especially older women, are now often the main carers of grandchildren and people who are sick.

In Swaziland as is the case in many countries in Africa, older people who have suffered a lifetime of poverty enter old age with very little or no resources at all and often in poor health. Older people are seen as a low priority by most humanitarian agencies, and very few develop programmes that consider their specific needs. Older people's particular needs need to be recognised and supported if poverty is to be halved by 2015 (Millenium Development Goals). The contributions of the elderly are needed in every society and the systematic plans for drawing on their resources can only benefit all the people in the country (Taylor 1983). In parenthesis, current policies and programmes need to acknowledge the contribution of the elderly in society, with a view to curb the increased responsibilities they are shouldering.

1.2 Rationale to the study

This research project has emerged out of the Umchumanisi strategy which is a Civil Society support initiative which aims at addressing the crisis of poverty in the country. This initiative aims at finding out which public policies can contribute to and sustain a pro-poor policy environment. Umchumanisi also aims at bringing the voices of the often marginalized groups such as the **elderly**, disabled, women and the poor to the fore in order for them to be able to influence policies.

The Coordinating Assembly of Non Governmental Organisations (CANGO) has held poverty dialogues in more than 20 constituencies in the country. One of the most recurrent issues in these dialogues is the issue of the elderly who are often

neglected yet with the advent of the HIV / AIDS epidemic, the elderly are left to care for orphans yet they themselves do not have any source of income. Therefore the study seeks to systematically identify and highlight the plight of the elders, as well as examine the factors which contribute to their vulnerability.

1.3 Statement of the problem

In the Swazi context, the "traditional social security system" assumes that children will take care of their elderly parents. However, the reality is that due to a number of reasons, including unemployment, migration, disintegration of the extended family, and HIV/AIDS the children do not take up the filial obligations. As a result, the elderly are abandoned, receive no remittances, and hence have to grapple with caring for themselves. Moreover, these elderly have assumed the added responsibilities of caring for their adult children, grandchildren and relatives due to the deteriorating economic conditions in the country. Also, with the advent of HIV/AIDS the traditional safety nets have been stretched to the breaking point, reducing the number of adults in their prime and putting fresh responsibilities on elderly people (Kaleeba 2002). Consequently, the elderly have to care for their sick adult children who eventually die; have to bear with the funeral responsibilities; go through the emotional trauma; care for the orphans; and at times the orphans are themselves infected and eventually die. Concomitantly, all these responsibilities and problems are occurring at a time when the health of the elderly is deteriorating due to degenerative conditions and their economic status is poor.

Most of the elderly live in the rural areas where farming is the main source of income. Calamities such as drought, and the increasing cost of farming inputs have compromised the ability of rural households to be self-sufficient in food production. Farming has therefore increasingly become an unreliable source of livelihood. This, combined with the prevailing economic conditions, makes hunger and poverty a characteristic of the rural population. The elderly, who are vulnerable, have been left to raise a generation of Swazi children. It is essential therefore that we investigate the vulnerability of the elderly and to assess the responsiveness of the policies and programmes designed to address issues of the elderly.

1.4 Objectives

The specific objectives of the study are:

a) To investigate the vulnerability of the elderly in Swaziland
b) To investigate and assess the extent to which the policies and programmes respond to the needs of the elderly in Swaziland
c) To provide policy recommendations for poverty alleviation among the elderly

2.0 LITERATURE REVIEW

For the purposes of this study, ageing has been defined as "the process of human aging involving physiological and psychological changes that are sequential, cumulative, and irreversible, but it is generally agreed that the changes do not occur at the same rate in any one individual, let alone in all people of the same chronological age. Ageing can be defined as a chronological category or as a degenerative process, while operationally it may be defined as that age at which functional limitations occur on physical mobility. In the economic sense, aging may be defined as that age at which retraining for new skills does not pay the company for the cost of training. This is in terms of expected future employment. Socially it may be defined as the age when one exits permanently from the labour force and retires (Kahn and Kamerman 1980:236).

At the International Conference on Population and Development (1994) the issues of the elderly were discussed and governments' including Swaziland, committed themselves that they will develop social security systems that ensure greater equity and solidarity between and within generations and provide support to elderly people.

Some countries have non contributory pensions which have a great potential of reducing poverty. Poor people in Africa face high levels of unemployment, rising cost of living and the burden of HIV / AIDS.

2.1 Conceptualisation of Social protection

Social protection can be defined as those policies and interventions that both protect and promote the livelihoods and welfare of the poor people and it needs to be considered in relation to other forms of support to poor people (Ageing and Development 2003: 6). Social protection is defined as a set of policies and programs designed to reduce poverty and vulnerability by promoting efficient labor markets, diminishing people's exposure to risks, and enhancing their capacity to protect themselves against hazards and interruption / loss of income (www.adb.org 2/28/03). Social protection consists of five main areas:

1. **labour markets**: policies and programmes designed to promote employment, the efficient operation of labour markets and the protection of workers.
2. **social insurance:** programmes to cushion the risks associated with unemployment, ill health, disability, work – related injury and old age.
3. **social assistance and welfare service programmes** for the most vulnerable groups with no other means of adequate support, including single mothers, the homeless, or physically or mentally challenged people.

4. **micro and area based schemes**: to address vulnerability at the community level, including micro insurance, agriculture insurance, social funds and programs to manage natural disasters.
5. **child protection** to ensure the healthy and productive development of children.

In essence social protection reduces risks and increases opportunities for all citizens of a country.

Economic growth is crucial to reduce and prevent poverty. However, growth is not adequate to prevent and fight poverty and social exclusion. Without additional measures, the advantages of the market economy may be limited to a part of society only, namely those who are educated, own productive assets, and have participated in successful economic activities (www.adb.org).

What are the benefits of social protection?

Social protection benefits both the poor and the non-poor as they are all exposed to risks that are hard to cope with alone, such as crop failures, illnesses, accidents, disability or death of the breadwinner, or simply getting old and not able to work. At the macro level, when natural disasters such as the drought strike, many people slip into poverty or sink deeper into it. The role of social protection is to assist people get out of poverty and cope better with the risk.

- Social protection helps countries become more competitive by ensuring human capital development and increasing productivity. Investments in social protection reduce risks for the whole population covered, and not only of the poor. In countries without social protection, people constantly worry about the health of family members, and become indebted to cover catastrophic and life cycle events such as bad crops, disability, and natural disasters. Social protection can reduce the impacts of those risks, and allow people to fully concentrate in their livelihood and economic activities, even taking new entrepreneurial risks, and becoming more productive. Productivity per worker is higher in countries investing more in social protection.
- Social protection prevents poverty, reduces criminality hence contributing to social and economic stability. People should not have to sell their assets to pay for health costs. People who lose their capacity to work can have access to basic resources. Families who lose their breadwinner should be able to get support. Without social protection all these would fall into poverty (www.adb.org 2/28/03)

According to **Ageing and development (2003: 6),** In developing countries, the probability of experiencing poverty increases in later life. Rapid population

ageing in developing countries will therefore have important implications for poverty levels and poverty reduction strategies. Therefore, as poverty deepens in Swaziland, as in other parts of the developing world, social measures to enhance poor people's capacity to manage risks and 'lift' themselves out of poverty becomes increasingly important.

2.2 Social Welfare in Africa

In many cultures, the elderly members of society are respected and revered for their wisdom and knowledge. They are the important members of society and their decisions are very influential in shaping the direction of our culture. Thus in most African cultures the above are very true.

Dixon (nd) edited a book titled "Social Welfare in Africa. In which a number of countries services provided have been analyzed. In Ghana, the traditional family insured a person throughout life. But with shifting from a productive unit to a consumptive unit, family members rely more on their efforts to meet their needs. The aged holds a very special position in the traditional family structure. But nowadays some aged persons are without a family support therefore are impoverished.

In Mauritius the family is still the primary care of its elderly members and attempts to provide for the needs of the elderly. In Nigeria old age is still considered to be deserving of the care of the young and attention of government and the increasing disintegration of the extended family, which previously provided such social security for the aged, all have mad the welfare of the aged very precarious.

The neighbouring South Africa have a philosophy which promote the care of the aged, but the onus for making provision for the aged is still the responsibility of individual families. Only when the individual is unable to help himself/herself will the state provide financial assistance. Also it has become accepted policy to maintain old people in the community, whenever possible and regard institutional care as a last resort (Dixon, p.193).

The Tanzanian case is that in the Arusha Declaration of the ruling party, Chama cha Mapinduzi, sees the care of the aged as being the shared responsibility of the family, the village community, and the State. Generally it accepted as a cultural given that the senior citizens enjoy the support of their grown up children in terms of meeting their material as well as psychological needs.

In Zambia, the elderly have always been seen as a family and community resource because of their wisdom. As result care of the aged has been seen as a family and community responsibility. In a developing country like Zambia, a number of factors contribute to the poor condition of the aged (Dixon n.d).

2.3 Social Welfare in Swaziland

The origin of Social Welfare Services in Swaziland dates back to 1952 during the colonial days, but was expanded after independence. At that time the Local Administration was responsible for providing Social Welfare Services, which later was moved to the Ministry of Home Affairs. Social welfare Department was transferred to Ministry of Health in 1996, having been gazetted under the Legal Gazette No 147 and renamed the Ministry of Health and Social Welfare (Kaseke, 1997).

Thus as Kaseke (1997) stated that the responsibility to provide Social Welfare services is designed to improve the welfare of the people of Swaziland has been mandated to the Department of Social Welfare in the Ministry of Health and Social Welfare. Some of the vulnerable groups the department focuses on are the children, the elderly, persons with disabilities, etc. The services provided include public assistance to destitute, maintenance payments, foster care, adoption, military pension, family counselling and disaster relief.

A social service that directly concerns the elderly people in Swaziland is the Public Assistance. It was estimated that 40% of Swaziland population is needy and requires public assistance (Kaseke 1997). Public Assistance is a means-tested programme provided to the needy and destitute members of society. Only 10% of the eligible population is able to access the programme. Beneficiaries include the elderly, the terminally ill, widows and persons with disabilities. Destitutes are supposed to apply for assistance at the Regional Social Welfare Offices or Tinkhundla centres. There after social workers provide an assessment on the degree of destitution. Kaseke's (1997) situational analysis revealed that assistance provided to beneficiaries ranged from E40 to E65 and this was paid on quarterly basis. Kaseke noted that the social welfare service in Swaziland is fragmented because not all services were administered directly by the department. (P15).

It was noted further that public assistance programme was not responsive to the needs of the poor, particularly given that the amounts given to the beneficiaries has no bearing to the cost of living. The assistance is inadequate and falls short in meeting the beneficiary's basic needs. According to a recent newspaper article (Weekend Observer has also confirmed this 15-16 March 2003), the elderly receive E120 every three months. Considering that the amount is paid every 3 months, it is clear that the assistance is very inadequate. The grant has little positive effect on the social economic situation of the majority of the elderly.

2.4 Hypothesis

- HIV/AIDS increases the vulnerability of the elderly
- Socio-economic context of Swaziland predisposes the elderly to high levels of morbidity, abject poverty and social exclusion.
- The social responsibilities have increased with the mounting poverty in Swaziland
- Current policies and programmes in place are insignificant to the alleviation of the elderly problems.

3.0 METHODOLOGY

3.1 Research Design:

This was an exploratory, qualitative – quantitative research. It involved the identification of:

- Caring responsibilities of elderly people
- Assistance received by the elderly and their coping strategies in the face of poverty and HIV /AIDS.

Triangulation of qualitative and quantitative methods were given premise because it allowed detailed data, provided a deeper insight into actual problems faced, as well as the number of people affected and the extent of the problem.

3.2 Sampling

Participants were selected from the rural and urban Tinkhundla in the four (4) regions of the country. Two hundred and seven (207) individuals were interviewed from the four regions of which fifty participants were from each of the four regions. About 3% of the total sample constituted the disabled elderly people. The constituencies were purposefully selected according to a ration 3:1 (rural: urban) since the majority of the elderly people reside in the rural areas.

Key informants for the agencies that provide services to the elderly were also part of the sample. These were from Baphalali Swaziland Red Cross, Umtfunti Wemaswati ,and Social Welfare Offices (Regional Offices and Head Quarters)

3.3 Data collection

The following research techniques were used for data collection in the course of the study. They were Focus group discussions and in-depth interviews. These methods were used in both the study participants and the key informants.

3.4 Pilot Test

The questionnaire was piloted by ULARN at two Tinkhundlas (urban and rural) in Manzini. This was followed by necessary adjustments on the data collection tools prior to conducting the main study.

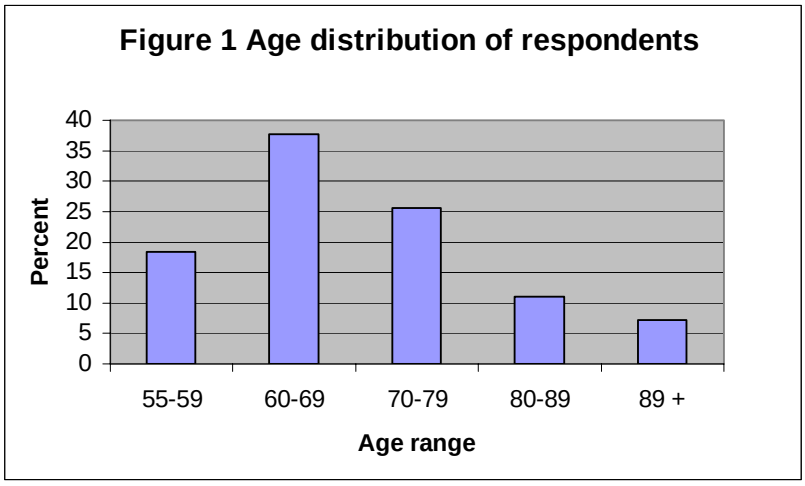
3.5 Data analysis

Data was analyzed by computer using the SPSS software version 11.0

4.0 RESULTS

4.1 Characteristics of the respondents

For the purposes of this study, elderly were defined as people that are 55 years and older. A total of 207 elderly people were interviewed, more or less evenly distributed from the four administrative regions as about a quarter come from each region (see Appendix 1). The majority were female (67.4%) and came from the rural areas (76.3%). A special effort had to be made to get male respondents. About 60% of the respondents were married, 25.7% were widowed, 6.6% separated and 6.1% single. Only 59.2% of the respondents had ever been to school and the majority of them, (58.7%), had gone up to primary as the highest level of education, while less than 30% had gone beyond primary school, and 12.7% had attended the Sebenta Literacy Programme. Forty six per cent of the respondents were protestants, while 32.9% belonged to the Zionist church.



About 20% had never worked and of those who had worked, very few had been in skilled employment. Only 34.5% had contributed to a pension/provident fund while they were working, and 14% had private savings, mostly with cooperatives.

4.2 Socio-Economic effects on the elderly

Both the urban and rural aged are susceptible to social and economic problems. According to S Howard 'Social problems in the USA include the suffering of elderly people from poverty related illnesses and isolation. The changes in the social, cultural and economic developments in Swaziland have contributed to the recent phenomenon of the elderly dire straits. Elderly people of Swaziland face problems of abandonment and isolation, HIV /AIDS pandemic, health problems, homelessness, rape and physical abuse, mythical stereotypes associated with witchcraft and old age and mutilation and murder (Dlamini Happiness 2003:27).

When the key informants were asked about the biggest problems facing the elderly they cited social, economic and health related problems as follows*:*

- *Poverty, and lack of basic needs* such as food, clothing, housing, and health care. The government grant of E120 was considered inadequate, for most of the elderly it is just enough to cover the bus fare to go and collect and nothing else.

- *Abuse by their children*. This abuse takes several forms: neglect and desertion, being used as a 'dumping ground' to take care of grand children without the support of the parents of these children; their fields taken away from them, and sometimes physical abuse, discrimination.
- *"Being remembered" only when it is election time* and their offered assistance by politicians as a campaign tool.
- *Being affected by HIV//AIDS as primary care givers* for the sick, looking after orphans.

Some of the socio-economic problems of the elderly are attributed to the colonial history of the African continent. During the colonial period, the majority of the Africans were engaged in labour wage migration. To get them into wage employment, a tax was imposed on those age 18-65. Before 1950's these workers left their families and wives and children in the rural areas (villages) which they were expected to periodically visit and eventually retire there. The wages and accommodation were based on a single person family. The low wages put people in a position not to save. Most of them were junior clerks. Although there was a pension scheme for civil servants, very few were employed as civil servants. The independence governments took over the pension schemes but appear to have taken a long time to adapt/adjust the schemes to suit the prevailing socio-economic context

Due to these highly exploitative labour relations in the colonial period, it is therefore not surprising that the data reflects that only 35.5% of the people who were gainfully employed were able to save into pensions. Among those who contributed 76.9% received the pension when they retired and among these only 17.5% are still getting their pension. The vulnerability of the elderly is exacerbated by the fact that they could not save from the meager wages they received. Only 11.7% had private savings as most of them had been employed as domestic workers / labourers or not employed at all. Almost half of those who had other private savings had invested the savings in cooperatives. Of the

respondents that had access to some income, over 80% of them made the decisions about how the money should be spent.

While the expectation is that the progeny is supposed to support the elderly, the reality is that only 16.4% of the respondents are receiving remittances from their children. Instead, it is the elderly who are taking care of their adult children who would otherwise be taking care of these elderly but can not because they are currently unemployed. Furthermore, a small percentage of the elderly still afford to work as 11.1% still receive wages and a majority (34.3%) rely on farming for survival. Of those who rely on farming, the yield has been worsened by inadequate farming inputs and mechanisms, and natural calamities such as droughts and poor implementation of farming policies has affected the food security of the elderly in Swaziland. Very few respondents received income form state grants (17.4%), private pension (1.4%), investments (1%), and private maintenance from ex-spouse or father of children (5.6%).

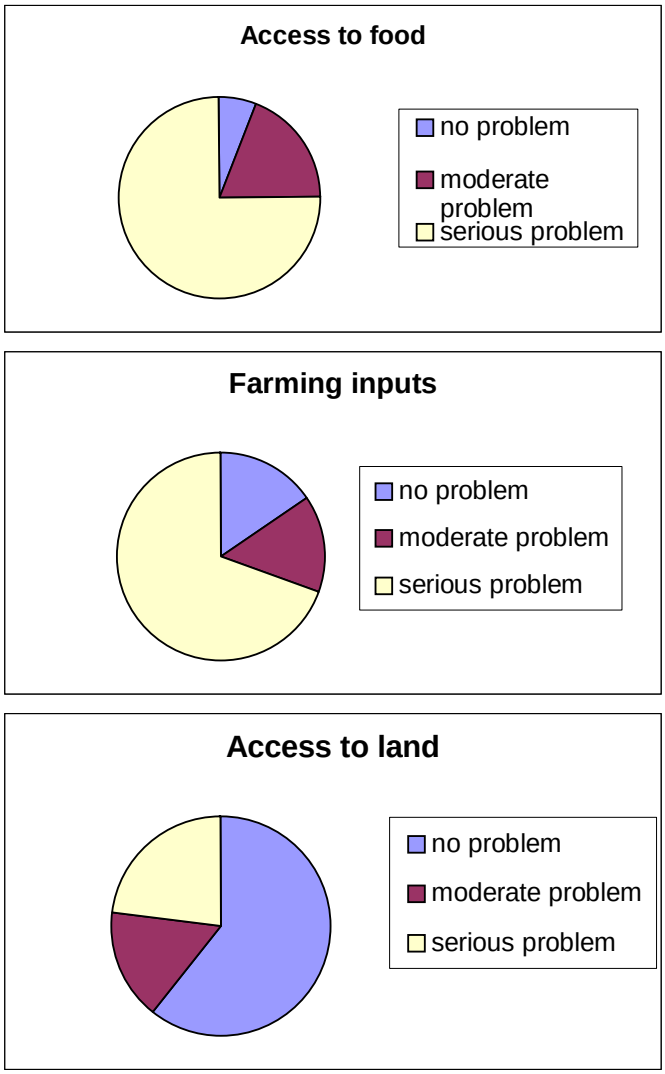
In addition to the caring responsibilities, the elderly also provide basic needs such as food, shelter, clothing, education and maintenance which also require money though the elderly are already overstretched in terms of resources. As a result, in one of the focus group discussions, the elderly indicated that they often rely on neighbours from whom they borrow money for food. But this puts their lives at risk as they borrow the money knowing very well that they will not have any means of returning the borrowed money.

Whilst we recognize that the elderly in Swaziland are faced with the social problems mentioned above, we also take cognizance of the fact that the elderly are shouldered with more responsibilities. Of the interviewed respondents, 83.1% of the elderly care for the people in their household and 35.5% care for people outside their household. Out of those with caring responsibilities 81.4% care for grandchildren 59.3% care for children while16.9% are relatives. Irrespective of the place of residence (urban /rural) the elderly still have caring

responsibilities. It is however, worth noting that the elderly in Lubombo and Shiselweni regions had the highest caring responsibilities and these two regions are also the worst affected by poverty.

As much as the elderly are burdened with so many caring responsibilities, there is very little assistance given to them in return. Only a third of the elderly (35.5%) reported that there are people who care for them within the household. The majority (66.2%) of the people caring for the elderly are their adult children and 26.8% are other relatives. About 23.4% of the respondents reported to be receiving help from outside the family circles and a significant proportion of these (38.3%) get help from neighbours. For instance : One respondent from Matsanjeni highlighted that all her meals are provided for by the neighbours. The form of assistance that is given to the elderly is skimpy, juxtaposed to the enormous needs of the elderly.

However, it is important to note that while both sexes claimed to have caring responsibilities for the relatives and grandchildren, *ceteris paribus*, women in the African context have more caring responsibilities than men as the gender roles demand that they do the housekeeping, including provision of food, maintenance of the household, caring for the sick, whilst men are expected to supply financial resources. Men by virtue of being custodians of everything in the household, so whoever is being cared for in the household is regarded as their responsibility. In essence, men do not do the drudgery tasks involved in the caring.



Food Security seems to be a major concern for the elderly as 15.2% feel comfortable if food is available. As figure 2 above shows, for the majority of the elderly (75%), access to food is a serious problem for them. While land does not seem to be a problem, lack of farming inputs appear to be a major cause for the food insecurity.

From the FGDs it was gathered that the poverty situation has increased the number of criminals in the area. The elderly also expressed frustration at the fact

that there are so many people conducting research but nothing is done to attend to the concerns expressed.

From the focus group discussions one “male respondent said the following to show the abject poverty of the elderly :

> “*Usibona sibambe umlomo silele sinje, uma ngifika ekhaya ngitobhuca bulongo nginatse”*

Loosely translated it means that “As we are gathered here, we slept without taking any food and from here I will go home and eat cow dung and sleep.”

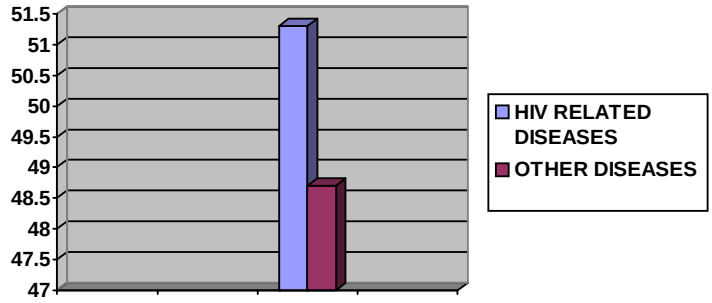
4.3 HIV/AIDS

The HIV prevalence rates have increased from 3.9% in 1992 to 38.6% in 2002 (Ministry of Health 2002). Due to the high rates of HIV/AIDS related illnesses, the health system is not in a position to absorb all the people in need of health care. This has inevitably led to the concept of home based care where relatives especially the immediate families are expected to take care of the sick. However, this added responsibility of caring for the sick falls largely on the elderly and is not accompanied by the required support in order to empower the elderly to give the necessary care. With more people in the reproductive ages infected and eventually dying of HIV/ AIDS it is the elderly people who are left with the responsibility of caring for the sick.

About three quarters (74.4%) of the respondents had a member of the family who was sick in the last 12 months and out of those who were sick in the last 12 months 51.3% suffered from HIV related illnesses. About 95.9% of the people suffering from HIV/AIDS related illnesses are cared for by the elderly. About 55.1% of the respondents had one or more funerals in the last 12 months and a significant proportion of these deaths could be due to HIV/AIDS. Besides economic setbacks this has psychological and emotional strain on the elderly

people. The data reflects that almost half (45.9%) of the respondents who experienced funerals had no financial and material support to cater for the funeral expenses. This was expressed during the focus group discussions where one of the respondents indicated that since they did not have money to cater for funerals they use any available material such as Off –cuts to make stretchers "***luhlaka"*** for burying relatives. This is evidence that the elderly do not only have to care for the sick but also bear the added burden of financing the funerals. It is also worth noting that the elderly are still taking care of other relatives especially children and grandchildren.

Figure 1 Proportions of people cared for by the elderly by disease (CANGO 2003)



4.4 Health

Disintegration of health caused by old age and poverty are some of the reasons why the elderly are prone to diseases. The data reflects that 78.4% of the respondents reported that their health is poor and therefore does not warrant their mammoth task of caring for the sick and the other family members and relatives. Among some of the diseases listed as affecting the elderly were diabetes, kidneys, heart problems, chest pains, arthritis and high blood pressure. Stress seemed to be quite high among the elderly. Sixty three percent of the respondents were paranoic about poverty related conditions, which impact on their social security. Lack of food, frequent sickness, HIV / AIDS, poor housing, lack of access to safe water and many other variables were cited as factors

affecting their well being. It is worth noting that in one of the focus groups the respondents indicated that they compete with the livestock for the same source of water and this increases their vulnerability to diseases. This has been aggravated by the famine.

Whilst the Ministry of Health is said to be providing free health services to the elderly, the findings show that the elderly are still paying for the services. This poses a serious problem to the elderly as they can not afford to pay for the services; hence the majority go without such. For the rural areas, the Rural Health Motivators who should be providing assistance to the elderly in these communities do not have the adequate resources. Asked about the access to medication in one of the Focus Group Discussions (FGD) one respondent replied:

> *"Kute!...Kute imitsi! Bagcugcuteli betfu bayetama mane sibanyenti imitsi iyaphela. Siyacacametela nje ngaphandle kwemitsi angeke ke sikhone nekufika esibhedlela ngoba site nemali"(FGD respondent)*

This means that they have no access to medication. One of the respondents pointed out that though the Rural Health Motivators try to supply with medication, we are too many we cannot even go to the hospital because we do not have money. On the obverse, the plight of the elderly in the urban areas has been completely glossed over. No strategies have been put in place to cater for the urban elderly.

Table 1 Ranking of access to basic needs

Basic need	Not a problem (Percent)	Moderate problem	Serious problem
Food	6.1	18.8	75
Clothing	11.7	38.5	49.8
Shelter	39.4	26.3	34.3
Water	36.2	26.3	37.6
Sanitation	52.6	23.5	23.9
Farming inputs	15.6	15.1	69.3
Land	60.6	16.4	23
Money	5.2	10.8	84.0
Medication	22.5	36.6	40.8

Emotionally, a considerable number of respondents expressed a sense of despondency. They indicated that nothing brings them happiness and they only rekindle their hope by going to church. Church is a place where the elderly get comfort from their everyday problems . Therefore the role of the church in providing the support to the elderly cannot be over emphasized.

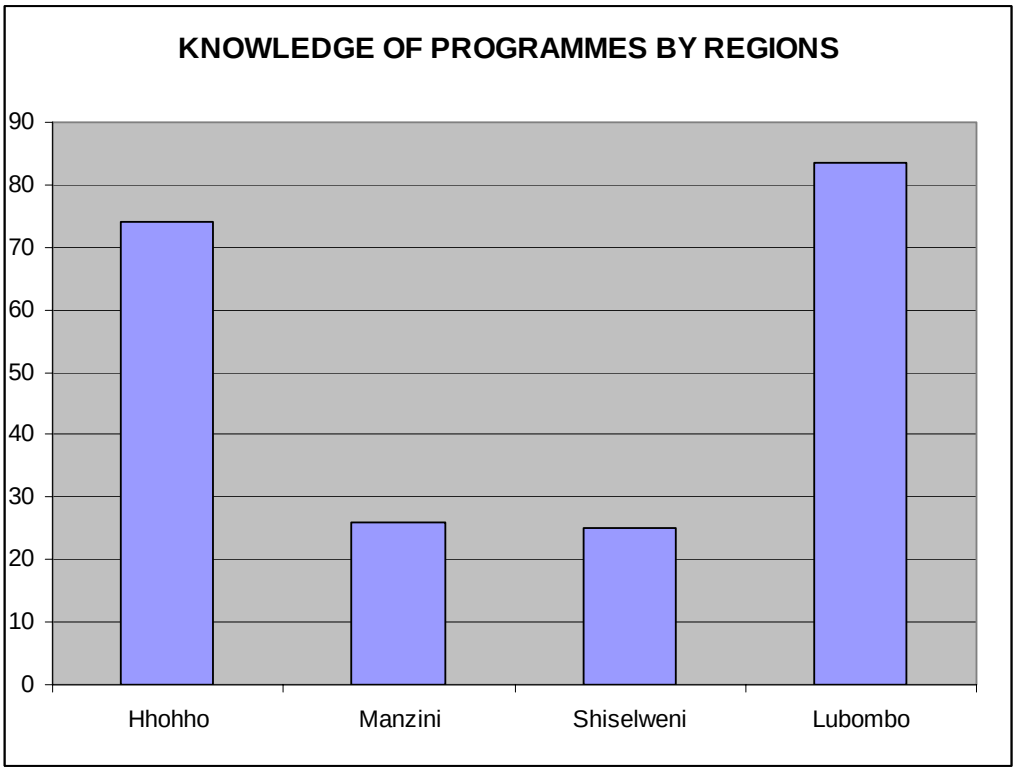
The elderly in Swaziland are faced with many serious problems and the disabled elderly problems are more acute. This was evident in one of the focus group discussions where the moderators were told not to pay attention to what one respondent was saying because she is disabled. This is an indication that the voices of the marginalized groups such as the disabled are often suppressed and

therefore there is no way that their problems can come to the fore in order for them to be addressed appropriately.

4.5 Programmes

When the key informants were asked about who provides the most support for the elderly, NGOs, Christian organizations, neighbours, government families, were mentioned. However very few of these organizations are able to take care of the elderly in a regular and sustained manner. Support tends to be sporadic, not consistent and reaches very few of the destitute elderly. Except for the social welfare, very few of the organizations are able to extend coverage to all the parts of the country. However even with the social welfare, coverage is not consistent, there were case of chiefdoms who did not have a single elderly person that was receiving a grant from social welfare. The general feeing was that the elderly do not receive adequate support, from any source. Right from policy level, the key informants felt that there was no political will to support the elderly as the draft policy was never even discussed.

To ascertain the level of knowledge of the elderly about any programmes that assist them, respondents were asked to indicate if they were aware of such programmes. Slightly more than half (53.6%) were aware of the existence of a programme either in their area or nearby their area or anywhere in Swaziland. It was confirmed in the FGDs that knowledge of programmes was low. The major sources of information about the programmes were community meetings (38.9%), relatives (22.2%), Rural Health Motivators and radio (14.8%), respectively. It is interesting to note that in terms of knowledge of programmes by region the respondents from the Lubombo region had higher knowledge (83.6%) and the lowest was in Manzini and Shiselweni (26.1%) and 25.0% respectively). The differences were statistically significant.



Out of those who knew about the programmes 36.7% had benefited from the programmes and a majority 63.3% who knew about the programmes but had never benefited.

Among those who received some kind of assistance a majority (82.0%) received food, 30.9% received clothing, 6.7% received farm inputs and 38.7% received money.

It is worth noting that the beneficiaries of these programmes are few more so because the criteria for benefiting from the Social security grants provided by the Social Welfare department is biased as it is the Rural Health Motivator who has to register the beneficiaries with the Regional Social worker. A classic example of the bias in benefiting from the programmes is illustrated by the case of one respondent who said she could not get assistance from the Rural Health Motivator who was her neighbour because they had personal differences.

Among those who get assistance 29.2% had no problems accessing assistance and they mentioned the following problems: 30.4% face transport problems, 13.0% complained about the criteria used in choosing beneficiaries, 10.9%, do not have information on where and when assistance is given and 4.3% are being harassed by social welfare officers and that the rate of poverty is affecting most of the elderly people in Swaziland. A majority of the respondents indicated that they needed to get consistent and frequent assistance. Also contributing indirectly to the poverty which affects the elderly, chieftancy disputes were cited by the elderly as one of the problems that affect them.

The high percentage recorded by food is justified given the humanitarian food Aid that is given to people hit hard by drought. However, this is a temporary measure by government and agencies to alleviate the current drought situation. Participants in the Focus Group Discussion expressed the need for food as one was quoted as saying:

"Sigcoke emanikiniki nje sitsenga kudla"
"We wear tartared because we buy food"

Out of the respondents who received assistance only six (6) people reported to have received money.

Whilst the government has tried to alleviate the rate of poverty among the elderly through Public Assistance programme among others, it is quite intriguing to note that only 16.9% reported to be receiving state grants.

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According to the key informants, problems and constraints with the programmes designed to assist the elderly range from budgetary constraints to the program design not made to suit the situation of the elderly in Swaziland. Some of the problems cited by the Welfare officials include:

- Most of the elderly reside in the rural areas and have to travel long distances to receive the aid and transport costs are high. Furthermore they have to join long queues at the welfare offices.
- They are required to have identity cards which is not easy for the elderly.
- The money is given in cheque form, making it necessary for the elderly to travel to get their money from the bank; and yet some of them are not able to meet the requirements of the bank
- Most of those who need the assistance are not able to come because they are bed ridden, disabled or do not have relatives that can assist or do not have the resources to come to town.
- The elderly have to queue at the welfare offices and the banks for a long time.
- For those who receive the aid, the money is too little for their needs.
- Budgetary limitations make it impossible to help new applicants
- For remote areas, those in need of assistance do not know about the assistance and the lack of information means a lot of destitute elderly are not being reached by the available assistance.

For the NGOs, budgetary constraints are making it impossible for them to assist the elderly at a time when the need is very high because HIV/AIDs has increased the number of orphans that are being taken care of by the elderly. All the organizations have waiting lists that can not be assisted because of the budgetary constraints.

5.0 DISCUSSION AND CONCLUSIONS

From the results of this study, it is clear that even though the majority of the elderly had been employed, very few were able to prepare for old age and retirement by making adequate provisions in terms of pension and investments. The elderly are therefore not financially equipped to take care of themselves, let alone other dependants. It can be concluded that the state grants, wages,

remittances, business and farming become vital sources of income for the elderly. For others, they are forced to work beyond the retirement age. The financial well being of the elderly therefore is determined by their ability and willingness to save and invest for retirement.

In the absence of adequate pension, most of the elderly rely on farming and in times of drought, they become vulnerable to hunger. Consequently, food security is a major concern for the elderly.

Regardless of whether they are in rural or urban areas, the elderly have caring responsibilities for their children and grandchildren but very few of them are cared for in return. It can also be concluded that the elderly bear the brunt of the HIV/Aids scourge: they take of the sick, the orphans, the funeral expenses, with the emotional and psychological strain taking its toll.

The elderly have caring responsibilities that they are financially, physically ill-equipped to undertake. This is a time in their lives when their finances, health and physical conditions are at an all time low and yet the caring burden is at an all time high.

Very few respondents knew about the assistance available to the elderly. Even those who knew about the programmes, very few of them had access to the available assistance. It can be concluded the elderly have no access to information about programmes designed to assist them, and the available assistance is inadequate, sporadic and inaccessible because if the criteria used to target the beneficiaries and the distances they have to travel. Accessing the state the grant in particular, has become a burden especially to the disabled.

Crosstabs

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
cared for by others * coded caring for others	207	100.0%	0	.0%	207	100.0%

cared for by others * coded caring for others Crosstabulation

			coded caring for others		
			no caring responsibilities	caring for others	Total
cared for by others	being cared for	Count	19	77	96
		% within coded caring for others	63.3%	43.5%	46.4%
	not being cared for	Count	11	100	111
		% within coded caring for others	36.7%	56.5%	53.6%
Total		Count	30	177	207
		% within coded caring for others	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.056[b]	1	.044		
Continuity Correction[a]	3.298	1	.069		
Likelihood Ratio	4.069	1	.044		
Fisher's Exact Test				.050	.035
Linear-by-Linear Association	4.037	1	.045		
N of Valid Cases	207				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 13.91.

It is interesting to note that there is a significant difference (p=.04) among the elderly with caring responsibilities and those without, who are being cared for by other people. It is important to note that a majority of elders without caring responsibilities (63.3%) are also the ones who receive care from other people. Only 43.5% of those elders with caring responsibilities get care from other

people. However, as noted above, the kind of care received is normally inadequate to solve their problems.

Direct logistic regression analyses were performed on elderly caring responsibilities, elderly benefiting from programmes and the elderly health conditions. Benefiting from any programme, age of the respondent, and number of household members were significant as reliable predictors on the caring responsibilities of elders. However, the Wald statistics and 95% confidence intervals confirm that number of individuals in a household is the most effective predictor of caring responsibilities of elders, with elders caring responsibilities increased by 33% for any additional member to a household (see appendix 2).

Those elders in the age group 55-64 and 65-74 are almost 4 (p=.02) times and 6 times (p=.01) respectively more likely to have caring responsibilities than those elderly aged 85+. Those in the age group 75-84 caring responsibilities are not significantly different from those 85+ (p=.06). This might be true in the sense that the majority of those 55-64 might still be gainfully employed hence their caring responsibilities are still less than those in the cohort 65-74. Those 65-74 are also still more active, recently retired, hence are bound to be relied upon by their children, adding more responsibilities on them. The age groups 75+ are those due to degenerative ages are fragile, and need to be cared for more than any other group, hence their responsibilities are less than other groups.

There is a significant difference (p=.02) between those who do not benefit from any programme than those who do, in terms of caring responsibilities. Those elders who do not benefit from any programme are 80% less likely to have caring responsibilities compared to those who benefit from any programme. This comparison does not necessarily mean that those who do not benefit from any programme have less responsibilities, but that those who do benefit are overwhelmingly burdened. Appendix 3 shows that those not being cared for by others are 75% less likely to benefit from any programme (p=.00) than those

being cared for, while those with caring responsibilities are 76% less like to benefit from such programmes than those without any caring responsibilities. This again raises questions on the selection criteria of those who should be benefiting from any such programmes. It seems the most needy are not being targeted, although not underscoring the fact that all the elders are in desperate need.

Also, while the majority of the elders reported not being a healthy condition, either sickly or due to poverty, the classification table in appendix 4 suggests that even those who reported being healthy are not at all. However, the regression analysis shows that those elders that are not being cared for are 4 times more likely to be unhealthy than those who are cared for (p=.01). Given the fact that the programmes in Swaziland do not cover much of the elderly; irrespective of region, type of residence – urban/rural , sex, or age; and that adult children can not fulfill their filial obligations due to economic hardships, compounded by the HIV/AIDS epidemic; the elderly are therefore left vulnerable to numerous responsibilities. Due to rising unemployment, the elderly are forced to care for their adult children. Also, the scourging HIV/AIDS epidemic has affected most of the adult children who should be caring for these elderly. These elderly care for the sick, bear with the funeral costs when they die, and also care for the orphans left behind. The emotional toll accompanying all these trajectories in their lives is unmeasurable.

Even though the majority of the elderly had been employed, very few were able to prepare for old age and retirement by making adequate provisions in terms of pension and investments. The elderly are not financially equipped to take care of themselves, let alone other dependants. It can be concluded therefore that the state grants, wages, remittances, business and farming become vital sources of income for the elderly. For others, they are forced to work beyond the retirement age. The financial well being of the elderly therefore is determined by their ability and willingness to save and invest for retirement.

In the absence of adequate pension, most of the elderly rely on farming and in times of drought, they become vulnerable to hunger. Consequently, food security is a major concern for the elderly.

Regardless of whether they are in rural or urban areas, the elderly have caring responsibilities for their children and grandchildren but very few of then are cared for in return.

It can also be concluded that the elderly bear the brunt of the HIV/AIDS scourge: they take care of the sick, the orphans, the funeral expenses, with the emotional and psychological strain taking its toll.

The elderly have caring responsibilities that they are financially, physically ill-equipped to undertake. This is a time in their lives when their finances, health and physical conditions are at an all time low and yet the caring burden is at an all time high.

It can also be concluded that the assistance the elderly get is sometimes unknown, inadequate, sporadic and inaccessible because of the criteria used to target the beneficiaries, and the distances they have to travel. Accessing the state the grant in particular, has become a burden especially to the disabled.

Based on these conclusions and suggestions from the respondents, the next chapter will discuss recommendations that are being advanced as ways of improving the well being of the elderly in Swaziland:

6.0 RECOMMENDATIONS

1. ***A policy on the elderly.***

The policy is long overdue and there appears to be no urgency on the part of government to finalise the policy that has been in draft form for a number of years. The policy should also provide for the restructuring of the Welfare Department.

2. Improvement in criteria for determining eligibility

The present system for determining eligibility for assistance is biased in terms of identifying the beneficiaries and the coverage. It is considered less objective and does not reach the majority of destitute elderly in the country. Furthermore, this study indicates that the available assistance is not reaching the most needy.

3. ***A need for "elderly friendly" procedures***

Strategies to make the available assistance more accessible must be devised. The practice of giving the grants only in regional offices, in the form of cheques that can only be cashed in banks, does not take into account the physical, health and socio-economic circumstances of the elderly. A more decentralized system and more fluid assistance would make the grants more accessible to the elderly.

4. ***A need to acknowledge the role of the elderly in the welfare of families, particularly children.***

The packages/money should be increased because what the elderly get benefits the whole family, especially the children/orphans that are being taken care of by the elderly. Regardless whether they were in the urban or rural area, the elderly have significant caring responsibilities. An effective social security system would therefore not only improve the situation of the elderly, but also the children who are living in poverty because of the destitution of the primary care givers, who are their grand parents It is also necessary to make the assistance continuous and more regular

5. Assistance with other services

The needs of the elderly are varied because of their caring responsibilities. Besides food and money, the elderly need assistance with: houses, water, people to look after them; subsidized treatment in health centers; assistance with farming inputs and with school fees.

6. Policies and programmes on HIV/AIDS should recognise the role of older persons as care givers to the sick and orphans

Organizations such as NERCHA should focus a significant part of their activities on the elderly because of the increasing developmental role they play in households and communities. Training programmes for Home based care should focus on the elderly because they are the ones who take care of the sick.

7. ***Introducing a culture of saving***

There is a need to promote programmes designed to help people to prepare for old age and retirement by introducing culture of saving and investing. From the results of this study it would seem that old age automatically means destitution and the ability and willingness to save and invest for retirement was a major determinant of the financial well being of the elderly.

8. Collaboration of stakeholders

There is a need to coordinate the efforts of government ,NGOs and the private sector. The need for collaboration and networking and improving communication among partners was expressed by the key informants. Providing information and receiving new applicants for state assistance, for example should involve others like RHMs , churches, CBOs, NGOs and traditional structures. This would also alleviate the budgetary and under staffing constraints in the Welfare offices.

9. Community based efforts to provide food for the elderly and the needy should be encouraged.

Food security was a major concern for the elderly. Local efforts to address the food situation of the elderly and destitute should be encouraged.

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APPENDIX 1

Background characteristics

Characteristic	n	%
Sex	(207)	
Male		35.3
Female		67.4
Region	(207)	
Hhohho		26.1
Lubombo		26.6
Shiselweni		25.1
Manzini		22.2
Type of residence	(207)	
Rural		76.3
Urban		23.7
Marital status	(206)	
Single		5.3
Married		61.2
Cohabiting		1.5
Separated		6.3
Widowed		25.7
Religion	(200)	
No religion		6.5
Zionist		33.5
Catholic		11.5
Protestant		48.0
Other		.5
Age	(207)	
55-64		41.1
65-74		30.9
75-84		15.9
85+		12.1
Knowledge of programme/s	(207)	
Knowledge		53.6
No knowledge		46.4
Benefiting from programme/s	(112)	
Yes		35.7
No		64.3
Caring for the sickness in recent past	(154)	51.3
HIV/AIDS related sicknesses		48.7
Other sicknesses		
Funeral/s in past 12 months	(207)	
One or more funerals		44.4

No funeral	55.6
Caring responsibility for others	(207)
Yes	85.5
No	14.5
Other people caring for respondent	(203)
Yes	46.4
No	53.6
Condition of respondents health	(204)
Healthy	78.4
Sickly	12.3
Living in poverty	9.3

Appendix 2

Odds ratio from logistics regression analyses on the probability of an elderly person caring for

Logistic Regression

Case Processing Summary

Unweighted Cases[a]		N	Percent
Selected Cases	Included in Analysis	207	100.0
	Missing Cases	0	.0
	Total	207	100.0
Unselected Cases		0	.0
Total		207	100.0

a. If weight is in effect, see classification table for the total number of cases.

Dependent Variable Encoding

Original Value	Internal Value
no caring responsibilities	0
caring for others	1

Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)
Step 0	Constant	1.775	.197	80.816	1	.000	5.900

Omnibus Tests of Model Coefficients

		Chi-square	df	Sig.
Step 1	Step	39.649	6	.000
	Block	39.649	6	.000
	Model	39.649	6	.000

Model Summary

Step	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
1	131.668	.174	.310

Classification Table[a]

			Predicted		
			coded caring for others		
	Observed		no caring responsibilities	caring for others	Percentage Correct
Step 1	coded caring for others	no caring responsibilities	9	21	30.0
		caring for others	5	172	97.2
	Overall Percentage				87.4

a. The cut value is .500

Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)
Step 1[a]	KNOWLEDG(1)	1.124	.619	3.299	1	.069	3.077
	BENEFIT(1)	-1.637	.685	5.714	1	.017	.195
	AGECAT			8.506	3	.037	
	AGECAT(1)	1.406	.614	5.250	1	.022	4.080
	AGECAT(2)	1.852	.673	7.576	1	.006	6.374
	AGECAT(3)	1.364	.722	3.572	1	.059	3.912
	Q102	.283	.074	14.556	1	.000	1.328
	Constant	-1.263	.642	3.874	1	.049	.283

a. Variable(s) entered on step 1: KNOWLEDG, BENEFIT, AGECAT, Q102.

Appendix 3

Odds ratio from logistics regression analyses on the probability of an elderly person benefiting from any programme

Logistic Regression

Case Processing Summary

Unweighted Cases[a]		N	Percent
Selected Cases	Included in Analysis	207	100.0
	Missing Cases	0	.0
	Total	207	100.0
Unselected Cases		0	.0
Total		207	100.0

a. If weight is in effect, see classification table for the total number of cases.

Dependent Variable Encoding

Original Value	Internal Value
benefit	0
have not benefited	1

Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)
Step 0	Constant	1.429	.176	65.908	1	.000	4.175

Omnibus Tests of Model Coefficients

		Chi-square	df	Sig.
Step 1	Step	78.328	6	.000
	Block	78.328	6	.000
	Model	78.328	6	.000

Model Summary

Step	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
1	124.897	.315	.504

Classification Table[a]

Observed			Predicted		
			coded benefiting from a programme		
			benefit	have not benefited	Percentage Correct
Step 1	coded benefiting from a programme	benefit	10	30	25.0
		have not benefited	2	165	98.8
	Overall Percentage				84.5

a. The cut value is .500

Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)
Step 1[a]	REGION			3.353	3	.340	
	REGION(1)	.277	.496	.312	1	.577	1.319
	REGION(2)	-1.080	.775	1.941	1	.164	.340
	REGION(3)	.418	.816	.262	1	.608	1.519
	CARED(1)	-1.385	.474	8.530	1	.003	.250
	CARING(1)	-1.444	.693	4.344	1	.037	.236
	KNOWLEDG	21.316	3795.180	.000	1	.996	1.8E+09
	Constant	1.494	.445	11.274	1	.001	4.457

a. Variable(s) entered on step 1: REGION, CARED, CARING, KNOWLEDG.

Appendix 4

Odds ratio from logistics regression analyses on the probability of an elderly having an ill health condition

Logistic Regression

Case Processing Summary

Unweighted Cases[a]		N	Percent
Selected Cases	Included in Analysis	204	98.6
	Missing Cases	3	1.4
	Total	207	100.0
Unselected Cases		0	.0
Total		207	100.0

a. If weight is in effect, see classification table for the total number of cases.

Dependent Variable Encoding

Original Value	Internal Value
healthy	0
not well	1

Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)
Step 0	Constant	1.969	.214	85.004	1	.000	7.160

Omnibus Tests of Model Coefficients

		Chi-square	df	Sig.
Step 1	Step	12.853	4	.012
	Block	12.853	4	.012
	Model	12.853	4	.012

Model Summary

Step	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
1	138.912	.061	.116

Classification Table[a]

Observed			Predicted		
			coded health condition		Percentage Correct
			healthy	not well	
Step 1	coded health condition	healthy	0	25	.0
		not well	0	179	100.0
	Overall Percentage				87.7

a. The cut value is .500

Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)
Step 1[a]	CARING(1)	-.568	.581	.955	1	.328	.567
	CARED(1)	1.287	.517	6.183	1	.013	3.621
	RES(1)	.771	.474	2.641	1	.104	2.162
	FUNERAL(1)	-.902	.489	3.398	1	.065	.406
	Constant	1.632	.502	10.547	1	.001	5.112

a. Variable(s) entered on step 1: CARING, CARED, RES, FUNERAL.

Appendix 5: The questionnaire

ELDERLY QUESTIONNAIRE

INTERVIEWER'S NAME _____

NAME OF COMMUNITY _____

REGION_____

QUESTIONNAIRE NO._____

INTRODUCTION

My name is, ……and I am here on behalf of CANGO (explain who CANGO is). We are collecting information on the problems that the elderly people are facing in Swaziland. CANGO through the umchumanisi is facilitating poverty dialogue in an attempt to gather views of the marginalized groups (elderly) and to get possible solutions to these problems. Recommendations will be forwarded to stakeholders.

I would therefore be very grateful if you would give me a few minutes of your time to answer the following straightforward questions. Please answer as honestly as possible as this will enable CANGO to know exactly what needs to be done for your benefit and that for your community.

It is important for you to know that anything you say will be kept confidential and that nobody will have access to the information given.

Thank you.

NOTE

ASK RESPONDENTS FOR AGES, IF THEY ARE AGED 55 AND ABOVE CONTINUE WITH THE INTERVIEW BUT IF NOT KINDLY THANK HIM/HER AND DISCONTINUE THE INTERVIEW

Ask the elderly person to indicate members of the household, their age, sex and their relationship to him or her. Fill the responses in the table below.

Sex	Age	Relationship to the elderly

Section 1: Background characteristics

No.	Questions and filters	Coding categories	Skip to
Q101	RECORD SEX OF RESPONDENT	MALE 1 FEMALE 2	
Q102	How many people stay in this household?	[__|__]	
Q103	When were you born?	_____	
Q104	How old were you at your last birthday	[__|__]	
Q105	Have you ever attended school?	YES 1 NO 2	→**Q107**
Q106	What is the highest level of education attained?	Sebenta 1 Primary 2 Secondary 3 High school 4 Tertiary 5	
Q107	What religion are you? **CIRCLE ONE**	NO RELIGION 1 ZIONIST 2 CATHOLIC 3 PROTESTANTS 4 NO RESPONSE 99 OTHER (specify)----------77	
Q108	What is your marital status?	Single 1 Married 2 Cohabiting 3 Separated 4 Widowed 5	
Q109	Is your spouse still alive?	YES 1 NO 2	

Section 2: Household source of income

No.	Questions and filters	Coding categories	Skip to
Q201	From which of the following sources does the household usually receive money	YES NO Wages /salaries 1 2 Earnings from own business /farm 1 2 State grants (old age pension, child support, disability, foster care grant) 1 2 Private pension 1 2 Unemployment insurance fund 1 2 Investments 1 2 Remittances 1 2 Private maintenance (from ex –spouse or father of children) 1 2 Other (specify)_____1 2	
Q202	What paid work do you do/did you do	Domestic worker 1 Factory worker 2 Construction 3 Never **ADD MORE CATEGORIES**	
Q203	When last did you do paid work	In the past 3 months 1 In the past 6 months 2 In the last year 3 Two years ago 4 Five years ago 5 More than five years ago 6	
Q204	When you were still working, did you pay into pension/provident fund	YES 1 NO 2	
Q205	When you retired, did you receive income from that fund	YES 1 NO 2	
Q206	How long did it last	**PUT REALISTIC PERIOD**	
Q207	Do you/did you have any other private savings	YES 1 NO 2	
Q208	If yes, mention it	LIST POSSIBLE RESPONSES	
Q209	Who makes decisions about how the money should be spent	Myself 1 My spouse 2 Joint 3 My children 4 My relatives 5	
Q210	Is there a source of income that you yourself make most of the decisions about	YES 1 No 2	

Section 3: Responsibility and caring

No.	Questions and filters	Coding categories
Q301	Do you have caring responsibilities for any one in the household	YES 1 NO 2
Q302	Which people	Spouse 1 Children 2 Grandchildren 3 Great grandchildren 4 Other relatives 5
Q303	What do you do for them	Spouse _____ Children _____ Grandchildren_____ Great grandchildren _____ Other relatives_____
Q304	Do any of the people in the household have special responsibilities for you	YES 1 NO 2
Q305	Which people	Spouse 1 Children 2 Grandchildren 3 Great grandchildren 4 Other relatives 5
Q306	What do they do for you	Spouse _____ Children _____ Grandchildren_____ Great grandchildren _____ Other relatives_____
Q307	Do you have regular caring responsibilities for any people not in your household	YES 1 NO 2
Q308	Who and where do they live	LIST POSSIBLE RESPONSES
Q309	What do you do for them	
Q310	Do any people-family and others-who do not live here have special responsibilities for you	YES 1 No 2
Q311	Who are they	
Q312	What do they do for you	
Q313	Has anyone been sick in the family recently	YES 1 NO 2
Q314	Who	
Q315	How long have they been sick	A week 1 2-4 weeks 2 A month 3 More than a month 4

Q316	Did you have to care for them	YES 1 No 2
Q317	What was the cause of sickness	

Section 4: Resources for support

Q401

	Source	How much	How often
Grandchildren's school fees			
Access to health service			
House maintenance and renovation			
Farming inputs			
Funeral expenses			

Q402 How many funerals has this household had to pay for the last 12 months?_____

Section 5: Elderly person's access to basic needs

Q501 Which of these things are a problem to you? Rate them as 3 if it is a serious problem, 2 if it is moderate and 1 if it is not a problem

	1	2	3
Food			
Clothing			
Shelter			
Water			
Sanitation			
Farming inputs			
Land			
Money			
Medication			
Other			

Section 6: Sources of support from outside family

No.	Questions and filters	Coding categories
Q601	Do you know of any programme that help elderly people?	Yes / No Here where you live 1 2 In the local area but nearby 1 2 Anywhere in Swaziland 1 2
Q602	What do these programmes do?	Yes / No Gives food parcels 1 2 Give clothing 1 2 Gives farming inputs 1 2 Gives maize/beans 1 2 Gives money 1 2 Other_____1 2
Q603	Have you yourself ever benefited from such programmes	Yes 1 No 2
Q604	What kind of assistance do/did you get	Yes / No Gives food parcels 1 2 Give clothing 1 2 Gives farming inputs 1 2 Gives maize/beans 1 2 Gives money 1 2 Other_____1 2
Q605	If you received money, how much was it?	_____
Q606	How often did you get it?	Once a month 1 Once in 2 months 2 Once in 3 months 3 Once in 6 months 4 Once a year 5 Occasionally 6
Q607	If you received materials support, how often?	Once a month 1 Once in 2 months 2 Once in 3 months 3 Once in 6 months 4 Once a year 5 Occasionally 6
Q608	If you received social or spiritual support, how often?	Once a month 1 Once in 2 months 2 Once in 3 months 3 Once in 6 months 4 Once a year 5 Occasionally 6

Section 6 conti.....

Q609	How did you come to know about the programme?	Community meetings 1 Relative 2 Children 3 Rural Health Motivator 4 Radio 5 Newspapers 6 TV 7 Funerals 8
Q610	How did you get access to the assistance	_____ _____ _____ _____ _____ _____ _____ _____ _____
Q611	What are the problems encountered when getting assistance. PROBE for Transport Time taken to process Having to get documents	_____ _____ _____ _____ _____ _____ _____ _____
Q612	Could these programmes/forms of assistance be improved PROBE for Eligibility Delivery	_____ _____ _____ _____ _____ _____
Q613	How do you think the government should do to improve the welfare of the elderly in Swaziland?	_____ _____ _____ _____ _____ _____ _____ _____
Q614	Where is the nearest place where you can get the following services and how much does it cost to get there	Place Amount Birth certificate Marriage certificate Death certificate ID Pin numbers

Section 7: Own sense of security

No.	Questions and filters	Coding categories
Q701	How would you describe your own state of health most of the time	_____ _____ _____ _____ _____ _____ _____
Q702	What are the things you fear most	LIST POSSIBLE RESPONSES
Q703	What Are the things that bring you happiness	LIST POSSIBLE RESPONSE