HEALTH CARE OF THE GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE

D.M.NAIDOO

M<PRAEX>MED.

PART 3.

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SUMMARY

THIS IS A STORY OF A POPULATION THAT IS LITERALLY TOO OLD TO COMPLAIN.A POPULATION THAT JUST SITS BACK AND ENDURES A PLIGHT THAT NO ONE SHOULD ALLOW.A PLIGHT THAT THEY THEMSELVES CAN DO VERY LIITLE ABOUT, BUT MAKES ONE THINK WHAT IS IT THAT THAT MAKES THESE OLD PEOPLE JUST WHAT THEY ARE?

THE INDIAN POPULATION OF PORT SHEPSTONE IS MADE UP OF JUST OVER 7.4% (1980 CENSUS) OF A TOTAL POPULATION OF 12000(1986 ESTIMATE).THIS ELDERLY POPULATION OF OVER FIFTY FIVERS HAVE AN EXTREMELY HIGH RATE OF DISABILITY IN THE POPULATION.

A SAMPLE POPULATION OF 457 INDIVIDUALS WAS STUDIED. THIS SAMPLE HAD 195(47.7%) OLD AGE PENSIONERS AND 82(17.9%) DISABILITY PENSIONERS .THEIR MORBIDITY RATE WAS HIGH IN THAT 171 HAD SHOWED A DISEASE PROFILE OF SINGLE CHRONIC DISEASES THAT LED TO SOME FORM OF DISABILITY.

HYPERTENSION,DIABETES MELLITUS, SKELETAL DISEASES FORMED THE GREATEST MAJORITY OF CRIPPLERS,RESPIRATORY DISEASES,VASCULAR AND CARDIAC PROBLEMS ALSO WERE PRESENT AND SO WERE THE OTHERS BUT TO A LESSER SEVERITY.

THE STUDY SHOWED THE HIGH DEGREE OF DEPENDENCE THAT EXISTED IN THE COMMUNITY,THE MAJORITY OF WHOM EARN LESS THAN R150.00. PER MONTH AND PAY HIGH RENTALS AND THE EXTENT OF NEED, BOTH IN ECONOMIC AMD MEDICAL SENSE.

THE ATTITUDE OF THIS COMMUNITY IS ONE OF MERE EXISTENCE WITH WHAT THEY BEST CAN.THEY STILL MAINTAIN THEIR DIGNITY AND STATUS WITHOUT COMPLAINING AS BEST THEY CAN.BUT AT WHAT PRICE?TOLERANCE OF THE PITTANCE OF A PENSION THAT THEY RECEIVE,POOR HOUSING, AND POOR MEDICAL CARE.ALL THIS REQUIRES A HIGH ENDURANCE RATIO AND THIS IS WHAT IS NOT LACKING IN THEM.

THE STUDY TRIES TO SHOW SOME OF THESE PROBLEMS AND ATTITUDES OF ALL CONCERNED, AND TRIES TO POSTULATE A SOLUTION.YES IT DOES TRY!

INTRODUCTION

"I long for laughter but dwell in pain,

I love the sunshine but kiss the rain;

My song is meant to be of mirth,

But here with you, it has no birth"

(A Blackman speaks of freedom.)

I think that this sums up the plight of the elderly Indian persons in Port Shepstone,not that it does not apply elsewhere.

The aging of populations is a new challenge.Although ageing of a population creates certain problems it also reflects past achievement.Not only does it unfold a life span full in years and opportunity for the individual,but also the advantages to the community in terms of a longer period of productivity and old people whose experience can provide valuable contributions.The Challenge therefore entails :

1.The reinforcement of the health of the aged themselves, and

2.the promotion of Society's awareness of the needs and possibilities of its older members.

The Indian population of Port Shepstone is faced with an increasing number of old age and disabled pensioners.

The decline in the number of Nuclear Family Units because of the deteriorating housing problem has left many of these people to fend for themselves.Many aged are uncared for,and suffer increasing immobility and malnutrition.

These people have no other source of income and rely on the goodwill of their families ,friends and welfare organiations for an existence.

They often exist in shocking environmental conditions awaiting merciful termination in degenerate accommodation.

The problem is not ageing or the aged.The problem is the rapidly increasing number of dependant non-productive aged.

The Black population have traditionally tended to look after and retain their elderly in the community and in their families.Does this situation still prevail today?

Many are in poor health and in need of constant treatment which they receive from the local hospital and District Surgeon.Notwithstanding this, many still see the need to consult local GPs,at great expense to themselves.

The seriously handicapped and disabled are no longer productive.It is imperative to prevent them from becoming a mounting burden to the community and to the younger generation groups who already live in increasingly stressful times.(Are the families prepared to keep them?)

More women go to work, with neither the facilities nor the time to care for ailing and aged relatives, whom they have taken into their homes.The acceptance of an aged relative who is well has difficulties.But if disability,incontinence of urine and stools, paralysis and senile confusion intrude, the stability of marriage is shaken and children are affected.

No old age homes exist.The fees of private nursing homes and hospitals preclude all but the wealthy. The general hospital admits geriatric cases but are reluctant to retain them as patients once the acute phase of the illness is over.

S.W.van der Merwe,Minister of Health.Opening Address at the Bi-ennial

Meeting of the S.A.National Councilfor the Aged, 9/11/1976.

" Unfortunately,many urgently needed beds are blocked by elderly long stay patients who cannot be discharged because they cannot look after themselves or have no family.Thought must be given to providing alternative and less costly facilities - either in the form of wards for the chronically ill , attached to hospitals or convalascent type nursing homes for the bedridden aged.Extending geriatric hospital services into the community by establishing day centres with medical ,nursing, and domiciliary services should also be considered. Follow up services for elderly hospital patients ready to be discharged into the community would ease the situation and bring about better co-operation and understanding between members of the health team, the aging patient and his family."

Aged persons who are terminally ill,generally require hospitalisation.There is no place such people can be discharged to from hospital; nor is there adequate provision for assisting them after discharge.

Old age homes isolate the elderly from their families and communities.There is no escape from old age homes except death.

The disabled pensioners are reviewed periodically by the Welfare Authoritiies.This whole process gives them a sense of insecurity which leaves them open to exploitation by all those that they think assist in ensureing the continuity of their pensions.

The plight of these people is much worse than a mere deprivation of housing, finance and social benefits.

The extent of the problem is the motivation for this study.

THE OBJECTIVES OF THE STUDY were

1.To establish the health status of the elderly Indian community in Port Shepstone.

2. To investigate the multiple epidemiological factors related to occurance of illness in terms of the person affected(man),and in terms of the environment.
(family,domiciliary,social and community)

3.To investigate the alleviative measures that have been taken.

4. To determine which authority is responsible for the operating and funding of the geriatric services.

5. To identify existing services for the elderly in Port Shepstone , the cost of maintaining those services ,and to identify current patterns of use.

6. .To determine whether retention of the aged in the community for as long as possible is desireable.

7. To make recommendations in respect of

a). the alleviative measures that could have been taken, in terms of the first, secoond and third levels of comprehensive health care.

b). the need for primary health care services with regard to this population.

.c). the most appropriate type of service with regard to need, cost and acceptability.

d). improving the health status

e). Maintaining the independance for as long as possible.

f). establishing the need for an old age home.

DEFINITION OF CRITERIA

Primary Health Care:

Health Care outside institutions at a cost which can be afforded by both the consumer and the provider and which involves the opinion and participation of the community.

Need:

The requirement for health services which are considered by health professionals to reduce present or future levels of ill health.

Acceptability:

The willingness to use or participate in the functioning of the proposed services by the community to which the services will be directed.

Cost:

In this context only financial cost will be considered.

Health Status:

Physical, mental ~~and social wellbeing~~.

Physical wellbeing: with no physical disability that precludes the person from performing the functions of daily living.

Mental Status: The mental capability to attend to his or her own affairs and to perform functions of daily living.

Social wellbeing: Living in harmony and satisfaction inrespect of:

number and proximity of surviving children and siblings,
frequency of visits by spouse, cildren, siblings and friends.

GERIATRIC:

Persons 55 years and over and are residents of Port Shepstone.

Port Shepstone:

The Magisterial District of P/S.

Chronic illness is an illness which has-

a)persisted for at least three months,or which could normally be expected to last for at least three months, and which has

b)resulted in disability causing any one or more of the following:

1.Lack of mobility rendering a person homebound unless aided.
2.Dependancy
3.Unemployment, or the inability or claim of inability to persue the gainful level of employment before the onset of the chronic illness.

Extent of occurrence:

Occurrence in the population sample at a point or short period in time limited by the duration of the study in the population.ie.Period prevalence and not incidence. How much occurrence there is at the time of the survey.

Disability:

The prevention of or incapacitation from doing work or other activities of parallel significance previously carried out by the person observed and normally carried out by persons of similar age group, sex and community grouping.

Pensioner :
Any individual who is dependant on the State or industry for an income because of not being able to work due to old age or ill health.

Household: All persons living on the same lot.

SELECTION OF SAMPLE GROUP

Every fifth household will be included in the study.

All geriatric persons in the household will be included.

If no geriatric person/s are resident in the household selected,the next immediate household with a geriatric person/s will be included.

No Control Study is considered necessary.

METHODS OF DATA COLLECTION

1.Permisssion to carry out this study will be obtained
from all the relevent authorities.

2.Each identified person will be interviewed and requested to participate in the study.Thereafter a standard questionaire and checklist will be administered in strict confidentiality.

Each person will be subsequently examined clinically and medically assessed in the researchers surgery according to a common criteria applicable to all geriatric persons .Transport will be provided.

3.Information regarding the availability and use of existing facilities will be obtained from the case notes of these persons at their usual primary care centre. These will be consulted and the relevant data extracted.

If this is not possible,information in respect of health and other services provided by authorities, voluntary bodies ,general practitioners,district surgeons,or any other source, will be obtained by communication with the appropriate authorities ,voluntary bodies and personnel.

Where information is not obtainable from the case notes or from the person,friends and relatives will be requested to provide the required information.

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Reduction of Variation:

Variation will be reduced by:

i) adherence to defined criteria,

ii) the use of a standardised checklist and questionaire

iii). interviews and clinical assessment will be done by the researcher only

RESULTS

GENERAL

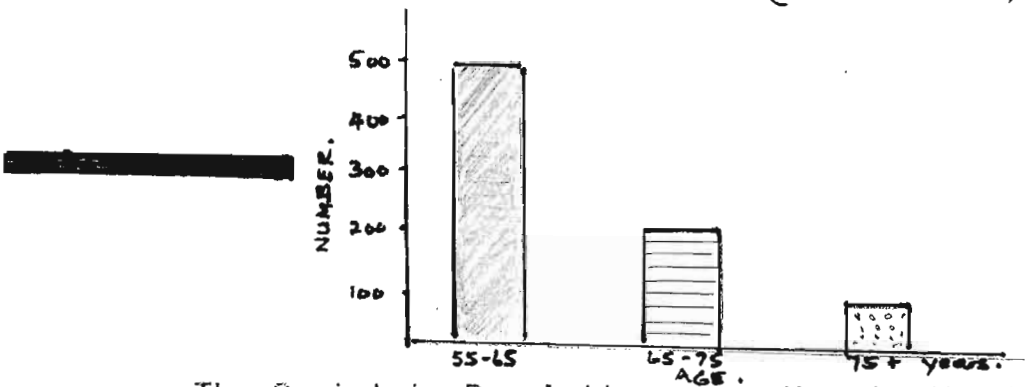
Total Indian Population of Marburg/Port Shepstone.

The Indian Population in the Magisterial District of Port Shepstone is 10428.
(1985 Census)

The actual population is over 12000. (Marburg Town Board-personal contact).

The age analysis for 1985 is not yet available but the 1980 Census revealed that the Population was 9729.The age analysis is reflected in TABLE 1 (appendix).

GERIATRIC INDIAN POPULATION (PORT SHEPSTONE) BY AGE (1980).



The Geriatric Population,according to the 1980 Census was 723, which is equal to 7.4% of the total Indian Population.TABLE 2 - (APPENDIX.)

The Census figures for 1985 are not yet available for this age group.

The growth rate figure of 1,89% p.a. applies to the whole of the Republic.(National Census -1985).

Moreover, in 1980 there were 784 people from age 45 to age 54, and the total number of deaths for all ages in the last year have been 291 (Marburg Town Board).

What proportion or number now are over 55 years is hard to ascertain.Nevertheless some reasonable number would now be considered as elderly.

The Indian Pensioners

The total number of Indian pensioners in the Republic of South Africa is 58246 .Table 3-(appendix.)

Of this total,42529 (73%), pensioners are in respect of disability and old age.

[redacted]

It is virtually impossible to obtain statistics for separate Magisterial Districts.A total of 657 pensions were paid out at the Port Shepstone Post Office in February 1986 to Indians in respect of old age and disability . Table 4- (appendix.)

This can be interpreted as approximately 1.55% of all Indian Disability Pensioners in the Republic live in Port Shepstone and that a high proportion of the elderly are either aged or disabled.

AGE AND SEX

In this study a total of 457 ()55years) persons were interviewed. There were 223(48.8%) males and 234(51.2%) females.Table 5-(appendix.) The same table shows that between the ages of 55 years to 64 years there were 117(25.6%) males and 144(31.5%) females,showing a female preponderance in the age group of 1·2 : 1

There were 168 (36.8%) in the age group - 55 years to 59 years. Table 5-(appendix)

EDUCATIONAL LEVEL

There was only 1 postmatriculant in the study while 267(58.4%) had no education or had only been up to Class 2.Table 6- (appendix)

MARITAL STATUS

There were 336 (73.5%) married persons and 116 (25.4%) divorced or widowed persons in the study population.Table 7 -(appendix.)

LIVING STATUS

301 (65.9%) of persons in the study were living with a married or unmarried child and 129(28.2%) with spouses.Table 8 -(appendix.)

PENSIONERS IN SAMPLE POPULATION

The sample group was made up of 82 (17.9%) disability pensioners and 195 (42.7%) old age pensioners . Table 9 -(appendix).

(Further information on income is dealt with later in this report.)

HEALTH STATUS (Objective 1)

EXTENT OF OCCURRENCE OF DISABILITY:

The Geriatric Population studied ,comprised 60.6% of people who were pensioners either through old age or some form of disability. Table 9- (appendix.)

89 (19.5%) suffered from impaired mobility.-Table 10-(appendix)

21.5% of males and 17.5% of females in the total study had mobility problems- Table 11 -(appendix) ie. causing them to be homebound or not.(A total of 39%)

Disability present : 66(29.6%) of males and 50(21.4%) females responded as having some obvious physical disability present in the total study.Table 12 - (appendix)

Applying our criteria for judging disability, it was found that 341 persons in the study population were disabled.Table 13-(appendix)

This was due to the fact that they did not interpret chronic illness as a debility as set out in the criteria.This was not known to them. Their perception of debility is the cause for the discrepency.

There were 289(63.2%) persons over 60 years of age,yet only 80 responded that they did have some disability present.
Table 14-(appendix)

DURATION OF DISABILITY:

Of those that responded as having a disability present, 56(84.8%) of males and 42(84%) of females had been disabled for more than 2 years. TABLE 15-(appendix)

104(22.8%) were disabled for greater than 1 year.TABLE 15-(appendix)

In the study 147 (32.2%) indicated that they were on no pension. Of these 12 said they were suffering from some DISABILITY.

116 (24%) said they had no illnesses.Table 21-(appendix)

SEVERITY OF DISABILITY:

HOUSEBOUND OR HELPLESS:

7(10.6%) of males and 9(19.2%) of females considered themselves to have been housebound or helpless. Table 16-(appendix.)

UNEMPLOYED:

41(64.1%) of males and 23(48.9%) of females were unemployed because of the disability.Table 16 -(appendix)

IMPAIRED FEEDING:

A total of 34(7.4%) persons had impaired feeding or were unable to feed themselves.Table 17- (appendix)

WASHING:

A total of 43 (9.4%) had difficulty with washing themselves.

EXCRETION

A total of 34 (7.4%) persons had problems with excretion.

HEARING

61 (13.3%) of the study group had impaired hearing or were deaf.

VISION

Impaired vision or blindness was present in 129 (28.2%) of the study group.

Table 17-(appendix)

Is is surprising that such a high number admitted to a vision or hearing defect on questioning, but ignored this as a diagnosis.It would appear that these defects were "just taken for granted" as part of the ageing process.

The severity and extent of disability in this community is obviously very high.

DIAGNOSIS

Diagnosis of their illnesses causing or contributing to their disability was therefore considered important to ascertain and to implement preventative factors for future, if not the present generation of elderly.

The most common diseases were as shown in table 13-(appendix)

It must be remembered that 116 responded that they were suffering from no illnesses Table 21-(appendix)

According to our criteria, 341 persons were disabled
Table 13-(appendix)

Firstly many patients suffered from two or more diseases, but the first diagnoses or the most troublesome diagnoses was considered only. By far the commonest CHRONIC diseases in the elderly population were hypertension,diabetes and skeletal disorders.These alone made up 68% (232 cases) of the disease profile. TABLE 13 -(appendix.)

Hypertension made up 30.5% (104 cases) of the disease profile. Table 13-(appendix)

Diabetes Mellitus was responsible for 17.6% (60 cases), and the skeletal disorders were responsible for 19.9% (68 cases) of the morbidity rate respectively.Table 13-(appendix)

90 (26.3%) of patients suffered from:

cardiac,GIT, respiratory,C.N.S. and vascular problems.

Table 13-(appendix)

The rest of the diseases made up only 5.7% of the disease spectrum.

Table 13-(appendix)

MENTAL STATE

349(76.4%) persons were in a GOOD mental state.

92(20.1%) persons were in a FAIR mental state, and

16 (3.5%) persons were in a POOR mental state

.Table18(Appendix)

ABILITY TO MAKE DOMESTIC DECISIONS

328(71.8%) persons had a GOOD ability to make domestic decisions , 91(19.9%) had a FAIR ability and 38(8.3%) had a POOR ability to make domestic decisions.

Table 18(Appendix)

SOCIABILITY

350(76.6%) persons had a Good Sociability.

74(16.2%) persons had a FAIR sociability, and

33(7.2%) persons had a poor sociability.

Table 18(Appendix)

NO DANGER TO SELF &/OR OTHERS:

363(79.4%) were considered to have been of no danger to themselves and to others,while 94(20.6%) had some chance of this.
Table 18(Appendix)

ACUTE EPISODES IN LAST THREE MONTHS:

(58%) 265 SAID THEY HAD AT LEAST ONE ACUTE EPISODE of illness in the last three months.
Table 19(Appendix)

Circumstance of Occurrance of Disability:

Disease profile by sex

The females in the study outnumbered the males by a ratio of almost 2:1 in regard to prevalence of hypertension and diabetes mellitus., while the men had a higher prevalence of cardiac diseases (5:1).,and respiratory diseases(2:1).
There was an almost equal prevalence of skeletal and G.I.T. diseases. More men succumbed to renal and infectious disiases while the reverse was true in regard to thyroid , blood and vascular disorders.Accidents

were relatively rare. C.N.S. disorders were equally common in both sexes.

The low prevalence of vision, E.N.T and psychoneurotic ailments was noted TABLE 20-(APPENDIX)

CHRONIC ILLNESS AND AGE: TABLE 21-APPENDIX

Disease profile by age

The prevalence of chronic disease in the 55-59year age group was 70.8% , while that in the 60-64year age group was 78.5% and that in the over 65year age group was 76%.

(The percentages are almost the same for each group. Important for planning future.)

An interesting aspect here was that 62% of the diagnoses ascertained were in respect of persons between the ages of 55 and 59 years old.

MARITAL STATUS AND DISEASE

Table 22-APPENDIX shows that the prevalence of disease was almost three times more in married individuals than in widowed or divoced persons.

BUT there were 336 total married persons and 116 total divorced or widowed persons in the study population. Table 7-(appendix)

This means that 72.6% of married persons and 80.2% of widowed/divorced persons were ill in the total study population, if they were considered separately.

LIVING AND SOCIAL CONDITIONS

Living and Social conditions not only contribute to disease but also dictate constraints on the chronically disabled.It therefore addresses itself to health status and is included here.

Their Social Circumstance becomes very apparent when their living conditions and the sizes of the households are considered.

68 (14.9%) of persons lived in wood and iron houses.
Table 25-(appendix)

5(1.1%) lived in shanties.Table 25 -(appendix)

ENVIRONMENT AND HEALTH STATUS:SOCIAL FACTORS

TABLE 23

The number of persons either renting or living in council houses was 202 (44.2%) ~~of the study.~~

191(41.8%) lived in their own homes.

8(1.8%) were living in company homes.

112 (24.5%) lived in Council Houses [redacted]

Table 23 -(appendix)

There were 173 persons that were renting and had some form of chronic ailment.Of this group 92(53.2%) paid rent(including lights and water) of between R81 and R140 per month.

Only 15.6%(27) of those with chronic diseases paid rents of over R140.00 per month.

Table 45-(appendix)

This may mean that the higher economic group had a smaller prevalence of chronic illness, or that the scarcity of houses forced them to pay such high rents, therefore making it incumbent on them or their families to live together.

This in itself may lead to dependency of the one or both parties involved irrespective of harmony or disharmony in the families concerned.

~~This needs to be looked at.~~

The disease profile according to rent paid is in table 45-(appendix).

COMPANIONSHIP AND ISOLATION

SIZE OF HOUSEHOLDS

TABLE 26-(appendix)

54.5%(249) of the study population lived in households with 3 adults or less.

17.9% (82) lived in households with 4 adults and

12.9% (59) lived in households with 5 adults.

14.2% (65) lived in households with 6 or more adults.

2.4% (11) lived in households with between 8 and 13 adults.

Table 27-(appendix)

When the number of children are considered the problem becomes more complicated.

247 (54%) persons lived with no or 1 child.

140(30.6%) of persons lived with between 2 and 3 children.

70 (15.3%) of persons lived with between 4 and 14 children.

Children do not live alone.The elderly can if they so wished.Therefore these persons were living with adults and/or children.

The mean household would have 3 adults and 1 child living together with an elderly person.Tables 26 and 27-(appendix)

Table 24-(appendix)

232(50.8%) of elderly were living in 4 room houses.ie. 2 bedrooms,lounge/cum dining room and kitchen or less.

Table 24 -(appendix)

50 (10.9%) were living in 3 room houses,

27 (5.9%) in 2 rooms and

5 (1.1%) in 1 room.

The remainder of 225 (48.2%) lived in 5 or more rooms.

EPIDEMIOLOGICAL FACTORS (Objective 2)

Overcrowding is present.

This can play an important part in aetiology of disease both in the young and old in regard to physical and psychological diseases.

It is therefore a calculated assumption that 232 (50.8%) of the elderly were living in 4 room houses or less with 3 adults and 1 child.

How calculated See T24

The study reveals that 202(44.2%) were either renting or living in council houses.Table 23-(appendix)

The Marburg Town Board has provided 220 (4 room) homes for the indigent.

Of these , at least 190 such homes are occupied by the indigent, a large proportion of whom would be elderly.(Personal contact).

communication — with whom

These homes exist in two different localities and are all together. ie. the indigent and elderly disabled and aged all live together. Their location is far from shops and other facilities. One of these is however within walking distance to the clinic and library(Civic centre)..,but stll some way off from shops ,etc.

Some of these houses have been occupied by elderly couples only, and

after the demise of one of them, approaches have been made to the Authorities re : relocation and reduction of rentals because in reduction of income as a result of the death of a spouse. Over 5 such requests were entertained by the Marburg Municipality.

RENTS PAID

The present rents are between R32.00 and R41.00 ~~- R40.00~~.But many find it difficult to pay for lights and water, which brings their total rental to over R100.00.

~~This is discussed under ecomomic contributors of ill health.~~

~~There were 91 deaths and 208 births registered in Marburg over the past year.~~

A new terraced housing scheme is scheduled to be ready by March 1987 and will house 160 families. indigent or affluent ?

The adequacy or inadequacy of these structurs is decided upon by the Authorities without consultation of the people earmarked to live in such structures.The needs of these people are not ascertained.

The social circumstance becomes very apparent when the living conditions and the size of households are considered.

LOCAL POLITICS

Local politics of the people plays an important part in the epidemiology of disease.The elderly are torn between the Municipality of Marburg who are part of the Government, and the people that see the present 'struggle'from a different idealistic viewpoint.This polarity leads to much dissension in the community at the expense of implementing basic services for the elderly.

COMPANIONSHIP AND ISOLATION

Although there were 336 married persons in the study, only 129(28.2%) were living with their spouses. why ?
Tables 7 and 8-(appendix)

301 (65.9%) were living with a married or unmarried child/children.

10 (2.2%) were living alone.Tables 7 and 8-(appendix)

PAST OCCUPATION

The present disease profile was made up of elderly from all past occupation groups.The present elderly were mainly labourers and housewives. Table 38.

THE INDEPENDANT ELDERLY ie those that said they were not ill:

SEX

There were 68 males and 48 females

AGE

49(42.2%) were in the 55-59year age group.

20(17.2%) were in the 60-64 year age group.

47(40.5%) were over 65 years.

MARITAL STATUS

Single persons numbered 1(.09%).

married persons numbered 92(79.3%).

Widow/divorced persons made up 23(19.8%)

EDUCATION

17(14.7%) of those that were not ill - went over std 5

99(85.3%) only had education up to std 5.

ACCOMMODATION

17(14.7%) lived in wood&iron/shanties.

99(85.3%) lived in brick houses/flats.

COUNCIL HOUSE

In total study 112 (24.5%) lived in council houses.

How do you know?

SPOUSES AND AGE OF SPOUSE

The greatest contributor to widower/widowhood are hypertension,diabetes,cardiac and respiratory diseases.The unfortunate part is that the majority of sucha group will be over 50 years old in such an eventuality.The loss of a healthy spouse can lead to greater dependancy on the part of the ill, and caring for a dependant spouse in this age group can well lead to premature stresses and strains during life,especially if living conditions are not good.

reported some illness.

79% of all spouses over the age of 50 years ~~were sickly~~.
TABLE 64

SEWERAGE AND WATER

Almost 66(19.5%) of the diagnoses were in people with no waterborne sewerage facilities.TABLE 75

26.5% of all skeletal problems belong to this group. Table 75

43 (12.7%) of these diseases were in people with no tap water,depending on tanks or rivers.TABLE-74

so what does this imply.

ELECTRICITY

Although only 56 (16.9%) in the study had no electricity,

17(25%) of all skeletal diseases,

5(29.4%) of all G.I.T diseases and

2 (20%) of all cns(cvas)

language?

make the picture look very gloomy for these people.
TABLE - 73

Readers Digest

Although 10 persons are living alonem, there is no lack of visiting in this community.Table 46

WORK AND THE ELDERLY

42 people with diseases are working.
SEE TABLE 47

Of those with chronic disease - 69.1% earned greater than R150.00 p.m. in the past.Now 72% had a total income of <R150.00 p.m.This may be forcing the 42 people with chronic disease to work.Table 30

255(55.8%) never worked prior their disability.Table 48.

59(12.9%) stopped working before the age of 50 years.Table 48.

123(26.9%) were not working because of ill health and

86(18.8%) because of old age.154(33.7%) considered

themselves housewives.Table 49 .

EPIDEMIOLOGICAL FACTORS OBJ 2

ECONOMIC FACTORS

To establish their economic circumstance, the following were taken into consideration:
rent paid/past and present income/pension/capital assets

Rent paid:
243 (53.2%) paid no rent as they were living with family.

107(23.5%) paid rents of under R100.00.

A similar %age paid rents of over R100.00.Of these,

72(15.8%) paid

rents of R101-R140. (table 29)(appendix)

Past Income:

129(28.2%) had earned nothing or did not disclose this.

259 (56.7%) had earned less than R200 p.m.
TABLE 30(APNDX)

The majority of pensioners earned

approximately R 150.00

Table 26-(appendix)

Capital Assets were hard to come by.But my observation was

that very

few of these people had much.

PRESENT EMPLOYMENT :TABLE 47(APNDX)

377(82.5%) are unemployed or not fit to work.

80 (17.5%) are in employment.

AGE STOPPED WORKING - TABLE 48(APNDX)

255(55.8%) never worked.

107(23.4%) stopped working before age 55 .

REASON STOPPED WORKING -TABLE 49(APNDX)

81(17.7%) DID NOT DISCLOSE why they had stopped working.

8 (1.8%) said they ahd stopped working because of a lack of jobs.

86 (18.8%) were not working because of old age and,

123(26.9%) said that ill health prevented them from working.

154(33.7%) were housewives.

5 (1.1%) were required by family.

Occupation and employment were assessed not only for

economic reasons but to assess mental attitudes and future

planning.

EDUCATION:

The prevalence of the chronic debilitating diseases in those who had no schooling was more than double than in the persons who had been up to std 5. This is clear in table 42(apndx)

Hypertension, diabetes and skeletal disorders are in the ratio of 1:2 in the two groups.

Cardiac,G.I.T.,respiratory and vascular disorders are the commonest diseases in these groups.TABLE 42(Appendix)

Accommodation and disease:Table 43(appendix)

Although this table implies that chronic illness is less prevalent in wood and iron homes and shanty dwellings, than in brick buildings, this is not so. Up until the last year,the majority of the elderly population lived in other than brick buildings.Many of these persons have now been moved into brick council homes.

When one compares the table below, this factor is made abundantly clear.This study therefore gives the impression that there is an almost equal chance of developing chronic illness no matter where one lives.It ,however does not take into account the type of house that one lived in ,in the past and for what period.It also excludes affluence as an indicator of aetiology of chronic illness.

From TABLE 43,- 56 out of 73 persons living in shanty/wood & iron had chronic illness ie 76.7% and Table 44 :89 (79.5%) out of 112 that

are living in council houses,had chronic illnesses.ie elderly that are earning less than R250.00 /month.

23 PERSONS WERE NOT ILL IN COUNCIL HOUSE.ie 19.8%

hypertension - 7 lived in own/relatives or company house

diabetes - 40 lived in as above

skeletal -35 as above

NEED

Two important variables which influence need are the size of the elderly/geriatric population and the degree of economic dependence of that population.

Data regarding both criteria were obtained from the respective Govt.Depts and from the survey.

10 people are living alone. table 8 (appendix)

214 (46.8%) are renting. table 23

107 (23.4%) of the persons in the total study were paying rents of

<R100 .and an equal percentage are paying rents of >R100.00.

TABLE 29 (APNDX)

When one considers that there are 277 (60.6%) disability and old age pensioners in the sample group, TABLE 9(APNDX) whose income is less than R200.00 per month,their degree of dependence becomes obvious.

The survey also reveals that of those people paying rents of over R100.p.m.

28.2% are living with their spouses,

and 53.4% are livuing with a married child/children

and 12.5% are living with an unmarried child.

TABLE 32 (APNDX)

It is considered importantto esatablish the degree to which individuals lived alone.Although only 10 people are living alone,the

question must also be asked as to whether this is out of necessity,because there are no alternatives or whether the traditional family set up still prevails.

We should address ourselves as to who needs who.

SHELTERED EMPLOYMENT:

24(5.25) people indicated that they would be prepared to work again provided the job was less demanding on their health.

80(17.5%) in the study were earning a wage.,(working) (TABLE 47) and of this group 21 (4.6%) DID NOT DISCLOSE THEIR WAGE.

OBJECTIVE 6: RETENTION OF AGED IN COMMUNITY:

The Black Community has always taken care of their aged.This is probably cultural or part of the extended family system.The question as to whether this still pertains today was addressed.

Table 8 shows that only 10 (2.2%) of the study population were living alone.

129(28.2%) were living with their spouses and
308 (67.4%) were living with their families.

The study therefore shows that 95.6% (437) persons were living within a family unit.

Whether this was due to tradition, or being observed because of need or lack of facilities (housing in particular) was assessed.

To answer this the opinions of the population were ascertained in respect of:

where would they PREFER to live? (Table 31)

84(18.4%) preferred to live alone with their spouses..,and

301(65.9%) preferred to live with their families.

The most interesting feature is that only 5 (1.1%) of the study pop. preferred to live in a Council home.TABLE 31(APPENDIX)

59 (12.9%) preferred to live in an oah.or warden type housing.

Table 31(Appendix)

43 people preferred not to live with their families and their reasons for this were varied .Some of the reasons were:

-financial :17 (3.7%) Table 39(Appendix)
-not accepted : 8 (1.8%)

-unfit : 2 (0.4%)

-Other reasons : 16(3.5%)

Almost 66% of the population studied indicated their perference to live with families.But when asked later after having informed them that an O.A.H was being contemplated for PortShepstone, the ff. responses were obtained:

OAH ESSENTIAL	PREFER TOSTAY IN OAH	
YES 356 (77.9%)	YES 170(37.2%)	TABLE 40(appndx)

Although 77.9% of persons thought that an oah was ESSENTIAL, ALL would still not live in one. Nevertheless the number that said they would live in an OAH rose more than threefold to 170. TABLE 40 (APNDX)

Was this because of their initial perceptions of an aoh, or hopes of an improvement of their (those that opted for oah) present qualities of life or that the present generation of the "better off elderly" could see the problems facing their colleagues.The presence of empathy between and among them made them feel that an oah would "solve their problems but not their own, which was to a lesser dgree than some of their compatriots.

Althouigh 301(65.9%) preferred to live with their families, the study also showed that

212 (46.4%) indicated that their families would ACCEPT them living in an OAH.ie their families would not object.

But 159(34.8%) thought that living in an O.A.H. would affect their independence.(Tables 31 and 40-Appendix)

54.2% (248) were being visited by their siblings at least once a month.TABLE 46 (APNDX)

The number of visits by children other than those that they were living with was:TABLE 46 (APNDX)

1-4/month ;295(64.5%)

>5 visits/mth 60(13.1%)

no visits :102 (22.3%)

Persons enjoyed adequate visits at home.

~~OPINIONS regarding assistance required at home indicated that the following were required so that people could live~~ easier within the community:

home helps 219

voluntary vists 228

meals on wheels 183

sitters in 188 Table 41

The opinion of the elderly concerning the supportive services which they would find useful was sought. Home helps were considered useful by 219 (%), meals on wheels by 183 (%), voluntary visitors by 228 (%) and "sitters" by 188 (%) (Table 41).

EXISTING SERVICES AND PATTERNS OF USE :OBJ 5

PHC SERVICES were provided for the elderly by the District Surgeoncy, by Port Shepstone Provinvial Hospital.A tertiary type of service was provided by the Marburg Municipal Clinic and some Voluntary Community

Organisations.

The Services identified by each of these headings are discussed below.

1) Medical Services are available to this population.This is merely palliative or curative levels of treatment at no cost to the pensioners.

Of those on treatment,256 (56%) received the same either at the Port Shepstone Hospital or the District Surgeoncy.

182(39.8%) were attended to by General Practitioners. The rest were seen by the local Clinics.Table 50.(Appendix)

There are 292(63.9%) persons on drug therapy.

TABLE 51apndx

D.S:

The District Surgeon provides a permanent fixed clinic at his rooms in Reynolds St.These clinics are operated on two fixed days of the week.

No home visiting service is provided for those that are unable to attend the former type of service.

In the comprehensive report of the District Surgeon for 1986 it is shown that almost 350 items of service were performed in the last 6 months.Of these 100% were in respect of the elderly/disabled African and Indians.

The distribution of services was as follows:

Main Clinic 100%

The services provided include the management of minor ailments and follow ups on chronic diseases.(eg.Blood pressure,urine tests,taking blood samples and weighing)

Social problems are referred to the Voluntary Bodies.

There has been no liason between the District Surgeoncy and TAFTA .

The cost of these services is made up of a salary in respect of the District Surgeon and the cost of the prescriptions, which average out at R44.00 per script. Source

b Port Shepstone Hospital Services:

P.H.C isprovided for the elderly in the Outpatient Dept.

In addition to this there Special Clinics held weekly for the chronically ill .

The chronically ill are seen once per month or 3 monthly, with a pink card system operating.
There is no liason with the Marburg Municipal Clinic as regards care for the elderly.
There is no District nursing service extending into the community for the care or after care and follow up of previously admitted patients.
There is no Social Work Dept. for those in need of its services.

The total number of outpatient attendances in 1986 was difficult to ascertain .

The services provided are of a routine medical nature and both acut and chronic illnesses are managed.Medical problems requiring specialist management are referred to the relative department or to King Edward/Wentworth Hospital.This is done either as an outpatient or an inpatient according to the circumstances.

2) Social Services do not extend into the community from the hospital or the District Surgeon.
The Regional Dept. of Health and Welfare is present and only extend

their services to the Community at the request of the Hospital Authorities or the District Surgeon.

c Marburg Municipal Clinic

The Marburg Municipal Clinic has a registered Nursing Sister and 1 health assistant and 2 other workers that help with the administration of the Clinic.The Annual Report for the year ending 1985, indicated that no Geriatric Services are rendered, but a total of 116 homes (excluding T.B.) were visited (non-specific).A total of 9 patients attended the clinic for "general care" ie besides child health,T.B., and A.N.C., and family planning.

No pink card system exists and there is no social worker .

d VOLUNTARY ORGANISATIONS.

The Child Welfare Society renders a Social Service.

FOSA and the Blind Society assist in a small way in the field of the elderly.

Other womans organisations and religious bodies exist and do their best, but these are not specifically towards the elderly.

There is no specific geriatric organisation and liason with the local branch of TAFTA was non existent.

The services provided by these organisations are exclusively supportive and protective. There is no preventive component.

Recently a new geriatric welfare organisation has been launched.This is the Port Shepstone/Marburg Haven for the Aged.Liason with TAFTA HAS NOW BEEN established.

Alleviative measures were understood as what was offered to the patient and what the patient did for himself. What was offerred included the Authorities and the welfare bodies.

Authorities:

a. disability pension.

b. free medical service.

Unfortunately this free medical service is obtainable at several P.H.C. Centres as shown in table 50 APNDX,WHICH do not operate on the three levels of comprehensive levels of medical care.Only curative aspects and control are emphasised, as will be indicated under patterns of use.

The Port Shepstone Hospital and the District Surgeoncy are overloaded with work, and are therefore not working to the potential required of them by these chronically ill elderly.

PATTERNS OF USE

59 (12.9%) were non committal in the survey as regards their visits to a P.H.C. Centre.

321 (70.2%) visited a P.H.C. Service atleast once a month.,

53(11.6%) visited the same twice a month, and

20 (4.4%) visited a P.H.C. SERVICE between 3 to 4 times a month.

4 (0.9%) attended a P.H.C. Centre more than 4 times a month.

TABLE 55

Interval in weeks considered necessary for PHC visits

noncommittal - 73(16%) TABLE 56 APNDX

36 (7.9%) considered 1 visit p.m as sufficient contact with a P.H.C Centre to control their chronic diseases.

71 (15.5%) considered 2 visits p.m. as necessary,and

220 (48.2%) thought that 3-5 visits was optimum interval.

57 (12.5%) said that more than 5 visits were necessary.
TABLE 56.

COMPLIANCE

Weeks since last visit to PHC Centre

Non committal - 20 (4.4%)

317 (69.4%) HAD VISITED a P.H.C. centre within the last 5 weeks.

35 (7.7%) said that they had attended the P.H.C. centre within the last 5-9 weeks.

only 85 (18.6%) had been to a P.H.C. Centre in over 9 weeks.
TABLE 57

Many see the need to attend their own G.P.182 -TABLE 50 APNDX

It was ascertained that 292 persons were on drug therapy. (table 51 APNDX).Instructions on tae taking of medication was gi ven in English.

Only 11(2.4%) had received physiotherapy (Table63-APPENDIX).

A very small percentage receive assistance from the respective disciplines as seen in table 63 below:

Physiotherapy - 11 (2.4%)

Psychiatrist - 5 (1.1%)

District Nurse - 6 (1.3%

health visitor - 5 (1.1%)

specialist - 2 (0.4%)

social worker 14 (3.1%)

There were no facilities such as :

tape aids

home helps

meals on wheels

occupational therapist

sheltered employment

day centre for recreation

that were extnded into this community.

Consultations:(table 58)

The feedback we got was that consultations lasted as

ffs:did not know -91 (19.9%)

Consultations of less than 5 minutes amounted to 25. (5.5%).

Consultations of 5-9 minutes numbered 64 (14%).

181(39.6%) said they received consultations of between 10 and 15 minutes.

96(21%) of the study showed that consultations lasted more than 15 minutes.

TABLE 58 apndx

Procedures done at PHC CENTRE TABLE 60apndx

	urine test	B.P.	Auscult.	New Rx	ReviseRx
yes	347(75.9)	381(83.4%)	238(52.1)	125(27.4%)	224(49%)
no	110(24.1)	76(16.6%)	219(47.9)	332(72.6)	233(51%)

	bloodtest	X-Rays	eye/fundi	ecg	
yes	117(25.6)	74(16.2)	15(3.3)	7(1.5)	Hosp D.S G.P CLINIC
no	340(74.4)	383(83.8)	442(96.7)	450(98.5)	HOSP D.S G.P CLINIC

P.H.C. BLOODS DONE

TABLE 60apndx

	bloods	X-Rays	fundi	other
Hospital	72 (15.8%)	59(12.9)	13(2.8)	7(1.5)
G.P.	41 (9.0%)	28(6.1)	27(5.9)	2(0.4)
D.S	13 (2.8%)	3 (0.7)	2 (0.4)	1(0.2)
Other	0	2 (0.4%)		3(0.6)

Why not taking treatment
table 61 apndx

This table shows that 76(16.6%) were taking treatment on a P.R.N basis and that 56(12.3%) did not see the need for treatment as they did not consider themselves ill.

Among other reasons given for not taking treatment regularly were finance, transport and attitude to the dr.

Access to PHC Centre

Table 62 apndx

The majority either travel by car but a significant

number either walk or travel by hired vehicles -121(16.4%).

Table 52 apndx

147 (32.2%) of those interviewed indicated their preference to receive treatment at either the P.S.Hospital or the District Suregeoncy.

109(23.9%) showed their preference to be treated by G.Ps and 31(6.8%) by the marburg clinic.

This means that almost 54.1% who responded to this question preferred treatment in a place other than th hospital or district surgeoncy.

[redacted].

What are the Authorities doing about this problem.What do they think of the service?

(What they are doing/ not doing for their disability?

If doing something -What,, where and under what circumstances in terms of cost, convenience/inconvenience and the results?)

If not doing anything ,, why not?

OBJECTIVES 7A

Alleviative measures that could have been taken, in terms of the three levels of Comprehensive Care.

The opinion of the elderly population was elicited as regards their requirements pertaining to health care facilities and other needs.

[redacted]!

Table 54 shows that a high proportion indicated that there was a need for:

ALLEVIATIVE

The GERIATRIC OPINION on the requirements for health care facilities and other needs were as ff.

More Med officers :	320(70%)
Specialists :	413(92.6)
O.P.D :	365(79.9%)
Wards	339(74.2%)
Nursing Staff	305(66.7%)
Clerks	318(69.6%)
Social Worker	241(52.7%)
Occupational Therapist	412(90.2%)
D.S	188(41.1%)
GPS	122(26.7%)
Home Help	380(83.2%)
visiting	326(71.3%)
Laundry	304(66.5%)
transport to clinic	437(95.6%)
Tape Aids	414(90.6%)
Economic Aid	434(95%)

TABLE 54

The Alleviative Services available at the time of the study were primarily curative and palliative in terms of Comprehensive Health Care.

ALLEVIATIVE

ACCEPTABILITY OF ALTERNATE SERVICES TO WHAT IS BEING USED AT PRESENT

147 (32.2%) Table 52 , prefer to receive their t eatment at the hospital or the D.S.

BUT the following services would be acceptable if made available.

HOME VISITING 336(73.5) .....WILL make use

mobile clinic 442(97)

polyclinic 438 (96)

Nurse Operated phc centre..358(78)

Separate for elderly 389(85)

TABLE 53

Acceptability of alternative services:

	will make use	will not use
home visiting	336(73.5)	121(26.5%)
mobile clinic	442 (96.7%)	15(3.3%)
polyclinic	438(95.8%)	19 (4.2)
nurse operated PHC	358 (78.3%)	99(21.7%)
Separate for elderly	389(85.1%)	68(14.9%)

table 53 apndx (above)

The type of personnel cosidered necessary for tha managements was considered as an indicator of NEED.The greater the level of severity, the greater the level of training of the personnel required.It is surprising that such highly trained personnel are considered necessary. What is surprising is that 28.7% of the individuals said that they had to wait for 1-5 hours at the hospital.TABLE 59 and 11.1 % stated the same time for the District Surgeon.TABLE 59

327(71.5%)TABLE 56 - considered it necessary to visit a P.H.C.Centre at least once a month. 57 people thought more visits were necessary.73 people did not require treatment. 374 (81.8%) visit a P.H..C. Centre between 1-2 times per month.

TABLE 55

ACCESS TO PR.H.C.CENTRE:

39(8.5%) travel by bus

45(9.8) hire a vehicle

76(16.6) walk

The rest go by car.

TABLE 62

DISCUSSION

This dissertationm pertains to the NEEDS OF THE ELDERLY as PERCEIVED BY THEM and not FOR THEM.The only subjective element is my examination and clinical assessment of patients.

OBJECTIVE 1

HEALTH STATUS :PHYSICAL ASSESSMENT

introduction to health status:

Assessment of the present health status of the elderly and the evaluation of the current care that they were receiving was regarded as a priority prerequisite to evaluate their present needs.

Emphasis was placed on those suffering from a Chronic Illness . This however led to problems of definition.

The definition of Chronic Illness is as stated in the Criteria.

TWO important questions have faced research workers in the field of chronic illness, and how it can be measured. Although the answers have tended to be idiosyncratic, certain trends may be identified.

The two main approaches to the definition of chronic illness may be described as either-

disease orientated or

disability orientated.

The former involves identification of certain diseases likely to run a protracted course ie hypertension or diabetes.2/3

It also includes the definition of chronic illness as "impairment",a descriptive term which comprises physical or psychological malfunction or defects.4

However, it is frequently not the disease or impairment perse which

creates problems for the person.More often these are related to the subsequent loss or reduction of functional ability rather than to the structural defect5/,the need to alter behaviour and performance 6/, and the inability to maintain personal and economic independence./7
For these reasons, several workers have defined chronic illness in terms of disability, thereby taking into consideration not only the medical aspects of the disease process, but also the patients' attitudes to their illnesses, their interactions with family and community and the socioeconomic factors involved8/.
We must include dependency of old age since it is frequently impossible to differentiate between this and disease related dependency in the elderly.A claim of inability to persue gainful employment by the chronically ill person was included because it is accepted that individuals attitudes towards their diseases and their own concepts of their capabalities,have an important bearing on their immediate functioning and ultimate prognosis.9/11.

As disability orientated criteria are used to describe the chronic illness, then identification methods utilising lab screening tests, techniques which involve perusal of hospital records are not necessary.
But if proper control of patients is required /or if they have been using the facilities at their disposal is important for future needs of this population group, then this is necessary.

A). We are witnessing the passing of a generation that had and do

have a low educational and socio-economic standard, and poor expectations of health care.
Formerly sheltered by the extended family as an almost invisible group, they are now FORCED to make moral claims.

Although the study may show that the elderly seem to be non-complaining, I think this is due to:

more leisure?
they enjoy the company of others
freedom from work and responsibility
enjoyment of children and grand-children.
knowing no better
basking in the achievements(no matter how simple) of children and grandchildren
a higher pain threshold due to past hardships

But they still greatly fear poor health,lonliness,financial problems,dependency and boredom.

Morbidity and Mortality:

See writings by Prof YL Seedat

The high morbidity rate is alarming.Hypertension, supposedly a disease of the affluent formed the greatest percentage of the disease profile in this rather "poor" socioeconomic group studied.Is this a sign of the stresses of earlier years of this present generation of elderly? "Frustrations and emotional conflicts that begin in earlier life, shed important lifgt on present problems of the elderly".W.H.O-TECHNICAL REPORT SERIES NO.171 pp14.

The prevalence of diabetes is disturbing, yet not significantly different from other studies done by the University of Natal amongst the Indians of Durban.

The management of these two diseases ,together with the high profile of skeletal diseases must be imposing great hardships on this very poor community,living in their present environment.

The general disease profile ought to present a lot of work on the part of any health team that aspires for good control and low mortality and deterioration of these conditions.

The obviously low prevalence of the anaemias,urogenital,malignancy, vision and hearing defects needs to be further investigated.Are these diseases taken for granted as a aprt of the 'natural' ageing process or are patients not made aware of these conditions,with more emphasis being place on the more sinister diseases.

Neuroses are a rarity. Are these not being diagnosed or are they too just accepted as part of ageing.? Are neurotic conditions really a rarity?

The low incidence of accidents and dependency of old age may well bear this out.Or is it the close family unit that prevents this.?

The underlying factor that peratins to this community is the close kinship that is apparent in the study.The family kinship and lack of isolation brings sanity to this population despite the difficulties that are present.

This unfortunate generation show a very high resilience to pain and suffering.This is because they have been subjugated all their lives

and know no better.This may even be better than what they have always endured in their early lives.

The close family ties and seeing their aspirations bearing fruit in the better quality of life of their children and grand children may be a driving force for this generation, whom we are seeing through our younger eyes and making assessments for.

The majority of the elderly are piously religious.It may be that thier religious philosophies make them non-complaining.

Notwithstanding all this, do they really deserve these 'hardships'?

The severity and duration of their disabilities is an indication of the extent and circumstance of the plight of this generation studied. It would take a mamoth team of dedicated health workers to ameliorate the degree of their suffering.But is this the case as it pertains today?In the ensuing pages I hope to find the answers to this and to suggest preventative measures lest the problem worsens for future elderly populations.

Pension Allocation:

Some in the study , CLAIMED TO BE DISABLED AND YET NOT ON ANY PENSION, deserves looking into.It is an indicator that a better system of disability pension allocation be investigated.

The persistent re-appraisals of pension renewals must be undertaken in a better manner where no stresses and anxieties are transmitted to the grantees.This in itself leads to premature "ageing" and the development to neuroses.

It also leads to loss of status in the elderly, and this 'uncertainty' can lead to their being exploited for fear of losing their pensions. The elderly are naturally suspicious.This is the reason why the eliciting of data for this study was so difficult and may be criticised in several respects.

C). COMMUNITY ATTITUDES

"All would live long,but none would grow old" (Churchill),epitomises the "ambiguity and dubiety" with which we think about ageing.Our ATTITUDES towards the elderly is one reason why the reactions of old people may be more closely moulded by the environment than by intrinsic changes.

The appearance of symptoms such as nervousness,irritability,depression,outbursts of anger,personality change,apathy or withdrawal, in the YOUNG are regarded as definite indicators for psychotherapy.In the elderly they are frequently considered as par for the course of old age.Carp perceived these not as signs of old age, but as indicators of difficulties of adjustment since both the young and elderly find themselves in the position of alternately seeking the favours of a society, and finding it hostile.(Carp F.M. 1969 JOURNAL OF GERONTOLOGY 24:2)

Alleviative Measures taken:

Evaluation of current care.:

What peercentage receiving optimal care.?

What pecentage receiving any care at all?

What services are available?

Patterns of use of these services.

These questions will be answered under ' existing services for the elderly'.

There are many problems of care evaluation.The results must be treated with caution.

Must attempt to Standardise the doctor's assessment of " optimal care".It was considered that the essence of clinical medicine allowed for flexibility in clinical judgement, and that it would not be possible to provide rigid,standardised criteria indicating which particular disease with which specific problems should be referred to which services.It was therefore impossible to avoid bias during thisstudy.The limitations which this imposes on the data must be accepted.

Any doctor's approach to a given medical problem will be coloured by his training and experience.

The alleviative measures that were taken as seen in the study,were primarily curative.

OBJECTIVE 2: AETIOLOGY/epidemiology

Information concerning:

class differences in ill-health

differential utilisation of med . facilities by different groups, regional and class differences in expenditure on health, are all important in building up a general picture of helath, illness and medicine in our society.

Working class people die sooner, and generally suffer more ill-health than do middle class people.Distribution of income and patterns of work and consumption- may explain these differences.
Occupational risk factors do not account for all the morbidity and mortality.
"Increased rates of morbidity and early mortality among the wives of male manual workers remain un explained." This too was the caes in our study.
This study shows this preponderance of chronic ailments in females also.
The exact cause is not known.

But most important: we must not forget to consider in depth the BROADER ROLE OF MECICINE IN SOCIETY.Failure to do so ends up accepting a particular view of society and reinfoces widely held beliefs about the role of medicine in our society.

We must understand the political and economic structure of the medical care system., and its relationships to the wider society.

Industrialisation led to tremendous improvement in average life expectancy for people.But this 'development' led to an exploitation of

the underdeveloped world,which was damaging to the health of these people, and it created new health problems,many of which are only now bwcoming apparent.

Some of these differences derive from :

physical proximity to the production process.

Workers import dangers from the workplace to the home.

they are more likely to live near industrial plants and thereforeto be more affected by pollution and industrial wastes.

But all this is not enough to explain all class differences in health and illness.

The distribution of ill health in our sociey broadly follows the distribution of income.Those with lower income s tend to have higher ratets of morbidity and mortality for a no. of reasons.In our society INCOME is a major determinannt of the standard of HOUSING indindividuals and families can obtain, of where they live , of their diet, and of theeir ability to remain warm and wellclothed.All of these factors are significant for health.Moreover the quality of life (and therefoere of health) is increasingly influenced by access to the goods and servicves provided by the State.

We have seen the diverse opinions regarding old age homes and family expectations within an inherent concern for the 'good' of their elderly,no matter how poor in this study .

Even where these are in principle distributed on a universalistic basis, in practice they are allocated neither equally nor in terms of

need.For example ,children of unskilled workers are likely to receive an inferior education and therefore to go on to low paid and probably dangerous jobs themselves.

Little sense to demand more med care without recognising the need both for a critical evaluation of treatments currently in use, and for a greater awareness of the social and economic processes involved in their development and continued use.

.Economic, family and social, and vocational factors involved in the process of transition from disease to disability are apprent in this study.
We mut be able to recognise the needs for this population although they themselves do not see this.However, these needs must be ascertained by them or with their co-operation and not by us or he authorities alone.

It is essential to define early groups at risk of chronic illness and the contributory factors to ill health before providing services. Although not much can be learnt about the intangible ageing processes from this study,it can be hypothessised that,environment,poor early economic circumstance and living conditions eventually lead to a "deprived" generation of elderly who become easily prone to disability.
Poor education and lack of insight to causative factors leads a population to early disability and poor pre-retirement planning sees them ill equipped for such an early eventuality.

For interception need:doctors,social workers,financial relief community nurses,voluntary agencies, and institutions of care.

Improving health status:

Not receiving Rx because of:

unfavourable attitudes towards their disease or towards the services provided and that motivation is reqiured

emphasises the need for doctors totake into account the psychsocial aspects of chronic illness, and not merely the physical components25

The Commission on Chronic Illness 7 estimated that over 50% of severely disabled chronically ill persons required some change in their attitudes towards their physical and mental condition, this need increasing with i

INCREASING AGE.

OBJ. 7d Improving health status:NEEDS

These are some of the basic needs pertaining to our Community.This leads to the advantages of keeping the aged within the community.If these pre-requisites are not met, then what?

Mr Cowan(Human Sc. Research Council) states that the elderly had 7 basic needs, which could not adequately or satisfactorily be met by conventional institutions for the aged - they being:-

- Security of tenure - aged dread being forced to move

- Physical Security - elderly cannot defend themselves well against smugglers and burglars.

- Comfort which includes privacy, quiet and warmth

- Provision of at least one meal a day.

- Commpanionship - the aged loose their friends and colleagues as the years go by, and their mobility tends to be restiicted.

- Occupational interest in the form of hobbies, gardening and assisting members of the Community.

ACCOMMODATION:

Dr Cowan looked at the whole question of providing appropriate and affordable housing for Senior Citizens and in great detail describes the concept of providing retirement centres, which allowed for unit/units for the aged.

Four types of accommodation that were considered basic to a suitable housing scheme are described. I doubt the first applies to us.

2. Flats let to residents.

3. frail care facilities providing accommodattion for full time and part time nursing care to residents; and;

4. A SERVICE CENTRE providing a whole ranged of services for the centre and for the aged in the neighbourhood.

He pointed out that the solution is increasingly being seen to lie in the building of retirement complexes which provide four basic facilities.

- Suitably designed cottages or flats owned (in one of various forms) by older people who have financial resources.

- Flats specifically designed for elderly people- let to residents. Referred to as category a residents by the dept. of local Govt. and Housing Workers.

- A frailed Aged Complex - to accommodate physically and mentally infirm residents needing care and nursing. This unit also provides emergency medical assistance and where necessary,personal physician (category C patients)

- A Service Centre - which provides a whole range of services including meals, laundry physiotherapy, foot care, hairdressing, library, entertainment, recreation, spiritual help.

- Recreation, spiritual help.

- HOUSING

Housing was conisidered from two aspects viz.:

providing for the disabled

as a causative factor of chronic illness

Providing for the disabled:

This study found the following relevent facts:

1.Projection of the number of aged for the next few years

births vs deaths

influx due to industrialisation

.

2.The present number that require housing.

3.Overcrowding is more of a problem than isolation.

4.Finances were inadequate to pay the present rentals.

5.Table 21 shows the feelings of these people about the houses that have been provided.(Only 5 are happy??)

6. The locality of the present housing for the indigent elderly and its limitations.

7.The following personal data about the elderly:

a. that 63.7% of the study population were either old age or disability pensioners with an income of less than R200.00 p.m.

b. 19.5% suffered impaired mobility problems

c. 39% had mobility problems.

d. 7 males and 10 females were housebound or helpless.44 males and 23 females were unemployed because of their disability.

e. 34 had impaired feeding problems.

f.43 were impaired or were unable to wash themselves.

g. 34 had problems with excretion.

h. 190 had either a vision or hearing defect.

Causative Factor:

The general housing shortage has resulted

a. in general overcrowding

b. unhygeinic shanty towns with no services

refer table xxx 25

c.generally high rentals

d.lack of privacy

e. dificulty on the part of the disabled to cope with their physical inadequacies.

f. inadequate environment jo prevent the deterioration of their chronic illnesses

g. premature surfacing of chronic ailments in potential patients that could be prevented given the correct living circumstances.

h. an incorrect interpretation of health in old age by the younger generation leading to a "don't care " attitude towards their own health.

Old people , by nature, are loath to leave a familiar home.

Therefore in trying to improve the Health Status of the elderly, these factors must be taken into account before embarking on what we think is right for them.

The most suitable solution may be "cluster housing". These units should be designed "to accommodate the psychophysical and social needs of both physically fit and handicapped aged people, whether single or married.(Macagnano)Dr.Macagnano has concentrated on "design criteria which would offer a minimum floor area and at the same time,ensure quality of design..."The proposed unit "offers great flexibility through the use of 'combined activity ' spaces and equipment, and by immediate response to psychophysical changes in the occupants."This alternative "allows continuity in living conditions and the individual to retain basic human needs such as dignity,the tendency to socialise and the search for privacy and independence for as long as posible."This enables greater mobility,independent living and a mor 'normal' life.

With the above in mind and the knowledge that the elderly Indian population hold a very strong family kinship,it is futile planning accommodation for such a population,in the hope that the provision of a roof is all that they want.They want a roof with the rest of the

family.Planning and views on housing must bear this in mind.The elderly must be accommodated within the community, and within the family.It is futile planning to circumvent housing needs in the community by separating the young and the elderly.This will only lead to greater hardships to both the young and the old.A compromise situation must be attained where the two generations are accommodated side by side, and yet independent of each other if and when the occasion arises.

The present system of separate for the elderly imposes many problems for them, and is reduobled when they try to solve problems alone.Eg. Bringing in relatives because of lonliness/family ties, to a house that is not modifiable to accommodate the excess needs, threby causing an inconvenience to all concerned.If this were accounted for, by the planners,life would be much easier for all concerned.

Planning for such a scheme, involves a whole team, not only of builders, but of health personnel,family planners,social workers and similar personnel orchestrated by the Authorities themselves.If this is not done, then we are only planning in a vacuum and will solve nothing in the long term.

EXISTING SERVICES:

Many different services are involved in provlding health care for the elderly.The failure of these services to communicate effectively with each other about common patients is one of the major defects in PHC .

TACKLING these NEEDS involves VOLUNTARY COMMUNITY ORGANISATIONS AND the AUTHORITIES.

The question which face a voluntary organisation are :

1. Is there a need for us ?
2. If so what are the specific needs ?
3. What are our resources ?
4. Which of these and how much of these can we mannage ?
5. What are we going to do about that which we can't manage?

The answer to the first question -" Is there a need for Us"? - is both easy and difficult. There will always be someone needing your care so the answer is yes - but the difficult question is "are there not other care groups who need us more" If the answer is yes a group must then decide whether or not it is willing or able to attend to these.

We need to know what is the need - and here we need two answers - how much and what type.

These are not easy to get -so how do we find out ? There is no perfect way but we in practical terms don't need perfect answers - just answers to point us in the right direction.

We need to know if they need us and in what way - and this is the difficultt part.

This is where we must accept that voluntary organisations cannot function in splended isolation. Alone we can't find this out - and here we come to a sensitive topic. We are all, to a greater or lesser extent, individualists - and voluntary organisations are also like us - they like to preserve their identity and I am all for this. But we should be careful not to regard our area of work or the population we serve as our own personal preserve. It can easily be confused whether we are serving the community or whether they are serving us. I belive we should share our knowledge and welcome input from other organisations so that together we can more fully contribute to the needs of the elderly.
But why is this not always the case ? Again I belive this is partly a result
of our isolation from one another.

The reason is quite simple- lack of endeavour of co-ordination . There is little more disrupting than to have one organisation moving in on an area served by another organistion without prior consultation. This leads to confusion of the elderly and wasteful duplication of services.
To find what is needed we need the help of other organisations. They can be visited, determining whether they want our help.

Prof. Arbuckle of the University of Natal believes that we need above all else to achieve these ends:

1. Liasion and co-operation between likeminded organisations.

2. A register of elderly people in need so we can sensibbly direct our resources so that we can best serve them.

The next stage is to look at our resourses in terms of manpower, material,machines and money, and decide what we can do properly and reliably - and then set about it.

But a word of caution: Beware - liaison and co-operation can mean "BOSS'.(Prof.Arbuckle)

This is not the intention - co-operation and liaison does not mean CONTROL. Each organisatin should be autonomous in what it does in providing care and how it uses its resources. If any big brother co-ordinating body tries to take these rights away from you, resist - as unless this autonomy is maintained, interest wanes at the local level and it is likely that the organisations life will be short and unspectular.

OBJECTIVE 7A ALLEVIATIVE- THAT COULD HAVE BEEN TAKEN- IDEAL

Alleviative measures that have been taken, and those that could have been taken, in terms of the three levels of Comprehensive Care.

Are the right people receiving the right care from the right services at the right time?

Consider promotive and preventive services?

Are there primary preventive programmes which are clearly defined, eg.infectious diseases.

Is the care provided - too little and too late?

Diseases where levels of intervention have been identified:

Eg. Ischaemic Heart Dis.-

Is implementation of this information possible?

Should actually start in childhood.

Secondary comprehensive care = Early diagnosis and prompt adequate Rx.

Tertiary comprehensive care = Rehabilitation

These often overlap in chronic illness.

The role of screening programmes in controlling chronic illness has not yet been fully evaluated 7. 7 = .[Commission on Chronic Illness(1957):Chronic illness in the United States,vol 4.Cambridge,Mass.Harvard University Press.]

[Kuller,L. and Tonascia,S.(1970):Arch. environm. Hlth,21,656.]

NB -Watch if TB,Hypertension, Diabetes- could not have been detected

earlier.

Thus preventing long term illnesses becoming chronic illnesses.

The Commission on Chronic Illness(refer above) 7, estimated that while the preventive potential of chronic illness decreased with increasing age , overall, the progression of 40% of the chronic illnesses identified could have been retarded.

In the study by Trussel and Elmson 9 of chronic illness in a rural area, it is indicated that secondary prevention was judged to have been possible in a substantial proportion of cases in practically every major classification of disease.

In the present study it is difficult to quantify the amount of chronic illness which might have been prevented.

9= Trussell,R.E. and Elmson,J.(1959): Chronic illness in the United States,vol.3.Cambridge,Mass.:Harvard Univ.Press.

However, it is likely that whereas certain of these diseases may not have been preventable at a primary level,early diagnosis and adequate treatment might have prevented them from becoming chronic illnesses.This would have been true not only in terms of the progression of the diseases themselves, but also in terms of the secondary psychosocial effects, repercussions, of chronic illness.10

10 =Pless,I.B. and Roghmann,K.J.(1971):J.Pediat.,79,351.

What they are doing/ not doing for their disability?
If they are doing something - What, where and under what circumstances in terms of cost, convenience/inconvenience and the results are present?

If they are not doing anything - why not?

Role of patient in Chronic Illness:

The patient has a much greater contribution to make in chronic illness, as opposed to acute illness.

In many instances,like coronary heart disease,it is the potential patients who are responsible for the individual decisions necessary for the prevention of illness. In general, affected persons are , to a large extent, responsible for assisting with early diagnosis, for ensuring that Rx regimens are complied with, and for accepting their diseases once a late stage has been reached. The attitudes of chronically ill patients are of paramount importance as far as the outcome of their disease is concerned.7,24,32,33.

Primary Health Care is provided for the elderly by the D.S and the Port Shepstone Hospital.The Marburg Clinic only sees geriatric patients from a curative aspect.

The provisions and utilisation of institutionalised care will have a considerable effect on the prevalence, epidemiological characteristics, and care facilities for non institutionalised chronic illness in the community.

In general, the relative absence of care being carried out in peoples homes, would suggest that either chronically ill individuals are being unnecessarily institutionalised or that the community services are not being effectively mobilised to provide the

necessary community care for homebound individuals.

Concern has been expressed about the inappropriateness of much institutional care ,several studies indicating that a large proportion of those persons institutionalised do not in fact require this type of care.15-18

15 =Davis,J.W. and Gibbin,M.J.(1971): Amer.J.publ.Hlth,61,1146..

16 = Dunlop,B.D.(1976):J.chron.Dis.,29,75.

17 = Nauer,R.,Weitzner,M.and Muller,J.N.(1968):Amer.J.publ.Hlth.,58,2111.

18 = Williams,T.F.(1973):J.Amer.Med.Ass.,226,1332.

It has also been emphasised that it is clearly unrealistic to recommend the closure or phasing out of chronic care institutions,as is taking place regarding chronic mental illness in Britain and America ,19 unless adequate services are provided in the community.It would appear from the results of the present study that facilities in the community are unsatisfactory, either through inadequate provision, or through inadequate utilization, or both.Not only would existing services have to be augmented in order to accommodate more chronically ill persons in the community, but is likely that intermediate care facilities would need to be provided to act as a stepping stone between the hospital and the home.15,16.

That the aim of care should be directed towards retaining people in the community hardly needs to be re-iterated.11,12,20.What does require emphasis however,is that if chronically ill patients are

to be retained in the community, there must be adequate provision of the necessary facilities.The people and the profession must be made aware of these services offered.

There is a need for hospital-centred medical personnel to become more community orientated.13,a need for doctors to become more aware of the unique problems associated with the doctor-patient relationship with regard to chronic illness,23-26, and a need for an adequate orientation towards total patient care,something which differs considerably in chronic illness when compared with a symptomatic or acute illness orientation;10,22,23.,it requires 'a shift from the concept of sick care to that of well care'.27

MOST APPROPRIATE TYPE OF SERVICE WITH REGARD TO NEED, COST AND ACCEPTABILITY

THE most appropriate service would be:

established by one Govt. Dept.

delivered by one Health Team -Geriatric

be the responsibility of this one Health Team for all racial groups

to work outside the Hospital - to decrease work load

deliver the service with least inconvenience to the aged

alleviate the woes of the aged -not only with medication

prevent deterioration of present ill health by supervised control

prevent complications and further illness

alleviate stresses such as isolation and financial and insecurity

inculcate dignity into the ageing

Make them feel worthwhile -sheltered employment

Home visits

Day care centre

meals on wheels

Home help

Good housing principles

Transport

Clubs

community involvement

housing

hospital - short term unit

totally dependant

retirement village- for those that find extreme difficulty in remaining in the community.

This unfortunately is not practical at present.

The Indian aged are mainly resident in Marburg which has a municipal clinic.

The aim now would be to :

implement as many of the above as possible

remove the pressure from the hospital and d.s.

implement the pink card system under proper supervision and with the patients' approval

remove the uncertainty from the patients that their pensions will be withdrawn if they do not visit the correct phc

establish liason with the gps and other phcs to reduce cost of management to the patient

educate the family and win their confidence

reassess the efficacy of the municipal clinic -geriatrics

reassure the health team that their jobs are secure and that no trespassing will occur for monetary gain, but that the changes are in the interest of the aged.This will circumvent a lot of human error which can be rationalised to the detriment of the patient.

Must be able to recognise the needs for this population although they themselves do not see this.

Interception of factors in the Community:

Delay normal deteriorative progression as much as possible,

Delay institutional or hospital care for as long as possible, perhaps avoid it altogether,

and when it does occur, reverse it and rehabilitate the person back into the community.,whenever possible.

Institutionalisation, if it becomes necessary, should be brought as near as possible to the end of life.

Consideration of the appropriateness of a Service must take account of:

1. Its ability to satisfactorily manage the majority of patients health needs

2.its accessability to patients

3. its acceptability to patients

4.its cost efficiency in terms of delivery of health care.

Sheltered employment:

In view of the recommendations for sheltered employment, and the fact that severely chronically ill patients were assessed as being able to return to work if less demanding occupations were available, it is considered that a more detailed evaluation of the attitudes and opportunities for the employment of handicapped persons in S.A. is warranted.

Considering the financial implications of unemployment, it is important that every encouragement and opportunity be provided for those persons for whom it is considered that employment would be possible.This will necessitate education and motivationof the medical profession, the chronically ill persons and their repective employees.

PRIMARY HEALTH CARE.

Keith Thomson has referred to P.H.C. Services for the elderly as "a sleeping giant"....Concern is being increasingly expressed that Primary Care for the elderly is not measuring up to what is expected or required.There are many resons for this, ...not least the crucial deficiencies in other key services; good practice in one sector is

only possible when others maintain similarly high standards.It is undeniable that MANY DOCTORS NOW ESTABLISHED IN GENERAL AND HOSPITAL PRACTICE NEVER RECEIVED THE INSTRUCTION OR INSPIRATION IN CARE OF THE ELDERLY as in subjects such as Pediatrics or obstetrics."I hope that the giant can expect a pleasant awakening."(J.G.Evans,The Care of the Elderly in General Practice.)

Provisions must be made for the elderly under the following categories and should not be assessed as one age group with similar needs:

The fit & independant elderly

Those in need of some assistance

Those relatively fit but are no longer able to remain in the community

The chronically disabled either physically and/ mentally

Information solicited:

1.Total Elderly

Pensioners

Non pensioners

Disabled

Prevalence of Chronic illness

Age

Illness by age and sex

2.Disease Profile

Single

Multiple

3Accidents related to chr illness

4.No of illnesses related to accidents

5Education level

6.Income

7.Dwelling

8.Rent

9.Occupation prior to illness/disability

10.Need for sheltered employment

11.Illness vs disability

PATTERNS OF USE OF FACILITIES

Chronically ill persons currently receiving care

Chronically ill persons not currently receivibg care but who in the past received care.

APPROPRIATE SERVICE

** The danger facing the elderly may be the consensus view that may turn elderly people into passive,suitable clients for the Welfare State.The aged are avid consumers,not so much of material goods, but of social and institutional services.Society devotes large resources and much talent to prolonging human life,but fails to provide meaningful social roles for older people.To engage in social welfare programmes may mean the loss of ability to establish one's own future. "We must involve the aged in a lifelong creation of a future, and thinking about ageing must be a thinking about living." GPBook
No assessment of the care of the elderly is complete without a simultaneous evaluation of the provisions of services.We must assess

how effectively these are utilised.

UTILISATION OF SERVICES

Establishing the environment of the patient by Social Worker.

Education of the patient about their disease..,side effects of drugs, follow ups are an essential factor in the prevention of the early onset of the sequelae of Chronic Disease.The time interval will vary individually.But patients must not be given the impression that follow ups are a pre-requisite to them being on pension.This inculcates uncertainty and fear,the very stresses that we are supposed to eradicate.

To decrease the work load from the hospital/d.s ,the municipal clinic should be utilised via the pink card system.

Home visiting by District nurse

Provision of transport to clinics and pensions

Establishment of a Day Care centre ,Meals on wheels,Sheltered employment.,recreation

Working as a TEAM

Not discouraging patient from seeking assistance on NON-CLINIC DAYS.If the patient is properly educated, there will not be an abuse of this.

Patients should only be seen at one PHC Centre.The overlap that exists is costly.

The lack of liason between the PHC Centre and gps is also costly and sometimes can be fatal to the patient.

Primary Health Care is provided for the elderly by the D.S and the

Port Shepstone Hospital.The Marburg Clinic only sees geriatric patients from a curative aspect.

In Durban a Home Visiting Service is provided for those that cannot attend the Clinic.In addition the services provided include minor ailment service,

the routine monitoring of illness(B.P.,urine tests,taking blood samples and weighing),pedicures and heat treatment

Addington Hospital:

. In addition to the outpatient service,a District Nursing Service is provided for aftercare and follow up of previously admitted patients.A Social Work Dept.is also available.

Westville: a once weekly clinic at which the " pink card" system is used.Home visits are done by the Sister in Charge.

Queensburgh: Once weekly geriatric clinic.

Foot care by Chiropodist-monthly.Fees paid by the Lions.

Pink Card System and Home visits.

Kingsburgh and Amazimtoti:

Weekly municipal geriatric clinic.

Pink Card System

Community Services eg entertainmentt ,games and craft,competitions- by Welfare and Community organisations.

Cost of Services 1980: (for elderly/geriatric)

Durban :R64,731.00 (D.S.)

Addington :R1960561.00

Westville :R2876.00

Queensburgh:R7934.00

Amazimtoti R2490.00

Kingsburgh R3948.00

Pinetown R7501.00 ref.Arbuckle Prof.

Marburg Town Board receives/spends approx. R142000.00 p.a.,in the Clinic.Of this amount only approx. R47,000.00 is spent on Comprehensive Medical Care,mainly family planning and child care,since R93000.00 of milk sales is included.In the last financial year 171 geriatric patients were seen for minor ailments.

Use should be made of nurse clinicians specifically trained in the Mx of chr ill 29-31.

Cause of problems:

financial

pensions too low

Family Helpers:

The fear of becoming dependant plays a major role in adjustment to old age.Family Helpers can do much to minimise this anxiety and to give them a feeling of independance and an assurance that they are able to carry on in the presence of varying degrees of disability.

public health measures must be coordinated.

Home visiting by District nurse

Provision of transport to clinics and pensions

Establishment of a Day Care centre ,Meals on wheels,Sheltered employment.,recreation

RETENTION OF AGED IN COMMUNITY-OBJECTIVE 6

That the aim of care should be directed towards retaining people in the community hardly needs to be re-iterated.11,12,20.What does require emphasis however,is that if chronically ill patients are to be retained in the community, there must be adequate provision of the necessary facilities.The people and the profession must be made aware of these services offered.

In this study "emphasis was laid on the principles of maintaining the old as far as possible in their own homes(with domiciliary assistance where required) and reintegrating them into the community as soon as possible after any essential period of treatment elsewhere."
"Increased application of these principles could be of advantage to the aged and could relieve pressure on the health and welfare services." W.H.O.

T he Black Community has always taken care of their aged.This is probably cultural or part of the extended family system.The question as to whether this still pertains today was addressed.
*result : if no - what are the constraints?

In this study it was evident that the mejority of the elderly were not only living in a family set up but also PREFERRED to do so.

What was significant was that while 95.6% of the study population were actually living under a family set up, only 84.3% PREFERRED to do

so.When we consider the further 12.9% that PREFERRED an OAH,then the situation needs to be looked at in depth.
What prompts an elderly person to leave home?

46.4% noted that their families would not OBJECT , but would accept to their living in an OAH.
22.3% were visited by children other than those they were living with less than once a month.
Why would such a high proportion of children allow their parents to leave home?

Ever so often a GP is sanwiched between a family that requests transfer of a n ill patient and the hospital authorities put up their shutters and refuse admission.At a great expense that they can never afford without getting into debt, the patient is admitted as a private patient.,because of the social conditions at home.

All this sounds rather paradoxical.

LACK OF INSIGHT:

It is always important to know why it becomes necessary for an old person to leave their own home, in order that social breakdown can be prevented, or delayed.Sanford(Sanford J R A 1975 Tolerance of debilityin elderly dependants by supporters at home:its significance for hospital practice.BMJ 3: 471-3) pointed out that too little significance had been paid to the patients' supporters, who are in

fact the hub around which the patients ' future depends>.The problems encountered by principal helpers and supporters are:

-dependent behaviour patterns

-limitations in the supporter in relation to the patient

-environmental and social conditions.

Sanfords' study showed that three most intolerable features in the elderly were:

sleep disturbance

immobility problems

daytime wandering.

In relation to this situation , the SUPPORTERS' own limitations showed up as

restriction of social life

personality conflicts

anxiety and depression

embarassment

It is therefore important for the health team to forsee a breakdown in the principal helper or at least be aware of it, for this may be THE REASON FOR LEAVING HOME BY THE ELDERLY.

It is remarkable how people with numerous physical defects can continue to live with support at home" GP pp273

GPpp273 "patients will recognise the need to enter sheltered housing because of frailty, and will request it.My experience notes that such requests emanate more from well kept homes, than from those in whom it is more patently obvious that management has never been a strong virtue."

This is in keeping with this study and becomes even more apparent when the socio-economic factors are considered.

GENERATION GAP:

"It is axiomatic that, in the management of old people,the doctor should envisage them as members of families.Tht family may be deceased,but is not dead in the mind of the patient."GPBOOK PP271 The older generation still believe in the notion of the extended family.The home to them envisages articles,belongings and other "paraphenalia", which all enshrine the memory of relatives and pleasant moments in their lives.

Younger members of the family cannot understand why mother will not go and live with them, and prefers to do her own cooking."Living apart does not affect the cohesion of the family, any more than the fact that a family living together under one roof guarantees harmony" GP PP271

Lack of SUPPORT at home:

Although family size may be declining(cf tables),

more woman are working

modern housing is becoming unsuitable for multi-generation occupation and

adults are more mobile

increased longevity may mean that one elderly person is left responsible for an old age patient.

there is a lack of social care services both to the patient and the family support team

HOUSING:

modern housing is becoming unsuitable for multi-generation occupation and
SLUM CLEARANCE PROGRAMMES AND NEW TOWN SCHEMES have destroyed a traditional community, leading to the aridity of a single generation township.

YOUNG PEOPLE migrating to cities for jobs,the effects of aging were felt more acutely in rural areas.GP BK

EXtended Family:

The view is often expressed that the growing burden thrust upon the health and welfare services by the aged in many countries has been largely created by the withering of family affection and the general disintegration of the extended family.
"Sociological investigations indicate that this view should be modified".
"Wherever careful studies have been carried out,the lasting devotion of children for their parents has been amply demonstrated.The great majority of old people are in regular contact with their children, relatives or friends.Development increases social and geographical mobility, and a small proportion of the aged...10%-20%...are as a result left with few human contacts,particularly in the large cities."WHO
"There is also a marginal group, a still larger number of aged people whose survival in the community is precarious and bought at the cost

of hardship to relatives and friends.If the adjustment of a high proportion of individuals in this group were disturbed,an overwhelming burden would fall on the health and welfare services."WHO
Not withstanding this,"providing more human contact for those without relatives and friends must claim high priority in any endeavour on behalf of the aged in the community." WHO

Nuclear Family

It has been claimed that the nuclear family is better adjusted to the social and economic needs of certain civilisations.
The old kinship patterns in which the son assumed the occupation of his father may no longer be compatible with a world which requires the young to be free to move where opportunity beckons,untramelled by the complicated duties and obligations of the extended family.Whatever the truth of this,a number of investigators have shown that the three generation family is very much alive.The human relationships which it fosters are preferred by a high proportion of young people no less than old ones.Generations continue to shoulder their traditional obligations, of the elders towards their children, and the children towards the aged.As social changes which disrupt the three generation family would destroy the main form of social support which is now enjoyed by the aged, we need to enquire whether human relationships can safely be left to readjust themselves without planned intervention.

This may vey well account for the findings of this study.

Apart from the isolation of the aged, there is evidence that the separation of parents from children is exerting some undesirable effects upon the mode of life and the mental health of the younger generations in suburban areas and in satellite towns of young people.Young parents are restricted in participation in social and community activities.Young mothers are deprived of their mothers' experience.This results in some lonliness in her life when the spouse is at work and the children are at school.There is evidence to indicate that this makes people more vulnerable to mental ill-health.

The wisdom and experience of the old,transmitted to the younger generations, is a heritage of great value.The well balanced, well adjusted aged person is a valuable element in our society.It is not only for the sake of the aged themselves that we must try to raise their conditions of life to a level of dignity - it is also for the sake of their children.

Death and dying. :

Most of the present generation of elderly started of leading a rather difficult aerly life in the sugar and tea and lime factories in Port Shepstone.

They lived under trying socio-economic circumstances living in the slum barracksses that were provided and existing on the "rations" and low pay that were provided.

It was only through "hard resolution" that they managed to branch out into other fields of employment.Medical care was provided ,but were only hospitalised when most were "terminal".Very few ever returned alive.To many ,hospitalisation was a death sentence.

Hence the strong resistance today, amongst this generation for institutionalised care.

WHO: "Psychoanalysts hold that .....frustration and unresolved conflicts that begin in earlier life....,failure uf sustained adjustment in adoloscence and adult life,resulting in chronic unhappiness,unfulfilled and unsublimated yearnings, in general, foreshadow difficulties in senescence.""Middle age, in industrialised countries,is when gains and achievements begin to be outstripped by losses and disappointments".When this balance sheet is upset,the problems of the elderly begin to come to the fore.

This is the past of he present elferly generation.Loss of whatever little status , the loss of a meaningful role and isolation through loss of friends and relatives they had has certainly left them in this predicament.; a predicament they most certainly do not desreve after a lifetime of contribution towards the upliftment of the economy of the town itself.

good neighbour nschemes
volunteers to provide transport
granny annexe
schools providing luncheon clubs

"It is widely felt that the economic burden imposed by the aged in certain countries will rapidly become more serious.Yet the proportion of dependant individuals,as distinct from those in the working age group 15-64 years,is unlikely to undergo any important change in the

'elderly ' nations, for at least some decades. Many old folk who are not in paid employment are still productive ."

A more immediate possibility is a rapidly growing volume of chronic mental and physical sickness which will overload the health services. The increasing number of old people tends to augment the number of physical and mental invalids in the community.

But the evidence from Sweden suggests that the expected increase there in the proportion of invalids in old age may have been more than offset by SOCIAL and MEDICAL progress.The proportion of invalids in Sweden has shown a steady decline."WHO

Voluntsry Visiting Services:

Lonliness and isolation-Visiting service-shopping, library,laundry,transport to clinics, social outings.

Practical aids for the disabled.

Meals on wheels.

Sitters in

Geriatric Registers

The provisions and utilisation of institutionalised care will have a considerable effect on the prevalence, epidemiological characteristics, and care facilities for non institutionalised chronic illness in the community.

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15 =Davis,J.W. and Gibbin,M.J.(1971): Amer.J.publ.Hlth,61,1146..

16 = Dunlop,B.D.(1976):J.chron.Dis.,29,75.

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It has also been emphasised taht it is clearly unrealistic to recommend the closure or phasing out of chronic care institutions,as is taking place regarding chronic mental illness in Britain and America ,19 unless adequate services are provided in the community.It would apear from the results of the present study that facilities in the community are unsatisfactory, either through inadequate provision, or through inadequate utilization, or both.Not only would existing services have to be augmented in order to accommodate more chronically ill persons in the community, but is likely that intermediate care facilities would need to be provided to act as a stepping stone between the hospital and the home.15,16.

CURE:

There is a need for hospital-centred medical personnel to become more community orientated.13,a need for doctors to become more aware of the unique problems associated with the doctor-patient

relationship with regard to chronic illness,23-26, and a need for an adequate orientation towards total patient care,something which differs considerably in chronic illness when compared with a symptomatic or acute illness orientation;10,22,23.,it requires 'a shift from the concept of sick care to that of well care'.27

Retention in the community

Home Helps:

Elderly given this assistance could remain in the community /-relief of hospitals and institutions-great saving.

Home helps are women recruited from community,given short orientation course,free transport,work a few hours a day,receive a small payment which supplements their family income.Regular visits and bringing assistance to aged persons living alone,or left alone when relatives go to work,permit the aged to live in the community.They do laundry,bathing, washing hair cutting nails and shopping.Adapt this to each community.

RECOMMENDATIONS

present trends - likely to dilute the concept of extended family. re-education of family responsibilities to elders is the answer in part.

Answer:

The only answer to this is a team effort which is discussed under primary care.

OLD AGE HOME RESULTS(NEW)

TABLES 55

350(76.6%) -THOUGHT AN OAH essential

165(36.1%) - would live in an OAH

212(46.4%) - said that their families would accept OAH

153(33.5%) - WOULD AFFECT THEIR INDEPENDENCE

REQUIREMENTS TO MAKE IT MORE COMFORTABLE FOR THEM AT HOME

HOme Helps 212 (46.4%) -said woild reqiure it.

Voluntary visiting -221 (48.4%) said would require it.

Meals on wheels - 174 (38.1%) said would require it.

Sitters in - 179(39.2%) would require.

IMPROVING HEALTH STATUS

The cost of medical care is rising rapidly, while the effectiveness of that expenditure is constantly being questioned.

The poor have always been acutely aware of the gross deficiencies in the medical facilities available to them.

There is a common belief that the problem of providing effective health care for all, like the problem of poverty,can ultimately be resolved throough the normal process of parliamentary democracy., and pressure group politics.

The typical view is that this is that these discrepenacies can be improved/changed, within the limits of an 'acceptable level' of public expenditure..What share of the national cake can go on medical care ?What proportion of this should be spent on the old and the young,etc?

Medical buraucracies and industrialised medicine can be obstacles to a healthy society.

Buraucracy can manipulate individuals for its own advantage.The functioning of these buraucracies basically reflectthe nature of the society within which they have been creted.

Those that choose to lead their own lifestyles and want to reject these manipulative buraucracies, must give thought as to how this committment to change is likely to come about.

It is necessary to examine the complex role played by medicine (science) in generating ideology and in social control.

1We need to question the social or economic origins of ill health.Poor health ,for some , is seen as a necessary consequence of economic growth,which is itself assumed to be a desireable goal for everyone.

Thus ,if it is ultimate profit,rather than a concern to improve overall living standards,which is the most important determinant of economic and

social decision-making in our society,this will be reflected in various ways in patterns of health and illness.
Labour should be organised in less damaging ways, and income more equally distributed.

Similarly medical care is not allocated solely on the basis of need. While a more egalitarian allocation of med. resources could not remove inequalities in morbidity and mortality, it is evident that present inequalities in resource allocation serve to reinforce more fundamental class differences in health and illness.
As EYER and STERLING have said, "A large component of adult physical pathology and death must be considered neither acts of GOD nor of our genes, but a measurs of the misery caused by our present social and economic organisation." cf p.s.market

up to pp27.
InBritain -most opposition to the current crisis in med. care - organised around a defence of working class interests- protecting the right to med.care.
Resistance to - reductions in med services
demands for increased state expenditure on health care
more equal social distributtion of med resources.
Modern health care must fight to save existing health services,to ensure their avaialabilty to all and to obtain a higher economic priority for them.

A struggle which is centred around these issues alone- which merely demands ' more of the same'- has limitations.
first, it tends to exclude debate about the value ,or otherwise, of medicine in its present form.

The way in which it is delivered is rarely challenged.
Second and more important,struggles to obtain more med care usually ignore

the crucially important and logically prior question of the social

production of health and illness- what makes us ill in the 1st place and how much of this illness is avoidable?pp292

Social organisation of medicine needs to be looked into. as it reinforces the present status quo.Ashking for more merely shows a failure to understand how present medicine reinforces the present social order.

Doctors and drug co : the avarice of these groups is sabotaging the future?
Control is necessary.

May effect changes - if the admission policies of med schools,
the content of med education or
the control exercised by Drs within the health service.

This is only one spectrum of the struggle for better health.

The abolition of scarcity in med provision is a necessary but a sufficient condition for achieving effective health care.More qualatative zspects of the current organisation of medicine and a redefinition of our health needs.
pp294

provide equal access
to demystify medical knowledge
to break down barriers of authority and status both among health workers themselves and also between workers and consumers.

3rd world excuses : climate
lifestyle approach
affluence in developed countries
is said to be the problem
people have higher income and greater vlongevity, result - choose to spend their money and increased leisure time on commodities and activities -

Individauls to blame for own health problems and it is up to them to adopt a healthier life style. The Victorian notion of " the undeserving poor" is being replaced by the equally inappropriate notion of " the undeserving sick".

Such victim blaming ideologies have emerged.
Wilful failure to use birth control or maitain a balanced diet, for instance, are often cited to explain ill health in the third world.
seepp297

The trend now amongst International agencies,eg W.H.O. ,is a move from high technology medicine to Community orientated public health care.
"However, there are serious obstacles to the creation of such schemes while the social and economic relations in most third world countries remain so profoundly undemocratic".pp286
W.H.O.Planners: "Health by the people is both a philosophical and a pragmatic idea ."But the main reason why this is the starting point in many countries is a lack of funds.South Africa has and can generate enough resources for this programme.
pp287:""...arguments in favour of strenghtening preventive and primary services therefore begin with a ritual obeisance
to the value of ' community' projects,BUT STRESS THE ADVANTAGES IN COST-BENEFIT TERMS."
These programmes will have certain progressive effects,but it is important to recognise the limitations of such policies as they are currently conceived."

The most common prototype used is the "barefoot Doctors of China".It is useed as a example for the recruitment and training of local health workers.Their success is strongly emphasised."However a closer examination of the organisation of health carein China illustrates that the achievements arising out of revolutionary change are not divisible - that health policies cannot simply be transferred from one social,economic and

political context to another"pp288

Roneghy and Solter compared the Chinese barefoot Doctor with those in Iran. In China - the local health worker-

is democratically selected

has a proven willingness to serve the people

has no formal education (apart from literacy) or it plays no part in the selection process

is trained in theory and practice

and is trained entirely in the rural areas.

and receive no SPECIAL payment.

On the other hand, attempts to 'import 'barefoot drs into Iran and other countries,have not been conspicuously successful.Reasons for failure:

Western System of medicine predoninates

any attempts to train auxilliary personnel to take responsibility for 'medical' tasks has met with resistance from the medical profession.

auxiliaries regarded as threat to the profession

Partly resolved by compelling all newly qualified Drs to serve 18 months in rural areas.

Village health worker- selection- presents problems because of the social set up.:

democratic selection - difficult.Headman or one of relatives is put in charge because the position is perceived as a potentially important position in the village.

Women are never selected

Their training reflects a bias towards curative rather than preventative med.These attitudes are perceived by the village on their return from training, to the detriment of the community aspect.

Similar problems in Tanzania and India:

negative attitudes towards the locals

tended to regard them as uncivilised ,ignorant and stubborn

they identified strongly with the richer peasants

they sought their inspiration from the 'real' doctors from the top of the medical hierarchy

Besides foundering, these schemes provide new mwchanisms of social control over the peasant population,who are expected to put their own resources and labour into health schemes over which they will have no control.

"Western medicine has tended to avert death without improving life in the third world" pp290

Improve prevention:

early detection

adequate treatment

rehabilitation

for groups at highest risk of chr illness.

To ensure adequate services are provided and utilised.

100

None of this is recommendation!

RECOMMENDATIONS

language

1. THE ALLEVIATIVE MEASURES THAT COULD HAVE BEEN TAKEN IS STILL NOT TOO LATE AS COMPREHENSIVE MEDICINE IS ONGOING AND YET RETROSPECTIVE.THE PATIENTS NEED TO STILL HAVE THEIR CURATIVE MEDICINE IN A BETTER QUALITATIVE PACKAGE.

Thesis Discussion

TO PREVENT THE PRESENT SITUATION, THE AUTHORITIES MUST IMMEDIATELY HAVE A CHANGE OF ATTITUDE IN THEIR BUDGET,AND HEALTH DELIVERY SERVICES .

THE PATIENTS NEEDS HAVE TO BE IMMEDIATELY ASCERTAINED BY A GENERAL MANAGER FOR SUCH A SERVICE FOR THIS WHOLE POPULATION GROUP, WHO WILL NOT BE TIED DOWN BY BURAUCRACY AND DEPARTMENTALISATION.

THE ATTITUDE OF THE HEALTH TEAM AND THE COMMUNITY NEEDS A CHANGE.WE NEED NOT ONLY TO LOOK TO SERVE THIS POPULATION MEDICALLY.THEIR NEEDS GO BEYOND THIS.

HOUSING,RECREATION,PREVENTION OF MALNUTRITION,SPIRITUAL,TRANSPORT,DECREASING THE PHYSICAL ASPECTS OF THE HARDSHIPS OF LIVING ,PAYING RESPECT TO THIS HARD WORKING GENERATION AND IMPROVING THEIR GENERAL 'STATUS' AND SELF IMAGE.

2.THE STUDY LEAVES NO DOUBT THAT P.H.C. FACILITIES ARE A PRIORITY.THE DISTRICT SURGEONCY AND THE MARBURG TOWN BOARD SHOULD IMMEDIATELY ACT ON THIS.

3.THE MOST APPROPRIATE TYPE OF SERVICE WOULD BE A SINGLE ONE FOR THE WHOLE POPULATION,RUN BY ONE DEPARTMENT, AND RESPONSIBLE TO ONE AUTHORITY.IT SHOULD WORK AS A HEALTH TEAM SYNERGISTICALLY AND NOT IN POCKETS.
EDUCATION OF THE PRESENT GENERATION OF ELDERLY AND ESPECIALLY FUTURE ONES IS A PRIORITY.ATTITUDES NEED TO BE CHANGED BY BOTH THE DELIVERERS AND THE RECIPIENTS OF SUCH A SERVICE.
THIS SERVICE SHOULD EXTEND INTO THE COMMUNITY AND SHOULD NOT JUST STOP AT THE P.H.C. SERVICE CENTRE.IT SHOULD BE A TWO WAY SERVICE, WHERE PATIENTS WILL BE MADE COMFORTABLE NOT ONLY IN THE MEDICAL CONTEXT, BUT FROM THE POINT OF HAVING A HOME AND FRIENDS FROM HOME BASIS.

4.THE MOST IMPORTANT WAY TO IMPROVE THE HEALTH STATUS IS TO INVOLVE THE FAMILIES OF THIS GENERATION, BESIDES THE ABOVE.RETENTION OF THE ELDERLY IN THE COMMUNITY IS DEFINITELY THE IDEAL WE SHOULD WORK TOWARDS.WITHOUT AN IDEAL BACKUP SERVUICE THIS IS DEFINITELY NOT POSSIBLE.THE BACKUP REQUIRED IS NOT ONLY MEDICAL, PARAMEDICAL,BUT INVOLVES SOCIAL WORKERS AND OTHER DISCIPLINES SUCH AS HOUSING AND ADMINISTRATION.

5.THE ESTABLISHMENT OF AN OLD AGE HOME IS STILL A NECESSITY,BUT ON THE LINES AS ENVISAGED AS IT BEING THE LAST RESORT OF A MEDICAL AND HOUSING SOLUTION.

CONCLUSION

It is necessary to retain a sense of perspective to adopt the art of the possible." In our attempts to help the elderly to enjoy their later years, a balance has to be kept between what is possible and beneficial, the overall medical and social resources that are available, the proportions which should be used for the care of the elderly and, above all, to respect and take note of the wishes of the individual old person.""Keith Thompson.

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FINALLY, I THANK MY DEAR WIFE AND CHILDREN FOR TOLERATING ME DURING THE PREPARATION OF THIS DISSERTATION,AND FOR LITERALLY COMPLETING IT FOR ME, WHEN I HAD GIVEN UP.

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Dr.Cowan D,National Building Institute,C.S.I.R.

TABLE 1

THE INDIAN POPULATION OF THE MAGISTERIAL DISTRICT OF PORT SHEPSTONE/MARBURG BY AGE IN 1980: NUMBER AND PERCENT

Total population (all ages) :9729		
AGE	NUMBER	PERCENT
Less than 1 year	: 223	2.3
1 - 4 years	: 900	9.2
5 - 9 years	:1332	13.7
10 - 14 years	:1186	12.2
15 - 19 years	:1079	11.1
20-44 years	:3502	36
45 -54 years	: 784	8.1
55-64 years	: 473	4.9
65 -74 years	: 178	1.8
75+ years	: 72	0.7
Total	:9729	100
Econmically active	:2838	29.2
Not economically active	:6891	70.8
Total	:9729	100.0

TABLE 2

GERIATRIC INDIAN POPULATION

OF PORT SHEPSTONE:NUMBER AND PERCENT

AGE	NUMBER	PERCENT
45-54years	784	8.1
55-64years	473	4.9
65-74years	178	1.8
75+ years.	72	0.7
TOTAL	1507	15.5

TABLE 3

TOTAL INDIAN PENSIONERS IN THE REPUBLIC OF SOUTH AFRICA BY

CATEGORY:NUMBER AND PERCENT

CATEGORY	NUMBER	PERCENT
Old age :	23893	41
Blind :	275	0.5
War Veterans:	248	0.4
Disability:	18113	31.0

Total 42529

Maintenance:	13991	24
Foster Parents:	1726	2.9

(Dept.of National Health and Pop.Dev.

Feb.1986:Mr.J.C.Visser)

TOTAL	58246	100

TABLE 4

TOTAL INDIAN PENSIONS PAID AT PORT SHEPSTONE POST OFFICE IN FEB.,1986 BY CATEGORY: NUMBER AND PERCENT

CATEGORY	NUMBER	PERCENT
Old Age :	344	52
Blind :	2	0.3
War Veteran:	1	0.2
Disability: 310	47	
Total:	657	
Civil Pensions:	4	0.6
Total:	661	

(Mr.van der Nest -Post Office
Port Shepstone.)

Maintenance and Foster Parent Grants not included.

TABLE 5

DISTRIBUTION OF INDIAN POPULATION STUDIED BY AGE AND SEX: NUMBER AND PERCENT.

AGE	MALE	FEMALE	TOTAL
55-59 years	78(46.4%)	90(53.6%)	168(36.8%)
60-64 years	39(41.9%)	54(58.1%)	93(20.4%)
65-69 years	50(49.5%)	51(50.5%)	101(22.1%)
70-74 years	26(60.5%)	17(39.5%)	43(9.4%)
75-79 years	18(69.2%)	8(30.8%)	26(5.7%)
80-84 years	7(50%)	7(50%)	14(3.1%)
85+ years	5(41.7%)	7(58.3%)	12(2.6%)
Total:	223(48.8%)	234(51.2%)	457(100%)

TABLE 6

EDUCATIONAL STATUS OF GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE: NUMBER AND PERCENT

CATEGORY	NUMBER	PERCENT
none-class2	267	58.4
std.1-5	144	31.5
std.6-8	44	9.6
std.8-10	1	0.2
postmatric	1	0.2
Total:	457	100

TABLE 7

MARITAL STATUS OF GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE: NUMBER AND PERCENT.

CATEGORY	NUMBER	PERCENT
SINGLE	5	1.1
MARRIED	336	73.5
WIDOWED	113	24.7
DIVORCED	3	0.7
Total	457	100

TABLE 8

LIVING STATUS OF GERIATRIC POPULATION STUDIED IN PORT SHEPSTONE;NUMBER AND PERCENT

CATEGORY	NUMBER	PERCENT
ALONE	10	(2.2%)
MARRIED CHILD	244	(53.4%)
UNMARRIED CHILD	57	(12.5%)
SPOUSE	129	(28.2%)
SIBLINGS	4	(0.9%)
RELATIVES	3	(0.7%)
OTHER	9	(2%)
NO RESPONSE	1	(0.2%)
TOTAL	457	(100%)

TABLE 2
DISTRIBUTION OF PENSIONERS IN SAMPLE GROUP BY CATEGORY:NUMBER AND PERCENT.

CATEGORY	NUMBER	PERCENT
DISABILITY PENSION	82	(17.9%)
OLD AGE PENSION	195	(42.7%)
TOTAL	277	(60.6%)

TABLE 10

PREVALENCE OF IMPAIRED MOBILITY IN GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE BY AGE NUMBER AND PERCENT

CATEGORY	IMPAIRED	UNIMPAIRED	TOTAL
<60years	23(13.7%)	145(86.3%)	168(36.8%)
60+years	66(22.8%)	223(77.2%)	289(63.2%)
Total	89(19.5%)	368(80.5%)	457(100%)

TABLE 11

PREVALENCE OF IMPAIRED MOBILITY IN GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE BY SEX: NUMBER AND PERCENT

CATEGORY	IMPAIRED	UNIMPAIRED	TOTAL
MALE	48(21.5%)	175(78.5%)	223(48.8%)
FEMALE	41(17.5%)	193(82.5%)	234(51.2%)
TOTAL	89(19.5%)	368(80.5%)	457(100%)

TABLE 12

PREVALENCE OF DISABILITY IN THE GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE BY RESPONSE AND SEX: NUMBER AND PERCENT

CATEGORY	YES	NO	TOTAL
MALE	66(29.6%)	157(70.4%)	223(48.8%)
FEMALE	50(21.4%)	184(78.6%)	234(51.2%)
TOTAL	116(25.4%)	341(74.6%)	457(100%)

TABLE 13

DISEASE PROFILE IN THE GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE BY NUMBER AND PERCENT

	NUMBER	PERCENT
hypertension	104.0	30.5
diabetes mellitus	60.0	17.6
skeletal	68.0	19.9
cardiac	23.0	6.7
G.I.T	19.0	5.6
Respiratory	29.0	8.5
cns-incl cva	10.0	2.9
ugs- renal	3.0	.9
metabolic	1.0	.3
blood	3.0	.9
infections	4.0	1.2
thyroid	1.0	.3
vascular	9.0	2.6
vision	1.0	.3
ent	1.0	.3
malignancy	0.0	0.0
neurosis	2.0	.6
old age	1.0	.3
accidents	2.0	.6
total	341.0	100.0

TABLE 14.

PREVALENCE OF DISABILITY IN THE GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE BY AGE,NUMBER AND PERCENT.

CATEGORY	YES	NO	TOTAL
<60years	36(31%)	132(38.7%)	168(36.8%)
60+years. 80(69%)	209(61.3%)	289(63.2%)	
TOTAL	116(25.4%)	341(74.6%)	457(100%)

TABLE 15

DURATION OF DISABILITY IN GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE BY SEX:NUMBER AND PERCENT

CATEGORY	MALE	FEMALE	TOTAL
3MTHS-1YR.	2(33.3%)	4(66.7%)	6(5.5%)
1YR.-2YRS.	3(50%)	3(50%)	6(5.5%)
2YRS.-3YRS.	5(83.3%)	1(16.6%)	6(5.5%)
3YRS.-4YRS.	7(58.3%)	5(41.7%)	12(10.9%)
4YRS.-5YRS.	6(75%)	2(25%)	8(7.3%)
>5YRS.	38(52.8%)	34(47.2%)	72(65.5%)
NO RESPONSE			6(5.1%)
TOTAL	61(55.5%)	49(44.5%)	116(1

TABLE 16

SEVERITY OF DISABILITY IN GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE: NUMBER AND PERCENT

CATEGORY	NUMBER	PERCENT
UNEMPLOYABLE	64	(14.0)
IMPAIRED MOBILITY	31	(6.8)
PERSON TO BE HOUSEBOUND	12	(2.6)
PERSON TO BE HELPLESS	4	(0.9)
NONE + NOT SPECIFIED	346	(75.5)
TOTAL	457	(100.0)

TABLE 17

DISTRIBUTION OF SYMPTOMS OF DISABILITY IN THE GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE BY SEX :NUMBER AND PERCENT.

CATEGORY	IMPAIRED	NORMAL	TOTAL
IMPAIRED FEEDING	34(7.4%)	423(92.5%)	457(100%)
IMPAIRED EXCRETION	34(7.4%)	423(92.5%)	457(100%)
IMPAIRED WASHING	43(9.4%)	414(90.5%)	457(100%)
IMPAIRED HEARING	61(13.3%)	396(86.6%)	457(100%)
IMPAIRED VISION	129(28.2%)	328(71.7%)	457(100%)

TABLE 18

CATEGORY OF MENTAL HEALTH IN GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE:NUMBER AND PERCENT. [redacted]

CATEGORY.	GOOD.	FAIR.	POOR	TOTAL.
MENTAL STATE	349(76.4%)	92(20.1%)	16(3.5%)	457(100%)
ABILITY TO MAKE DECISIONS	328(71.8%)	91(19.9%)	38(8.3%)	457(100%)
SOCIABILITY	350(76.6%)	74(16.2%)	33(7.2%)	457(100%)
DANGER TO SELF AND OTHERS	363(79.4%)	70(15.3%)	24(5.3%)	457(100%)

TABLE 12

ACUTE EPISODES OF ILLNESS DURING THE LAST 3 MONTHS IN THE GERIATRIC INDIAN POPULATION STUDIED:NUMBER AND PERCENT.

NUMBER OF EPISODES	NUMBER	PERCENT
NONE	3	0.7
1	265	58.0
2	108	23.6
3	68	14.9
4	13	2.8
TOTAL	457	100

TABLE 20

DISEASE PROFILE BY SEX:NUMBER AND PERCENT

	MALES		FEMALES	
	NUMBER	PERCENT	NUMBER	PERCENT
hypertension	37	35.2	67	64.4
diabetes mellitus	22	36.6	38	63.3
skeletal	29	42.6	39	57.3
cardiac	19	82.6	4	17.3
G.I.T	10	52.6	9	47.3
Respiratory	19	65.5	10	34.4
cns-incl cva	5	50	5	50
ugs- renal	3	100	0	0
other	11	7	14	7.5
Total	155		186	

TABLE 21

PREVALENCE OF CHRONIC DISEASES IN GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE BY AGE:NUMBER AND PERCENT.

	55-59 yrs.		60-64 yrs.		>65 yrs.	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Hypertension	33.0	31.7	23.0	22.1	48.0	46.2
Diabetes mellitus	22.0	36.7	13.0	21.7	25.0	41.7
Skeletal	19.0	27.9	20.0	29.4	29.0	42.6
Cardiac	8.0	34.8	5.0	21.7	10.0	43.5
G.I.T	9.0	47.4	2.0	10.5	8.0	42.1
Respiratory	11.0	37.9	3.0	10.3	15.0	51.7
Cns-incl cva	3.0	30.0	1.0	10.0	6.0	60.0
Ugs- renal	0.0	0.0	2.0	66.7	1.0	33.3
Other	14.0		4.0		7.0	
total(ill)	119.0	62.0	73.0	21.4	149.0	43.7
total not ill	49.0		20.0		47.0	
total in age group (whole study)	168.0		93.0		196.0	
Therefore percentage of each age group that are ill is:	70.8%		78.5%		76.0%	

TABLE 22

PREVALENCE OF CHRONIC DISEASES IN GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE BY MARITAL STATUS:NUMBER AND PERCENT.

[redacted]	[redacted] SINGLE		[redacted] MARRIED.		WIDOWED + DIVORCED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Hypertension	2.0	1.9	75.0	72.1	27.0	26.0
Diabetes mellitus	2.0	3.3	41.0	68.3	17.0	28.3
Skeletal	0.0	0.0	50.0	73.5	18.0	26.5
Cardiac	0.0	0.0	19.0	82.6	4.0	17.4
C.V.T	0.0	0.0	13.0	68.4	6.0	31.6
Respiratory	0.0	0.0	22.0	75.9	7.0	24.1
Cns-incl cva	0.0	0.0	6.0	60.0	4.0	40.0
Ugs- renal	0.0	0.0	3.0	100.0	0.0	0.0
Other	0.0	0.0	15.0		10.0	
total	4.0	1.6	244.0	71.6	93.0	27.3

TABLE 23

LIVING CONDITIONS OF GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE: NUMBER AND PERCENT.

CATEGORY	NUMBER	PERCENT
OWN	191	41.8
RENT	90	19.7
RELATIVES OWN	52	11.4
RELATIVES RENT	4	0.9
COUNCIL HOUSE	112	24.5
COMPANY HOUSE	8	1.8
Total:	457	100

TABLE 24

LIVING CONDITIONS OF GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE :NUMBER OF ROOMS: NUMBER AND PERCENT

NUMBER OF ROOMS	NUMBER	PERCENT
1	5	1.1
2	27	5.9
3	50	10.9
4	150	32.8
>4	135	29.5
Total:	457	100

TABLE 25

LIVING CONDITIONS OF GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE:TYPE OF HOUSE:NUMBER AND PERCENT.

TYPE OF HOUSE	NUMBER	PERCENT
WOOD AND IRON	68	14.9
SHANTY	5	1.1
BRICK	382	83.6
FLAT	2	0.4
Total:	457	100

TABLE 26

SIZE OF HOUSEHOLD IN GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE BY ADULTS: NUMBER AND PERCENT

NUMBER OF ADULTS	NUMBER	PERCENT
NOT DIVULGED	2	0.4
1	8	1.8
2	110	24.1
3	131	28.7
4	82	17.9
5	59	12.9
6	42	9.2
7	12	2.6
8	8	1.8
9	1	0.2
11	1	0.2
13	1	0.2
Total:	457	100

TABLE 27

SIZE OF HOUSEHOLD IN GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE BY CHILDREN: NUMBER AND PERCENT

NUMBER OF CHILDREN	NUMBER	PERCENT
0	140	30.6
1	107	23.4
2	80	17.5
3	60	13.1
4	28	6.1
5	23	5.0
6	8	1.8
>6	11	2.4
Total:	457	100

TABLE 28

REFER TABLE 24

TABLE 29

DISTRIBUTION OF RENTALS PAID BY GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE BY AMOUNT: NUMBER AND PERCENT.

RENT PAID	NUMBER	PERCENT
R0-WITH FAMILY	243	53.2
R1-20	14	3.1
R21-40	28	6.1
R41-60	22	4.8
R61-80	8	1.8
R81-100	35	7.7
R101-140	72	15.8
R141-175	6	1.3
R176-225	17	3.7
R226-300	3	0.7
>R300	9	2
Total:	457	100

TABLE ~~28~~ 30.

PAST INCOME OF GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE: NUMBER AND PERCENT.

AMOUNT	NUMBER	PERCENT
NONE+NOT DISCLOSED	129	28.2
R1-50	54	11.8
R51-100	33	7.2
R101-150	16	3.5
R151-200	27	5.9
R201-250	22	4.8
R251-300	14	3.1
R301-350	13	2.8
R351-400	7	1.5
R401-450	8	1.8
R451-500	20	4.4
R501-600	7	1.5
R601-750	7	1.5
R751-1000	7	1.5
>R1000	1	0.2
R0	92	20.1
Total:	457	100

TABLE 31

DISTRIBUTION OF "PREFERANCE TO LIVE" IN GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE: NUMBER AND PERCENT.

CATEGORY	NUMBER	PERCENT
NOT KNOWN	4	0.9
ALONE WITH SPOUCE	84	18.4
WITH FAMILY	301	65.9
OLD AGE HOME	50	10.9
WARDEN TYPE HOUSING	9	2
OTHER	4	0.9
CONCIL HOUSE	5	1.1
Total:	457	100

TABLE 32

DISTRIBUTION ACCORDING TO "WHERE ACTUALLY LIVING" OF GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE:NUMBER AND PERCENT.

PERSONS LIVING WITH	NUMBER	PERCENT OF TOTAL SAMPLE
NOT SPECIFIED	1	.2
ALONE	10	2.2
MARRIED CHILD + CHIDREN	244	53.4
UNMARRIED CHILD	57	12.5
SPOUSE	129	28.2
SIBLINGS	4	.9
RELATIVE	3	.7
OTHER	9	2.0
Total:	457	100.0

ABLE 33

DISTRIBUTION OF "CHILDREN LIVING" IN GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE :NUMBER AND PERCENT

IUMBER OF CHILDREN	NUMBER	PERCENT OF TOTAL SAMPLE	
	14	3.1	
-3	104	22.7	
-6	159	34.8	
-9	126	27.6	
0+	54	11.6	TOTAL
457	100.0		

TABLE 34

PROXIMITY OF NEAREST CHILD,RELATIVE AND SIBLING WITH % OF TOTAL SAMPLE

CATEGORY	CHILD		RELATIVE		SIBLINGS	
DISTANCE	NUMBER	%	NUMBER	%	NUMBER	%
NOT KNOWN	39	8.5	31	6.8	70	15.3
-5 KM	367	80.3	321	70.2	175	38.3
5.3 61	13.3	79	17.3			
10.1-20 KM	2	.4	3	.7	18	3.9
20.1-30 KM	1	.2	4	.9	7	1.5
> 30 KM	19	4.2	37	8.1	108	23.6
TOTAL:	457	100.0	457	100.0	457	100.0

TABLE 35

AGE OF NEAREST CHILD, RELATIVE AND SIBLING IN THE GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE: NUMBER AND PERCENT.

AGE	CHILD		RELATIVE		SIBLING	
	NUMBER	PERCNT	NUMBER	PERCENT	NUMBER	PERCENT
NOT KNOWN+NONE	11.0	2.4	74.0	16.2	135.0	29.5
0-20 YRS	60.0	13.1	2.0	.4	0.0	0.0
21-30 YRS	176.0	38.5	5.0	1.1	4.0	.9
31-40 YRS	132.0	28.9	28.0	6.1	6.0	1.3
41-50 YRS	56.0	12.3	72.0	15.8	59.0	12.9
51-60 YRS	18.0	3.9	144.0	31.5	129.0	28.2
61-70 YRS	4.0	.9	108.0	23.6	98.0	21.4
>70 YRS	0.0	0.0	24.0	5.3	26.0	5.7
TOTAL:	457.0	100.0	457.0	100.0	457.0	100.0

TABLE 36

PAST OCCUPATION OF GERIATRIC INDIAN POPULATION STUDIED IN PORT PORT SHEPSTONE:NUMBER AND PERCENT.

CATEGORY	NUMBER	PERCENT
NONEOR NOT STATED	7	1.5
PROFESSIONAL	4	0.9
NONMANUAL	24	5.3
MANUAL-SKILLED/SEMI	123	26.9
MANUAL/UNSKILLED	107	23.4
HOUSEWIFE	157	34.4
UNEMPLOYED	35	7.7
TOTAL:	457	100

TABLE 37

AGE OF SURVIVING SPOUSE

AGE	NUMBER	PERCENT
NOT KNOWN + NONE	135.0	29.5
21-30 YRS	4.0	.9
31-40 YRS	6.0	1.3
41-50 YRS	59.0	12.9
51-60 YRS	129.0	28.2
61-70 YRS	98.0	21.4
>70 YRS	26.0	5.7
TOTAL	457.0	100.0

N.B.55.3% OF SPOUSES WERE > 50YRS. OLD.

TABLE 38

PAST OCCUPATION BY DISEASE PRESENT (NUMBER)

Occupation	Disese Present	Disease not present	Total
Professional	4	0	4
Non-Manual	21	3	24
Manual-skilled and Semi-skilled	91	32	123
Manual -unskilled	70	37	107
Housewife	127	30	157
Unemployed	24	11	35
Not stated	-	-	7
Total:	337	113	457

TABLE 39

REASONS WHY "PREFER NOT TO LIVE WITH FAMILY" IN GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE.

CATEGORY	NON-COMMITTAL	YES	NO	TOTAL	
FINANCIAL	178(38.9%)	17(3.7%)	262(57.3%)		457
NOT ACCEPTED WITH FAMILY.	184(40.3%)	8(1.8%)	265(58%)		457
UNFIT WITH FAMILY	184(40.3%)	2(0.4%)	271(59.3%)		457
OTHER REASONS	196(42.9%)	16(3.5%)	245(53.6%)		457

TABLE 40

OPINIONS OF GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE AS REGARDS OLD AGE HOME: CATEGORY, NUMBER AND PERCENT.

CATEGORY	YES	NO	TOTAL
O.A.H. ESSENTIAL	356(77.9%)	101(22.1%)	457
WOULD PREFER TO LIVE IN O.A.H.	170(37.2%)	287(62.8%)	457
FAMILY WILL ACCEPT	212(46.4%)	245(53.6%)	457
WILL AFFECT INDEPENDENCE	159(34.8%)	298(65.2%)	457

TABLE 41

OPINIONS REGARDING CATEGORIES OF ASSISTANCE AT HOME IN THE GERIATRIC INDIAN POPULATION STUDIED IN PORT SHEPSTONE: NUMBER AND PERCENT.

CATEGORY	REQUIRED	NOT REQUIRED	TOTAL
HOME HELPS	219(47.9%)	238(52.1%)	457(100%)
VOLUNTARY VISITS	228(49.9%)	229(50.1%)	457(100%)
MEALS ON WHEELS	183(40%)	274(60%)	457(100%)
SITTERS IN	188(41.1%)	269(58.9%)	457(100%)

TABLE 42

PREVALENCE OF CHRONIC DISEASE ACCORDING TO EDUCATION IN THE GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE.

DISEASE	up to std 5		no schooling-to class 2	
	number	percent	number	percent
hypertension	32.0	32.7	66.0	67.3
diabetes mellitus	19.0	33.9	37.0	66.1
skeletal	19.0	31.7	41.0	68.3
cardiac	9.0	40.9	13.0	59.1
G.I.T	6.0	35.3	11.0	64.7
Respiratory	10.0	40.0	15.0	60.0
Other	15.0	42.8	20.0	57.1
total:	110.0	35.1	203.0	64.9

TABLE 43

PREVALENCE OF CHRONIC DISEASE ACCORDING TO ACCOMDATION IN THE GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE.

	wood and iron shanty		flat and brickhouse	
	number	percent	number	percent
hypertension	8.0	7.7	96.0	92.3
diabetes mellitus	8.0	13.3	52.0	86.7
skeletal	19.0	27.9	49.0	72.1
cardiac	4.0	17.4	19.0	82.6
G.I.T	6.0	31.6	13.0	68.4
Respiratory	4.0	13.8	25.0	86.2
Other	7.0	18.5	31.0	81.5
total:	56.0	16.4	285.0	83.6
NOT ILL	17	14.7	99	85.3

TABLE 44

PREVALENCE OF CHRONIC DISEASE ACCORDING TO ACCOMADATION IN THE GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE.

	renting/ relatives rent		council house	
	number	percent	number	percent
hypertension	18.0	36.0	32.0	64.0
diabetes mellitus	14.0	56.0	11.0	44.0
skeletal	13.0	38.2	21.0	61.8
cardiac	3.0	33.3	6.0	66.7
G.I.T	7.0	63.6	4.0	36.4
Respiratory	6.0	55.6	8.0	44.4
Other	12.0	63.2	7.0	36.8
total:	73.0	45.1	89.0	54.9

TABLE 45

PREVALENCE OF CHRONIC DISEASE ACCORDING TO RENT PAID IN THE GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE: NUMBER AND PERCENT.

(RENT FREE NOT INCLUDED)

	<R40.00		R41-R80		R81-R140	
	number	percent	number	percent	number	percent
hypertension	5.0	6.7	8.0	10.7	35.0	46.7
diabetes mellitus	1.0	2.3	2.0	4.5	14.0	31.8
skeletal	11.0	17.7	6.0	9.7	18.0	29.0
cardiac	0.0	0.0	0.0	0.0	5.0	15.6
G.I.T	3.0	10.8	2.0	5.4	4.0	10.8
Respiratory	8.0	2.9	1.0	2.9	5.0	14.7
other	4.0		3.0		11.0	
total	32.0	18.5	22.0	12.7	92.0	53.2
					1.0	100.0

TABLE 45 CONTINUED

	>R141.00	
	number	
hypertension	10.0	
diabetes mellitus	5.0	
skeletal	1.0	
cardiac	3.0	
G.I.T	3.0	
Respiratory	1.0	
other	4.0	
total	27.0	15.6%

TOTAL NUMBER OF PERSONS PAYING RENT WAS 173

TABLE 46

AVERAGE MONTHLY VISITS BY SIBLINGS, OTHER PERSONS AND CHILDREN IN THE GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE NUMBER AND PERCENT.

NUMBER OF VISITS	SIBLINGS	OTHERS	CHILDREN
0	52(11.4%)	156(34.1%)	102(22.3%)
<4	131(28.7%)	159(34.8%)	295(64.6%)
5-8	28(6.1%)	48(10.5%)	10(2.1%)
>8	246(53.8%)	94(20.6%)	50(11.0%)
Total:	457(100%)	457(100%)	457(100%)

TABLE 47

STATUS OF EMPLOYMENT IN THE GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE: NUMBER AND PERCENT.

CATEGORY	NUMBER	PERCENT
EMPLOYED	80	17.5
UNEMPLOYED	377	82.5
Total:	457	100

TABLE 48

AVERAGE AGE AT WHICH THE GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE STOPPED WORKING: NUMBER AND PERCENT.

CATEGORY	NUMBER	PERCENT
NEVER WORKED	255	55.8
1-20 years	27	5.9
21-40 years	11	2.4
41-50 years	21	4.6
51-55 years	48	10.5
56-60 years	47	10.3
61-65 years	39	8.5
65+ years	9	2
Total:	457	100

TABLE 49

THE REASON WHY THE GERIATRIC INDIAN POPULATION ARE NOT WORKING BY CATEGORY:NUMBER AND PERCENT.

CATEGORY	NUMBER	PERCENT
NOT DISCLOSED	81	17.7
NO JOBS	8	1.8
OLD AGE	86	18.8
ILL HEALTH	123	26.9
HOUSE WIFE	154	33.7
REQUIRED BY SIBLINGS	5	1.1
Total:	457	100

TABLE 50

PLACES WHERE PRIMARY HEALTH CARE RECEIVED IN THE GERIATRIC CENT. INDIAN POPULATION OF PORT SHEPSTONE BY CATEGORY:NUMBER AND PER

CATEGORY	NUMBER	PERCENT
PORT SHEPSTONE HOSPITAL	85	18.6
MARBURG CLINIC	4	0.9
DISTRICT SURGEON	171	37.4
GENERAL PRACTITIONER	182	39.8
OTHER	14	3.1
PORT SHEPSTONE CLINIC	1	0.2
Total:	457	100

TABLE 51

DRUG THERAPY RECEIVED IN THE GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE BY CATEGORY:NUMBER AND PERCENT

CATEGORY	NUMBER	PERCENT
YES	292	63.9
NO	165	36.1
Total:	457	100

TABLE 52

PREFERENCE OF TREATMENT FOR PRIMARY HEALTH CARE CENTRE OF GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE BY CATEGORY:NUMBER AND PERCENT.

CATEGORY	NUMBER	PERCENT
HOSPITAL	64	14
DISTRICT SURGEON	83	18.2
GENERAL PRACTITIONER	109	23.9
CLINIC	31	6.8
OTHER	11	2.4
AT HOME	3	0.7
SPECIALIST	7	1.5
MOBILE CLINIC-DISPENSARY	13	2.8
NORESPONSE/NOT REQUIRED	136	29.8
Total:	457	100

TABLE 58

ACCEPTABILITY OF ALTERNATE SERVICES IN THE GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE: NUMBER AND PERCENT.

CATEGORY	WILL MAKE USE	WILL NOT USE	TOTAL
HOME VISITING	336(73.5%)	121(26.5%)	457(100%)
MOBILE CLINIC	442(97%)	15(3.3%)	457(100%)
POLYCLINIC	438(96%)	19(4.2%)	457(100%)
NURSE-OPERATED P.H.C.	358(78%)	99(21.7%)	457(100%)
SEPARATE FOR ELDERLY	389(85%)	68(14.9%)	457(100%)

TABLE 54

OPINION ON HEALTH CARE NEEDS IN THE GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE: NUMBR AND PERCENT.

CATEGORY	NUMBER	PERCENT
MORE MED. OFFICERS	320	70
SPECIALISTS	413	92.6
OUT-PATIENTS DEPT.	365	79.9
WARDS	339	74.2
NURSING STAFF	305	66.7
CLERKS	318	69.6
SOCIAL WORKERS	241	52.7
PHYSIOTHERAPIST	412	90.2
DISTRICT NURSE	400	90.0
OCCUPATIONAL THERAPIST	412	90.2
DISTRICT SURGEON	188	41.1
GENERAL PRACTITIONERS	122	26.7
HOME HELP	380	83.2
VISITING	326	71.3
LAUNDRY	304	66.5
TRANSPORT TO CLINIC	437	95.6
TAPE AIDS	414	90.6
ECONOMIC AID	434	95

TABLE 55

VISITS TO PHC CENTRE IN THE GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE BY CATEGORY PER MONTH: NUMBER AND PERCENT.

NUMBER OF VISITS	NUMBER	PERCENT
0	59	12.9
1	321	70.2
2	53	11.6
3	9	2
4	11	2.4
>4	4	0.9
Total:	457	100

TABLE 56

OPINIONS ON INTERVAL IN WEEKS CONSIDERED NECESSARY FOR PHC VISIT IN GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE BY CATEGORY NUMBER AND PERCENT.

CATEGORY	NUMBER	PERCENT
0	73	16
1	36	7.9
2	71	15.5
3	4	0.9
4	216	47.3
6	1	0.2
7	2	0.4
8	19	4.2
9	35	7.7
Total:	457	100

TABLE 57

"WEEKS SINCE LAST RECEIVED TREATMENT" IN THE GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE BY CATEGORY: NUMBER AND PERCENT.

CATEGORY	NUMBER	PERCENT
0	112	24.5
1	49	10.7
2	56	12.3
3	100	21.9
4	5	1.1
5	3	0.7
6	1	0.2
7	26	5.7
>8 [redacted]	85	18.5
Total:	457	100

TABLE 58

AVERAGE DURATION OF CONSULTATIONS IN THE GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE BY CATEGORY: NUMBER AN PERCENT.

CATEGORY	NUMBER	PERCENT
DOES NOT KNOW	91	19.9
LESS THAN FIVE MINUTES	25	5.5
FIVE-TEN MINUTES	64	14
TEN-FIFTEEN MINUTES	181	39.6
FIFTEEN-TWENTY MINUTES	64	14
> TWENTY MINUTES	32	7
Total:	457	100

TABLE 59

AVERAGE WAIT IN HOSPITAL OF PATIENTS IN THE GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE BY CATEGORY:NUMBER AND PERCENT.

CATEGORY	NUMBER	PERCENT
UNDISCLOSED/NOT APPLICABLE	213	46.6
<15 MINUTES	27	5.9
15-30 MINUTES	3	0.7
30-45 MINUTES	5	1.1
45-60 MINUTES	6	1.3
1-2 HOURS	21	4.6
2-3 HOURS	23	5
3-4 HOURS	12	2.6
4-5 HOURS	14	3.1
>5 HOURS	133	29.1
Total:	457	100

TABLE 58

Average wait in hospital:		D.S.	G.P
non-committal	-46.6% (213)	46.8% (214)	43.5%(199)
< one hour	- 9% (41)	47.3% (216)	53%(242)
1-2 hours	- 4.6% (21)	3.3% (15)	3.1%(15)
>2hrs to 4hrs	- 10.7% (49)	2.4% (11)	0.4%(2)
>5 hours	- 29.1% (133)	0.2% (1)	0.2(1)

TABLE 60

PROCEDURES DONE AT PHC CENTRE IN THE GERIATRIC INDIAN POPULATION BY CATEGORY:NUMBER AND PERCENT.

PROCEDURE	YES	NO	TOTAL
URINE	347(75.9%)	110(24.1%)	457(100%)
B.P.	381(83.4%)	76(16.6%)	457(100%)
AUSCULTATION	238(52.1%)	219(47.9%)	457(100%)
NEW TREATMENT	125(27.4%)	332(72.6%)	457(100%)
REVISE TREATMENT	224(4%)	2330(51%)	457(100%)
FUNDOSCOPY IN LAST YR.	15(3.3%)	442(96.7%)	457(100%)
E.C.G.	7(1.5%)	450(48.5%)	457(100%)
BLOOD TESTS	117(25.6%)	340(74.4%)	457(100%)
X-RAYS	74(16.2%)	383(83.8%)	457(100%)

TABLE 61

REASON FOR NOT TAKING TREATMENT IN THE GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE BY CATEGORY:NUMBER AND PERCENT.

CATEGORY	NUMBER	PERCENT
NO RESPONSE	308	67.4
NO FACILITIES	1	0.2
FINANCE	8	1.8
TRANSPORT	3	0.7
ATTITUDE TO DOCTOR	1	0.2
OTHER	2	0.4
PRN.	76	6.6
NOT NECESSARY+NOT ILL	56	12.3
DOCTOR AWAY+NO HELP	2	0.4
Total:	457	100

TABLE 62

ACCESSIBILITY TO PHC CENTRE IN THE GERIAYRIC INDIAN POPULATION OF PORT SHEPSTONE BY CATEGORY:NUMBER AND PERCENT.

CATEGORY	NUMBER	PERCENT
BUS	39	8.5
CAR	278	60.8
HIRE	45	9.8
WALK	76	16.6
OTHER	19	4.2
Total:	457	100

TABLE 63

RECEIPT OF SERVICES RENDERED BY DISCIPLINES IN GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE: NUMBER AND PERCENT.

CATEGORY	NUMBER	PERCENT
PHYSIOTHERAPY	11	2.4
PSYCHIATRIST	5	1.1
DISTRICT NURSE	6	1.3
HEALTH VISITOR	5	1.1
SPECIALIST	2	0.4
SOCIAL WORKER	14	3.1

TABLE 64

PREVALENCE OF CHRONIC DISEASE BY AGE OF SURVIVING SPOUSE IN GERIATRIC INDIAN POPULATION:NUMBER AND PERCENT.

	21-30 YRS		31-50 YRS		51 AND OVER	
	number	percent	number	percent	number	percent
hypertension	0.0	0.0	9.0	12.5	63.0	87.5
diabetes mellitus	0.0	0.0	10.0	24.4	31.0	75.6
skeletal	4.0	8.0	8.0	16.0	38.0	76.0
cardiac	0.0	0.0	1.0	5.6	17.0	94.4
G.I.T	0.0	0.0	5.0	38.5	8.0	61.5
Respiratory	0.0	0.0	6.0	33.3	12.0	66.7
Other	0.0	0.0	6.0	26.1	17.0	73.9
total	4.0	8.2	45.0	19.2	186.0	79.1

TOTAL of 235 responses

TABLE 65

PREVALENCE OF CHRONIC DISEASE BY AVERAGE MONTHLY VISITS BY SIBLINGS IN GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE: NUMBER AND PERCENT.

	1-8 VISITS		10-12 VISITS		MORE THAN 20	
	number	percent	number	percent	number	percent
hypertension	29.0	30.2	11.0	11.5	56.0	58.3
diabetes mellitus	29.0	53.7	3.0	5.6	22.0	40.7
skeletal	21.0	35.6	8.0	13.6	30.0	50.8
cardiac	6.0	31.6	2.0	10.5	11.0	57.9
G.I.T	6.0	40.0	1.0	6.7	8.0	53.3
Respiratory	10.0	41.7	0.0	0.0	14.0	58.3
Other	18.0	51.4	2.0	5.7	15.0	42.9
total	119.0	81.3	27.0	9.0	156.0	51.7

TABLE 66

PREVALENCE OF CHRONIC DISEASE BY MONTHLY VISITS BY OTHERS IN GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE:NUMBER AND PERCENT.

[redacted]	<10 VISITS		10 to ≥20 VISITS		>20 visits.	
	number	percent	number	percent	number	percent
hypertension	48.0	62.3	23.0	29.9	6.0	7.8
diabetes mellitus	26.0	70.3	6.0	16.2	5.0	13.5
skeletal	32.0	78.0	6.0	14.6	3.0	7.3
cardiac	9.0	47.4	7.0	36.8	3.0	15.8
G.I.T	10.0	76.9	1.0	7.7	2.0	15.4
Respiratory	14.0	66.7	7.0	33.3	0.0	0.0
Other	24.0	80.0	5.0	16.7	1.0	3.3
total	163.0	74.8	55.0	23.1	20.0	8.4

TABLE 62

PREVALENCE OF CHRONIC DISEASE BY MONTHLY VISITS BY CHILDREN IN GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE:NUMBER AND PERCENT

	Less than 10 visits		10 - 20 visits		20 - 30 visits	
	number	percent	number	percent	number	percen
hypertension	74.0	88.1	2.0	2.4	8.0	9.5
diabetes mellitus	45.0	90.0	2.0	4.0	3.0	6.0
skeletal	37.0	72.5	5.0	9.8	9.0	17.6
cardiac	17.0	89.5	0.0	0.0	2.0	10.5
G.I.T	18.0	100.0	0.0	0.0	0.0	0.0
Respiratory	18.0	90.0	1.0	5.0	1.0	5.0
Other	24.0	92.3	1.0	3.85	1.0	3.85
total	228.0	95.4	11.0	4.2	24.0	9.1

TABLE 68

PREVALENCE OF CHRONIC DISEASE BY PRESENT EMPLOYMENT IN THE GERIATRIC INDIN POPULATION OF PORT SHEPSTONE:NUMBER AND PERCENT

	PRESENT EMPLOYMENT			
	YES		NO	
	NUMBER	PERCENT	NUMBER	PERCENT
hypertension	6.0	5.9	96.0	94.1
diabetes mellitus	7.0	11.9	52.0	88.1
skeletal	8.0	11.9	59.0	88.1
cardiac	6.0	27.3	16.0	72.7
G.I.T	5.0	26.3	14.0	73.7
Respiratory	8.0	27.6	21.0	72.4
Other	2.0	5.7	33.0	94.3
total	42.0	12.6	291.0	87.4

TABLE 62

PREVALENCE OF CHRONIC DISEASE BY TOTAL MONTHLY INCOME IN GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE:NUMBER AND PERCENT

	1-150 RANDS		151-300 RANDS		OVER 300 RANDS	
	number	percent	number	percent	number	percent
hypertension	66.0	75.9	11.0	12.6	10.0	11.5
diabetes mellitus	38.0	76.0	5.0	10.0	7.0	14.0
skeletal	47.0	77.0	5.0	8.2	9.0	14.8
cardiac	15.0	71.4	1.0	4.8	5.0	23.8
G.I.T	8.0	44.4	2.0	11.1	8.0	44.4
Respiratory	17.0	63.0	2.0	7.4	8.0	29.6
Other	20.0	70.0	6.0	20.7	3.0	10.3
total	211.0	72.0	32.0	10.9	50.0	17.1

TABLE 70

PREVALENCE OF CHRONIC DISEASE BY PAST INCOME IN GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE:NUMBER AND PERCENT

	1-150 RANDS		151-300 RANDS		OVER 300 RANDS	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
hypertension	19.0	25.0	15.0	19.7	42.0	55.3
diabetes mellitus	8.0	22.9	3.0	8.6	24.0	68.6
skeletal	20.0	40.8	11.0	22.4	18.0	36.7
cardiac	5.0	31.2	7.0	43.8	4.0	25.0
G.I.T	6.0	42.9	1.0	7.1	7.0	50.0
Respiratory	6.0	33.3	3.0	16.7	9.0	50.0
Other	10.0	32.3	8.0	25.8	13.0	41.9
total	74.0	31.0	48.0	20.1	117.0	49.0

TABLE 71

PREVALENCE OF CHRONIC DISEASE BY "AGE STOPPED WORKING" IN GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE:NUMBER AND PERCENT

	1-55 YEARS		56-60 YEARS		61+ YEARS	
	number	percent	number	percent	number	percent
hypertension	28.0	58.5	8.0	18.6	12.0	27.9
diabetes mellitus	13.0	54.2	4.0	16.7	7.0	29.2
skeletal	17.0	50.0	9.0	26.5	8.0	23.5
cardiac	7.0	46.7	5.0	33.3	3.0	20.0
G.I.T	4.0	57.1	1.0	14.3	2.0	28.6
Respiratory	7.0	58.3	3.0	25.0	2.0	16.7
Other	14.0	58.3	6.0	25.0	4.0	16.7
total	85.0	53.5	36.0	22.6	38.0	23.9

TABLE 22

PREVALENCE OF CHRONIC DISEASE BY "REASON NOT WORKING" IN GERIATRIC INDIAN POPULATION OF PORT SHEPSTONE:NUMBER AND PERCENT.

	NO JOBS		OLD AGE AND ILL HEALTH		HOUSE WIFE AND REQD. FAMILY	
	number	percent	number	percent	number	percent
hypertension	2.0	2.1	51.0	52.6	44.0	45.4
diabetes mellitus	2.0	3.6	28.0	50.9	25.0	45.5
skeletal	0.0	0.0	34.0	56.7	26.0	43.3
cardiac	0.0	0.0	16.0	88.9	2.0	11.1
G.I.T	0.0	0.0	9.0	64.3	5.0	35.7
Respiratory	0.0	0.0	13.0	65.0	7.0	35.0
Other	1.0	3.0	22.0	66.7	10.0	30.3
total	5.0	1.7	173.0	57.9	121.0	40.5

TABLE 73.

	Electr.present		electricty not	
	no	%age	no	%age
hypertension	89.0	86.4	14.0	13.6
diabetes mellitus	53.0	88.3	7.0	11.7
skeletal	51.0	75.0	17.0	25.0
cardiac	22.0	95.7	1.0	4.3
G.I.T	12.0	70.6	5.0	29.4
Respiratory	25.0	86.2	4.0	13.8
cns-incl cva	8.0	80.0	2.0	20.0
uga- renal	2.0	66.7	1.0	33.3
metabolic	1.0	100.0	0.0	0.0
blood	2.0	66.7	1.0	33.3
infections	3.0	75.0	1.0	25.0
thyroid	1.0	100.0	0.0	0.0
vascular	8.0	88.9	1.0	11.1
vision	0.0	0.0	1.0	100.0
ent	1.0	100.0	0.0	0.0
malignancy	0.0	ERROR	0.0	ERROR
neurosis	2.0	100.0	0.0	0.0
old age	1.0	100.0	0.0	0.0
accidents	2.0	100.0	0.0	0.0
total	275.0	83.1	56.0	16.9

TABLE 74.

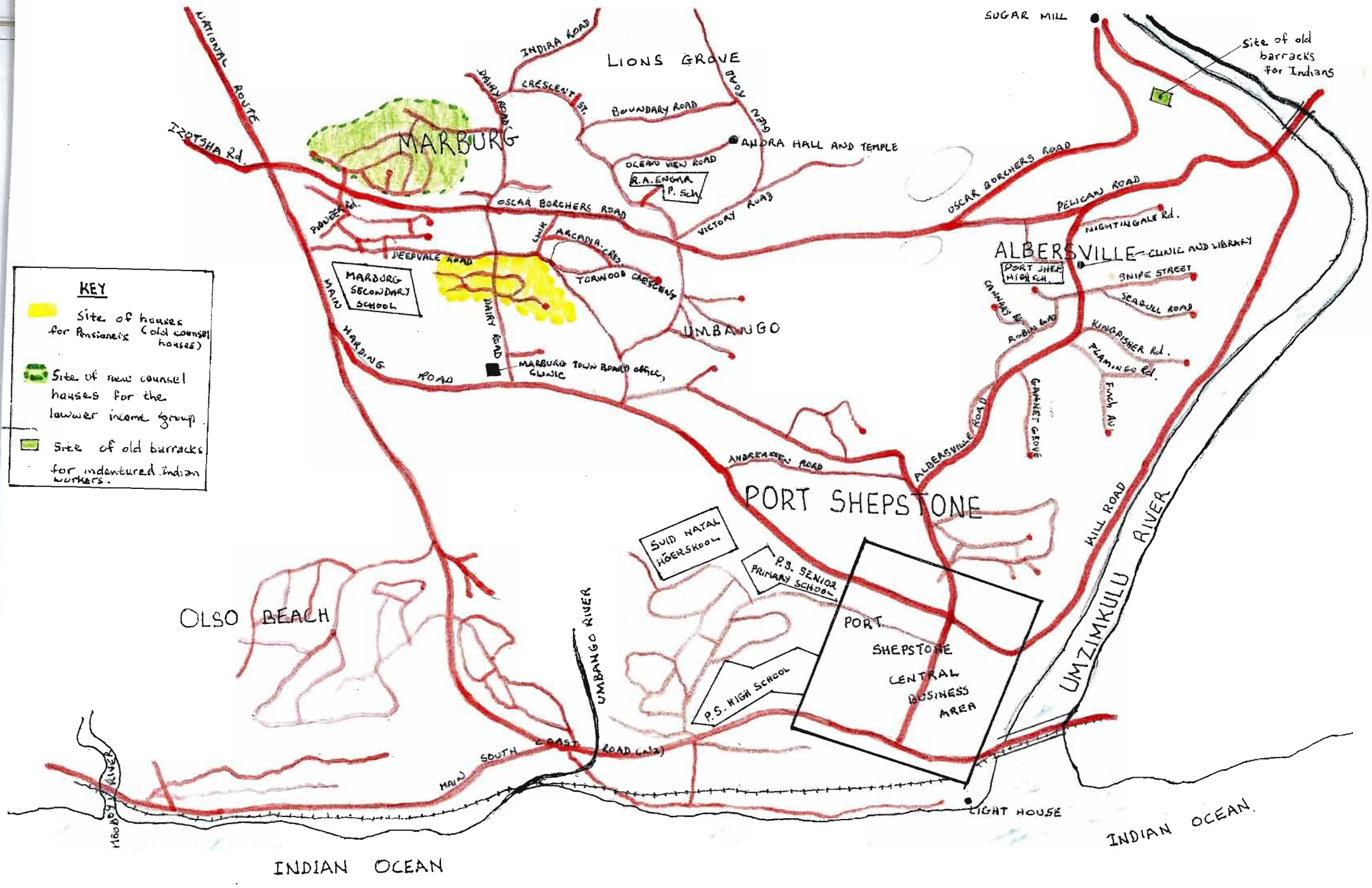
DISEASE BY WATER

[redacted]	[redacted]	TAP.		TANK/RIVER.	
hypertension	92.0	89.3	11.0	10.7
diabetes mellitus	56.0	93.3	4.0	6.7
skeletal	55.0	80.9	13.0	19.1
cardiac	22.0	95.7	1.0	4.3
G.I.T	11.0	64.7	6.0	35.3
Respiratory	26.0	89.7	3.0	10.3
cns- incl cva	9.0	90.0	1.0	10.0
ugs- renal	2.0	66.7	1.0	33.3
metabolic	1.0	100.0	0.0	0.0
blood	2.0	66.7	1.0	33.3
infections	4.0	100.0	0.0	0.0
thyroid	1.0	100.0	0.0	0.0
vascular	8.0	88.9	1.0	11.1
vision	0.0	0.0	1.0	100.0
ent	1.0	100.0	0.0	0.0
malignancy	0.0	ERROR	0.0	ERROR
neurosis	2.0	100.0	0.0	0.0
old age	1.0	100.0	0.0	0.0
accidents	2.0	100.0	0.0	0.0
total	295.0	87.3	43.0	12.7

TABLE 175.

SEWERAGE BY DISEASE --TABLE 175.

	WATERBORNE		NONWATERBORNE	
hypertension	87.0	84.5	16.0	15.5
diabetes mellitus	48.0	80.0	12.0	20.0
skeletal	50.0	73.5	18.0	26.5
cardiac	21.0	91.3	2.0	8.7
G.I.T	12.0	70.6	5.0	29.4
Respiratory	22.0	75.9	7.0	24.1
cns-incl cva	8.0	80.0	2.0	20.0
ugs-- renal	2.0	66.7	1.0	33.3
metabolic	1.0	100.0	0.0	0.0
blood	2.0	66.7	1.0	33.3
infections	4.0	100.0	0.0	0.0
thyroid	1.0	100.0	0.0	0.0
vascular	8.0	88.9	1.0	11.1
vision	0.0	0.0	1.0	100.0
ent	1.0	100.0	0.0	0.0
malignancy	0.0	ERROR	0.0	ERROR
neurosis	2.0	100.0	0.0	0.0
old age	1.0	100.0	0.0	0.0
accidents	2.0	100.0	0.0	0.0


KEY
Site of houses for Pensioners (old council houses)
Site of new council houses for the lower income group.
Site of old barracks for indentured Indian workers.
SUGAR MILL
Site of old barracks for Indians
NATIONAL ROUTE
IZOTSHA Rd.
MARBURG
INDIRA ROAD
DAIRY ROAD
CRESCENT ST.
BOUNDARY ROAD
LIONS GROVE
GLEN ROAD
ANDRA HALL AND TEMPLE
OCEAN VIEW ROAD
R.A. ENGMA P. SCH
VICTORY ROAD
OSCAR BORCHERS ROAD
PELICAN ROAD
NIGHTINGALE Rd.
PRIVATE Rd.
DEEPVALE ROAD
LINK
ARCADIA CRES.
TORWOOD CRESCENT
MARBURG SECONDARY SCHOOL
MAIN
HARDING
ROAD
DAIRY ROAD
MARBURG TOWN BOARD OFFICE, CLINIC
UMBANGO
ALBERSVILLE
CLINIC AND LIBRARY
PORT SHEP. HIGH SCH.
SNIPE STREET
SEAGULL ROAD
KINGFISHER Rd.
FLAMINGO Rd.
FINCH AV.
CANARY Rd.
ROBIN Rd.
GANNET GROVE
ALBERSVILLE ROAD
ANDREWSEN ROAD
PORT SHEPSTONE
HILL ROAD
UMZIMKULU RIVER
SUID NATAL HOERSKOOL
P.S. SENIOR PRIMARY SCHOOL
PORT SHEPSTONE CENTRAL BUSINESS AREA
P.S. HIGH SCHOOL
OLSO BEACH
UMBANGO RIVER
MAIN SOUTH COAST ROAD (N2)
MZOBOSI RIVER
LIGHT HOUSE
INDIAN OCEAN
INDIAN OCEAN

HEALTH CARE OF THE GERIATRIC INDIAN POPULATION IN IN PORT SHEPSTONE

THE PROBLEM

1.Inadequate Knowledge of the extent and circumstance of occurance of Chronic Illness causing significant disability in the GERIATRIC Indian population of Port Shepstone., and of the relevant alleviative measures.

2. The magnitude and nature of the needs in the Geriatric Indian community and the optimal type of service reqiured for the use of this community.

3. The extent of dependance of this community and the reasons for this.

OBJECTIVES

1.To establish the health status of the elderly community.

2. To investigate the multiple epidemiological factors related to occurance of illness in terms of the person affected(man),and in terms of the environment (family,domiciliary,social and community)

3.To investigate the alleviative measures that have been taken.

4. To determine which authority is responsible for the operating and funding of the geriatric services.

5. To identify existing services for the elderly in Port Shepstone , the cost of maintaining those services ,and to identify current patterns of use.

6. .To determine whether retention of the aged in the community for as long as possible is desireable.

7. To make recommendations in respect of

a). the alleviative measures that could have been taken, in terms of the first, secoond and third levels of comprehensive health care.

b). the need for primary health care services with regard to this population.

.c). the most appropriate type of service with regard to need, cost and acceptability.

d). improving the health status

e). Maintaining the independance for as long as possible.

f). establishing the need for an old age home.

CRITERIA

Primary Health Care:

Health Care outside institutions at a cost which can be afforded by both the consumer and the provider and which involves the opinion and participation of the community.

Need:

The requirement for health services which are considered by health professionals to reduce present or future levels of ill health.

Acceptability:

The willingness to use or participate in the functioning of the proposed services by the community to which the services will be directed.

Cost:

In this context only financial cost will be considered.

Health Status:

Physical, mental and social wellbeing.

Physical wellbeing: with no physical disability that precludes the person from performing the functions of daily living.

Mental Status: The mental capability to attend to his or her own affairs and to perform functions of daily living.

Social wellbeing:Living in harmony and satisfaction inrespect of:

number and proximity of surviving children and siblings,

frequency of visits by spouse, cildren, siblings and friends.

GERIATRIC:

Persons 55 years and over and are residents of Port Shepstone.

Port Shepstone:

The Magisterial District of P/S.

Chronoc illness is an illness which has-

a)persisted for at least three months,or which could normally be expected to last for at least three months, and which has

b)resulted in disability causing any one or more of the following:

1.Lack of mobility rendering a person homebound unless aided.
2.Dependancy
3.Unemployment, or the inability or claim of inability to persue the gainful level of employment before the onset of the chronic illness.

Extent of occurrence:

Occurrence in the population sample at a point or short period in time limited by the duration of the study in the population.ie.Period prevalence and not incidence. How much occurrence there is at the time of the survey.

Disability:

The prevention of or incapacitation from doing work or other activities of parallel significance previously carried out by the

person observed and normally carried out by persons of similar age group, sex and community grouping.

Pensioner :
Any individual who is dependant on the State or industry for an income because of not being able to work due to old age or ill health.

Household: All persons living on the same lot.

SELECTION OF SAMPLE GROUP

Every fifth household will be included in the study.
All geriatric persons in the household will be included.
If no geriatric person/s are resident in the household selected,the next immediate household with a geriatric person/s will be included.

No Control Study is considered necessary.

METHODS OF DATA COLLECTION

1.Permisssion to carry out this study will be obtained from all the relevent authorities.

2.Each identified person will be interviewed and requested to participate in the study.Thereafter a standard questionaire and checklist will be administered in strict confidentiality.
Each person will be subsequently examined clinically and medically assessed in the researchers surgery according to a common criteria applicable to all geriatric persons .Transport will be provided.

3.Information regarrding the availability and use of existing facilities will be obtained from the case notes of these persons at their usual primary care centre. These will be consulted and the relevant data extracted.
If this is not possible,information in respect of health and other services provided by authorities, voluntary bodies ,general practitioners,district surgeons,or any other source, will be obtained by communication with the appropriate authorities ,voluntary bodies and personnel.

Where information is not obtainable from the case notes or from the person,friends and relatives will be requested to provide the required information.

Reduction of Variation:

Variation will be reduced by:
i) adherence to defined criteria,
ii) the use of a standardised checklist and questionaire
iii). interviews and clinical assessment will be done by the researcher only

T

IME BARRIERS

Protocol submission :14.08.85.

Commencement of field study: 01.09.85.

Completion of collection of data : 30 October 1985

Completion of collation and analysis of field data: June 1986.

Completion of paper:28.02.86. 30.9.86

APRAISAL OF THE LITTERATURE AND OTHER AVAILABLE INFORMATION ON THE PROBLEM will be ongoing throughout the study.

COLLATION OF COLLECTED DATA

Data will be collated by computer.

EVALUATION OF THE INTER-RELATIONSHIPS OF THE COLLECTED DATA will be done by the researcher.

ADVANCEMENT OF HYPOTHESES OF CAUSATIVE FACTORS AND METHODS OF INTERCEPTION : on completion of the research project.

FIELD TRIAL OF HYPOTHESES : not applicable.

FINAL DEFINITION OF THE CAUSATIVE FACTORS DETERMINED AND RECOMMENDATIONS MADE OF METHODS OF INTERVENTION TO CONTROL THE PROBLEM : 28.02.86.

QUESTIONAIRE

HEALTH CARE OF THE GERIATRIC INDIAN POPULATION IN PORT SHEPSTONE

Study No.__|___|___|___|

NAME:
.....

HOSPITAL NO. |__|__|__|__|__|__| CLINIC I.D.|__|__|__|__|__|

DISTRICT SURGEON ..... G.P. .....

objective 2

PERSONAL CHARACTERISTICS

1.Age |____| 55yrs-59yrs =1, 60-64 =2, 65-69=3,70-74=4, 75-79 =5, 80-84 =6, 85 and over=7.

2.Sex |___| male =1 female=2

3.Marital Status |__|

(Single=1,Married=2,Widowed=3,Divorced=4)

4.Education |___|

(0=no schooling to class 2, Std 1-5=1, Std6-8=2,8-10=3, post matric=4.)

SOCIAL

5. Accommodation |___|

(flat=1,wood & iron=2,brick=3,shanty=4)

6.House |___|

(Own=1, Rent=2, Relatives own=3, relatives rent=4) Council house=5

7.no. of rooms |___|___|

8.Size of household : adults |___|___| . children |___|___|.

Potential isolation:

7 Living with |___|

(alone=1, spouse=2, unmarried child=3, married child=4,
(married children=5, sibling=6,friend=7, relative=8)
other= 9

Number of children living |___|___|

Proximity of nearest child |___|___|

(0-5 km =1, 5.1-10km =2, 10.1-20km =3,
20.1-30km =4, >30km =5)

Proximity of nearest relative |___|___| as for child .

Proximity of nearest sibling |___|___| as above.

Age of nearest child |___|___|

Age of nearest relative |___|___|

Age of nearest sibling |___|___|

7 Age of surviving spouse |___|___|

(0-20yrs.=1, 21-30=2, 31-40=3,
41-50=4,51-60=5,61-70=6,>70=7)

Average frequency of visits per month by:

spouse..|___|___| siblings |___|___|

children.|___|___| others...|___|___|

7 Rent |___|___|

R0.00.=0, 1-20=1,
21-40=2, 41-60=3,
61-80=4, 81-100=5,
101-140=6.141-175=7.176-225=8.226-300=9.

301 and over =10.

Past income |___|___|___| 1-50 =1, 51-100=2,

101-150 =3, 151-200 =4,201-250 =5,251-300=6,
301-350 =7,351-400 =8, 401-450 =9,451-500 =10, 501-600
=11,601-750 =12, 751-1000 =13,>1000=14.
00.00 =15.

	yes=1, no=2.	Income as above.
old age pension.....	|___|___|___|	|___|___|___|
disability pension.....	|___|___|___|	|___|___|___|
Maintenance pension....	|___|___|___|	|___|___|___|
other pension.....	|___|___|___|	|___|___|___|
wage.....	|___|___|___|	|___|___|___|
family.....	|___|___|___|	|___|___|___|
investments.....	|___|___|___|	|___|___|___|
other	|___|___|___|	|___|___|___|
Total.....		|___|___|___|

Receiving pension.... |___|___|___| yes = 1, no =2.

Value of capital assets (Rands) |___|___|___|___|___|___|___|

Employment :Present .....|___|___|___| (yes=1, no=2)

Age stopped working .....|...|...|

1-20years =1,

21-40=2,41-5=3,

51-55 =4, 56-60=5,61-65=6,65 and over=7.

Reason not working .....|...|...|

(no jobs=1, old age=2, ill health=3, housewife=4,
(required by siblings=5)

Occupation past.....|...|...|

Present...|...|.. |

future....|...|. |

Professional=1, non-manual=2,
manual skilled/semiskilled=3,
manual unskilled=4,housewife=5
unemployed=6

(same as previous=1, any occup.=2, less demanding=3,
sheltered=4, unfit to work=5)

8 Electricity..|...|...| .(yes=1, no=2)

9. Water.....|...|...| .(tap=1, Tank=2, river=3)

10.Sewerage ...|...|...| .(waterborne=1, pit=2, bucket=3,nil=4)

11.
Opinion (objective 5)

Where would you prefer to live? |...|...|.

(alone with spouse=1, with family=2, o.a.h=3,
(warden type housing=4,other=5)

Will you manage to live there? .....|...| |
(yes=1, no=2, unsure=3)

Give any reason why you dont live with your family?

Financial..... |...| yes=1

not accepted..... |...| no =2

unfit..... |___|

other..(specify)..... |___|

PHYSICAL STATUS ASSESSMENT

Mobility..... |___| .(impaired=1, unimpaired=2)

Disability:

present |___| yes=1, no=2

duration |___|

3mths-1 yr=1,1- =2,
2- =3, 3- =4,4- =5,
5- =6.

severity |___|

Disability causing unemployment, or the inability or claim of inability to persue a gainful level of employment. = 1

Disability causing impaired mobility but not homebound =2.

Diszbility cuasing a person to be homebound unless aided =3.

Disability causing dependancy such that the person cannot do anything for oneself such as feeding,excredtion and washing=4.

Feeding..... |___| .(not possibe=1, impaired=2, easy=3)

Washing..... |___|

excretion |___|

hearing |___|

vision |___|

Diagnosis

i .....

ii.....

iii.....

Mental Status: |___| (good=1, fair=2, poor=3)

Ability to make daily domestic decisions .....
No danger to self or others .....
Sociability .....

Alleviative Measures

Treatment

Where received? |....|.
(P.S.Hosp=1, Marburg Clinic=2,D.S.=3, G.P.=4,traditional=5)
other =6

Are you receiving drug therapy?..... |__|
(yes = 1, no = 2.)

Do you receive Rx or assistance from any of the ff.? (yes =1, no =2)

physiotherapist	|__|	psychotherapist	|__|
psychiatrist	|__|	health visitor	|__|
district nurse	|__|	social worker	|__|
occupational therapist	|__|	home help	|__|
meals on wheels	|__|	tape aids for blind	|__|
economic aid	|__|		

other (specify).....

Average duration of each consultation..|__|.. less than 5 min =1,
5- = 2
10- =3
15- =4
greater than 20=5

Average duration of waiting for treatment:

in hosp.....	|__|	less than 15 mins =1,
DS.....	|__|	15 - mins = 2,
GP.....	|__|	30 - mins = 3,
Clinic.....	|__|	45 - mins = 4,
		60- mins = 5,
		2 hours - = 6,
		3 hours - = 7,
		4 hours - = 8,
		greater than 5 hrs =9.

Number of visits per month to prim.care centre:..... |__|

Contact interval considered necesary for attendance at P.H.C.Centre in weeks?.....|__|

How many weeks ago did you go for Rx |__|__|

Procedures done at PHC visits : yes =1 no=2

urine.....	|__|
B.P.....	|__|

Auscultation...|.. |

New Rx..... | |

Revise Rx..... | |

Other(specify).....

Special Investigations done in last year?and place of investigation.

Bloods.....	| |	| |
X-Rays.....	| |	| |
Fundoscopy.	| |	| |
Other...	.....	.....

yes=1, no= 2. (hosp=1, GP=2, DS=3,Clinic=4) other=5

If not taking Rx, Why not?..... | |

(no facilities=1,finance difficulties=2, transport diff=3, attitude towards illness=4, attitude towards doctors=5) other =6.(specify)

.....

Access to PHC centre:..... | |
(bus=1, car=2, hire=3,walk=4,other=5)

Where would you prefer to receive your Rx? | |
(hosp=1, DS=2,GP=3, Clinic=4)
other=5

Cost of PHC service: free = 1

Hosp.....	| |	<2.00 =2
DS.....	| |	2-5 =3
GP.....	| |	5- =4
Clinic....	| |	10- =5
		15- =6
		20- =7
		25- =8

Episodes of Acute Illness in last 3 months.

nil | | 1 | | 2-3 | | >3 | |

Objective 7:

Geraitric opinion on reqiurement for health care facilities. and other

Hospital Facilities:	NEEDED	AVAILABLE	ADDITIONAL
med officer,			
specialist			
opd			
wards			
nursing staff			
clerks			
social worker			
Physiotherapist			
Chiropedist			
District Nurse			
Occupational Therapist			
District Surgeon			
General Practioners			
home help(specify)			
meals on wheels			
visiting			
shopping			
library			
laundry			
transport to clinics			
social outings			

Geriatric origins	NEEDED	AVAILABLE	ADDITIONAL

Continued

sitters in			
meals on wheels			
Tape Aids for blind			
other (specify)			
economic aid			

Acceptability ofalternate services to what is being used at present:`

will make use =1, will not make use= 2

home visiting	
mobile clinic	
polyclinic	
nurse operated PHC centres	
separate for elderly	

Need for old age home :
opinion.

		yes=1.
Is it essential?		no =2
Would you prefer to stay in one?		
Would your family accept this?		
Would it not affect your independence?		

What assistance would you require to make it more comfortable for you at home?

i)Home helps	
ii)Voluntary visiting	
iii)Meals on wheels	
iv)Sitters in	