

Palliative Care for Older Persons

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Introduction

It is important that social policies recognise ageing as an integral part of human life and development. This does not imply that the specific needs of older persons should be denied or ignored.

Older people, because they are reaching the end of their lives and are perceived to be of less value to society, are one of the most neglected groups in South Africa in terms of rights and care. The responsibilities of older women, with regard to caring for others, are increasing when they should be decreasing. The role of the older women is changing from being grandmothers to be cared for to becoming 'mother' again and to care for orphaned and vulnerable children, often without the financial and emotional support they need.

In South Africa, an older person is defined as, in the case of females: a person who is 60 years or older and in males 65 years or older (Older Persons Act 2006). In October 1996, there were approximately 1.94 million people over the age of 65 of whom 61.4 per cent were female, according to the National Strategy on Elder Abuse.

This chapter discusses current pressures on older persons in South Africa. The case study of a grandmother living in a township illustrates how HIV/AIDS, poverty and family pressures affect the way in which she is able to cope with all that she has to each day by virtue of being the head of her household. Her situation is not uncommon, with aspects of her life being shared by many other older people who live in poverty. The current environment in South Africa is overshadowed by the devastating effects that the HIV/AIDS epidemic is having on the lives of families. Coupled with sickness and death of younger people, poverty, crime, elder abuse and lack of education, older people are having to find ways of meeting the challenges that face them every day. The effect of the AIDS pandemic in South Africa is such that the burden of care of orphans falls on older people. There is not sufficient acknowledgement of this phenomenon, not sufficient attention to developing the capacity of older persons and supporting their efforts. Universal recognition that the future of South Africa is in the hands of older people has not taken place and consequently much more emphasis needs to be put on the needs of the older person.

Terms you will read in this chapter:

Anecdotal evidence: based on the account of someone, not on scientific evidence or direct experience

Autonomy: respecting the right for people to make their own personal informed decisions

Disenfranchisement: to deprive a person of the right to vote, but in this chapter, the right to grieve

Collaboration: working together with one or more people to achieve a goal

Cumulative negative effect: the increasing and stronger effect of successive negative occurrences

Custody: the legal right to look after a child

Intra-familial: relationships (or whatever) within the family

Misconception: a mistaken view resulting from a misunderstanding

Phenomenon: something that is out of the ordinary and creates interest and curiosity

Proactive: acting rather than reacting to events – taking the initiative

Stigma: the shame or disgrace attached to an illness or anything which society does not accept

CASE STUDY ILLUSTRATING SOME OF THE DIFFICULTIES FACING OLDER CAREGIVERS

Mrs N grew up in rural Eastern Cape and had three daughters until, in 1970 at age 31, she came to Cape Town when her husband died and she took up domestic work as the main breadwinner. She is now a 69-year-old widow who has had five daughters who all live in Cape Town and she has produced fourteen grandchildren, five of whom have died. She has a five-year-old grandchild with AIDS and there is a newborn baby grandchild with TB and who is HIV positive.

Mrs N's fourth daughter died in 1998 at the age of 21. At that time Mrs N did not know where to turn in her grief and also did not dare to talk to anyone about the 'mysterious illness' that had caused her daughter's death, for fear of what the community might think and might do to her. She became depressed and isolated from her circle of support, her neighbours and fellow church members.

In 2001 Mrs N was introduced to an NGO (Grandmothers Against Poverty and AIDS – GAPA) in Khayelitsha where she met other grandmothers who had lost family members to AIDS. She received education about the disease and learned coping mechanisms. In time she became a peer group leader, counselling and assisting other grandmothers to understand and cope with the results of the AIDS epidemic. Participation in the group meant that she and the group members had an outlet for their grief and at the same time were able to earn extra money by making craft items which they sold.

Mrs N owns a one bedroom home in Khayelitsha where she cares for her youngest daughter P, who at age 26 has end stage AIDS. In 2002 P was diagnosed as being HIV positive when she gave birth to her first son. Mrs N looked after the little boy until its father stepped in. Her daughter embarked on a wild lifestyle, abusing alcohol, running away, being unruly and abusive towards her mother. In the subsequent years P had three more children. P's second son, L (who lives with her now), was born HIV positive, is now five years old, on antiretroviral medication and attends a preschool. Towards the end of every month money runs out and there is no food in the house. In order for L to take his medication for AIDS, a neighbour provides a bowl of porridge for him before he sets off for preschool. Mrs. N's response to the lack of food in the house was to say 'God will provide'. P's third baby died at two months from AIDS complications and the latest baby has yet to be released from the hospital where it was born with TB and AIDS. Mrs N took her daughter to the clinic where she was offered ARVs but her daughter has not continued with the treatment.

So in all Mrs N cares for her adult daughter who has AIDS, her five-year-old grandson with AIDS and the newborn baby, if it survives, will live with her as well. Mrs N receives a state pension. Two of her daughters occasionally bring her gifts of food, but they too live in a state of poverty.

Mrs N is nursing P as she is desperately ill and close to death. She has tried to get hospice respite care for P, but the nearby NGO only cares for terminally ill children up to the age of 18 years.

In 2007, on the way to her sister's funeral in the Eastern Cape, Mrs N was involved in a bus accident. When she arrived back she was unable to walk. Friends and neighbours, her GAPA friends and daughters, when they could, helped with washing, fetching chronic medication and housework. Mrs N had to give up hosting her weekly group as she was unable to make preparations for the visitors. Today Mrs N walks with difficulty. Mrs N also has cardiac disease and hypertension.

Mrs N, encouraged by her two 'non infected daughters' pays each month for a burial policy for herself, her daughter P and another HIV positive daughter who is not yet sickly. The baby's funeral cost her R2000. It is very important to her that burials are done in the correct manner and she is prepared to do without food in order to pay the premiums. She said that she has to pay 'because our sons and daughters are careless – they don't care'. It would be a 'disgrace in the neighbourhood and rude if there is not a proper funeral'.

Mrs N is worried about the fact that all the cemeteries in Khayelitsha are full and families have to go further and further away from their homes to find a burial plot. She has come to terms with the fact that she will have to be buried in Cape Town, rather than the Eastern Cape because her family will not be able to afford to transport the body 'home'. Nevertheless, all other burial and funeral traditions have to be carried out according to custom.

Palliative Care and the Aged

Significant linkages exist between palliative care and geriatrics, for example, frailty syndrome, elderly cancer, neurodegenerative disorders, end-stage organ failure, elderly with chronic pain, and the bereaved elderly. As Lo and Woo noted:

Both palliative care and geriatrics focus on patient-centred holistic care, emphasizing quality of life, adding life to days when days can no longer be added to life. Both specialities take a patient-centred rather than an organ-based approach, carefully considering the benefits and burdens of intervention and treatment in advanced disease and age ... Both geriatricians and palliative-care physicians attend to families' needs, e.g. ameliorating bereavement and stress associated with caregiving for the demented and the terminally ill ... Older people are [also] more likely to face bereavement, for which counseling and support should be available.

Indeed, using Dame Saunders' concept, the potential components of 'total pain' experienced by the aged are shown in Table 1.

Moreover, there is a growing recognition of the need to establish closer links between palliative care and the aged globally. Indeed, the theme for the 2007 World Hospice and Palliative Care was *Across the Ages: From children to older persons*, emphasizing that people of all ages need access to hospice and palliative care, either as patients, as family members, or as informal carers of people facing progressive, life-limiting illness.

Table 1: Potential components of total pain in elders (different components may overlap)

Physical Pain	Psychological Pain	Social Pain	Spiritual/existential Pain
Pain from cancer	Worry	Poor living conditions	Indignity
Pain from metastases	Anxiety	Financial Hardship	Meaning of suffering
Pain from treatment	Fear	Inadequate communication	Meaning of life
Pain from joints	Negativity	Inadequate information	Purpose of life
Pain from trauma	Low self-esteem	Loneliness	Value of life
Pain from wound	Despair	Isolation	Sanctity of life
Pain from sores	Depression	Neglect	
Pain from immobility	Demoralisation	Abuse	
Pain from poor oral/dental hygiene	Derealisation	Burden on family/carers	
		Family disharmony	
		Discharge placement	

Grandmothers and the AIDS epidemic

The impact of the AIDS epidemic extends well beyond persons with HIV or AIDS. Most adults who die of AIDS have parents who survive them who are affected in several ways by the illness and the death. Since adults with AIDS are typically in their twenties and thirties, their parents tend to be in their fifties, sixties and seventies, and they constitute a substantial population of older persons who are directly impacted by the epidemic. AIDS is referred to as 'the grandmothers' disease', because elderly women so often assume the role of caregivers, tending for their dying son or daughter, and then the children left behind.

The 4th *Report on the Global AIDS epidemic*, published by the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2004), states that the worst orphan crisis is in Sub-Saharan Africa, where 12 million children have lost one or both parents. It is estimated that this number may climb to more than 18 million by 2010. The death of the parents adds an immense burden predominantly on the shoulders of the grandmothers, as they become the primary caregivers, often without financial and emotional resources. In addition, the grandmother often has to take care of the children from more than one household, when more than one of her own children die of AIDS-related illnesses. The grandmother thus has to cope with her own multiple losses, as well as caring for grieving, and often infected, children. She has to prepare herself emotionally for grieving over these grandchildren eventually as well. She finds herself in a constant grieving environment.

Research into the plight of grandmother-headed households living on the Cape Flats in 2000 showed that grandmothers were ill equipped to deal with the effects of the AIDS epidemic. Grandmothers found that they were faced with the deaths of their children and grandchildren after a relatively short period of progressive weakening, weight loss and being bedridden. Their normal channels of support such as neighbours, other family members and communities closed as everyone feared the possible consequences and stigma of being associated with the disease, the origin of which is clouded by misconceptions in many communities.

Grandmothers in the study reported that they were becoming poorer because of the additional costs of caring for a sick person, their pensions being now the only income for their households and their responsibilities for caring for grandchildren being now full time. Furthermore, the grandmothers did not have any knowledge of HIV/AIDS and were powerless to begin to know how to care for their sick children and grandchildren.

Older people are considered to be the 'keepers of the culture' and because of the huge expense of a culturally correct funeral, household income dropped considerably as grandmothers borrowed money from neighbours and friends to pay for the funerals of their children and grandchildren.

Grandchildren still at school relied on their grandparents' income to keep them at school after the death of their parents. Although there might be relief in some schools from paying fees, the children still need uniforms, pens, pencils, files, glue etc. and still have to pay for outings or they are excluded. Children, below school going age, have to remain in grandmother's care everyday as there is no money to pay for crèche or preschool fees. Grandmothers found that they have no time for themselves, having to line up at hospitals and clinics from the very early hours of the morning with small children while they waited for their medication or doctor visits. No provision is made for the children or the older people at the hospitals.

The stress of loss of children to HIV/AIDS, lack of money, their own chronic illnesses, presence of small children all day and night, lack of understanding about the illness and lack of neighbourly support diminished the older people's sense of worth resulting in widespread depression and thoughts of suicide.

The challenges that grandparents, and specifically grandmothers, face in fostering their grandchildren, are summarised as follows:

- Financial implications;
- Emotional strains resulting from negative community reactions towards the fostered grandchildren, or worries about the cost of childcare;
- Physical strain and exhaustion resulting from taking care of infants and younger children, as well as from additional work required to cover the escalating cost incurred for taking care of the grandchildren;
- Reduced participation in social activities due to the fear of the community of including the infected children. Intra-familial relations may become strained in the event of conflict over custody or if the grandparents judge other family members to be negligent about sharing responsibility.

The grandmother's own health status must be added to this list of challenges with which she is confronted.

Rights of older caregivers

The Older Persons Bill 2006 and the Constitution of South Africa are some of the guidelines regarding the rights of older persons. The National Action Plan (NAP) is a national initiative, whereby the South African Government responded to the call for a detailed policy and legislative programme to realise the fundamental rights and freedoms enshrined in the Constitution. The NAP affirms that no one shall be unfairly discriminated against on the basis of age. The NAP also refers to the right of access to justice, and as a result, the Department of Justice ensures that courts are made more accessible for older people. The older persons are also protected under the Right of Access to Health Care Services. The NAP encourages the following to be addressed on provincial level:

- Providing adequate state funding
- Establishing homes and frail care centres
- Providing funding for home-based care
- Improving the quality of care in homes and frail care centres.

South Africa is a member of the United Nations and has adopted the UN principles for older persons. The authors have added some suggestions on how palliative care may be able to contribute to these principles.

Independence

- Older persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family support and community support and self-help. (Palliative caregivers assist by identifying the needs of the elderly and provide resources to a certain extent and within the means of the relevant Hospice.)
- Older persons should have the opportunity to work or have access to other income-generating opportunities.
- Older persons should be able to participate in determining when, and at what pace, withdrawal from the labour force takes place. (Older persons in the employ of Palliative Care organisations should be included in this decision-making process.)
- Older persons should have access to appropriate educational and training programmes. (Palliative care training programmes are a means of empowering the healthy elderly to become involved in care-giving in the community and to advocate for palliative care amongst all population groups.)
- Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.
- Older persons should be able to reside at home for as long as possible. (The wish of the dying older person to die at home should be respected by palliative caregivers.)

Participation

- Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
- Older persons should be able to seek and develop opportunities for service as volunteers in positions appropriate to their interest and capabilities.
- Older persons should be able to form movements or associations of older persons.

Care

- Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.
- Older persons should have access to health care to help them to maintain or regain an optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.
- Older persons should have access to social and legal services to enhance their autonomy, protection and care.
- Older persons should be able to utilise an appropriate level of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.
- Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility. These should include full respect for their dignity, beliefs, needs, privacy and the right to make decisions about their care and the quality of their lives.

Self-fulfilment

- Older persons should be able to pursue opportunities for the full development of their potential, even when they have been diagnosed with a terminal illness.
- Older persons should have access to the educational, spiritual, and recreational resources of society.

Dignity

- Older persons should be able to live in dignity and security and be free of exploitation and physical and mental abuse.
- Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.

All of the above-mentioned principles should be addressed and adhered to through policy implementation in palliative care.

There are no specific rights, recognised in the Older Persons Bill 2006, for older persons who find themselves in a care-giving role. However, in order to afford older persons the right to remain in their communities for as long as possible, which is a clearly stated right, they should have access to support programmes. If they become frail while in a care-giving role, then provision should be made for home-based care.

Alpaslan & Mabutho (2005), identified the following challenges experienced by grandmothers taking care of AIDS orphans.

All of these challenges affect the rights of the elderly:

- Limited and/or lack of income prevents grandmother caregivers from providing orphans' basic needs;
- Elderly grandmother caregivers experience difficulties with Government Aid;
- Elderly grandmother caregivers are the only ones left to be economically active, but their own health problems challenge and prevent them from earning a decent income;
- Elderly grandmothers face the challenge of no support from the children's fathers and the extended family;
- Elderly grandmother caregivers face the challenge that the AIDS orphans in their care do not accept their authority.

It is common to discover that older people in South Africa suffer from low self esteem and consequently feel that they are unable to think of solutions to problems concerning life choices. Often they are not proactive in seeking help outside their communities. The reason for this may be that they have spent most of their lives living under the apartheid system, when their movements, their educational opportunities, their access to health facilities and work opportunities were all controlled by the state. This system continuously eroded their sense of self esteem, creativity and problem solving ability. Older people, when exposed to education on human rights, are required by human rights workshop facilitators to take a hard look at their lives. This reflection leads to the recognition that they have been disadvantaged. Furthermore, they realise that this previously enforced environment fostered feelings of lack of self worth and helplessness. Once older persons recognise that they need not remain quiet or compliant, a large obstacle to their taking charge of their lives and demanding their human rights disappears.

Elder abuse

Elder abuse is a growing phenomenon worldwide and is emerging as a growing social problem. The responsibility for dealing with elder abuse shifted from the Department of Social Development (South Africa) and has become the responsibility of the community and other non-governmental sectors. The Department of Health took the lead and formed a committee for the Development of Elder Abuse Strategy in 1998. This was in collaboration with key departments and NGOs. The Department of Social Development, in the Older Persons Bill 2006, focused on the protection of older persons in the community and in residential facilities in Chapter 5 of the Act.

Older persons who are in need of care and protection are defined as follows:

- Have their income, assets or old age grant taken against their wishes or who suffer any other economic abuse.
- Have been removed from their property against their wishes or who have been unlawfully evicted from any property.
- Have been neglected or abandoned without any visible means of support.
- Live or work on the streets or beg for a living.
- Abuse a substance or are addicted to it and are without any support or treatment for such substance abuse or addiction.
- Live in circumstances likely to cause, or to be conducive to, seduction, abduction or sexual exploitation.
- Live in circumstances which may harm them physically or mentally.
- Are in a state of physical, mental or social neglect.

Data on elder abuse and neglect in South Africa are not collected systematically. An opinion poll done by the National Department of Health reported that there is a widespread awareness of abuse of older persons in South Africa. Concealment of abuse occurs due to the stigma attached to it and fear of victimisation. There is therefore a lack of accurate and current figures for the abuse and neglect of the elderly, and more specifically, elderly females, in South Africa.

The profile of older persons who are likely to be abused and neglected is summarised by the *National Strategy on Elder Abuse* as follows:

Older persons who:

- Are dependent on one person for all or part of their care.
- Exhibit difficult or inappropriate behaviour, confusion or memory loss as a result of previous mental or psychological disturbances or due to more recent conditions such as impairment through some kind of illness

- Have communication problems
- Have longstanding negative personality traits
- Have feelings of low self-esteem
- Have a background of conflict and tension
- Have limited social contact and networks

The above-mentioned profile is of vital importance in the palliative care environment, as it assists in identification of the vulnerable elderly and in the approach towards care. Abuse of older persons must be brought to the attention of the Director General of the Department of Social Development. At a local level, abuse should be reported to a social worker or a police official. However it is the responsibility of all people to report cases of abuse.

Abuse of children by older persons

There is anecdotal evidence that the Child Care Grant given by the Department of Social Development is often used by the mothers of the children for their own use. In some cases children are left with grandparents, without the intended financial grant being given to the grandparent for the child's upkeep. In other cases, when a grandmother has managed to secure a grant for the upkeep of a child, the mother of the child has kidnapped him/her from the grandmother's care so that the grant can be paid to her. Many grandmothers, once the parents of a child have died, apply to foster the orphan which entitles them to a substantial foster care grant. Rarely is the money used solely for the child. It is used for the purchase of food for the whole household.

Palliative Care for older persons

Many areas of palliative care for the elderly are yet to be explored, such as their attitudes toward their own death; their reactions to the death of others; the meaning and impact of multiple deaths; and the bereavement coping styles of older persons.

It is difficult to predict the timing or quality of life at the end of life for people with chronic or terminal illness. Moss, Moss and Hansson state that the terminal decline in cancer tends to be relatively predictable, but fewer than one fourth of older persons die of cancer. Most people die from other chronic diseases which are not as predictable. The nearing death of an older person is often viewed as a normal process of life. Emotions attached to this process are overlooked, thus leading to disenfranchisement or little social permission to grieve the death of an older person. This in itself attacks the right of the older person to die with dignity as well as the rights of the loved ones to grieve the death of the deceased.

The death of an elderly parent is seen as an expected psychosocial loss and is influenced by the following domains:

- Anticipation that the parent will predecease the child;
- Disenfranchisement – where there is little social permission for family members to grieve the loss of an elderly parent;
- The circumstances of the death – indicating sudden death, prolonged illness, or a violent death;
- Social construction of the loss; and
- Maintaining the tie with the deceased

Old age is a time of multiple and sequential losses, thus exposing the elderly to the risk of bereavement overload and a cumulative negative effect. It is a regular occurrence that people view older person's normal responses to bereavement, such as fatigue, social withdrawal, and confusion, as problems of old age. Loss of siblings spouses, parents and grandchildren have specific meaning for older persons and should certainly be addressed in bereavement programmes.

Available support structures for older people

Since 2001 – when a pilot project by the Albertina and Walter Sisulu Institute of Ageing in Africa at the University of Cape Town and a group of NGOs was run in Khayelitsha to educate grandmothers about HIV/AIDS and coping skills – worldwide interest was awakened to the potential capacity of grandmothers to successfully step into the role of carers, mothers to orphans and educators of their communities. It was found that grandmothers, when taught in their own language, benefited greatly from educational workshops on a number of related subjects. The subjects were, HIV/AIDS knowledge, home nursing, food gardening, human rights, bereavement and very basic business skills. Furthermore, the formation of psychosocial groups where grieving grandmothers were counselled by their peers was very successful in curing depression and lessening stress levels. The manufacture of handicraft by the groups not only attracted grandmothers to the groups, but contributed to their self esteem and the household income.

The acknowledgement of the important role that grandmothers have to play in the maintenance of family structures and their capability to run households has been made worldwide. In South Africa, many organisations make provision for the education and support of their older population. In the Free State, the ACVV has organised grandmothers' groups, Age in Action, in all provinces, to promote the training of older people about HIV/AIDS. In all provinces NGOs are including older people in their training programmes. Examples are: GAPA, Ikamvalabantu in the Western Cape, and Muthandane Society for the Aged in KwaZulu-Natal.

Conclusion

A telephonic help-line for older people who are being abused is manned by counsellors from the organisation, Halt Elder Abuse (HEAL). The line can also be used by the general public to report cases of abuse. The number to dial is 0800 003 081.

Gender considerations

Most older people and most of their carers are women. Women are perceived as nurturers and carers and in the event of an older man becoming ill, his wife will care for him at home. Caring is not seen as a male role and men do not perceive themselves as having the skills for nursing. If the wife becomes ill, the husband may feel inadequate in the caring role. Often this means that women are admitted to a care home or to hospital rather than being cared for at home. As well as the distress of moving from her own home, this has implications for the cost of care.

In general, women have a longer life expectancy and there are more elderly widows than widowers. It is also true that men more commonly remarry when their spouse dies than do women. This reinforces the fact that more older women are on their own than older men. In relationships where there was inequality or sharp division of roles such as the man paying the accounts, the woman on her own may not have the skills to take on these tasks. Similarly, the man may not have learned how to cook and finds himself without the skills to produce a meal.

As described earlier in this chapter, the effects of the AIDS epidemic has impacted heavily on the elderly. Grandparents often have the distress of caring for their adult children who are sick and may be dying as well as caring for their grandchildren who are orphaned. This is usually the grandmother.

The worldwide role of older persons, as a source of accumulated knowledge and guardians of moral values, takes on new dimensions in South Africa. Grandparents do not have the luxury of watching their children rearing their grandchildren, visiting them occasionally, helping out where needed and offering guidance or insights about family history. The time has come when older people have to take on the total responsibility of young families because their children have died from AIDS related diseases. At the same time grandparents are themselves becoming frail due to age-related disease. The challenges for grandparents in coping with all that comes their way, cannot be met without the assistance of all agencies that interact with older people. These agencies need to offer insight and information into human rights, education about HIV/AIDS, education about age-related diseases and psycho-social support for older people. The state-run agencies must provide basic necessities of living such as housing, water, health and protection against abuse.

Bibliography

- Act No 13 of 2006: Older Persons Act. 2006. *Government Gazette*, 497 (29346).
- Alpaslan, A.H. & Mabutho, S.L. 2005. Caring for AIDS orphans: The experiences of elderly grandmother caregivers and AIDS orphans. *Social Work/Maatskaplike Werk*, 41 (3), 276–295.
- Brodrick, K. 2004. Grandmothers affected by HIV/AIDS: New roles and occupations. In: Watson, R. & Swartz, L., eds. *Transformation through Occupation*. London: Whurr Publishers, Chapter 16.
- Brodrick, K. & Mafuya, M. 2005. Effectiveness of the non-profit organisation, 'Grandmothers Against Poverty and AIDS' – A study. *Southern African Journal of HIV Medicine*, 19, 37–41.
- Ferreira, M. et al. 2001. *Older women as carers to children and grandchildren affected by AIDS: A study towards supporting the carers*. Unpublished report, Institute of Ageing in Africa, Faculty of Health Sciences, University of Cape Town.
- Ferreira, M. & Brodrick, K. 2001. Towards supporting older women as carers to children and grandchildren affected by AIDS: A pilot intervention project. Unpublished report, Institute of Ageing in Africa, Faculty of Health Sciences, University of Cape Town.
- Help Age International. *Ageways: Practical issues in ageing and development* [online]. Available from: <http://www.helpage.org/Resources/Regularpublications/Ageways/>
- Knodel, J. & Vanlandingham, M. 2002. The impact of the AIDS epidemic on older persons. *AIDS*, 16 (3), 77–83.
- Moss, M.S. et al. 2001. Bereavement and old age. In: Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., eds. *Handbook of bereavement research. Consequences, coping and care*. Washington, D.C: American Psychological Association.