DEPARTMENT OF SOCIAL DEVELOPMENT

Full Report on the Implementation Evaluation of the Older Persons Act, 2006 (Act 13 of 2006)

September 2018

This report has been independently prepared by Creative Consulting and Development Works (CC&DW). The Evaluation Steering Committee comprises the Department of Social Development (DSD), the Department of Planning, Monitoring and Evaluation (DPME), the South African Police Services (SAPS), the Department of Justice and Constitutional Development (DoJ&CD), the Department of Health (DoH) and the Department of Sports and Recreation (DoSR). The Steering Committee oversaw the operation of the evaluation, commented and approved the reports.

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Acronyms

BI	Beneficiary interview
CC&DW	Creative Consulting and Development Works
CGE	Commission for Gender Equality
CoGTA	Department of Cooperative Governance and Traditional Affairs
DIRCO	Department of International Relations and Cooperation
DPME	Department of Planning, Monitoring and Evaluation
DoH	Department of Health
DoJ&CD	Department of Justice and Constitutional Development
DSD	Department of Social Development
DoSR	Department of Sports and Recreation
EU	European Union
FGI	Focus Group Interview
HDI	Human Development Index
HSRC	Human Sciences Research Council
IEC	Electoral Commission of South Africa
KII	Key Informant Interview
MoU	Memorandum of understanding
MSC	Most Significant Change
PPPSD	Programme to Support Pro-Poor Policy Development
SAHRC	South African Human Rights Commission
SAOPF	South African Older Persons Forum
SAPS	South African Police Services
SASSA	South Africa Social Security Agency
SC	Steering Committee
StatsSA	Statistics South Africa
ToC	Theory of Change
ToR	Terms of reference
UN	United Nations

Policy Summary

The implementation evaluation for the Older Persons Act, 2006 (13 of 2006) found that the Act provides a strong basis for the improvement of the situation of older persons. Although the Act has not yet been fully implemented, significant progress has been made and important successes have been achieved, despite several challenges. From a somewhat slow start, the implementation of the Act has gained momentum. The will to implement the Act exists and capacity to implement the Act has been improved. Other challenging areas have impeded full implementation. In order to address these challenges and improve implementation, and to ensure that the Act is responsive to issues of gender, disability and geographical location, it is recommended that:

1. A revision of the costing of the amended Act and its implications is required to ensure full implementation. Adequate funding is required to implement the Norms and Standards. Government departments should be encouraged to ring-fence budget for older person's programmes to protect funding from competing priorities.
2. Innovative and sustainable funding models are required for facilities. DSD could play a role in capacity-building and facilities should explore the crowd-sourcing model.
3. More integrated planning and coordination between government departments and across the three levels of government is required.
    a. Coordination structures should be formalised and institutionalised.
    b. Existing institutional arrangements should be strengthened.
    c. The implementation of a robust monitoring and information management system, based on a comprehensive set of key indicators covering all levels of government, is recommended.
4. Due to the inaccuracies of data for facilities at provincial level, an audit of the list of facilities is strongly recommended to ensure improved accountability and to form a reliable basis for monitoring of facilities.
5. Collaboration between DSD and DoH is a matter of importance and a MoU clarifying roles and responsibilities, particularly regarding health services, frail care and services to older persons with mental health conditions, should be implemented.
6. DSD should fast-track capacity-building in the sector, specifically in relation to training of caregivers and the provision of bursaries to social work students. Serious consideration should be given to developing progressive career-paths for caregivers.
7. Infrastructural development, upgrades and maintenance of residential facilities as well as community-based service centres need immediate attention. Consideration should be given to revamping government buildings that are not in use, particularly in rural areas, to function as community-based service centres.
8. DSD should implement a nation-wide and cost-effective awareness campaign on the ageing process and rights of older persons, on an on-going basis. This should address negative stereotypes related to the ageing process, gender, disability and age-related mental health conditions as well as older persons living with HIV. Perspectives of older persons as active citizens who make a valuable contribution to society should be promoted and intergenerational initiatives should be expanded.

9. In order to improve the protection of older persons' rights and safety, more SAPS and DoJ&CD staff need to be trained. Implementation of the electronic abuse register must be fast-tracked and a 24-hour toll-free line for reporting elder abuse should be considered.
10. Research and knowledge generation is required to build the evidence base for older persons' programmes. Strategic partnerships with tertiary institutions and relevant entities is suggested. DSD should also maximise the potential of its website for knowledge sharing.
11. A strategy for the enhancement of older persons' participation in decision-making should be developed.
12. Partnerships and projects aimed at developing skills and knowledge of older persons should be identified. A focus on improvement of technological skills and training older persons in caregiving to children, grandchildren, other older persons, including persons living with HIV is suggested.

Challenges in the implementation of the Act provide opportunities for solutions and innovation. All government departments and other sectors of society have a role to play in ensuring the Act is fully implemented and the rights of older persons as citizens are secured and protected.

"A society that does not value its older people denies its roots and endangers its future. Let us strive to enhance their capacity to support themselves for as long as possible and, when they cannot do so anymore, to care for them." ~ Nelson Mandela in a message announcing 1999 as the United Nations International Year of Older Persons, 17 December 1998 #International Day of Older Persons

Executive Summary

The Department of Planning, Monitoring and Evaluation (DPME) and the Department of Social Development (DSD) commissioned an implementation evaluation of the Older Persons Act, 2006 (Act 13 of 2006), hereafter referred to as 'the Act', in 2016 to assess if the Act was being implemented as intended, and to identify how it could be strengthened. The findings and recommendations of the evaluation would be used to strengthen the implementation, and to inform the amendment of the Act. Concurrent with the evaluation process, DSD undertook a process to review the Act.

Creative Consulting and Development Works (CC&DW) employed a design and implementation evaluation following a mixed-method approach, which included quantitative and qualitative data. Evaluation questions were determined in consultation with the Steering Committee (SC) and aimed to answer questions regarding efficiency, effectiveness, institutional and implementation capacity, resource allocation, learning and best practice pertaining to the respective chapters, aspects and thematic areas of the Act. The evaluation further considered the extent to which responsiveness to issues related to gender, disability and geographical location could be improved. Thematic focus areas covered in the five chapters of the Act are: the implementation, application and general principles; creating an enabling and supportive environment for older persons; community care and support services; residential care facilities and outreach programmes; and protection for older persons.

The evaluation included a design component and accordingly a Theory of Change (ToC) was developed as a first step, in consultation with key stakeholders. Subsequently an updated 3-tier ToC (national, provincial and local level) was developed.

The implementation evaluation made use of both primary and secondary data. The latter was used in a literature review, comparative analysis with three (3) countries and a document review. Various primary data collection methods were used in this evaluation, and appropriate sampling strategies and sizes were determined for each data collection method and participant groups, which included national and provincial government departments, Chapter 9 Institutions, non-governmental organisations and beneficiaries in various geographical locations in all 9 provinces. In total: 76 beneficiary interviews (BIs) were conducted; 15 focus group interviews (FGIs) were conducted; 49 key informant interviews (KIIs) were undertaken; 25 facility observations were made; and 60 survey responses were received.

1 Introduction

1.1 Background to the Act

The Older Persons Act, 2006 (Act 13 of 2006), hereafter referred to as "the Act", along with its regulations and Norms and Standards, aims to recognise and address the plight of older persons[1] by putting in place a framework for the empowerment and protection of older persons and the maintenance of their status, rights, well-being, safety and security, and to provide for matters related to these aspects.

Developed by DSD, the Act is informed by research, national legislation and broader international priorities. Global and national population statistics and projections have indicated a growth in the ageing population.

Given international recognition of this phenomenon and in the context of a constitutional democracy with challenging socio-economic conditions, various national and international policy and legislative responses were enacted, such as the development of national legislation and the development and signing of international treaties (Statistics South Africa (StatsSA), 2014: 1).

StatsSA estimates that the 4.2 million older persons in South Africa will grow to 6.8 million by 2030. According to Census 2011, 7.3% of the South African population was older than 60 years. StatsSA estimates that persons older than 60 years will make up 9.3% of the population by 2030.

The Act, which came into effect on the 29th of October 2006, is embedded in the Constitution of the Republic of South Africa (Act 108 of 1996), which aims to establish a society based on democratic values, social justice and fundamental human rights. In this context, the Act fosters an environment that makes it possible to respect, protect and fulfill the rights of its citizens. This Act shifts the focus from institutional care to community-based care and support services, in an effort to enable older persons to remain in their communities for as long as possible. This requires that affordable, accessible, effective and efficient services are delivered to older persons in partnership with other parties committed to the creation of a caring society.

Since coming into effect, progress with the implementation of the Act had not been measured. As such, an evaluation was required to assess the status of implementation, particularly with the view to improve legislation and future implementation.

1.2 Background to the Evaluation

1.2.1 Purpose of the Evaluation

The DPME and DSD commissioned an implementation evaluation, also incorporating a design evaluation component, of the Act in 2016 to assess if the Act

[1] Defined by the Act as persons older than 60 years of age.

was being implemented as intended, and how it could be strengthened. In particular, the evaluation assesses the extent to which all five chapters of the Act were being implemented on national and provincial level, as intended. The findings and recommendations of the evaluation would be used to strengthen the implementation and inform the amendment of the Act.

Concurrent with the evaluation process, DSD undertook a process to review the Act. The Draft Amendment Bill of the Act was published on 2 June 2017 in Notice 426 of the Government Gazette, requesting public comment to be submitted to DSD by 30 June 2017. The purpose of the amendment was to provide clarity and improve implementation and compliance.

This evaluation forms part of formalised evidence-based policymaking and implementation system, which is intended to assess public management performance through four phases: diagnosing; planning; output; and outcome and impact. As illustrated in Figure 1 below, this evaluation forms part of the output phase by reviewing implementation of the Act in order to make improvements in future implementation.

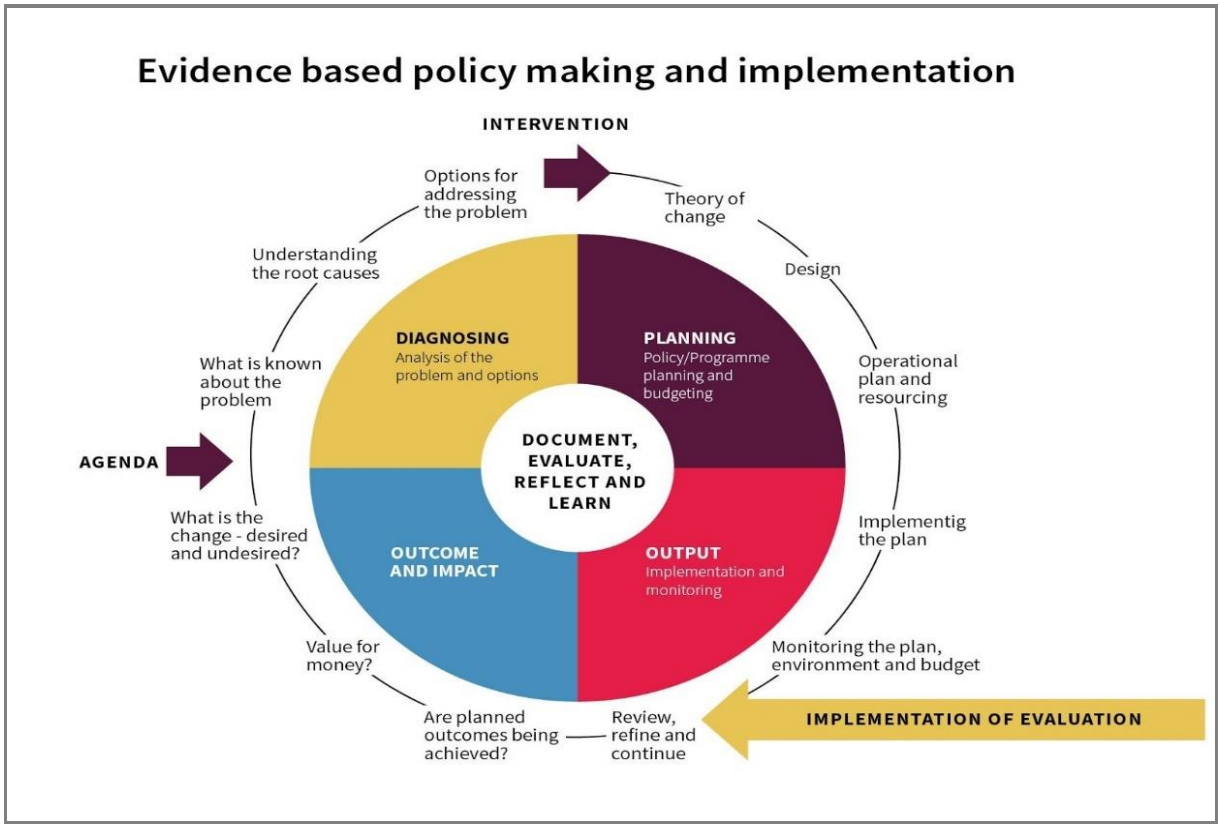

Figure 1: Evidence-based Policymaking and Implementation Process

1.2.2 Evaluation Questions

The evaluation questions and related sub-questions in Table 1 below explored how the Act was being implemented, whether the required institutional resources were in place and efficient in supporting the implementation of the Act, whether the necessary resources were allocated to facilitate implementation, and if the required

capacity existed to implement the Act. Furthermore, the evaluation considers successes, best practice and learning, and makes recommendations and proposals for improvement. Relevant overarching themes addressed in the evaluation include gender, disability and geographical location.

Table 1: Evaluation Questions and Sub-questions

Questions and Sub-questions
1. To what extent has the Act been implemented as intended? What is the status of the current practice? Is it working? If not why?
a) What are the successes achieved because of the implementation of the Act and what are the contributing factors to successful implementation?
b) Are there any critical gaps in service provision (systematic and legislative) by government and non-governmental stakeholders?
c) What are the main barriers and challenges of implementing the Act?
d) How can the Act be more responsive to gender, sexual orientation, disability, HIV/AIDS, and geographic location?
2. To what extent do the current institutional arrangements support the performance and implementation of the Act, with specific reference to coordination, administration and management arrangements?
a) To what extent are duty bearers aware of the provisions of their core duties in relation to the Act?
b) To what extent is there a shared understanding of roles and responsibilities by different role-players (government and non-government) in implementing the Act?
c) To what extent has the appropriate legal framework, regulations, systems, coordination structures and mechanisms been put in place to support the implementation of the Act?
d) To what extent are relevant managerial structures, oversight mechanisms and information sharing mechanisms in place?
e) Has appropriate and sufficient monitoring and evaluation frameworks been put in place to ensure ongoing, timely feedback regarding successes and challenges of implementation of the Act?
f) Are the M&E systems in place aligned to the Act and reporting requirements and performance targets?
g) What data should be collected and disseminated to ensure that government planning processes are cognisant of and incorporate the current and future needs of older persons?
3. Has there been a shift in terms of resource provision which includes budget allocation towards the implementation of the Act (since April 2010 to March 2016)? What are the trends in budget allocations for meeting the needs of all older persons?
a) To what extent have national, provincial and local government budget allocations in support of the Act and related to providing of services to, and protection of older persons, increased since 2010?
b) Is there any evidence of increased infrastructure spend related to providing services and access to older persons?
c) To what extent have budget allocations for older persons been spent?
d) To what extent are older persons and related issues reflected in national, provincial and local government's budget priorities?
e) To what extent is the social protection/the social safety net of government aligned to the contextual reality of older persons?
f) To what extent are budgeting processes gender responsive?
g) Is there evidence that specific budget allocations have been made for disability related infrastructure and resources?

4. Do government and non-governmental stakeholders have the capacity to implement the Act?
a) What are the assumptions around the capacity of the government and non-government service providers to effectively deliver the programmes and services regulated by the Act, and are these assumptions realistic?
b) Are non-government stakeholders able to provide the quality and range of services required?
c) Are there any plans in place and are they being implemented to (systematically) develop the capacity of non-governmental stakeholders?
d) Are there any monitoring, feedback and evaluation systems and mechanisms in place to ensure that service providers comply with relevant standards and contractual conditions?
e) Are current M&E processes able to demonstrate the impact of the Act?
f) How can existing M&E systems be strengthened to ensure that appropriate, reliable, timely data is collected?
5. What best practices and examples of excellence have emerged because of implementing the Act, or specific aspects of the Act on national, provincial and local government level?
a) On a legislative and policy level, what best practices and examples of excellence have emerged because of implementing the Act?
b) What best practices and examples of excellence have emerged within the Department of Social Development (national and provincial), on a systemic inter- and intra-departmental level?
c) What best practices and examples of excellence have emerged because of implementing the respective chapters of the Act?
d) What best practices and examples of excellence have emerged in relation to implementation in a diverse environment in terms of geographical characteristics, as well as gender and disability?
6. What are the lessons learnt from implementing the Act?
a) What are the lessons learnt regarding policy, planning, budgeting and reporting?
b) What lessons have been learnt regarding implementation of the various chapters of the Act?
c) What lessons have been learnt regarding implementing structures, coordination mechanisms and M&E systems?
d) What lessons were learnt because of unintended consequences and outcomes of the implementation of the Act?
7. What are the recommendations and proposals for effective implementation of the Act?
a) What are the recommendations based on the above questions?
b) How can the existing M&E system be strengthened to address the management and performance monitoring needs of DSD? What data collection is needed to monitor implementation?
c) How can the Act be more responsive to gender, disability and geographic location?

1.3 Methodology

The methodology aims to answer questions regarding efficiency, effectiveness, institutional and implementation capacity, resource allocation, learning and best practice pertaining to the respective chapters, aspects and thematic areas of the Act. Thematic focus areas covered in the Act were: the implementation, application and general principles; creating an enabling and supportive environment for older persons; community care and support services; residential care facilities and outreach programmes; and protection for older persons.

1.3.1 Mixed Methods Design

Considering that quantitative or qualitative methodologies alone could not answer all of the evaluation questions sufficiently, a mixed methods design was utilised in three phases, as depicted in Figure 2 below.

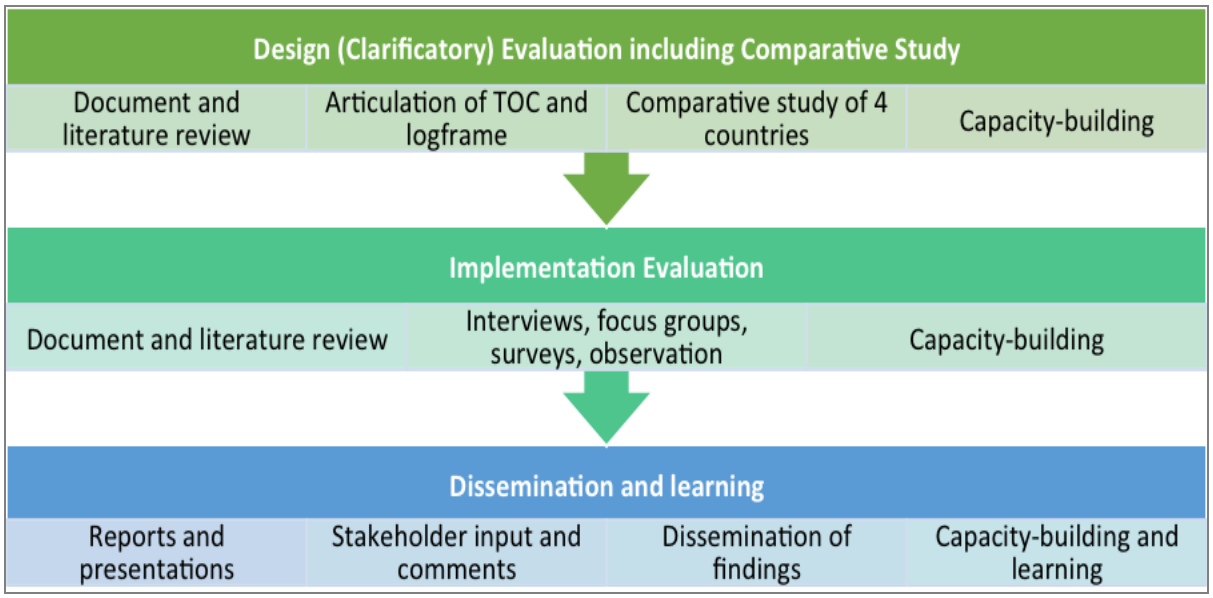

Figure 2: Evaluation Design

The methodology for primary data collection in the implementation evaluation phase was designed to ensure that optimal breadth and depth could be achieved through 1) coverage of the national and provincial situation in all nine provinces, and 2) an in-depth focus on specific geographical areas in each province. Provision was made for an iterative process throughout the evaluation phases.

Data collection instruments consisted of: 1) survey questionnaires for specific stakeholder groups (DSD, other government departments, NGOs and Chapter 9 Institutions); 2) interview schedules for national and provincial Focus Group Interviews (FGIs) and semi-structured Key Informant Interviews (KIIs); 3) Observation Checklists for residential and community-based facilities; 4) Facility Manager KIIs, and Beneficiary Interviews (BIs) and; 4) guidelines for mapping (community mapping or transect walks).

1.3.2 Sampling Strategy

Various data collection methods were used in this evaluation, and appropriate sampling strategies and sizes were determined for each data collection method as illustrated in Table 2 below.

Table 2: Sampling Strategy per Data Collection Method

Data collection method	Sampling strategy
Document and budget review	Purposive sampling of type of document according to the following criteria: planning, budgeting and reporting. Departmental and Chapter 9 Institution documents selected based on relevance to Terms of Reference (ToR) and mandates in relation to the ToR: National and provincial DSD; South Africa Social Security Agency (SASSA); DoH; SAPS; DoJ&CD; DoH; Cooperative Governance and Traditional Affairs (CoGTA); Commission for Gender Equality; Electoral Commission; and Human Rights Commission.
Survey	Purposive sampling of respondents: All national departments represented on the evaluation Steering Committee (SC) and corresponding Provincial departments; DSD registered NGOs and Facilities; and selected relevant Chapter 9 Institutions.
Focus Group Interviews	Purposive, stratified and convenience sampling. National **FGI 1:** All government departments on SC to be invited to FGI, 8 - 10 participants **FGI 2:** All 3 selected Chapter 9 Institutions to be invited, 1 – 2 delegates per institution, i.e. 3 – 6 participants **FGI 3:** All NGOs on DSD list to be invited, 8 – 10 participants Provincial **FGI 1:** Government Departments, 8 – 10 participants **FGI 2:** NGOs, 8 – 10 participants
Key Informant Interviews	A combination of purposive, convenience and snowball sampling were used. The sample of KIIs were selected based on the functions of the interviewees, specific issues that arose in the literature and document review and other data collection methods. Selection of KIIs also depended on references made to specific stakeholders by evaluation participants. Availability of KIIS at the time of fieldwork also played a role.
Beneficiary Interviews	Combination of purposive and convenience sampling was used. Geographical areas were purposively selected by the client. Selection of interviewees depended on selection of facilities and/ or areas; circumstances at the time of fieldwork (which could include certain incidents or based on observations); and also depended which beneficiaries would visit facilities, or who would be present in the geographical area at the time of fieldwork.
Observations	Combination of purposive, simple random, convenience and snowball sampling were used. Geographical areas were purposively selected by the client.

Geographic areas per province, as advised by the evaluation Steering Committee (SC) in consultation with the service provider included urban, semi-urban and rural areas as illustrated in Table 3 below.

Table 3: Geographic Areas Selected

Province	District	Local Municipality		
		Urban	Semi-Urban	Rural
Mpumalanga	Ehlanzeni	Mbombela	White River	Kabokweni, Khanyamazane, Matsulu
Eastern Cape	Amathole	Buffalo City Metro Amathole District	Amahlati	Nkonkobe
Northern Cape	Francis Baard	Sol Plaatjie	Dikgatlong, Phokwane	Magareng
North West	Ngaka Modiri Molema	Mafikeng		Ratlou Tswaing
Free State	Mangaung	Bloemfontein	Botshabelo	Thaba Nchu
Western Cape	City of Cape Town & Overberg District unicipality	City of Cape town (Inner City)	City of Cape Town (Cape Flats)	Selected towns in Overstrand Municipality
KwaZulu-Natal	Ethekwini	Durban (City)	Durban (KwaMashu) Durban (Phoenix and Chatsworth)	
Limpopo	Mopani	Ba-Phalaborwa LIM368 (Mookgopong & Modimolle)	Maruleng	Greater Giyani
Gauteng	Sedibeng	Vereeniging	Meyerton	Lesedi

A combination of convenience and purposive sampling was used to ensure that core city areas, sub-core areas, as well as peripheral city areas were included, and that these areas could be covered within the time and budget constraints of the evaluation. Coverage of specific types of municipalities are as follows:

1. Four metropolitan municipalities (category A)
2. Three secondary cities (category B1)
3. Two large towns (category B2)
4. Eight small towns (category B3)
5. Three mostly rural areas (category B4)

A list of residential and community service facilities obtained from DSD indicated that there were 548 facilities in the selected areas which were used to form the sample frame. Random sampling was used to select a proportionate number of residential and community service facilities in the selected areas. A detailed description of the replacement strategy was drafted to ensure a systematic approach in cases where initial sampling could not be implemented. This included situations where facilities sampled could not be contacted, and where duplicate, incomplete and incorrect entries occurred on the list.

1.3.3 Data Collection

Figure 3 briefly describes the data collection process as well as the final sample. Additional data was collected where verification was needed, or where information gaps were identified.

Ethics

Ethical clearance obtained from HSRC and relevant provincial DSD[2].

Fieldworker Training

Training on facility checklists, mapping and KIIs for facility managers and beneficiaries.

Training on provincial KIIs and FGIs

Pilot

All data collection tools piloted in Gauteng and revisions were incorporated, where necessary.

Data Collection

Data Collection Method	Target	Achieved
Online survey	10%	31%
KIIs (national & provincial)	28-48	29
KIIs (facility managers)	27	24
FGIs	20	15
Facility observations (checklists)	27	25
Facility environment observations (mapping)	27	22
BIs	27-81	76

Data Verification and Quality Assurance

Various measures for quality assurance and data verification were implemented and included cross-checking, tracking, consultations and supervision.

Figure 3: Data Collection Process and Final Sample

2 Literature Review and Comparative Analysis

The literature review paid specific attention to indices commonly used to measure the situation of older persons. The Global AgeWatch[3] Index ranking of the four countries selected for this review (South Africa, Kenya, Mauritius and Malta) was discussed briefly. A comparative review of the legislative and policy responses, as well as a comparative review of the situation of older persons and the progress made based on eight key indicators, derived from various indices used to measure the situation of older persons, was included for the four countries.

[2] Only Western Cape DSD required additional ethical clearance. All other provinces accepted HSRC ethical clearance as sufficient.

[3] The Global AgeWatch Index responds to core issues of concern of persons aged 65 and above and is a framework for governments and the international community to develop and implement policy and programmes to ensure no older person is left behind. It measures four key domains of older persons, covering the most crucial aspects of their wellbeing, experiences and opportunities.

2.1 Literature Review

South Africa is one of the few developing countries experiencing a steady increase in the proportion aged 60 years and older, from 7,3% in 2001 to 8,0% in 2016 as illustrated in Table 4 below.

Demographic ageing is creating new challenges such as protecting the rights of older persons. Older people's rights to access to justice, equality before the law, and the rights to housing, privacy and a private life all require greater attention. A continued commitment has been made at both international and national levels to create age-friendly societies that attend to the health and socio-economic needs of older persons. This is evident in international law, international frameworks and regional frameworks.

Table 4: Distribution of persons aged 60 years and older in relation to the total population, 2001-2016

PROVINCE	2001		2007		2011		2016	
	RSA ('000)	60+ ('000)	RSA ('000)	60+ ('000)	RSA ('000)	60+ ('000)	**RSA ('000)**	**60+ ('000)**
Eastern Cape	6 436	591	6 527	626	6 562	638	**6 996**	**563**
Free State	2 706	197	2 773	222	2 745	228	**2 834**	**245**
Gauteng	8 837	544	1 0 451	718	12 272	892	**13 399**	**1 167**
Kwa-Zulu Natal	9 426	652	10 259	723	10 267	779	**11 065**	**805**
Limpopo	5 273	408	5 238	443	5 404	467	**5 799**	**438**
Mpumalanga	3 122	195	3 643	238	4 039	284	**4 335**	**295**
Northern Cape	822	67	1 058	95	1 145	98	**1 193**	**114**
North West	3 669	269	3 271	250	3 509	292	**3 748**	**300**
Western Cape	4 524	352	5 278	452	5 822	520	**6 279**	**594**
South Africa	**44 819**	**3 280**	**48 502**	**3 770**	**51 770**	**4 151**	**55 653**	**4 525**

Source: Census 2001, CS 2007, Census 2011, CS 2016 (Based on Census 2011 boundaries).

Although progress has been made to protect the rights of older persons embedded in international human rights conventions that include economic, social, civil and political rights, large gaps and inconsistencies exist. Regional instruments are based on different principles, and different regions have varying aspirations for the rights of older persons. Gaps and inconsistencies can be broadly categorised as a lack of clear definitions for broad constructs, implementation issues, a lack of a monitoring mechanisms and a lack of disaggregated data and statistics (see Table 4 above).

2.2 Comparative Analysis

The comparative analysis below includes best practice examples from comparison countries, and in addition, relevant best practice examples from other countries are also included.

2.2.1 Overview of Comparative Countries

Table 5 below provides a comparative analysis of the four countries selected for this review (South Africa, Kenya, Mauritius and Malta). The comparison gives specific attention to indices commonly used to measure the situation of older persons and the progress made based on eight key indicators. The Global AgeWatch Index ranking is discussed briefly.

Furthermore, selected international best practices which may be relevant to the circumstances of older persons in South Africa are discussed. Findings exhibiting the improvement of the situation of older persons are presented and relevant policy issues are highlighted.

According to Table 5 below, Malta and Mauritius have the largest percentages of older persons in the population at 19% and 10%, respectively. Older persons[4] make up 5.03% of the population in South Africa, and only 2.8% of the population in Kenya. All comparison countries hold UN membership, and are members of relevant regional bodies. Malta has the highest life expectancy, followed by Mauritius. South Africa has the lowest life expectancy. South Africa has a markedly higher percentage of unemployed people of 25%, while the other countries' unemployment levels are below 10%. More than half of the South African population was reported to live in poverty, while the percentage for Kenya is slightly below 50%.

Table 5: Overview of Comparative Countries[5]

		 SOUTH AFRICA	 KENYA	 MAURITIUS	 MALTA
	**UN membership**	Yes	Yes	Yes	Yes
	**EU membership**	N/A	N/A	N/A	Yes
	**AU membership**	Yes	Yes	No	No
	**Life expectancy at birth**	57	62	74	81

[4] Please note: IndexMundi regards age 65+ as "older persons".

[5] Source: The World Bank, as reported by Graphiq, 2016; AgeWatch Index 2015

	Unemployment rate	25%	9%	8%	6%
	Population living in poverty	54%	46%	*Data unavailable*	*Data unavailable*
	Adult literacy rate	95%	78%	91%	94%
	Population older than 65	5%	3%	10%	19%
	Global AgeWatch Index ranking	78	Not ranked	42	47
	**Legislative and policy response to older persons**	Older Persons Act (13 of 2006)	National Policy on Older Persons and Ageing	Protection of Elder Persons Act (44 of 2005)	National Strategic Policy for Active Ageing (2014-20)

Figure 4 below illustrates the situation of older persons based on Global AgeWatch Index[6] data. In comparison to comparable countries, South Africa ranked as follows, on the four (4) domains of the Index:

- South Africa was ranked second highest on income security[7] of old persons. Mauritius was ranked highest.
- With respect to capability[8], South Africa was regarded as having the most capable older persons compared to Malta and Mauritius.
- South Africa had the least enabling environment[9] for old persons to attain a fulfilling life.
- South Africa ranked the lowest for health status[10] of old persons.

[6] The Global AgeWatch Index rates 98 countries worldwide. Kenya is not included in this index, and other information sources were used to review the situation of Kenya.

[7] Income security indicators are pension income coverage, poverty rate in old age, relative welfare of older people, and GNI per capita.

[8] Capability indicators are employment of older people, and educational status of older people.

[9] Enabling environment indicators are social connections, physical activity, civic freedom, and access to public transport.

[10] Health status indicators are life expectancy at 60, healthy life expectancy at 60, and psychological and mental wellbeing.

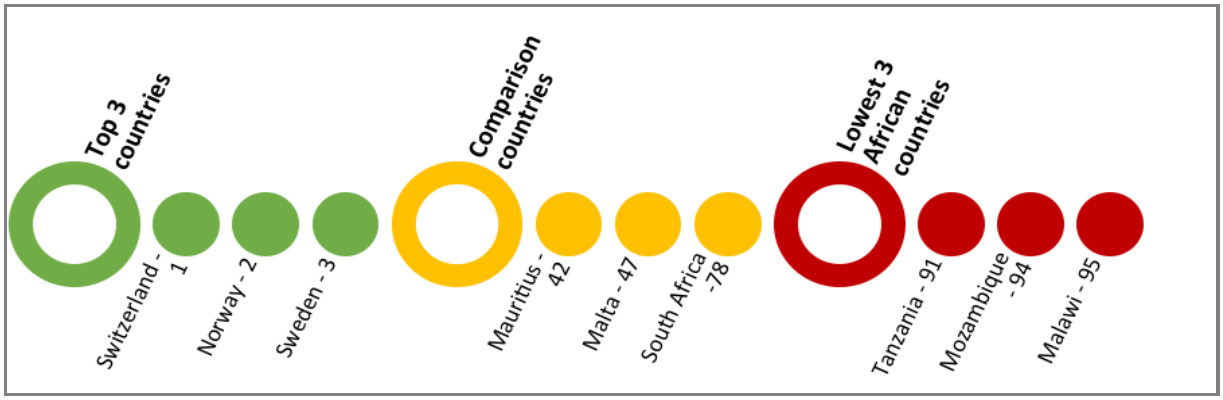

Figure 4: Global AgeWatch Index Ranking[11]

2.2.2 Older Persons and Social Exclusion

Figure 5 below illustrates the levels of social exclusion[12] for each country under analysis. South Africa was ranked 116th on the Human Development Index (HDI) and falls into the "medium human development" category. Kenya was ranked 145th and was considered a "low human development" country. Mauritius and Malta, ranked 63rd and 37th respectively, were regarded as "high" and "very high" human development countries.

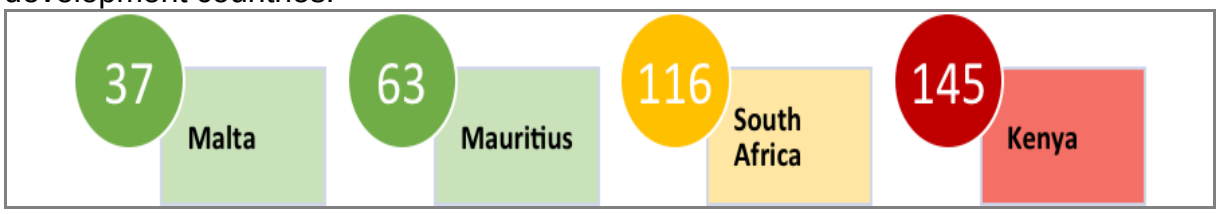

Figure 5: HDI Ranking

Irrespective of the rankings on the HDI, there are lessons to be learnt from all three countries, which are listed below:

- **Kenya** provided an example of strengthening family and community support systems to appreciate ageing, and to respect and honour older persons through a positive ageing culture. Older persons are also considered in poverty reduction programmes.
- **Mauritius** has made considerable progress promoting awareness of the needs of older persons in society. Opportunities are created for older persons to educate and impart knowledge and skills to younger generations.
- **Malta** was shown to be adept at promoting healthy living, developing flexible responses to older persons' changing needs, and facilitating social inclusion in community events.

Some lessons learnt reflect integration of international best practices such as the drafting of legislation focusing on the recognising of the inherent value and wisdom

[11] Source: Global AgeWatch Index 2015

[12] A reliable way to measure social exclusion could be to use relevant indicators from current international indices such as the Human Development Index (HDI) (United Nations Development Programme [UNDP], 2015) which is composite measure of human development in the three key dimension indices, namely: health; education; and economic status.

of older persons, inter-generational approaches and the improvement of financial literacy amongst older persons.

2.2.3 Social Security for Older Persons

Table 6 describes each country's social security environment. Kenya was the only country under analysis that had made limited progress in terms of social security.

Table 6: Social Security Environments per Country

Country	Form of Social Security	Description
Kenya	National Social Security Protection Policy (2006)	Little progress has been made to implement this and other policy documents that make provision for the needs of older persons.
South Africa	Social grant system	The provision of old age grants as social security has improved the standard of living and the quality of life of older persons as well as their households. However, the prevalence of chronically poor households has partially eroded the potential benefits of the grant.
Mauritius	National Social Protection Policy	Non-contributory benefits are entirely financed by government and are payable to every Mauritian citizen. These benefits include basic pensions which cater for older persons. These allowances include social aid, food aid and unemployment hardship relief. In addition, free public transport is provided for older persons and disabled.
Malta	Social Security Act (1987), Pension System Reform (2006)	Child-rearing credit is provided for each child reared, and the insured person receives two years (or four years for a child with a disability) of credited contributions to finance old-age benefits. Provision is also made for survivor-pension which is paid to a widow(er).

2.2.4 Disability and Older Persons

Both globally and nationally the following trends appear:

- Older persons are more likely to suffer from disability;
- Disability is linked to a higher probability of being poor;
- Access to services, stigma and socio-economic exclusion are worsened by disability;
- Disability is likely to reduce social mobility of households due the cost of care; and
- Disability is gendered and women are more likely than men to report that they have a disability.

All countries under analysis have a form of social protection in the form of legislation in place, specifically for disabled individuals. However, in South Africa, older persons do not qualify for the disability grant, whose recipients must be between 18 and 59 years of age. In addition to financial aid for disabled persons as required by legislation, various countries have non-financial mechanisms to protect and provide services to older persons with disabilities as listed below.

South Africa: The South African Plan for Action on Ageing (2004) makes provision for disabled older persons, including the provision of free health services to older persons, especially those with disabilities and who are unable to meet costs.

Kenya: The Constitution and a National Social Security Fund makes provision for the employment of disabled persons in elective and public bodies.

2.2.5 Gender and Older Persons

A comparative analysis of gender and older persons is reflected in Table 7 below and considers the following aspects: discriminatory cultural practices; pension income or coverage (including social grants); socio-economic deprivation ratio; level of education; and employment ratio 60+. Additionally, national responses focusing on gender differential, if any, are provided per country.

Table 7: Analysis of Gender and Older Persons Per Country

Aspect	Country Examples
Discriminatory cultural practices	In Malta, women (42%) are more socially isolated than men (38%) South Africa and Kenya have discriminatory practices related to inheritance and as well as stigmatisation often related to witchcraft.
Pension or income coverage (including social grants)	In South Africa, more men (35%) men and women (19%) are employed and qualify for pension/
Socio-economic deprivation ratio	In South Africa, more women (42%) than men (37%) face social-economic deprivation.
Level of education	In Kenya, more women (66%) than men (38%) have no formal education.
Employment ratio 60+	In every country more men than women are employed: South Africa: 29% of men and 9% of women Kenya: 71% of men and 59% of women Mauritius: 28% of men and 11% of women Malta: 13% of men and 3% of women

The Czech Republic and Slovakia are examples of international best practice, with employment programmes that focus on ensuring employability and productivity for older persons. In the Czech Republic, a Counselling and Motivational programme focused exclusively on disadvantaged older women concurrent with efforts to influence labour market stakeholders to eliminate prejudice against females.

2.2.6 Elderly Abuse

Abuse of elders is a worldwide phenomenon which has become more predominant in public discourse in the late 1900s. Until the advent of initiatives to address child abuse and domestic violence in the last quarter of the 20th century, the abuse of older persons by family members remained a “private matter”, hidden from public view. Like other forms of family violence, abuse of the older persons has developed into a public health and criminal justice concern. Data on the rates of abuse remain limited, and this can be attributed to the often-marginalised position of older persons in the community. The World Health Organisation (2008) and other experts estimate that elder abuse is under-reported by as much as 80%.

Although South Africa does not collect national statistics on elderly abuse continuously, studies by Statistics South Africa[13], have illustrated some evidence to confirm the prevalence of elder abuse. In response, legislation, protocols, frameworks and services to prevent and respond to cases of abuse have been established and implemented. Lessons can be learnt from the responses in Mauritius and Malta, specifically:

a) Establishing screening, detection and reporting systems for the prevention and treatment of elder abuse;
b) Amend legislation to address elderly abuse in the domestic and institutional setting;
c) Professional providing services to older persons should be trained and sensitised; and
d) Develop robust procedures for responding to abuse and provide whistle blowers with the means to communicate concerns to authorities on a confidential basis.

2.2.7 Health Services for Older Persons

Of the comparative countries, varied approaches are in place to establish and strengthen health care services for older persons. Figure 6 below lists some component of national healthcare systems that address the needs of older persons. Components related to decentralisation, community- and family-based approaches, preferential treatment of vulnerable groups and monitoring of older persons.

[13] STATS SA . 2017. Profile of Older Persons 2011-2015

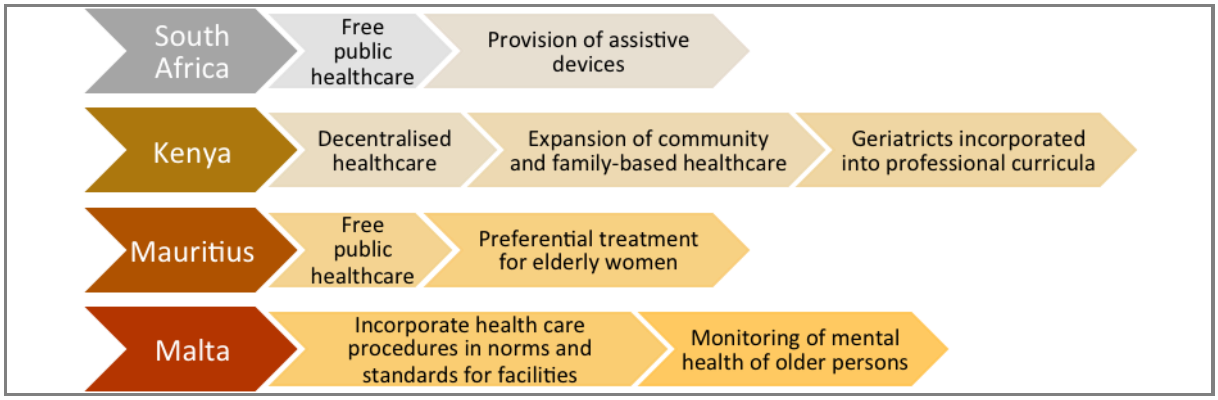

Figure 6: National Healthcare Systems Per Country

2.2.8 HIV/AIDS and Older Persons

In countries such as Kenya and South Africa as depicted by Figure 7, where HIV/AIDS prevalence[14] is comparatively higher, there has been an increase in the vulnerability of older persons in a variety of ways. The devastating impact of poverty, conflict, migration, and HIV and AIDS means that older men and women cannot rely on support from their adult children. The roles of older persons in their immediate and extended families, and to some extent in society, have changed in many instances from those who are being cared for, to those who must (continue to) provide care to their children and orphaned grandchildren.

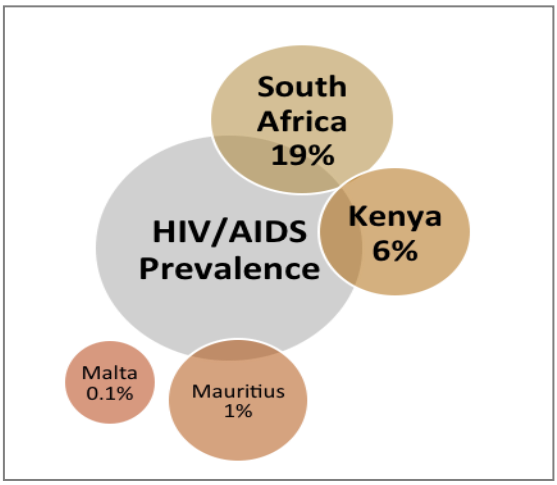

Figure 7: HIV Prevalence

Government responses to HIV/AIDS in relation to older persons in South Africa and Kenya has seen a recent recognition of the needs of older persons living with HIV/AIDS as well as older persons affected by HIV/AIDS. In South Africa, antiretroviral (ARV) therapy provision is available for all people living with HIV and awareness and educational programmes include older persons. In Kenya, resources have been mobilised to manage HIV/AIDS infection in older persons. In addition, older persons affected by HIV/AIDS have been capacitated to care for their families. Despite not having a high prevalence, Mauritius noted that older persons need to be taken into consideration in prevention, testing and treatment services for HIV/AIDS.

Botswana provides a specific, but useful example of an intervention targeting older persons affected by HIV/AIDS. Key lessons from this example, listed below, can be applied in other responses to older persons infected or affected by HIV/AIDS.

Key lessons from Botswana's responses to grandmother caring for HIV-positive

[14] As reported for adults aged 15-49 years old.

orphans:

- Consider cultural beliefs and health literacy;
- Assist older caregivers to identify and access existing resources; and
- Interventions should be tailored to the context

2.2.9 Older Persons and Independent Living

Living independently, either alone or only with a spouse, is rare among older persons in developing countries but is the dominant living arrangement in developed countries. Almost 75% of all older persons in the more developed regions either live alone or only with their spouse compared with only 25% in less developed regions, and just over 10% in the least developed countries. The predominance of independent living among older persons is likely to increase as the world's population continues to age (United Nations (UN), 2012).

Comparative statistics for South Africa and comparison countries, in Table 8 below, indicates that in South Africa a significantly higher percentage of older men (31%) than women (19%) are living independently. In Kenya, equal ratios of older men and women are living independently. The proportion of older persons in the labour market is the highest for older persons, specifically older men, in Kenya. There are significant gender differences between men and women active in the labour market in all comparison countries.

Table 8: Independent living and labour market activity

	South Africa	Kenya	Mauritius	Malta
Proportion of older persons living independently	31% of men and 19% of women	21% of men and 21% of women	No data	No data
Proportion of older persons in the labour market	21% of men and 9% of women	71% of men and 59% of women	28% of men and 11% of women	3% of men and 61% of women

Source: UN, 2012

Key lessons from developments in ensuring the right to independent living in Spain:
A number of programmes have been implemented in Spain since 2004 to ensure older persons maintain their right to an independent life. However, determining the effectiveness of these programmes was challenging because of different interpretations of independent living. In response, a standardised set of Independent Living Indicators were developed.

2.3 Lessons Learnt from the Literature Review and Comparative Analysis.

A synthesis of the lessons learnt, best practices mentioned and possible policy implications for the above-mentioned themes is presented below:

a) It is important to strengthen the family and community support systems to appreciate ageing, and to respect and honour older persons. This contributes to the promotion of a positive culture that recognizes diversity, protects, and respects the dignity and worth of older persons in the society.

b) Concurrently, issues of older persons must be mainstreamed in all development processes, and awareness regarding older persons must be created among educators, social workers, policy makers, health carers, youth and the community.
c) It is essential to mobilise communities to ensure meaningful involvement and participation in management of the life-long healthcare needs of older persons.
d) Care must be taken to ensure that all development aid for poverty reduction mainstreams needs, concerns and interests of older persons.
e) Age-specific development programmes for older persons are required.
f) Opportunities must be created for older persons to share experience, knowledge and skills with younger generations, and to include older persons in community events. This must take place within the context of healthy living campaigns that are responsive to older persons' changing needs.
g) Different social security benefits are required to meet the needs of older persons, which may vary because of their personal circumstances, social status and macro-societal factors outside of their control.
h) It is essential to identify and create awareness of the negative socio-cultural attitudes towards older persons and engender positive change, particularly through the education and eradication of gender bias.
i) The issue of elder abuse and gender-based violence and other discriminatory practices must be a priority focus area. This should include the promotion of older persons' rights and protection against abuse, through *inter alia* community awareness campaigns and sensitisation programmes against all forms of abuse of and discrimination against older persons, at all levels of society.
j) Obligations of various role players must be clear and robust procedures for responding effectively to suspicion, or evidence of abuse or neglect, must be in place.
k) Capacity to care for an ageing population requires that geriatrics and gerontology research and studies are included in the education and training curricula of various professions.
l) Specific education programmes providing knowledge to work with older persons, geriatric services, as well as services to those suffering from Alzheimer's and dementia are required.
m) Healthcare must be decentralised to ensure easy access for older persons within their local environment. Community and family-based older persons' healthcare support systems must be strengthened at the same time.
n) Affordable and accessible healthcare is essential for older persons to maintain, or regain their optimum physical, mental, social, emotional and psychological wellbeing.
o) Healthcare services for older persons incorporates a wide range of specialised services, such as: physical and mental health promotion and maintenance, community care services, acute and geriatric rehabilitation, dementia-friendly communities and services, and end of life care.
p) Older persons at residential facilities must receive medical and nursing care that assists them in retaining optimal physical and mental health, for as long as possible. They must be provided with the opportunities and facilities that enable them to continue to be physically and mentally active, to maintain the

highest level of independence possible (including their autonomy) with respect to decisions about their health.

q) Mental health of older persons in residential facilities must be monitored regularly to ensure timely preventative and therapeutic action.
r) HIV/AIDS responses need to account for age-related demographics by reflecting risks and trends and providing appropriate prevention, testing and treatment services to older persons. HIV services for people aged 50 years and over would be helpfully integrated with non-communicable disease screening and treatment, as well as other age-appropriate health services.
s) Review and revision of the legal frameworks and data collection policies related to HIV and older persons is required to ensure that efforts and resources are mobilised for awareness, prevention, control and management of HIV/AIDS amongst older persons.
t) At the same time, the capacity of older persons to care and provide support to their relatives living with HIV/AIDS, must be strengthened.

3 Case studies

An iterative data analysis process was used to identify key themes emanating from the ToC Workshop and the Comparative Literature Review. A synopsis of each case study is provided in Figure 8. Case studies elucidate key themes relevant to the evaluation: Human Rights; Vulnerability and Protection; Invisible but Growing; The Golden Games and Active Ageing; Functional Diversity; Capacity for Caring; Residential Care, Community-based Service Centres; and Home-based Care. These themes indicate the complexity of issues related to the key themes. Where relevant, best practice examples encountered during field work have been integrated with case studies. Although each case study stands alone, there are linkages between case studies.

Figure 8: Synopsis of Case Studies

4 Learning

The following is learning derived from the case studies:

a) A **massive and concerted effort** is required to ensure full implementation of the Act across the country, where the inequalities created by the previous political dispensation coupled with the demographic impact of HIV/AIDs, high unemployment and endemic poverty poses a daunting challenge.

b) **Communication of successes** and improved information sharing has the potential to make implementation easier and to motivate those who are doing their best in difficult circumstances.

c) While the urgent need to redress of **past imbalances** cannot be ignored, planners (in government, the private and NGO sector) should also consider **future demographic scenarios** to provide for a situation where one in five persons will be over the age of 60.

d) Simultaneously, the projected **impacts of climate change** on older persons need urgent attention as older persons are more vulnerable.

e) In the monitoring of the Act, it may be necessary to consider a distinction between **compliance monitoring**, and monitoring and evaluation of programme implementation.

f) In an increasingly **constrained funding environment**, ongoing lobbying for funding and finding innovative solutions are essential and create potential for linking up with programmes driving big fast results, particularly in the area of science and technology. Factoring the older population into programmes associated with younger beneficiaries, creates potential for win-win solutions that incorporate improvement of the situation of older persons.

g) The successes in the implementation of the **Child Justice Act should** be used to inform improving the implementation of the Older Persons Act.

h) In light of the enormous backlogs in services in more remote areas, the potential for **employment creation and technological innovation** could be explored.

i) Considering older persons as one homogenous category is a grave error and more should be done to understand this group better. **The age group 60+ should be disaggregated** into refined developmental stages within this age category, to ensure alignment of service offerings to diverse needs of older persons.

j) While the Act applies universally to the entire country, the ideal implementation of the Act may look very **different from place to place**. One-size-fit-all solutions are therefore not appropriate.

5 Evaluation Findings

The findings are presented under the respective evaluation questions in this section.

5.1 The extent to which the Act was implemented as intended

The Act provides a strong basis for the improvement of the situation of older persons, and although the Act has not yet been fully implemented, significant progress has been made and important successes have been achieved, despite several challenges. From a somewhat slow start, the implementation of the Act has gained momentum. The will to implement the Act exists, and capacity to implement the Act has improved. Other areas faced implementation challenges that impeded full implementation. Progress has been made in the seven years since the Act has come into force. High level significant changes brought about by the Act and the implementation of the Act, include the following:

- availability of clear Norms and Standards;
- improvement of community-based services for older persons;
- slightly higher budget allocations for older persons since 2010 (albeit still not totally sufficient); and
- initiatives to promote the safety of older persons through the implementation of the:
  - Abuse Register;
  - Protocol for the management of abuse; and
  - the SAPS National Instruction regarding older persons; and the work of the Victim Empowerment Programme (VEP).

As could be expected, varied progress has been made with the implementation of the Act, some successes recorded, particularly in response to specific challenges which include:

- Improvement of human resources for providing professional services to older persons:
  - Providing bursaries to social work practitioners and absorption of graduates into DSD; and
  - Implementation of a retention strategy for social workers in DSD.
- Developing skills in the NGO Sector:
  - Capacity building of NGOs have taken place.
- Enhancement of sectoral coordination:
- In some cases, MOUs have been signed with key role players.

5.1.1 Implementation, application and general principles

Through this Act, South Africa has managed to rise to some of the challenges posed by an ageing population and realizing and protecting their rights within the context of local and international legal frameworks. The *mere fact that the Act exists* - and the fact that it makes provision for the protection of the rights of older persons and provides a basis for the improvement of the situation of older persons - is regarded as an achievement in itself.

The Act intends to protect the rights of older persons, promotes the protection of older persons (physically and socially) and initiatives that will enable them to live an active life independently are promoted, while the focus shifted from institutional care to community-based service delivery, which includes home-based care. Importantly, norms and standards have been developed for all categories of facilities that cater of older persons, and training and support have been provided to implement these norms and standards. Implementing a policy shift as proposed by the OPA is by no means an easy task, and particularly providing community-based services for older persons, who have a diverse range of needs, has been challenging. Many older persons are not yet reached, and it is not always possible to fulfil all the needs of those who are reached. However, significant progress has been made, which provides a basis to build on in future.

5.1.1.1 Rights and status of older persons

There are indications that the status of older persons as respected citizens in society had improved since 2010 through the recognition, awareness and protection of their rights, as well as increased sensitivity regarding the needs of older persons.

Most beneficiaries interviewed noted that they were aware of their rights as older persons. Awareness of rights was the result of education within residential facilities, and through awareness campaigns as service centres, and some facilities had awareness posters on the walls. Where beneficiaries were not aware of their rights, it may be because of language barriers and literacy levels, and awareness materials may not always be accessible to those with disabilities and impairments.

Beneficiaries agree that older persons deserve respect and care, but views regarding the need to get special attention varied. These differences could possibly be related to the diverse life stages of older persons interviewed, as well as their individual needs for special treatment, based on their own level of independence. Older persons who are still active take pride in their ability to be independent and to contribute to society.

5.1.1.2 Shift to community-based services

The number of residential facilities run by DSD is very low in comparison to the number of facilities run by NGOs, and since 2010/11 the number of residential facilities funded per province has either remained the same or decreased (Eastern Cape, Free State, Limpopo, Mpumalanga and Northern Cape)[15] (see Figure 9 below). In Gauteng the number of residential facilities funded increased from 71 to 73 in the same period. Contrastingly, there was a marked increase in funding for community-based service centres: In Limpopo the number of Community-based Service Centres more than doubled from 45 to 105 (133,3%); in the Eastern Cape the number increased from 247 to 388 (57,9%); and in Gauteng from 190 to 248 (30,5%). Marginal increases were noticeable in Mpumalanga where there was a slight increase from 88 to 90 facilities (2,3%) and in the Free State a small increase from 174 to 176 facilities (1,2%). In Northern Cape the number of facilities decreased from 59 to 55 (-8,5%).

[15] 2010/11 data was not available for KwaZulu-Natal and Western Cape.

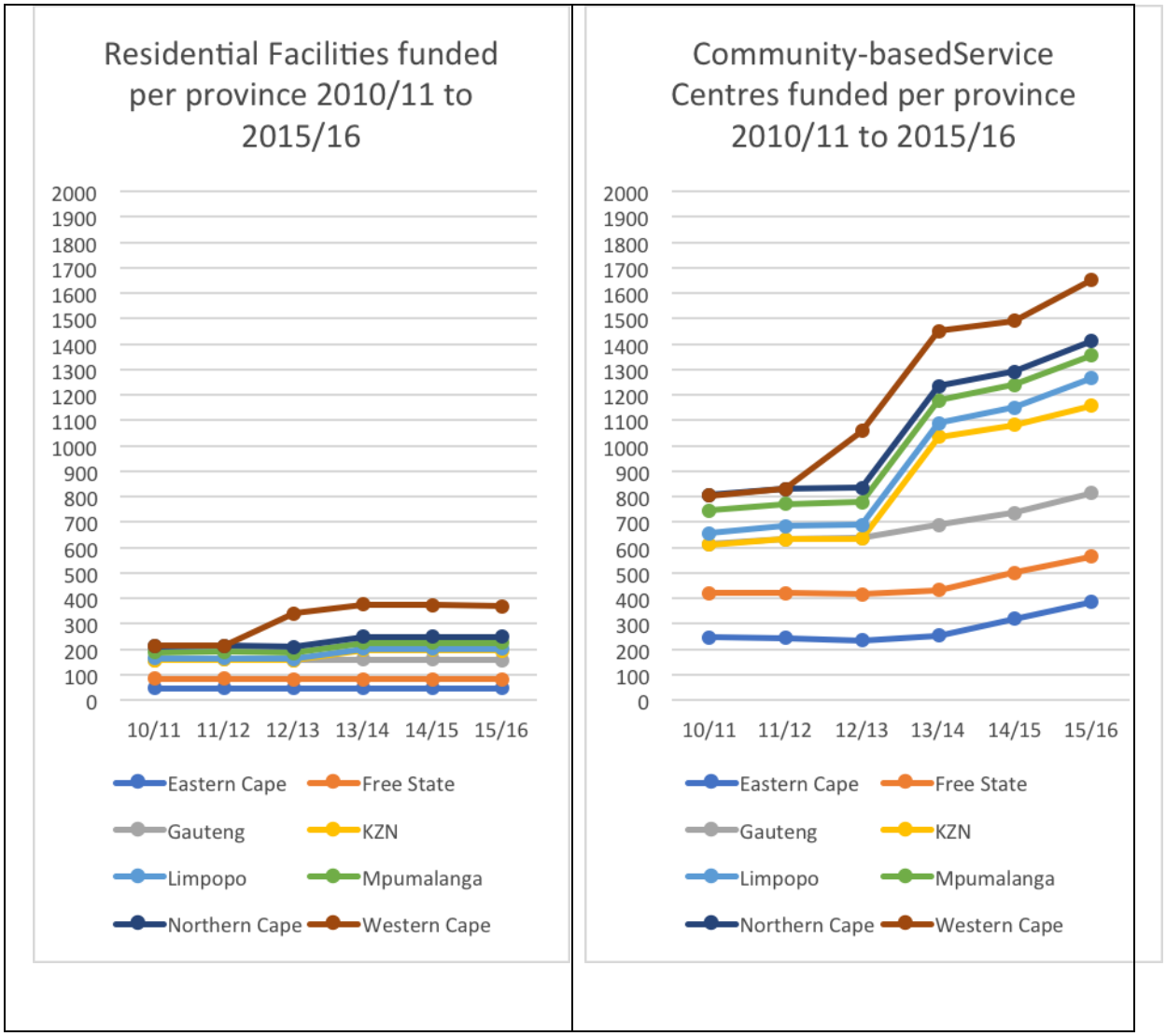

Figure 9: Residential Facilities and Community-based Service Centres

The focus and shift to providing community-based services and promotion of healthy ageing seems to have contributed to delaying the age of entry into residential facilities and is in line with the healthy ageing policy. Older persons interviewed indicated that they appreciate healthy ageing activities offered, and those who were still able to function without assistance, cherished their independence, which shows that the healthy ageing policy is in line with older persons' needs.

Further, a steady decrease in the number of beds available in residential facilities in all provinces indicate a gradual shift away from residential care, to community-based care (see table 9 below). This may, however create gaps in terms of providing care for those who are frail, or in need of institutionalised care for various reasons. In this regard the 2015 SAHRC Investigative Hearings Report has recommended that there should be more old age homes in townships, and further that the Department of Health should take action regarding the supervision of care for frail older persons in communities.

The focus and shift from residential care in urban areas to providing community-based services also demands a shift in capacity for a range of occupational groups, notably enhancing capacity for community- and home-based caregivers. However, it has not yet been possible to provide access to all older persons in the community, to the full range of services they need. Further to the direct services provided to older persons in the community, a shift to community-based care requires additional resources needed to provide adequate services, such as additional human resources, transport and infrastructure.

Table 9: Number of residential and community based services for 2017/18

Province	Number of Residential Care Facilities	Number of Older Persons accessing Services at Residential Care Facilities	Number of CBCSS	Number of Older Persons Serviced accessing Services at CBCSS Facilities
Eastern Cape	30	1 581	425	20 578
Free State	40	1 831	152	6 461
Gauteng	80	6 954	188	6 151
KwaZulu-Natal	43	2 998	193	21 817
Limpopo Province	8	658	258	17 614
Mpumalanga	24	1 335	95	5 811
North West	31	904	121	1 654
Northern Cape	24	842	60	2 435
Western Cape	138	10 530	221	15 381
National	**418**	**27 623**	**1 713**	**97 902**

Source: Provincial DSD internal administrative data

5.1.1.3 Residential and frail care facilities

Some of the residential facilities visited were well-resourced, and in other cases facilities were aware that they needed to make provision for more professional staff as a result of growing numbers of residents. Many facilities have established systems in place to access supplementary resources (funding and non-monetary donations) to enable them to deliver the required services.

Many beneficiaries of services provided by residential (including frail care) and community-based care facilities appreciate the care and services they receive, and those who were still able to participate actively in society valued their contribution, and their ability to assist other older persons.

5.1.1.4 Maintenance of facilities

The maintenance of facilities appeared to be a challenge for both relatively well-resourced facilities, and facilities with limited resources.

5.1.1.5 The role of NGOs

The NGO sector seems to have a positive view of government's implementation of the Act, because the Act is a binding law, which enables quality services to be provided to older persons; opens up opportunities for older persons to engage with the state in a meaningful way: and promotes government coordination with the NGO sector.

NGO successes with implementation of the Act include dedicated service provision to older persons at community level, by addressing critical gaps in service delivery, such as transportation to service access points, and the development of innovative ways to deliver services to older persons in need.

5.1.1.6 Barriers and challenges

The Act has not been fully implemented for several reasons, with the main challenges and barriers to implementation being resource constraints, which includes funding, human capacity, transport and infrastructure, coupled with inadequate coordination and less than ideal levels of awareness.

Historical backlogs and inequalities in the provision of services to older persons remains a significant systemic challenge, and the growing ageing demographic exacerbates this situation. Further, implementation of the Act is hampered by inadequate harmonization with other legislation, particularly in relation to health services, and domestic violence. Coordination on various levels is clearly an aspect that can be improved, both within government and between government and other stakeholders, such as NGOs and Chapter 9 Institutions.

5.1.1.7 Community-level coordination

The apparent lack of coordination between community workers from various departments creates a less than optimal situation, which could be confusing to older persons who are in contact with community workers from various departments and entities. There is a clear need for improved coordination and harmonization of activities to ensure more efficient spending and implementation.

Some integration with other community work programmes does exist, such as the EPWP, and it has been noted that an assessment of community workers has been commissioned, which should contribute to harmonization of effort.

5.1.1.8 Development agenda of government

It is also important to note that older persons are on the development agenda of government and are being considered in high-level government planning. Many

departments, have dedicated units to vulnerable persons, which include older persons. It is evident, however, that the multiple vulnerabilities that older persons face are not always considered. Officials at national level may focus on either older persons, or gender, or disability, or children. Integrated complexity thinking is required to plan appropriately for vulnerable groups holistically.
The establishment of desks for older persons in the Offices of the Premier (OTPs) and in some Provincial DSDs, is evidence that the older persons' agenda is taken seriously at provincial level and could assist in promoting complexity thinking at that level. However, indications are that the extent to which these desks are functional, varies from province to province. The functionality of these units is dependent on the resources provided and the level of capacity within the unit.

Some departments that are not regarded as core in terms of the implementation of programmes for older persons are aware of and considered in their planning for the growing ageing population. However, many government departments have a limited understanding of their responsibility regarding the rights and protection of older persons, which is an impediment to creating a better dispensation for older persons.

While many departments and specifically DSD, Department of Health, SAPS and DOJ&CD do plan for older persons, budget constraints are a reality. Some NGOs are of the opinion that funding constraints which makes it difficult to fully address the needs of older persons is an indication that in practical terms, older persons are not as key in the government agenda as could be expected.

5.1.1.9 Mainstreaming of health services for older persons

While the Department of Health has opted to mainstream older persons in all their services, there are clear indications that this policy does not necessarily best serve the needs of older persons, and in many instances health services may not be adequately aligned to the needs of older persons. The need for a close working relationship between DSD and DoH is also felt on provincial level.

The DoH includes older persons in all their service offerings and does not budget separately for an older persons' programme. Older persons also benefit from the DoH ward outreach programme. There are indications that health services are not always sensitive, and that older persons are excluded from some specialized treatments (e.g. dialysis and certain operations) at government hospitals, because of their age, and in view of limited resources available at government hospitals.

In many instances, older persons with HIV are not adequately catered for and in some cases stigmatized by health workers. It appears that this situation may contradict the intent of the Act and further has the potential to jeopardize the dignity and rights of older persons.

5.1.2 Creating an enabling and supportive environment for older persons

5.1.2.1 Norms and Standards

The formulation and availability of clear Norms and Standards is a significant achievement as has established a foundation for minimum standards of care which promotes equality of care. However, budgetary constraints mean that some components of the Act have not been fully implemented, and this is a concern that requires urgent review.

There are indications that although older persons are on the government agenda, this priority does not always filter through to budgeting processes, which means that older persons are not always adequately budgeted for.

Financial constraints relate to the actual value of funding for facilities, as well as waiting periods for the receipt of funding. Limited funding creates challenges for facilities to be fully functional, both in terms of delivering services, and administratively.

Another key element of implementation of the Norms and Standards is that compliance need to be monitored systematically, but the reality is that monitoring of the implementation of Norms and Standards remains a challenge.

Facilities receive funding every three (3) months, and some complain that they do not receive the money timeously.

5.1.2.2 Access to social grants

There are indications that the overall wellbeing of older persons has improved, not only because of the existence of the Act, but because of improved access to social grants.

Social grants make it possible for older persons with limited or no other resources to at least meet their own basic needs, thereby contributing to the physical and emotional wellbeing of older persons. Uptake of social grants for eligible older persons is 80%. The 20% deficit may be related to the fact that some older persons may not have the necessary documentation (IDs), may not be aware of changes in thresholds for accessing grants, and may have difficulty in accessing application systems and procedures for grants.

Social grants do make provision for the increased needs of very old persons in that a slightly higher amount is paid to persons 75 years and older. However, the difference is minimal, and not sufficient to address the increasing health and welfare needs of much older persons. The increased amount of R20 on a grant of R1,600 is less than 2%, and can be regarded as insignificant in real terms.

The Grant-in Aid exists, but is under-communicated, meaning that many who may be eligible are not aware of the grant and therefore do not apply for it. Older persons with disabilities could apply for this grant, as it is not possible to receive an old age grant as well as a disability grant. Considering the sharp increase in disability between age 60 (<20%) and age 85 (>50%), which indicate that persons have an incremental need for care and assistance as they age, may not be optimal. The Grant in Aid is less than R400 per month, and although this will assist older persons

with greater needs, it may be necessary to consider what could be practically done with this amount.

An amount of R400 could for example cover a salary of less than four days for a privately employed caregiver paid at the minimum wage for domestic workers; or it would cover the cost of less than 50 adult nappies purchased commercially. Bearing in mind that South Africa's overarching constitutional human rights framework and considering concepts such as "the right to an independent life" (which means that older persons with diverse functionality should be able to live an independent life irrespective of economic status and other factors) for disabled persons dependent on social grants, will not be easily achieved.

The current dispensation where older persons who are disabled are not allowed to receive both an old age grant and a disability grant, could be regarded as a form of unfair discrimination, given that they are excluded from disability benefits, regardless of the fact that they are disabled and need additional assistance, like any other disabled person.

5.1.2.3 Understanding of older persons' issues

Generally, awareness about older persons has improved, and some older persons feel respected in their communities. Although progress has been made regarding understanding of older persons rights and needs, massive gaps remain, particularly regarding a deeper understanding of the ageing process and related needs of the older persons.

Specifically, issues related to older persons with HIV, and older persons with Dementia and Alzheimer's are not well-understood by communities. Some progress has been made with awareness raising on Dementia and Alzheimer's, but a lot more has to be done.

A lack of understanding about older persons, and an absence of tolerance for their vulnerability has a direct implication on the violation of rights of older persons. There are strong indications of deeply rooted negative perceptions about older persons that are in direct opposition to the South African human rights dispensation.
Vulnerability of older persons is affected by general human development problems in the country, such as backlogs with delivery of basic services such as water and sanitation, high levels of crime, unemployment and HIV.

Another area where there seem to be gaps in providing services, is providing support to older persons who are released from correctional facilities, particularly those who have been incarcerated for lengthy periods, and have to reintegrate into society as an older person.

5.1.2.4 Social inclusion

Implementation of the Act has promoted the social inclusion of older persons through initiatives such as the annual Older Persons Parliament, and through this initiative older persons can make contributions to decision-making about them. This initiative

in Older Persons' month also provides opportunities to communicate older persons' issues to a wider audience, and to address negative stereotypes about older persons.
The concept of healthy ageing has gained momentum, and the implementation of care and active ageing programmes are contributing to the overall wellbeing and social inclusion of older persons.

The Active Ageing programme incorporates various activities, such as the Golden Games, combined with the Older Persons Parliament and cultural activities.
Participation in Older Persons Parliament varied considerably per province (see Figure 10 below):

- KwaZulu-Natal reported the highest cumulative participation over the period under review with a total of 12,000 older persons;
- National Older Persons' Parliament reported participation of a total of 4,450 older persons over the review period;
- Mpumalanga, North West and Eastern Cape reported cumulative participation figures of respectively 1,800; 1520; and 1,058;
- Northern Cape reported a cumulative total of 311, and Free State 300 older persons participating.

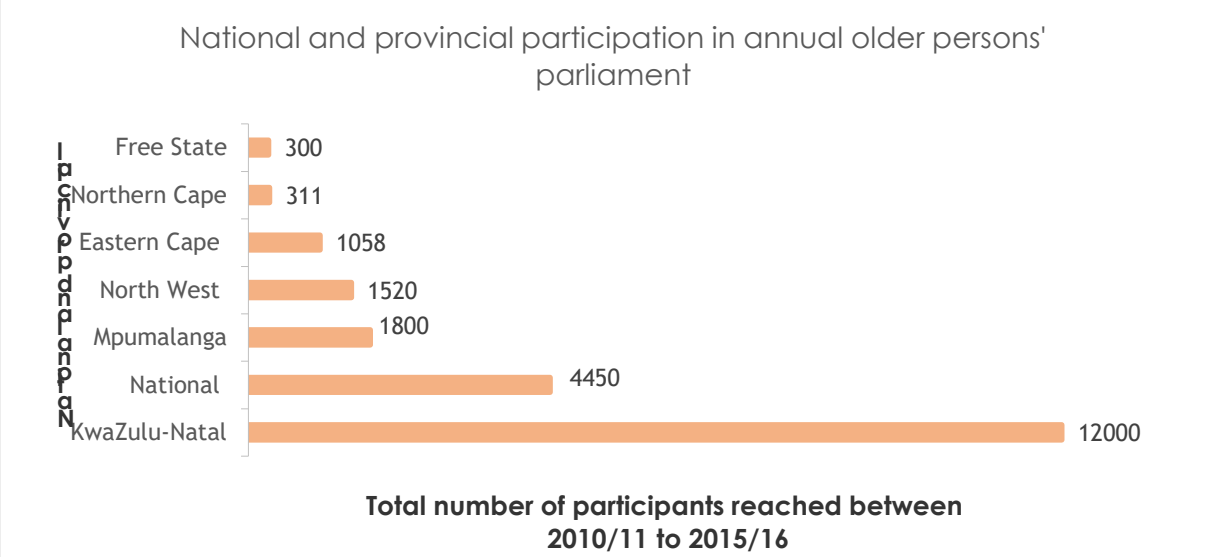

Figure 10: National and Provincial participation in Older Persons Parliament from 2010 to 2016

5.1.2.5 Access to services and assistive devices

Evidence indicates that the implementation of the Act has contributed to improvements in access to services, particularly in rural and previously disadvantaged areas. This does not mean, however, that optimal or even adequate coverage has been achieved.

Access to assistive devices for older persons in many rural and poorer urban areas remains low. The inherited inequalities in the system of care for older persons are

often still in place, and significant differences in access to services and quality of services remain, depending on geographical location.

In residential facilities, care equipment such as wheelchairs were available. The situation at community-based service centres is different:

- About half of the facilities had lists detailing the depots that could be contacted for lending of assistive devices. Therefore, information on assistive devices is available at some facilities.
- Most facilities visited did not have training programmes on the correct use of assistive devices.
- One facility mentioned they had received training in the correct use of assistive devices from the Department of Health. This facility reported that their manager maintained assistive devices used by older persons, but other facilities do not have capacity for maintenance of assistive devices.

In communities, access to assistive devices varies. One beneficiary perceived access to assistive devices for walking as adequate, whilst another noted their wish to have better access to wheelchairs.

5.1.3 Community-based care and support services for older persons

It is clear that an effort has been made to increase and enhance service delivery to older persons through community-based care and support. This, however does not mean that de-institutionalization of care is a resounding success. There are clear indications that adequate coverage of older persons' needs through community-based service centres and home-based care has not yet been achieved and will only be achieved through a substantial increase in effort, funding and capacity building.

Improved funding of NGOs has been a successful intervention and is a critical element of implementing the de-institutionalization policy. More will have to be done, however, to ensure that NGOs are fully able to provide the required services.

Services for older persons is a specialized field, and extensive competence is required to render adequate services to frail or impaired older persons. NGOs may not always have the full spectrum of skills required to care adequately for the changing and diverse needs of older persons and a review of service provider capacity to undertake these services may be required. (See Annexure I, Case Study 6 for learnings based on the Life Esidimeni tragedy regarding providing de-institutionalised mental health services for older persons).

Subsidies for NPO service providers vary across provinces. This creates inconsistencies that may be impacting on the quality of service provided and the levels of compliance with norms and standards being achieved.

Progress made regarding the implementation of Norms and Standards for Community-based Service centres are summarised below.

5.1.3.1 Delivery of services

5.1.3.1.1 a. Physical environment

The physical environment of facilities visited were largely influenced by the characteristics of the areas in which they are located. Most facilities had sheltered meeting places or used suitable spaces such as nearby community halls to host their activities. One home-based care centre operated from a corrugate iron structure (see Case Study 9). More than one facility reported that they “used a local tree” as their meeting place.
Access to suitable eating spaces varied, and in some instances the eating spaces were not clean. Kitchens and food preparation areas at community-based facilities varied – most facilities did have food preparation areas, but some were very small, a few did not have food preparation areas. Many facilities had challenges with storage of prepared food.

Generally, facilities did not have separate hand washing or ablution facilities for staff, and at some, hand-washing took place in the kitchen. Most facilities had running water, and where running water was not available in rural areas, large drums or water tanks were used to provide adequate water. There were, however facilities that did not have water available at all. Access to hot water was limited.

Toilet facilities did not always meet the requirements of the Norms and Standards. Facilities in more developed areas, which were housed in permanent structures, provided better access to clean, well-serviced toilet facilities. At some facilities there were toilets for both sexes; at others only one toilet used by men and women; other facilities used toilets nearby; and some facilities used pit toilets.

Most facilities did not have access to hot water, and many facilities did not have facilities for older persons to wash hands.

5.1.3.1.2 b. Statutory requirements

Registration documents for all facilities visited were available. However, none of the facilities visited and checked had the required standardised background report of the service provider organisation and members of the organisation available.

5.1.3.1.3 c. Provision of care and support programmes and social and economic independence

Some facilities had fundraising activities such as crafts, knitting, baking, soap making, laundry services, and vegetable gardens. There were also facilities that did not provide any economic empowerment or income generating activities. (See Case Study 8).

5.1.3.1.4 d. Capacity building

Programmes to enhance older persons’ capacity to live full and healthy lives in old age included story-telling programmes, others had programmes to build older persons’ capacity to teach or assist their grandchildren. Poverty relief and financial

sustainability programmes available at some facilities varied. Some had vegetable gardens that also benefited the community. There were also facilities that are developing older persons' skills and expertise to provide educational programmes, and to involve the broader community in the centre.

5.1.3.1.5 e. Community participation and Volunteerism

Most facilities promoted community participation and voluntarism, and there is evidence of community participation in projects and events. At some facilities community involvement takes the form of visits from stakeholders such as Care Buddies, churches and community members.

5.1.3.1.6 f. Information on access to health and social welfare services

Almost all facilities visited had some form of information-sharing activity, e.g. through door-to-door campaigns, home visits, or using Care Buddies for information sharing. Information shared related to clinics, local service centres and church activities. Some centres made use of community forums to share information.

Although most community-based service centres visited did not provide healthcare on-site they did provide information on and transport to nearby clinics and/or government hospitals. Some facilities provide psychogeriatric services once a week, and others have a referral system to relevant NGOs, and at some facilities no information regarding psychogeriatric services is available.

Regarding information on, and access to assistive devices, it should be noted that about half of facilities visited had lists detailing the depots that could be contacted for lending of assistive devices. However, most facilities did not have any training programmes on the correct use of assistive devices – only one facility mentioned that they have received training from the DoH in the correct use of assistive devices.

5.1.3.1.7 g. Access to transport

Some community service centres are not easily accessible via public transport, and the available transport is not always reliable or convenient, especially where community service centres are located some distance away from other services, such as clinics. Some centres have submitted funding proposals and others already use private transport. Those who have their own transport, make it possible for older persons to access the community-based service centre, as well as other service resources, such as healthcare facilities.

5.1.3.1.8 h. Provision of food

Meals provided were influenced by the cultural background of the community where the facility was located, and some were able to provide meals in line with specific cultural and religious preferences of older persons. Some facilities had access to a dietician and were able to cater for special needs such as diabetes. Menus were generally available beforehand, but facilities that were struggling were not able to provide meals according to a pre-planned schedule. Although facilities did their best

to provide nutritious meals, vegetables were not generally available, and at some facilities meals provided can be described as the bare minimum. Funding constraints influenced the nutritional value of the meals provided and inhibited providing meals suitable for those with special dietary requirements, particularly where a dietician was not available. Facilities that did provide food parcels had a register to record the distribution. Some facilities only provided food parcels in winter.

5.1.3.2 Management services

All facilities visited had approved budgets, as well as a financial management system in place, and at most of these facilities monthly financial statements were accessible. However, most of the financial management staff at community-based facilities are not trained in finance but are able to perform the required financial management functions. At the facilities visited, organogram structures were in place, and roles seemed to be clearly defined and understood. Relevant legislation was available at the centres visited, and some also displayed evidence of awareness of the Latour Relations Act. It should be noted that most facilities had no human resources policy in place, none of the facilities had a staff recruitment policy in place, and volunteer registers were not available. Most facilities visited did not have induction or training programmes for staff, and governance procedures were not available at any of the facilities visited.

5.1.4 Residential facilities

Although some progress has been made with the registration of facilities, more work is required in this respect, and a dedicated effort is required to ensure that all facilities are registered. Alongside registration of facilities, monitoring does take place, but could be improved.

DSD should prioritise the streamlining of the registration processes, to ensure that all facilities are registered within a specific timeframe and that ongoing registration of facilities is implemented against clearly defined service standards.

The way in which the Act is communicated and implemented leads to the exclusion of a significant part of the facilities for older persons. Given that private and un-subsidized non-state facilities are not adequately regulated, partially due to limited DSD resources, as well as the lack of adequate multi-sectoral planning, e.g. through implementation of housing regulations for older persons. The resources required to implement this requirement should be clearly described, costed and budgeted for by government.
Further, the exclusion of a considerable proportion of facilities, because of non-registration of private facilities, makes it difficult to form the full picture of services for older persons, irrespective of economic status. Therefore, it is virtually impossible to make an assessment on the wellbeing of all older persons in society. It is further important to note that the population census typically excludes persons in institutionalized care.

There are indications that the entry age into residential care is being delayed and this points to successful implementation of de-institutionalization of care. The concurrent improvement of community-based services is also a success, and it is noted that in many cases services are being provided under extremely difficult circumstances. (See Case Studies 7, 8 and 9)

It is evident that institutional care in the form of residential facilities, which are able to accommodate frail older persons and those who suffer from Dementia and Alzheimer's disease, are mostly located in urban areas, leaving the frail and mentally impaired in semi-urban or rural areas at risk.
It is important to note that with older persons staying in the community for longer, it is essential that departments other than DSD, particularly DoH, SAPS and DOJ&CD are able to adapt their service offerings to cover the needs of older persons in the community.

Progress made regarding the implementation of Norms and Standards for Residential Facilities (including independent living facilities, assisted living facilities and frail care services) are summarised below.

5.1.4.1 Delivery of services

5.1.4.1.1 a. Physical environment determined by the type of service delivered

Frail care units were available at almost all of the residential facilities visited, and they generally complied with the required maximum of four (4) beds per room. Some had only two (2) beds per room. Floor areas complied with norms and standards, and doors were wide enough to accommodate wheelchairs, beds, trolleys and tripods in all the facilities visited.

Frail care facilities had the required service kitchens available, for the preparation of beverages and heating up of food, and generally complied with the requirements for washing up of cutlery and crockery.

All residential facilities had a constant supply of hot and cold water, as well as suitable facilities for the preparation and storage of foodstuffs, although the quality of premises and preparation areas varied. In some facilities, small kitchens did not have separate hand basins.

Sanitation and clean drinking water requirements were met, and some facilities had generators in case of power failure. The standard of utilities and municipal services at the facilities visited generally matches that of the area in which the facility is located.
Most of the facilities visited had their own in-house laundry spaces, and laundry rooms were generally of adequate size according to the number of residents, and adequate laundry equipment was available. Ventilation in laundry areas was mostly adequate, while one facility had only small windows in the laundry area. One facility made use of an outside contractor, and as far as could be determined, this service provider was qualified to render the service. Provision for linen rooms varied, with

some facilities having linen rooms in every ward, while others did not have separate storage areas for linen.

Dining areas of all the facilities visited met the requirements of the Norms and Standards, and some had very large dining areas. These areas were generally well-ventilated and had suitable heating systems installed. These areas were clean and free of offensive smells.

Recreational areas were fit for purpose and were also used for occupational therapy and other activities such as choir practice, exercises, gatherings, watching television, and socialisation. Some facilities also used recreational areas as a library space.
Most facilities visited had adequate separate storage facilities for linen, furniture, suitcases, household cleaning agents, tools, medicines and corrosive and other harmful substances.

Lockable cupboards were available for each resident, windows were adequately protected through a combination of alarm systems, CCTV cameras, electric fencing, burglar bars and guarding services. One of the frail care units did not have the required CCTV cameras installed. Some facilities had CCTV cameras in every passage, kitchen lounge and office. Security systems related to, and control over medicines were also observed.

At most of the facilities, emergency routes were appropriately and clearly identifiable, and at all except one facility emergency exits would be visible at night. Fire protection certificates were noted at the facilities visited, and fire extinguishers were visible at all facilities visited but all fire extinguishers were not installed properly. Smoke detectors were observed at facilities and were assumed to be functional.

Building layouts were found to be fit for purpose, ensuring accessibility for disabled persons, particularly those who make use of wheelchairs, walkers and tripods.

5.1.4.1.2 b. Legal status for service facility development and delivery of services

The facilities visited indicated that professional persons working at the facilities were registered with their respective professional bodies. Some of the facilities visited did have their own registers for both caregivers and social workers. Most of the facilities visited did not have register of accredited caregivers.

All facilities visited confirmed that an abuse register was in place. Some used the R29 form. Facilities also mentioned that quarterly reports were submitted to DSD. The existence of a national toll-free helpline was not optimised (see point 2.6.2 of the Norms and Standards for Residential Facilities). Site visits indicated that this telephone number was not readily shared with residents, nor displayed prominently in most facilities. Some facilities were not aware of the number at all. The utility of this number in the protection of abuse is potentially that it may assist with the prevention of abuse. However, this number was tested and is found to be linked to SASSA, rather than serving as an abuse prevention resource. (See Annexure H-1).

Facilities visited were aware of health, nursing and pharmaceutical policies and procedures, and had systems and processes in place to adhere to these.

5.1.4.1.3 c. Capacity building

Some facilities indicated that they had programmes to train, develop and support caregivers. Information and referral systems to support caregivers were also available, but the level of uptake was unclear, in absence of a comprehensive, coordinated programme.

5.1.4.1.4 d. Residential care

At the facilities visited, programmes for the prevention of injuries and infections were in place, and measures implemented included awareness talks with staff. Trollies with suitable equipment and consumables were available in some facilities, and facilities provided handwashing liquid and gloves.

Some Residential Facilities, particularly those who provided frail care, resembled hospital wards.

Some facilities set a portion of their budget aside to care for residents with special needs, and others provided affordable accommodation through rate concessions. Safe beds and subsidised beds were not available at all facilities

The facilities visited had spaces available for private discussions and/or interviews. Some facilities used the boardroom or manager's office for this purpose.

Suitable furniture and equipment that meet the requirements of the Norms and Standards were found in all the facilities visited. Facilities had adequate catering equipment, as well as adequate clean bed linen, blankets, pillows and towelling per bed.

Maintenance equipment were available at facilities, and some had access to the services of a handyman.

5.1.4.1.5 e. Independent and assisted living programme

At the time of the visits to the facilities, residents were out of bed where possible, and appropriately dressed. At the residential facilities visited, Facility Managers indicated that residents did remain self-sufficient as far as possible, depending to the extent to which they are willing to do so.

Facilities made provision for various activities but residents are free to decide if they would like to participate or not.
Activities provided include socialisation activities, and some had monthly programmes for these activities. Some facilities celebrate events like Valentine's Day and heritage events. Other facilities have only one event per year, such as the Christmas function. Most facilities provided recreational activities such as film

screenings, exercise classes, Bingo and flea markets. Many facilities had libraries, and some had hairdressing facilities.

It should be noted that facilities where staff shortages were experienced had challenges in providing progammes for residents.

Residential facilities were generally able to provide services to residents in their home language.

5.1.4.1.6 f. Information on health and welfare services

Facilities generally made information available on primary health care services, government services and multi-purpose centres. Some facilities provided limited curative care, and did, for example have a private physician visit the facility on a weekly basis. However, curative care was mostly provided via government hospitals.

Some facilities had their own social workers, and only some facilities were able to provide residents with access to psycho-geriatric services. It should be noted that these services could mostly be accessed only by those who had private medical aids.

5.1.4.1.7 g. Information on access to transport

Where facilities were centrally located, or had transport for residents, it was easier for older persons to access other services in the community, such as hospitals, clinics and churches. Many facilities provided transport, particularly where safe and reliable public transport was not available. However, some facilities reported that lobbying for older-person friendly and safe transport was a gap.

5.1.4.1.8 h. Support to caregivers, including family

Most of the facilities visited did not provide home-care services for older persons in the community. Some facilities did not have outreach programmes for caregivers (including family) who take care of older persons in the community. The Social Workers at some facilities are involved in outreach programmes, and one facility had an outreach programme in the form of a social club.

5.1.4.1.9 i. Community involvement and volunteering

Community involvement in facilities take place through fundraising through events such as golf days, and some facilities use local community radio stations to garner community support. Community involvement also take place through visits to facilities by schools and for example dance companies in the community.

Some facilities reached out to the community through visits on commemoration days like Mandela Day.

5.1.4.1.10 j. Provisioning of assistive devices

First aid emergency equipment as well as care equipment such as bedpans and wheelchairs were available.

5.1.4.1.11 k. Provision of food

Facilities visited had adequate cold storage facilities available, and adequate meals were provided to residents. Meals were pre-panned and, in some cases, provision was made for special dietary requirements. Menus were generally available in advance, and food were prepared in line with residents' cultural and religious practices.

5.1.5 Protection of older persons

Efforts to promote the safety of older persons through implementation of various initiatives such as the Abuse Register, the Protocol for the Management of Abuse, the SAPS National Instruction, and Victim Empowerment Programmes (VEP) is noted. Key role players acknowledge that although progress is encouraging, implementation should be upscaled considerably to achieve the intended outcomes.

5.1.5.1 Abuse and Reporting:

The abuse of older persons remains an area of concern, and it is alarming that abuse registers are not implemented at all facilities. The electronic abuse register seems to not be functional, and therefore appropriate vetting of staff that apply for jobs where they work with older persons cannot be implemented.

It has also been noted that the number of abuse cases reported has not declined, but prosecution rates seem to have improved. While this may result from improved reporting because of increased awareness of abuse, it only highlights the need for a more concerted multi-sectoral response to abuse against older persons, including economic abuse.

5.1.5.2 Abuse Awareness

The SA government, civil society and the private sector have come together through the global 16 days of activism campaign to raise awareness of violence against women and girls. Older persons are not excluded from the impact of other societal problems, and drug abuse has specifically been mentioned as impacting on the safety of older persons, particular women.

The 16 Days of Activism platform could be leveraged to further mobilize awareness of violence against older women, and older persons in general. Abuse against older persons also include economic abuse, and some variations of psychological abuse.
Further, indications are that law enforcement agencies at community level may not be as responsive and knowledgeable on elder abuse and protection, as expected and required.

5.1.5.3 Protection of older persons in the community

Specific concerns have been raised about protection of older persons in unregistered facilities and older persons, particularly those who are frail or mentally impaired, who live in communities on their own, or with their families.

Door-to-door campaigns can assist with the identification of abuse of older persons living in communities, although access to a dwelling is not always guaranteed. Community members, including older persons may also be hesitant to report abuse, because of their own vulnerability.

5.1.5.4 Older Persons' perceptions of safety

It is interesting to note that older persons in residential facilities generally feel safe and socially connected too. This is in contrast with the 2015 SAHRC Report on Older Persons where concerns are raised regarding the safety of older persons in residential facilities. Some residential facilities have mentioned safety issues that have to be addressed, and in those cases the facility was able to put interim measures in place.

Older persons in Residential Facilities had positive comments on feeling and being safe, and in some instances, there was a realisation that more security features may be needed particularly where recent external threats occurred. Feelings of safety in some cases also extends to a sense of being cared for and having social contact. A safe environment also promotes activities like walking, which contribute to healthy living. Some security measures, such as security cameras, do not only provide protection from external threats, but is also a protective factor against abuse. Some older persons, when they venture out of the facility where they live, rely on others to get around safely.

Some older persons living independently feel less safe, and may be even more exposed to crime, due to their vulnerability. In some instances, their safety is compromised by family members. In other instances, they feel protected due to the presence of supportive family members. In some communities, older persons feel safe, free to move around, and enjoy interaction with other community members.

It can be assumed that the level of safety in a specific community impacts to a significant extent on the safety of older persons. Different perspectives on safety when living in the community indicate that older persons' sense of safety varies depending on the communities they live in, and some feel more vulnerable than others. There are also different perspectives of safety within the same communities, probably due to older persons' personal experiences of crime.

Those who feel less vulnerable, are free to engage in meaningful activities. Community-based Facilities do not only provide services but are also safe havens for those who feel vulnerable at home. It is further evident that older persons feel safer when they have someone living with them or assisting them. Some older persons do feel safe in their homes, but mention that they mostly stay at home, and do not move

around too much. Others feel that living in a rural area is safer than living in a city or town.

Despite progress made, the Act as well as the Norms and Standards have not been fully implemented for various reasons as listed in Table 1010 below.

Table 10: Reasons for Lack of Implementation of the Act

Aspect	Detail
Socio-economic factors	• Uptake for the old age grant is 80% due to some older persons not having necessary documentation and lack of awareness about changing thresholds; • Old age grants have not increased significantly in real terms; and • Grant-in Aid is under-communicated. Therefore, eligible older persons may not be aware of the grant and may not apply for it.
Access to services	• Access to assistive devices is low; • Access to quality services varies according to geographical location; • Monitoring of registration of facilities could be improved and include private and unsubsidised, non-state facilities to ensure a true representation of services to older persons can be established; • Coverage of community-based services requires expansion through increased effort, funding and capacity-building; • Older persons are not adequately catered for in terms of the public health system.
NGO performance	• Extensive competence is required; and • The logic of expecting compliance to a certain standard with different levels of funding is unclear.
Safety and security of older persons	• Number of abuse cases reported have not declined; • Indications of limited responsiveness and knowledge on elder abuse by law enforcement agencies; and • A dysfunctional electronic abuse register.

5.2 Institutional arrangements to support implementation and performance of the Act

Institutional arrangements to support implementation and performance of the Act were assessed with specific reference to coordination, administration and management arrangement. The evaluation found that various institutional arrangements have been put in place, both on national and provincial level, in DSD, SAPS and DOJ&CD for older persons. Alongside this, the existence of units for vulnerable groups in other departments is a positive development. The most common challenge in units is limited capacity for extensive implementation. Another challenge is that officials are often responsible for various vulnerable groups (not only in DSD) becoming overwhelmed by a range of requests and obligations from units at national level. While the multi-functional nature of the provincial officers' jobs is often lamented, it could promote integrated thinking regarding multiple

vulnerabilities, but better coordination is required between separate units at national level.

The establishment of the SAOPF is an important development, and this forum plays a significant role in the sector. An area of concern, however, is whether the numerous presentations made to various bodies, including parliamentary committees results in issues and recommendations that are addressed and implemented.

There is wide support for DSD to play a strong coordinating role and create awareness of responsibilities for older persons issues. The development of a multi-levelled ToC can improve coordination so that the national DSD can play a stronger strategic and forward-looking role.
On national level, some coordination does take place, but there is no clear evidence of a strong, well-functioning coordination structure, and it may be necessary to have a national dialogue on Older Persons, in order to activate such a structure. Perceptions regarding coordination vary, depending on the department and existing relationships with DSD.

The conceptualization and development of a multi-level ToC addresses this issue, and maps out a multi-sectoral, multi-stakeholder approach that is both effective and sustainable.

The implementation of the Active Ageing Programme is an example of inter-departmental coordination and how departments can work together within their respective mandates. It is noted with concern, however, that some key departments are no longer funding this initiative, which is well-established and also linked to a larger programme that includes the Older Persons Parliament and cultural activities. In the past inter-generational programmes have also been successfully incorporated into this initiative.

Some coordination takes place in terms of monitoring and reporting, in the form of monthly, quarterly and annual reports. However, an integrated data collection and monitoring system is absent, and data collection mostly takes place manually.

Where coordination does take place, it is experienced positively, and is recognised as an efficient and effective strategy for service delivery in a resource-constrained environment.

5.3 Resource provisioning for implementation of the Act

Assessment of resource provisioning for the implementation of the Act included budget allocations since April 2010 to March 2016. Evidence from the evaluation indicated that dedicated DSD budget allocations have been assured, although significant increases in proportion to the departmental budget were not evident. In real terms, less funding may be available for older persons' programmes, due to competing priorities and the current economic climate. National Treasury ensures forward planning for social grants, based on population estimates. Due to the Department of Health's mainstreaming policy it is not possible to discern how much, if any, funding is spent specifically on older persons programmes and issues.

5.3.1 Available budget

5.3.1.1 National

An analysis of annual reports indicates that national DSD budget allocations for older persons increased annually both in the total allocation amount and as a proportion of the DSD national budget. A substantial proportion of the national annual budget for older persons was allocated to the old age grant.

However, the annual percentage increase as a percentage of the overall DSD budget did not exceed more than 1% per year, a percentage increase that was significantly lower than an average annual inflation rate of 5.5% over the period 2010-2016 as Figure 9 below illustrates.

Annual increases expressed as a proportion of departmental budget fluctuated between 2010 and 2016, with the largest increases occurring between 2013 and 2015. In 2016, the percentage increase in national DSD's older persons' budget allocation declined compared to the percentage increase in 2014 and 2015. This may be indicative of future declines in budget allocations for older persons, if the current economic challenges persist.

An analysis of the proportion of national DSD budget allocation to older persons' shows that older persons account for over a third of the national Department's budget in the period under analysis as illustrated in Figure 10 below. It should be noted that the proportion of DSD budget allocation to older persons increased from 34, 5% in 2010 to 38, 4% in 2016. This budget is significant given the Department's other priority areas of work and groups such as children and youth.

National Treasury ensures forward planning for social grants, based on population estimates. With regards to older persons the Department of Health has implemented a mainstreaming policy. It is difficult to identify how much, if any funding is spent specifically on older persons programmes and issues.

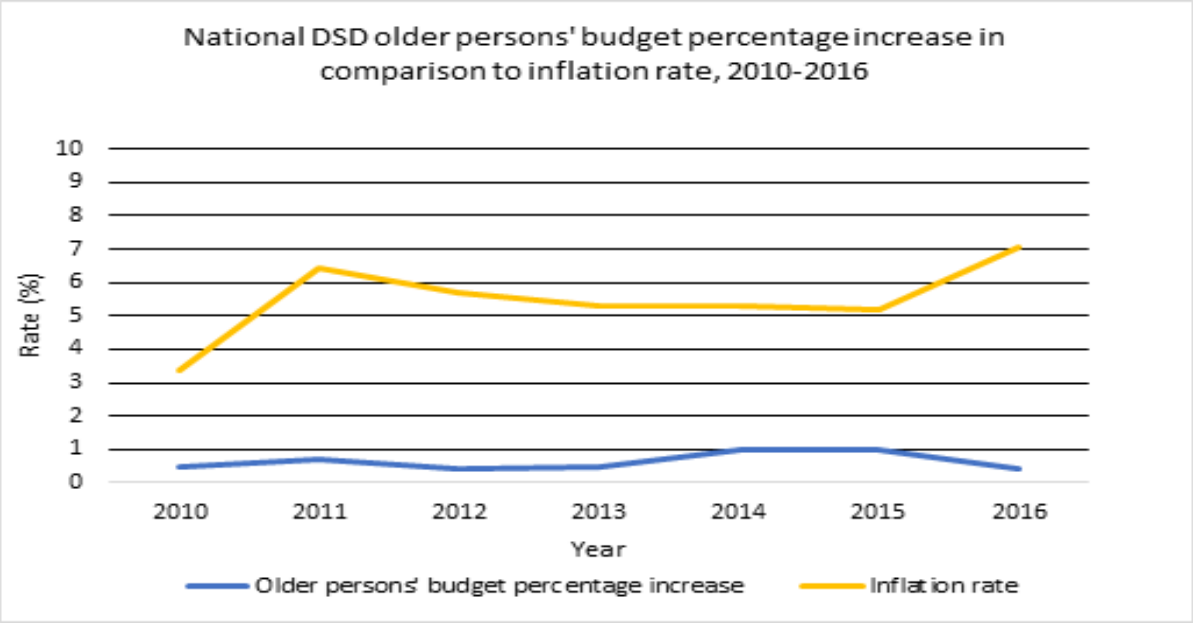

Figure 11: Comparison of budget allocation increases and inflation rate from 2010 to 2016

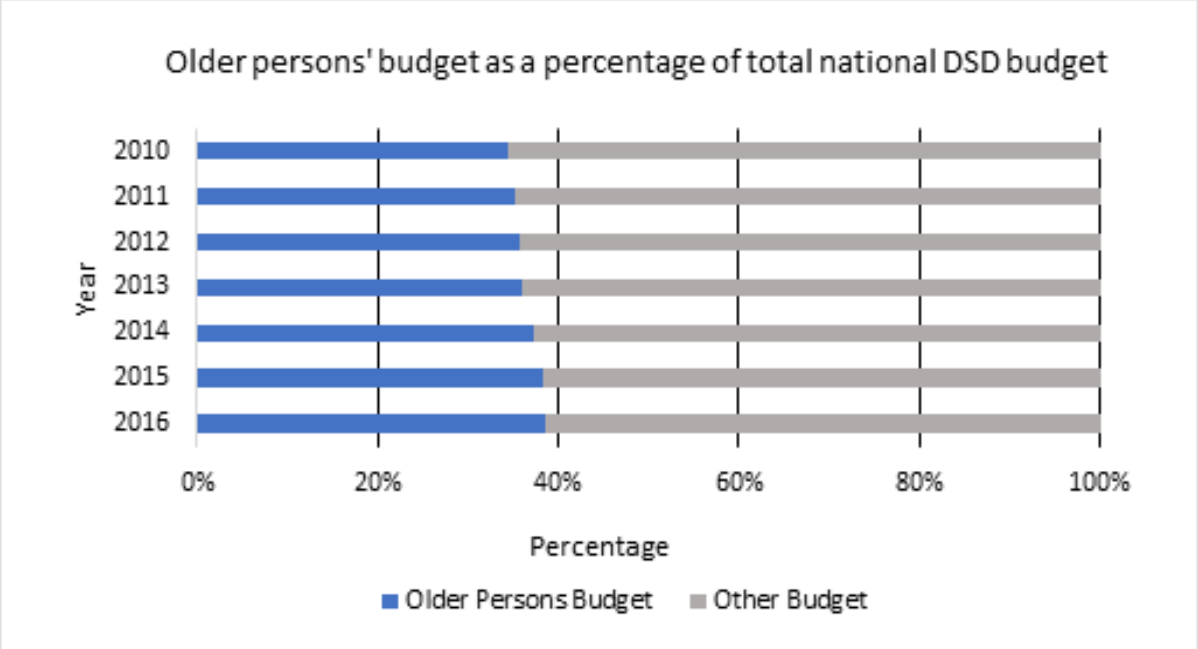

Figure 12: Older person's budget as a percentage of National DSD budget 2010 to 2016

5.3.1.2 Provincial

Provincial departments' budget allocation as a percentage of the total provincial DSD budget for the older persons programme frequently fluctuated in the period under analysis as illustrated in Figure 11 below. However, some emerging trends are notable in budget allocations to older persons programmes at provincial level. Most notably, the North West Department of Social Development showed continuous increases in the proportion of budget allocation for the older persons programme.

However, most provincial departments showed increases in the proportion of budget allocations to older persons between 2015 and 2016. Large fluctuations are seen in Gauteng and Western Cape Departments. In the case of Gauteng, this may be a result of annual reports reporting on both the Department of Health and the Department of Social Development.

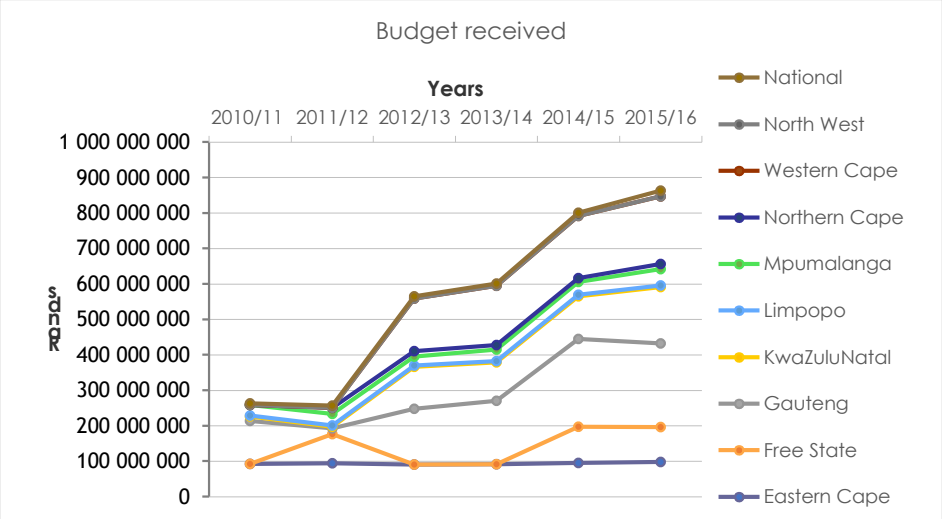

Figure 13: Actual budget received: National and Provincial DSD 2010 to 2016

5.3.1.3 Department of Health

The Department of Health (DoH) does not budget specifically and/or separately for older persons, and instead follow a mainstreaming process, which promotes the incorporation of services for older persons in the DOH service offerings. In addition to the services provided at Residential Facilities, older persons in the community are reached through clinics, government hospitals and the DOH's ward outreach programme.

5.3.1.4 Human Resources

Resources in the form of human capacity are available, and training has taken place in various departments, notably DSD national and provincial as well as SAPS and DOJ&CD. The development and piloting and training on accredited curriculum for caregivers by DSD is also a positive development. It is however clear that resources available for capacity building do not correspond to the extent of the need for capacity building related to care and protection of older persons.

5.4 Capacity for the implementation of the Act

The capacity of government and other stakeholders to implement the Act varies. In most cases the will exists to implement the Act, but resources allocated to

implementation are not sufficient to build the capacity that is required. The question should be considered in light of the de-institutionalisation policy. A critical aspect of enabling caregivers to provide professional and compassionate services to older persons is that there should be adequate support mechanisms and structures in place for them. Although there are some initiatives in place, this aspect is relatively under-developed, and not widely recognised.

The main concern with the capacity gaps is that contravention of human rights and provisioning of inadequate services at facility level is easily detectable. These issues are much harder to pick up when services are rendered in communities and by families. In light of the prevailing negative societal attitudes against older persons with impairments, coupled with apparent lack of elder-friendly law enforcement, there should be serious concern about capacity to fully implement the de-institutionalisation policy in a way that honours and protects the rights of older persons. Enhanced monitoring and compliance regulation should be a much stronger component in the context of de-institutionalisation, and at present a focus on developing this aspect as a priority is not evident.

5.5 Successes and best practices in implementing the Act

Progress has been made with the implementation of the Act, and various successes have been recorded. The fact that the Act exists and makes provision for the protection of the rights of older persons, can be regarded as an achievement in itself. The significance of the existence of the Act is that it provides a basis for the improvement of the situation of older persons across the board. Similarly, the availability of clear Norms and Standards is an achievement in that it lays the foundation for minimum standards of care which promotes equality of care. The Act has also stimulated the development and implementation of policies and procedures for the protection of older persons, specifically to prevent and report abuse against older persons.

The successes and best practices that emerged in the implementation for the Act include:

- The issuance and implementation of norms and standards for both residential facilities and community-based service centres;
- The development of the Protocol on the Prevention of Elder Abuse;
- Development of provincial strategies addressing specific issues related to older persons in provinces:
    - **Eastern Cape** DSD's Draft Strategy on the Response to Killings of Older Persons and Children as well as a policy developed with the Office on Rights of the Child and Older Persons Directorate, to strengthen planning, coordination and M&E services rendered to beneficiaries;
    - **Northern Cape** DSD's 'Provincial Strategy for Transformation' of homes and services to older persons, which makes provision for the restructuring of services to older persons and the strengthening of community-based services. Since 2015, the Department also reported the establishment of specialized services to older persons suffering from Alzheimer's or Dementia. These

services involved the establishment of a database, also with training, support groups and referrals.

  - **North West's** Department reported on the development on a Programme of Action on the Rights of Older Persons. In more recent years, the department reported undertaking a special programme focusing on older persons and coordination of governance systems. This special programme convened an Older Persons' Rights Machinery Summit.

- Improvement of community-based services for older persons, as well as improved access to, and quality of services;
- Slightly higher budget allocations for older persons since 2010 (albeit still not totally sufficient);
- Initiatives to promote the safety of older persons through the implementation of the Abuse Register; Protocol for the management of Abuse; and the SAPS National Instruction regarding older persons, as well as the work of the Victim Empowerment Programme (VEP);
- Improvement of human resources for providing professional services to older persons, through providing bursaries to social work practitioners and absorption of graduates into DSD; implementation of a retention strategy for social workers in DSD; and developing skills in the NGO Sector;
- Improved wellbeing of older persons, and enhanced social inclusion; and
- Institutional arrangements put in place to enable and support the implementation of the act.

It has been observed that limited sharing of successes and learning takes place within and between stakeholder groups and strengthening this element could form an important aspect of capacity building in future. Improved sharing of knowledge and learning could be a meaningful component of the coordination role of DSD. Other successes are listed in **Error! Reference source not found.** below.

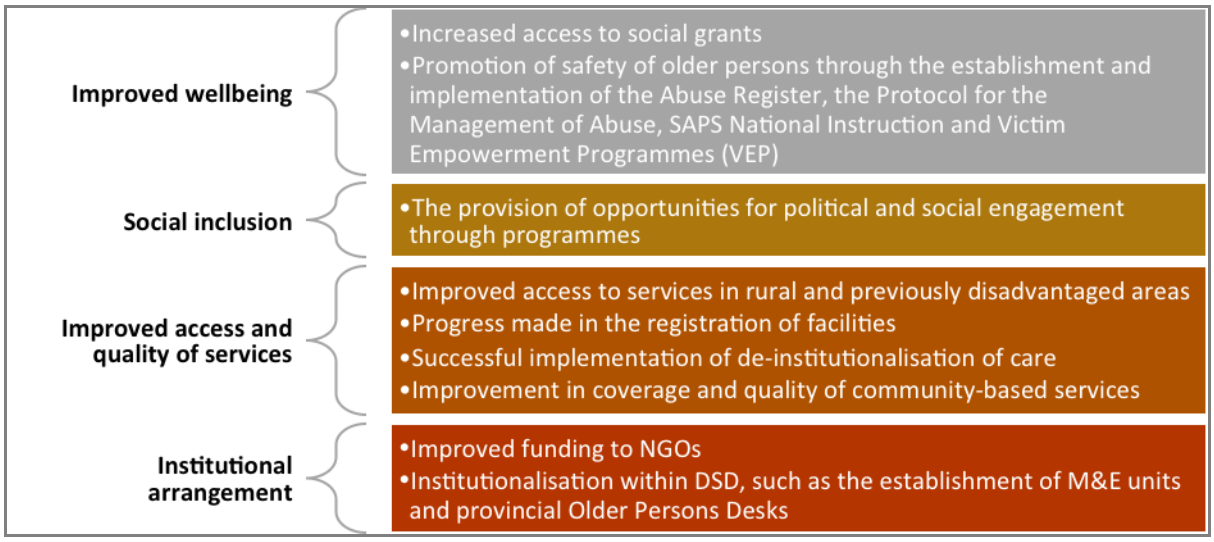

Figure 14: Successes in the implementation of the Act

5.6. Lessons Learnt from implementing the Act

The most important learning point that emerged is that **a massive effort will be required to fully implement the Act in its entirety across the country**. The inequalities created by the previous political dispensation coupled with the demographic impact of HIV/AIDs, high unemployment and endemic poverty poses a daunting challenge.

Most of the responses to the needs of older persons seem to be aimed at dealing with the current situation. This is important, and as pointed out above, the challenge is immense. **It is, however important that planners (in government, the private and NGO sector) adjust their planning to future demographic scenarios,** in order to be prepared for a situation where one in five persons will be over the age of 60.

The projected impacts of climate change on older persons is a specific aspect that needs urgent attention, as some impacts are already experienced. It is common knowledge that predictions of the impact of climate change has under-estimated or overseen some impacts, and consideration should be given to the fact that older persons are more vulnerable to the impacts of climate change. The learning point here is that **climate change is also the business of DSD, and specifically the Unit for the Care and Protection of older persons**.

DSD is tasked to monitor the implementation of the Act, which includes assessing compliance to norms and standards. Many social workers are of the opinion that this falls outside of their area of expertise, and **it may be necessary to consider a distinction between compliance monitoring and monitoring and evaluation of programme implementation.**

The funding environment is becoming increasingly constrained, and this trend is likely to continue. **While lobbying for more funding is important, it is equally important that innovative solutions will have to be found to ensure the wellbeing of older persons in future**. The need for innovative solutions creates huge potential for linking up with programmes driving big fast results, particularly in the area of science and technology. These types of programmes are frequently associated with younger beneficiaries, but when the growing older population is factored in, potential exists to find win-win solutions that incorporate improvement of the situation of older persons.

There have been many successes in the implementation of the Child Justice Act. As such, **key stakeholders can potentially learn from the implementation of the Child Justice Act.**

In light of the **enormous backlogs in services in more remote areas, the potential for employment creation and technological innovation could be explored**. It is clear that the full implications of implementing the de-centralization policy has not been considered, and it is essential to ensure that this is done. The learning here is that if such an analysis can be done from a possibility perspective which considers local assets that can be used in service of implementing the policy, it may be possible to find context-sensitive solutions to leapfrog service delivery in areas where it is needed most.

In the communication of successes, and information sharing across provinces, different professionals involved in the delivery of services **could have the potential to make the task easier** and give hope to those who are doing their best in difficult circumstances.

Considering older persons as one homogenous category is a grave error, and **much more should be done to understand this group better**. The age range is vast – almost like "youth", which stretches from birth to 35 years of age. However, services for "youth" should be tailored to the specific development phase, i.e. early childhood, pre-teen, teenage, and young adult phases. Similarly, **the "older persons" life stage should be unpacked into development phases that make practical sense**, to ensure that service offerings can be tailored to the specific developmental phase of persons over 60 years.

Finally, while the Act applies universally to the entire country**, the complex diversity of South Africa creates a situation where the ideal implementation of the Act may look very differently from place to place.** This creates interesting challenges, not only for implementation, but also for monitoring and evaluation.

5.7. Responsiveness of the Act to gender, disability and geographical diversity

The evaluation findings indicated various gender-related issues including older persons' vulnerability, particularly older women are more vulnerable because of multiple factors, such as poverty, geographical location, social inequality, disability and HIV. Older women's vulnerability is substantially increased when they suffer from age related mental conditions such as Dementia and Alzheimer's and coupled with low levels of understanding of the ageing process and related behaviours, older women are at risk of being accused of witchcraft in some areas. There are indications that needs of older men and women may need to be addressed more diversely, and generally services provided do not take this into account sufficiently.

Some understanding of disability of older persons did exist, but understanding of progressive age-related disability, particularly mental impairment was generally not well understood. With a growing ageing population - which means growing numbers of persons with some form of impairment - it is essential for government, business and the non-government sectors to become more aware of age-related disability, and to adapt service offerings and products to this group. Given that a sizeable proportion of older persons are dependent on grants, improved access to low-cost assistive devices and medicines was a major challenge. De-stigmatisation of

disability and specifically mental disability is an aspect that requires intensive attention.

Historical inequalities prevail, and as a result severe service delivery backlogs pertaining to older persons are evident in rural areas. These backlogs exist not only in relation to the human capacity aspect of providing services, but also to infrastructure available. The level of general municipal infrastructure determines older persons' access to basic services in any community, and where a community has limited access to running water, sanitation and electricity it also means that older persons have limited access to these services.
Challenges provided by lack of access to basic services are more pronounced for those living with illness and disability, and therefore insufficient basic services impact older persons more severely than the general population.
Additionally, funded facilities received very little assistance with infrastructure repair and maintenance. In addition to repair and maintenance of existing facilities there is a dire need for establishing suitable and accessible spaces for older persons to gather. The upgrading of several SASSA pay-points is a positive development, but in many cases older persons have to access services where insufficient infrastructure is available.

5.8. M & E system for implementation of the Act

The existing M&E system provides the bare minimum required for accountability in terms of annual reporting. The implementation of a multi-level ToC which reflect inter-governmental relationships, will form the basis for more focused M&E. The current M&E system can be further strengthened through the introduction of shorter feedback loops, and by creating feedback loops between different components of the system.

Reporting should be aligned to indicators in the Logic Model, and the development of a dashboard for key indicators would be useful. Coupled with this, simple electronic data collection and capturing systems should be implemented to ensure that M&E is resource-efficient, at the same time making monitoring data more accessible.

Disaggregated statistics (gender, age, geographical location) is important in creating a knowledge base about older persons in general and monitoring of services for older persons. It was also noted that the "complete and final" list of DSD funded facilities provided by DSD was not updated, and it appeared that the fidelity of the list was very low. This is concerning, since up to date, and accurate database forms the basis for monitoring.

5.9. Did the underlying assumptions hold?

The TOC workshop was held and the underlying assumption were developed and tested through the evaluation process.

The underlying assumptions as articulated by workshop participants and supplemented by the CC&DW team, were:

- There is a basic level of awareness about the Act;
- Policies provide role clarity for different stakeholders;

- Costing of the Act will result in increased budget;
- Sufficient resources were available to provide the services as planned;
- Social Workers providing services to older persons were registered in line with the Act;
- Residential facilities employed suitably qualified and trained staff; and
- NGOs were available and willing to provide services in line with the Act.

These assumptions, as well as the assumptions developed as part of the Design Clinic ToC, were interrogated during consultation with the client. Many of the assumptions did not hold, and others held only partially. This implies that assumptions must be re-developed, and assumptions must be more specific.

6. Recommendations

These recommendations are grouped according to ten core themes.

R1: Costing, Budget and Sustainable Funding Models

While the current Act has been costed, it is unlikely that implementation has taken place exactly according to costing. It would be critical to cost the amended Act, and all its implications. Without adequate funding, implementation of the Norms and Standards is not possible. Priorities should be determined and adequate funding should be provided to ensure complete implementation in those areas. Additionally, government departments should be encouraged to ring-fence budget for older persons programmes.

It is clear that government subsidies will not cover all needs of facilities to function optimally, and fundraising is therefore an essential skill that facility managers and NGOs must have. DSD can play an important role in developing the capacity of these stakeholders in fundraising and financial management including the development of sustainable funding models for facilities, to diversify the income streams for facilities for older persons. Additionally, the ageing and the older persons' agenda has to be put on the public agenda so that funding can be attracted. Models such as the crowd-sourcing model that is currently being implemented by one of the commercial banks to support university students, could also be relevant to older persons.

R2: Integrated Planning in All Spheres of Government

DSD has to take up its advocacy and coordination role within government with vigour and vision. Specific attention should be given to ensuring that all other government departments understand demographic projections related to older persons and the implications thereof. DSD also has a major role to play to change the discourse about resource distribution. A dedicated effort to find innovative linkages between the needs of older persons and the development agendas of departments such as Human Settlements, Economic Development, Science and Technology and Tourism needs to be made.

Integrated planning on national level is important as it filters through to provincial and local level. DSD has to ensure that at least in its own national department, there is harmonisation between units responsible for different vulnerable groups. Silo thinking about different vulnerable groups is unproductive and has to be replaced by a holistic approach to development and the needs of human beings, not only in DSD, but in key departments such as Health and StatsSA. Existing mechanisms for including older persons in planning about them should be strengthened and promoted to ensure inclusion of all older persons across the population spectrum.

R3: Research Agenda, Monitoring, Evaluation, Knowledge Generation and Sharing

In order to be able to provide better services to older persons, their needs have to be much better understood. This is particularly important in a diverse society where a "one-size-fits-all" approach does not produce the required results. Specific research projects to create knowledge about older persons is essential. In this regard collaboration and partnerships with entities such as the Programme to Support Pro-Poor Policy Development (PPPSD) should be explored. Lobbying for undertaking research on geriatrics and gerontology, and the inclusion of issues related to these fields in social science and natural science curricula at tertiary level, such as HIV/AIDS in older persons, should be a key function for DSD national.

More opportunities should be created for knowledge sharing regarding older persons and the implementation of programmes for older persons. Given resource constraints such opportunities could take various forms, including on-line discussions, blogs, webinars and on-line courses.

R4: Collaboration and Coordination for Effective and Efficient Implementation

Departments recognise DSD's mandate in terms of the Act and coordination structures and processes should be formalised and institutionalised. The functioning of the desks for older persons in OTPs should be monitored and strengthened, inter alia through exchange of knowledge on best practices. The implementation of an information management system that contains monitoring data on most important indicators is recommended.

It is essential for DSD to have a reliable system with compliance data, and in this regard an electronic database of facilities funded should be established and operationalised to ensure that real-time data is available. Analytical capacity built into such a system would identify where bottlenecks occur. Appropriate action should be taken to remove bottlenecks. Additionally, major inaccuracies in provincial facility level data were observed. It is recommended that an audit of the list of facilities provided by DSD be undertaken without delay as an urgent first measure, to ensure a complete and final list.

Collaboration between DSD and DoH for providing frail care and other caregiving services should be addressed as a matter of importance, and a memorandum of understanding (MoU) should be implemented to ensure that roles and responsibilities of both parties are clear. DSD should also engage in discussions with

DOH about the policy of excluding older persons from certain treatments at government hospitals, based on age.

The extent of collaboration and coordination between DSD and the SAHRC and the SAOPF should be strengthened.

R5: Extensive Awareness-raising on Various Levels

DSD should implement a major cost-effective information raising campaign on the rights of older persons on an ongoing basis, and for all population groups in all geographical locations. It is important that awareness raising campaigns address negative stereotyping and promote older persons as citizens who make a valuable contribution to society, even though they may need more assistance and care than others. Awareness campaigns regarding older persons should include knowledge building on the nature of ageing as a natural process, which could include mental impairment. Traditional leadership structures should be engaged to support efforts to change the discourse and perceptions around older persons. Additionally, existing inter-generational initiatives should be expanded.

R6: Promotion of professionalism and capacity development

DSD has already started to promote the social work profession through bursaries and employment of graduates. This practice, as well as internships in the social work field, particular to older persons should be strengthened. In order to develop and professionalise caregiving, particularly for older persons, DSD should fast-track the implementation of training for caregivers, and registration of caregivers. This process should also address issues related to gender-and culturally sensitive caregiving, through building a gender-balanced cadre of care-givers, able to provide services to South Africa's diverse population. DSD should give serious consideration to develop progressive career-paths for caregivers, aligned to employment creation and skills development initiatives.

R7: Prioritisation of Infrastructure Maintenance and Upgrading

Infrastructure upgrades and development of new infrastructure is a pressure point and should receive immediate attention. Consideration should be given to revamping government buildings that are not in use, particularly in rural areas, to function as community-based service centres. Long-term planning has to be done at facility level for the replacement of equipment, bearing in mind the life span of equipment.

R8: Enhancement of Older Persons' Participation in Decision-Making

A strategy for the enhancement of older person's participation in decision-making about them should be developed. As part of this, lessons learned and successes in this regard should be communicated.

R9: Improvement of the Protection of Older Persons' Rights and Safety

Valiant attempts to improve the protection of older persons' rights and safety are recognised, but intensified efforts by DSD, SAPS and DOJ&CD are required to

ensure better protection of older persons. In addition to awareness raising in SAPS and DOJ&CD, staff at community level need to be trained. It is further important to understand the attitudes towards older persons, and the basis for these attitudes, in order to implement projects aimed at changing such attitudes. In addition, implementation of the electronic abuse register has to be fast-tracked. A 24-hour toll-free line for reporting elder abuse is suggested.

R10: Creating Opportunities for the Development and Use of Older Persons' Skills

DSD should identify opportunities for partnerships and projects aimed at development of older person skills and knowledge. This could include intergenerational initiatives. Development of older persons' technological skills are equally important, as this could promote independence of older persons and their ability to access basic information and services without assistance. This is an important consideration for large-scale coverage of older persons' information and other needs. Considering cellular phone coverage in South Africa, plus the specifications of cellular phones used in these areas, there are innumerable opportunities for using technology to speed up and broaden coverage of services. Should South Africa overcome the current difficulties experienced with the digital migration process, such opportunities will multiply exponentially.

Since many older persons provide caregiving to children and grandchildren, including persons with HIV/AIDS, capacity building for older persons should also include training on caregiving, particularly for people who live with HIV/AIDS.

R11: Gender, disability and geographical location

Older persons' vulnerability, particularly older women are more vulnerable because of multiple factors, such as poverty, geographical location, social inequality, disability and HIV. Older women who suffer from mental conditions such as Dementia and Alzheimer's are at high risk. DSD should allow for services for older men and women that takes this issues into consideration.

Age-related disability, particularly mental impairment is not well understood. Government, business and the non-government sectors should adapt service offerings and products to this group, by improving access to low-cost assistive devices and medicines. Furthermore the DSD should create awareness campaigns to de-stigmatise mental disability, especially in rural areas.

Lack of access to basic services are more pronounced for those living with illness and disability, and older persons. Existing institutions should be repaired and maintained to ensure suitable and accessible spaces for older persons to gather, especially where insufficient infrastructure is available.

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