Family care for older persons in South Africa: heterogeneity of the carer’s experience

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The article highlights the heterogeneity of employed women’s experience of family care for older persons by focusing on multigenerational households. First, I argue that care for older persons must be understood in the context of multiple family responsibilities. Second, I show that care for older persons occurs in a context of inequalities that remain in post-colonial settings where there is highly uneven access to material resources, high levels of unemployment, poverty and limited social welfare provision. From this understanding of care, I argue that women’s position within wider care relations reveals elements of differentiation between women who occupy different class and racial positions.

Key words older persons • family care • carer • Global South

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Introduction

In South Africa, increasing longevity, together with an increase in non-communicable diseases, increases on aggregate the care needs of older persons, which will be provided predominantly by families (Aboderin, 2006; Harling et al, 2020). Despite this, many aspects of family care for older persons are not documented, analysed or theorised. Researchers have almost exclusively focused on older persons as carers, using their Older Persons Grant (OPG) (explained later) and unpaid labour to care for kin (Ogunmefun and Schatz, 2009; Button and Ncpai, 2019). While, more recently, research has begun to consider the care needs of an ageing population (Nyirenda et al, 2015; Schatz and Seeley, 2015), research on the care of older persons in South Africa has typically focused on experiences and perceptions of care in formal settings (Roos and Du Toit, 2014; Kelly et al, 2019; Makiwane et al, 2020).

While South Africa has a social grant system that provides people over the age of 60 with a relatively large and consistent source of income (Seekings and Moore, 2014), eldercare is not provided and is only partially subsidised by the South African government (Aboderin, 2006; Hoffman, 2016). There are 417 residential facilities registered with the Department of Social Development (DSD) (and many unregistered private facilities), nine of which are managed by the government, and 1,713 registered community-based care and support services for older people focused
on providing home-based care or community activities. Services can be patchy and non-governmental organisations (NGOs) are often poorly funded (DSD, 2021). For individuals with greater financial means, paid caregivers in the home (as paid care workers in the home or domestic workers) can provide support, but market-based care options are unaffordable for many. Furthermore, in South Africa, in a context of high levels of unemployment and poverty, older people take on high levels of care for children (Hatch and Posel, 2018; Moore, 2020) and for adults with HIV and related disability (Urdang, 2006; Gouws and van Zyl, 2015). This means that in taking care of an older person, a family carer may also have to take responsibility for relatives who the older person is no longer able to support.

Older people often look to younger relatives and household members for assistance (Hoffman, 2016), but we know very little about how families manage these care needs. Decisions, and families’ capacities, to care for an older person are shaped by many factors, including demographic change, migration and the impact of HIV in limiting the capacity of the middle generation to provide care to older persons (Schatz and Seeley, 2015; Schatz et al, 2015). The research that exists indicates variation in support for institutional eldercare (Russell, 2003; Ramaboa and Fredericks, 2019). In their study, Russell (2003) reported that 86 per cent of rural black South African participants, 60 per cent of urban black South African participants and 49 per cent of urban white South African participants disagreed with the idea of sending an older relative to an institution to be cared for. However, Ramaboa and Fredericks (2019) showed that among their Muslim sample, there was also support for paid care workers in the home, and in Hoffman’s (2016) study, younger adults were more open to placement in aged-care homes as a way of balancing employment with care responsibilities. Research on care at home has mostly examined care for people living at home with dementia (Pretorius et al, 2009; Gurayah, 2015; Ramaboa and Fredericks, 2019; Smith et al, 2020; 2022) and Alzheimer’s disease (Hendricks-Lalla and Pretorius, 2020; Mahomed and Pretorius, 2021), and shows that family care is not only associated with increased support needs (Smith et al, 2020), but also linked to a negative impact on quality of life (Hendricks-Lalla and Pretorius, 2020) and family relations (Gurayah, 2015; Smith et al, 2020).

We know very little about cultural variation in the care of older people in South Africa, nor do we have any understanding of how family members negotiate and divide responsibility to care for older persons. There is scant research and poor understanding of such factors as the quality of personal relationships, employment commitments and conflicting responsibilities, including other care. Understanding the role of family composition and dynamics on the need for, and delivery of, care is a key challenge for ageing research in sub-Saharan Africa (Aboderin and Hoffman, 2015).

In this article, we seek to better understand these issues through the experiences of employed women who care for a co-resident older person. Unlike other countries in the region and in the Global South, care for older persons in South Africa is also shaped by low rates of marriage and high rates of women-led or female-dominated households (Posel and Hall, 2021). By focusing on employed women who are carers of co-resident older persons, the care challenges they experience in balancing multiple care responsibilities with employment can be drawn out, expanding our understanding of the crisis of social reproduction, as well as of the economic consequences of eldercare for gender equality. While recognising that women who are not employed are more likely than employed women to be physical care providers to older people
(and children), the women in this study, despite being employed, self-identified as the primary carer. In this case, the primary caregiver was understood to be responsible for the care of older persons, which included both financial and physical support.

The article first outlines the unequal context in caring for older persons in South Africa. It then highlights key changes in women’s working and family lives relating to employment and care for dependants. Thereafter, the diversity of experiences of caring for a co-resident older person in the low- to middle-income and middle- to upper-income households in the study is presented. In doing so, the article outlines the caring obligations that shape racialised and classed patterns of care in families in South Africa.

Social circumstances of older persons in South Africa

South Africa has approximately 5.4 million people over the age of 60 (Statistics South Africa, 2020), approximately 9 per cent of the population. It is estimated this will grow to 17.5 per cent by 2050 due to decreasing fertility rates and increasing longevity (United Nations, 2015: 30). In 2015, almost two thirds of black and coloured1 older persons lived in multigenerational households, with about two fifths of black and over one third of coloured older persons living in households of three or more generations. The number of ‘skip generation’ households (where grandchildren are living with one or more grandparents in the absence of any biological parents) represents a very small minority of households in South Africa (Hall and Mokomane, 2018: 35).

There is state financial support for older persons in South Africa and the OPG is the main source of income for most older persons, especially those living in rural areas and in women-headed households (Statistics South Africa, 2017b: 55). Eligibility for the grant is means tested; in 2022, it was worth R1,980, over four times the value of a Child Support Grant and well beyond the upper poverty line (which was set at R1,417). Approximately 3.7 million older persons over the age of 60 receive the grant, and approximately two in three OPGs are paid to women (Moore and Seekings, 2019: 6). Research has indicated that OPG beneficiaries in South Africa often use their grants to support entire households (Sagner and Mtati, 1999; Kimuna and Makiwane, 2007). Despite the OPG, three quarters of older persons lived below the lower-bound poverty line in 2011 (Statistics South Africa, 2017b: 55).

The increase of non-communicable diseases is a notable concern (Mayosi et al, 2009). Just under half (45.3 per cent) of people over 60 have high blood pressure, 16 per cent have diabetes and 14 per cent have arthritis (Statistics South Africa, 2017a: 72). Only 22 per cent of older people have medical insurance, varying from 6 per cent of black South Africans to 74 per cent of white people (Statistics South Africa, 2017a: 68). Although social protection and social grants specifically assist with care, uneven access to healthcare for an increasing ageing population is a critical aspect of understanding the care context in South Africa.

Old-age pensions were a major part of welfare provision for white older persons under apartheid (Sagner, 2000; Seekings, 2020). However, the post-apartheid state radically cut care provision for white older persons, shifting responsibility for care on to family, community and home-based carers. The 2000 Policy on Ageing and the Older Persons Act 2006 state that formal institutional care was intended for very ‘frail and dependent’ elderly persons needing full-time care. The state, through non-profit organisations and the DSD, supports only a limited range of public care provision,
through limited financial support to NGOs and residential care for older men and women (Vetten, 2019). Growing concern about financial viability, especially since the COVID-19 pandemic, has left publicly subsidised facilities on the brink of collapse (Stent, 2020; Vetten and Grobbelaar, 2020). This rollback of publicly provided care contrasts with the post-apartheid expansion of financial assistance, explaining much of why the state remains dependent on families for the delivery of care for older people (Seekings and Moore, 2014).

**Multiple care responsibilities in unequal care contexts**

In the Global South, family carers provide care in contexts of inadequate welfare provision and high levels of poverty, inequality and unemployment. Given the absence of adequate institutional care, a family member assumes primary responsibility for the care of an older person, which often occurs alongside physical and financial care of children (Hatch and Posel, 2018; Moore, 2020), as well as care for family members who are disabled or have HIV-related illnesses (Urdang, 2006; Gouws and van Zyl, 2015). Time-use surveys in South Africa continue to show that women spend more time in caring activities than men (Statistics South Africa, 2013), but less is known about the existence and extent of the gendered nature of care for older persons in South Africa.

Older persons themselves are key caregivers to children and other family members (Schatz and Ogunmefun, 2007; Hoffman, 2016). Chazan (2008) highlighted the huge gaps in both social (absence of adequate childcare provision and of care for those living with a disability and/or HIV-related illness) and economic policies (absence of state support for unemployed working-age adults), and showed that older women were filling or ‘cushioning’ the gaps. This concern was also noted during the COVID-19 pandemic (Cantillon et al, 2021). If an older person becomes ill, caregiving for them may be coupled with taking on the care responsibilities that the older person once carried.

Households and women in South Africa have to make decisions about how to manage both care work and paid work, considering the resources available (among family members inside and outside the household, and in different parts of the country) and the care support required. South African households have been characterised as ‘porous’ and ‘fluid’, in the sense that household composition and individuals’ membership of household units often change over time (Spiegel et al, 1996), as members of connected households move from place to place and families choose who can best provide care, based on adult employment options, labour migration and limited childcare, eldercare and other opportunities. In some cases, moving an older person to an urban area assists families in caregiving or in obtaining better access to healthcare, but some older people resist such moves (Ferreria and van Dongen, 2004).

Posel and Hall (2021: 806–7) show how household formation has become more gendered in recent years, reporting that:

in 1995, approximately a quarter (26 percent) of households included resident adults of one gender only (16 percent of households were female-dominated, while 11 percent were male-dominated). By 2018, almost half (46 percent) of all households had resident adults of only one gender (25 percent were female-dominated, and 21 percent were male-dominated). Female-dominated
households are far larger, and they are much more likely to include children (under 18 years) and adults of pensionable age (over 59 years).

While the older person may be a care provider, if they require care themselves, care responsibilities in the household can become extensive.

While the presence of an older person may add to existing care responsibilities, their OPG can provide financial security in the household (Schatz and Seeley, 2015). Despite the high levels of unpaid care work, more women are also engaging in paid work in South Africa, where black South African women are responsible for much of the increase in labour force participation (Mosomi, 2019). Most new jobs recorded for women (2.8 million) were in waged employment, with only 600,000 in self-employment, mostly (500,000) in the informal sector or unregistered businesses (Mosomi, 2019). Familial dependants have become reliant on women’s work, both paid and unpaid, particularly in women-headed households. Rogan and Reynolds (2019) showed that in 2012, just over a fifth of all employed South Africans spread their earnings and other income sources so thinly across their households that the income could not meet the minimum of the most basic needs of all household members. Thus, despite women’s increased participation in the labour force (Casale et al, 2021), the division of performing and financing care remains highly gendered (Hatch and Posel, 2018). Cumulative care needs, both practical and financial, are extensive, while the benefits that an income and/or OPG bring are limited by the number of dependants it supports.

Feminist scholars have pointed to a growing crisis of care (Fraser, 2017) as a global phenomenon, and for some time, scholars have seen women as the ‘shock absorbers’ of the crisis (Elson, 2002, quoted in Razavi, 2011). Razavi (2011: 874) reminds us that even if the care crisis is global, ‘it is far from homogeneous’. The state’s familialist policies have pushed care further into the private family space, deepening inequalities across and within households. Examining women’s positioning within family relations in financing and undertaking care needs to differentiate between women who occupy different class positions. The crisis of care is due not only to the unequal contexts in which care occurs and the racialised and classed inequalities in accessing good care, but also to gendered inequality within families about who cares and the tensions that this creates among (mostly) adult siblings. The crisis of care in such contexts includes strained family relations when the burden of care falls to employed adult daughters or sisters who combine paid and unpaid care in the absence of state support.

Methods

The study reported here is part of a larger project on intergenerational relationships and support in South Africa. Earlier work examined how social grants shape intergenerational relationships (Moore and Seekings, 2019), but understanding of how resources are negotiated and shared in households where there are other resources, particularly income from stable employment, is limited. In the study, we sought to recruit households where at least one person had full-time ‘secure’ employment (in nursing, teaching, the police force and so on). The inclusion of an earner in multigenerational households was used to explore how both material and non-material care is shared within and across households. In this article, the focus is on employed
women’s co-residential experience of care for an older person in 50 households in two sites: Cape Town and Johannesburg. The research was carried out in 2018 and 2019, and ethical approval was obtained from the University of Cape Town.

Sampling requirements were that the household was multigenerational and that the carer was living in the same household as the older person (‘a co-resident caregiver’) and in paid employment. Informed consent was obtained from participants at multiple stages of the research. Participants were recruited through formal networks, including health clinics located in middle-class and low- to middle-class suburbs, and from a range of other clubs, such as running and soccer clubs. This strategy was supplemented by snowball sampling (introductions by participants to their colleagues, friends and neighbours) and looked specifically at the provision of care to older people as experienced by employed women.

Interviews were conducted primarily with the middle generation. When speaking about care of the older persons, participants identified themselves as the primary caregiver, understood in terms of the responsibility to provide care themselves or with the support of others. The study sought to explore a range of experiences among women with different incomes and occupations. A total of 20 participants lived in Cape Town and 30 in Johannesburg; 35 identified as black, eight as white and seven as coloured. More of the black participants co-resided with their elderly parents.

Participants were aged 35 to 60 years old. All but two of the Cape Town participants, but only two of the Johannesburg participants, were married. All the older persons being cared for in Johannesburg, but only five in Cape Town, received OPG. The Cape Town sample comprised fewer low-income participants. All women caregivers were employed full-time, except two participants who had stopped paid work to care for the older person. The participants in Johannesburg were mainly employed in nursing, teaching and the police force, while those in Cape Town included teachers, nurses, accountants, architects, physiotherapists and graphic designers.

The author, supported by an experienced researcher in Johannesburg, conducted all interviews, in almost all cases in English and in participants’ homes. All interviewees were visited at least twice (often three times), partly to follow up on certain issues, but also to develop family maps and monthly budgets. A family map was drawn for each participant, showing the names, ages, occupations and residence of each family member named by the participant, and the relationship between the participant and each family member was discussed. In total, 115 interviews were undertaken with the 50 participants. Interviewing was semi-structured and used open-ended questions about their understanding, interpretations and experiences of intergenerational relationships of care. The interviews provided the flexibility needed to explore unanticipated topics that are important to the participants.

The older persons who were being cared for had multiple non-communicable diseases, including cancer, stroke, diabetes (involving leg amputations), hypertension, severe arthritis and severe mental health concerns. The older persons were not interviewed; most had physical disabilities and many could not leave their homes unaided. The care and support required mostly related to washing, cleaning, feeding, dressing, assisting with travel to clinics, cooking healthy meals and ensuring medication was taken. All identifiers were removed from the data. In the findings that follow, pseudonyms are used.

The interviews were electronically recorded and transcribed for analysis. The analysis examined the experience of care at the individual and household levels;
comparative analysis was also undertaken to compare experiences across the sample. The findings are presented in two interrelated parts, with the aim of understanding the different aspects of the caregiving experience in context. The first part looks at how, in taking responsibility for caring for an older person, the caregiver may also have to take responsibility for other relatives who the older person is no longer able to support. The second part reveals the ways in which access to material resources shapes the experience and pressures involved in providing this care.

Findings

Taking on the care of older persons and the responsibilities of the older person

In becoming a co-residential carer for an older person, women in lower-income households explained that this care was accompanied by taking responsibility for the care of other kin who had previously been looked after by the older person. Samkelo, a 48-year-old teacher, began her interview with: “I take care of my mom, then I’ve got my brother’s child too.” The overwhelming majority of black participants (28 of 35 carers) described and explained this phenomenon. Many alluded to their care obligations as a duty, as Lindi (a teacher) noted: “I feel that it’s a lot of burden … but it’s my responsibility, so I can’t run [away].”

Zandile, a 37-year-old nurse and the primary carer for her 72-year-old mother, explained that she had moved into her mother’s house after her mother, who is diabetic, had had a stroke. Figure 1 shows her household: all members inside the line are living in this household, where Zandile now looks after her brothers’ four children who had resided with their grandmother before her stroke and need for more care. In some cases, caring for an older person coincided with caring for the dependants of relatives who had died of HIV/AIDS. Zoleka, for example, lives with her daughter (16), niece (23, living with disabilities and needing significant care) and nephew (11). She took on the care of her nephew and niece following their mother’s death. This was the context in which Zoleka (a teacher aged 49 when interviewed) became her mother’s co-resident carer for three years. This began when her mother came from the Eastern Cape to access better healthcare at a hospital in Cape Town. While residing with Zoleka, the mother had severe arthritis and was unable to walk more than a short distance.

In taking on her mother’s care, Zoleka also had to take on the care of her uncle, who has severe back pain and struggles to walk, and can no longer be supported by Zoleka’s mother. Zoleka not only cooks and cares for him, but also helps him with administrative support, such as applying for his identity document and OPG. Zoleka cooks and cleans for the household, caring for her mother (while she was living there) and the dependent children and uncle. She worries about her daughter and nephew doing well at school, and is concerned about her uncle, who will often not leave his room for days. At the time of the interview, Zoleka was trying to find full-time institutional care for her niece, as she was unable to cope with all the care demands upon her. In the family map (see Figure 2), the mother is shown outside the household, as she had passed away before Zoleka’s interview. Care for the older person in this household had needed to take account of the pre-existing care needs of other household members, as well as the care responsibilities that the older person had previously carried.
Figure 1: Zandile's family map
Figure 2: Zoleka’s family map
Lindi is a 40-year-old teacher and lives with her children (aged 17 and five years), mother (65), aunt (68) and younger sister, and her sister’s two children and two other nephews (see Figure 3). Three months before her interview, Lindi had been living with, and taking care of, her maternal grandmother, who was residing in the house. The grandmother had a stroke in 2016 and passed away in 2019. Lindi took over the responsibility for the two nephews after the grandmother became ill.

Lindi was responsible for managing the care, which involved providing care herself, typically at night and weekends: “So, on weekends, I was bathing her, and at night, I was changing her nappy and sleeping beside her.” Her care responsibilities also included finding adequate support during the day when she was at work. Lindi asked a cousin to come a few mornings a week to bathe the grandmother and paid her R600 for this work. Lindi was responsible for organising and engaging in this care, pointing out: “When I came in, she was leaving.”

The three cases just described (see Figures 1–3) illustrate extensive responsibilities for multiple dependants, sometimes extending across households or to others in linked households. The flow of intergenerational caregiving involving nieces, nephews, aunts and uncles included horizontal, vertical and ‘diagonal’ flows of care. In contrast, the care responsibilities of the women in middle-income households were limited to their own children and older parents, rarely extending to adult siblings, nieces, nephews, aunts and uncles. Moreover, the responsibility of caring for young children and older persons coincided in only three of the 15 cases; in all other instances where co-resident
Maryam Osman, a 56-year-old Muslim divorcee, took on the care of her mother, father and brother at a time when her adult child was fully employed and living elsewhere (see Figure 4). While Maryam’s family is complex, it is small and has far more resources than the cases described in Figures 1–3. Maryam invited her brother to move into the house’s garden cottage, where he was recovering from a stroke. Maryam cooked for everyone and was providing financially for the whole family.

Alice, a white married woman, worked part-time from home while caring for her mother, mother-in-law (several years previously, so not shown on her family map in Figure 5) and husband over many years. The caring needs of her mother-in-law and husband coincided, and Alice said that she had felt completely drained by the responsibility and work: ‘‘Having my mother-in-law live with us was taxing … [caring for] my mother was much easier. But my mother became much frailer and, um … then her memory went, and it’s … difficult.’’

These findings show the importance of understanding that care for an older person often occurs within a wider network of caring responsibilities. In some households, these were limited to biological children and parents. In others, care responsibility extended to nephews, nieces, adult siblings, aunts and uncles. The family maps we produced indicate the range and number of persons requiring support in each kin group, and that caring for an older person occurs in a wider set of care relations, responsibilities and dependencies.

**Co-resident caring with limited resources**

Carers in low- to middle-income households are disadvantaged not only by being more likely to be called upon to provide care for family members, but also by having fewer resources with which to ease the situation. Our findings show that in low- to middle-income households, employed women’s incomes, together with the OPG paid to older persons in their households, have to support multiple dependants, leaving employed women with very little at the end of each month. Moreover, the extensive and wider care needs of household members, in which care of the older person is embedded, also impact on their time, leaving little opportunity for rest or social activities. In most cases, additional care support was obtained by inviting a cousin to reside in the house to assist with caring for the older person(s) and rewarding them either financially or in kind.

Zandile (see Figure 1) pays for her mother’s medical insurance, funeral policies and food costs. She also pays her cousin Xoli what she can afford (R500 per month) for the work she undertakes in caring for Zandile’s mother when Zandile is at work, and covers the cost of her (adult) children’s school fees, transport and groceries. Lindi (see Figure 3) pays her cousin R600 per month for her support. All the employed female carers in our study were responsible for the financing of care in the household; even where payments were not made to cousins/kin providing additional care, participants often provided them with indirect financial support, such as covering costs for these relatives’ children or parents.

The costs of care were more difficult for participants when household members did not pool their incomes. Thus, Joy, a nurse, cared for Zedwa (69), who was living with a disability (see Figure 6). The household has two incomes (nurse and police officer salaries), two OPGs and several Child Support Grants. Joy took primary responsibility for Zedwa (who has diabetes) after finding she was not being properly cared for by
Figure 4: Maryam's family map
Figure 5: Alice’s family map
her uncle. Joy’s sister Anna cannot support her financially, as she has significant debt. Another sibling (Vuyo) collects Zedwa’s OPG on her behalf and controls how it is spent. Although Joy has requested that he contribute a portion of Zedwa’s OPG to their shared costs, he does not do this even though Joy is now responsible for caring for and cooking for Zedwa.

Despite being gainfully employed as a nurse, Joy is struggling to meet the financial needs of the household. This is due to the costs of her extensive caring responsibilities, which leave her financially and physically drained. The complexity of social relations and household dynamics is evident in this family, who live and cook together but keep their financial resources separate. The gendered aspects of taking on practical care activities and financing care are also highlighted in this case.

Carers living in low- to middle-income households also have limited or no respite from their responsibilities, as their caring duties follow their work/employment duties. The situation is exacerbated when several other household members require care in addition to an older person. Black participants in low- to middle-income households explained that daily routines and care activities started at 5 am and rarely ended before 9 pm. On top of a full day’s work at a place of employment, there was a day of care that included food purchasing, cooking, cleaning, supervising homework, managing younger children’s daily routines and transport. Participants expressed deep frustration about the uneven responsibility they carried and the inadequate support they received from adult siblings. Lindi spoke about the enduring sacrifices she makes:

‘I always sacrifice with my time… Maybe I have to go somewhere, then here at home they say something that I should attend to, so I have to leave my appointment, then attend to their situation. The challenge is that you don’t live your life, but you live their life.’

One participant reflected on the cognitive labour she engages in daily while ensuring her mother is well looked after, outlining the sacrifices she constantly makes: “I see to it that she wears a night dress; I see to it that she has toiletry all the time. I left my things, like dating, buying stuff from the mall, and I do her errands.” Phindile, another participant, explained how her work included paid and unpaid labour, and left her unable to do much else: ‘I work and my social time is gone; there’s laundry, ironing, I do not have fun…. There’s nothing I do…. Even now, I’m supposed to buy clothes for kids and I haven’t done my hair, but I’m still doing the laundry. It’s difficult, and it’s not nice.”

Carers in middle- to upper-income households are able to pay someone else to provide home-based care, reducing the constraints on their own time. Caring for an older person in a middle- to upper-income household, regardless of ethnicity, may thus occur in the context of resources that can be used to obtain respite care, thereby easing the drain on the carer’s time and physical resources. Merle, a coloured mother with four children, noted:

‘I have realised through a process of trial and error that there are things I just can’t cope with because I have four children. I cannot manage my mum’s diary as well. This drives me nuts because she is very slow, but what I have
done is that I have a lady who looks after mum as her companion. She has
got a time when she needs to get up and go for walks; she has a schedule
and the lady manages that.’

In other cases, care support was drawn in at the end of life, when care needs became
more extensive. Michelle explained that she had negotiated this with family members:
“I said, ‘We need palliative care’; I could not do it anymore. It was going to cost money
… but I had to do it, a day and night shift…. I needed agreement to say, ‘I am not
passing mom on, but I can’t do it anymore.’” Maryam, introduced in Figure 4, employs
a full-time domestic worker for all the household’s cleaning and some food-preparation
tasks; her presence allows Maryam some respite. Resonating with other research
findings (Ramaboa and Fredericks, 2019), if resources were available, participants
expressed a strong desire to use paid carers at home. In some cases, they were hired to
assist, especially when care needs were significant, or the degree of impairment meant
professional care was required. Some participants said that they requested domestic
workers (a person paid to help with cleaning) to undertake caring work:

‘My mother lives with us and we have Thembi here during the days. She is
a domestic worker. She has been with me for almost 20 years and it’s just
… she’s moved from being the kids’ nanny to being, like, being their au pair,
to now looking after my mother and helping around. So, at nine o’clock in
the morning, she goes in and just helps mom get dressed, washed and up,
and goes for a walk with her.’

Women in middle- to upper-income households could draw on sibling or spousal
support to assist with the cost of such respite care. In some cases, other (highly paid)
adult children helped with the costs of care for the older person. It was evident
that middle-class carers had more options and were paying for substantially more
substitute care.

Discussion and conclusion

The experiences of these carers provide insight into how individuals in different
circumstances experience caring for an older person. In seeking to understand such
care, it is important to recognise the impact of wider care responsibilities on individuals
and families. Further, care for an older person in South Africa occurs in highly disparate
contexts. Some households have to meet extensive care needs with limited resources, while
others have far more resources, both time and money, with which to meet care needs.

This article illustrates how three interrelated factors are affecting care for older
persons in South Africa. The first is the rapid ageing of the population (Schatz
and Seeley, 2015; Hoffman, 2016; Maharaj, 2020) in the specific context of South
Africa’s social security arrangements for older people (Seekings and Moore, 2014).
Second, the feminisation of the paid labour force (Casale et al, 2021) means that
women’s informal caring is combined with their paid work, including paid work in
the informal economy (Mokomane, 2021). Third, the crisis of social reproduction in
South Africa is heightened by the ongoing impact of HIV, COVID-19 and high levels
of unemployment and poverty (Fakier and Cock, 2009). This is exacerbated by
the need to care not only for those living with COVID-19, HIV or related illnesses, but
also for the dependants of those suffering from, or who have died as a result of, HIV/AIDS or COVID-19. When older persons are the most common providers of care for ill or orphaned relatives (Urdang, 2006; Schatz and Ogunmefun, 2007; Fakier and Cock, 2009), the care required in a household increases markedly if they themselves require care and can no longer care for family members who rely upon them.

This study shows that living in a middle- to upper-income household, with the ability to purchase some personal care at home and to insure against health risks, makes life relatively easier for employed women providing care. The South African state provides an OPG for the majority of older persons, making it an upper outlier in the region (regarding the value and reach of state pension arrangements). However, the family is central to its care regime, as extended kin depend upon the wage(s) of employed family member(s) and families provide most care. As Button et al (2018) have shown, the post-apartheid care regime remains characterised by inequality. The findings reported here show that in seeking to increase intergenerational support and care for older kin, current state policies on families disadvantage women, especially women in poorer households, who may already have experienced the gendered consequences of AIDS/HIV and COVID-19, and are disproportionately impacted by such policies.

When an older person becomes ill or can no longer act as a primary carer, gaps in formal childcare provision and the precarity of relying so heavily on informal care and extensive intergenerational interdependence are exposed. Often, taking responsibility for the care of an older person means a family member may also have to take responsibility for the other relatives that the older person can no longer support. The state has largely ignored the role older persons play in contributing to the economy and to families, however. This work is now being carried out by the next generation of women, but it continues to be ignored. The article contributes new insights into the complexities of caring for older relatives by highlighting the care responsibilities the latter have often had for grandchildren and other extended family members.

This broader context has classed and racialised consequences for co-resident caring that are reshaping patterns of care in South African families. Employed women do not experience the pressures of providing care equally, as households that are larger and have more dependants tend to be female dominated and often have fewer resources. Co-resident care is always demanding, but women in middle- to upper-income households have greater material resources that give them more options in managing time commitments and constraints. As older persons in low-income households have the greatest ill health, their families are under the most pressure in providing care yet have fewer financial resources to support that care.

Looking at women’s care responsibilities and practices in this area, the findings shed light on how marital status (of the older person and caregiver) affects the provision of care that is received and provided. The proportion of older persons married in South Africa is approximately 50 per cent (Statistics South Africa, 2017b: 17). In South Africa, there are approximately three times more widows (34.2 per cent) than widowers (11.3 per cent). The reasons are multiple, but men are more likely to die before their wives because there are higher levels of male mortality (that is, the majority of older persons are women, and female predominance tends to increase with age) and men marry younger wives (Statistics, 2017b: 17). While we know little about who cares for older men as daughters, wives, sisters or sons, older women receiving care are less likely to have a male spouse providing care. Moreover, given the very high rates of non-marriage among younger black South African women, carers are less likely to be married and therefore less likely to share care.
responsibilities, including the costs, with a spouse. The gendered and racialised structure of marriage in this regard is an important consideration when contemplating how care practices and responsibilities for working women come to be differentiated.

The 1996 White Paper on Social Welfare and the 2012 White Paper on Families in South Africa foreground neoliberal ideas of economic self-reliance, while positioning the family as the primary site of care for vulnerable individuals, including the elderly (Sevenhuijsen et al., 2003; Button et al., 2018). The findings of this study highlight people’s everyday realities and the results of the gendered, racialised and classed assumptions embedded in policy texts about who is doing the care and in what context (Sevenhuijsen et al., 2003). They also show that important policy documents have not addressed the crisis of care affecting employed black women in low- to middle-income households, who are tasked with caring in multiple unequal caring contexts. The article recognises the impact of the OPG but highlights the limitations of relying on cash transfers in line with policy aims of facilitating and supporting caregiving in families, rather than meeting needs for care directly (Sevenhuijsen et al., 2003: 203; as cited in Button et al., 2018: 605). As others have argued: ‘if we really want to subvert gender, class, and racial injustice, we need to admit that income transfers are not enough’ (Stevano et al., 2021: 283).

The study reported here increases understanding of how caring for older persons is located in multiple care contexts, making a new contribution to the literature. This insight can assist health professionals, home-based/community-based care programmes and policymakers responsible for facilitating care for older persons. The study has highlighted the role of employment and the need to understand the context in which care occurs from the perspectives of the carer and their wider family. Such understandings may assist in designing tax policies or family care policies that assist employed carers more concretely. A broader range of programmes to support carers is needed to enable greater equity between households. As the number of older persons requiring care is set to increase, we need to resist policies that put all responsibility on individual households, and specifically on female-dominated households.

The study has limitations that the author acknowledges. These include that the sample of employed female carers did not include poorer white or coloured families. More research is needed to investigate co-residential care practices across a more diverse range of carers to help shape policies that matter.

The invisibility of family care work for older persons in South Africa is a gap in the literature and in understanding of how inequalities within and across families are reproduced. The findings of this research indicate the importance of family caring for older persons and the often gendered, racialised and classed nature of this, especially in female-dominated households. It is clear that we need more evidence about the heterogeneity of the experience of caring for older persons. We need to know how men are engaged in their care in order to recognise and address inequalities within families, and we need to know more about adult sibling tensions, how decisions about care for older persons are made and what this tells us about filial responsibility in Africa’s changing political and economic contexts.

**Note**

1 Racial terminology in South Africa has a long history. The four racial categories of ‘black’, ‘coloured’, ‘Indian’ and ‘white’ are used to refer to the Statistics South Africa categories.
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Conflict of interest
The author declares that there is no conflict of interest.

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