

Health determinants on healthy ageing in sub-Saharan Africa: A psychosocial and theo-gerontology

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This article explored health determinants on successful, healthy ageing in sub-Saharan Africa, using the case of Ramotswa in Botswana. The study used contextual, descriptive and qualitative approaches. It also explored the integrative nature of determinants to healthy and successful ageing by examining the biopsychological and physiological challenges. The article made use of the pastoral theological approach in understanding the complexity of ageing and revealing solutions for mitigating the health challenges encountered by older persons. While the article was theological in its approach, it acknowledged the interconnectedness with other disciplines, such as sociology and psychology, as fundamental in dealing with this topic. The findings revealed the elderly caregivers' need for emotional support. This study maintained that emotional support could minimise the burden on elderly caregivers, because reports during the study indicated that elderly caregivers experienced a mixture of emotions such as loneliness, frustration, anger, depression, guilt, anxiety, love, acceptance and warmth, which could have negative consequences on them.

Contribution: In conclusion, the article suggested that given the complexity of the understanding of successful and healthy ageing, as well as the integrative nature of determinants of successful ageing, it is crucial for caregivers and policymakers to avoid a blanket approach in dealing with elderly persons in a context of care.

Keywords: health determinants; healthy ageing; sub-Saharan Africa; psycho-social; theological; gerontology; Botswana.

Introduction

Ageing has become a global concern. It is estimated that by the year 2050, people in the age ranges of 60 plus will be more than double (WHO 2020; UNDESA 2014), especially in low- and middle-income countries such as Botswana. In the year 2050, the number of people aged 80 plus is estimated to be 395 million, and 62% of them live in developing countries (World Bank 2020; UNDESA 2014). This means that during those times, more children would know their grandparents and great-grandparents, especially their grandmothers, because they live longer than men on average. Because of improved health systems and other factors, people in Africa are also living longer than before. Ageing is a natural process; all are bound to age, but there are factors that may lead to unhealthy ageing, such as one's unhealthy lifestyle and the environment one lives in. Smoking, drinking alcohol and an unhealthy diet are considered health risks (see Padrão et al. 2007:1–9). Noncommunicable diseases such as cancer, heart disease, high blood pressure and diabetes add to a list of health risks and determinants of healthy ageing. They are, in fact, classified as the main causes of mortality in the African region (WHO 2020).

On the other hand, research shows that poorly managed human immunodeficiency virus (HIV) infection exacerbates ageing illnesses such as cancer, heart disease, high blood pressure and diabetes, which might have been previously considered of low importance because of their low prevalence. These illnesses are now regarded as the major causes of low quality of life and death (Negin & Cumming 2010). That being the case, some service providers have not yet made plans for the elderly people who are HIV positive, because no one expected them to be sexually active. The number of elderly people living with HIV and acquired immunodeficiency syndrome (AIDS) is increasing (Negin & Cumming 2010). In many countries, HIV and AIDS preventive and control

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strategies are more focused on the younger generation, neglecting the elderly. The COVID-19 pandemic has further exposed unpreparedness by communities and governments on issues of care to elderly persons (see, Lebrasseur et al. 2021:1–17; cf, Mishra et al (2020: 143–146)).

In dealing with the issues raised regarding the topic, the article is grounded in a pastoral theological approach. While the article is written from a theological point of view, it acknowledges the interconnectedness of this topic with other disciplines, such as sociology and psychology, as fundamental in this article. The aim of bringing the above two interconnected disciplines is to help empower the research to explore internal and external factors that impact the health of the elderly in sub-Saharan Africa. This article uses Botswana as a case-study, and it adopts a theological point of view on successful healthy ageing.

Psychosocial intercultural theological gerontology

Even though epistemologically diverse, positive psychology, pastoral theology and sociology have some common ground. This article encourages collaboration between these disciplines because they have a common goal of an outcome of growth or transformation of people's lives. There is much that people from these diverse disciplines could learn from each other. Positive psychology has mainly to do with inward strength away from outward influence. Positive psychologists facilitate a shift to the bright side of what seems to be troubling people. It is a catalyst of change that directs people away from being preoccupied with the worst of thoughts and towards building positive qualities (cf, Seligman & Csikszentmihalyi (2000: 1–17)). Psychotherapists aim at instilling positive emotions in order to bring about a pleasant life in the present and in the future (Seligman 2002; Seligman & Csikszentmihalyi 2000).

According to positive psychology, authentic happiness is earned through an exercise of character. The individual's strengths and virtues have a direct bearing on their happiness. Individual strengths and virtues also inform one's outward behaviour. This means that those who have never invested in building their inner character have no base and would remain depressed and without having any meaning in life (Seligman 2002). Positive psychology is oblivious to people's socio-economic situation. It suppresses any memory that may cause pain and discomfort to a being, thus leaving a human being inactive, despite one's surroundings. No attention is given to grieving, loss or anger. Rather, thoughts are spanned positively (Fonagy 1995). Through psychotherapy, people are encouraged to be optimistic and hopeful in their lives. They are also encouraged to identify their strengths and to find ways of adapting in order to continue going about life. Psychotherapy tends to create fearless individuals because fear is regarded as a sign of weakness (Clinebell 1977).

However, pastoral theology starts with making people aware of and acknowledging their vulnerabilities. Pastoral

psychology emphasises accepting one's vulnerability and vulnerabilities in others. From the perspective of pastoral psychology, people's inner strength is authored by God. In a pluralistic setting, we can say that there is a transcendental entity behind people's strength. Therefore, we cannot relegate positive thoughts and actions to ourselves. From the perspective of existentialism, the fear of meaninglessness cannot be calmed by strength and virtues, because everything about a person is affected by that fear that we want to avoid (Fonagy 1995).

Pastoral psychologists believe that an effective response to human needs entails the psychological interpretation of the human experience (Louw 2010, Patton 1993 & Clinebell 2011). Clinical pastoral care is practised in a pluralistic setting. This means that apart from being interdisciplinary in approach, it should also adopt an interfaith perspective for it to be appropriate. According to Townsend (2004:121), pastoral care should acknowledge inclusive religious care.

In this model, human beings are seen as first and foremost God's creation. Genesis 1:26 indicates that a human being is created in the image of God (Louw 2008; cf, Hiltner 1954). This is the concept of the *imago Dei*. It affirms the amazing possibilities in human beings. Being God-like means that people have self-awareness, conscience, valuing capacity, autonomy, rationality, compassion and caring. It also means that they have the ability to communicate with the transcendental entity and are united with the divine reality (Clinebell 1977:40). This means that there is some form of value and importance that other nonhuman creatures do not possess. All human beings possess this quality, regardless of their class, age, gender and background. Therefore, pastoral care should make it possible for one to feel significant and essential.

The above theological concepts with classical paradigm focus on the sinner as one who needs guidance for salvation and purification. However, the main focus of clinical pastoral paradigm uses psychological approaches to address the person in crisis as one who needs empathy, acceptance and a companion in her or his pain (Clinebell 1977:14–17). According to Clinebell (1977:15–17), counselling is more to do with helping the whole individual, family unit, church and community to grow into wholeness instead of merely solving specific problems. By wholeness, Clinebell (2011:30) refers to holistic caregiving which attends to all dimensions of human existence, which include physical, mental, relational, social and spiritual or ethical.

Any religious guidance or care to the elderly should also be able to assess the elderly's self-awareness of social position and the development of motivation for change (Graham 1996). This knowledge could make it possible for caregivers to advocate effectively for potential services for the elderly or even enlighten the elderly to advocate for themselves. If the elderly are allowed to advocate for themselves, they will have ownership of the processes for resolving their problems (Clinebell 2011:26).

Moreover, group-based self-management programmes could provide an opportunity for self-learning and peer support. The elderly who have similar experiences could be grouped to share their experiences and encourage each other (Clinebell 2011:25–26). Religious caregivers could create such platforms and invite health professionals, social workers, policymakers and other relevant people in those gatherings to come and learn about the challenges and needs of the elderly. Pastoral care should support behaviour change and movement to a valued social position. Such a change could be brought through collaborative efforts (Patton 1993:224).

Pastoral care should take care of matters that are a source of pain. Moreover, when people are wounded by their political, social and religious struggles, pastoral care should reach out to address those dimensions (Clinebell 1984). Fear could only be calmed by the belief that we have absolute relational ground for our existence. Both psychotherapists and pastoral psychologists see a human being as being at the centre and in charge by turning to their inward resources. Pastoral psychologists help the elderly to be aware of themselves and their interpersonal connections. Both approaches value the importance of personal growth for the well-being of people and are also preventive in approach. While positive psychology predicts a satisfactory past, hopeful future and a happy present (Seligman & Csikszentmihalyi 2000), pastoral psychology argues that people's achievements in the past influence the present and the future (Clinebell 1977).

Social gerontologists would want to know what informs a certain behaviour. If it is traditional culture that informs a community's negative and harmful behaviour, social gerontologists would prefer to use the same tools in enforcing a positive behaviour (Bowling & Dieppe 2005). Psychologists would try to understand how an individual's characteristics such as personal values, religious beliefs, principles and norms may influence harmful attitudes that may impede active and successful ageing (cf, Urtamo et al 2019: 359–363).

They see a correlation between religion, personality and ageing. Both psychologists and sociologists are aimed at improving the life and welfare of the elderly for the sake of social cohesion and growth. Theological gerontology is interdisciplinary in approach. It seeks to understand the person, the context and the person's needs. This is a task which other disciplines such as Sociology and Psychology are also engaged in attempt to create wholeness on

individuals needing care. The theological pastoral approach is normally understood in the literature as an approach that deals with people's faith alone or a discipline that is mainly confessional in approach. Instead, the pastoral approach deals with people's spirituality in a holistic way. It uses a 'cure of the soul tradition' which aims at attending to the existential needs of the people thoroughly (Lartey 1997). For instance, if a person's pain and suffering is structural, theologians would get to the bottom of the problem by addressing structural pain. At the same time, the spirituality of an individual and community may be impediments to successful ageing. Pastoral theologians would start with understanding belief systems or those cultural traditions that are embedded in people's way of life through respectable, empathic communications that allow persons to uncover innate tools that may facilitate healing and growth (Clinebell 1984:26).

A psychological theory of existentialism could be used by pastoral theologians to emphasise the importance of restoring the individual's inner potentialities. However, the concept of inner potentiality is not understood in theory and practice as individualistic personhood but more in terms of rebuilding inter-relational networking and systemic interaction. From a psychosocial perspective, there is no way one could fully understand individual personality away from the context of that particular individual (Graham 1992). In other words, each and every attempt to understand human personalities should be informed by that individual's reality. This shows that the person's needs are taken into consideration in the context of care. The individuals are the leading characters in informing the nature of care that should be provided. There is indeed an indisputable connection between the three disciplines. Research findings using principles from psychology and sociology could be beneficial to pastoral counsellors. Psychology and sociology could also learn about the religious dimension of human beings from pastoral theology to enrich practice.

In summary, Table 1 provides an overview of major differences and similarities between positive psychology, psychoanalysis, pastoral theology (psychology) and sociology.

Ageing Chronological and social ageing

Ageing is understood differently by different people in different contexts. In some instances, people define ageing in terms of the number of years since someone was born.

TABLE 1: Overview of Difference and Similarities.

| Reflection | Positive psychology | Psychoanalysis | Pastoral theology | Sociology |
|------------------|---|--|--|---|
| Past | The past should be forgotten. Forgiveness emphasised. | People work through the past for the sake of the progressive present and future. | Our lives cannot be reduced to the present, future and the past. | The past is a window of experience and could inform us on designing a desirable future. |
| Wishful thinking | People should be optimistic and futuristic. | Reality should not be ignored. We must be more realistic about reality. | Hope is informed by the infinite, but it should be realised now. | Promotion of welfare, social growth and cohesion. |
| Relationality | Inward strengths and values of an individual. | Relational psychology enabling critical analysis. | Relational and justice oriented. | Relational and justice oriented. |

Different groups have constructed social character traits and dispositions for particular people of a particular age group. Belonging in a society therefore means living up to the values and norms of that particular society (cf. Idang 2015:97–111). On the other hand, those who fail to live up to the standards, principles and norms of their respective societies may face stigma and discrimination. As people pass through different phases of their life course, they are expected to behave in a certain way. Their maturity is informed and fashioned by religion, culture, values and norms in the society (Crowther et al. 2002).

This calls for a sociotheological constructionist approach that appreciates the inter-related system of mutual relationships. In my 2018–2019 doctoral study on pastoral care to the elderly caregivers of orphans affected by HIV and AIDS, I established that cultural beliefs, values and religion have effects on care-seeking and care provision behaviours of elderly women. In this context, external factors such as culture have an influence on the ageing process. Caretaking roles are culturally prescribed roles that are not only physically draining but could also cause stress and strain if an elderly caretaker is economically disadvantaged.

Cultural norms and values also inform familial roles, relations and kin obligations. These are also informed by gender, age and socio-demographic correlates. This study reveals that indigenous Setswana knowledge systems may act as both an impediment and encouragement for successful ageing. The aim is to foster better intrapersonal and interpersonal relations that are informed by cultural values and principles. Theological gerontologists should therefore appreciate Setswana indigenous traditional culture as a major component that informs care for elderly people.

Many governments and policies are not tailored to address the particular needs of the elderly because elderly people are lumped together under a category of age. Any approach that aims at facilitating successful ageing should appreciate the dynamism of networking and the integrative nature of the determinants of ageing. In the context of HIV and AIDS, the elderly find themselves under economic, physical and psychological strain. Traditional cultures' gender roles are deeply engraved in elderly people as well as the community. As a result, their enormous strain on elderly people, especially elderly women, remains overlooked and unattended.

Biological ageing

Wu et al (2021: 1) state that, "biological aging refers to the underlying aging processes at the biological level." It is regarded as a natural process that leads to a decline in physiological ability. The decline in physiological ability is connected with the decline of a cell or organism caused by ageing. With time, the physiological system fails to withstand diseases. That cannot be reversed, but it could be modified by environmental factors such as good nutrition and genetic factors. Illnesses and diseases may further act as impediments to successful ageing. The physiological system, whether in

advanced years or not, needs maintenance in terms of the availability of health care resources. There should be a balance between cellular damage and repair mechanisms. Even though ageing is a natural factor, environmental factors may influence the process of ageing (Adams & White 2004; Gibson 1998).

There are other factors that may act as an impediment towards successful, active or healthy ageing. Socio-gerontologists continue to investigate the social constructions of successful ageing, and they have come up with different views on successful, active or healthy ageing. Their constructions on successful ageing are informed by elderly people from different contexts and empirical research. Their findings may reveal potential solutions for dealing with the physiological challenges of elderly people in different contexts. In their social construction of successful ageing, Adams and White (2004) connect a favourable socio-economic environment with successful ageing. This could mean that where there is equal and careful sharing of resources, the elderly are likely to experience successful ageing. It could also mean that elderly people with strong economic resources are more likely to experience successful ageing than those who are poor.

Rowe and Kahn (1997:433) understand successful ageing as a low probability of disease, high physical and cognitive capacity and active engagement with life. They argue that people exchange information, emotional support and direct assistance through interpersonal relations. Interpersonal relations play a fundamental role in facilitating successful ageing. Other socio-gerontologists argue that successful ageing is associated with one's ability to adjust and cope with the demands of old age. These scholars argue that with the right guidance and direction, elderly people could use past experiences to cope with current life circumstances, despite diminished capabilities. They should be in a position to allow other people to help them (Bowling & Dieppe 2005:1549).

Other scholars from a sociotheological perspective have since found the connection between spirituality and health and its impact on successful ageing. Results from the above scholars, Rowe and Kahn (1997), as well as Bowling and Dieppe (2005), suggest an association. Other scholars suggest the incorporation of positive spirituality into a model of successful ageing. Interventions directed at improving the lives of elderly people should consider that people are diverse and that they have different beliefs, attitudes and practices. Furthermore, any care directed to the elderly should be centred on the individual, respecting the autonomy of a care seeker. Spiritual interventions should happen upon mutual agreement between an elderly person and a pastoral caregiver, and values of respect and sensitivity should guide any interaction between them (Crowther et al. 2002). Scholars here are suggesting a shift into each individual's spiritualities.

The argument brought forth is that positive spirituality could facilitate successful ageing. This does not negate the fact that there are socio-economic issues and unhealthy practices that

may impede healthy ageing; the argument is that positive spirituality may inform individual positive behaviour. Theo-socio-gerontologists further argue that the individual should take it as their responsibility to care for themselves (Hooyman & Kiyak 1999). On the other hand, faith and non-faith-based organisations, social workers, health care providers, academics and other stakeholders should forge partnerships to provide resources that promote successful ageing. Together with the concerned elderly, all structures that limit outreach to the disadvantaged elderly should be addressed. This can also justify the efficacy of unifying theoretical frameworks in the area of the health promotion of the elderly for optimal results.

Psychological ageing

Psychological ageing has to do with mental changes that occur during adulthood. People's personality and mental functioning may go through some changes. Their senses, intelligence and perception of life would also change. Their worldviews and life preferences are uniquely defined by them. Successful ageing at this stage therefore entails autonomy in mental exercise on the part of the elderly people (Bowling & Dieppe 2005; Crowther et al. 2002; Hooyman & Kiyak 1999). A person is characterised by two entities, those being mental or spiritual and physical. The physical component refers to condition that can affect the body, through illness such as high blood pressure, strokes, hearing loss, diabetes, depression, dementia and others.

The above-mentioned medical conditions may be temporarily attended to medically if the mental or spiritual entity is left unattended to. This is to say that diseases may affect people's mental and physical activities. Furthermore, diseases bring other psychological challenges to a person and thereby deter them from functioning to their maximum abilities. Elderly people, as a result, may lose a sense of value, appreciation and meaning (Holly 2011). At the same time, elderly people are believed to have a deeper and richer understanding of their cultural and religious values. They have the potential of designing their own interventions that acknowledge spiritual elements of their lives and strengthen positive health and mental outcomes in their own way and to their own benefit (Holly 2011).

In a context where elderly people live alone due to lack of support and necessary care, they become vulnerable and their quality of life deteriorates. In such circumstances, they may require emotional support in order that the quality of life is improved. Coupled with their pain of isolation are the anxieties about their body and mental changes. They may also be challenged by existential issues that have to do with their own death and meaning of life. Others at this stage are still grieving the loss of their children or people who were close to them. Emotional pain at this stage may manifest as a physical pain. Many are very much aware of the kind of help they need, even if they are referred to medical facilities. It is unfortunate that their right of determination and preference

is overlooked in health care institutions (Bowling & Dieppe 2005; Hooyman & Kiyak 1999).

Changes, either physiological, mental or chronological, are bound to happen (cf, Fernandes et al 2018). The ageing process is influenced by physical, mental, spiritual and cultural entities of life. These entities may shape people's behaviours towards care. It is therefore important to know the relationship between the body and the mind. Medicine may help, to a lesser extent. Biased and culturally insensitive approaches by medical professionals may even worsen the situation of the elderly people. Therefore, any intervention to the phenomenon of ageing should appreciate the integrative nature of determinants of ageing, the person or subject of care, culture, traditions and religion associated with the subject of care and the context in which people live. All three discussed dimensions of biological, social and psychological ageing are interactive. People experience them differently, and it mainly has to do with how they relate with others in a given society. Interventions towards successful ageing should consider diversity in terms of physical and mental capacity. Policies should be framed to improve functional ability in accordance with one's stage of life (WHO 2020).

From a psychological approach, Bowling and Iliffe (2011) argue that successful ageing should not be about maintaining a healthy outlook. The focus should rather be on maximising one's psychological resources. People should learn to be resilient and to appreciate themselves. According to Susana et al. (2018), low mental functioning is caused by biological, physical, social and psychological factors. Even though ageing is inevitable, factors such as a lack of interest, depleted hope and anxiety should be considered. Any intervention to healthy ageing should facilitate independence and quality of life in the lives of the elderly. Perhaps health care systems could appreciate that health and healing are a process instead of focusing on the curing part.

The World Health Organisation (2020), emphasizes spirituality as a vital tool in helping the elderly people improve their quality of life. Spirituality may not only be expressed in an institutional life, because it is more personal and subjective. It has to do with the search for meaning or significance in connection with transcendental entities. The latter informs people on how they think, evaluate information and act. Spirituality is also expressed communally. It informs where and how people are to express their spirituality through gatherings, rituals and ceremonies. One's spirituality often correlates with that of the community they live in. In other instances, one's spirituality, or that of the community, may inculcate negative or harmful behaviour. Positive aspects of one's spirituality should be engaged to facilitate wellness and growth. Spirituality should be integrated in health care structures. There is a need to come up with strategies that create more compassionate systems of care (Puchalski et al. 2014).

There is also a need to appreciate an integrated approach when coming up with ways of promoting successful ageing.

Spirituality comes into dialogue with the psychotherapeutic dialogue when people are exposed to complex determinants to ageing. The integrated psychotherapy approach will have implications on the disciplines of practical theology and psychology or psychiatry, especially with regard 'to how we understand, assess and treat the needs of different people exposed to trauma and other existential crises' (Magezi 2016:5).

Meaning of health and implications on healthcare delivery

Health is understood as 'a state of complete physical, mental and social well-being and not just the absence of disease or infirmity' (WHO 2020:1). This means that interventions that neglect these factors are limited. According to the WHO factsheet, 'In developing countries, socio-cultural beliefs and practices strongly influence the health-seeking behaviours of people' (2007). These are also informed by gender, age and socio-demographic correlates. Client-focused integrated service delivery is vital in any of the therapeutic itineraries. People's spirituality should not be overlooked, because it is an important dimension of people's quality of life (WHO 2020). Perhaps health care professionals, either from public, private for-profit, private nonprofit and traditional medicine practices (Ministry of Health [MOH] 2006) could learn to improve the quality of people's lives by drawing on spiritual resources.

However, the skills that are lacking in biomedical personnel include the ability to take into account the health seekers' social life, relationships, external environment and spiritual well-being (Simwaka et al. 2007). The mentioned aspects are taken into account within the traditional and faith healing systems. A holistic approach to health and healing is needed. In other words such approach to healing should be able to address both the mind, body and soul for complete healing. Spiritual assessments during the first encounter with a healthcare provider from any healthcare system are vital. There is further need for holistic people-centred healthcare in Africa (Blanchard 2009; De LaPorte 2016). Nissen, Viftrup and Hvidt (2021) maintain that in the first encounter, a healthcare provider should identify spiritual needs and resources. Upon understanding these, the special needs of care seekers are to be taken into consideration. The next step involves developing the individual's spiritual care treatment plan. It is important to involve the relevant health care or spiritual care professionals.

People in Botswana and in most African countries have the opportunity to use any kind of healing suitable to them. They may mix two or three health and healing systems at the same time to acquire healing (Morekwa 2004; Togarasei 2016). Healing in Botswana, as well as for the rest of the African continent, is connected with people's beliefs and faiths. The allopathic health system, alongside Christianity, was brought to Botswana and to most parts of Africa. In that regard, health and religion were inseparable entities. The mission doctors

found traditional doctors using the methods of healing that were similar to theirs – a combination of remedies and prayer (Morekwa 2004; Togarasei 2016). Mudumbe, however, contends that the formal education system that was introduced by missionaries was designed to alienate the indigenous Africans from their culture (1994:104–121).

Research method and design

This section is based on data that were collected between February 2019 and May 2019. It sets off by identifying challenges experienced by the grieving elderly caretakers of orphans affected by HIV and AIDS. The main research question focused on establishing how pastoral care is being used to address the situation of individuals who are:

- grieving the loss of their child or children who died because of HIV and AIDS
- elderly and trying to cope with the effects of ageing
- caretakers of their grandchildren, orphans, who are struggling to deal with their parents' deaths.

In essence, the study sought to explore and describe the experiences of both the pastoral caregivers and the grieving elderly caretakers of children orphaned by AIDS so as to eventually establish the extent to which pastoral care is presently extended to the grieving elderly caretakers of AIDS orphans. The study uses a multifaceted approach encompassing qualitative, descriptive, contextual, explorative and phenomenological approaches.

From a total of 50 grieving elderly caretakers of AIDS orphans of the Evangelical Lutheran Church in Botswana (ELCB), 45 agreed to participate in the study, translating to 90% of the sample size. Meanwhile, the Ramotswa district or province has a total of 10 potential pastoral caregivers in the form of elders. From the 10 potential pastoral caregivers, 2 declined to participate in the study, resulting in 80% of the sample size partaking. For this study, the purposive sampling technique guided the recruitment process. The study targeted the grieving elderly caretakers of AIDS orphans who had been primary caretakers of the orphans for more than a month. Data collection methods included in-depth interviews, semistructured questionnaires and focus group discussions. There were two sessions of focus group discussions among the pastoral caregivers and church leaders, which were meant to encourage self-disclosure among the participants and to complement findings from the questionnaires. The first group consisted of eight participants, while the last group consisted of six participants. There was a forum for five focus group discussions with eight elderly participants. A total of 40 grieving elderly caretakers of AIDS orphans participated in the focus group discussion after having completed the questionnaire.

The quantitative data were managed and analysed with the aid of the Statistical Package for the Social Sciences (SPSS), while the qualitative data were analysed with the aid of NVivo 8 (Gibbs 2007). The software helped in coding, content

analysis, categorising and sorting of the text. Transcripts were read repeatedly, coded and then categorised into various themes. Thematic challenges of the grieving elderly caretakers of AIDS orphans identified in this study include the following:

1. physical
2. social
3. economic
4. psycho-emotional
5. intrapersonal.

Whereas 1–4 are interpersonal challenges that encompass the external environments of the grieving elderly caretakers of AIDS orphans, the comprehensive pastoral caregiving package included mitigation measures encompassing:

- coping skills
- financial assistance
- emotional assistance
- spiritual assistance.

The attributes of coping skills, financial assistance and emotional assistance will be assessed across the five thematic challenges of the grieving elderly caretakers of AIDS orphans with the aim of developing a comprehensive pastoral caregiving tool. In the event that the study reveals insufficient or no pastoral care in the context of the above themes and subthemes, the study presents a comprehensive model referred to as pastoral caregiving to grieving elderly caretakers of AIDS orphans. Meanwhile, in the event that the study reveals the existence of a comprehensive pastoral caregiving, the study will propose an enhancement. The burden of re-mothering of orphans made vulnerable by HIV and AIDS has a remarkable impact on the grieving elderly.

Ethical considerations

Participants were provided with information about the study and were also allowed to decide whether or not to participate in the study. They were informed of their freedom to withdraw from participating in the research and have their information destroyed in their presence whenever they felt they needed to stop participating. They were also assured that no harm would occur as a result of their participation in the research study.

Results

This section describes the demographic features of the participants. The main instrument that was used here was a questionnaire. In terms of gender, the majority of the participants, that is, 35 of them, were women (87.5%), while 5 (12.5%) participants were men who took up the caregiving roles. It could then be concluded that overall, the carers are more likely to be female than male. These findings are consistent with those of the Population and Housing Census 2011 Analytical Report, where it was established that most of the elderly in Botswana are women (59.8%), whereas 40.2% are men. Another report states that 42.5% of orphan caregiving households are headed by grandmothers in Botswana

Statistics Botswana (2017). This means that there is a need to reduce the burden of caring from women and promote an equal sharing of responsibilities. The traditional barriers that prevent men from taking up caring responsibilities should be broken. Besides, some elderly men may feel more comfortable when cared for by men than by women. On the other hand, some elderly women may feel more comfortable if cared for by their spouses than by strangers.

The majority of the participants were in the age group of 80–84 years, which made up 22.5% of the sample size. This age group was closely followed by the 65–69, 75–79, 85–89, 90–94 and 95 plus years age groups, respectively. Participants who were 81 years of age and above were all elderly women. This is in concurrence with the Statistics Botswana (2017) report, in which there are more female elderly who are aged 75 years and older. The report states that this can be attributed to disproportionate higher male mortality at older ages. More than half of the participants argued that caregiving for orphans was negatively affected by ageing. They maintained that ageing affected their mental, physical and emotional capability. Table 2 shows the number of participating elderly caregivers per age group.

Table 2 shows that all the age groups range between a 12%–15% share of total participants, save for age group 80–84, which stands at a higher participant percentage of 22%. According to them, their willingness to take part in this survey in such large numbers was because of the fear that they are approaching an age that is highly threatening to their caretaking ability; hence, they believed this could be a perfect opportunity for them to speak out and seek the necessary support.

Discussion

Interwoven challenges and pastoral care needs

Expected pastoral interventions are summarised in Table 3.

Table 3 shows multiple dimensions of suffering and the need for a multidisciplinary approach. Based on the data collected from the grieving elderly caregivers, what the elderly need from pastoral caregivers includes the following:

- Assistance with strategies promoting human dignity to cope with ageing, grieving and re-parenting.
- Accompanying the elderly in seeking the direction of their life with respect to the uniqueness of individuals, including the uniqueness of their spirituality and background (interpathy).

TABLE 2: Age of the participants.

| Age groups | Frequency | % |
|--------------|-----------|------------|
| 65–69 | 5 | 12.5 |
| 70–74 | 6 | 15 |
| 75–79 | 5 | 12.5 |
| 80–84 | 9 | 22.5 |
| 85–89 | 5 | 12.5 |
| 90–94 | 5 | 12.5 |
| 95+ | 5 | 12.5 |
| TOTAL | 40 | 100 |

TABLE 3: Summary of challenges, interwoven challenges, pastoral care needs of the elderly and expected pastoral interventions.

| Challenges | Description | Pastoral needs |
|------------------|---|---|
| Physical | Chronic pains or illness, physical incompetence and reduced functionality | Empowering the elderly on practical and coping skills, caretaking assistance, financial assistance, emotional support, spiritual support, health care services and free time |
| Psychophysical | Depressive symptoms and physical incompetence or reduced functionality | Improved physical activity; nutrition education |
| Social | Social isolation or reduced interaction and tolerance, a lack of social support, stigmatisation, a lack of parenting skills | Empowering the elderly on practical and coping skills, caretaking assistance (family and community support), financial assistance, emotional support, spiritual support |
| Psychosocial | Depressive symptoms, a lack of social support, stigmatisation and a lack of parenting skills. | Relationship integration, self-management skills and resources, social development, advocating for services for the elderly |
| Economic | Living demands exceeding resources | Empowering the elderly on practical and coping skills, caretaking assistance, financial assistance, emotional support, spiritual support |
| Psycho-emotional | Loss of confidence or feeling a sense of physical incompetence, grieving, depression, anxiety, sleep disturbances, role conflict of parent(s), constant worries about the welfare of the grandchildren and increased uncertainty about the future, hopelessness because of failures in grandparenting | Empowering the elderly on practical and coping skills, caretaking assistance, financial assistance, emotional support, spiritual support, holistic care, individual and family care |

- Reaching out to all dimensions of human existence (holistic) of the elderly (person-centred), their dependents and families (communal).

Spiritual support

The findings of the study reveal that most elderly caretakers felt that they were not in good health; 36 (90%) concurred that spiritual beliefs and faith were essential in maintaining health and well-being, while 39 (98%) maintained that the church should play a role in them meeting their health, financial, social, spiritual and psycho-emotional needs. All the elderly caretakers maintained that they often cling more to spiritual resources for coping during trying times. During discussions, one of the study participants mentioned that he often has concerns about his future and that of his grandchildren. They could not agree more that they are faced with death as a result of ageing.

Questions about death and the process of death as well as questions on who will continue caring for their grandchildren are common among the elderly. Most of them expressed that turning to spiritual resources such as prayer and ancestral veneration enables them to cope and adjust, seeing life as a challenge to be lived. Others, however, feel hopeless about their life situations; in their case, spirituality negatively influences their health outcomes. The following extract reflects:

'I know I am punished and abandoned by God and the ancestors for being such a bad mother. I used to neglect them leaving them with housemaids while going for discos and other functions.'

In another instance, a respondent shared the following:

'I cannot connect with God that is why I am suffering. I need to connect with God so that I can feel the presence of God in my life. My suffering denotes to disconnection with God.'

The researcher also observed that during discussions, some of the study participants appeared to be having psycho-existential sufferings such as loss of meaning of life or meaning of existence; they appeared to be hopeless. Therefore, there is a need for care intervention that elevates spiritual well-being in these hopeless elderly people. Based on these findings, the spirituality dimension of the elderly

should be addressed in order to reduce suffering. Dealing with the challenges of the elderly entails holistic approaches to caregiving, realising the relationships between body, mind, and spirit in order for the elderly to achieve peace on Earth and when they die.

Moreover, the kind of care provided to the elderly should respect individuality. This means that care should not be judgemental and should not entail the imposition of one's beliefs and faiths on another person. The care that respects individuality places emphasis on the individual, respects his or her beliefs, worldview, principles and feelings. This kind of care elicits strength for the sake of transformation; in the cases where strengths are not realised, one's spirituality should be used to evoke strength from within. The article is of the view that it is because of clear knowledge of one's essence of life and existence that one could bring change into one's life. This concept of pastoral care supports the dignity of elderly people, and it also helps them to realise their potential as human beings.

The study findings reveal the elderly caregivers' need for emotional support. This study maintains that emotional support could minimise the burden on elderly caregivers, because reports during the study indicate that elderly caregivers experienced a mixture of emotions such as loneliness, frustration, anger, depression, guilt, anxiety, love, acceptance and warmth, which could have negative consequences on them. The study highlighted that dealing with the emotional burden may entail helping the elderly caregivers to acknowledge and reconcile with these emotions in order to cope with the challenges of being a caregiver. It also entails helping the caregiver to find strength from within, to acknowledge their capabilities for improving their quality life.

This study also identified financial assistance as an area where elderly caregivers need support. Diseases like HIV and AIDS have huge financial implications on the lives of the elderly. Their greater impact is felt highly among those who have low incomes per month and to whom they produce a higher level of burden. Caregiving of the young ones is time demanding; therefore, elderly caregivers are forced to provide substantial amounts of care to their young

dependents. In the meantime, they would be diverting their time from other productive chores, resulting in financial hardships. Caregiving therefore leads them into further poverty as a result, which in turn creates more stress on the caregiver.

Lastly, this study established that support with physical care in activities of daily living is identified as an area of need. Most caregivers find it hard to keep up with housekeeping routines. The respondents made it clear that assisting them with daily activities may alleviate their hardship, and such help should come from other family members, church members with the same cultural background or the elderly with similar experiences.

Conclusion

Ageing is a very complex, multidimensional phenomenon. Different people from different cultures have their own understandings of what ageing entails. Their conceptions on ageing could either facilitate or impede successful and healthy ageing. On the other hand, ageing may be determined from the environment that people live in. Circumstances such as weather conditions, poverty or culture may impede healthy and successful ageing. The umbrella approach of dealing with challenges of ageing might not work in other societies. The word 'health' also has a multidimensional meaning. It is connected with a lack of sickness in the physical, economic, psychological, spiritual and emotional areas of life. Through spirituality, caregivers are able to determine challenges of the elderly and improve their well-being. We cannot aim at curing diseases and illnesses and leaving the psychological or spiritual being unattended. Theological, sociological and psychological insights are used to unveil the complexity of ageing and come up with solutions for the mitigation of health challenges encountered by older persons. This article argues that the necessary support should be coupled with training or orienting the elderly in coping and management strategies in the phase of pandemics.

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Competing interests

The authors have declared that no competing interest exists.

Authors' contributions

M.T.J. and B.G.T. are the authors of this research article. M.T.J. was responsible for the draft idea, methodology and data collection. B.G.T. was responsible for writing of the article and conceptualisation.

Ethical considerations

Participants were provided with information about the study and were also allowed to decide whether or not to participate in the study. They were informed of their freedom to withdraw from participating in the research and

have their information destroyed in their presence whenever they felt they needed to stop participating. They were also assured that no harm would occur as a result of their participation in the study (ref. no. CLG 14/14/3/1 ii [298]).

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Data availability

Data sharing is not applicable to this article as no new data were created or analysed in this study.

Disclaimer

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