

**OLDER PEOPLE'S PERCEPTIONS OF HEALTH SERVICES AND THEIR  
HEALTH SEEKING BEHAVIOUR IN THE ERA OF HIV/AIDS: A CASE STUDY  
OF ETHEKWINI MUNICIPALITY IN KWAZULU-NATAL**

**BY**

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## **DECLARATION**

I hereby declare that this dissertation is my original work. Any work done by other persons has been properly acknowledged in the text. This dissertation has not been submitted for any other degree or examination at any other university.

Signature:  .....

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## **ABSTRACT**

In sub-Saharan Africa - the region with some of the world's highest levels of HIV prevalence - AIDS has reached pandemic proportions. At present, the highest rates of infection are in the region where the main route of transmission is heterosexual intercourse. Although HIV/AIDS is a major concern for all age groups, to date there has been very little exploratory research conducted on the population aged 50 and above. This dissertation seeks to analyse older people's perceptions of health services and their health seeking behaviour in the era of HIV/AIDS.

This study utilized both qualitative and quantitative methodologies for data collection. The qualitative data relies on focus group discussions and the quantitative data from the exit interviews. In total, two hundred interviews were conducted and two focus group discussions were conducted: one with men only and one with women only. For the purpose of the study, older people referred to those persons aged 50 years and above.

The study found that awareness of HIV/AIDS was relatively high. The majority of older people were aware of the main routes of HIV transmission and also the measures that they can use to protect themselves. An important source of information is public health facilities. Few older men and women perceived a medium or high risk of HIV infection. This is likely to have influenced their attendance at HIV/AIDS services. Few respondents reported ever using HIV/AIDS services. There are a number of factors inhibiting use of HIV/AIDS services including perceptions of health services, stigma and discrimination, high transportation costs and poor interpersonal relationships with providers. For the HIV/AIDS interventions to be successful, the task remains to address these factors influencing health-seeking behaviours.

## **LIST OF ACRONYMS**

AIDS	Acquired Immuno Deficiency Syndrome
ARV	Antiretroviral
CBHWs	Community Based Health Workers
CDC	Centre for Disease Control and Prevention
DOH	Department of Health
DHS	Demographic Health Survey
FGD	Focus Group Discussion
HAI	Help Age International
HEARD	Health Economics and HIV/AIDS Research Division
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
HST	Health Systems Trust
IOM	International Organization on Migration
KZN	KwaZulu-Natal
MUSA	Muthande Society for the Aged
PHCs	Public Health Clinics
PLWHAs	People Living with AIDS
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

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## **CHAPTER ONE: INTRODUCTION**

### **1.1 Introduction**

According to the Older Persons Act No. 13 of 2006, 'older people' are those, in the case of a male, 65 years of age or older and, in the case of a female, 60 years of age or older (Government Gazette, 2006:3). However, a growing number of studies have indicated that there has been a tendency to focus public health care interventions on young people but very limited research has focussed on older people aged 50 and over (Goqwana, 2003:12). Health strategies and interventions overlook their vulnerability and hence there is a need for 'an approach that directs health services and support to all older people on the basis of their needs, rather than to particular older people on the basis of their status as being more susceptible to HIV infection' (De Carlo and Linsk, 1997:1). For the purpose of this study, an older person refers to people aged 50 years and over (Siverson, 1999).

### **1.2 Motivation for the study**

South Africa is currently experiencing one of the most severe HIV/AIDS epidemics in the world. By the end of 2005, there were five and a half million people living with HIV in the country, with almost 1,000 AIDS deaths occurring daily, (UNAIDS, 2006). Brockerhoff and Biddlecom (1999) pointed out that the epidemic was for many years considered to be for sexually active young people, which led to a neglect of older people and thus an increase in HIV infection among this sector of the population. The literature on the spread of HIV/AIDS among older people in South Africa is generally not extensive. However, a national survey conducted in South Africa found that HIV prevalence amongst persons aged 50 – 54 years was estimated to be 6.5% with a higher prevalence in females (8%) than males (5%). In the age category 55 years and above, the HIV prevalence was 7% among both males and females (Nelson Mandela/HSRC, 2002)

The South African National HIV Survey (HSRC, 2005) estimated that persons aged 50 – 54 years had an HIV prevalence of 10.8% with a higher prevalence in males (14.2%) than in females (7.5%). In the age category 55 years and above, HIV

prevalence was 4.5% with a higher prevalence in males (6.4%) than in females (4.5%). Although there are no statistics that indicate HIV prevalence amongst older people in the previous years, the South African National HIV Survey (HSRC, 2005:34) reported that the overall HIV prevalence in people aged 50 and above was estimated to be 5.7% and the HIV prevalence was higher in males than females. These statistics indicate that the epidemic has been spreading unnoticed for a long period. However, few studies have looked at how health services are responding to the needs of older people in the era of HIV/AIDS.

Studies have found that limited knowledge of safer sexual methods, high levels of sexually transmitted infections (STIs), negative attitudes to condoms, sexual violence, poverty, ignorance, sexual abuse, low education, unemployment, social instability, and mobility, (particularly migrant labour) are just some of the notable factors, which increase the spread of HIV (Booyesen, 2004; Fee, 1983). The scarcity of information and research on older people has been the motivating factor in undertaking this exploratory study on how they perceive health services in the era of HIV/AIDS.

### **1.3 Statement of the problem**

The high prevalence of HIV/AIDS in Southern Africa is having a significant impact on older people, leading to large numbers whose welfare is threatened or compromised by a variety of changes to their lives, including being infected and affected by HIV/AIDS (UNAIDS, 2005). South Africa has the sixth largest prevalence of HIV in the world with 18.8% estimated to be infected (ibid, 2005). The South African National HIV Survey (HSRC, 2005:35) found that HIV prevalence is highest in KwaZulu-Natal followed by Mpumalanga and the Free State provinces. Furthermore, people living in urban informal (17.6%) areas have a higher prevalence than those in either urban formal (9.1%) or rural formal (9.9%) areas (ibid, 2005:35). With regard to older people and HIV in South Africa, there is little specific HIV-related information. The gaps in prevention, awareness, treatment and care for HIV infected and affected older people are expected to have long-term developmental impact on the region (UNAIDS, 2005). In addition, health services are required to meet the needs of older adults in the era of HIV/AIDS even though public health

interventions have primarily been targeting 'high risk' age groups neglecting older adults as if there were 'immune to HIV/AIDS infection' (Entwisle, 2000:3).

There has been some research in other areas of South Africa into the needs of older adults, as well as into the impact of interventions and their ability to meet the needs of older adults (Smith, 2002:2). In Gauteng, Akpan et al., (2006) indicated that although the need for HIV prevention and health services is great, many older adults do not access services because of fear of discrimination and dissatisfaction with the quality of care and they have negative experiences trying to access services. Njaramba et al., (2006) asserted that lack of knowledge and a strong association of HIV/AIDS with loose morals were blamed for the poor attitudes towards people living with HIV/AIDS (PLWHAs). However, there is relatively little research on health services themselves, notably how intervention programmes are identified, how they are planned and implemented and what they regard as critical needs of older adults to be addressed (Quinlan and Rushby, 2004).

Health services are on 'frontline' of tackling the devastating effects of HIV/AIDS on the welfare of older adults. However, evidence to date suggests that many health services work in the absence of coordinated and coherent national strategies, informed programme support and information to substantiate interventions. Therefore, it is difficult to enable these programmes to be refined and adapted to meet the needs of older adults as they identify and define them (Quinlan and Rushby, 2004). The sexual health needs of older people are generally ignored since they fall beyond the realm of family planning (Petersen and Swartz, 2002). Smith (2002:3) has indicated that access to information and treatment for other infections that facilitate the transmission of HIV and the onset of AIDS, including sexually transmitted infections (STIs), are limited because of weak public health services, health providers' negative attitudes, and the high cost of treatment. This has made it even more difficult for some older men and women to have access to medicines, as drugs are very expensive.

The proposed research attempts to address these gaps in the research by focusing on older people aged 50 and above. The broad aim of the study is to explore older people's perceptions of health services in the era of HIV/AIDS. The study attempts to improve our understanding of how public health services meet the needs of older

people not only infected but also affected by HIV/AIDS. The study was conducted in health facilities in the eThekweni Municipality in Durban.

#### **1.4 Aims and Objectives of the study**

The specific objectives of this project are:

- To explore older people's perceptions of health services in the era of HIV/AIDS
- To investigate health seeking behaviour of older people with regard to the prevention and treatment of HIV/AIDS
- Through the clients' account, analyse the needs, opportunities and constraints facing older people at health facilities.

This study is interested in examining the following questions:

- How are health services meeting the needs of older people for information on HIV/AIDS?
- Would older people want to receive information about HIV/AIDS at their health facility?
- How do older people perceive health services in the era of high levels of HIV/AIDS?
- What are some of the factors facilitating and inhibiting use of health services among older people?

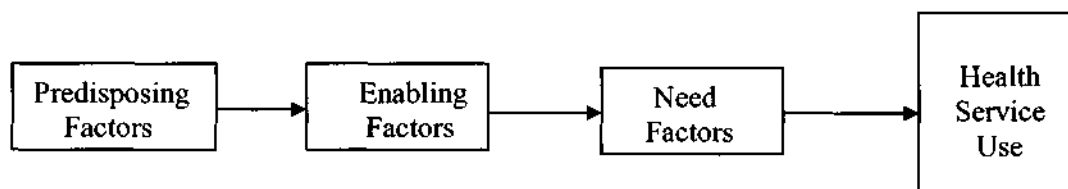
#### **1.5 Conceptual Framework**

This section discusses the conceptual framework that informs the study. The conceptual framework draws on the health care utilization model sometimes referred to as the 'socio-behavioural model' for health services. The health care utilization model emphasizes contextual as well as individual determinants of access to health care. Furthermore, the model seeks to integrate economic and socio-cultural aspects into health seeking behaviour. Campbell (1993) argued that prevention of HIV infection in communities requires intervention on several levels, because factors inhibiting and/or facilitating health seeking and other behaviours occur on personal,

interpersonal and environmental levels. Therefore, the uptake of such an intervention is influenced by the social, cultural, economic and political issues affecting the individual, community and the environment.

This study largely draws on the health care utilization model, which investigates health seeking behaviour of older people with regard to the prevention and treatment of HIV/AIDS. According to the health care utilization model, three factors facilitate and/or inhibit health seeking behaviour including predisposing, enabling and need factors (Hausmann-Muela et al., 2003:12). The model was developed primarily to investigate the use of biomedical health services (ibid, 2003). However, more recent versions of the model have also looked at other health care sectors, for example, traditional medicine and domestic treatments (ibid, 2003). Figure 1: below graphically outlines the different categories influencing health care utilization.

Figure 1: The Health Care Utilization Model.



Source: Hausmann-Muela et al., (2003:12)

Health seeking behaviour of older people with regard to HIV/AIDS prevention, treatment and care is influenced by many factors including but not limited to predisposing, enabling and need factors. First, some of the 'predisposing factors' include age, gender, religion, marital status, prior experiences with illness, formal education, general attitudes towards health services, as well as knowledge about the illness. Second, the 'enabling factors' include availability and accessibility of services, financial resources to access services, and social network support and finally, the 'need factors' include a perception of severity, total number of sick days for a reported illness, total number of days in bed, days missed from work and help from outside for caring and so forth (Hausmann-Muela et al., 2003).

This model is context dependent – the main argument is that the context influences health seeking behaviour. For example, gender differentiation plays a role in influencing health seeking behaviour in certain cultures. In some African traditional households, women often request permission from spouses to visit health facilities but men visit these facilities without their partner's knowledge. However, the advantage of using this model is that it captures structural levels within the macro-political and economic context (Hausmann-Muela et al., 2003). In other words, it puts into context all the social determinants influencing the utilization of health services. The disadvantage of this model is that it shows that predisposing factors influence enabling factors and these enabling factors further influence need factors that in turn influence health seeking behaviour behaviours. However, factors inhibiting and/or facilitating health seeking are intertwined. For instance, availability and accessibility of services could influence attitudes towards health services.

## **1.6 Methodology**

The study employs a combination of quantitative and qualitative research methods was used in this study. Quantitative method draws on exit interviews using closed questions while qualitative method draws on open-ended questions from focus group discussions.

The quantitative method consists of a questionnaire administered to two hundred respondents at a health facility in the eThekweni Municipality while the qualitative method consisted of two focus group discussions held with older men and women attending health facilities in the eThekweni Municipality. The sample was purposively selected with the assistance of health providers.

## **1.7 Organisation of the study**

The first chapter provides background information on the study. This introductory chapter has outlined the motivation for conducting the study, statement of the problem, aims and objectives, conceptual framework, methodology and organisation of the study. The second chapter reviews relevant literature on factors influencing health care utilization. The third chapter outlines the research methodology of the

study, including the research questions, methods of sampling and data collection and data analysis techniques. Furthermore, the ethical aspects of the study as well as the shortcomings and limitations are discussed in this section. The fourth chapter presents the quantitative findings of the study while the fifth chapter presents the qualitative findings of the study. The sixth chapter presents the discussion of the main findings of the study and also compares the findings to previous studies. It further provides recommendations for future research on HIV/AIDS amongst older people.

## **CHAPTER TWO: LITERATURE REVIEW**

### **2.1. Introduction**

This chapter explores the experiences of the ‘neglected population’ at health facilities. The intention is to provide a comprehensive review of literature on HIV/AIDS among older people since there are some indications that the level of HIV/AIDS is increasing among this section of the population. This chapter also reviews studies on factors inhibiting and/or facilitating health seeking behaviour

### **2.2. Knowledge and Awareness of Health Services**

Simbayi et al., (2005) indicated that in South Africa, knowledge of HIV/AIDS-related services is much lower among older people. This is partly due to the neglect of older people in information and prevention campaigns that seem to target young people. In most sub-Saharan countries, HIV/AIDS information targets the so-called “sexually active” young people and overlooks older people. However, HIV/AIDS information extends beyond campaigns and programs.

In South Africa, health facilities and various organizations working with the aged population are seen as important sources of HIV/AIDS information amongst older people (Simbayi et al., 2005; HAI, 2005). This is because older people often consult health facilities for various illnesses linked to but not limited to the ageing process. In most developing countries especially sub-Saharan Africa, organizations and agencies working with older people such as Help Age International (HAI), Muthande Society of the Aged (MUSA) amongst others, have been particularly helpful in creating awareness of health services. However, older people who do not consult health facilities especially public health facilities have limited knowledge and awareness of HIV/AIDS-related services.

### **2.3. Utilization of Health Services**

Although older people access health services more than their younger counterparts, Wright et al., (1998) asserted that there was a lower level of knowledge of HIV/AIDS



among older people compared with young people with levels of HIV/AIDS knowledge decreasing with an increase in age. Although older people may be aware of some facts about HIV/AIDS such as transmission, prevention and treatment, many older people view it as a disease of the young (Simbayi et al., 2005). This has impacted negatively on their utilization of health services for the prevention and treatment of HIV/AIDS.

Despite well-established VCT systems in South Africa, studies have indicated that within all population groups, uptake has been low as most people are reluctant to test for HIV infection (Simbayi et al., 2005; van Dyk, 2001). The World Health Organisation (2004) asserted that access to VCT prompts knowledge of HIV status, which is a critical aspect of prevention, treatment and care of the epidemic. This process also serves as an entry into seeking treatment for opportunistic infections and anti-retroviral (ARV) in the case of advanced HIV infection (WHO, 2004). As VCT services continue to be promoted in both metropolitan and remote rural areas, they should also be considered for older people seeking health care for other reasons, for example, "...sexually transmitted patients and patients with illnesses associated with HIV infection" (Simbayi et al., 2005:140).

Mariano (2005:2) defined HIV testing and counselling as "a direct, personalized and person-centred intervention, tailored to prevent transmission and obtain referral to additional medical care, preventive, psychosocial and other needed services in order to remain healthy". The success of VCT is rooted in older people's perceptions shaped by cultural beliefs and values, opinions about the role of health care services and the nature of interactions with health providers (Rosenstock, 2005; Bender, 1998; Avanzini et al., 2006). Addressing perceptions of VCT is crucial to improve their satisfaction and health outcomes, ensuring continued and sustained use of services (Ovretveit, 1998).

Recent studies indicate that overall coverage of testing and counselling is extremely poor in countries with the highest HIV/AIDS burden (Mariano, 2005:2). Access to testing and counselling is the key to successful prevention, treatment and care. It also prevents HIV re-infection and transmission by promoting behavioural changes (Mariano, 2005; Fyikesnes et al., 1999). Voluntary HIV counselling and testing is not

available in most regions in Africa (Kipitu, 2005; van Dyk, 2001). Some of the barriers to availability include staff shortages, inadequate facilities and poor infrastructure. There are few studies describing barriers to HIV testing in sub-Saharan countries (WHO, 2004), which are particularly related to disclosure of HIV/AIDS status to sexual partners, fears of VCT attendance due to stigma and discrimination. One study in Mozambique explored the consequences for women testing HIV positive. Several women perceived fear of rejection and blame as a consequence of disclosure of HIV/AIDS status (Mariano, 2005:3). The positive motivations among older people in seeking VCT were curiosity and to a lesser extent, perception of personal or one's collective susceptibility to be at risk (Fyikesnes et al., 1999).

In a study conducted in Tanzania, HIV/AIDS prevalence is estimated to be high and the national coverage rate for VCT programs is low (Kipitu, 2005). In Botswana, Bender (1998:42) indicated that the spread of HIV/AIDS is associated with cultural beliefs and practices, ignorance, religious affiliation and stigmatisation. Uptake of VCT services could also be inhibited by the same factors, as there are no studies covering older people's perceptions of health services in the era of HIV/AIDS in South Africa. Fyikesnes et al., (1999) argued that older people's behaviour is mainly influenced by psychosocial and cultural norms and values.

Some older people may also seek treatment from traditional healers or diviners depending on their cultural beliefs and religious affiliation. Health seeking behaviour is rooted in culture, norms and values. To transcend the dogmatic underpinnings of culture, "perceptions of personal susceptibility to HIV/AIDS infection as the main factor motivating older people to overcome barriers for seeking VCT" (Mariano, 2005:3) need to be addressed. In other words, health seeking behaviour must transcend culture, norms and values in the reduction of the epidemic. This could affect the utilization of the majority of health programs including VCT (Bender, 1998).

One of the widely known and relatively easily accessible prevention methods is the condom. Condoms have also been widely promoted as an important component of HIV/AIDS services. However, like voluntary counselling and testing (VCT), condom use among older people is low (Simbayi et al., 2005:142). Condom distribution in sub-Saharan countries has not been adequate to meet the needs of sexually active

population (Taylor, 2004). In sub-Saharan Africa, the urban population easily access condoms in health care centres such as hospitals, clinics and other recreational places while the rural population is underserved with condoms even in health care facilities (Blaauw, 2004). In a report supported by HAI in collaboration with MUSA, it was indicated that older people who consult health services for any health-related problems and those affiliated to organisations working with older people are likely to know about condoms, have access to them though there is no correlation between condom knowledge, access and their use (HAI, 2005).

Mantell, Schinke and Akabas (1988:20) indicated that the goals of condom campaigns are to:

*“...increase peoples’ awareness of the benefits of condom use in the prevention of HIV infection and other sexually transmitted diseases (STDs), increase the availability of condoms and the acceptability of their use, teach people the correct use of condoms, and help people to learn to negotiate the use of condoms with their sexual partners”.*

The assumption of free condom distribution program is that there is the possibility that increased access to condoms will increase condom use. As a result, condom distribution could be used as a means to initiate contact and open up communication channels between health service providers and older people. However, there is no conclusive evidence that increased access to condoms results in increased condom use (Kelley et al., 1989; Mantell et al., 1988).

Kelley et al., (1989) found that older people are less likely to use condoms, less likely to have used condoms in their last sexual experience, more likely to be diagnosed with STDs, endorsed a negative attitude towards condom use though condoms in these age categories are mainly used as preventative method for HIV infection and other sexually transmitted diseases. Therefore, a fight against HIV infection is less likely to be effective due to the low condom use among older people (Taylor, 2004). Avanzini et al., (2006) have identified various attitudes and beliefs that affect condom use such as culture, gender and power. They emphasized the value of making condoms available to older people at health facilities and other community-based health

services regardless of sexual activity. However, it is not entirely clear whether condom availability is sufficient to ensure condom use by older people.

Myer et al., (2002) indicated that a lack of access to condoms presents a fundamental barrier to HIV prevention across most of sub-Saharan Africa. Condoms available at health care facilities are usually free while those accessible outside the bounds of health facilities are normally fee-laden.

It is evident that there is a huge need for prevention, treatment and care of HIV/AIDS especially in sub-Saharan countries where HIV prevalence is highest compared to other regions. The latest information regarding the anti-retroviral (ARV) rollout in South Africa done by the Treatment Action Campaign (TAC) - South Africa's leading AIDS activist group - indicates that many South Africans are infected by HIV, which causes AIDS, and are in dire need of treatment (TAC, 2007). However, there are a number of barriers that prevent people from accessing such health services. For example, one of the barriers is a lack of capacity to provide services. Research has shown that though health facilities may be accredited to deliver necessary prevention, treatment and care to people in most need of such services, the roll-out and uptake of such services tends to be low due to a lack of properly trained and an adequate number of health care providers (Nyblade and Field, 2001).

In South Africa, TAC reports confirm that there are significant demands for HIV/AIDS prevention, treatment and care services. The demands for services outweigh current health services capacity to deliver. This is also a problem in developed countries. Hendryx et al., (2002:85) noted that in United States which has a fast-growing aging population and a greater demand for health care services, people without health insurance wait for long periods in long queues when seeking health care from public health facilities.

### **Factors influencing use of health services**

Studies have indicated that there are a number of factors influencing access to health care services. These factors include but are not limited to demographic factors - demographic factors are normally "used to describe social characteristics" - referred

to as background information about the target population on issues such as age, gender/ sex, race/ethnicity, income, educational status and geographical area (Centre for Disease Control, 2005). Other factors inhibiting health seeking behaviour include the negative attitudes of health service providers (Niang and Tapsoba, 2001); stigma (Sherr, 1996); discrimination and prejudice (Knodel et al., 2002; Nyblade and Field, 2001) as well as client-provider interpersonal relationships (MacPhee, 2005). Studies have also indicated that ageism (MacPhee, 2005; Craft, 2002; Bennett and Ebrahim, 1992; Hazell, 1976); the high cost of services (Burger and Swanepoel, 2006); distance and transportation (Arcury et al., 2005, Bender, 1998); and other illness associated with the aging process (Craft, 2002) also influence use of health services among older people.

### **2.3.1. Socio-economic and Demographic Characteristics**

The aging process is often accompanied by deterioration in health (CDC, 2005:20). While older people may be concerned about how to cope with ill health, health service delivery systems will be concerned about how to make services accessible to address the needs of the elderly. In this context, it is important to determine older people's perceptions of how they ought to be. Ageist attitudes are reasoned to be deeply rooted in a person's cultural context and society (MacPhee, 2005:722) and in any culture, men and women often have different perceptions of illness and health seeking behaviours.

In sub-Saharan countries, little has been published that identifies the process of physical aging as a barrier to accessing health services. Physical aging is defined as "the changes that happen to a person's body as they grow older" (MacPhee, 2005:722). In contrast to the traditional definition of "good health as the absence of disease, many older people define 'good health' as being uninhibited by one's physical and medical conditions" (MacPhee, 2005).

According to Kroll et al., (2006), older people feel uncomfortable to accept the aging process but as people grow older some illnesses are inevitable. In addition, some older people may refuse to seek health services when they have health problems associated with HIV (e.g. schizophrenic tendencies, weight loss, night sweats, chronic fatigue

etc) attributing these to the natural process of aging (MacPhee, 2005; Craft, 2002; Bennett and Ebrahim, 1992; Hazell, 1976). Older people with serious health problems may not suspect HIV infection because they are not aware of their own risk of HIV infection. For one, their aging bodies make them more vulnerable to contracting HIV as their immune system has weakened (New Mexico AIDS InfoNet: 2005). HIV/AIDS has been referred to as “the great imitator” because many of the early symptoms of infection mimic the aging process (Craft, 2002:2).

Vaillancourt et al., (2005) asserted that the Ethiopian health system’s capacity to prevent and treat many health conditions including STIs is widely available but there is limited support for HIV/AIDS activities. One specific example referred to was the lack of support for HIV counselling and testing services. Craft (2002:4) indicated that some reasons for not having an HIV test include “...attributing symptoms to other illnesses, perceiving an absence of symptoms, and thinking that one is not at risk and denial.” Studies have indicated that older people do not go for HIV testing (Knodel et al., 2002; Nyblade and Field, 2001; Fyikesnes et al., 1999).

Shortus et al., (2005:65) stated that, “...inasmuch as older people would want to have a complete medical check-up, some health service providers perceive ageing symptoms as the cause of all illness”. The bias of health service providers emanates from the presentation of ageing symptoms that is difficult to distinguish from HIV/AIDS-related symptoms. Furthermore, Shortus et al., (2005:67) indicated that some health service providers lack experience and knowledge of the needs of the older population and the situation is made worse by the complications of HIV/AIDS. On the one hand this is due to a lack of knowledge and on the other hand, an overlap of HIV/AIDS-related symptoms with some aspects of the aging process. Kroll et al., (2006:289) indicated that health service providers perceive older people as “complex patients whose needs were too extensive and impossible to meet during short appointments times”.

A study conducted in the United States of America by Poindexter and Keigher (2004) found that there is a lack of knowledge of HIV symptoms amongst older people. In their study, they argued that many aspects of HIV overlap with similar aspects of the

aging process. Therefore, without proper clinical tests, it is difficult to ascertain whether any person may be HIV infected (MacPhee, 2005; Shortus et al., 2005).

Studies also suggest that women are biologically more prone to HIV infection than men (Linsk, 2000). Siverson (1999) indicated that due to hormonal changes in their bodies, the resulting decrease in vaginal size and lubrication increase the likelihood of microscopic and macroscopic vaginal tears during intercourse, which provides easier entry for the virus into the bloodstream. In the United States, HIV/AIDS prevalence studies have found about 10% – 15% of female HIV cases among those aged 50 years and above (De Carlo and Linsk, 1997; WHO, 2004), while in South Africa studies have found that about 7% of female HIV cases occur among those aged 55 years and above (United Nations, 2002).

Older women often have to assume primary responsibility for care of their sick and dying children, and as a result, are physically, emotionally and financially disadvantaged. In their study in rural North Carolina, Reif et al., (2005:558) indicated, more female clients reported a greater number of barriers to accessing services. For instance, apart from caring duties in households, females have to spend much more time doing household duties for their husband and/or children and this leaves them with limited opportunities to access health facilities. In addition, sometimes women are economically dependent on men and this makes it difficult for them to access health facilities.

In most societies, health services are seen as women's domain and often they are the providers of health services (Bawah, 2002). Traditionally, women have held the responsibility for the health of their families and beyond. They have "assumed this caring duty as a profession" (Fee, 1983:17) as they are taught various preventive, treatments and care measures. Studies have indicated that women are dispensers of health care (Simbayi et al., 2005; Bawah, 2002). Statistics on health care provision in KwaZulu-Natal show that the majority of health care providers are women (eThekweni Municipality, 2005).

Gender relations may also inhibit and/or facilitate health seeking behaviour. Bawah (2002) argued, "...men play an influential role in most household decision making in

many countries of sub-Saharan countries. The social structure in most of these countries is patriarchal...and these tend to transfer conjugal power to men". Men make decisions to seek VCT freely and independently, whereas women feel obliged to discuss the use of VCT services with their partners (WHO, 2004). Gender is also strongly correlated to health care utilization. For example, Arcury et al., (2005:36) found that because men see health services as women's domain, women had 1.26 times more regular health care visits than men.

Ethnicity may also influence health care utilization as it influences responses to symptoms and places where older people seek health care. Studies have shown that culture and belief systems influence health care utilization (Cox, 1986; Roos and Shapiro, 1981). Ethnicity and culture are not necessarily barriers but may promote the use of traditional health care services such as the use of special herbs and teas.

Studies show that ethnic groups differ in utilization patterns, concepts of disease and illness, provider and institutional interactions (Stein, Fox and Mutara, 1991:101). According to Burton (1997: 238), "many racial and ethnic differences in preventive health behaviours are clearly due to economic and educational disadvantages". Ethnic groups with low socioeconomic status such as education and income have 'decreased awareness of health measures and less access to health care' (Stein, Fox and Mutara, 1991). In South Africa, the overall HIV prevalence amongst the African population is highest (11.8%) followed by 3.8% among the Coloureds, 2% among Whites and 0.9% among the Indian population (HSRC, 2004).

Studies in the United States have also indicated that amongst all races, the native Afro-American population is worst affected by the HIV epidemic followed by the Hispanic and to a lesser extent the White population. Fleishman, Hsia and Hellinger (1994:527) found that African American respondents were more likely to report hospital admissions and longer lengths of in-patient stay than other respondents. This could have been caused by a lack of insurance amongst African Americans who rely on public and/or free health care services.

Studies have indicated that marital status may also determine health care utilization. Whereas some studies have found isolated and widowed persons are more frequent



users of medical health services (Fleishman, Hsia and Hellinger 1994; Cox, 1986), others have found that being married was a key predictor of use of health services among the elderly (Coulton and Frost, 1982). One study conducted in Zimbabwe argued that married people are less likely to be HIV infected compared to their single counterparts (Akpan et al., 2006). Most often, married people tend to have steady relationships and fewer sexual partners compared to single people who tend to have frequent sexual intercourse with a number of sexual partners. Supporting that argument, MacPhee (2005) indicated that vulnerability to HIV infection was strongly associated with non-marital status and multiple sexual partners.

Cox (1986) argued that ethnicity in conjunction with marital status must not be overlooked in assessing health care utilization. In his comparative study conducted in the United States, he claimed that being Portuguese, female and married were significant predictors of health care utilization. On the contrary, Cox (1986:673) indicated that being an older Vietnamese and unmarried Hispanic was a key determinant of health care utilization.

The availability of health services may also influence use. Studies have indicated that health seeking behaviour is higher in urban than rural areas because health care services are easily accessible. People in rural areas tend to face many barriers in accessing health care services compared to their urban counterparts. Reif et al., (2005:558) indicated, "...rural areas often lack infrastructure to support the delivery of comprehensive HIV services".

Cox (1986) indicates that education and employment, which are some of the factors that influences a woman's access to health care services, are all affected by the place of residence of the individual. This observation is true because in many developing countries, better education and employment opportunities are found in the urban areas. As such, an individual living in the rural area has a lower chance of getting a higher education and employment than someone living in an urban area. Access to health services for people living in urban areas differs from that of people living in rural areas.

Reif et al., (2005), using data from Demographic Health Surveys (DHS) from many countries, found that the association of health services and education becomes stronger in urban areas than rural, as well as in advanced socio-economic societies that are more egalitarian than in gender stratified settings. On the same note, Reif et al., (2005:559) indicated that “high levels of STDs, poor health infrastructures and exceptionally high levels of poverty [in developing countries] where proportions of people are without health insurance”, long distances to care and lack of adequate, efficient and reliable transportation are some of the challenges faced by rural areas.

Studies have highlighted the importance of socio-economic variables in influence access to health care services in urban and rural areas and in less-developed and more developed countries. Stein, Fox and Mutara (1991) agree that the poor of all ages and races are less likely to make use of health services than the other groups. However, the higher a woman’s socio-economic status the more likely she would be to access health care services (Akpan et al., 2006).

Stein, Fox and Mutara, (1991:102) indicated that in the United States, economic and educational disadvantages are key barriers to the adoption of prevention strategies. However, Stokes (1970) had an opposing view as he argued that most research findings focusing on socio-economic factors affecting health seeking behaviour indicate that there is an inverse relationship between health seeking behaviour and a person’s socio-economic status. Stokes (1970) observes that the higher the socio-economic status, the lower the health seeking behaviour.

Kupinsky (2005) maintained from a socio-economic perspective that health seeking behaviour among women is commonly influenced by area of residence, which determines access to other socio-economic services. This further facilitates their choice of where to seek consultation, based on their living conditions. However, Avanzini et al., (2006) cautions against generalization of the finding that residence is a critical factor affecting a person’s health seeking behaviour because the definition of urban or rural differs from country to country due to differences in socio-economic levels.

Rosenstock (2005) argued that younger or middle-aged people with a relatively better education and higher income - although perhaps not those people with the highest levels of education and income, mostly use health care services. To concur with Rosenstock, Simbayi et al., (2005) indicated that more females than males visit the health facilities. Furthermore, higher socio-economic groupings (defined in terms of educational and income level) are also more likely to obtain hospital services. Studies indicated that those who delay visiting health facilities (even if they are sick) are older, of low educational status and, at least in some studies, males (Simbayi et al., 2005; Rosenstock, 2005). This serves to demonstrate that "health decision making is a process in which the individual moves through a series of stages or phases" (Rosenstock, 2005:4). The situation was made even more complex by interactions with other older people or events at each of these stages that influences the individual's decisions and subsequent health seeking behaviour (Hausmann-Muela et al., 2003).

### **Cost and Distance**

Some of the factors influencing health seeking behaviour in older people include but are not limited to cost of health services and distance to health facility. In some countries in sub-Saharan Africa, older people (those aged 50 and above) are not required to pay for consultation fees in public health facilities. However, those older people who need specialized health care visit private health providers, for instance, pharmacists, doctors and traditional healers who charge them for medical attention. In addition to accessing free health care services, some older people are motivated to seek health care from nearby health facilities where they can walk or commute especially in urban areas. Although cost of health services and distance to health facility may not serve as a barrier, older people experience a lack of access to resources, discrimination, dissatisfaction with quality and lack of knowledge of HIV/AIDS related illnesses from both the patient and the health provider alike (Mariano, 2005).

It has been found that older people are met with difficulties in meeting transport and health care service costs (De Cock et al., 2001), although attendance at primary health care (PHC) clinics is free and geographically often more accessible (Veenstra and

Oyier 2006:267). A study examining the burden of HIV-related illness on outpatient health services in KwaZulu-Natal by Veenstra and Oyier (2006:263) found that ‘the costs of treating HIV-related illness are higher compared to non-HIV patients’ as people have to pay for drug costs, laboratory costs, radiological costs and consultation time costs amongst other service costs. Although there is a good availability of HIV/AIDS treatment and care services in South Africa, HIV/AIDS treatment costs are generally higher than that of other illness (ibid, 2006:266).

Older people’s need for seeking early voluntary HIV testing and treatment in developing countries is inhibited by health care systems that are unaffordable and inaccessible. In some countries like Botswana, Zambia and Zimbabwe, outpatient treatment at clinics and hospitals are subject to user fees even for older people and this act as a “disincentive for people collecting monthly drugs or seeking treatment for a minor ailment” (Veenstra and Oyier, 2006:267). Even though the majority of older people in South Africa do not have medical aid and cannot pay for health care services they have access to free health services at public health facilities due to their age and low-income status.

In their study, Burger and Swanepoel (2006:2) have argued “elimination of user fee for clinics and expansion of the clinic network have helped to make health services more affordable and geographically accessible to the poor” and they noticed an association between free primary health care clinics and a rise in health service utilization. The argument concurs with other studies which have found that poverty often result in older people neglecting to seek the necessary health care (De Cock et al., 2001; Bender, 1998).

Often older people encounter difficulties in accessing health facilities because these facilities are often far from their homes. In such cases, older people tend to hire cars and/or use alternative transport systems to get to the health facility. A comparative study of Botswana and Zambia by Nybiade and Field (2001) also highlighted a similar problem stating that health facilities are far and long distances to health facilities are an inhibiting factor to people consulting health care services especially in poor rural settings.

Studies have indicated that distance to health facilities is a problem faced by older people in utilizing health care services (Kroll et al., 2006; Arcury et al., 2005). Reif et al., (2005:562) asserted that long travelling distance to receive health care services in conjunction with a lack of accessible transportation for clients are barriers for health care utilization. Arcury et al., (2005:31) argued that in most parts of the developing world, older people especially in rural areas stay far from health facilities. If they are able to walk, they walk long distances to the nearest health care facility; otherwise, some older people rely on caregivers to deliver medication, as they are not able to walk. The most crucial time is when the outpatient has to consult a health provider - at least once a month - for an appointment. In rural KwaZulu-Natal, poor roads and public transportation impacts negatively on health seeking behaviour (Whiteside, and Sunter, 2001).

In their study, Reif et al., (2005:559) indicated that in most rural areas, long distances to care and lack of adequate, efficient and reliable transportation were some of the factors inhibiting health seeking behaviour in rural areas. In their study in Eastern Cape, Blaauw et al., (2004:94) indicated that one of the respondents claimed that “our province is so rural that some of our clinics are about fifty kilometres away from the nearest town...its frustrating and it’s a major problem”.

Transportation was one of the issues frequently arising from the literature as a barrier to accessing health care services. Bender (1998:3) indicated that access to transport is the real issue preventing older people from seeking health services. Arcury et al., (2005:36) indicated that access to transportation for health care is far from universal and where it is available, it is often restricted to those older people with chronic conditions and/or those affiliated to a medical scheme (e.g. medical aid).

Access to transportation (especially public transportation) increases health service utilization. In South Africa, though some public clinics are within walking distances in urban and peri-urban areas and distant in rural areas, some sickly older people still need transport to consult health service providers. In this instance, “...having transportation is an enabling factor for health care utilization” especially to those older people residing in rural areas of sub-Saharan countries (Arcury et al., 2005:35).

Furthermore, they argue that transportation, as an enabling factor may be more important than distance as a barrier for understanding health care utilization.

### **2.3.2 Partner Communication**

MacPhee (2005:723) argued, "...perceptions of vulnerability to HIV are strongly associated with older people who were not married, believed that their sexual partner would not approve of using condoms and had less comfort in communicating with their partner[s] about sex". In their study, Kroll et al., (2006) asserted that the vast majority of older women are infected through heterosexual contact. This form of transmission is largely promoted by poor partner communication particularly negotiation strategies around condom use.

Some studies have indicated that partner communication is a hindrance to accessing health care services (Cox, 1986; Stein, Fox and Mutara, 1991). For example, in patrilineal societies, men tend to be a barrier to women accessing health care services pertaining to their illnesses. In contrast, men seek health care services without partner consultation. A study in Ghana indicated that men tend to access health facilities without consulting their sexual partners even though there might be a clear sign of a sexually transmitted disease. This 'veil of secrecy' or 'unfrankness' has been found to motivate men to seek health services from traditional healers and other forms of health providers (Niang and Tapsoba, 2001).

### **2.3.3 Client-Provider Interaction**

Kroll et al., (2006:290) suggested that patient-health service provider communication is important in promoting a healthy working relationship. Shortus et al., (2005:67) indicated that, "as older people lack information about HIV-related symptoms and health services... it might be arguably true that the physiological and mental changes overwhelm them and empathetic communication with health service providers serves to build a dialogue, which further enhances health service utilization".

In their study, Kroll et al., (2006:288) indicated that older people felt that their preventative, treatment and care needs were frequently overlooked due to aging. This

was partly due to lack of patient-health service provider communication and health service provider's lack of knowledge. The results found that health service providers with aging knowledge are better equipped to communicate with older people who, at times, feel embarrassed to discuss their health needs (Shortus et al., 2005:67). Sometimes, older people are afraid to say what they feel because they fear that they would receive poor health care services.

De Cock et al., (2001) have indicated that health service providers' attitudes are pivotal in promoting satisfaction. Kroll et al., (2006:291) asserted that older people who were satisfied with health service provider's attitude towards them were more likely to return for further consultation for other health-related issues and were likely to communicate their needs. For example, a study found that courtesy provided by health service providers in the form of listening to the needs of the patient and asking how the patient felt from the last consultation prompted a caring attitude that further promotes patient's satisfaction (Kroll et al., 2006).

The attitude of health providers is another factor hindering VCT uptake. A study conducted in Kenya and Uganda suggests that health providers' attitude towards teenage indulgence in sex is negative and therefore, young people are scared away by such attitude (Horizons 2001). Moreover, health workers may sometimes have an unpleasant attitude towards people living with HIV and discriminate against them (Oberzaucher and Baggeley, 2002). If people encounter discrimination at health facilities there is a high chance that they will not go for VCT service because their results might be positive.

Older people dissatisfied with the attitudes of providers show a low uptake of health care service utilization (Mariano, 2005; Roeder, 2002; Hazell, 1976). Niang and Tapsoba (2001) argue that the negative attitudes of providers are likely to impact negatively on the presentation of health problems. Furthermore, these negative attitudes prompt stigma and fear resulting in low uptake of health care services especially in older people. Burger and Swanepoel (2006:2) in their study, in Cape Town, further indicated that older people's poor health care service utilization "...is driven by perceptions that services offered in public hospitals and clinics are of a low and variable quality". It was also pointed out that there was widespread negligence by

staff in public health care facilities such as hospitals and clinics. These perceptions seem to be encouraging some older people who can "...pay for private health services to opt out of the public health system" (Burger and Swanepoel, 2006:2).

Therefore, complaints by the users of public health facilities on health service provider's 'rudeness'; 'lack of sensitivity, courtesy and respect towards their needs' were barriers to the use of health services (Bender, 1998). For example, a study in Namibia indicated that older people were dissatisfied and frustrated by the nurse's attitude. They felt that the nurses were "so aloud that anyone could hear what was said to them" (McCourt and Awases, 2006:4) after an HIV/AIDS therapy session. Kroll et al., (2006:289) argue that, "'inappropriate or unprofessional behaviours on the part of the health service providers motivate older people not to seek health care from the public health care system". In addition, Niang and Tapsoba (2001:2) reported that client-provider interactions are influenced by the negative attitudes of both health service providers as well as older people themselves who 'felt shy or refuse to participate in the screening processes'.

#### **2.4. Factors Inhibiting Access to Health Services**

There are some people who hold the belief that they are not at risk of contracting HIV such as people who are not married, people who are in a monogamous relationship and the elders. However, a study conducted in Kenya and Uganda found that although young people visit VCT sites, they have the perception that they are not at risk of contracting HIV. Furthermore, parents and community leaders in Kenya concurred that testing is only for those who are ill. Therefore, such people are not likely to visit VCT services until they get more information that is appropriate, maybe from their peers such as community health workers, community support groups and other community groups (Horizons, 2001). In low prevalence countries, uptake of VCT is low due to people's scepticism. In Mali urban settings, more people were doubtful about the existence of HIV and those who believe it exists reported that they have seen somebody who died from AIDS (Castle, 2003).

Sometimes utilization of VCT services may cause physical abuse of vulnerable partners (Avanzini et al., 2006). If men would beat their wives and accuse them of



being promiscuous just because they are seeking help this will hinder use of VCT services. In Zambia, women said that it was thought to be shameful to have HIV and if they were known to be HIV seropositive, they were worried that they would suffer discrimination (UNAIDS, 2000). Studies from Kenya have also shown that women may be particularly vulnerable following VCT and in some cases have lost their homes and children or have been beaten or abused by their husbands if their status become known (ibid, 2000).

Confidentiality is one factor that people take serious when it comes to HIV testing. Many people are afraid to seek VCT services because they feel that if their status can be known they will suffer discrimination from families and community. However, if people doubt the confidentiality at the centre offering services then uptake will be very low. Therefore, VCT services should always preserve individual's need for confidentiality (UNAIDS, 2000). Trust between the clients and the counsellor enhances adherence to care, and discussion of HIV prevention. In situations where people who test seropositive may face discrimination, violence and abuse it is important that confidentiality be guaranteed (ibid, 2000).

Stigma and fear associated with HIV/AIDS is another factor that serves as a barrier to VCT uptake. Entwisle (2000) indicates that, HIV is stigmatized in many societies and people who are known to be HIV positive suffer discrimination. Berger and Swanepoel (2006: 40) state that, "local cultural beliefs and explanations about the disease and the cause of disease may also contribute to HIV/AIDS related stigma and discrimination". People are being discriminated because of stigma attached to HIV; therefore, people who would be eager to attend VCT services would fear that they would be discriminated against by the community. WHO (2003) states that studies from Africa suggest that AIDS related stigma is associated with people's bad sexual behaviour and their fear of breaking the taboo. Castle (2003) suggests that the main reason that educated people in Mali could not take the HIV test was the fear that they would be rejected by society and individuals would be discriminated against by their families if they were HIV infected.

One of the barriers to health service utilization is fear of stigma and discrimination. While older people are vulnerable to HIV/AIDS infection through sexual transmission

and other methods - such as caring for an infected child without the use of 'effective and necessary' prevention like wearing gloves –stigma associated with HIV infection is likely to inhibit health seeking behaviours. Stigmatisation leads to discrimination and people with HIV/AIDS "...experience prejudicial and discriminatory behaviour in many spheres of life and across many cultures" (Avanzini et al., 2006:60). For example, Avanzini et al., (2006) have indicated that people living with HIV/AIDS (PLWAs) are socially ostracised in employment settings and discouraged to take part in community activities.

Studies have shown that fear of stigma and discrimination act as barriers to seeking health services including VCT (Knodel et al., 2002; Nyblade and Field, 2001; Bender, 1998). Stigma refers to "attitudes or perceptions of shame, disgrace, blame, or dishonour associated with the disease" (Sherr, 1996:88) and vulnerability refers to "enhanced susceptibility to HIV infection or its consequences because of socio-economic, cultural, political, or biological reasons" (Schiltz and Sandfort, 2000:1572). Older people affected and infected with HIV/AIDS face greater stigma, limited accessibility, and restricted resources that further isolate this historically underserved target population (Moatti, 2003).

In Zambia, older people did not disclose their status for fear that their families would be embarrassed and disappointed while in Botswana older people indicated that they do not disclose their status for fear of how they will be judged (Bender, 1998). Reif et al., (2005) showed that in North Carolina, community stigma resulted in poorer adherence when it interfered with access to services or when fear of disclosure resulted in non-adherence to medical recommendations. Knodel et al., (2002) indicated that uptake of VCT is low in South Africa as community members including health service providers and care workers are not testing for HIV for various reasons like stigma and discrimination, traditional beliefs and gender issues. It is clear that stigma and discrimination against people living with HIV/AIDS are perhaps the most significant barriers to overcoming the epidemic and accessing health services (WHO, 2004). In a study conducted in Uganda on HIV positive patients, WHO (2004) asserted that HIV positive patients and those affected by AIDS are stigmatised by the health care system through health service providers and care workers.

Other studies have also indicated that friends and neighbours hold negative perceptions about older people infected by HIV (Caldwell, 2000; Berger, McBreen and Rifkin, 1996). This evidence proves that some societies have negative attitudes towards people who are HIV infected. This is amongst many issues that have an adverse impact on sexual health-related programmes. Bender (1998:12) indicated that due to stigma, older people seek treatment 'at night' or far away from their homes because they are deeply ashamed of their situation. There is the belief that people with whom they live with will treat them differently after their positive status disclosure. Stigma and discrimination is the worst enemy to older people as they find themselves on the already neglected side of health services prompting further social exclusion.

Despite the introduction of well-established voluntary HIV counselling and testing (VCT) systems in South Africa, generally, the uptake of VCT services has been low as most people are reluctant to get tested for HIV infection (Simbayi et al., 2005:140). A study conducted by Fyikesnes et al., (1999) to examine factors affecting the readiness for HIV VCT amongst older people found that self perceived risk and high-risk behaviour were positively associated with initial willingness but not with actual use. In their study, 37% of older people were willing to go for VCT but the actual number of those who utilized the service was 3.6% (Fyikesnes et al., 1999).

Older people could be willing to come to voluntary HIV counselling and testing centres but fear of stigmatisation and discrimination, being HIV positive and negative attitudes of health providers might be the cause of a general reluctance to test yet this opportunity could also make them access treatment to ensure their good health and longer life expectancy. HIV/AIDS discrimination leads to low uptake of health services. A common belief is that older people are sexually inactive and as a result, the risk of infection is low (Hall et al., 1982; Simbayi et al., 2005). Furthermore, the myth of sexually inactive older people may serve as a barrier to the use of HIV-related health services.

Oberzaucher and Baggley (2002) indicated that discrimination from their own village people where they live was the major cause of mental depression for older people infected by HIV. In their study, the interviewees reported that discrimination from other villagers existed extensively. Because of discrimination, older people infected

with HIV/AIDS suffered not only illness but also mental depression (Oberzaucher and Baggley (2002). Therefore, the existence of social discrimination also becomes the obstacle for older people affected by HIV/AIDS getting social support, which is not only a medical problem but also a social challenge.

Older people suffering from HIV/AIDS suffer social exclusion, as they are ashamed to reveal to their families, friends and health service providers their status because this incurs blame, discrimination and exclusion, loss of self-respect and self-esteem and even bodily harm (Oberzaucher and Baggley (2002). These challenges prevent them from going for HIV testing when some symptoms appear to resemble HIV infection. Because of discrimination, a study in Ghana, indicated that older people used fake names in health service consultations while others “intentionally conceal the actual situations” increasing the possibility of infecting others (Reif et al., 2005:14).

#### **2.4.1. Institutional Barriers**

Older people face barriers in accessing health care services inasmuch as health care facilities are limited in rendering services to older people because of a number of reasons including a lack of personnel, poor administration, equipment shortages, poor infrastructure and expanding demands in rendering health services (Veenstra and Oyier, 2006). Tshego (2000) indicated that the biggest hospital in South Africa - Chris Hani Baragwanath Hospital – serving, as an outpatient and referral hospital could not cater for loads of people consulting on a daily basis due to institutional barriers. The study claims that poor organisation and inadequate capacity leads to unnecessary long waiting times at health facilities (Tshego, 2000). Reif et al., (2005) observed that patients queue for a maximum of between three to six hours to receive not more than five-minute consultation with health providers.

Mathauer and Imhoff (2006) asserted that there is a great shortage of medical staff in South Africa, for example, geriatric specialized doctors. Geriatric medicine is defined as “the branch of medicine concerned with the diagnosis, treatment and prevention of disease in older people and the problems specific to aging” (Hazell, 1976:44). Furthermore, they also offer limited counselling services to older people due to a shortage of qualified counsellors. A study in Namibia indicated that older people felt

that health service providers were overworked hence they had to wait to form a group in order to be counselled and educated. This form of 'counselling' goes against the ethical guidelines of confidentiality but health service providers had no option but to take this route (McCourt and Awases, 2006).

Anderson (2004) indicated that though people are in need of health care services, health providers also face a huge burden. Health care providers are overworked and lowly paid even if they perform more than one duty (such as conducting medical check-ups and distributing treatments). Furthermore, this is largely due to a huge turnout of patients consulting health care facilities. Reif et al., (2005) argue that staff shortages are associated with long waiting times and inadequate treatment and care services.

Older people need specialised care in order to live a healthy life. However, the four most common illnesses of older people - arthritis, diabetes, heart disease and hypertension – are not being adequately treated because of equipment shortages (Blaauw et al., 2004). Older people perceive deficits in public health care services and agency resources as 'major problems' in rendering services. For example, some people need specialised treatment but health facilities are not able to meet the need for services. One of the examples is of people who may require liver dialysis at least twice or thrice a week but there is a scarcity of the dialysis machines, which are only found in major public and private hospitals (Reif et al., 2005). Veenstra and Oyier (2006) argue that many South African clinics have a limited list of drugs at their disposal and very rural clinics may not have access to laboratory facilities or radiological procedures. As a result, limited infrastructure and equipment, HIV/AIDS management has not managed to reach the neglected population.

With respect to the several health problems including HIV/AIDS affecting older people, there has not been an intensive campaign to inform them about risk reducing behaviours and about available services and to persuade them to use such health services (Rosenstock, 2005). This is despite the acknowledgement that preventive; treatment and care services cannot be equally available to all older people. South Africa's health services continue to face major challenges with regard to redressing

the health inequities inherited from apartheid. Amongst these challenges is addressing the HIV epidemic in the context of manageable and good quality health care.

Ovretveit (1998) argued that health care utilization has been low due to 'dissatisfaction with quality'. Therefore, knowing what older people expect is the first and most vital point in systematically analysing and delivering quality care (Reif et al., 2005:3). However, satisfaction is influenced by perceptions of service, costs, situation and personal factors (ibid, 2005). Older people's perceptions of the knowledge and courteousness of health providers, availability of equipment, communication and the accessibility of services were issues promoting dissatisfaction with quality of health services (Reif et al., 2005).

Reif et al., (2005:1) argued, "patients prefer private hospitals due to alleged inferior services offered at public hospitals". Dissatisfaction with quality emanates from staff shortages, budgetary constraints caused by too many patients resulting in long queues. A study in Botswana found that patient's satisfaction was considerably higher if the medical or health provider was friendly and the patient's expectations fulfilled (Bender, 1998).

The HIVAIDS prevention strategy consists primarily of encouraging people to reduce their number of sexual partners and to use condoms (Campbell, 1993). However, the primary predictor of reduction of the number of sexual partners and condom use is awareness. Studies have indicated that lack of knowledge is a hindrance to accessing health services (Anderson, 2004; Ovretveit, 1998). Although health care services are readily available in South Africa, older people lack knowledge of these services. However, despite the readily available health services, there is a lack of human resources, inadequate infrastructure and failure to improve on the quality of service delivery in the public health care facilities.

## **2.5. Other Illnesses Affecting Older People**

Health is a key contributing factor to quality of life and poor health is closely associated with low socio-economic conditions (Sususman, 2006:22). Studies have argued that older people are more vulnerable to disease because of "decreased

physiological reserves and defence mechanisms” (Blaauw, 2004:8). Despite this, however, older people are availing themselves for general medical and health services (Blaauw, 2004).

Some health conditions affecting women include but are not limited to changes in the skeletal, cardiovascular, nervous, skin genitourinary and gastro-intestinal systems as caused by declines in the ovarian hormonal levels triggered by menopause (CDC, 2005:22). Due to the absence of natural or synthetic substances that regulate body function, chronic diseases such as coronary heart disease and cerebro-vascular develop (Tinker et al., 1994). Furthermore, psychological problems such as social isolation, depression and dementia also become significant health problems.

Men also have health problems of their own. Some health conditions affecting men include but are not limited to cough, problems with joints (arthritis), chronic diseases (such as piles, problems with joints associated with arthritis, blood pressure, heart disease, urinary problems and diabetes). This may be due to social, behavioural and economic factors like education, religion, the use of tobacco, especially smoking, consumption of alcohol and income (CDC, 2005:23).

In a study in India among rural elderly people with chronic diseases, it was reported that they encounter arthritis, cough, and blood pressure as the major health problems experienced. CDC (2005) indicated that females aged 60-64 years were more likely to have arthritis than their male counterparts (44% and 33% respectively). Men aged 60-64 years were more likely to experience cough problems than their female counterparts (25% and 23% respectively). Furthermore, female aged 65-69 years were more likely to experience blood pressure problems compared to their male counterparts (21% and 19% respectively) (ibid, 2005). In South Africa, a country with a high prevalence of HIV/AIDS and TB-related to the epidemic, TB-related mortality has increased and the prevalence rate was reported to be increasing in the older age group (Simbayi et al., 2005).

There is also a heavy burden placed on older people as a result of HIV/AIDS. The emergence of the epidemic has made older people to assume the role as caregivers of HIV/AIDS at household and community level (Makiwane, 2004). In most

communities, women are the main carers when people fall sick, for example, they support orphans and provide the backbone for most voluntary efforts to raise awareness and change behaviour. However, there is a need of rethinking gender roles when forced to care for the sick or orphans (WHO, 2002).

There are few health services that specifically target older adults and this is manifested in the misconception that HIV infection affects the younger people (Entwisle, 2000). Due to the epidemic, older people are often faced with a task of caring for orphans and also their own children who are sick and/or dying of AIDS. In South Africa, one in three households is headed by older people, and within 66 per cent of these households, older people care for children (HAI, 2004). Older people are often faced with caring for children who are orphaned by AIDS without receiving any financial, emotional or physical support (May, 2003). In his study, Makiwane (2004) found that almost 10% of older people in Mpumalanga province are caring for sick and dying young adults living in the household. Caring for their sick and dying children makes them vulnerable to HIV infection due to lack of knowledge of preventative measures.

## **2.6. Summary**

In most parts of the world, older people are often neglected by prevention and treatment programmes. Although scarce literature indicates that older people are becoming highly vulnerable to HIV infection, there are many factors inhibiting and/or facilitating health seeking behaviour. There is lack of knowledge concerning HIV-related issues such as voluntary counselling and testing (VCT), anti-retroviral (ARV) therapy and so forth. For such issues to be addressed, awareness campaigns need to respond to the barriers associated with the utilization of health care services among older people.



## **CHAPTER THREE: METHODOLOGY**

### **3.1 Introduction**

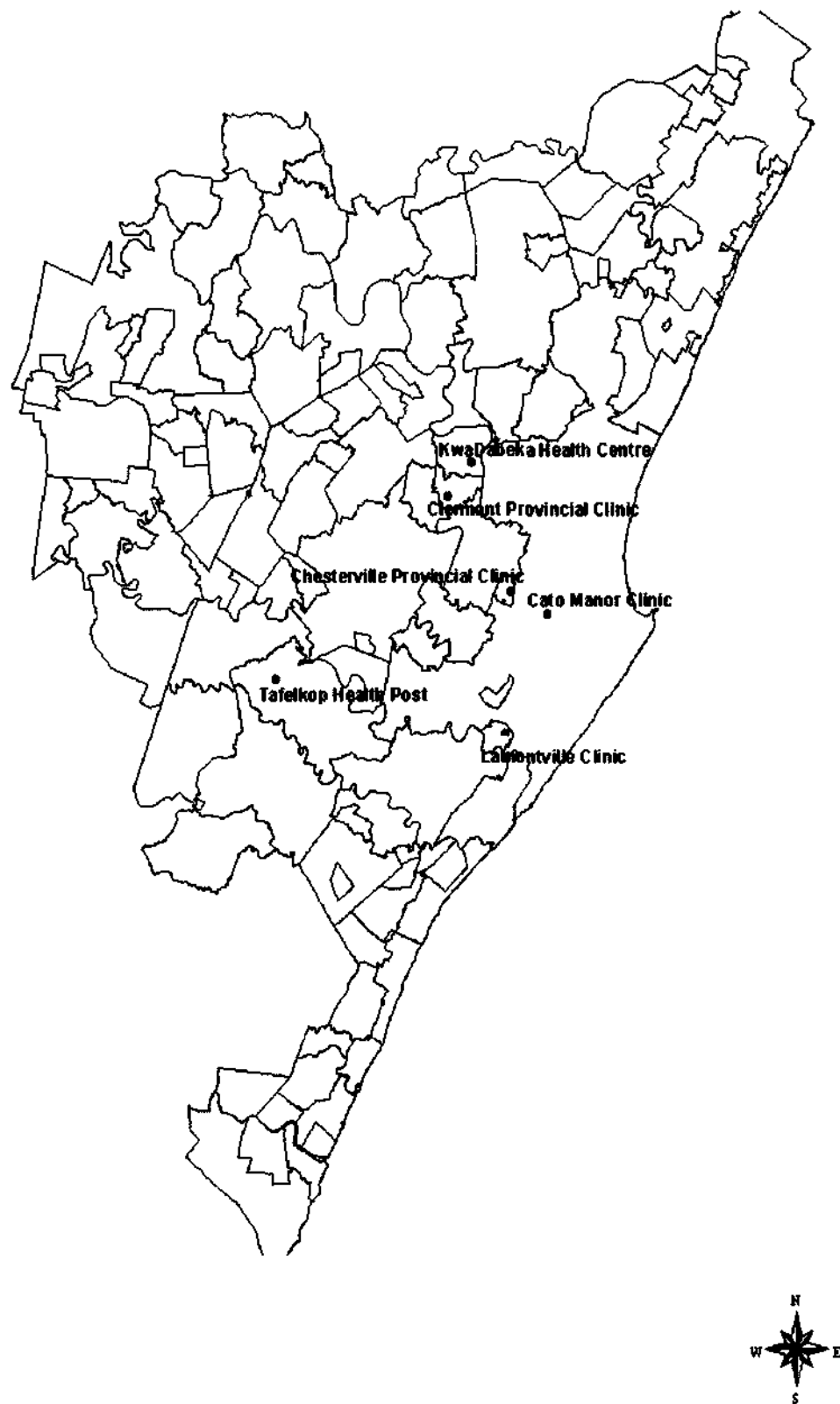
This chapter looks at the different methods of data collection used in the study. A combination of quantitative and qualitative methods was used. The quantitative data draws on exit interviews and the qualitative data draws on focus group discussions. This chapter first starts by providing a brief description of the study setting and then discusses the methods used in the study and the methods of data analysis.

### **3.2 Description of the Site and Population**

#### **3.2.1 Area of Study and Population**

The study was carried out in five sites – one rural and four semi-urban areas within the magisterial district of eThekweni Municipality, which falls under the jurisdiction of KwaZulu-Natal Province, one of South Africa's nine provinces, and the traditional home of the Zulu-speaking people. The province is the third smallest, with a total of 9.4 million inhabitants living on 94 361 square kilometres of land (Statistics South Africa, 2004). The 2001 Census shows that KwaZulu-Natal province has the largest population ratio in proportion to the country's total population (Statistics South Africa, 2005). The study comprises one rural site and five urban sites of which one of the urban site was used as a pilot study area and was not used in the actual data collection process. These facilities in the five sites were selected due to: (1) the large proportion of older population residing in these areas and (2) the high rate of HIV/AIDS infection. Figure 2 provides a map of the eThekweni Municipality which is the focus of this study.

Figure 2: Map of eThekweni Municipality



Source: eThekweni Metropolitan Municipality, Geographical Information Systems 2007

Along with high population rates, KwaZulu-Natal has high rates of poverty and one of the highest HIV prevalence in the country (Magnani et al., 2001). In South Africa, 37% of the population live in poverty, compared to 53% in KwaZulu-Natal as a whole. In addition, 31% of the country's working age population are unemployed, compared to 26% in the province, and the annual income per capita for South Africa is R5018, compared to R4023 for the province (KwaZulu-Natal Department of Health, 2005).

The results of the national HIV prevalence survey estimates that around six million South Africans are currently living with HIV/AIDS (Simbayi et al., 2005). HIV prevalence increases with age from 3.3% in children aged 2-14 years to 16.2% in adults 15-49 years of age. In older adults, the HIV prevalence is estimated to be 5.7% (Simbayi et al., 2005:1). Veenstra and Oyier (2006:265) argue that "there might be many more HIV-positive people attending health facilities for problems unrelated to HIV, most likely asymptomatic and not disclosing their status" due to stigma and discrimination associated with the disease and/or a lack of knowledge about the disease.

KwaZulu-Natal has the highest HIV prevalence in the country. Almost 40.7% of the population are estimated to be HIV positive, compared to the national figure of 29.5% (Health Systems Trust, 2005). The eThekweni Municipality is a more urban district than others in KwaZulu-Natal, and the population is largely clustered around rural areas, with 60% living in urban areas, compared to 46% in KwaZulu-Natal as a whole (ibid, 2005). The level of HIV infection is higher in urban dwellers than rural dwellers (Simbayi et al., 2005). HIV infection is higher in men than women and also higher in Africans (13.3%) than other race groups (2%) (ibid, 2005:3).

There are many factors contributing to HIV/AIDS prevalence in the eThekweni Municipality. Some of the factors promoting HIV/AIDS prevalence in the province include the existence of the harbour, which is claimed to be the busiest in the African continent (Manning, 2002). The Durban harbour as the "economic hub of the city" and province is a gateway for truck-routes that travel to various business centres throughout the country and the prevalence of sex workers regarded as HIV/AIDS

catalysts around these areas may be contributing to the spread of HIV/AIDS in the province (eThekweni Municipality, 2006:15).

The vision of eThekweni Municipality is to build a caring city through health care provision, holistic approach to mental and physical well-being and protection of the marginalized, poor, sick and young (eThekweni Municipality, 2006:15). The municipality ensures the delivery of the following health services amongst others: health promotion, prevention of diseases, HIV/AIDS services such as voluntary counselling and testing (VCT), condoms, HIV vaccines and tuberculosis (TB) and anti-retroviral (ARV) treatment (ibid, 2006:15).

The Health Unit of the eThekweni Municipality is implementing its own strategy based on the national strategy aimed at amongst other things “prevention, care and support of the infected and affected, human rights issues” (eThekweni Municipality, 2006:39). In 2005, the eThekweni Municipality had 104 public health facilities. Despite a large number of public health facilities, the utilization rate has remained constant at 1.9 visits per person per year in 2003/2004; 2004/2005 and 2005/2006 (KZN DOH, 2007). Statistics for the eThekweni Municipality indicate that more than 80% of the municipal primary health care centres are providing VCT, which is a key strategy in the treatment of HIV/AIDS (eThekweni Municipality, 2006:39). However, very few public sector facilities offer specialized ARV treatment programs and as such, the waiting period of accessing treatment is still too long due to a lack of “adequately trained staff, laboratory and pharmaceutical support, client and community participation in prevention, treatment and care of the epidemic” (ibid, 2006:39).

The study employed a layered sampling frame thus the selection of public health facilities was purposive in that it focused on provincially supported, local authority, health posts (mobile services) and clinics within the eThekweni Municipality. The interviewer considered this sampling frame in that: (1) it would be easy to get older people; (2) there would be many older people attending health facilities and (3) with the help of health care providers, it would be easy to solicit interviews. Facilities within the eThekweni Municipality were “randomly selected” based on the above-mentioned assumptions.

There are ethical guidelines by which the study had to adhere to when conducting research on older people's perceptions of health services and their health seeking behaviour in the era of HIV/AIDS. Interviewing older people was a multistage process involving a number of key stakeholders before the interviews could finally take place. The first stage was to receive the ethical approval from the University of KwaZulu-Natal, which did not take so much time and gave me a false belief that everything would run smooth. More permission required to start interviews and focus group discussions. The second stage was to consult and seek permission from relevant authorities. The researcher used the letter of approval from the University of KwaZulu-Natal to further seek permission from MUSA who were the key stakeholders in granting approval to access study participants and/or respondents. There were some challenges to finally get into the field and start data collection. Delays were experienced at this stage as the committee for MUSA had to sit and evaluate my proposal in order to respond to my request. A response came after four months, following a series of phone calls, meetings, and e-mail correspondence.

### **3.3 Research Methodologies and Design**

#### **3.3.1 Quantitative Methods**

The study employed both quantitative and qualitative methods. The quantitative data comes from exit interviews with older men and women attending health facilities in the eThekweni Municipality. The advantages of using this method are that it is relative easy to administer and is less expensive than other methods of data collection (Creswell, 1997). They could be made confidential or anonymous, thus encouraging respondents to provide honest and accurate responses (Durrheim and Wassenaar, 1999). Another advantage is that it offers less opportunity for 'irrelevant information than do group interactive processes' (Marshall and Rossman, 1999:42). Information could be gathered in a relatively short period and generally be aggregated and analyzed by computer processing (Kane, 1985) to provide statistical description of the study matter.

The disadvantages of this method are that the questionnaire development process can be complex, time-consuming, and expensive (Creswell, 1997). In addition, Kane

(1985) asserts that if the questionnaire is too short, it is usually too general to be useful. If it is too long, it may be too costly to develop and administer, and respondents may not want to take the time to answer. This normally prompts a low response rate resulting in a non-representative sample (ibid, 1985). There is no assurance that the questions or items would be accurately understood (Durrheim and Wassenaar, 1999:32), as 'there may be a lack of assurance that the intended respondent was the one who actually answered the survey questions'. Furthermore, Durrheim and Wassenaar (1999) indicated that responses to open-ended questions could be difficult to summarize and analyze.

### **Questionnaire**

The questionnaire used for the study comprised of close-ended questions (Durrheim and Wassenaar, 1999). These are a useful tool for collecting quantitative data of attitudes, perceptions (on sensitive topics), opinions, and practices (Creswell, 1997; Durrheim and Wassenaar, 1999). Respondents were selected through convenience sampling with the assistance of health providers at public health facilities within the eThekweni Municipality. In total, two hundred questionnaires were administered to older men and women attending facilities within the eThekweni Municipality. Each interview took approximately thirty minutes. A breakdown of these interviews shows that at each facility, 40 exit interviews were conducted. An attempt was made to ensure an equal distribution of men and women. However, more women than men participated in the study. All the respondents were African.

The respondents were approached directly after consultation with the health provider and asked if they would be willing to participate in the study. They were informed about the objectives of the study and that their participation in the study was voluntary. Only those who agreed to participate in the study were interviewed. All their responses were kept strictly confidential and anonymity was maintained at all time. The questionnaire was an extensive battery of 62 questions. Questions in the instrument were included based on a review of similar international and South African surveys on health seeking behaviour and attitudes towards health services. The questionnaire asked older people about their general socio-economic and demographic characteristics, knowledge and awareness of health services, factors inhibiting and/or

facilitating access to health services (such as stigma, discrimination, distance, transport, costs, providers' attitudes, shortages of staff and equipment), sexual behaviour and relationship characteristics, knowledge of and attitudes toward HIV risk and AIDS (*see Appendix I*). Results from individual interviews were backed up with information from two focus group discussions.

The quantitative approach is used to solicit statistical, representative hence generalizable data, but its predetermined and standardized data collection and analysis techniques (such as questionnaires) elicits shallow responses which lack contextual detail on key issues relating to the subject matter (Ulin et al., 2002). For instance, the proposed study collected information that touched on HIV/AIDS, testing for HIV, use of condoms, and so forth. With this in mind, many studies have revealed that in studies of this nature, participants feel uncomfortable discussing personal issues (Ulin et al., 2002; De Cock et al., 2002; Schiltz and Sandfort, 2000; Sherr, 1996).

### **Techniques of Analysis**

Data analysis was performed using SPSS version 15, software package (SPSS, Inc., Chicago, IL). First, frequencies were conducted to describe and summarize the data. Crosstabulations were also used to determine the associations between variables. The study applied the logistic regression to analyse the influence of predictive variables on health care service utilization.

#### **3.3.2 Qualitative Methods**

This study also draws on qualitative research methods. Qualitative research has been defined as a type of research involving the interpretation of non-numerical data (Welman and Kruger, 2003). According to Babbie and Mouton (2001) qualitative research gives a more in-depth description and understanding of events or actions and this helps the researcher to gain insights into why and how these events or actions take place rather than just presenting a phenomenon or the what, where, and when of quantitative research. Kvale (1996) defines qualitative research as an attempt to understand the world from the subjects' point of view, to unfold the meaning of peoples' experiences, to uncover their lived world prior to scientific explanations.

As an inductive approach, qualitative research allows respondents to express feelings and opinions in their own words. According to Kane (1985), qualitative researchers often rely on interpretive and critical social science which speaks the language of cases and social contexts. Therefore, qualitative method involves documenting real events, recording what people say (with tones, words or gestures) observing certain behaviour to develop new ideas as one is examining a particular natural setting. The researcher preferred this method as it allowed much more detailed investigation of issues, for example, what were the factors inhibiting and/or facilitating health seeking behaviour.

Ulin et al., (2002) argues that interpretive or exploratory studies require techniques that offer room for a researcher to engage in a seemingly informal conversation that encourages the subjects' free participation to enable the researcher to elicit relevant information. In such scenarios, pre-determined data collection techniques such as questionnaires (as used in quantitative research approaches) are less preferred and instead, qualitative data collection techniques (such as focus group discussions) are used since they allow in-depth exploration of issues relevant to the study.

Largely, the choice of the qualitative approach has, therefore, been made to enable the researcher to obtain detailed answers to questions posed in this study. Lofland and Lofland, (1984) supported the use of qualitative approaches arguing that the approach facilitates flexibility to edit and re-design the study approach and methods while it is in progress, focusing on areas of particular importance and excluding information deemed unproductive to the study. It is for this reason that this study employs the qualitative approach, to enable soliciting of relevant, precise and specific data.

Although qualitative methods yield rich in-depth data that emerges from probing and deeper exploration of the subject matter, its sample selection techniques are argued to offer limited breadth in terms of selection of participants and as a result, may contribute to data distortions (Ulin, et al., 2002). This characteristic may result into eliciting of inaccurate data with less precision.



## **Focus Group Discussions**

A qualitative research approach is used to collect primary data using focus group discussions with selected participants. The qualitative data from focus groups discussions will supplement the quantitative data. The main advantages of using the focus group discussions as a data collection tool is that it provides insights into not just 'what' participants think, but also 'why' they think it (Durrheim and Wassenaar, 1999). This tends to reveal consensus and diversity of participants' needs, experiences, preferences, and assumptions about the issue at hand.

Brief information about the study was provided before the commencement of the interview; first the researcher's name and institution was provided, then the study's purpose, procedure, relevance and the importance of the respondents' participation in the study. An informed consent statement was given to respondents, which explained the type of questions to be asked and how the information provided through the interviews was used, as well as assuring them of confidentiality. Participants were informed that their responses would be written down in the form of notes by the researcher, as well as tape-recorded, in order to ensure that no information given by the participants was missed. Participants were also requested to sign the form indicating their agreement to participate in the study.

In total, two focus group discussions were held - one focus group was conducted with men only and the other, with women only. Each group comprised six participants and lasted approximately one hour. Convenient sampling was used in the selection of participants with the assistance of health care providers. The focus group was homogeneous, with participants of similar backgrounds as much as possible in terms of age (being 50 years and above), race (being black Africans) and also by the fact that they want to be interviewed. The idea behind the use of this method is that the researcher was seeking older people perceptions of health services based on the "day's consultation" or the "day's visit to the health facility". This meant that prospective participants were selected on the spot with their consent and in cooperation with health service providers or those in charge of the facility.

The focus group interview guide collected information on a range of topics including knowledge, attitudes and perceptions of risk of HIV infection as well as older people's perceptions relating to health service providers' behaviour and attitudes as motivators and/or barriers of accessing health services (*see Appendix 2*).

Focus groups discussions were chosen as one of the methods used for this study because older people may feel more comfortable and less vulnerable in a group situation than they would feel in individual interviews. It is without doubt that focus groups allows interactions such that participants are able to build on each other's ideas and comments to provide an in-depth view not attainable from individual interviews (Kane, 1985). This further increases knowledge as 'unexpected comments and new perspectives can be explored easily' due to the interactive nature of group discussion where "participants are given the leverage to express their perceptions, experiences, feelings fully and honestly" (Creswell, 1997:25).

### **Techniques of Analysis**

The focus group discussions were tape-recorded and the interviewer also took notes during the discussions. The data analysis involves sorting and coding of the data commenced in the field. The data collected from the field was later transcribed and typed in MS Word, whereupon appropriate codes were assigned to particular themes emerging from the data. A report was produced which presented preliminary findings of the study; thereafter a thorough scrutiny of the plausibility of findings as well as the consistency of arguments was made before producing the main report.

### **Triangulation**

Triangulation is the method used to 'enhance trustworthiness' or 'verify findings using different data collection methods' of the data collected (Patton, 2002:55). It is argued that this method "involves using multiple sources and perspectives to reduce the chance of systematic bias" (Patton, 2002:56). Therefore, quantitative and qualitative data collection methods were used to "corroborate, elaborate or illuminate" research findings (Marshall and Rossman, 1999:194). This study applied 'triangulation by methods' where different data collection methods were used,

namely, focus group discussions and exit interviews. Triangulation as a data analysis method was used to seek out information that could provide insights about the factors inhibiting and/or facilitating health seeking behaviour in the era of HIV/AIDS.

Triangulation methods are often opted for when the researcher is interested in the behaviour and/or opinions of large groups of people about a particular topic or issue (de Vaus, 2002; Fraenkel and Wallen, 1993). This allowed older people to express their opinions and views. It also helped the researcher to have a correct understanding of the phenomena by approaching it from several perspectives because 'more than one data gathering method strengthens the study's usefulness' (Marshall and Rossman, 1999:194).

### **3.4. Limitations of the study**

Many older men and women regard sexual and HIV/AIDS matters (that are core concepts of this research) as sensitive and private matters. Therefore, some respondents may feel "intensely embarrassed or threatened when asked to reveal what they do, think, and feel during their sexual encounters" (Catania et al., 1990:340). Also, there may be a possibility of respondents giving socially desirable responses. According to Catania et al., (1990:340), gathering information on sexual and HIV/AIDS matters is subject to "measurement error" and "participation bias". Furthermore, Catania et al., (1990:341), argues that "measurement error is of critical concern to AIDS research". High levels of measurement error may distort and consequently, weaken behavioural epidemiological work.

Given the sampling procedures as well as the small sampling size, the study does not claim to be representative of the entire population of people aged 50 and above. According to Zeisel (1981:65), using this method tends to yield results that are not generalisable to other situations – as the sample is not representative of the population as a whole. This implies that the data generated on the perceptions of older people at these public health facilities at the eThekweni Municipality will not be applicable to other public health facilities across the province of KwaZulu-Natal or South Africa. By covering a limited number of areas, the study reflects perceptions, attitudes and

opinions of older people in the research sites and cannot reflect situations in other parts of the province nor country as a whole.

Bias and error are endemic in any scientific study. As for this study, errors are likely to arise from the fact that the study touches on sensitive issues such as sexuality, safe sexual behaviours, health seeking behaviour in the context of high levels of HIV/AIDS and other related diseases. This situation was noted among respondents who openly argued that issues of sex are private and cannot be discussed openly, as is the case in a research study. Although the researcher produced proof of ethical clearance for the study and made assurances of confidentiality, some respondents were reluctant to provide detailed and/or informative statements on sensitive issues. Such a scenario limited both the amount and depth of information yielded in such interviews, which may impact on the quality of data collected.

Another major set back in this study was that due to the sensitivity of the research focus, many people felt uncomfortable to talk about sexual issues in public, let alone with a stranger (the researcher). For instance, some respondents felt it was taboo to discuss such issues, while others argued that their religion does not permit them to talk about such issues. As such, respondents found it generally hard to express their views on the subject.

Despite these limitations, the study's strength lies in its "exploratory and qualitative character" (Mathauer and Imhoff, 2006:6), for instance, it sheds light on what is considered important by older people seeking health services in public health facilities. Such a study is not only intended to give older people a voice but also finding out what really matters to them in accessing health services in the era of HIV/AIDS. The study may unearth some of the crucial issues pertaining to HIV/AIDS and which requires urgent attention in the community.

## **CHAPTER FOUR: QUANTITATIVE FINDINGS OF THE STUDY**

### **4.1 Introduction**

This chapter deals with the main findings of the study. It examines the results from the exit interviews conducted with older men and women to determine their perceptions of health services and their health seeking behaviour in the era of HIV/AIDS. Based on the theory, the analysis focussed on socio-economic, demographic and environmental factors affecting access to health services in the eThekweni Municipality.

### **4.2 Background Characteristics**

In analysing and interpreting the study findings, it is important to give a picture of the socio-economic and demographic characteristic of the respondents. Table 4.1 depict the socio-economic and demographic characteristics of the study population in the eThekweni Municipality.

The sample comprised persons aged 50 and above who were accessing health facilities for various reasons. More females (70%) than males (30%) participated in the study (see Table 4.1). Although the researcher wanted an equal number of men and women, it appears that women are more likely than men to seek health care services. In South Africa, a clear trend is that women are most likely to consult health providers or visit health facilities to access health services (Tshego, 2000).

The age of the respondents ranged from 50 to 87 years. The mean age of the sample was 59 and 38.5% of the population were older than 70 years. Of the total sample, 41% of the respondents fall in the age category 60 to 69 years and 31.5% fall in the age category 70 to 79 years.

**Table 4.1: Background Characteristics of the Sample**

	<b>N.</b>	<b>%</b>
Total	200	100
<b>Gender</b>		
Male	60	30.0
Female	140	70.0
<b>Age Group</b>		
50 - 59	41	20.5
60 - 69	82	41.0
70 - 79	63	31.5
80 +	14	7.0
<b>Level of Education</b>		
None	56	28.0
Primary	60	30.0
Secondary	81	40.0
Tertiary	3	2.0
<b>Marital status</b>		
Married or cohabiting	66	33.0
Single or Never married	43	22.0
Divorced, Separated or Widowed	91	45.0
<b>Occupational status</b>		
Employed	12	6.0
Unemployed	188	94.0
<b>Place of Residence</b>		
Urban	160	80.0
Rural	40	20.0
<b>Current sexual partners</b>		
No partner	94	47.0
1	91	45.0
2 +	15	8.0

The level of education of the sample was relatively high. Most of the respondents had at least primary school education. The majority of the respondents (40%) had secondary education, followed by primary education (30%). Few had more than secondary education. The findings of the study illustrate that only 2% of the respondents had tertiary education. The respondents who choose 'none' for their level of education specified that they have attained some other type of education by taking up courses such as sewing, weaving and craft making. The study found that 45% of

the respondents were divorced, separated or widowed, followed by 33% who were married or cohabiting and 22% who were single or never married (see Table 4.1).

The majority of the sample (94%) reported that they were currently unemployed. Only 6% reported that they were in formal employment. Although the majority of older people reported that they were not in formal employment, some of them engaged in informal trade such as bead making, weaving, dressmaking, and as community caregivers. Almost 80% of the respondents reside in urban areas while the remaining 20% reside in rural areas. This result was largely influenced by the sampling methods, which choose four urban sites and one rural site within the eThekweni Municipality.

The study also looked at the number of current sexual partners of respondents. Almost half of the respondents indicated that there had no sexual partner and 45% indicated that they had only one sexual partner (see Table 4.1). Few respondents reported more than one sexual partner. Only 8% indicated that they had two or more sexual partners. Although there were a limited number of men participating in the study because fewer men were attending health facilities, men were more likely than women to have multiple partners. Respondents were also asked if they ever used a condom with their most recent sexual partner. Almost 14.5% reported ever using a condom. The majority reported that they had never used a condom with their most recent sexual partner.

The study found that the majority of respondents (65.5%) received an old age pension. A significant proportion reported receiving remittances (21.5%) and disability grant (21%). Few respondents were employed. Only 14.5% reported that employment was their main source of income (see Table 4.2). Interestingly, 4.0% reported that they had no main source of income while other respondents indicated that care dependency; foster care and child support grants were their main source of income.

**Table 4.2: Percentage of respondents who reported their main source of income**

<b>Main source of income</b>	<b>%</b>
None	4.0
Employment	14.5
Remittance	21.5
Old age pension	65.5
Disability grant	21.0
Care dependency grant	1.5
Foster care grant	1.5
Child support grant	1.5

### **4.3 Knowledge and Awareness of HIV/AIDS**

The study examined knowledge and awareness of HIV/AIDS among older people participating in the study. Awareness of HIV/AIDS is universal. All the respondents had heard of HIV/AIDS. In the first instance, respondents were asked about the main routes of HIV transmission. Knowledge of the main routes of HIV transmission is fairly high. Table 4.3 shows that the majority of respondents (81%) reported that HIV/AIDS is transmitted through sexual intercourse. A significant proportion (75.5%) reported contact with blood or blood products as the main source of HIV/AIDS transmission. It is worth noting that 23.5% reported that there were 'other' forms of transmission. They indicated that contact with fluids such as urine when caring and/or washing the HIV infected without the use of gloves as a form of HIV/AIDS transmission. In 'other' forms of transmission, it is interesting to note that 14.5% reported infection could occur through casual contact with an infected person. Interestingly, 0.8% reported that they are not aware of any method of HIV transmission.

**Table 4.3: Percentage of respondents reporting methods of HIV transmission**

<b>Main routes of transmission</b>	<b>%</b>
Infection through sexual intercourse	81.0
Infection through blood or blood products	75.5
Other forms of transmission	23.5
Don't know	0.8



The study also examined measures used to protect against the risk of HIV infection. The majority (97%) reported that a person could protect himself or herself from contacting HIV/AIDS. Few older people (2%) reported that they were unsure whether a person could protect him or herself from contacting HIV/AIDS. Only 1% reported that a person could not do anything to protect himself or herself from contacting HIV/AIDS.

Table 4.4 illustrates respondent's knowledge of ways of protecting against HIV infection. The study found that 67% of the respondents reported consistent condom use as the main method of HIV/AIDS protection, followed by 32% for abstinence. A large percentage of respondents also stressed the need to limit number of sexual partners or have only one partner. Interestingly, 14% stated that it was important to avoid sex workers. Twenty-nine percent (29%) reported 'other' ways of protection such as the use of gloves when washing the infected person.

**Table 4.4: Respondents reporting their knowledge of ways of protection**

<b>Knowledge on ways of protection</b>	<b>%</b>
Abstain from sex	32.0
Non-penetrative sex/thigh sex	21.0
Always use condoms	67.0
Limit number of sexual partners	19.0
Have only one sexual partner	32.0
Avoid sex workers	14.0
Use sterilised needles	1.0
Require partner to have blood test	9.0
Other ways of protection	29.0

#### **4.4 Sources of HIV/AIDS Information**

The majority of respondents (96%) reported public clinics or hospitals as the main source of information about HIV/AIDS. Some of the reasons for this might have been the notion that health services are women's domain in terms of accessing health care services as studies have shown that more women than men seek health care services (Akpan et al., 2006; Cummins, 2002). It is worth noting that respondents in rural areas indicated mobile clinic are an important source of HIV/AIDS information, followed

by 'other' sources of information such as friends, community caregivers etc. Furthermore, 4% reported work while 2% reported that they were unsure of the sources of information (see Table 4.5).

**Table 4.5: Sources of information about HIV/AIDS**

<b>Knowledge on sources of information</b>	<b>%</b>
Public clinic or hospital	96.0
Private doctor	6.0
Place of employment	4.0
Other sources of information	47.0
Unsure	2.0

#### **4.5 Perception of risk of HIV Infection**

The study also explored the perception of risk of HIV infection amongst older people. A substantial proportion of respondents reported little or no risk of HIV infection. The study found that 38.5% of older people reported 'no chance' of HIV infection followed by 37% who reported that they had a low chance of contracting HIV infection. It is worth noting that few (3.5%) respondents perceived a high risk of HIV infection.

**Table 4.6: Respondents reporting their chances of contracting HIV/AIDS**

<b>One's chances of contracting HIV infection</b>	<b>N.</b>	<b>%</b>
High	7.0	3.5
Medium	42	21.0
Low	74	37.0
No chance	77	38.5

Table 4.7 shows that males were more likely than female to perceive a medium or high risk of HIV infection. Almost 36.7% of men, compared with 19.3% of women perceived a medium or high risk of HIV infection. The younger age groups were more likely than the older age groups to perceive a medium or high risk of HIV infection. The perception of risk of HIV infection decreased with increasing age. Respondents in the 50 to 59 age group reported the highest risk of HIV infection. It is worth noting that none of the respondents aged 80 and above reported a medium or high risk of HIV infection.

The level of education was also used to determine the perceived risk of HIV infection. Importantly, perceived risk of HIV infection increased with level of education. Respondents with tertiary education were more likely to report a medium or high risk of HIV infection compared with those with no or primary school education. Those with primary school education were least likely to report a medium or high risk of HIV infection.

Single or never married older men and women were most likely to report a medium or high perceived risk of HIV infection. They were followed by the married and cohabiting respondents. A number of studies suggest that men and women in stable sexual relationships may be at risk of HIV because of their partner's sexual behaviour. Divorced, separated or widowed respondents were least likely to report a medium or high perceived risk of HIV infection. It is likely that they do not perceive themselves at medium or high risk of HIV infection because they are not in a sexual relationship.

Employed respondents were more likely than the unemployed to report a medium or high risk of HIV infection. Only 23.4% of unemployed respondents report a medium or high risk of HIV infection, compared with 41.7% of employed respondents. The study also examined perceived risk of HIV infection by number of current partners. The findings show that older men and women with two or more sexual partners were most likely to perceive a medium or high risk of HIV infection. Almost 78.6% of older men and women with two or more partners perceived a medium or high risk of HIV infection. Those with no partners were least likely to perceive themselves at medium or high risk of HIV infection. Only 17% of older men and women with no partners perceived a medium or high risk of HIV infection.

**Table 4.7: Risk of HIV Infection by background characteristics**

<b>Risk chance for HIV Infection</b>	<b>N.</b>	<b>High/Medium (%)</b>
<b>Gender</b>		
Male	22	36.7
Female	27	19.3
<b>Age Group</b>		
50 - 59	20	48.8
60 - 69	10	12.2
70 - 79	10	30.2
80 +	0	0.0
<b>Level of Education</b>		
None	16	28.6
Primary	12	20.0
Secondary	19	23.5
Tertiary	2	66.7
<b>Marital status</b>		
Married or cohabiting	20	30.3
Single or Never married	14	32.6
Divorced, Separated or Widowed	15	16.5
<b>Occupational status</b>		
Employed	5	41.7
Unemployed	44	23.4
<b>Place of Residence</b>		
Urban	34	21.3
Rural	15	37.5
<b>Current sexual partners</b>		
No partner	16	17.0
1	21	23.1
2 +	12	78.6

#### **4.6 Knowledge of HIV/AIDS-related services**

Table 4.8 illustrates the main reasons for visiting health facilities. The study found that 84% of older people visited health facilities for personal illness, followed by 11.5% for HIV/AIDS treatment services and 4.5% for VCT.

The findings of question directed at exploring “where older people usually go for HIV counselling and testing?” revealed that the majority (40%) consulted hospitals or

clinics followed by 31% for private doctors. The striking point was that although there are mushrooming VCT centres around the Municipality, older people do not seem to use these centres for counselling and testing. The study found that only 15% of the sample ever consulted these centre voluntary counselling and testing. Furthermore, 8% of older people indicated they consult traditional healers with regard to HIV/AIDS-related services. This showed that although traditional healers are a source of health restoration especially amongst older people, they are not commonly used as a source of voluntary HIV counselling and testing. Only 6% of the respondents were unsure or did not know where older people seek HIV counselling and testing. None of the respondents reported having gone to the facility to fetch condoms.

**Table 4.8: Percentage of respondents reporting a reason for visiting health facility**

<b>Reason for visiting health facility</b>	<b>N.</b>	<b>%</b>
Total	200	100
VCT	9	4.5
ARV Treatment	23	11.5
Personal Illness	168	84.0

#### **4.7 Use of HIV/AIDS-related services**

Table 4.9 illustrates respondents' knowledge of HIV/AIDS health services provided at health facilities. The study indicates that there is high level of knowledge of HIV/AIDS services provided at health facilities. However, there was greater knowledge of HIV counselling and testing services than treatment services. The study found that 63% of the respondents reported that voluntary counselling and testing were provided at the facility while 48% reported that HIV/AIDS treatment were provided at the facility. A significant proportion of respondents were not sure if either HIV counselling and testing or treatment services were provided at the health facility. It is also worth noting that 31% percent of the respondents were unsure whether counselling and testing services were provided at the health facility while 42% reported that they were unsure whether HIV/AIDS treatment services were provided at the health facility. Most of the respondents knew that condoms were offered at the health facility. The majority of respondents (85%) reported that condoms were offered

at health care facilities with significantly low percentages either being unsure (10%) or indicating that condoms were not offered (5%). Forty-eight (48%) percent of older people indicated STI services were offered at the facility while 34% were unsure whether these services were offered at the health care facilities. A significant minority (18%) of respondents reported that the health facility did not offer STI services.

**Table 4.9: Percentage of respondents reporting services provided at health facility**

<b>Health services</b>	<b>Yes</b>	<b>No</b>	<b>Unsure</b>
HIV/AIDS counselling and testing	63.0	6.0	31.0
HIV/AIDS treatment	48.0	10.0	42.0
Condoms	85.0	5.0	10.0
STI services	48.0	18.0	34.0

Table 4.10 illustrates older people ever use of HIV/AIDS-related health services. The study findings indicate that few use HIV/AIDS-related health service. Only one quarter (25.5%) of the respondents reported ever using HIV counselling and testing services. It is interesting to note that 15.5% of the respondents reported ever use of HIV/AIDS treatment while 84.5% reported that they have never used the service. In addition, few respondents (22.5%) reported ever using a condom in contrast to 77.5% who reported that they have never used the service. Treatment for STIs is also not very popular. Only 29.5% reported having ever used STI services in contrast to 70.5% who have never used the service.

**Table 4.10: Percentage of respondents reporting ever use of health services**

<b>Ever use of HIV/AIDS-related health services</b>	<b>Yes</b>	<b>No</b>
STI services	29.5	70.5
HIV/AIDS counselling and testing	25.5	74.5
HIV/AIDS treatment	15.5	84.5
Condoms	22.5	77.5

#### **4.7.1 Ever use of HIV/AIDS services by background characteristics**

The study found that men were significantly more likely than women to ever use HIV/AIDS services. Statistics indicate that 40% of men ever used HIV/AIDS services

compared to 22.9% of women that ever used HIV/AIDS services. The age group 50 – 59 were significantly more likely than other age groups to ever use HIV/AIDS services. None of the respondents in the age group 80 and above reported ever using HIV/AIDS services (Table 4.11).

With regard to level of education, the study found that older people with secondary education or higher education were more likely to ever use HIV/AIDS services than any other group. Statistics indicate that 37% of older people with secondary education reported ever use of HIV/AIDS services (Table 4.11). Older people with no education were least likely to report ever use of HIV/AIDS services. The study found that employed respondents were significantly more likely than unemployed respondents to have ever used HIV/AIDS services. However, it is important to point out that few respondents were employed. Employed respondents reported 41.7% ever use of HIV/AIDS services compared with 27.1% of unemployed respondents.

With regard to place of residence, there was little difference in ever use of HIV/AIDS services between urban and rural respondents. Almost 28.1% of urban respondents reported ever use of HIV/AIDS services compared with 27.5% of rural respondents. The study also looked at ever use of HIV/AIDS services by marital status. Married or cohabiting respondents were most likely to report ever using HIV/AIDS services. A large percentage of respondents who were married or cohabiting (37.9%) reported ever use of HIV/AIDS services followed by 30.2% of single or never married and 19.8% of divorced, separated or widowed respondents (Table 4.11). Respondents with two or more sexual partners were significantly more likely than respondents with one or no sexual partners to report ever using HIV/AIDS services. Almost 73.3% of respondents with two or more sexual partners reported ever use of HIV/AIDS services compared with 30.8% and 18.1% of respondents with one partner and no current sexual partner respectively.

**Table 4.11: Ever use of HIV/AIDS services by background characteristics**

	<b>N.</b>	<b>%</b>
<b>Gender</b>		
Male	60	40.0
Female	140	22.9
<b>Age Group</b>		
50 - 59	41	53.7
60 - 69	82	29.3
70 - 79	63	15.9
80 +	14	0.0
<b>Level of Education</b>		
None	56	17.9
Primary	60	25.0
Secondary	81	37.0
Tertiary	3	33.3
<b>Marital status</b>		
Married or cohabiting	66	37.9
Single or Never married	43	30.2
Divorced, Separated or Widowed	91	19.8
<b>Occupational status</b>		
Employed	12	41.7
Unemployed	188	27.1
<b>Place of Residence</b>		
Urban	160	28.1
Rural	40	27.5
<b>Current sexual partners</b>		
No partner	94	18.1
1	91	30.8
2 +	15	73.3

The logistic regression model was used to test the relationship between the dependent variable ‘ever using HIV/AIDS services’ and the independent variables (gender, age, level of education, marital status, place of residence and current sexual partners).

Table 4.12 presents the odds ratios for older men and women ever using HIV/AIDS services. The logistics regression shows that men have a higher odds of ever using HIV/AIDS services than women. Among all age groups, older men and women aged 50 – 59 have a higher odds of using HIV/AIDS services. Level of education is also a



significant predictor of ever use of HIV/AIDS services. Older people with secondary or more education are 2.20 times more likely to ever use HIV/AIDS services than older people with less than secondary education.

Looking at the independent variable 'marital status', divorce, separated or widowed respondents had a higher odds of ever using HIV/AIDS services than older people who were single or never married and divorced, separated or widowed. After adjusting for other variables, single or never married people were least likely to report ever use of HIV/AIDS services. The place of residence also has a positive effect on ever using HIV/AIDS services. The study found that rural respondents were 8.89 times more likely to ever use HIV/AIDS services than urban respondents. It is important to note however that the sample size for rural respondents is small.

The other independent variable looked at was current sexual partners. The study found that after adjusting for other variables older people with two or more current sexual partners are 6.69 times more likely to report ever using HIV/AIDS services than older people with less than two current sexual partners.

**Table 4.12: The odds ratios of ever use of HIV/AIDS services: results from the logistic regression.**

<b>Background Characteristics</b>	<b>Odds Ratios and 95% confidence intervals</b>
<b>Gender</b>	
Male	1.00
Female	0.83 (0.36 – 1.88)
<b>Age Group</b>	
50 - 59	1.00
60 - 69	0.41 (0.16 – 1.03)
70 +	0.04 (0.01 – 0.21)
<b>Level of Education</b>	
None	1.00
Primary	1.70 (0.58 – 5.00)
Secondary or More	2.20 (0.83 – 5.86)
<b>Marital status</b>	
Married or cohabiting	1.00
Single or Never married	0.73 (0.24 – 2.18)
Divorced, Separated or Widowed	1.30 (0.45 – 3.79)
<b>Place of Residence</b>	
Urban	1.00
Rural	8.89 (1.74 – 45.34)
<b>Current sexual partners</b>	
No partner	1.00
1	1.25 (0.45 – 3.46)
2 +	6.69 (1.25 – 35.82)

#### **4.8 Perception of Health Services**

Table 4.13 shows older people's perceptions of health services. The table indicates that 30% of the respondents agreed that staff gave them an opportunity to ask questions during their consultation. The study indicates that 28% percent of the respondents agreed that they were provided with all the information about HIV/AIDS during consultation. Interestingly, 53% of the respondents reported that staff was too busy to answer their questions. On the question whether staff answered older people's questions to their satisfaction, 28% of the respondents agreed that staff answered questions to their satisfaction. Furthermore, 22% of older people reported that they find it difficulty to talk to staff about sexual matters while 21% percent of the

respondents reported that they find it difficult to talk to staff about HIV/AIDS. A majority of respondents (42%) agreed that there was insufficient privacy during consultation.

The other point considered for analysis was the waiting time for consultation. The study indicates that 47% of the respondents felt that the waiting time for consultation was reasonable. Furthermore, only 48% percent of the respondents reported that they felt that they received good quality care. The majority of respondents (81%) reported that health providers must provide information regarding HIV/AIDS to older people. The study also found that 11% reported that health services targeting older people would increase health seeking behaviours.

**Table 4.13: Percentage of respondents reporting their perceptions of health services**

<b>Perceptions of health services</b>	<b>%</b>
Staff gave me an opportunity to ask questions	30.0
I was provided with all the information about HIV/AIDS during consultation	28.0
Staff were too busy to answer my questions	62.0
Staff answer questions to my satisfaction	28.0
I find it difficult to talk to staff about sexual matters	22.0
I find it difficult to talk to staff about HIV/AIDS	21.0
There was insufficient privacy during consultation	42.0
Waiting time for consultation was reasonable	47.0
After consultation I felt I received good quality care	48.0
Health providers must provide information about HIV/AIDS to older people	81.0
Health services targeting older people will increase health seeking behaviours	11.0

Older people were asked what the kinds of treatment, do they think, people living with HIV/AIDS get at the health facility. Table 4.14 shows that 31% felt that people living with HIV/AIDS receive kindness, followed by 20% who felt that they receive love and 16% who indicated that they encounter isolation. Therefore, with higher knowledge about HIV/AIDS in the society, older people have accepted the existence of HIV/AIDS mainly from their sick and dying children but also from encountering

the disease as infected persons. It is worrying that some older people report quite negative reactions from the community. The study further indicates that 3% encounter physical abuse, 5% encounter rejection from community and 6% encounter rejection from home.

**Table 4.14: Perceptions of the kinds of treatment people living with HIV/AIDS get at the health facility**

<b>Kinds of Treatment</b>	<b>N.</b>	<b>%</b>
Total	200	100
Isolation	32	16.0
Physical abuse	6	3.0
Verbal abuse	24	12.0
Rejection from home	12	6.0
Rejection from community	10	5.0
Receive love	40	20.0
Receive kindness	62	31.0
Receive help	14	7.0

#### **4.9 Summary**

The quantitative findings have indicated that there is some knowledge and awareness of HIV/AIDS-related services among the older population. The use of HIV/AIDS services such as voluntary counselling and testing remains low. However, males were significantly more likely to have ever used HIV/AIDS services. The age group 50-59 were also more likely to use HIV/AIDS services than other groups. As level of education increases so does ever use of HIV/AIDS services. Older people are most likely to visit health services for personal illness. In general, respondents were satisfied with the services that they received at the health facilities but they would like to receive more information about HIV and AIDS. They also felt that they would like to have their questions answered more satisfactorily.

## CHAPTER FIVE: QUALITATIVE FINDINGS OF THE STUDY

### 5.1 Introduction

This chapter presents the findings from the focus group discussion. The findings of the focus group discussions are organized into particular themes. The main strength of using focus group discussion is the rich descriptions that are provided. In this section, the researcher draws extensively on the verbatim responses of the group.

### 5.2 Knowledge and Awareness of HIV/AIDS

In general, older people have some basic knowledge and awareness of HIV/AIDS. Although older people interviewed clearly showed some knowledge and awareness of HIV/AIDS, the knowledge they had about the epidemic was largely from caring for their sick and dying children. However, a few older people affiliated to community or home-based care organizations had been taught about HIV/AIDS including caring for the sick. Older people reported that home-based caregivers taught them about the disease although most teachings were directed towards caring for the sick rather than educating them on reducing their own risk of HIV infection.

*'No...we are in constant search of knowledge. We would like to deepen our knowledge about HIV/AIDS. We must add some new knowledge on top of what we already know in order to understand more about the disease. In fact, as you are talking to us now, we would expect you to teach us something about the disease' (FDG#1).*

*'It's like everyone here one-way or the other knows about this disease. I have had first-hand experience with my grandson's infection. Older people know about this disease, if not, then this might not be complete ignorance but some form of limited knowledge about it. We have seen it and it has also affected our families' (FGD#2)*

Despite a fair amount of knowledge and awareness regarding HIV/AIDS, older people indicated that they would like to receive more information about HIV/AIDS. In

particular, they wanted to obtain more information about symptoms experienced by people living with HIV/AIDS. They felt that if they were aware of the symptoms they could protect themselves against the risk of HIV infection especially if they were caring for someone who was sick and/or dying of HIV/AIDS.

Women were more interested than men in increasing their knowledge of symptoms of HIV/AIDS, as they are, in most cases, the primary carers for any sick members of the household. Some women indicated that by knowing the symptoms of HIV/AIDS, they will be able to protect themselves when caring for their infected children who only inform them of the cause of illness when the disease is at advanced stage. Therefore, older women want to take precautionary measures when caring for the sick in order to reduce their own risk of infection. Although some women tend to use gloves, in most cases, the use of gloves comes later when the sick person is at an advanced stage of the epidemic. This places older women at risk of contracting the disease.

*'Our biggest problem is the identification of the symptoms and as you are explaining to us, it's really our first time to hear of it. What we know about HIV/AIDS is that the disease is spread by unprotected sexual intercourse amongst younger people. Among older people, the disease is spread through washing sick grandchildren without wearing gloves and in most cases, they don't tell us what would be their problem until we take them to the health care facility' (FGD#2).*

Knowledge of the means to protect themselves against the sexual transmission of HIV/AIDS was fairly high. Older people indicated that they had heard of condoms but they had never used them. This was largely due to lack of knowledge on how to use them. In one focus group, one male participant explained that older people are sometimes told about condoms but are not shown how to use them. In both focus group discussions, older people expressed an interest in knowing how to use a condom. The promotion of condom use in a setting with a high prevalence of HIV is important even among older people. Condoms provide older people with protection against STIs (including HIV/AIDS).

*'Let me set the facts straight. Older people know condoms but they do not use them. Health providers must teach us how to use these condoms. However, as an older person, I think condoms are useful as they prevent sexually transmitted diseases and other infections that one might not know of' (FGD#1).*

*'We would be grateful if only health providers could help us know how to use condoms. Caregivers and other health workers should visit us at homes in order to tell us more about diseases affecting older people such as arthritis, diabetes, cancer and so forth...they can also bring medicines, gloves and condoms maybe we might learn to use them' (FGD#2).*

Most older people feel that access to condoms is not a problem. Condoms are widely available at public health facilities at no charge. In addition, they can also be purchased from retail outlets if one does not get them from a health facility.

*'Older people get condoms at health facilities free and they are also sold in shops. We do not buy them as they are provided by the government hence most of the time we get them in health facilities but we can buy them in shops if it happens that one wants to use them and they are not available in public health facilities' (FGD#2).*

The study also explored other methods of protection among older people other than the use of condoms. The probe was aimed at exploring perceptions of other age-specific prevention measures. The study found that older people believe in the practice of thigh sex – a non-penetrative form of sex. They indicated that it is difficult to abstain from sex and although they are sexually active, they would sometimes practice thigh sex with occasional partners.

*'These days, people seem to be behaving well because it's us men who normally spread the disease. In the past we never engaged in sexual activities until one got married. We used to practice thigh sex (ukusoma) most of the times and it did work wonders for us' (FGD#1).*

Although thigh sex is depicted as a form sexual affection and not a form of abstinence, older people indicated that this practice was only done until the partners got married. Older people also indicated that abstinence is not doing any good because as much as people are taught about it, they still engage in sexual intercourse and at times, the sex is unprotected.

*'No...because there's no one who can bar anyone from engaging in sexual activities, we must be provided with condoms to protect ourselves from the epidemic. One must always be carrying condoms wherever they go...you never know...we are men, as you know though it is vitally important to trust the person whom you are with' (FGD#1).*

### **5.3 Perception of risk of HIV Infection**

Whipple and Scura (1996) argued that, older adults should be considered at risk for HIV/AIDS because they express themselves sexually, may be (or have been) intravenous drug users, may have received blood transfusions, and may already have a compromised immune system due to other age and health related conditions. Societies or communities need to realize the magnitude of the problem that older people are facing because some of them are not faithful to their partners and some may also visit sex workers (De Carlo and Linsk: 1997).

In the focus group discussions older men and women admit that they engage in sexual intercourse and therefore are at risk of HIV infection. However, men are more likely than women to engage in sexual relations. Women argue that their interest in sex has declined with age.

*'We get it from older men or our husbands who refuse to get old by engaging in sexual activities with younger women and later come home to infect us. These older men are known as 'sugar daddies' because they are resource providing male partners. Older women cannot really instruct their partners to wear condoms as we might be subjected to violent attacks and intimidation. Although older men know that they have to use condoms when having sexual intercourse with other sexual partners they*



*refuse to use them at home and chances of them using condoms outside the home is limited' (FGD#2).*

The above statement indicates that older women sometimes knew that their partners were at risk of contracting HIV and infecting them afterwards but were not able to address the issue because of fear of sexual violence and intimidation. Whipple and Scura (1996) argue that among other factors, poverty, low self-esteem, and social instability, and unequal gender relations, influence occurrence of such risky sexual behaviours among these groups of people. They further assert that these factors have been exacerbated by drug abuse and higher rates of alcoholism noted among these people. Furthermore, they felt it was appropriate to safeguard their long-standing marriage for the benefit of their children.

It became clear in the focus group discussions that some older men have sexual relations with younger women. They often provide these younger women with resources in exchange for sex. Some women expressed fear of contracting HIV because their partners had more than one sexual partner. This was largely due to the acceptable norm of men having multiple partners practiced within the study area. However, this behaviour was not seen as acceptable to all men. Indeed, some men were critical of the practice especially in this era of HIV/AIDS. They felt that multiple sexual partners were exacerbating the AIDS epidemic in South Africa.

*'Polygyny is as ancient as culture, it is important to trust and to respect each other in a relationship. The bible says that one man must have one woman and not to have three or twenty because I am not a king. However, this is different with our traditional African cultures. Some men are allowed to have as many women while others are not allowed' (FGD#1).*

Although older people expressed the need to follow tradition, they felt that this was fraught with difficulties because of the dangers associated with risky sexual behaviour in the era of HIV/AIDS. A few older people, especially men, supported the practice of polygamy. They were in favour of having more than one wife because they would be faithful to these wives and they would not have to have sex with unknown sexual partners and therefore increase their risk of HIV infection.

Some older people also were aware of the risk of HIV transmission through blood or blood products. Sometimes they may become infected through the sharing of contaminated instruments. Even though tradition is important, older people also expressed fear of contracting HIV infection when consulting traditional healers who sometimes use one razor blade for the whole family when performing rituals.

*'Culture plays an important role in this society and it is significant to us as older people. The use of one razor blade to cut the whole family puts everyone at risk of contracting the epidemic. Therefore, in such instances culture is a hindrance of taking hygienic measures to protect people from the epidemic' (FGD#2).*

There were clearly some concerns regarding HIV/AIDS and dogmatic traditional beliefs. On the one hand there were some older people who accepted the traditional way of doing things while on the hand there were some older people who expressed fear of contracting HIV/AIDS because of these traditional beliefs.

Some older people felt that they were being stigmatised and discriminated against in health facilities by health providers and in communities by close relatives and friends. Their stigmatisation and discrimination emanates from the myth that older people are asexual beings. However, older people are potentially at risk by having more than one sexual partner, engaging in unprotected sexual intercourse and also due to caring for the sick and the dying without necessary protective care. A focus group discussant indicated that:

*"It's a shame that someone of my age is found to be positive...HIV positive in the community however, it's even better that going specifically for HIV/AIDS treatment as there are specific days and specific queues for people with such illness...well, everyone will know why you are queuing in that line instead of the other"(FGD#1).*

In the early days of the epidemic there was a secrecy surrounding HIV/AIDS. Many people were often isolated, ostracized and stigmatised by fellow members of the society. Although stigmatisation and discrimination still persists, most societies have

come to understand and witness that HIV/AIDS kills many people indiscriminately. The way people perceive HIV/AIDS has changed drastically.

#### **5.4 Perception of HIV/AIDS services**

It is important to note that while older people have a number of concerns regarding health care services; this has not hindered them from seeking care at health facilities. However, these concerns may serve as a deterrent to older people's future health care seeking behaviour if they are not addressed. The study explored barriers to health care utilization amongst older people.

Interpersonal relations, according to Bruce (1990), refer to the personal dimensions of service. Interpersonal relations are defined as the effective content of the client-provider transaction. This dimension may strongly influence clients' confidence in their own choices and ability, satisfaction with the services, and the probability of a return visit. Almost all older people expressed a general satisfaction with the services they had received. They felt that they had been satisfied with the services they had been offered.

*'Doctors, nurses, social workers and caregivers are helpful although sometimes, we don't seem to be getting everything that we need from this place' (FGD#2).*

*'On prevention and treatment, I must say...health providers in this health facility are trying their best in treating older people and we are provided with benches where we can sit in queues' (FGD#1).*

In general, older people described the providers as friendly and helpful but some felt that providers require more training to deal with the concerns of older people. For instance, some older people indicated that there was not sufficient time to ask questions and some felt that providers did not give them the opportunity to ask questions about issues that they thought were important such as diseases associated with the aging process and/or HIV/AIDS.

In addition, some older people complained about the services that they received at the health facility. They were concerned about the lack of respect on the part of health providers. Older people felt that the health providers treated them disrespectfully. Some complained that they were shouted at, harassed and sometimes not offered help when they needed it the most or even given clear instructions on how to take medications while at home.

*'Nurses sometimes harass us for forgetfulness. Health providers complain that older people are an unmanageable group who always want attention and special treatment. We are old and from time to time you have aches...we have come to accept this but the nurses have not come to acknowledge this situation we are living with' (FGD#2).*

Some older people also expressed dissatisfaction with the care offered by health care providers at some health facilities. Although health providers are helpful and most of the times, older people leave health facilities satisfied with the services they had received, some older people indicated that there are some providers specifically nurses who lack professionalism and empathy. They indicated that most of these nurses are young and really do not seem to understand the aging process which might also be complicated by the diseases associated with HIV infection. During the focus group discussions, older people indicated the challenges they are faced with when attending health facilities. They complained bitterly about the attitudes of health providers especially nurses who do not seem to care much about their needs.

*'Some challenges we face at these health facilities is the care offered by health providers especially nurses. They take so much time when they take tea breaks. No matter how sick one is, they would sit back and talk amongst each other and their friends. Older people would appreciate attentive, spontaneous treatment and care because we are sick' (FGD#1).*

The study has found that the long waiting period is a cause of dissatisfaction among older people. One of the women stated that they have to wake up early in the morning to queue for tablets or consult with the doctor. The clinics are normally overcrowded and they have to wait in the queue for at least six hours in order to see the doctor.

*'The problem at this place is the long queues. I used to think twice before I could visit this place but now caregivers queue for us and we join later thus saving us time to wake up early in the morning. The long queues may sometimes cause confusion. For example, after visiting the toilet we may forget which queue we need to join and sometimes the nurses harass us for forgetfulness' (FGD#2).*

Older people consulting health services identified special negative qualities of the health providers. One focus group respondent complained about the rudeness of health providers.

*"Other health providers are very rude to us when we go there, it's like they don't care about us older people...sometimes, you don't even hear what is being said because of hearing dysfunctions but you are told that you don't hear. They say: I can't repeat myself as I don't have all the time in the world...Next" (FGD#2).*

Some older people felt that they received good treatment from health providers when they went for their consultation. One respondent indicated that there were some health providers who stand out as 'preferred health consultants' for older people.

*"The doctor asked me what has brought me to the clinic today because I look fine ... I look as if I can walk to Pinetown and back. It made me think of my days when I was young, when I could run and this made me to believe in myself"(FGD#1).*

The study found that some older people prefer consulting health providers with the same ethnic background. There was a view that providers of a similar ethnic background might be able to better understand the needs of the patient. One respondent indicated that:

*"Well, I can understand him well as he speaks my language and it makes me happy as I can ask questions about my health...which is why I don't like to be attended by the other (races)...they don't understand me though nurses*

*are sometimes brought in as interpreters, something is not right about this because I want to spend time with my doctor” (FGD#2).*

On the contrary, ethnicity preference is not considered in terms of health service satisfaction and/or experience of the service provided. In focus group discussions, one older person argued that local health providers lack some of the expertise of foreign health providers.

*“I have been with this disease for long now...in 1982, I was treated by Dr Smith at King Edward Hospital and after consultation my knees would just stop aching because he knew the right medicine...but now, I have a pile of tablets that I take home after consultation because I am given the wrong medication which makes me feel worse than before” (FGD#1).*

This statement also indicates a preference based on experience/skill and use of particular medicines. Often the western health providers are favoured because they prescribe medication while traditional healers are chosen due to their skill and experience in treating certain kinds of illnesses especially spiritually oriented discomforts associated with and believed to be evil-induced.

## **5.5 Knowledge of HIV/AIDS-related services**

There is a high burden of HIV/AIDS in South Africa and it is therefore important to try to determine awareness of HIV/AIDS services. The study explored what knowledge older people had regarding HIV/AIDS services. One of the services mentioned were condoms. Most older people indicated that they had heard of condoms and further argued that they were generally used as a preventive and protective measure against HIV infection.

*As we have said earlier, older people know condoms but they don't use them. Health providers must teach us how to use condoms as we think that condoms are useful as they prevent sexually transmitted diseases and other infections that one might not know of because of the complexity of the epidemic (FGD#1).*

*As older people, we have been taught, we know about condoms and also when to use them but we don't use them. At this health facility, health providers (as in nurses) sometimes give us boxes of condoms and we take them home to our children sleeping rooms although we don't tell them about condoms. Since we are failing to use them, it's also fine that we give them to our children. (FGD#2)*

During the focus group discussions, some older people also indicated that they had heard of condoms but the challenge was to know how to use them correctly. Equally important was the importance of keeping and/or taking condoms home in order to give to their children. Therefore, older people act not only in their own best interests but also try to curb the epidemic among younger people. With knowledge of HIV/AIDS-related services, older people are able to help provide their children with condoms and hence promote family health.

#### **5.6 Use of HIV/AIDS-related services**

Some older people indicated that they have never seen an older person infected with HIV/AIDS except those infected who consult health care services for HIV/AIDS management such as receiving anti-retroviral (ARV) treatment. Older people reported that the most resourceful HIV/AIDS service provided in health care facilities is 'testing' for HIV/AIDS. Upon further probing concerning whether older people access HIV/AIDS testing services and what were their perceptions regarding this service, one older person indicated that testing for HIV/AIDS is the only way to know one's status.

*'It has been said that one cannot really see the disease by mere fact of talking to you or even looking at you. I do not know whether the disease is there or it is not there but they say that the blood test is the only way of knowing whether such a thing really exists. I am thinking that is the only way of knowing one's status' (FGD #1).*

*'I think one of the best solutions is to encourage each other to go for testing, other than that, no...I don't see any other way of dealing with the matter' (FGD#1).*

The study has found that some older people especially those attending community-based centers are more likely to have regular, structured health care consultations compared to the non-affiliates of any community organization. When asked, “Where do you go or whom do you consult when you are ill?” older people indicated that they consult clinics and in exceptional cases, they would visit the hospital. One respondent indicated that:

*“The clinic is very near; in fact, it’s just a walking distance from my place...but would prefer to go to hospital since doctors are sometimes available”(FGD#2).*

Distance to health care facilities is also factor influencing the decision to seek treatment. The reason for clinics as the first health service entry facility is due to the fact that some older people stay within the closer proximity to clinics. However, this study has found that distance is closely related to where one seeks treatment. In rural areas, older people walk a long distance to the nearest health facility while the opposite is true for urban areas. In urban areas, health facilities are often situated close to residential areas. A focus group discussant indicated that:

*“Though you might be sick, you think twice of going to the clinic as it is very far and public transportation in this area is not good at all...children have to hire a special car to take you to the facility but that is costly as well...so we find yourselves sick but as you see...there are no jobs, our children are unemployed, we find yourselves living at the mercy of God”.*

Most of the urban population is well served with health facilities within close proximity to residential areas while the majority of the rural population have to travel a long distance to get to the health care facility.

## **5.7 Summary**

The chapter has presented the qualitative findings from focus group discussions. It has raised interesting issues regarding knowledge and awareness of HIV/AIDS, knowledge and the use of HIV/AIDS services. The study has found that some older people have some knowledge and awareness of HIV/AIDS in the form of



transmission and preventive methods and caring for their sick and dying children. Although it was made clear that most older people know about condoms, the challenge facing both older men and women is the information regarding use of condoms.

## **CHAPTER SIX: DISCUSSION AND CONCLUSION**

### **6.1 Introduction**

This chapter presents a discussion of the main findings of the study taking into consideration the quantitative and qualitative data. The discussion is aimed at elaborating on older people's perceptions of health services in the era of HIV/AIDS and their health seeking behaviour. Furthermore, the study findings are compared to previous studies.

### **6.2 Discussion of findings**

Bernstein (2004) elaborates that, as part of older people being at risk for HIV/AIDS, much of it is based on how much they know about HIV/AIDS. This study has found that older people have relatively basic knowledge of HIV/AIDS. Unfortunately, this population has not been targeted with HIV prevention messages because they are not considered to be at risk and yet their risk is probably rooted in their limited knowledge and awareness about the disease. Furthermore, this study has found that older people have limited knowledge of their own risk of HIV infection. This finding concurs with other studies that have indicated that older women are less likely to be knowledgeable about their own risk for HIV infection compared with younger women (Siverson, 1999; De Carlo and Linsk, 1997).

The situation in sub-Saharan Africa, as revealed by the available literature, points to the universal problem whereby older women often care for HIV/AIDS patients and orphans (Bureau of Statistics: 2003). The study has found that some older women are caring for their sick and dying children and orphans. Although they expressed the need for more information on HIV/AIDS, the responsibility for caring for their sick and dying relatives has resulted in increased knowledge and awareness among older people. Despite greater knowledge and awareness of HIV/AIDS fewer women than men reported ever use of HIV/AIDS-related services.

The study also found that a large proportion of older people are aware of condoms. For example, study findings indicate that the majority of older people knew that

condoms were provided at health facilities at no cost and that they are also sold in shops and other recreational centres. It is also necessary to point that they knew condoms were used as protection for HIV infection and older people also expressed the need to abstain from sex and having only one sexual partner. Condom use among older people was not common. Many older men and women stated that they do not know how to use condoms. It is also possible that some older men and women do not see the need for condoms because there is no or limited risk of pregnancy. Therefore, educational strategies are needed to provide information about correct use of condoms. Although older people know about condoms, there have less knowledge and awareness of other HIV/AIDS-related services such as VCT and ARV treatment. Few reported ever using HIV/AIDS services. Needless to say that older people want to receive sexual health services at health facilities but there are institutional barriers that need to be addressed for older people to know and use HIV/AIDS-related services.

The study also found that the majority of respondents indicated that HIV infection is transmitted through sexual intercourse and blood/blood products. Although they knew the major routes of transmission, there were some myths regarding transmission. The issue here is that until older people are taught about HIV/AIDS so that they acquire relevant information regarding the epidemic, it is difficult to dispel the myths associated with the epidemic.

The other interesting finding is that a small but not insignificant proportion of respondents had two or more sexual partners. This phenomenon is exacerbated by widely acceptable practice of having multiple sexual partnerships which is prevalent in KwaZulu-Natal. In most instances, men are more likely than women to report having more than one sexual partner. Furthermore, studies have also indicated that although people might not be in polygamous relationships, older men tend to have younger female sexual partners (Fee, 1983) hence putting themselves and their older sexual partners at risk of contracting HIV and other STIs. Within these polygamous relationships, there are some unfaithful partners. For instance, older women feared for their lives because of their male partners who had sexual relationships with younger women and further articulated that these men were most likely to engage in unprotected sex. A few older women also engage in sexual activities with younger men, further promoting the spread of the epidemic. However, there is a difficulty in

studying sexual behaviour because older people consider sexual issues as a private matter and hence it is considered a taboo topic. Hence, people may over- or under-report their number of sexual partners.

The study also found that perception of risk of HIV infection among older people was low. This study has found that perception of risk of HIV infection was higher in males than females. In other words, the majority of older people did not perceive themselves at risk of HIV infection. This was influenced by the fact that a few older people especially women did not have any sexual partners. This study reveals that there are some older people who do not have sexual partners. However, they may be at risk of HIV infection because of caring for the sick and dying.

Studies have indicated that there is a general acceptance that people with many sexual partners are at a higher risk of contracting HIV and STIs (van Dyk, 2001; Fee, 1983). Although this study did not explore this point in great detail, sexual activities involve older men and younger women have been raised as a factor facilitating the spread of HIV/AIDS among older people. This has highlighted the need for interventions focussing on educating people to reduce the number of sexual partners, being faithful to one partner and the use of condoms. Although the study has generally indicated that older people have basic knowledge of the disease, there has been no clear-cut interventions aimed at addressing, especially prevention issues amongst this population.

The study found that older people are more likely to consult health services for personal illness. Older people are more likely to consult health facilities for other diseases associated with the aging process. Most respondents have indicated that they encounter illnesses including but not limited to cough, problems with joints (arthritis), chronic diseases (such as piles, problems with joints associated with arthritis, blood pressure, heart disease, urinary problems and diabetes). The most interesting finding is the 11.5% reported for HIV/AIDS management such as consulting health care facility to obtain treatment. This indicates that HIV/AIDS is also a problem to older people. Although it might be possible that some older people were infected before they reach 50 years of age, there is also a possibility that some of them were infected at later stage.

The costs associated with health care may also play a critical role in influencing use of health care services especially amongst older people who are in the informal sector. For instance, although the study findings indicate that the majority (94%) of the respondents were unemployed, the operating times at health care facilities were not convenient to some people, as they had to engage in daily economy activities such as street trading in the informal economy.

As far as medical services are concerned, most poor people rely on public health clinics and to a lesser extent, private doctors or specialists. This study has found that one of the problems encountered by older people accessing clinics was the long waiting period. The implication was that older people are unattended for a long time and worse, some faint while in the queue. Therefore, studies have indicated that if poor people would rather pay for health care services than avail themselves for free public health care; it raises interesting questions amongst other issues, accessing public health facilities and the quality of services offered in such institutions. Long waiting times, rude and uncaring staff, lack of drugs coupled with a sizable number of complaints about the poor quality of health facilities were the major problems faced by older people, more particularly in public health facilities. The findings of the study indicate that older people expressed overall satisfaction with services but felt that there was a need to strengthen prevention strategies that directly target older people.

Other studies have indicated that older people's presentation of health problems is hampered by the negative attitudes of health care providers or staff (Mariano, 2005; Roeder, 2002; Niang and Tapsoba, 2001). Furthermore, these negative attitudes prompt stigma and fear resulting in low uptake of health care services especially in older people. This study has found that older people find it difficult to present at health facilities because of the fear of not being properly treated by health providers who are either too young and/or unskilled to understand their health needs. Some older people expressed the need of health providers of their own ethnicity as they felt that they would be able to communicate with them and hence understand their health needs.

The need for older men and women to seek early HIV testing and treatment in developing countries is hampered by health care systems that are unaffordable and

inaccessible. In their study, Burger and Swanepoel (2006:2) have argued “elimination of user fee for clinics and expansion of the clinic network have helped to make health services more affordable and geographically accessible to the poor and were associated with a notable rise in health service utilization”. This study found that since older people access free health care services in public health care facilities, many of them are willing to access health care facilities for various diseases including HIV/AIDS.

Studies have also indicated that poverty; transportation issues and long waiting hours often result in older people neglecting to seek the necessary health care (De Cock et al., 2001; Bender, 1998). In addition, client-provider interaction is hampered by negative attitudes of both health service providers as well as older people themselves who “feel shy or refuse to participate in screening processes” (Niang and Tapsoba, 2001:2). This lack of health service accessibility is compound by older people’s acceptance of health problems as part of the normal aging process. Gender relations further restrict access and use of health services.

The study indicated that few older people use HIV/AIDS-related services such as voluntary counselling and testing and STI services. For example, only a quarter of respondents reported using HIV/AIDS counselling and testing services. This was partly due to a lack of knowledge and awareness of HIV/AIDS-related services and also stigma and discrimination in the form of verbal abuse and isolation. However, older people indicated that since HIV/AIDS affects almost all households, the epidemic can no longer be kept a secret and infected people must receive love and kindness rather than suffer stigma and discrimination in their communities.

One of the barriers to health service utilization is fear of stigma and discrimination. This study has found that older people are afraid to access HIV/AIDS counseling and testing services due to stigma. A commonly held perception is that older people are not sexually active; however, this study has found that some older people are having sex. Some older people report having at least one sexual partner and some report more than two current sexual partners. This concurs with other studies that have shown that fear of stigma and discrimination is one of the major barriers to seeking health services including VCT (Knodel et al., 2002; Nyblade and Field, 2001; Bender, 1998).

Nyblade and Field (2001) indicated that some people do not want to disclose their HIV test results when positive due to fear of stigma and discrimination. In Zambia, people did not disclose their status because of the fear that their families would be embarrassed and disappointed while in Botswana people indicated that they do not disclose their status for fear of how they will be judged (Bender, 1998). Other studies also indicated that friends and neighbors hold negative perceptions about those who are HIV infected (Caldwell, 2000; Berger, McBreen and Rifkin, 1996). This evidence proves that some societies have negative attitudes towards people who are HIV infected. This is one of the many issues that might have a negative impact on VCT and other sexual health related programmes.

Bender (1998:12) indicated that due to stigma, older people seek treatment 'at night' or far away from their homes because they are deeply ashamed of their plight. There is the belief that people with whom they live with will treat them differently due to their positive status being known. Stigma and discrimination is the worst enemy to older people as they find themselves on the already neglected side of health services prompting further social exclusion.

Studies have identified structural-environmental and process barriers to accessing health services (Kroll et al., 2006; Shortus et al., 2005; Arcury et al., 2005). Structural-environmental barriers include "inaccessible facilities and examination equipment" (Kroll et al. 2006:284) and process barriers include "a lack of older people health-related provider knowledge, respect and skilled assistance during health facility visits" (Kroll et al. 2006:284) inhibit people from accessing health care services. The study has found that process barriers inhibit older people from accessing health care services. Some older people indicated that lack of knowledge of illnesses affecting older people and a lack of respect from health providers prevents them from utilizing health care services.

There is evidence that due to the increasing availability of HIV/AIDS treatment in some developing countries the number of older people with HIV/AIDS is going to increase because some older people would be receiving ARV treatment. In some communities where HIV/AIDS is rampant, older people would become a valuable caring source for their sick children and orphans.

The study found that older people appear to believe that health education and knowledge are two important and correlated components of health care utilization. Furthermore, the findings of the study indicate that socio-economic and cultural (e.g. personal and community) factors and also service-related factors are important factors that influence health seeking behaviour and utilization. Also, barriers to accessing health services such as poor perceptions of health services are also significant components influencing health care utilization among older people.

### **6.3 Recommendations**

This section discusses the implications and recommendations for future research. The main objective of the study has been to document older people's perceptions of health services and their health seeking behaviour.

Generally, there are several challenges that confront older people seeking health care services. To support this argument, this study has found that older people are faced with many barriers that prevent them from accessing health care services. Although health seeking behaviour is a personal issue, there are some motivations for accessing health care services including but are not limited to close proximity of health facility, free health care services, and interpersonal relations with health care providers. Therefore, there is a need for health care services to address the problems experienced by older people.

This study also explored older people's needs, opportunities and constraints for dealing with the risk of HIV/AIDS. The fact that older people access health services mainly for diseases associated with the aging process can be an opportunity to provide more information on HIV/AIDS prevention and treatment. Therefore, older people presenting themselves at health facilities for various diseases associated with the aging-process might also be motivated to utilize HIV/AIDS-related services.

This study has introduced a new line of thought that seeks to explore older people's perceptions of health services in the era of HIV/AIDS. Although some studies have looked at some of the factors inhibiting access to health services in South Africa, this study has gone further to explore perceptions of older people with regard to health



services in the era of HIV/AIDS. The research highlights the potential role of health services in providing information on prevention and treatment of HIV/AIDS.

The aims and objectives were achieved by seeking out pertinent issues regarding the use of health care services and older people's health seeking behaviour in the era of HIV/AIDS. As part of a 'reflective practice', older people in the study areas argued that they need to know more about this disease in order to protect themselves against the risk of HIV infection. Although infection through sexual intercourse seemed to have been of little importance to some older people due to 'faithfulness to partner', they want to know more about the disease so that they can improve their caring duties to their sick and dying children. The study has shown that older people are more affected by the disease than being infected, as they have to assume responsibility for caring for their sick and dying children.

The researcher recommends that health care providers (e.g. medical practitioners and nurses) undergo further training in geriatric care because of the general lack of education and training on geriatric-specific communication skills. Therefore, communication skills training will create and/or promote a supportive consultative environment which ensures optimum patient-provider relationship. Geriatric medicine is an important health care service; however, in South Africa there are a few local medical and nursing schools that offer specific training in this branch of medical service. This lack of training needs to be addressed within educational institutions.

The study has found that one of the factors contributing to the low uptake of HIV/AIDS services in public health facilities may be directly attributed to poor awareness of counselling and testing services, although this leads to treatment and care service benefits. Furthermore, for older people already accessing health services but not utilizing specific HIV/AIDS-related services such as testing and treatment they might be influenced by a number of important weaknesses in the training of staff which need to be addressed'.

Older people have different but overlapping medical and psychosocial needs to help them deal with the unfortunate situation of the HIV/AIDS epidemic. As a result, educational programs about HIV and its transmission should be established for older

men, women, and health care workers. As the epidemic continues at this alarming rate, especially in the region of sub-Saharan Africa, and as individuals survive longer, these groups will continue to grow and their problems will escalate unless there is strong interventions in place. Thus, as the population with HIV ages, HIV/AIDS intervention strategies are urgently needed that directly targets the older population and much more research needs to be done to explore further challenges and opportunities.

The current state of knowledge about these individuals is very low. Although the study has reported that many older people consider themselves not at risk of HIV infection, effective prevention strategies are needed to change this mindset. Therefore, HIV/AIDS interventions will need to de-stigmatise the epidemic among this population for prevention strategies to be effective. There is a need for improved prevention, treatment and care strategies. However, for such strategies to be effective, health care providers must have informed knowledge about diseases affecting older people including HIV/AIDS and their perceptions of health care services.

Misconceptions about older people's sexual activities have also led to the absence of education about HIV risk and prevention in many cases. HIV/AIDS education and prevention must be incorporated into primary health care for this category of people. Many health care providers are uncomfortable discussing HIV/AIDS risk with older people, although the study has indicated that some older people are comfortable discussing such issues with health care providers. Health providers need to realise that older people are having sex. Moreover, the involvement of older people in the design of educational programmes would help. Finally, the use of media, especially the television, may also help in trying to educating older people about the HIV epidemic.

#### **6.4 Summary**

Older people become infected with HIV and are dying in the same way as young people within the eThekweni Municipality. This study has looked at factors inhibiting and/or facilitating health care access and health seeking behaviour among older people in the era of HIV/AIDS. The study has found that there is the lack of knowledge and awareness of HIV/AIDS amongst older people. Although older people

were willing to learn more about the epidemic, prevention, treatment and care strategies have not yet been able to target them as an 'at risk' population. The consequences of the HIV epidemic affect older people significantly as they assume caring responsibilities for their sick and dying children and orphans. There has not been enough research on older people's perceptions of health services and their health seeking behaviour in this era of HIV/AIDS, especially in the developing parts of the world where the epidemic has spread significantly in the past two decades.

**Appendix 1: Interview Guide (Questionnaire)**

Name of interviewer:	
Date of interview:	
Time of interview:	Beginning of the interview..... End of the interview .....
Type of Health Facility:	(Specify).....

**Section One: Background Questions**

1. Sex	1. Male 2. Female
2. Age at last birthday (completed years)	
3. Current marital status?	1. Married 2. Cohabiting 3. Single, never married 4. Divorced, separated, widowed 5. Refused to answer
4. What is your highest level of education attained?	1. None 2. Primary 3. Lower secondary 4. Upper secondary 5. Higher education 6. Other (specify).....
5. What is your current occupational status?	1. Employed (go to Q 10.1) 2. Unemployed (go to Q 10.2)
6. If no, what is the reason for not working?	1. Financially supported 2. Retired 3. Health reasons 4. Family responsibilities 5. Cannot find a job 6. Other (specify).....
7. What is your main source of income?	1. None 2. Employment 3. Remittance 4. Old age pension 5. Disability grant 6. Care dependency grant 7. Foster care 8. Child support grant 9. Other (specify).....

## Section Two: Knowledge of HIV/AIDS

<p>8. Please mention all the ways in which you believe a person can get infected with HIV/AIDS (circle all ways mentioned by the respondent)</p>	<p>1. Sexual intercourse  2. Sharing needles (drug use)  3. Unclean medical equipment  4. Blood transfusion  5. Mosquito or insect bites  6. Contact with blood of infected person  7. Contact with infected person's toothbrush or shaving material  8. Casual contact with infected person (e.g. sharing food, cup, glass, handshake, hugging, clothes)  9. Accident  10. Other (specify).....  11. Has not heard about HIV/AIDS (go to Q20)  12. Don't know/ Don't remember</p>
<p>9. Can a person do anything to protect him/herself from getting HIV/AIDS?</p>	<p>1. Yes  2. No (go to Q16)  3. Unsure/ Don't know (go to Q16)</p>
<p>10. How can people protect themselves from getting infected with HIV/AIDS? (circle all ways mentioned by the respondent)</p>	<p>1. Abstain from sex  2. Non-penetrative sex/ thigh sex  3. Always use condoms  4. Limit number of sexual partners  5. Have only one sex partner  6. Avoid sex workers  7. Have sex with a virgin  8. Use sterilized needles  9. Require partner to take blood test  10. Other (specify).....  11. Unsure/ Don't know</p>
<p>11. Where did you get your information on HIV/AIDS? (circle all ways mentioned by the respondent)</p>	<p>1. Hospital/ clinic  2. Private Doctor  3. Pharmacy  4. Work  5. Mobile clinic  6. Other (specify).....  7. Unsure/ Don't know</p>
<p>12. I will not ask for the result but have you ever had a HIV test?</p>	<p>1. Yes (go to Q13)  2. No</p>
<p>13. If yes, where did you go for HIV testing?</p>	<p>1. Same Health Facility  2. Different Health  3. Other (specify).....</p>
<p>14. Would you like to be tested in the future?</p>	<p>1. Yes  2. No</p>
<p>15. If you wanted to have a test for HIV, would you take the test at this health facility?</p>	<p>1. Yes  2. No (go to Q16)</p>
<p>16. If no, why not?</p>	
<p>17. Where do older people usually go for HIV counselling and testing in this area? (circle all places mentioned by the respondent)</p>	<p>1. Hospital/ clinic  2. Private Doctor  3. voluntary counselling and testing centre  4. Other (specify).....  5. Unsure/ Don't know</p>

18. What kinds of treatment, do you think, people with AIDS get at this health facility? (circle all mentioned by the respondent)	1. Isolation 2. Verbal abuse 3. Physical abuse 4. Rejection from home 5. Rejection from community 6. Love 7. Kindness 8. Help 9. Other (specify).....
19. Would you be willing to receive treatment for HIV/AIDS at this health facility?	1. Yes 2. No
20. If no, why not?	

### Section Three: Communication and Behaviour change awareness

21. Has anyone talked to you about HIV/AIDS at this health facility?	1. Yes (go to Q30) 2. No (go to Q31)
22. If yes, what did they talk to you about HIV/AIDS?	1. STI 2. VCT 3. Condoms 4. Multiple sexual partners 5. Other (specify).....
23. Do you think you have sufficient information about HIV/AIDS at this health facility?	1. Yes 2. No
24. Would you like to receive (more) information about HIV/AIDS from the health facility?	1. Yes 2. No 3. Unsure/ Don't know 4. Refused to answer
25. How comfortable do you feel discussing the following issues with the health worker?	

	1. Very Comfortable	2. Somewhat Comfortable	3. Comfortable	4. Not Comfortable
25.1. STI				
25.2. HIV/AIDS				
25.3. Condoms				
25.4. Multiple sexual partners				

### Section Four: Knowledge and Use of health services available at facility

26. Does this health facility offer any HIV/AIDS services?	1. Yes (go to Q27) 2. No
27. What HIV/AIDS services do they offer?	
28. What was the main reason for visiting the health facility today? (circle one answer mentioned by the respondent)	1. VCT 2. To get condoms 3. HIV/AIDS management 4. Personal illness (specify)..... 5. Other (specify).....
29. Do older people receive information from health provider's during visits to health facility?	1. Yes (go to Q30) 2. No
30. If yes, did you receive information on	
[a]. STI	1. Yes                      2. No
[b]. Condoms	1. Yes                      2. No
[c]. Behavioural change	1. Yes                      2. No
[d]. VCT	1. Yes                      2. No
[e]. Other	1. Yes                      2. No

Health Services	31. I am going to read a list, tell me whether it is provided at this facility?	32. (If yes, go to Q33) Have you ever used this service?
	Yes No Unsure	Yes No
STI services	1 2 3	1 2
HIV/AIDS counselling	1 2 3	1 2
HIV/AIDS testing	1 2 3	1 2
Condoms	1 2 3	1 2
Other (specify).....	1 2 3	1 2
33.1. Are you happy with the way this health services offers prevention to older people in this community?	1	2
33.2. Are you happy with the way health services offer treatment to older people in this community?	1	2
33.3. Are you happy with the way health services offer care to older people in this community?	1	2

#### Section Five: Information, Education and Counselling

I am going to ask some questions regarding information, education and counselling (IEC) services.

34. Did you see any of the following today?	Yes	No	Don't know
1. Written material on STI's	1	2	3
2. Written material on HIV/AIDS	1	2	3
3. A sample of condoms	1	2	3

35. Did you receive any written material on HIV/AIDS to take home during the visit to the health facility?	1. Yes (go to Q46) 2. No
36. If yes, what was the subject of the written information? (Circle that apply)	1. VCT 2. Condoms 3. HIV/AIDS 4. Other (specify).....
37. Did you attend any talk on HIV/AIDS at the health facility?	1. Yes 2. No
38. What was the subject of the talk?	1. VCT 2. Condoms 3. HIV/AIDS 4. Other (specify).....
39. Are there any HIV/AIDS-related talks targeting older people at the health facility?	1. Yes 2. No (go to Q50)

## Section Six: Quality of Care

I am going to ask some questions regarding your visit to the health facility today. I would like you to say whether you agree, disagree or have no opinion about the following statements more specifically relating to HIV/AIDS and health services.

40. What are your perceptions about your visit to the health facility today?	Strongly Disagree	Disagree	Agree	Strongly Agree
a. The staff gave me the opportunity to ask questions about health issues including HIV/AIDS.				
b. I was provided with all the information I wanted about HIV/AIDS during today's consultation.				
c. Staff was too busy to answer my questions relating to HIV/AIDS.				
d. The staff answered all my questions to my satisfaction.				
e. I find it difficult to talk to staff about sexual matters.				
f. I find it difficult talking to staff about HIV/AIDS.				
41. There was insufficient privacy during the consultation.				
42. The waiting time for consultation was reasonable.				
43. I came away from the health facility feeling that I had received good quality care.				
44. I think that health providers must provide information about HIV/AIDS to older people.				
45. Health services targeting older adults will increase health-seeking behaviours.				

## Section Seven: HIV/AIDS & Non-HIV/AIDS clients

46. Did the provider mention anything specific about HIV/AIDS during your visit today?	1. Yes (go to Q47) 2. No		
47. Were the following issues mentioned to you during your consultation today?	Yes	No	D/know
1. Whether you have any concerns about HIV/AIDS?	1	2	3
2. If you discussed HIV/AIDS with your partner	1	2	3
48. Did the provider mention any specific HIV/AIDS prevention methods during your visit today?	1	2	3
49. Which methods did the provider mention?	1. Abstinence 2. Being faithful 3. Condoms		
	Yes	No	D/know
50. Did the provider discuss condoms with you?	1	2	3
51. Did the provider mention that condoms protect against HIV infection?	1	2	3
52. Would you have welcomed more information or advice on condoms on today's visit?	1	2	3
53. Did the provider talk to you about multiple sexual partners?	1	2	3
54. Did the provider ask whether your partner has more than one partner?	1	2	3
55. Did the provider advise you to have an HIV test?	1	2	3
56. Would your partner be willing to receive treatment for HIV infection at this health facility?	1	2	3
57. Were you told when to return for a follow up visit?	1	2	3



### Section Eight: Perceived risk of HIV/AIDS

To end up, I would like to ask you some questions about yourself. I would also like to remind you that this information you are giving me will remain strictly confidential.

58. How many sexual partners do you currently have?	Number..... Don't remember
59. Did you use a condom with your most recent partner?	1. Yes 2. No 3. Don't know
60. Before today have you ever thought about your own chance of contracting HIV/AIDS?	1. Yes 2. No
61. Considering all things, do you consider your chances of HIV infection to be high, medium, low or no chance at all?	1. High 2. Medium 3. Low 4. No chance
62. If a doctor or nurse advised you to use a condom, would it be possible for you to do so with your spouse or main partner?	1. Yes 2. No 3. Don't know

Thank you for participating.

## ***Appendix 2: Focus Group Guide***

- 1. What are some of the major health problems that older people are facing in this community?**  
(Probe: Do you think AIDS is a problem for older people? Why/ Why not? Is it a bigger problem for men? Women? Both? Are you aware of older people who are infected with HIV in this community? Have you attended the funeral of any older person who has died of AIDS?)
- 2. Are older people aged 50 and above aware of HIV/AIDS?**  
Where do older people get information about HIV/AIDS? (Probe: Main sources of information. Anything else? What information do they receive about HIV/AIDS?)  
What causes HIV/AIDS? (Probe: what about among older people? What are main factors contributing to HIV/AIDS among older people?)  
What are some of the measures used to prevent HIV/AIDS? (Probe: What methods, if any, do older people use to prevent HIV/AIDS?)  
Is there a cure for HIV/AIDS?  
Do you think older people have adequate knowledge of HIV/AIDS?  
What are some of the measures needed to improve knowledge of HIV/AIDS?
- 3. What are some of the factors that make older people vulnerable to HIV/AIDS?**  
What do you understand by risky sexual behaviour? What are some of the behaviours that put older people at risk of HIV infection?  
What are some of the factors that make older people vulnerable to HIV/AIDS? Socioeconomic factors? Cultural factors? Caregiving?  
Are older people aware of their risk of HIV infection? Why older people feel at risk of HIV infection? Why older people do not feel at risk of HIV infection?  
What can be done to improve awareness of their risk of HIV infection?
- 4. Are condoms known and accepted by older people?**  
How do older people view condoms? Positively? Negatively?  
Where do they receive information about condoms? Where do they obtain condoms? Health facilities?  
What are the main purposes of condom use among older people?  
What are some barriers to condom use among older people?  
What role can health services play in increasing awareness and access to condoms?
- 5. What sexual health services are available and accessible to older people?**  
Do older people want to receive sexual health services at their health facility?  
What sexual health services would they like to receive?  
Would older people like to receive information on condoms, STIs, VCT?  
How do you think older people perceive sexual health services? Positively? Negatively? Explain.  
How do you think older people would react to having sexual health services provided at the same time and place as other health services?  
Do older people experience any challenges to receiving sexual health services?
- 6. What HIV/AIDS services are these health facilities offering? Prevention and Treatment?**  
Do these health services work well for older people in the area? In what ways? What do you think about these health services?  
Are these services appropriate for meeting the needs of older people for prevention and treatment of HIV/AIDS?  
What are some of the problems with the health services with regard to prevention and treatment of HIV/AIDS among older people? Provider's attitudes? Financial resources? Quality of services?
- 7. How do health services equip older people to care for HIV/AIDS infected? Care for partners, orphans and their own sick children? Do older people have sufficient information to assume caring responsibilities?**
- 8. How can we improve the health services so that they better meet the needs of older people with regard to prevention and treatment of HIV/AIDS? Do you have any other information to add with regard to the issues we have discussed? If yes, go head.**

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