

Health in a changing South Africa: perceptions and experiences of older people in rural KwaDumisa, KwaZulu-Natal

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Declaration

Submitted in partial fulfilment of the requirements for the degree of Masters in Population Studies, in the Graduate Programme in the School of Built Environment and Development Studies,

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Durban, South Africa.

I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. It is being submitted for the degree of Masters in Population Studies, in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal, Durban, South Africa. None of the present work has been submitted previously for any degree or examination in any other university.

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Date

Abstract

Older people can be defined in different ways depending on the country's social policies and also their health status. The health interventions overlook the vulnerability of older people regarding their individual health needs and their general susceptibility to chronic illnesses. Increasing economic disparities between races and inequalities in access to health services despite a large expansion in government social grants is another growing challenge. The major socio-economic changes has also contributed and enhanced the health challenges of older people in rural areas. This study aims to investigate the health perceptions and experiences of older people in rural areas and explore the factors that influence the quality of health of older people in South Africa. The study relied on focus group interviews (FGIs) and in-depth interviews (IDIs) to acquire an in-depth assessment and overall understanding of the life course and health perceptions of older people. Results reveal that even though health has evolved in South Africa over time, more challenges continue to affect the health of older people in rural areas where there are constant issues of low socio-economic status, poverty, migration and poor education attainment. The findings also suggest that, under the new political power there has been a change in the management of health care systems. Older people in KwaDumisa also face challenges with access to health care facilities.

Dedication

This dissertation is dedicated to my mother, Princess Thab'sile Mngadi. There are no words in the world that could begin to describe my gratitude to you. Thank you for making me who I am today and who I will forever be. You have raised me out of nothing but made me something. May God bless you abundantly.

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Acronyms and Abbreviations

ADL – Activities of daily living

AIDS – Acquired Immune Deficiency Syndrome

ANC – African National Congress

FGDs – Focus group interviews

HIV – Human Immune Virus

IDIs – In-depth interviews

KZN - KwaZulu-Natal

NCDs – Non-Communicable Diseases

PHC – Primary health care

PWA – Persons with HIV/AIDS

PHCC – Primary Health Care Clinics

SADHS – South African Demographic Health Survey

SA-PPA – South African Participatory Poverty Assessment

SES – Socio-economic status

SRHS - Self Reported Health Status

WHO – World Health Organization

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CHAPTER ONE

Introduction

1.1 Introduction

The history of South Africa had an effect on the health of its population as well as access to basic health services. The disintegration of the apartheid system in the early 1990s had major implications for the health sector, leading to the reorganization of social life, access to basic resources and health services. Since the abolition of the apartheid system in 1994, the health system in South Africa continues to face many challenges. Increasing economic disparities between the various population groups and inequalities in access to health services despite a large expansion in government social grants is another growing challenge. Moreover, part of the challenges to the health delivery system stems from the unequal socio-economic classes that inform unequal access to health service. Even though the public health system has changed into an integrated and inclusive national service, there are still major weaknesses in health care delivery. Major socio-economic changes has also contributed to and enhanced these challenges (Coovadia et al. 2009). In many countries chronic diseases are the leading cause of death and 80 percent occurred in low income countries (Acosta et al. 2010).

There is evidence that the world's ageing population is increasing. The population aged 50 years and above is also expected to increase from 21% in 2011 to 34% in 2050 (Gomez-Olive et al. 2010). This increase will affect mostly the developing countries because of the major health care system problems that are high among developing countries (Gomez-Olive et al. 2010). Along with this population increase, the world's population age 65 years and older is projected to increase sharply in the years to come. As there are existing major problems with the health of older people such as early development of chronic diseases, this concern will exacerbate with the continuing growth of older people. This also means that there will not only be serious health care resource problems but also concerns about poverty and social security welfare. Today's main

global and local concerns overlook the issues of older people, whilst they are trying to fix the problems of the health care system which itself is exhausted by the growing number of older people with chronic diseases.

Older people can be defined in different ways depending on the country's social policies and also the health status of the population. They can be described by their physical attributes or appearance for example grey hair, wrinkles and obvious frailty but also by their life experiences as well as by the roles that they sometimes carry out in their communities (Cohen and Menken 2006). In most developing countries especially in Sub-Saharan Africa, chronological age is not always a useful indicator of aging. Sub-Saharan Africa is primarily characterized by low income countries, thus older people in these countries are more vulnerable to diseases and they exhibit aging signs much quicker than their counterparts in more developed regions. It is important to recognize that in some sub-Saharan African settings, people who are younger than 60 may be considered old because they exhibit morbidity profiles and take on status roles more usually associated with people over the age of 60 in other settings. Under the Older Persons Act No. 13 of 2006, older people in South Africa refer to those who are 65 years old in the case of a male and 60 years old in the case of a female (Cohen and Menken 2006).

There is a common view that old age in terms of chronological age is mainly common in modern societies, predominantly urban societies. These industrialized societies are aware and have extremely sophisticated systems of measuring time. The use of chronological age to signify the beginning of old age thus varies between less modern and industrialized societies (Moody 1998). The chronological age of older people in the African countries can only be estimated, since the beginning of this period of life in these countries is determined by changes of status or function that they carry out in their household and in the community not by the calendar or number of years lived (Cogwill and Holmes 1972). In most developing African countries old age is associated by great wisdom and access rights including ancestral land, nonetheless age in these countries is not estimated or measured by time or the number of years lived (Moody 1998). Contrary to this notion numerous studies have shown that as societies are becoming more modernized and industrialized, this comes with great change in societies and old age begins to be perceived more as the number of years, the type of illness, and the ability to be able to carry out

certain activities and longevity. For the purpose of this research older people will refer to men and women aged 60 years and above.

1.2 Why focus on the health of older people?

WHO (2003a) describes health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO 2003a, 11). Although this definition has been used for by many studies, it is sometimes critiqued for being unrealistic, particularly in its use of “state of complete” (Awofeso 2010). According to Awofeso (2010), the use of the word “complete” makes it highly unlikely that one can be healthy for a reasonable period of time. Awofeso further suggests that definitions that consider changing health needs should be used to restore and improve on the current definition provided by WHO (Awofeso2010). Nonetheless, other studies continue to consider the WHO health definition as a good model based on its holistic view of health and one that forms a good basis for understanding health in the African context (Alli and Maharaj 2013).

Over the years there has been a growing need to focus more research and attention on the health of older people, contrary to the general tendency that more attention has been given to young people. In South Africa there has been an on-going focus on the quality of health of children under the age of 6 as well as pregnant women and very little (if at all) emphasis on the health and health needs of older people. Health care systems have disregarded health care services and strategies that provide a holistic approach to the needs of both young and older people. The health interventions overlook the vulnerability of older people regarding their individual health needs and their general vulnerability to chronic illnesses. Longer life expectancy is now a reality for many people in the developing world compared to the past , and is partly due to the fact that the health system in developing nations are not geared towards meeting the needs of an aging population, but rather the health of the younger population and children (Bradshaw and Steyn 2001).

1.3 The Health situation of Older People

Older people in developing countries encounter two major barriers to healthcare, namely: the individual socio-economic status for example financial and education, and those that are related to health system's structure this involves the lack of trained professionals in adult health and geriatric care and; absence of adequate strategies and platforms for health promotion, including prevention and management and of the disorders which are common to older people. Furthermore, developing countries lack specific resources and training for the management of chronic conditions that affect older people. This has a major impact on the quality of healthcare for older people (Paleaz and Vega 2006). Government and relevant health care officials need to recognize the healthcare needs of older people and have the capacity to respond to these needs. Health strategies and policies need to address the major barriers that affect the quality of health care of older people, by taking into consideration the rapid growth of chronic diseases and they need to do away with the assumption that older people are ill because they are aging.

In many developing countries it is widely believed that older people make up a small proportion of the entire population. But, contrary to this general belief and as a result of demographic changes that are taking place, both the absolute size and the relative proportion of the population age 60 and above are projected to increase faster than all young ages (Gomez-Olive et al. 2010). Increase in population size together with the increase in development and modernization, migration and urbanization, will have an impact on the health of older people.

Severe illness and chronic diseases are associated with older people, a significant part of the older population are dying of chronic diseases. Chronic diseases such as diabetes mellitus, coronary heart, cerebrovascular disease and osteoporosis are the main cause of ill health and mortality among older people. The overall risk of having such diseases rises with an increase in the proportion of older people (Canbaz et al. 2002). The older ages of most developing country populations is usually associated with increased levels of communicable diseases and high levels of poverty, regardless of the impact of HIV/AIDS which has had a much severe impact on the quality of life of older people. This pandemic affects

older people in a much different way than any other disease as it comes with a much greater burden. This will have a severe impact on the health system, because they will be overburdened by cases of HIV, this will further complicate the health of older people.

Older people may not themselves be infected by the HIV virus, but they may have to care for their own children with HIV/AIDS and in some cases also care for their orphaned or HIV-infected grandchildren. The health and well-being of older people in rural South Africa has become a critical issue which raises many concerns. This might also have an impact on the well-being of the entire population. Nonetheless, the impact of the changing age structure and the increase in chronic disease and disability in older people is poorly understood.

The African societies have been changing in response to modernization and neo-liberal policies, hence the populations have to adapt to the new societal structures. These changes have altered the institution of the family, economy, education, religion and politics that have become part of the lifestyles of societies, particularly older people who live in the rural areas (Dubazana 1989). It is undeniable that older people living in rural areas are challenged by many problems as a result of poverty, living in levels far below the minimum income level by South African standards. The prevalence of poverty among rural older people is associated with many factors; it is also unquestionable that as social change continues to take its course the health and well-being of older people will also change considerably. Older women and men over the age of 60 are likely to have at least one type of chronic illness and they will further go through another transition due to the consequences of social change (Moody 1998).

In 2005, WHO re-emphasized the significance of chronic (non-communicable) diseases as a neglected global health issue. Chronic diseases, primarily cardiovascular disease, cancer, chronic respiratory diseases, and diabetes were estimated to cause more than 60% (35 million) of all deaths in 2005; more than 80% of these deaths occurred in low-income and middle-income countries (Abegunde et al. 2007). Older people are known to be susceptible to illness, as they are frail and their longevity has sustained them through many years. Older people around the world share a common factor, which is the likelihood of suffering from chronic diseases. Not only are these older generation of the population facing illness from chronic diseases, they also have to

adapt to the gradual change of these diseases. In South Africa the three most common chronic diseases that older people suffer from are heart attacks, cancer and stroke (Moody 1998).

In South Africa other chronic diseases that are common amongst older people are diabetes, hypertension, cardiovascular and respiratory disease, arthritis and osteoporosis (Moody 1998). Challenges relating to the quality of health of older people and the factors that affect these are under-researched. With an increase in the number of older people and an increase in health care problems, the factors and dynamics that impact on the quality of health of older people needs to be understood and addressed. The main objective of the study is to understand the health experiences and perceptions of older people in a rural area in KwaZulu-Natal, South Africa. Rural areas are usually dominated by older people who face many health problems. The study will look at the health and health status of older people. It will focus specifically on how social change including greater urbanization, migration and socio-economic status has influenced the health of older people over time. The study will pay particular focus on the way in which older people perceive their health to have changed over time with specific focus on illness that were common 20 to 30 years ago and illnesses that are more common presently and the factors influencing this transition.

1.4 Rationale of the study

The historical context and trajectory of South Africa is very important in understanding the health status of old people today and in the future. There are critical concerns about the health care system in developing countries which now have to carry the burden of a growing population and a growing number of older people. South Africa is one of the Southern African countries which have a significantly changing health care system. The well-being and health of older people is to a large extent affected by: social, economic and environmental factors (Coovadia et al. 2009).

There is a dearth in research that focuses on the health of the elderly in Southern Africa, including South Africa. Many studies avoid research about the well-being of old people and epidemics that affect them and focus on people below 40 years of age. The lack of research on

old people is influenced by the assumption that older people's health is also highly associated by their old age. Understanding the epidemic and the experiences and perceptions of older people's health is significant in order to have an understanding of how health has evolved in South Africa and how this has been influenced by the health system.

Investigating the health status and quality of health of older people is imperative in understanding health status, welfare and social security needs of the entire population. In a study done in Agincourt where the population continues to age, with millions living in rural settings, it has become increasingly important for health and social services to adapt and improve in order to provide effective care for the growing number of older people taking into considerations the major health problems (Kahn et al. 2003). This will provide information on how societal changes and contemporary factors are affecting older people's wellbeing and health, and be able to predict demand for health services. Moreover and also more importantly, the growing proportion of older people in South Africa will influence many policies in terms of relevancy. Older people have experienced the past political system and historical policies and therefore they hold experiences and perceptions that have critical potential to determine or influence new and relevant policies.

1.5 Theoretical Framework

The principal theoretical framework that will be used in this study is the life course approach which offers an interdisciplinary framework for guiding research on health, human development and aging. Life course approach or life course epidemiology can be defined as the long term outcome on later health or disease risk of physical or social exposures that may occur during childhood, adolescence, young adulthood and later adult life (Kuh et al. 2003). According to the life course approach various biological and social factors throughout the life of an individual will autonomously and cumulatively influence health and disease in old age life (Kuh et al. 2003).

Kuh et al. (2003) further states that "the life course approach attempts to integrate biological and social risk processes rather than draw false dichotomies between the two". The life course

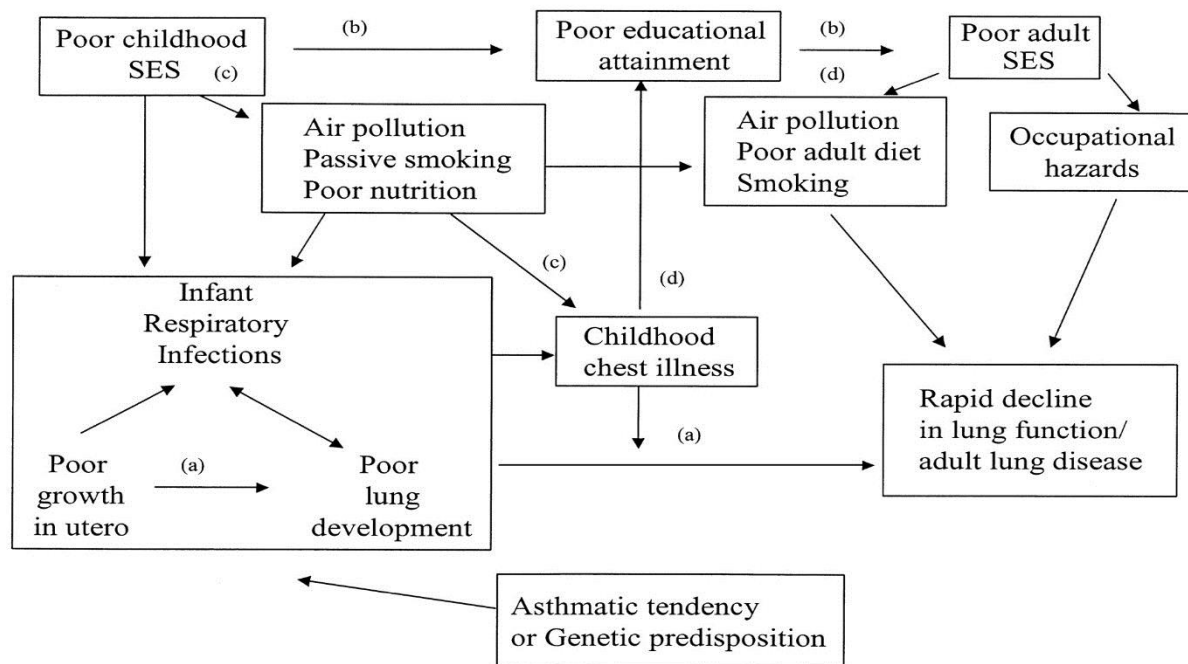
approach focuses on socially patterned exposures during childhood, adolescence, and early adult life influences, adult disease risk and socio-economic position, and therefore may account for social inequalities in adult health and mortality. The socio-economic factors at different life stages may function either via social chains of risk or by influencing exposures to causal factors at earlier life stages that form part of long term biological or psychological chains of risk (Kuh et al. 2003).

One of the purposes of the life course approach is to build and test theoretical models that suggest pathways linking exposures across the life course to later life health outcomes (Kuh et al. 2003). The duration of a particular experience and exposure to socio-economic conditions in early stages of life may provide significant evidence for the cause of the various health outcomes at a later stage of life (Kuh et al. 2003). The life course approach provides analysis of the different processes in life that leads up to specific conditions. The following life course event or processes describes the changes and influences that are positive in old age. These are the changes that are also influenced by the past experiences of older people.

The primary processes that are involved in the life course approach includes accumulation of risk which is due to the understanding that life course exposures gradually accumulate through episodes of illness and injury, these could be influenced by adverse environmental conditions, and health damaging behaviors. One of the main purposes of the life course approach is to examine the extent of cumulative damage on biological status. The duration and severity of exposures increase and as the body age they become less able to repair damage that has been accumulated over periods of time. The accumulation of different types of exposures such as environmental, socio-economic, and behavioural may cause long term damage with exposure risk being either independent or clustered (Power et al. 1991). The birth cohort effect refers to the location of an individual in historical time as indexed by their year of birth. An environmental change such as an improvement or deterioration of living standards that affects the health of children may show up several decades later (Kuh et al. 2003). Birth cohorts can also be differentially affected by rapid and extensive social change (Stein et al. 2002). The impact of such change can create possibilities for turning points on life courses with short and long term effects on health which often differs by age such as chronic disease in older people (Elder 1998).

The changing size of birth cohorts such as the period of the post-war “baby boom” is itself also one of the significant forces for social change that might have an impact on the life course of an individual. Cohort effects are easiest to distinguish when disease trends have accelerated, decelerated, or changed direction. Where they are steady and linear they cannot be reliably distinguished from period effects (Strachan and Perry 1997). The increase of the proportion of older people in the population has an adverse impact on the health of older people and the health of the population at large. Increase in social change has also shown that it is associated with an increase in health impacts on older people, particularly the change in common diseases among older people. One bad experience and exposure to disease risk can lead to another and then another will follow (Rutter 1989). This explains the continuities and pathways between early experiences and adult psychosocial function. The chronological links are probabilistic rather than deterministic. This also means that a chain of exposure and risk in early childhood or in early life course will not certainly determine a disease risk. It is also possible to perceive of two different types of chains of risk. Each exposure not only increases the risk of consequent exposure but it also has an independent effect on disease risk irrespective of later exposure. Some adverse experiences will increase the risk of disease exposure (Kuh et al. 2003).

Figure 1.1 A life Course Approach



Source: Ben-Shlomo and Kuh 2002

Figure 1.1 above presents the different periods across the life course which influences the phase of biological development, stability or decline of biological developments. This figure also shows the potential pathways between intrauterine growth and adult disease, Path (a) presents a biological pathway where impaired fetal development of the lung is associated with greater future susceptibility to impaired lung function in adulthood. Path (b) shows a prime social pathway where adverse childhood socio-economic position influences adverse childhood exposures as well as adult socio-economic position. Path (c) presents a socio-biological pathway where adverse childhood socio-economic conditions is associated with post-natal lung function and subsequently poor adult lung function. Path (d) presents a bio-social pathway, whereby repeated childhood infections results in adverse educational attainment and hence lower adult socio-economic position. This alternative illustrative representation of disease etiology is important in order to understand how exposures may differentially act in critical and in sensitive stages (Ben-Shlomo and Kuh 2002). The life course epidemiology appropriately shows the way in which various factors during the life course of an individual may influence certain outcomes. This highlights the outcomes that are evident in the lives of older people. Older people who are

affected by social changes including the effect of failing health services usually suffer from chronic diseases at the later stages of their lives.

1.6 Structure of Dissertation

The first chapter will introduce the aims and objectives of the research and also provide an indication of the state of health among older people in South Africa, in light of chronic diseases. This chapter will also highlight the background of the study and the theoretical framework. Chapter two will review literature on the health of older people as well as the factors that affect the health older people, it will also give an overview of and history of the health of older people in South Africa and how this is evolving over time. It will also provide some insight into existing literature on the health of older people. Chapter three presents the methods which are chosen for this research, explaining why they were chosen and how the data collection was carried out. The fourth chapter outlines the main findings from the focus-groups and in-depth interviews. The final chapter presents a discussion of the research findings in the context of the theoretical framework adopted by this research. The discussion chapter takes into consideration the theoretical knowledge and applies it to the empirical data in order to address the research questions. It will also provide the overall conclusion of the study and provide future recommendations.

CHAPTER TWO

Literature Review

2.1 Introduction

People are more likely to experience an increase in chronic diseases as they grow old nonetheless, survival until old ages is more common now for most developing nations than in the past. Older people have always been prone to illness and disease for many years, this phenomena is continuous and involves many factors. With the increase in the proportion of the older population, the number of chronic diseases also continues to increase among older people, placing pressure on health care system(Gomez-Olive et al. 2010).

The vast effect of an increasing older population will not only place pressure on the quality of health care system, this will also cause major problems in the management of chronic diseases according to older people's individual needs. Older people often require quality health care because of the fragility of their conditions, excluding the burden of chronic diseases. This chapter aims to review in detail literature that focuses on the well-being, health experiences and factors that affect the health of older people. This chapter will also highlight the significance of certain factors that influence the health conditions of older people in their later life.

Health is perceived differently, according to certain experiences as well as the state of physical well-being. Even in the absence of illness or diseases many people conceptualize health as the physical feeling of fitness, energy, being able to function and psychosocial wellbeing (Blaxter 1990). As the experience of health may vary across people, certain social and economic conditions may impact on the way people experience health, whereas people who are experiencing better social and economic conditions can report better health status regardless of the present of disease or illness (Blaxter 1990). This also suggests that people may perceive

themselves as healthy or in good health based on their socio-economic status and not entirely on their physical wellbeing.

Self-reported health status is also one of various possible measures of self-perceived health status and it is often considered to be a useful indicator of more objective health indices (Kroegeer 1983; WHO, 1984; Wolinsky and Johnson 1992). Health problems that are experienced by people can also be recognized as health problems in a particular socio-cultural context (Tishelman 1993).

2.2 The Health Situation of Older People

Evidence suggest that in developing countries older people are mainly taken care of, and supported by their household members and/or family (Cohen and Menken 2006, WHO 2003a). Modernization and urbanization seem to be threatening caretaking of old people due to the disintegration of extended family values in Africa. As a result older people are faced with major health issues without adequate social security systems and social network support and care (Alli and Maharaj 2012). The current health care system is constituted in a way that the public health programs are directed at eradicating or controlling preventable childhood diseases rather than treating or managing chronic diseases and the health care of older people (Cohen and Menken 2006). As a result, older people are left with unmanageable chronic diseases and difficulties in accessing health care services.

The aging population is associated with rising demands on the South African health care system caused by the change in the national diseases profile since the late 1980s .Due to demographic ageing, the projecting cause of death has changed from those associated with infant and child mortality to those associated with aging (Joubert and Badshaw 2006).This rapid change puts pressure on an already burdened public health care system. The transition to higher levels of chronic disease among the older population will demand a shift to more self-management, home-based care, and continuous care. This also had serious effects for the physical and human and infrastructural aspects of health delivery system (Robinson et al. 2007).

2.3 Factors Impacting the Health of Older People

Understanding the determinants of health among older adults is critical in developing countries where rapid population aging is requiring governments to respond to the growing health-related needs of elderly populations with limited economic resources (Smith and Goldman 2007). The state of health of older people is impacted by various factors, which are linked to their health background. These factors are relevant in order to understand the health outcomes of older people.

2.3.1 Migration and Urbanization

Migration is another factor that impact on the lifestyles and health of older people in rural areas. Rural-urban migration has been proven to disrupt the family structures that provide support for older people as they are often left financially stranded. In many cases older people are left to care for children in the household without any financial support because economically productive members of the family have moved to urban areas (King and Vullnetari 2006).

Increasing urbanization is also likely to impact on the health of older people. Urbanization may bring about changes in the family unit and social networks which contributes largely to the wellbeing of older people (Clark and Anker 1990). Even though young family members are not likely to provide support and care to their elderly in the rural areas but they might obtain financial support that can be used to assist older people and relatives left in the rural areas, such as taking care of the household and buying food. (Kinsella 2001). Studies suggest that both older women and men in rural regions reported or experienced more health problems than their counterparts in the urban areas, even though in these areas women were found to have more problems than men (Kabir et al. 2003).

Modernization and development have led to broad social and economic changes which have put in doubt the continued viability of traditional arrangements for the care and support of older people. For example, formal education and modernization are generally associated with weakening traditional social ties and obligations and greater independence and autonomy, factors that tend to undermine traditional extended family systems (Cohen et al. 2006). Similarly,

economic development is associated with young people migrating from rural to urban areas; leaving older family members geographically isolated. Studies suggest that once established in urban areas, migrants tend to form new nuclear households. Although children may remit money and goods, such flows are typically irregular and may not be enough to provide much in the way of real economic security. These changes have combined to alter, probably permanently, the nature of the relationship between generations (Cohen et al. 2006). This also means that the family structures in which older people get care and support are now disturbed. Older may also become more vulnerable to poor health if they do not have necessary care and support in their household.

2.3.2 Gender Differences

In the evaluation and analysis of the health of older people, gender and age differences play an important role, as they might create a distinction in terms of the types of illnesses that affect older men and women. In many societies it has become the norm that men die first and women become disabled or chronically ill, this also means that women have a higher morbidity rate than men (Arber and Cooper 1999). Many reasons have been put forward which could explain the disparities in the gender difference of older people with chronic diseases, significantly, women are more likely than men to over-report their illnesses and therefore their health is considered poor (Arber and Cooper 1999). Like men, more women have entered the paid labour force in order to gain financial independence and hence fewer women remain at home to take care of their children and the household. Because of the changes in gender roles, the orthodoxy of women being more ill or sick than male is increasingly being understood in the late 1990s (Arber and Cooper 1999).

Studies have shown that gender differences in health also vary in accordance with the stage of the life course; in this regard it is very important to also look at the different age groups to understand the relationship that occurs throughout the life course. Studies also show that even in developed countries even though male death rates are higher than that of women, women tend to report more illness, disability and the use of medication than male (Macintyre, et al. 1996). Another factor that could contribute to the gender difference in the health of older people

is the concentration of poverty among women; predominantly in later life (Arber and Ginn 1991; Ginn and Arber 1996). The aging process is different for women and men in many societies. The physical signs of aging are usually obvious and bring more severe consequences for women than men (Bell 1989).

The socio-economic gradient also increases or decreases with age and sex. Women's socio-economic disadvantage could result in the relative difference between their health than that of their male counterparts. The outcomes of a poor socio-economic status are unsurprisingly negative for the health of older people. There is an increased risk to women with an already compromised health status due to factors such as lack of health literacy, marital status and rural and urban differences (Aber and Cooper 1999).

Arber and Cooper (1999) emphasize the importance of examining the influence of structural factors such as social class and material disadvantage between older men and women, in order to understand gender differences in health in later life (Arber and Cooper 1999). Older women and men hold different structural positions within their societies and they also play different roles within their families this will hence result in different outcomes in their health status. It is also possible that men's health problems are under-reported because gender roles mean that men do not acknowledge illness as readily as women and they are less likely to report ill health (Doyal 1995; Rahman and Liu 2000).

2.3.3 Health Literacy

There is a strong counter relationship between increasing age and health literacy (Parker et al. 2003). With an increase in age there are many associated factors that could affect the health of older people, this also includes education attainment. In many cases older people are not well educated, if educated at all, and therefore this will result in a negative health literacy status.

In many cases, more positive health outcomes are associated with great literacy and levels of education. Many older people are not health literate; this sometimes determines their health and quality of life. Health literacy refers to the degree to which individuals have the capacity to obtain, process, and understand basic health information. The lack of this ability in older people

can have an effect on their health because they might not have the basic knowledge of how they need to maintain their health (Sudore et al. 2006).

The level of health literacy in older people, particularly in rural areas may be due, in part, to poor access to health care. Health care is defined by the Institute of Medicine as “the degree to which patients are able to obtain needed services from the medical system” and “the timely use of personal health services to achieve the best possible outcome” (Millman 1993). While studies have shown that lower socio-economic status is associated with worse health and poor healthcare access, it is not obvious that health literacy is correlated with healthcare access for older people, mean age did not differ between literacy categories (Singh-Manoux et al. 2004, Andrulis 1998 and Bindman et al. 1995).

In a study done to measure health literacy, it was found that limited or low health literacy was also more common in older people with chronic medical conditions, including hypertension, diabetes mellitus, obesity, and depression, and in those who reported worse self-rated health. Furthermore regardless of the need for accessible health care for older people with limited health literacy, particularly for those with chronic medical conditions, older people with limited health literacy were also more likely to lack any kind of medical care including a regular doctor visit. The relations between limited health literacy and poor healthcare access in older people may partly explain the significant association between poor or limited health literacy and chronic disease. Older people in the lowest literacy category are at greatest risk of many health disparities (Sudore et al. 2006). Another study also found that those with inadequate health literacy have less knowledge about their medical conditions or their treatment and therefore have worse health status and a higher rate of hospitalization than the rest of the population. The higher prevalence of health literacy problems among the elderly is crucial because they are also most likely to have chronic health conditions. In addition, research shows that health problems related to health literacy will continue to thrive since literacy problems are more common among the elderly in Africa (Parker et al. 2003). In studies done, inadequate health literacy was an independent risk factor for hospital admission among the elderly enrollees socio-economic status; health behavior, chronic diseases, and self-reported physical and mental health were adjusted for (Barker et al. 2002).

2.3.4 Place of Residence

The great majority of older people in Africa live in rural areas which are characterized by high unemployment, very limited opportunities and poor social protection (UNICEF 2010, Lloyd-Sherlock 2005). Due to the poor circumstances that older people are living in, their health situation is compromised and they further lack the opportunity to access quality health care. This is also due to the fact that many health facilities are more accessible in urban areas than rural areas because urban areas usually have better transport systems and better infrastructure.

Place of residence is an important determinant of health status, particularly in Africa. Various studies show that living standards, employment, consumption patterns, and access to health care and social services differ considerably between urban and rural areas (Kahn et al. 2003; Smith and Goldman 2007). An estimated one-third of rural residents live in extreme poverty versus one-tenth of urban residents in Africa (World Bank 2005). In rural areas, infectious diseases and malnutrition continue to be the major causes of mortality whereas in urban areas chronic diseases and other health problems associated with industrialization continue to be the dominant cause of mortality (Smith and Goldman 2007).

Many studies have reported differences in health status by place of residence. The first epidemiological study by Ibrahim (1988) on older persons in Bangladesh found greater reporting of health problems in the rural region compared with the sub-urban and city regions. Accessibility and affordability of health services are also key fundamentals which may be lacking in the rural areas and as a result leading to urban-rural health differences in older people (Kabir et al. 2003). As a result, older people living in rural areas tend to experience the health disadvantage of geographic location. KwaDumisa like other typical rural areas in South Africa has insufficient health facilities, particularly Primary Health Care (PHC).

2.3.5 Marital Status

One of the well-established findings in the literature on well-being of older people is the marked differences that exist between categories of marital status, both in the general population and among older adults in particular. For instance, the married report higher levels of well-being than the unmarried with respect to overall happiness (Glenn and Weaver 1988), self-confidence (Balkwell 1985), mental health (Gove 1972; Hughes and Gove 1981), life satisfaction (Acock and Hurlbert 1993; Strain and Chappel 1982), and loneliness (De Jong 1987; Perlman 1988). The favorable well-being of married people is usually explained by the importance of having a partner for the fulfillment of basic human needs and the provision of resources (Bowlby 1969; Chappel and Badger 1989).

Studies suggest that there are three main reasons that may explain the way in which marital groups differ in rates of acute and chronic conditions. The utilization of health services physician visits, dental visits, and hospitalization rates may vary by marital status due to physical morbidity, severity of conditions; and variability in readiness to use medical services when ill or injured. (Verbrugge 1979). It is apparent that marriage presents some health advantages. It offers security and social support and as a result, married people may be generally happier than people who are not married (Bradburn 1969; Glenn 1975). There is a notion that unhappy people often adopt "risky" life styles. If unmarried people drink, smoke, use drugs, and drive more carelessly than others, they expose themselves to chronic conditions and injuries caused by those behaviors. In addition unmarried people may also have less adequate nutrition and sleep, making them more susceptible to acute illness (Verbrugge 1979). These life course experiences of marital groups explains the health differences in married and unmarried older people. The various experiences and behaviors of the marital groups are highly likely to influence the health outcomes of older women and men.

2.3.6 Poverty and Health

Poverty is one of the major concerns when addressing or assessing the issues of older people and this is common in many developing countries. With its deleterious effects on health, education,

lifestyles and self-esteem it has caused a negative effect on the quality of health of older people (Okie 1991).

Poverty is often associated with many problems in rural areas, this is a common fact in all age groups, but there is an apparent stronger association between poverty and the health of older people. Poverty may be observed through the life course of many South Africans, but this relationship may be particularly significant in later life (Hardiman and Midgley 1989). The main causes of death and illness have shifted from infectious diseases, under nutrition and inadequate hygiene to a post-transition phase, where diseases of wealth which includes chronic disease have become prominent (Caldwell 1993; World Bank 1993; Frenk et al. 1991).

The South African Participatory Poverty Assessment (SA-PPA) recognized that exclusion and isolation as being the defining features of poverty in South Africa. Pension sharing has been an instrumental strategy in South Africa and one that affects living arrangements in old age. It is therefore contributing to the social integration of old age pensioners. The loss of family support is becoming a common feature of aging, and besides the direct cost of unreal expenses that will be incurred, for many people the death of an older relative may also imply the loss of the income from the pension of the deceased. The issues that relate to the demands of the pension money also involves the pressing need for grandmother's money for transport to take PWAs (Person with HIV/AIDS) for medical treatment and the money to pay for grandchildren's schooling, and money to purchase funeral insurance for dying PWAs. (May 2003).

Even though the social pension for older people is aimed at taking care of their needs and sustains their livelihoods, it has become apparent that the needs of older people are neglected in cases where they have to come to the rescue of their poor families who are also overwhelmed with caring responsibilities. Economic and demographic forces are key correlates of health status in old age. There is a strong inverse relationship between socio-economic status (SES) and health status and this cuts across racial, ethnic and gender lines (Feinstein 1993; Kaplan and Keil 1993; Preston and Taubman 1994). Income level can influence epidemiological conditions, as well as choices in housing, education, work, diet, medical care, and social support. And therefore as standards of living rise, the vulnerability of individuals in exposure to health-enhancing or

health-damaging factors can also increase (Smith and Goldman 2007). Moreover many studies have shown that attributes present or acquired in childhood may have an important and lasting effect on life chances, including health behaviors and coping mechanisms, and throughout the life course, as well as exerting a strong influence on adult socio-economic and socio-demographic experiences and later life circumstances (Barker1992; Bartley et al. 1997; Bosma, van de Mheen, and Mackenbach 1999; Brunner et al.1999; Davey et al. 1997; Wadsworth 1997).

The socio-economic differentials in relation to aging and health have been surprisingly neglected, particularly in more general discussions of the problems of aging and health in our societies (House et al. 1990).Socio-economic status is a very important factor in attempting to understand the changes in the health of older people; this can also be a determinant of other factors that influence health changes in older people, like educational attainment. SES is an indication of the quality of health, especially in older people in developing countries where the population is rapidly aging and requiring an increase in health and economic resources in order to respond to the needs of the older people (Smith 2007). The socio-economic disparities depend on the countries' economy as well as social factors.

Many studies have shown that the income level of a country can influence and contribute to the epidemiological conditions; this also includes medical care, education, and type of work, type of housing and social support. Some studies suggest that the level of health inequalities at older ages will depend largely on social welfare policies (Popkin and Gordon-Larsen 2004; Kim et al. 2004). Even though these welfare policies are implemented, such as health insurance, social support, social security, in most cases they fail to meet the healthcare needs of older people.

In many Western industrialized countries the relationship between socio-economic status (SES) and health is well-established. Individuals with lower SES experience higher rates of mortality and they are more likely to suffer from numerous health conditions. This social gradient in health has been observed across different time periods and age groups using a wide range of SES indicators, health measures, and methodologies (Smith 1999;Goldman 2001).Self-reported days of illness or doctor visits are themselves conditioned by socio-economic status and sometimes show correlations with income, with wealthier people apparently perceiving and treating their ill-

nesses more seriously than people with a low socio-economic status (Deaton and Paxson 1998). Moreover the combination of poor socio-economic status and socio-psychological circumstances will be equally harmful (Ben-Shlomo et al. 1993; Martikainen and Valkonen 1998).

In situations of weak safety nets for the elderly, socio-economic resources may become increasingly important in maintaining health at older ages. (Smith 1999; Goldman 2001). This is also due to the fact that when older people age, they become susceptible to many illnesses and they require necessary medical resources to manage and cope with their illnesses. Other studies also suggest that supportive networks will prevent the effect of stress, including socio-economic stress. These supportive networks will also become potential sources of practical help as opposed to paid assistance or hospices (Berkman, Leo-Summers, and Horowitz 1992; Uchino et al. 1996).

Education has also become the most commonly used measure of SES in epidemiological studies (Libaratos 1998). Education is generally considered the best indicator of SES at older ages because it is typically completed early in life (and therefore less affected by health impairments that develop in adulthood), and it is also a key factor determining subsequent occupation and income, and can be easily measured. However, variation in economic status for a given education level suggests that education may not capture important aspects of SES (Braveman et al. 2005). Education can increase feelings of personal control and hence promote better health behaviour in individuals. Education can also provide a route to high status with regards to well-paid occupations and so to accumulate wealth and better pensions in later life (Bosma, Schrijvers, Mackenbach 1999).

2.4 Chronic Diseases

In the current modern times it is almost impossible to address the issues of older people without the mention of chronic diseases. Chronic diseases in South Africa often lack urgency at every level of resource allocation. The health service has a shortage of scientifically based processes for appropriate resource allocation. As a result chronic diseases seldom receive the resource allocations required for prevention and cost-effective care. Moreover, health services in South

Africa like many poorer countries are mainly based on a model for treating acute illness. Such a model is not necessarily suitable, particularly in public sector health facilities catering for the poor and it rarely provides for appropriate health promotion initiatives or educational needs of patients with chronic diseases. For example, the logistics of dispensing long-term medication for chronic diseases is seldom organized so that patients can obtain repeat prescriptions in an efficient way (Bradshaw and Steyn 2001).

One of the major challenges for the management of chronic disease in South Africa is rooted in the health care system. Prior to 1994 the public health care system was hospital based and provided excellent care linked to academic health centers. Primary health care services were not universally accessed; the poor had limited access due to their marginal position in society. Since 1994, the primary focus of the African National Congress government's health plan has been the development of primary health care with universal access. This new health care development has resulted in an extensive shift of patients away from large hospitals to primary health care centers in the community. But, despite the large numbers of primary health care centers that have been set up since 1994, predominantly in rural areas of South Africa, there are still major problems including staff shortages and inadequate facilities for outpatient care (Bradshaw and Steyn 2001).

The Department of Health initiatives to improve primary health care provision includes the partnerships and working together of the primary health care team with patients and communities. The attempts to improve professional behaviour through the implementation of social teaching models are also part of current initiatives. Nevertheless, there have been financial limitations and inadequate resources. This has resulted in poorly organized primary health care clinics (PHCC), with limited numbers of trained staff and inadequate facilities, equipment and medication. Chronic disease prevention and care have proved to be inadequate under such conditions (Goodman 1997; Levitt 1999; Steyn 2001).

Chronic diseases, especially in older people are influenced by a multitude of factors. The determinants of chronic diseases among older people are mainly westernization, population aging and increasing urbanization. These factors influence or usually result in change of lifestyle,

diet and health related behaviour of older people (Alli and Maharaj 2012). This combination of factors could lead to the development of some of the chronic diseases in older people.

2.5 Quality of Health Care

In South Africa, despite recent attempts to improve access to health facilities, large inequities in coverage of health services persist (Ijumba and Ntuli 2004). The main focus has been on pregnant women and children, neglecting the health needs of the aging proportion of the population. Older people continue to face the failures of the health care system as well as the growing complexity in the management of chronic diseases.

Health status and access to health services of older people are strongly influenced by both their age and their condition of poverty, and the two effects often reinforce each other. (Llyod-Sherlock 2000). Access to health services is a major problem in rural communities and this mainly affects the sick and vulnerable older people. Without proper access to health services and health care, older people will lack the ability to manage their chronic diseases and their health at large.

Community-based primary health care (PHC) remains the only effective way of delivering some form of health care to the population in many developing countries. In much of Africa, problems of coverage, access, equity, management, high costs, and ineffectiveness confront the delivery of health services. This situation is being compounded by the increasing demands placed on these services by the HIV pandemic and re-emerging diseases (Tanser et al. 2006). Poor access to health care services in South Africa has become the main barrier to access and utilization of health services. Many rural areas in South Africa are largely populated by older people as a result of urban rural migration and they are faced with problems in accessing health facilities and challenging health conditions (Kahn et al. 2003).

The distance to health services has created a challenge to the delivery of quality health care in the rural areas. Accessing health service for the elderly is not only a great challenge but it also adds more burden to the health challenges that they are already facing in rural areas. In addition,

utilization of primary healthcare services is an important determinant of health and a major economic cost. However, levels of utilization are far from equal, socially and geographically (Gross 1972; Andersen and Newman 1973; Knox 1982; Mayhew and Leonardi 1982; Joseph and Phillips 1984; Andersen 1995). These variations are highly significant and may directly affect health, both in terms of morbidity and perceived health. In extreme cases they may also influence access to secondary care and contribute to differences in mortality. Social factors thus play a large part in determining access to health services (Joseph and Phillips 1984; Eyles 1987; Haynes 1987; Jones; Moon 1987 and Birkinet al. 1996).

In South Africa older people usually expressed dissatisfaction with the quality of health care at the primary level including inefficient appointment systems, long waiting times and the apparent lack of interest of staff in the health problems of the elderly (Joubert and Bradshaw 2006). The frustration of older people about the quality of health care that they receive could result in less utilization of health care facilities and hence more major health concerns.

For older people reliance on household support tends to increase at later life, but due to a lack of alternative strategies, older women are particularly dependent (Lloyd-Sherlock 1997a; Chayovan and Knodel 1997). As a result, it is important to look at the welfare of older people with reference to the economic position of the households in which they live. A lack of employment opportunities for younger relatives will probably have a greater impact on elders than will target state interventions, such as low-value pension benefits (Lloyd-Sherlock 2000). Change in family structure tends to have an influence on the lives of older people. It is very common that when old people grow older and more dependent, there are fewer or no family members to support them

2.6 Social Policy and Health Reform

The dependency on old age pensions in South Africa is very high the ratio is 1:7, which means there are seven people depending on the old age pension of older person (Van Vuuren and Groenewald 2000). There are 40% of households headed by older person in South Africa, mainly because of the impact of HIV/AIDS; this has even worsened in the previous years. As a consequence, the old-age pension is crucial in the lives of the majority of older South Africans and frequently a lifeline for their entire families (Van Vuuren and Groenewald 2000). The extended demand on the old age pension has been shown to be associated with physical and economic abuse of older people in order to get to their pension money. Consequently the funds of the elderly which funds food, water, electricity and visits to clinics and hospitals are limited and this will impact on the state of their health and their chronic diseases care and clearly the poorer they are, the larger the impact (Bradshaw and Steyn 2001).

The social policies of a country can significantly influence the capacity for income generation which may also relate to the growing risk of serious illness. The increase in vulnerability of elder people may cause them to fall into poverty, regardless of their original economic status, unless comprehensive and effective social policies are in place. In both the developed and developing world studies have been conducted on the economic well-being of older people, and a major focus has been on the contributory pension and social security reform (Llyod-Sherlock 2000). In some developing countries particularly South Africa, the social pension has become a very important source of livelihood for many older people who are stricken by poverty. This also has a significant influence on the quality of health of older people who are relying on this social pension. However, for those who do receive a pension, the value of the benefit is not often sufficient to provide an acceptable level of livelihood (Llyod-Sherlock 2000).

It is apparent in some studies that the social pension does not significantly fill the gap that it was intended for, nor should it be assumed that old age pensions primarily benefits the aged. Studies from a number of developing countries have shown that income from pensions is often pooled at the household level and younger groups, particularly grandchildren, may receive a large share (Sagner and Mtati 1999). In a study done in rural South Africa, many older people claimed that

they spent around three times as much of their monthly pensions on the needs of younger family members as they did on themselves (Mohatle and Agyarko 1999). There are many rural households who are highly dependent on the pension of older people and as a result in many cases the health needs of older people are neglected and their health conditions could also deteriorate.

As such, the tendency to label contributory pension reform as primarily an issue concerned with the livelihoods of older people or of resolving issues facing the aged is usually misleading in the context of developing countries where poverty is very high. In addition, this has served to misrepresent research and policy development in areas of more direct relevance to the aged. Other than pensions, the forms of economic livelihood pursued by poor older people are varied in consideration of their heterogeneity as a group and the contexts in which they live in (Llyod-Sherlock 2000). However, a number of generalizations can be made.

Even though some policies attempt strategies to curb poverty among the elderly, but poor older people often continue to face both direct and indirect economic barriers to health services. User fees and co-payments for public health care are now commonly practiced in most developing countries. The fees may serve to generate additional revenue or actually rationalize usage. But, in practice, they have often been shown to be inequitable, even where exemptions are supposedly in place for vulnerable groups (Russell and Gilson 1997). Nonetheless; in South Africa social security has played a very important role in the lives and health of older people who do receive the pension grant (VanVuuren and Groenewald 2000).

Today, a few countries have a universal social security programs. For example, Botswana has a universal flat-rate pension scheme for all residents over the age of 65 like South Africa which has a means-tested benefit for women age 60 and over and men age 65 and over. This means that there is a very basic process for qualifying for the pension scheme. But the level is set at a point at which 80 percent of all age-eligible Africans may receive the pension (Lam et al. 2001). The South African pension scheme was introduced in 1928 as a measure to provide for the poorest retired white workers. Later in 1944, the State Pension was extended to all South Africans, and the value for the pension was equalized for all sections or sub-divisions of the society in 1993

before the first democratic elections in 1994. This historical evolution has led to significant changes in the lives of older people in South Africa, particularly in rural areas. Older people in rural areas usually experience major poverty related problems which has an influence on their health. Major discussions of social protection and well-being of older people in sub-Saharan Africa and in South Africa specifically would be incomplete without an account and understanding of the South African social pension program, which still remains unique amongst many African countries (Case and Deaton 1998).

South African men and women aged 60 and 65 years respectively can apply for a social pension irrespective of their employment history. The social pension was essentially a by-product of the undoing effects of the apartheid system, the program, which was originally intended to provide social protection for poor whites in the past, is now viewed in South Africa as a major pathway to achieve several broad development goals which include providing assistance to households in rural areas, targeting and assisting women, and keeping significant numbers of households out of poverty, particularly older people (Ardington and Lund 1995). This pension program has been a sole or major source of income for many poverty-stricken families (Van Zyl 2003).

With critical consideration of the above mentioned, it is apparent that the health and well-being of older people in rural South Africa is a crucial concern and this might also impact on the well-being of the entire population, mainly because the changing age structure and the growth of chronic disease is poorly understood in South Africa (VanZyl 2003). Despite the recent research into the poverty-alleviating impact of African old-age pensions and the institution of pension sharing in modern black South Africa from a historical perspective, very little was known about how the old-age social policy shaped the lives of both older and younger people (Sagner2000).

2.7 Conclusion

This chapter has provided the fundamental arguments and ideas for this research. The literature has demonstrates that the population of older in many developing countries is increasing and as a result, the health demands are also growing. It is evident that various social and health factors influence the health of older people, such as chronic diseases, access to health services, quality of

health care, poverty and change in lifestyle. Furthermore, health and social policy reform after 1994 provided a significant turning point for many older people. This chapter argues that the health of older people is changing over time in South Africa by providing insight into health reform, changing socio-economic status of older people. It is also apparent that older people are not only suffering from chronic diseases or ill health, but they are constantly challenged by their economic situation and that of their families.

CHAPTER THREE

Research Methodology

3.1 Introduction

Many rural areas in South Africa are inhabited by older people and there has been neglect in these rural areas in terms of service delivery. Conducting research in a rural area will provide insight into the factors influencing the health of older people in the parts of the country. Most research tends to focus on urban areas so it would be useful to also understand the situation in rural areas. By including both men and women in the study, the research will shed insights into the experiences of health of older men and women.

This chapter provides a brief description of the study area. The description of the study will be followed by a presentation of the sampling frame then a detailed description of the methods used in the study and data analysis.

3.2 Target population and study sample

Brief description of KwaDumisa

Figure 1.1 Map of KwaDumisa, KZN



Source: Mbhele (1998)

KwaDumisa is a typical rural area in KwaZulu Natal with very slow development and service delivery and mostly populated by older people. KwaDumisa like many other rural areas in South Africa has problems with scarce health facilities. This area is served by a mobile clinic based at Jolivet, which is adjacent to KwaDumisa, for more serious health problems residents' travel to hospitals in Umzinto, Park Rynie, Scotsburgh and Durban. There is a private medical doctor at Jolivet and a number of traditional healers. Accessing health services is expensive due to transport costs to the hospitals; residents also incur other costs due to the relatively high prices charged by traditional healers (Mbhele 1998).

3.3 Data Collection

This study adopted a qualitative methodology in which it aims to provide an understanding of complex psychosocial issues. Qualitative research has an advantage of interrogating the 'why?' and 'how?' of a phenomenon under study hence allowing for an in-depth understanding of the different realities constructed by social actors (Mbhele 1998). The researcher contends that qualitative approach is the most appropriate in addressing the research question of this study since an in-depth understanding of old age health is required. Qualitative research involves the collection of a variety of observed experiential materials and also involves and make use of case studies, personal experiences, introspection, life history, interviews, cultural texts and observational, historical, interactional, and visual transcripts that describe routine and problematic moments and meaning in individual's lives (Denzin and Lincoln 2000). Qualitative research implements a wide range of interconnected interpretive practices, attempting at all times to get a better understanding of the subject matter at hand (Denzin and Lincoln 2000). Qualitative research also emphasizes the importance of looking at variables in a setting in which they are found. Interaction between variables is important. Detailed data is gathered through open ended questions that provides direct quotations and in this process an interviewer is an integral part of the investigation (Weseen and Wong 2003)

Qualitative research is however criticized for not being 'scientific' in nature, and that is merely a collection of anecdotal data. Sometimes qualitative research is condemned for lacking generalization and that it tends to produce large amounts of detailed information from a small sample. (Carr and Kemmis 1986). Furthermore qualitative research may be criticized for being unreliable in predicting the population and that they can expand possibilities but cannot identify the best possibilities (Woodlife 2004).

However qualitative research was found to be suitable for this study because the aim of the study was to obtain detailed information about perceptions and experiences of participants, and therefore qualitative methods will enhance the meaning of the study by generating relevant results. This study uses qualitative data drawn from in-depth interviews (IDIs) and focus group interviews. In order to understand the health perceptions and experiences of older people,

qualitative research will be conducted using 10 semi-structured and 4 focus groups. The sample consists of male and female adults aged 60 and over residing in the rural area of KwaDumisa in KwaZulu-Natal.

Sampling is an imperial process for research as it allows for focus and concentration of efforts on high quality information with the small number of cases involved (Mann 1985). For this qualitative research, the researcher used purposive sampling methods, particularly snowball sampling to select the study sample. The primary advantage of purposive sampling is that it allows the researcher to select the sample based on knowledge of the phenomena of the study (Polit and Hungler 1999). The in-depth interviews together with the focus group interviews were used to provide an overview of the factors that influence the change in the health of older people from their perspective. The data for this study was collected from 34 male and female participants aged 60 and above.

A semi-structured interview guide was used during the interviews and a voice recorder was used to record the interviews. After the in-depth interviews and focus group interviews were conducted and recorded the data was then transcribed verbatim and also translated by the researcher. After translation the researcher reviewed the data from the in-depth interviews and the focus group to highlight important content that could answer the study's research questions.

3.4 Data Collection Methods

3.4.1 In-depth Interviews

In-depth interviewing which is a qualitative research technique involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, issue, or situation (Boyce and Neale 2006).

In-depth interviews are essential in the use of a qualitative study in order to acquire an in-depth understanding of the health perceptions and experiences of older people in a rural area. In-depth interviews are useful when there is a need for detailed information about a person's or certain people's thoughts and behaviors and if the researcher wants to explore new issues in depth. In-depth interviews can be used in place of focus groups if the respondent does not feel comfortable

talking openly in a group, or when you want to distinguish an individual opinion from the group's perspectives about issues that are discussed. The primary advantage of in-depth interviews is that it may provide the most detailed information than other data collection methods such as surveys. Even though there are limitations within this data collection method, they are most valuable because they also provide a more relaxed and comfortable environment in which the respondent can feel free to have a conversation (Boyce and Neale 2006).

More studies reveal that interviews are a good way of accessing perceptions and meaning of participants (Punch 2005). However, like many other types of data collection methods, in-depth interviews may be a disadvantage because they are time consuming. It may take time to conduct in-depth interviews and to transcribe and analyze the data, this may not also be cost effective (Punch 2005).

The in-depth interviews provides an overview of individual perceptions of their health status and how it has changed over the years, for better or for worse. They were also given an opportunity to relate their experiences with chronic diseases and other illnesses which are common among the older population. The interviews also investigate the factors that impact on the quality of health of older people. Older people may experience and perceive ill health differently according to their gender and age, thus the research further explore these differences.

3.4.2 Focus-Group-Interviews

Focus groups interviews are a form of group interview that make the most of communication between research participants in order to generate data. Although group interviews are often used as a quick and convenient way to collect data from several people simultaneously, focus groups openly use group interaction as part of the method. This means that instead of the researcher asking each person to respond to a question in turn, people are encouraged to talk to one another: asking questions, exchanging anecdotes and commenting on each other's experiences and perceptions (Kitzinger 1994). The focus group method can help the respondents to refer and clarify their opinions within a group of people easily than it would have been in a one on one interview. This type of data collection method is especially useful when the researcher has a

series of open ended questions in which he or she wishes to encourage respondents to explore in a group in their own words while pursuing their own priorities (Kitzinger 1994).

The focus group discussions (FGDs) provide the study with collective health perceptions and experiences of older people. In addition, it gives an overview of how health has changed over time. The FGDs begin by asking questions about the place of residence and how this may impacted their health or perceptions of health.

3.5 Selection Process

In qualitative research sample selection has a profound effect on the ultimate quality of the research (Coyne 1997). Patton (1990), also states that “qualitative inquiry typically focuses in depth on relatively small samples, even single cases, selected purposefully” (Patton 1990, 169). For this study as mentioned above, older males and females aged 60 and above were selected using snowball sampling methods. Participants for the FGDs and IDIs were selected using snowball sampling method, a technique of using networks. Five participants were selected in the community and they were informed about the study and they also informed other participants. Participants for IDIs were also selected through the technique of networks; two participants were selected in the community and informed about the study. These participants also informed and invited other people in their networks about the study.

Older females and males were the focus of the study because they have experienced various health problems which could also be associated with the evolution of many events, with the consideration of their age. The health perceptions and experiences of older people are also influenced by the changing social factors that surround them; this also means that at their current ages they are likely to have experienced events that have impacted on their health. Moreover, older people remain an important proportion of the population as they hold historical knowledge and reference for their country, particularly on how health is changing in South Africa with particular focus on chronic diseases. Participants were asked by the researcher to meet in one common area in the community for focus groups interviews and in-depth interviews were also carried out in a common area separately in a venue where participants and the researcher felt more comfortable.

On average, the FGI's took about an hour and an average IDI lasted for about 45 minutes. KwaDumisa is largely (if not entirely) occupied by an isiZulu speaking population, and hence both the FGIs and IDIs were conducted by the researcher in isiZulu. The study only focuses on the black population as they are the dominant ethnicity in KwaDumisa rural area. Many rural areas in South Africa are occupied by the African population.

Men and women who are 60 years old and above are generally considered 'old' in many societies and they are likely to have experienced various health problems with the increase in age.

3.6 Data Analysis

Data analysis for this research was done using thematic analysis which involves analyzing transcripts and structuring the content of the interviews. In a thematic analysis, after data has been transcribed, a pattern of direct quotes or common ideas is listed and identified to already classified patterns. The quotes are then combined and catalogued into sub-themes (Taylor and Bogdan 1984).

3.7 Ethical Consideration

Prior to the study ethical approval for the research was sought. The University granted the researcher ethical clearance to proceed with the study. The College Higher Degrees Committee approved the research proposal after critical considerations about the sensitivity of some aspects of the study. Proper measures were taken into consideration about the health situation of some of the older people. Before each interview was conducted, a consent form was given to the respondent and the nature of the study was explained carefully before they signed the form. The researcher ensured that the respondent understood the purpose of the study before commencing with the interviews. The respondents understood that participation on the study was voluntary and there were neither rewards nor benefits that were involved in participating in the study. The researcher also explained to the participants that some or part of excerpts from the interviews

may be used in the final report. Confidentiality during the interviews was maintained and no names of participants were used in the final report. All tools that were used during the interviews will be destroyed after the study has been finalized

3.8 Limitations

The limitations of this study are first the sampling technique and the sample size, Snowball sampling tends to exclude older people who are outside the networks used by the researcher. Due to time constraints, only a small sample size was chosen and therefore the sample may not be a true representation of older people in KwaDumisa. The study only focused on older people which also meant that the researcher had to be cautious in the way of asking questions in both the IDIs and FGIs, and constantly guide the interviews and discussions because older people tend to often digress from the subject matter, as other issues of their own interest may arise.

3.9 Conclusion

This chapter has provided an overview of the study and the relevance of the methods to the study. Ethical considerations are stated clearly and highlights how the study was carried out without compromising the sensitivity of some of the issues that might surface during the study and the limitations of the study are clear and well observed throughout the study

CHAPTER FOUR

Results

4.1 Introduction

This chapter will present some perspectives of older men and women with regard to their health. The study draws on qualitative data that comes from in-depth interviews and focus groups. In order to understand the significant health changes that have characterized the lives of older people in South Africa, this study has allowed older people to narrate their health experiences and health perceptions over time. The chapter starts by outlining the characteristics of the sample and then outlining some of the key findings of the study.

4.2 Sample Characteristics

Tables 4.1 and 4.2 presents the characteristics of the sample participants for this research. In total, 34 participants were interviewed for the study. There were four focus groups and ten in-depth interviews. Each FGD consisted of six participants each. The age of the study participants ranged from 60 to 83 years. Almost all participants in the sample were born and grew up in KwaDumisa and about 5 percent started living in KwaDumisa after they got married. All participants have been living in the area for a minimum of 20 years. A total number of 34 participants were interviewed. The majority of participants were married even though a significant number reported that they were widowed. A total of 50 percent of the participants have no schooling and only 3percent had completed secondary school. Of the recorded chronic diseases, 76 percent of the participants had arthritis, 65percentblood pressure and 35percentdiabetes. All chronic diseases that were reported by the participants were diagnosed medically.

Table 4.1 Socio-demographic data of participants in focus group interviews (N=-24) 2012.

Gender		Female	Male
Age	60-69	14	2
	70-79	2	4
	80+	2	0
Marital status	Married	4	2
	Widowed	12	4
	Other	2	0

The analysis of the data in the table above shows the total participants of the focus group interviews with ages ranging from 60 to 81 and all are pensioners. The table also shows that almost 80 percent of the participants were widowed, this might also be due to the common fact that men tend to die earlier than women. Most women in rural areas are even more susceptible to poverty and vulnerable to chronic diseases when they lack support from their life partners. Moreover, about 75 percent of the participants were females revealing a skewed ratio that might be also the result of the age difference in morbidity of older people. Almost all participants mentioned that they suffer from at least one type of chronic diseases.

Table 4.2 Socio-demographic data of participants in in-depth interviews (N=-10) 2012.

Gender		Female	Male
Age	60-69	3	2
	70-79	3	1
	80+	1	0
Marital status	Married	0	1
	Widowed	6	1
	Other	1	1

Table 4.2 above shows that 70 percent of the participants were widowed, and this is most common among the female participants. This also shows, besides the fact that there are more females in the study sample that women usually live longer with health problems than men. The ages of participants' ranged from 60 to 83 and all are pensioners.

Table 4.3 Level of Education

Education level	Number of participants
No schooling	17
Completed Primary school	6
Some primary school	3
Completed Secondary school	1
Some Secondary school	5
Tertiary education	2
Total	34

Table 4.3 above shows the education level of the participants. There are a high number of older people with no schooling, only one participant had completed secondary schooling and two have tertiary education. For the purpose of this study, the education levels have been used as a way to show relations with ill health and the lack of health literacy. The low level of educational attainment could also be the reason for the low levels of health literacy in older women and men in rural areas.

Table 4.4 Types of chronic diseases by gender

Type of chronic disease	Number of males	Number of females	Total number of participants
High blood pressure	7	15	22
Diabetes	4	8	12
Arthritis	8	18	26
Cardiac/Heart condition	2	6	8
Respiratory problem	4	7	11
Vision/ eye sight	3	5	8

Table 4.4 above shows the prevalence of chronic diseases among the participants in the study. Many participants reported that they were suffering from arthritis more than any other disease followed by high blood pressure and diabetes. Many participants reported that they fear they might have diabetes but it may not be detectable yet. The table also indicates that women

reported more illnesses than men and fewer participants reported problems with eyesight and health conditions compared with other health problems.

4.3 The Health Experiences and Perceptions of Older People KwaDumisa

Perception of 'Ill health'

Older people in rural areas held quite negative attitudes towards their health, describing it to be an experience of pain brought about mainly by chronic diseases. In the interview, many older people reported that they experienced ill-health, which led to them being unable to perform certain tasks on their own. As older people age, they tend to rely on their many social support systems. These social support systems enable them to carry on with their daily activities. Some participants were accepting of their ill-health which they felt was brought upon by their age. Many older people also associated their ill health with old age. They felt that most of their illnesses are occurring because they are aging. Some participants reported that they do not dwell on the causes of their illnesses because they are due to circumstance that are not under their control, such as poverty, economic instability, domestic stress and the burden of orphaned grandchildren. When interviewed older people stated that they experience chronic conditions and that they are trying to manage them but they also experience difficulties due to barriers in accessing health facilities.

“For me I am not ashamed about the illnesses that I have. I would say ill health is the feeling that things you used to do are impossible, and pains that you start to feel that you didn’t have before, that I would call ill health. And your organs do not function the same way as they did before. For example if I was traveling 1km going to Joliet, before 15 minutes was more than enough when I was going there but now I would be glad if I can even make it there in an hour” (FGI 1)

“I think illness is feeling that some of the organs are not functioning properly and they are painful, for example the knees and the time you use to spend walking, it is different now because you take a longer time. And also poor eye sight, but this is also affected by diabetes and all those things” (FGI 3).

Participants further indicated that they view ill health as a phase in their lives where they lack the ability to help themselves and thus become highly dependent on others for their support like family, social networks and health systems. Older people also pointed out that ill health is a disability and it is also viewed in terms of not being able to provide and support themselves not only physically but also financially. One of the focus group participants mentioned that their precarious financial situation increases their vulnerability. She further mentions that the health of older people worsens because of the challenges that they experience in their daily lives.

“Ill health is something that disables us, and we can’t do things on our own as we are sick. Clinics are far and we have to travel far and we don’t have money. We are sick with sick and disabled children” (FGI 2).

Physical illnesses and constant discomfort were mentioned by many participants as a result of their ill health. They also reported that these symptoms make them suspect that they have chronic illnesses even though they have not been diagnosed. These symptoms are usually experienced by other people who are also at a similar age. It cannot be debated that many older people in some rural areas of South Africa experience premature aging effects because ill health is caused by the impact of various social circumstances such as poverty and socio-economic status as well as social support structures.

4.4 Common Health Problems

There are various chronic diseases that are associated with aging among older people and these were also common among the participants. Chronic disease among older people is evidently a serious and a growing problem and this was evident in the interviews with older people.

Older women and men in KwaDumisa reported mainly chronic diseases as the major cause of their deteriorating health. Almost all the participants in the focus group and in-depth interviews stated that they suffer from chronic diseases. Even though many elderly people are affected by ill health, their experiences and perceptions of ill health may vary. This is also due to the fact that they occupy different socio-economic status and they go through different life course

experiences. It is also evident that chronic diseases still remain the most common health problem for many older people in rural areas. It was also found that older people may experience or self-report diseases simply because their counterparts have the same disease or experience similar symptoms. This might be due to the fact that older people often experience common chronic diseases.

Participants stated that almost all their counterparts in their communities have some or one of the chronic diseases. During the discussion, older people complained about not being able to get medication from the clinics and hence they continue to suffer daily from chronic pain. They also stated that when they are ill they are given useless medication instead of the appropriate medication for their particular sickness. Participants also reported that they are suffering from other chronic diseases and they were concerned that they may have been misdiagnosed at the clinic.

“The disease that is hard on me the most is high blood pressure. What I think is hiding is diabetes, because I can’t say I don’t have that because sometimes they hide. Because sometimes I tend to feel dizzy, but the nurses cannot find this diabetes” (IDI 3).

“There is so much illness in our blood especially because we are old, and especially our knees and backache. We can’t even walk because of painful knees and backache” (FGI 4).

“We have problems in our bodies, problems that are incurable, but back in the past our mothers and fathers did not have these problems. They did not have diabetes and blood pressure [BP] like we have now. Even our children have this bad disease [HIV]. It is even worse now we don’t know who will bury the other” (FGI 2).

4.5 How are Older People Affected by Ill Health?

Older people mostly referred to the effects of ill health as the inability to do things that they were able to do in the past. Others reported that they are affected by ill health in terms of their quality of life. They felt that their quality of life has deteriorated because they are more dependent on others for assistance to carry out their daily tasks. Others stated that they often spend most of their time at health facilities because they are often ill. One participant observed that walking has become a problem. Another participant observed that they do not have the same energy levels that they had in the past. Many suffer from health ailments that are very debilitating. Some of the participants reported that most of their bodily functioning has been affected by chronic diseases. As a result, they face the burden of continuous treatment for their chronic conditions. Chronic medications however allow them to manage their ill-health. Even as people age, older people still believe they should enjoy some degree of independence where they are able to perform tasks on their own and live life without chronic diseases. Contrary to this, some other older people anticipate developing chronic diseases because they are old and they expect to experience symptoms of aging.

“It is not the same as I was younger, but that all started when I felt my health change, that is when I had blood pressure. I felt sick all the time and my energy was not the same anymore” (IDI 4)

“I can’t walk the same distance I used to walk anymore, when I walk my knees get tired and painful. And my eyes too, they don’t see like they used to, it’s because of all these sickness” (IDI 6)

During the interviews some respondents reported that they no longer have the sense of ownership of their health because they are dependent on health facilities and medication for good health. This may suggest that older people may view illness as a much anticipated phenomenon at some stage of their lives because of aging. And some view ill health as an effect caused by certain factors that develop in their life course. Respondents also added that, since they are chronically ill, they have to regularly take care of themselves and even visit the doctors when it is necessary although they cannot always afford it. Ill health for older people also caused strain on the

household because they constantly require care. In the in-depth interview some of the respondents stated that ill health is a common thing at their age and particularly in the present time and it gets worse as they grow even older.

“As I grow older I know my health will be worse, I will get all the diseases. Now in our times diseases are worse it was better in the past now. You can’t live a very long life with these diseases” (IDI 7)

In order to determine perception of health status, during the focus groups and in-depth interviews the participants were asked if they perceive their health to be poor, satisfactory or good. Almost all the participants reported their health to be poor, mainly because of illness and aging. Participants complained of ill-health and dissatisfaction with their low socio-economic status. They were particularly dissatisfied with the lack of proper health services in their area.

“I wouldn’t say that I’m satisfied with my health because there are things that I cannot do anymore, my health is now very poor” (FGI 4).

“I would say that my life and my health are getting worse as time goes on instead of getting better, I am always feeling ill. I just get more and more diseases.” (FGI 4).

Even though many older people reported the effects of ill health as being mainly physical, such as the effect of diseases causing disabilities in their bodies, others described ill health as having an effect on their livelihoods. This also means that sometimes they are unable to provide for their families financially, particularly their abandoned and orphaned grandchildren. There was a fear about the future, not only for themselves but also their dependents. They are worried about who will look after them and also, take care of their grandchildren. Older people sometimes find themselves feeling like a burden because they can no longer take care of themselves. For many, the experience of ill-health is very emotional. It causes a great deal of emotional distress because they realize they may never experience good health again and they will not be as healthy as they used to be.

“What can we say, when you are ill all the time, sometime you become like a burden because you have to be taken care of. Sometimes you find that there is even no one to take care of you, so your life just gets worse. The clinic does not help much as well because you cannot get to them and they donot give you enough medical attention” (IDI 6)

“Even when you are sick, you get very worried, because while you are sick lying down, you think who will take of this house and who will look after the little ones (grandchildren). You become very worried, but you can’t do anything because you can’t tell illnesses to go away.” (IDI 7)

4.6 Factors that Compromise the Health of Older People

Older people are usually prone to chronic diseases and in some cases it is due to their frailty and age, but it is without a doubt that certain factors and life conditions could have an impact on the health of older people. Factors such as the increase in urbanization and population aging may lead to increasing health problems for older people as also indicated by the participants. The change in lifestyle due to westernization may also force them to adapt to certain ways of living that may cause health problems, especially for older people. Older people in rural areas are usually faced with many challenges that result in ill health or the early development of chronic diseases. They are becoming accustomed to the changes around them; this also includes the types of foods that they eat and the way in which they live their lives.

As suggested by various studies that women and men in lower and middle income countries tend to have poorer health status than those in high income countries, older people in KwaDumisa exhibit adverse socio-economic conditions which could also be associated with the socio-economic conditions of their country. In countries where there is low income, there are usually high levels of poverty and hence high levels of morbidity. Participants often reported that because of poverty and their subsequent socio-economic status their health is often compromised or worsened. Older people also reported during the focus group discussions that their lack of financial stability and support has contributed to their ill-health. Their precarious financial

situation may have also led to poor health, because they often cannot afford good medical care and in some cases, good nutrition. Older people reported that if they could afford better health care they would not experience so much ill-health. They also did not seem to trust the health care services in their areas and felt that they are not improving their health.

“My child maybe if we had money our lives will be better and maybe we would not feel our illnesses, now we rely on these useless clinics that don’t help us. We worry too much about what is going to happen to us.” (FGI 4).

4.6.1 Poverty

Poverty is a common factor for poor health status in older people, particularly in rural areas. Many health related issues and challenges in rural South Africa are usually associated with poverty. A significant number of older people reported that they are ill because they do not have the means to take care of themselves and their households. They also reported that as older people they experience poverty in all forms, because there are no structures to assist or support them. Again, due to the large number of households headed by older people in rural areas, they often struggle to carry the burden of caring and providing for members of their household. Households with no income are forced to share the pension of the elderly person in the household. Some households may rely on remittances sent by relatives, but this form of income is not reliable.

“It is very hard on us as we grow old and living in these situations, sometimes you have no food for yourself or even your family, I don’t even mention the money to go to the doctor. We are poor my child and it is harder for us as we are old.” (FGD1)

“I have arthritis now I can’t even work and collect and sell wood like I used to. I don’t know what we can do because we live in this poverty. Because I maintain myself, my children are not working and so this makes me suffer too much” (FGD3).

“Oh my child, I can’t even mention the issues we go through as older people in this area. We face poverty every day. We don’t even see where this pension money goes because there is too much that is facing us.”(IDI 4)

Many older people felt that their poverty resulted in other factors that further deteriorated their health. The majority of the participants shared a common perception that they are not financially secure, even though they do receive the government pension; it is not enough to take care of them. They also added that one of the major contributors to their ill health is the constant stress and worry about the grandchildren and orphans who are abandoned by their children who moved to the city and this stress is further exacerbated by poverty. KwaDumisa like many rural areas in South Africa have many orphaned grandchildren who are cared for by older people. It is evident that many of the illnesses that are experienced by older people could also arise from their situation at home. Taking care of grandchildren and financing all their needs becomes a hard struggle for older people who are economically inactive and only depend on the government pension.

“We struggle and we share this money with the grandchildren. It doesn’t satisfy us at all, we even use this very pension for insurance in case we die” (FGI 2).

“No it [the pension] does not satisfy me because there are children, so I have to buy food and it is finished and then I have to go and get a loan” (IDI 7).

“This pension is little and it doesn’t satisfy my needs, it just finishes. It was better when I was working, nothing is improving, this pension does not improve my life but it is better than nothing” IDI 9).

Older people, particularly women added that the burden caused by assuming responsibility for the care of household members also contributed to their illnesses. It is a common fact that many rural households are headed by older people in South Africa and they are often forced to take

responsibility for raising their grandchildren. In many rural areas in South Africa poverty is rife and households headed by older people are struggling to secure their livelihoods. In this context, it is unlikely that older people are able to effectively manage their health conditions. In the interviews, many older people expressed the common concern that they had developed chronic illness in response to the stresses that they were experiencing at home and they noted that high levels of stress makes them more vulnerable and as a result their health worsens

“Being unhappy at home and stressed from our children make us unhappy , especially when they have children and leave them with us, all this make us very ill” .(FGI 3)

“When you are old you have so much to think about and you are always worried and eventually you get sick. Sometimes these illnesses even come before their time. It is hard.” (FGI 4)

4.6.2 Accessing Health Services

It is important to understand barriers to health care services in order to improve the quality of health care. The quality of health and the health status of older people in rural areas are impacted by the way in which health services are managed and how these services are made accessible to the people they are intended for. KwaDumisa is also one of the typical rural areas that are neglected in terms of service delivery. The limited health infrastructure in KwaDumisa is one of the major barriers to accessing health care services. Respondents reported that they have to use taxis to travel to clinics and hospitals and when they reach them, they are sent back because it is either full or they do not have medication. Furthermore there are no structures that are available to assist older people when they get to health facilities and the health workers do not treat them well. In consideration of the low socio-economic status of many older people in rural areas and the challenges with accessing health facilities, it is evident that they are facing serious problems.

Older people were dissatisfied with the functioning of health facilities and the fact that they are not meeting their needs. They were also concerned about the quality of health care that is provided at the health facility in their rural areas. Many participants also reported that health facilities are far and inaccessible and this does not help their deteriorating health. Older people

stated that health services significantly influenced the quality of their health, particularly in rural areas. In some few cases, older people also stated that they are forced to have medical aid that they cannot afford in order to be able to have access to proper care and management of their chronic diseases. The majority older people however do not have medical aid; and as a result their health is at the mercy of over-burdened health facilities, which are unable to meet the needs of the patients.

Rural areas are often characterized by lack of health facilities and KwaDumisa is no different. There are limited health services that are available to the oldest and most vulnerable sectors of the population. Many older people suffering from chronic diseases do not have easy access to health services. Health services are situated far from their place of residence. There are no clinics in the area and the older people have to either have to pay for transportation or walk long distances to the nearest health facility.

“I have a heart disease. I don’t even know what to do because in this place we don’t even have a clinic. The clinic is far. When you go there you come back very late and this places my child, it’s very painful. We even have medical aid, but we don’t have money to pay for this. It is very hard for us” (FGI 1).

One of the major barriers to quality of health in rural areas is the geographic location of most health care facilities especially primary health care facilities. Participants reported that the way in which the health systems are structured does not accommodate their health needs. They stated that there are no structures and personnel that attend to them at health facilities. They wait in long queues and suffer ill-treatment by the health workers. Participants stated that accessing health care services was never a significant challenge in the past because they believe there was better management within the system. With the health system being over-burdened with a number of health challenges it has become difficult to shift focus to the health of older people. The manner in which the public health care system operates is not particularly inclusive of the specific needs of the elderly

Access to health service is very crucial for older people with chronic diseases. In KwaDumisa older people do not have proper access to basic health facilities like primary health care which is very important for the health management of older people. With the increasing number of older people with chronic diseases and the increase in absolute numbers of older people in general, it is shocking that KwaDumisa still faces serious problems with accessing health facilities. Problems in access to health facilities will adversely affect utilization of health services. There are many broadly accepted barriers to accessing health services. In addition to the many societal, socio-demographic and behavioral factors affecting utilization of PHC services, it has been widely accepted that geographical accessibility of the health services has a direct bearing on utilization of these services (Tanser et al. 2006). Older people in some cases neglect their illness because of the common fact that they will not afford to reach a primary health care service or that they will not receive the care and medical attention that they need.

“They [health care facilities] will never satisfy us because they are very far. You have to travel far and sometimes you don’t even have that money to go to the hospital, so it’s hard” (FGD 1).

“In this mobile clinic they don’t do everything, they don’t take my urine to check for diabetes, they don’t check my blood pressure, so I have even stopped using the mobile clinic and I travel to the other clinic” (FGD 3)

Access to health services for older people in KwaDumisa appears to be a very serious concern and it is in this light that they shed insight about the way in which health is changing and the effect of this change. One of the participant exclaimed the health service will never satisfy them because they are far and unreachable and they do not have money to travel to the health care facilities in other areas. There are mobile clinics that come to the community but they do not provide comprehensive services for older people. They therefore have no alternative but to travel to the nearest facility for health care which is often situated a significant distance from their place of residence. Delays in improvement in access to PHC may have a direct impact on improved health outcomes for older people (Perry and Gesler 2000).

4.6.3 Lack of Health Care

Healthcare in health facilities or the lack thereof, is a challenging issue. Older people reported that health care in facilities, particularly PHC facilities are not accommodative to their needs and therefore it also makes it difficult for them to receive appropriate attention. Older people added that the medical attention they receive at the facilities is not adequate and there are not enough resources in facilities. These challenges were reportedly as one of the barriers that could prevent utilization of health services. Many primary health care facilities are aimed at rendering basic and immediate health services to the public or communities especially the most vulnerable. But these facilities lack adequate programmes and resources that are specialized to provide proper health services to older people. This is a matter of concern to older people who are suffering from various chronic diseases. In the focus group interviews older women expressed strong negative attitudes towards the poor quality of care that they receive at health care facilities, especially primary health care. They also stated that as they tend visit health facilities more often to manage their illness, it is important that they find adequate services. One participant explained that they are not given appropriate treatment for their illness and this caused them a great deal of pain.

“Now there is a lot of carelessness among the nurses. When you were going to give birth before, you were very well taken care of. When I went to give birth to my last child, I was in labour till the next morning, and when I called the nurses, they said they are busy and I told them my child was a bridge and I won’t be able to give birth like this and they said: ‘oh, you know better than us now’ and I told them I can feel it, and I almost died and they even beat me saying I must push the baby by force, and the doctor was passing by and I called him and told him what was wrong and he helped me and confirmed that the child was a bridge and I won’t be able to give birth. Nurses are rude and they don’t care about us”(FGI 2).

“At a hospital, the last time I was there, the doctor came after I had already told the nurse what was wrong with me. When I sat next to the doctor and I told him that this was problem and I also requested that they do an x-ray because I really didn’t feel well. He just didn’t say anything and wrote down on a piece of paper and said I must go fetch this from the dispensary. When I got there they gave me panado, you know just to go all the way for a panado. Everyone would always

complain about that colored woman. Even a resident from around here who drives ambulances, was in a car accident and he was given an aspirin by the same doctor. So we suffer so much and when we think we've reached places where we can get hope, its where we are hurt and made to suffer the most, both at the clinic and at the hospital. There is just nothing that we can do. It is better you just stay at home and die, but that just doesn't happen"(FGI 3).

Medical care is a growing concern for most public health services in South Africa and this issue is of particular concern for older people. In rural South Africa, health services are not available and the health of the vulnerable is severely compromised. The health care resources that reach rural areas are not adequate to provide for the health needs of older people. Older people in rural KwaDumisa have to travel by taxis to get to the nearest primary health care facility and when they reach the clinic they do not receive appropriate medical care. They are often sent back home or told that there is no medication for them. This is largely due to the fact that the health services are often overcrowded, with locals from the community who are given preference because the clinic is in their area. From the comments of the older participants it seems that health services are not equipped to provide geriatric services.

"This clinic does not have medication for arthritis they only give us rubbing ointment. When I came from the doctor and I went to the clinic for arthritis pills, they told me they do not have them" (FGD 2)

"There are problems in clinics. There is no system for admitting people. We are often told to go back because it is too full. Most of the time we don't really know where to go because even the hospital is far"(FGD 2)

"Maybe they should also have a program where there is a nursing sister who comes to check on the older people, because now there is only a focus on HIV and tuberculosis. But older people should also be taken care of. They should be registered as sick people to be cared for." (FGI 2).

Even though older people feel that they do not receive sufficient care and attention, they also indicated that they understand what they should be receiving from health facilities. Older people understand the structures that exist in the health facilities and how these have created barriers or limited access with regards to priority and medical attention.

4.6.4 Attitudes of Health Care Providers

Many older people reported major problems with health providers in terms of health care and service delivery. Interactions between older people and health providers have proved to be one of the primary concerns in terms of utilization of health facilities by older people. In the focus group discussions many older people complained about the treatment that they receive from the health care providers. They feel that providers do not have adequate training to deal with older people. Older people feel that many health care providers do not have the proper skills to care for the health needs of older people.

“In the last month I had a stroke, and I didn’t even want to go to the hospital, but I had no choice because it was really bad and my children took me to the hospital. When I got there, I stayed and stayed unattended and the nurses were just looking at me lying there. And then suddenly a nursing sister came and asked my child, “hey you, what’s wrong with your mother” and my child told her that I had a stroke and they then injected me. And then the next morning that woman that I don’t like came and she was told what was wrong with me, but she just looked at me and said I must go and fetch medication, and at that moment I couldn’t even walk. But someone helped me and put me in a wheelchair and pushed me to go fetch that medication and when I got there I got a lousy panado”. (FGI 3)

Many other older people in the focus group complained about the quality of service that they receive from the health workers. They felt that they were not treated in a respectful manner. The health providers were often unfriendly and unhelpful. Some older people felt that some of the health professionals treated them in an unprofessional manner. They did not show them empathy and it seemed like they did not enjoy their jobs. They did not seem to care for their patients.

“And then there is another problem that I don’t know how it can be fixed. You will find that some nursing staff did nursing because it was the only form of employment. It is not in them. So they are doing this just to get paid, they are not doing it so that people would live, whether they got help or not they don’t care”. (FGI 2).

Older people further stated when interviewed that the attitudes from health workers in the public health facilities were not welcoming, and they did not make it easy for them to visit the health facilities more often. They also refer to this as the change in the health care system where the health workers are not delivering health services properly. They also mentioned that there is a lack of commitment on the part of nurses and they are not caring. Some of the older people reported that they believe that the inefficiency in public health facilities is significantly influenced by the shift in political power which came with the change in the management of public health facilities.

4.6.5 The Burden of Caring

The major burden that participants face is the responsibility of care giving. Older people have primary responsibility for their abandoned or orphaned grandchildren, as well as their sick and/or dying children. Older people often have to care for their sick children who are suffering from HIV/AIDS and this also places a huge burden on them. It is not uncommon for grandparents in rural areas to take care of orphans left by HIV/AIDS infected parents. Participants mentioned that they suffer increased health problems because they have to struggle to keep these children alive and in school and some of the children are also sick and involved in substance abuse.

“My opinion, what contribute to our illness, especially blood pressure is that we are mothers and we have children, these children have children and they do this and that and all this comes back to you and you then start to have all these diseases. Even this grant from the government is too little. It is not enough and all these grandchildren need you, you need to feed them, they need to go to school, you see all those things. Through all these things you must struggle

and this pension grant is too little but you need to try so that we can also live in our home and all this causes blood pressure” (FGD 2).

“Another thing that I notice is the suffering we go through because of our sick and dying children, all this causes pain to us and results in health problems. You see my child I had only blood pressure and arthritis but this last year they found diabetes. So it’s these problems with our children because they go and do all these things” (FGD 3).

“Yes and then you think about the orphans and you don’t even know what to do with them. I have a house full of orphans. I don’t know who to give them to. Even if you were not sick but because of all this you eventually you get very ill”. (FGD 4)

It is apparent that a growing number of health problems that affect older people are not only caused by their chronological age or the fact that they are aging; rather they are experiencing many social and domestic problems. These problems cause them a great deal of distresses. They are worried about their financial situation because there is a high level of unemployment in the country and they do not receive any financial support from their children as a result. Although most receive the government pension this is not enough to make ends meet. They use the grant to support the entire household and they are feeling the pressure.

“Even this pension from the government is too little it is not enough and all these grandchildren need you, you need to feed them, they need to go to school, you see all those things. Through all these things you must struggle and this pension grant is too little but you need to try so that we can also live in our home and all this causes us blood pressure” (FGI 4)

Pension is the main source of income for many households, particularly the ones that are headed by older people. The pension money for one elderly household member is used to support the entire household and also support young children who are still in school. These are some of the

main events that disturb the harmony of the lives of older people. Forcing them to take up these responsibilities means that they often neglect their own health needs.

4.6.6 Change in Lifestyles

Faquhar (2005) reported that older people identify family relationships, standard of living, activities, social contacts and health as important factors that bring quality of life. Other studies have shown that good social relationships, financial circumstances and being independent will influence the quality of life and health of the elderly (Bowling 2005). Over the years there have been many changes in lifestyle which has impacted the health of older people. The change of lifestyles for older people might have an influence on their wellbeing and satisfaction with life. Because of the change in times, the elderly have to adapt to the changes that come about with modernization in their societies. Older people no longer have financial freedom and they also lose family structures and social activities which may have a negative impact on their health. Some elderly people believed that the way in which their diet have changed might have an impact on the health and this may have led to an increase in chronic diseases. Also, many older people believed that their health has changed significantly with time, as a result of the foods they eat and the stresses from their households.

“My life has change immensely, like eating things that we do and eat, eating things that we don’t know how they will result in our health, why I am saying this is because, when you go to a dietician and they tell you that you mustn’t eat this and don’t eat that. It means there are things that we eat that are not good for us as individuals because we are not the same” (FGI 2).

“Also, when we get married as women along the years your husband leaves you and go to someone else, and you are too old, this can make you sick, it causes pain in your heart and leads to BP. Because they do this in front of you, it makes us very ill. All the problems of the house fall on your shoulders. It’s better to be a widow who knows that their husband passed away than to be a widow who has a husband but who is with someone else; this makes your health even worse” (FGI 2).

Like many rural areas in South Africa, older people still believe strongly in traditional medicine and in some cases they have greater trust in traditional medicine than western medicine from medical practitioners. Some older people still have strong beliefs in traditional medicines and this might influence their utilization of services and their adherence to treatment.

“Another thing that really finishes us but I’m not saying it is bad but it is the truth. Now if you start to cough we run to the white people, the doctors and get these pills that are made in their own certain way and the human blood is not made out of pills so then this pill starts to cook your insides and you begin to have more illness and diseases because of these pills. Whereas before we didn’t use to take pills, I am not saying it’s a bad thing, it’s good because it is their time, but before we just use to go to the bushes and get leaves and mix and drink and you feel better, but now we take these pills because we are sick, you take pills for blood pressure which works in its own way in your blood and you take pills for asthma which also works on its own way in your blood and all this mixes together”(FGI 3).

Older people strongly believe that the change in their health status is also a result of the changes in their lifestyles and the breakdown of the traditional family structure. It is evident that many issues that affect the well-being and health of older people are not only particularly related to low socio-economic status and dissatisfaction with health service. Domestic stresses also have an influence on the health of older people. Some events may not cause older people ill health but they may lead to stress and disruption of their lives. The majority of the female participants reported that they were widowed and in some cases their children have died as well. This creates a gap in older people’s lives particularly their emotional wellbeing and the stress of taking on the burden of the household. Older people find it difficult to copy alone. They also find themselves isolated from the community and this affects their emotional well-being.

“When your husband leaves you, you remain in trouble and then your children leave you as well, and then your mind and heart begins to be troubled because you are always thinking” (IDI 7).

“We are always stressed because of our children, neighbors and just the place that we live in is not good, there is nothing good about this area. When you go to other areas you find that things are done and going well and then you suffer because you built in this area, so that is why we are always stressed. And wherever we go when we need assistance they don’t respect us, so it’s all those things that makes us ill’ (IDI 4).

“I would say it is better but I can’t because there are criminals now, so I can’t say it is better. We are just staying because we have already built our houses here and we can’t go anywhere, especially for me it’s hard for me to go anywhere because I am alone now” (IDI 3)

4.7 How has Health Evolved?

It is widely known that health related issues in rural areas in South Africa are often marginalized. Rural areas face problems with unequal distribution of health services, barriers to access health services and shortage of medication and personnel. These problems continue to remain as the health care system is overburdened with an increased number of patients who require services particularly older people with chronic conditions (Coovadia et al. 2009). During discussions most participants viewed their health concerns as important issues that are always left unattended in their health facilities. Participants also stated that the health systems have changed over time. They reported that they do not receive the medication that they need for their illnesses. In addition, the health workers are not accommodating and friendly. Many older people were concerned about the long queues at health facilities. Older people reported that the health facilities in the rural area often have long queues and as a result, they have to wait for long hours before they are attended to. Older people saw this as one of the factors that cause people to not attend health facilities, PHC facilities in particular.

“We have these diseases because the times now are different from the times back in the past and our children do their own thing. We are living in the current times; we are dying because of these current times.” (FGI 5).

“It’s a problem because we have to travel, sometimes you can be sick and not go to a clinic because you do not have money. So you will have to wait for that mobile clinic that only comes once a month” (IDI 7).

Older people stated that they are anxious about the issues relating to proper service delivery at the PHC facilities, this also involved availability of medication, availability of staff, immediate medical attention and staff attitudes. Other older people reported that their health is compromised largely due to the poor health care they receive at health facilities

4.8 Political Power

During the transition to democracy there was considerable restructuring of various important systems, particularly the health system which underwent major changes that continue to affect the health of many South Africans, including older people. The new health system was intended to provide a less discriminating approach to all citizens of the country. But the current regime is struggling to provide services to meet the health needs of the entire population. Older people states that their health needs in rural areas have been neglected. Older people referred to the previous health system as being better than what they are experiencing in the present health system in terms of access to facilities and proper health care. It has become apparent for many that the shift in power has not led to an improvement in health care. At the time of the interviews, older people state that the way in which is used has an influence on their lives and the health services that they receive from the public health care systems.

“What I would say is that, when white people were in power, supervision was strict, there were people supervising the workers on how they are treating the people, but we don’t have that kind of supervision now. Inspectors just came in when the workers didn’t even know, but now the inspectors report when they will come and do the inspections” (IDI 4).

The change in power for older people in rural areas has not brought the expected improvement in the delivery of health care. Some felt that health care has worsened because it led to a breakdown in health services. They are particularly worried about the lack of supervision of health care services and expressed concern about their treatment at health facilities. Older people now wish to turn back the clock and felt that they experienced better services and health care delivery under the oppressive apartheid regime.

“It is worse now because you can’t just go to any hospital because they will tell you that you don’t come from that area, but in the past I used to go to any hospital. They said they were doing away with apartheid but they brought it back in other different ways.”(IDI 5).

“In the past, there was so much oppression by white people, but they took care of us at the clinic and at the hospital. There is a huge difference now that black people are in power, black people do not know how to care for each other” (IDI 10).

“It was better in the past, white people took care of us and they could see when we were ill, and they protected us, yes there was apartheid but they had the care. Even today if it was like that, there would a great difference, but it is hard now because the laws are soft now” (IDI 5).

The shift in power has affected the management of health systems in South Africa and has drastically affected the lives of older people. They reported experiencing a number of challenges at health care facilities. Older people in rural areas are challenged by the resulting effects of the mismanagement of health care systems, in terms of care, health delivery and access and availability. This has happened to the extent that many older people have perceived the new political regime as neglecting the health and medical needs of the elderly. Many have feared that the way they are treated in respect to health care is so inferior and no different to the oppression of the apartheid period. They feel that even though the health care system of the past was in the hands of the oppressors, they state that they continued to be cared for accordingly and they were given appropriate medical attention and better health care services. It is apparent from the group

discussions and individual discussions that older people are disappointed with the current political dispensation because some feel that it has marginalized the health of the population.

The political views of older people in rural areas are changing due to the lack of proper health care service delivery. They feel that they have been influenced to vote in attempts to make their lives better, whereas they do not see the positive outcome of their votes.

4.9 Conclusion

The aim of this chapter was to shed insights into the health experiences and perceptions of older people in KwaDumisa. It is evident that older people suffer from a range of health ailments but chronic diseases are most common. Poverty is a dominant feature of their lives even with a government pension. Their health situation is exacerbated by the high burden of care giving. They have to take responsibility for the care of abandoned and orphaned grandchildren without any financial support. In this study it was also found that the elderly in KwaDumisa have challenges with health care facilities, in terms of accessing health care facilities, inadequate and inappropriate medication and the quality of care at facilities.

Older people expressed grievances over their neglect in the area, stating that the primary health care services are very far and out of their areas which makes it difficult to access their medication regularly and they are sometimes sent back home because they have exceeded the admission numbers in the facility. In some cases, even if they make the limit, they are told that there is no medication. A number of older people feel that the issue of health in South Africa has changed significantly and they have changed for the worse. The promise of a better life has not materialized with regard to their health. It was also found that many older people prefer the health care system of the past, during the apartheid era, simply because they believe they had better access to health facilities and they received great care compared to the current health care system.

CHAPTER FIVE

Discussion and Conclusion

5.1 Introduction

Older people in South Africa are faced with many challenges, but most importantly they are faced with many health problems. Aging in South Africa has not been a phenomenon that has received much attention and hence many matters concerning older people have been neglected. Chronic disease is the major health threat to the lives of older people. Without access to health services, adequate medication, and proper service delivery, chronic diseases will continue to pose a threat to the health of older people in rural areas. This study has aimed at trying to unfold these main research questions: the health experience and perceptions of older people in rural areas, the primary factors that affect the health of older people and how health has evolved in South Africa over time. The life course epidemiology was used as a theoretical framework in order to understand the biological and social factors that cumulatively influence health in later life. The study was based on a small sample of older men and women and therefore it is not possible to generalize to the whole South Africa population. However, this study does shed some insights into the perspectives and experiences of older people.

For the purposes of this study, in order to assess self-reported health, the participants were asked to respond to a specific question, ‘have you experienced any health problem in the past year?’ If the respondent responds affirmatively, they were asked what problems were experienced and if they had any chronic diseases. The researcher documented all the health problems reported by the older people verbatim. The self-reported health problems described during this research thus represent spontaneous responses from the older respondents. Many older people reported various chronic diseases as their main health problems. Even though other participants reported other physical illnesses most of these illnesses were a result of chronic diseases. Older people were also asked to rate their health status. About 90 percent of all the participants reported that their health was poor and worse than it was 15 years ago or more. It was clear that the health problems

reported tended to reflect the concepts of illness, which is the person's subjective experiences of the health problems as well as sickness experiences recognized as legitimate health problems in a particular socio-cultural context (Tishelman 1993). In this study it was found that respondents perceived ill health mainly as a physical strain and inability to perform certain tasks on their own, caused mainly by chronic diseases. Respondents reported that the failure of some parts of their bodies to perform certain tasks and the continuous reliance on medication was the actual ill health for them. Many older people expressed that health in South Africa has changed with time and with this change, their health is getting worse and not improving. Access to health care services, poor management of health care systems, changes in lifestyle and domestic challenges were some of the issues that also impacted on the well-being of the participants. Older people also stated that they experience stress in their households, especially when they are unable to support themselves and their families.

Poverty was one of the main factors that influenced the health of older people in KwaDumisa. This is also linked to various other factors that impact on the lives of older people, such as high unemployment. In South Africa, poverty is a major challenge and a cause of many health issues, especially in rural areas that are characterized by inadequate access to basic services. These areas are also mostly frequented by older people who are economically inactive. With the growing issue of rural-urban migration, rural areas are usually left with households that are headed by older people. Furthermore, the AIDS pandemic also perpetuates problems in families, leaving children in the care of grandparents which leads to more financial and emotional strain on older people. This is the basis of many health problems in KwaDumisa. These challenges faced by older people include the increase in premature chronic diseases. Older people are already vulnerable to chronic diseases without the addition of domestic stress and poverty, because of their age and other life course events.

It has long been recognized that poverty is a major risk factor for death; disease and disability, especially among the elderly where illness and disabilities lead to a vicious circle of marginalization, and therefore they continue to remain in poverty (Brundtland 1999). Previous studies show that with improved economic conditions and socio-economic status there will be a positive output on health status and vice versa. Older people live under difficult conditions as

they endure high morbidity, poverty and low socio-economic status. As presented in the life course approach, exposure to adverse socio-economic conditions and adverse health conditions had influenced the socio-economic and health outcomes of the respondents. Furthermore, participants presented a low education attainment, with only 3% of the participants finishing secondary school and 50% reporting no schooling at all. This reflects what has been shown in Path (d) of the life course approach model, whereby poor health conditions in childhood influences lower adult socio-economic conditions.

It has been more than 18 years since the dismantling of apartheid in South Africa and many citizens had hoped to see significant changes and improvement where they were needed, especially in terms of public services. But on the other hand, it appears many expectations were not met, instead the new democratic system might have brought about lack of management and organization with regard to service delivery. This is more evident on the public health care system where there are many challenges. A significant part of the South African population uses public health services. Due to the increase in diseases, this public sector continues to experience pressure and failure to provide adequate health care services to the public. This is mostly felt in the rural areas where there are very limited health care services and rising levels of poverty. These are also areas that are dominated by older people who are vulnerable to poverty and diseases.

The health issues of older people in rural areas have been ignored and hence there have been no proper adjustments in health services to improve the quality of health for older people. KwaDumisa is one of the rural areas that face major health problems. According to the respondents, access to health facilities in their area is a great challenge. The area of KwaDumisa does not have a primary health care facility or a nearby hospital. They have to rely on a mobile clinic which comes once a month and which usually does not have adequate medication for older people with chronic diseases. Older people in this area have to travel to other communities to access primary health care. They have to spend money on travel costs to get to other health facilities. This is not always reliable as they are sent back home by health workers because they have exceeded the client limit and in some cases because the facility does not have medication. These findings have also indicated that the health care of older people in rural areas has not been

given much attention and is not included in the health care strategies, causing lack of management of health services, particularly for older people.

Utilization of health care services is also an important factor when considering the health of older people. Even though this may be affected by access to health services but it may also be influenced by use of traditional medicines. Older people, especially in rural areas predominantly believed in traditional medicine and they sometimes use traditional medicine before consult medical health services. Thus, in some instances utilization of health care facilities may be compromised due to their traditional beliefs.

Rural-urban migration is also a significant factor that leads to the vulnerability of older people in rural areas. In terms of family structure and financial support, migration and urbanization has created opportunities for many young and economically active people from the rural areas, which have meant that they leave their rural homes. Without any financial and structural support, older people experience challenges not only to care for the households but also to care for themselves and their health. Many participants in the study reported that they became very ill due to the stress that is caused by domestic worries and problems, and the lack of support which exerts more pressure on them. Moreover, some older people believe that most of their illnesses are caused by emotional and physical strain. Because many older people in rural areas are burdened with taking care and managing their households, they tend to neglect their health and only visit the health facilities when their illnesses are serious. It is evident that with the passing of time, older people become more vulnerable to ill health because of their living conditions, and hence they require extra care from family members.

The deterioration in the health of older people is also a result of factors such as the change in lifestyles. Changes in lifestyle also negatively impacts the health of the elderly, in some cases it might also have led to some of the chronic diseases, because older people have to adapt to new ways of living. This includes the food that they consume, their social environments and family structures. It is a common fact that older people with chronic diseases should consume only certain diets or rather mainly a healthy diet, but their socio-economic status usually affect their decision to choose healthy diet options because of costs. This may lead to some types of chronic

diseases like diabetes and blood pressure. Many older people also stated that, they eat what they can afford and sometimes what is available to them. Participants reported that sometimes sticking to the correct and healthy diet as told by the doctors is not always easy, because it might be expensive for them. Thus, older people end up eating food that is not good for their health because they cannot afford the appropriate diet. Socio-economic status again is a dominant and constant factor in the lives of older people. The sudden change in the family structure of older people may also affect their well-being because they might have to live alone and adapt to a new lifestyle.

Even though older people believe that their ill health is caused by changing factors in their social and structural environments, such as poverty, health system and migration, many participants also believed that they are experiencing illnesses because they are old and hence they usually expect ill health to accompany old age. There is also a number of older people that believe that their health is worsening because they have stopped using their traditional medicines like they used to do in the past. In rural areas where older people are mainly dominant, the issue of traditional medicine verses medical health care cannot be ignored. Other older people reported that they sometimes need to supplement the modern medicine with their own traditional medicine because they feel the modern medicine cannot help them alone. With the growing number of problems regarding health care facilities and health care delivery many older people rely on traditional medicine and choose to bypass health facilities altogether.

The burden and responsibility of taking care of grandchildren is a great challenge for older people, and also affect all aspects of their life because they are entirely under their care as they are sometimes orphaned or abandoned. This causes great responsibility for older people who also do not have support and financial assistance. It has become common that many older people in rural areas take care of their children with HIV/AIDS, financially, emotionally and physically. This on its own causes a strain on the health of older people as well as their emotional well-being. Not only do the older people worry about their grandchildren but they are also in distress because of their own children's future and wellbeing.

Participants also perceived their community as being neglected, not only in terms of healthcare delivery but also in terms of basic service delivery. Amongst these issues, their major concern is that they do not have a primary health care facility in their area. Older people in KwaDumisa also do not have reliable running water and the water they do have access to is not completely clean but they use it because they have no other option, besides the stream which is also used by local animals. Furthermore, participants stated that very few households in their area have electricity, the rest have been waiting for many years as they were promised but with no delivery. Participants also expressed, that it is almost impossible to have a healthy lifestyle because they live in an area that has no reliable service delivery and they do not know who to hold accountable.

Older people's low socio-economic status is mainly attributed to their economically in-active status and the income that they receive from the pension is often shared and stretched in the household. This trend is observed in many rural areas in South Africa. Health status, along with income and consumption, is a key determinant of welfare (Deaton and Paxon 1998). Older people with low socio-economic status complained that their health becomes more difficult because they cannot take care of themselves adequately because they do not have the means to do so without financial support. Participants also affirmed that they cannot afford extra care and medication if they needed it. Older people also believe that, because of their low socio-economic status they do not receive proper respect when they visit facilities because they are seen as poor and old and hence deserving of ill treatment and neglect.

Even though it is generally known that older people, especially in rural areas are health illiterate (Sudore et al. 2006), the findings in this study showed that, the longer older people are exposed to diseases, they tend to understand more about its medical information. Many respondents reported that they understand a great deal about their illnesses as well as the necessary detail of their medication. In this case health illiteracy did not pose as a significant factor for the majority of the participants.

Due to the repressive past of South Africa and the oppression through the apartheid era, many policies changed when the ANC came into power. This included the management of public

health care systems. From the interviews it would seem that older people prefer the old health care system because it worked for them and their health needs were satisfied with appropriate services. This was a very common feeling for many participants. This is the reality for many older people in the rural areas who face challenges accessing health care facilities and is failed by the health care system. Even though many older people have a clear understanding of the implications of the past apartheid era, they are firm in their belief that health care was much better and they received quality health care compared to the present. Even though this might be the case in the perceptions of people due to their own experiences with the public system and their services, this also suggests that there is lack of monitoring and accountability in the health system and that the service users might also lack the understanding of the burdens and abilities of the health facilities.

Many studies have shown that the level of health inequalities at older ages will depend on social welfare policies and cultural context, such as health insurance, social security, and the availability of other forms of social support. In the study it is evident that older people have great concerns about the changes which have been brought by the current political dispensation. Many people including the aging population assumed there would be a great change that came with the change in power, but instead the new political dispensation has led to a failing health system. Older people feel they are not relevant to the country's population, because policy structures are not structured in ways that accommodate and incorporate their needs, especially their health needs. Health care facilities lack the structures that assist older people with their needs and this affects utilization of health services and hence the management and control of chronic diseases.

Furthermore, it was found that, together with the changes in the health care system, older people also believed that the quality of health workers and their work in public health facilities has changed. Health workers are not passionate and enthusiastic about their job and they do not treat patients with proper care, especially older people who require extra care and assistance because they are sometimes immobile and their vision is sometimes compromised. Many older people reported that the attitude of health workers at the health care facilities is not appropriate, and they are not accommodative of their needs. Older people believe that the current political system is the reason why there is very little improvement in the delivery of health care in rural areas.

The participants, considering their ages have experienced the oppression of apartheid period but this does not prevent them from preferring the health care of that era. They felt that it was more responsive to the needs of the population than the present system. It is evident that the health care system has affected the health experiences and perceptions of older people.

5.2 Recommendations

It is obvious that older people in general become ill because of a series of life course events, because they grow up in different circumstances and are influenced by different backgrounds, ill health for older is therefore sometimes inevitable. Nonetheless, major concerns still remain with regard to the management and control of ill health of older people. Older people continue to experience great difficulty with the health care system, which is important in terms of management of ill health and the provision of quality health care. The lack of care and consideration for older people in terms of access to health care facilities, utilization of health services and attitudes of health workers has had an impact of the quality of health care received by older people. Support and structures that are aimed at older people and their health needs should be considered and made available and accessible to older people. Rural areas should become the main focus in terms of distribution of health facilities, particularly because of the vulnerability of the elderly. Management of chronic disease should be a priority for all health facilities especially primary health facilities.

Age and sex differences in morbidity patterns affect broad utilization patterns (McKinlay 1972). Despite their longer life expectancy, females consistently exhibit higher morbidity rates than males (Riley and Foner 1968). This is of importance in designing services for older people, given the greater number of females in the older population. Additionally, age differences within the older population itself are significant. Neugarten (1974) distinguishes the "young-old" from the "old-old," pointing out that these groups have different interests and needs with regard to services. Past illness is also a predictor of future demands for health care utilization (Andersen and Newman 1973), a fact that suggests the existence of continuity in utilization patterns through the life course. It is important to measure geographic accessibility to PHC for other reasons. The

identification of deficiencies in coverage and vulnerable populations with limited access to care can inform the setting of new facilities and resource allocation (Joseph and Phillips 1984).

It is important that all factors that affect the health of older people be addressed, this include particularly access to health facilities, factors that affect utilization of health facilities. There are many other factors that affect the quality of health of older people like domestic problems and the burden of taking on the responsibility of looking after a household, grandchildren and orphans. Structures and outreach programs to take care of abandoned children should be considered in order to lessen the burden on older people. Policies and structures that are aimed at improving the lives of older people should extend to also assist them in their communities and at their homes. Unmet needs with regard to older people's healthcare can be addressed by improving healthcare resources. Adequate training of health care personnel is important in order to appropriately manage the burden of chronic diseases among older people.

5.3 Conclusions

Older people continue to constitute a growing number in the population. It cannot be ignored that the health and wellbeing of the country is judged by the health and wellbeing of older people. Chronic diseases are found to be the most common form of ill health for many older people. These diseases are influenced by multiple factors, but mostly caused by old age. It was evident from the study that the perceptions and experiences of health by older people depict how South Africa has changed over time and in the process some aspects of health has changed. Older people in rural areas are facing challenges with regard to accessing services and they have expressed frustrations over the negligence directed at their community. There are serious concerns over the management of the health care system and its functions in terms of the health needs of older people. This means that the health care system must also constitute strategies that will incorporate the health needs of older people. Moreover policies should stipulate and be transparent about the treatment and care of older people in health facilities and this should be practiced throughout the country.

The pension grant plays an important role in assisting older people financially and in improving their lives, but with the rise in diseases, urbanization and unemployment older people are forced to stretch their pension to meet the needs of other household members, including children, grandchildren and orphans. This will continue to impact on the well-being of older people, particularly in rural areas where older people experience low socio-economic status.

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Appendix I: Interview Guide

The questions below were developed to guide the semi-structured interviews conducted with all the participants. The questions were not necessarily asked in this order or posed as they are written below.

1. Questions about perceptions of ill health and health experiences

- 1.1 What do you understand by ill health?
- 1.2 What factors do you think contribute to ill health?
- 1.3 Would you say that these factors have changed over time, how?
- 1.4 Have you ever experienced ill health in the past, how?
- 1.5 Do you think that there are life events that have impacted on your health now?
- 1.6 How do you perceive your health, would you say it's poor, satisfactory or good?
- 1.7 Do you currently have any illnesses that you did not have 15 to 30 years ago?
- 1.8 How do you think your health has changed over the years, would you say that your health has improved or become worse, if it has improved can you state why you think it has improved?
- 1.9 If you think your health has become worse, can you state why you think so?
- 1.10 When you get sick, who do you usually rely on for assistance, has this changed?
- 1.11 How you get to your health facility?
- 1.12 What efforts do you think are in place to help with ill health; do you think these efforts are enough?
- 1.13 What do you think can be done to help ensure the quality of health and eliminate ill health in the future?
- 1.14 Who do you think is responsible for the initiatives or strategies that ensure health quality in your country?

2. Questions about the area that you live in.

- 2.1 Can you explain the type of environment that you grew up in?

- 2.2 How do you perceive this type of environment, would you say it was good for your general well-being or health?
- 2.3 Do you believe that the area and environment that you live in can determine your health, if yes, how?
- 2.4 Have you ever developed any health problems while living where you are currently living
- 2.5 In the past did you have proper access to health facilities?
- 2.6 What factors do you think may contribute to your poor or limited access to health facilities?
- 2.7 Do you think you that you have better health facilities now than before, why do you think so?
- 2.8 If you did not live in this area 15 years ago, how do you think the area that you lived in 15 years ago would relate to your wellbeing and health?
- 2.9 What would you say the most common illness was 15 years ago, has this illness changed over time?
- 2.10 What would you say the most common illness is now, amongst your counterparts in the area that you live in?

Appendix II: Informed Consent Form

(To be read out by researcher before the beginning of the interview. One copy of the form to be left with the respondent; one copy to be signed by the respondent and kept by the researcher.)

My name is Sithabile Mngadi (student number 206505752). I am doing research on a project entitled 'Health in a changing South Africa: perceptions and experiences of older people, case study in rural KwaDumisa, KwaZulu Natal' This project is supervised by Professor PranithaMaharaj from the School of Built Environments and Development Studies, University of KwaZulu-Natal. I am managing the study and should you have any questions my contact details are:

School of Development Studies, University of KwaZulu-Natal, Durban. Cell: 0781943425 .
Email: 206505752@stu.ukzn.ac.za or sithabilemngadi@yahoo.com.

Thank you for agreeing to take part in the project. Before we start I would like to emphasize that:

- your participation is entirely voluntary;
- you are free to refuse to answer any question;
- you are free to withdraw at any time.

The interview will be kept strictly confidential and will be available only to members of the research team. Excerpt from the interview may be made part of the final research report. Do you give your consent for: *(please tick one of the options below)*

Your name, position and organization, or	
Your position and organization, or	
Your organization or type of organization(<i>please specify</i>), or	
None of the above	

To be used in the report?

Please sign this form to show that I have read the contents to you.

----- (Signed) ----- (date)

----- (print name)

Write your address below if you wish to receive a copy of the research report:

(Interviewer to keep signed copy and leave unsigned copy with respondent)