A MODEL TO IMPROVE THE QUALITY OF LIFE FOR ELDERLY PEOPLE LIVING IN A RURAL SETTING OF UTHUNGULU DISTRICT, KWAZULU-NATAL

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Thesis submitted in fulfilment of the requirements for the Doctoral Degree in Nursing in the Faculty of Health Sciences at the Durban University of Technology

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Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

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Abstract

Background

An increase in the world's population of ageing people is occurring not only in developed countries but also in developing countries. In South Africa, the proportion of the population aged 50 and over increased from 14.8% in 2006 to 15% in 2009 and is predicted to be 19% by 2030. This means that the supply of services for the elderly people should match the demand at all times, otherwise the quality of life of these senior citizens will be compromised. This study aimed at developing a model that would improve the quality of life for elderly people living in the uMhlathuze and uMlalazi sub-districts of the uThungulu district, KwaZulu-Natal.

Methodology

A qualitative, exploratory, descriptive design was applied for this study. A semi-structured interview guide based on the Health Related Quality of Life Theory and Maslow's hierarchy of needs was used. Random sampling was used to select the elderly participants. Purposive sampling was used for the selection of the chairpersons of non-governmental organisations, and the District Programme Manager. Audits were conducted in the clubs that elderly people with chronic disease participate in. Data analysis followed Tesch's steps after which themes and categories were formulated.

Results

Three major themes that emerged from the data analysis were social well-being of elderly people, physiological factors and psychological factors. The results revealed that elderly people experience poor living conditions and suffer poverty due to a number of factors which including the high unemployment rate of their children. Often the children are involved in substance abuse using the elderly

person’s money pension money, which leaves them without any food items in the household. According to the District Programme Manager, there was a project on integrated chronic disease management that was conducted at uThungulu district by the Department of Health. The integrated chronic disease management focused on the population in general of all ages, yet in this study the focus has been on elderly people, which is why the researcher developed a model to improve the QoL of elderly people, due to their unique needs.

Conclusion

This research study gathered information regarding social, economic, health and environmental factors in rural areas which will help in bringing issues of elderly people’s quality of life to awareness. This research will deepen the knowledge and skills of professionals on ageing issues, especially in rural areas/communities.

Key words: Department of Health Information System (DHIS), KwaZulu-Natal (KZN), Health related quality of life (HRQoL), non-governmental organisation NGO, Quality of life (QoL), Elderly people.

Dedication

This work is dedicated to my husband France, my three children Bongumusa, Mbusisi and Amahle Ndlovu for the love and the support they have given me when I was busy with the study.

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Glossary of Terms

Aging

The process of becoming older, a process that is genetically determined and environmentally modulated (Rogina 2000).

Elderly

An individual who is 60 years old and above.

Health related quality of life (HRQoL)

The overall quality of life that affect health, either physical or mental. On the individual level, this includes physical and mental health perceptions and their correlates, including health risks and conditions, functional status, social support, and socioeconomic status. On the community level, HRQoL includes resources, conditions, policies, and practices that influence a population's health perceptions and functional status (Centres for Disease Control and prevention [CDC]: 2000).

Integrated chronic disease management (ICDM)

It is a model that was introduced to districts by the KZN Department of Health to support the HIV/AIDS programme as HIV/AIDS is a chronic disease. This programme incorporates the elderly as many of them are taking chronic medication. This programme decentralizes all chronic medication to community level, especially for the elderly and ARVs' irrespective of age.

Old age

The latter part of life: a period of life after youth and middle age, with reference to deterioration (United Nations 2009).

Operation Sukuma Sakhe (OSS)

A programme that was started by the KZN Premiers' office which to ensure that there is service delivery by all government departments.

Quality of life

The individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns, also a broad multidimensional concept that usually includes subjective evaluations of both positive and negative aspects of life (World Health Organisation [WHO] 2012).

South African Council for Aged (SACA)

An organization that deals with attends to the activities and issues of the elderly people within the community and regulates procedures and standards for the elderly.

Acronyms

Acronym	Full word/sentence
AIDS	Acquired Immune Deficiency Syndrome
ARVs	Anti-retro viral drugs
BP	Blood pressure
CCG	Community Care Giver
CDC	Communicable Disease Centre for Disease Control and Prevention
CHC	Community Health center
CPF	Community Policing Forum
DOH	Department of Health
DHIS	District Health Information System
DSD	Department of Social Development
DUT	Durban University of Technology
HIV	Human immune deficiency virus
HRQoL	Health Related Quality of Life
ICDM	Integrated chronic disease management
IDP	Integrated development plan
KZN	KwaZulu-Natal
MRC	Medical Research Council
NGO	Non-Governmental Organisation
OSS	Operation Sukuma Sakhe
PHC	Primary Health Care
QoL	Quality of Life
SACA	South African Council for Aged
SASSA	South African Security Services Agency
TB	Tuberculosis
USA	United States of America
WHO	World Health Organization

CHAPTER 1 : INTRODUCTION

1.1 INTRODUCTION AND BACKGROUND

The world's population is ageing and projections show that this increase will continue (Murray 1997: 1498). This increase will be noted not only in developed countries but also developing countries (United Nations 2009). The increase in the world population aged 50 and over is expected to increase from 21% in 2011 to 34% in 2050. In developing countries demographers have anticipated an increase of 140% between 2006 and 2030 (Velkoff and Kowal 2007: 95).

The health demands of this global demographic change are, as yet, not fully known but estimations predict that the change in population structure by age in coming years will contribute to an increase in mortality due to non-communicable diseases, thereby changing the profile of the most common causes of death in the different regions of the world and the world as a whole (Murray 1997: 1499). In 2005, it was estimated that a total of 37 million deaths due to chronic disease occurred worldwide, and more than three-quarters (77%) were in people aged above 60 (Strong 2005: 492).

According to the World Health Organization (WHO), the ageing process is a biological reality which has its own dynamic, largely beyond human control. The age of 60 or 65, generally proportional to retirement ages in most developed countries is said to be the beginning of maturity and yet it is exactly when dynamic commitment to the workforce is viewed as no longer viable (Gorman 2000: 11). In developed countries, rural elderly have significantly poorer health status than urban elderly, as they smoke more, exercise less, have less nutritional diets, and are more likely to be obese (Turok 2006: 15). Many of the major public health problems faced in rural areas, for example obesity and tobacco use, call for a social perspective with a focus on prevention and a healthy lifestyle (Bandora 2009: 2).

In South Africa, the proportion of the population aged 50 and over has slightly increased from 14.8% in 2006 to 26.7% in 2011 and is predicted to be more by 2030 (Statistics South Africa [Stats SA] 2011). South Africa has one of the most rapidly ageing populations in sub-Saharan Africa, after Nigeria, which houses the second largest number of older persons (4.1 million) in the region. Despite the impact of HIV and AIDS, the population of older people is expected to continue growing for at least the next two decades. According to the WHO, the increase in the numbers of elderly people suggests an increased prevalence of frailty, chronic disease and disability (WHO 2012: 20).

Although primary health care (PHC) in South Africa is available to all older persons without cost, dedicated geriatric services in the public sector has been neglected because of emphasis on child, maternal and reproductive health care. Several studies have highlighted older peoples' dissatisfaction with inefficient appointment systems, long waiting times, understaffed facilities and shortages of medication (Tollman 2008: 893). For the above reasons, there is a need to embrace research so as to build up a model that will address the health care needs of the elderly people particularly in rural areas and which can be adopted by policy makers.

The focus on quality of life (QoL) for elderly people can be characterised or used as a measure of disease type and treatment outcome (Mollenkopf and Walker 2007: 3). Literature in the field of ageing overlaps with concepts such as successful, active and healthy ageing. Broadly, psychological perspectives have focused on psychological wellbeing as a marker of successful ageing. Little is known about the factors that determine the QoL of elderly people and strategies for living in developing societies where there is rapid transformation in all sectors. There is a need to highlight the medical and psychosocial problems that are being faced by elderly people and strategies for enhancing their QoL.

As indicated by the Medical Research Council (MRC), households where elderly people carry the main responsibility of livelihoods tend to be poorer than

those with younger providers (Steyn, Fourie and Bradshaw 2006: 227). Of the households headed by elderly people, more than half are poor. These household have fewer people working to sustain the household. It is common that elderly people lack proper nutrition, shelter and clothing. They may encounter challenges to access basic health services due to lack of money and distance to the nearest clinic. Elderly people in rural areas need services specific to their needs. The attitudes of health care providers towards elderly people can be harsh and it is common that elderly people have been denied help. The elderly are often subjected to mental and physical abuse, neglect, isolation and hunger (Mabuza and Poggenpoel 2010: 99).

The United Nations identifies elderly people as a vulnerable group. A vulnerable group refers to a group that is more likely to be discriminated against and violated than others (United Nations 2009). The vulnerability of old age is a common challenge in developing countries. Changes in family and community values in numerous developing countries mean that elderly people are no longer afforded the respect, authority and care that they received previously. These changes expand the risk of financial, physical and psychological abuse (WHO 2012: 21). An element influencing the health status of the elderly person is poverty. It has been noticed that traditional care of elderly people is debilitating because of unstable economic conditions, migration, HIV and changes in the household structure and policies that are not sufficient to address elderly people's deteriorating life situation. The number of poor elderly people in rural areas is increasing, despite the fact that they receive pension benefits which are intended to be adequate to manage a comfortable life (Hutton 2008: 12).

The gap in living standards between elderly people living in rural and urban areas is widening because a large proportion of the population that live in rural areas can earn their living from agriculture, farming and livestock. More than 80% of the people at uThungulu, where research was done, live in rural areas. This area is held in trust for the nation by the King and it is directed by the Chiefs

which is similar to the situation in Swaziland and other developing countries (Bandora 2009: 2).

South Africa did not prepare for an ageing society and its changing health needs. Just when the growth rate of the older population in South Africa started its strong upward trend during the 1990s, the country was hit by the HIV and AIDS pandemic, a scourge of unprecedented proportions (Benatar 2004: 84). This primarily affected the country's child and young adult population, with major impacts on health planning and provisioning. However, many older persons are now themselves caring for those suffering with AIDS or looking after their orphaned grandchildren at a time when their physical abilities generally decline; a time when many of them can reasonably expect to receive, rather than provide care and housework assistance (Steyn, Fourie and Bradshaw 2006: 229).

There is significant research that is looking at the impact of HIV and AIDS scale-up on other services include those for the elderly people (Weltz *et al.* 2003: 1467). This together with the ability of communities and families to protect and care for the elderly people has been eroded. Many elderly people have lost their children and therefore have no one taking care of them (Xavier *et al.* 2003: 33).

In the rural communities, for an example uThungulu district within the rural sub-district, health programmes like chronic clubs were created in 2005 to cater for the down referral of HIV /AIDS patients from hospitals to ensure easy access to anti retro-viral drugs (ARVs). These clubs also cater for elderly people's activities. Most communities do not have facilities that provide an opportunity for elderly people to be active while receiving care and support.

UThungulu district has a total population of 979 513 (48% males and 52% females) and approximately 80% of the population lives in rural areas, where rural poverty, rampant crime and the HIV/AIDS pandemic are major challenges. The estimate number of elderly people within uMhlathuze sub-district is 29 505 per village, as there are more than two villages and for uMlalazi sub-district is

17 212 per village, as there are more than two villages. Out of the above number for uMhlathuze, 39.41% comprises of pensioner headed household and 43.43% for uMlalazi sub-district (Stats 2009). This is important, as it shows that this district has a high number of elderly people.

The percentage of households with access to portable water has improved from 60.3% to 79.2%. The proportion of households with access to toilets improved from 70.1% to 77.6%; but 22.4% of the population is without proper toilets which impacts negatively on their general health status putting them at risk of diarrhoea in the district. The district unemployment rate decreased from 34% to 27%; whilst 58% live below the poverty line of R283 per month, this means that above 50% of the district population is prone to poverty related diseases, one of them being HIV. Other contributory factors to poverty are increase in food prices and fuel prices, especially for poor people (Stats 2009).

1.2 THE RESEARCH PROBLEM

The provision of health care of elderly people in rural communities is limited by access to resources and professionals, thereby impacting their QoL. Despite the fact that the South African government has provided services that are aimed at improving the health status of elderly people, they do not focus on improving the QoL. Socio-economic factors seem to be more important than health status in improving QoL Geriatric services that were available in 1980s, have deteriorated (Xavier *et al.* 2003: 35).

The provision of health services to rural communities presents challenges in every country. In South Africa 43.6% of the population live in the rural areas, but they are only served by 12% of the doctors and 19% of the nurses. Of the 1200 medical students graduating in the country annually, only about 35 ending up working in rural areas in the longer term. Approximately 21.3% of households in metropolitan areas subscribe to a medical aid scheme in comparison with only 5.4% of households in rural districts thereby reducing the access to private care in these areas (Department of Health 2011b). From the

above literature, it shows that elderly people's QoL is affected as they are unable to afford private services and the difficulties they face in rural communities with shortage of skilled personnel, impacts negatively on their QoL. This is noted as access to PHC needs improvement in rural areas. There are a number of factors affecting QoL for elderly people such as, lack of health care professionals in rural areas affected by funding, historical deficiencies in infrastructure, lack of benefits for working in more inhospitable settings or policy priority settings, fear of safety, lack of opportunities for schooling for children, lack of work opportunities for spouses of health workers, poor social infrastructure and a lack of strategies to recognise these. All these are negative factors affecting QoL for elderly people.

1.3 AIM OF THE STUDY

The aim of the study was to determine the QoL of rural elderly people and ultimately to develop a model to improve the QoL for elderly people living in the uMhlathuze and uMlalazi sub-districts of the uThungulu district, KZN.

1.4 OBJECTIVES

The objectives of this study were to:

- Determine the QoL of rural elderly people living in uThungulu district,
- Determine the health status and the health seeking behaviours of the elderly
- Identify health indicators to be used to measure QoL.
- Develop a model and make recommendation for its use by community structures and non-government organisations to improve the QoL of the elderly.

1.5 SIGNIFICANCE OF THE STUDY

Research on traditional health indicators including social, economic, and spiritual aspects of QoL have failed to cover certain aspects of life such as health status (Qin 2007: 71). Global and some local studies have focused on

indicators individually not holistically. These indicators are socio-economic factors, nutrition, physical activity and certain conditions comparing them to QoL in general. This study has developed a model that incorporates all the relevant indicators in a holistic fashion to improve the QoL for elderly, especially in rural communities, where resources are limited.

The results of this study will inform professions and policy makers in the field, thereby adding to the existing body of knowledge and improvement of the QoL of elderly people in the rural setting of uThungulu district.

1.6 FOUNDATION TO THE STUDY

1.6.1 Maslow's' hierarchy of needs

This researcher chose to use a health related QoL (HRQoL) instrument. QoL is assessed by measuring one's subjective feelings of QoL and objective aspects of QoL. Subjective feelings are personal experiences of QoL, with a focus on one's feelings of happiness and life satisfaction. Objective factors include income, housing, services and all other living circumstances (Bowling *et al.* 2003: 306). Subjective and objective needs of human beings include material and non-material aspects. This study examines the above variables in conjunction with the basic needs of human beings proposed by Maslow's hierarchy of needs. This will be discussed further in chapter 2.

1.7 STRUCTURE OF THE THESIS

This thesis is presented in seven chapters, organised in the following order:

Chapter 1: This chapter covers the background of the study, which includes the introduction, the background information about the research problem, statement of the research problem, aim of the study, significance of the study,

and the structure of the thesis.

Chapter 2: This chapter covers the literature review, addressing the QoL for the elderly. The critical analysis and synthesis of the literature related to the health and QoL in the elderly people are addressed.

Chapter 3: This chapter presents the research design, methods, sampling, population of the study, data collection process, method, data analysis, trustworthiness and ethical consideration of the study.

Chapter 4: This chapter presents the data together with a description of the research findings which including the steps taken in analysing the information, categorisation and thereafter formulation of themes.

Chapter 5: Discussion of the research findings on the themes that emerged during the analysis and the conclusions thereafter.

Chapter 6: Development of the model for improvement of the QoL of the elderly with a focus on the rural community.

Chapter 7: Conclusions, recommendations and limitations are presented in the final chapter.

1.8 SUMMARY OF THE CHAPTER

This chapter provided the background information related to the focus of the study which highlights the core issues that stimulated the researcher's interest to investigate this topic. The issues included the HIV impact on the QoL of elderly as one example. The aims, objectives and significance of the study were presented. A brief summary of the foundations of the study were highlighted. The next chapter will present a literature review on the QoL of elderly people.

The next chapter will present a literature review on the QoL, global studies that have been conducted on QoL, effects of aging, different theories related to the study, just to name a few topics for the chapter.

CHAPTER 2 : LITERATURE REVIEW

2.1 INTRODUCTION

This chapter presents a critical analysis of the reviewed literature on the QoL, including certain theories that relate to old age and QoL. The concept the QoL is addressed, focusing on global and local studies. The important aspects relating to health, socio-economic and environmental measures are analysed, as their role has an influence on the formulation of the interview guide. Finally, the chapter draws upon the framework that was used as the underlying departure of the study which incorporated Maslow's hierarchy of needs and the support with use of HRQoL to guide the interview process.

2.2 A REVIEW OF THE LITERATURE

The world's population is aging, and with this, more than a quarter will be over the age of 60 by the year 2020 (Lee and Lee 2006: 293). This is a global issue that draws attention from scholastic, political, and economic fields. It not only is characterised as a social issue in developed countries where it has been most prevalent, but is also recognised as a social problem faced by more and more developing nations. One author predicted that from 1965 to 2025, the percentage of people 65 years and older is expected to increase from 17% to 82% in developed countries like Europe and close to 200% in some developing countries (Canbaz *et al.* 2003: 335).

QoL is a multi-level and amorphous concept**,** and is popular as an endpoint in the evaluation of outcomes of health and social care. While the main domains of QoL are relevant to adults of all ages, which can vary in priority among people in different age groups. QoL has been defined in macro (societal, objective) and micro (individual, subjective) terms (Bowling and Gabriel 2004:5). These include income, employment, housing, education, other living and environmental circumstances. On one hand, the perceptions of overall QoL, individual's experiences and values, are included. QoL is thus a complex

collection of interacting objective and subjective dimensions (Lawton 1999: 180).

In South Africa, the proportion of the population aged 50 years and over has increased slightly from 14.8% in 2006 to 15% in 2009 and is predicted to reach 19% by 2030. Therefore, research in this area is important for developing countries as the findings will provide invaluable evidence for policymakers and stakeholders to boost their social and health care programmes in dealing with vulnerable groups, such as, elderly people (Huguet 2008: 336).

Aging results in a higher probability of suffering from multiple health complaints and in most cases elderly over the age of 75 years live with one or more chronic diseases that cannot be cured completely. However, the consequences of these diseases might be prevented by focusing on health care and QoL of the elderly (Borglin *et al.* 2005: 147).

Before 1994 South Africans lived in a system characterised by racial discrimination, which meant inequality among the various racial groups when it came to accessing the country's resources. These racial groups had been classified by the previous government as "African [Black], Coloured, Indian and White". An historical analysis of South Africa's elderly can therefore not be ignored. There are historical inequalities such as land deprivation and limited access to education which manifest through high levels of unemployment and underdevelopment in the country (Makiwane and Kwizera 2006: 298). During this period 1994, White South Africans enjoyed a standard of living comparable to that of developed countries, while the majority of Black South Africans were in poverty and had inadequate levels of education. Women were relegated to low positions in the rural and cultural settings and environments (Turok 2006: 15). The elderly population was also directly affected, as there was unequal distribution of resources based on race classification. This was exacerbated by the lack of resources in rural communities compared to urban settings.

2.3 SOUTH AFRICAN CONTEXT

2.3.1 Legislative framework

The South African Constitution (Act 108 of 1996) provides the mandate for all legislation and policy in South Africa (Republic of South Africa 1996). The historical divisions of society along racial lines that prevailed during the apartheid system of governance required legislation that would address discrimination and protect the human rights of elderly from all racial groups. Legislation governing the elderly in the Republic of South Africa dates back to the Aged Persons Act, No 81 of 1967 (Republic of South Africa 1967). This Act provided mainly for the regulation of institutional care of the elderly, mainly White people. It was expected that black communities would take care for their elderly in the family context. The aim of the Aged Persons Amendment Act, No. 100 of 1998 was to fast-track the implementation of the new social welfare policy directives with the focus on transformation and community care (Republic of South Africa 1998). The Act was to ensure that subsidised homes for the elderly were accessible and representative of all racial groups and to restrict subsidies to frail residents, resulting in a sharp drop in the welfare budget for the elderly people.

2.3.2 Socio-economic aspects

The decline in government subsidies resulted in the closure of many service and community centres, as well as many residential facilities. In certain instances, there was a shift to operating economic units, which once again excluded the poorest elderly in South Africa (Makiwane and Kwizera 2006: 299). This contributed to a decrease in the QoL of elderly within the country. While the impending economic ‘burden’ of aging population pre-occupied government, there was an increased recognition that society needs to be concerned with maximising QoL for elderly people (Kendig and Browning 2012: 460).

2.3.3 Environmental aspects

Despite increased access to electricity and clean water from the late 1990s, one of the many problems affecting service delivery to deprived communities is equitable household access to potable water. According to StatsSA (2009), 30% of elderly-headed households from uThungulu district have piped (tap) water in their dwelling. Public taps (water from a tap outside the dwelling) provide water to nearly 15% of the elderly-headed households (StatsSA 2009). Furthermore 37% of households still derive their water from a river, a stream or other flowing water, and from other unsafe sources like dams, wells and springs and 18% of households use water from sources that are polluted and hazardous to health. Unavailability of water in the dwelling imposes an average walking distance of approximately twenty minutes to the source where water can be obtained. This considerable distance to the source of water not only poses a major problem because of the physical strain on elderly, but also threatens their safety (Makiwane and Kwizera 2006: 299).

Transport problems also affect the elderly who can only access clinics and pension pay-out points by walking long distances, which also makes them vulnerable to abuse and crime (Bohman *et al.* 2007: 323). The lack of infrastructure in communities where elderly Black people reside contributes to their isolation. The elderly indicated that they rarely visit each other on account of the distances between their homes (Chigali, Marais and Mpofu 2002: 21).

In South Africa, the vast majority of elderly stay in households with younger relatives (multi-generational households), while a high proportion live in skip-generation households (Makiwane and Kwizera 2006: 300). It is estimated that 60% of all Black pensioner households are three-generation households with children, as opposed to only 9% of White pensioner households in a similar situation. A further 14% are ‘skip-generation’ households, comprised of only elderly and young children, compared to 0% of White pensioner households (Burns, Keswell and Leibbrandt 2005: 105).

2.3.4 Health aspects

While increasing longevity is a cause for celebration globally, the WHO has called for ‘adding life to years’, which is an explicit recognition of the importance of QoL in addition to longevity for the elderly (WHO 2012: 22). Policy approaches that promote healthy aging reflect the desire to support the elderly to remain active, valued and engaged citizens for as long as possible and, during the last years of their lives, to live a comfortable, meaningful life. Such approaches are now strongly advocated globally as per the European Commission report (WHO 2012: 22).

During the 1980s, the average life expectancy at birth for South Africans increased steadily. However, the mortality impact of the country’s severe AIDS epidemic was evident in the considerable drop in life expectancy from 61.6 years to a projected low of 49.7 years in 2006. Nevertheless, there is an estimate that 4.1 million people in South Africa age 60 years and older, constituting 26.7% of the total population, as at 2011 This primarily affects the country's child and young adult population, with major impacts on health planning and provisioning (Stats SA 2011).

A study that was conducted in Limpopo, South Africa indicated that the QoL is dependent on physical elements, emotional factors, spiritual components, relationship with others and financial aspects (Murdaugh 1998: 59). The study noted that QoL is a function of the interplay and balancing of all the factors involved, especially those that are health related. The meaning of QoL for the elderly is about day-to-day life, trying to keep healthy, living with loss, the future, and being the age that they are (Hendry and McVittie 2004: 962).

Changes in the population have implications on the health, economy, security, family life, well-being and QoL of individuals. The aspects of health status, life-style, life satisfaction, mental health and well-being reflect the multidimensional nature of QoL in an individual. QoL is a holistic approach that not only emphasises an individuals’ physical, psychological, and spiritual functioning but also their connections with their environments and opportunities for maintaining

and enhancing skills. Aging, along with functional decline, economic dependence, social cut off and autonomy of young generation, compromises QoL (Batalden and Davidoff 2007: 2).

The WHO characterises QoL as the individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (WHO 2012: 22). The importance of the elderly's perspective in defining QoL, vary according to health status, gender, ethnicity and socio-demographic background. The concept QoL is used in parallel with life satisfaction, well-being, and happiness or utility. Well-being is related with health, which is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO 2004).

2.4 Perceptions of QoL

The precise description of QoL has consistently evaded consensus. The main obvious understanding is that it is a multi-dimensional construct, in spite of the fact that the number and kind of dimensions remain questionable (Albrecht and Devlieger 1999: 977). Generally, little consideration has been paid to understanding QoL as it is experienced, perceived and interpreted by elderly people (Gabriel and Bowling 2004: 675).

QoL as a concept has been subject to considerable academic gaze from many disciplines: philosophy, literature, geography, psychology, health, health economics, advertising and marketing, politics, and the medical and social sciences. Through these diverse lenses, QoL is viewed from global, national, individual, health-related and social perspectives, contributing to an extensive body of work on QoL (Raphael 2003: 55). The following paragraphs will show how different authors perceive QoL in relation to the physical, social and psychological well-being of elderly.

Mollenkopf and Walker (2007: 3) suggest that in order to examine QoL in the elderly there is a need to recognise the considerable heterogeneity of physical and psychological functioning across the age range of people over 65 years. There are risk factors that can drive the variation that comprises behavioural and psychosocial factors as key determinants and indicators of QoL in old age. QoL in the field of aging overlaps with concepts such as successful, active, healthy aging, psychological perspectives with focus on psychological wellbeing as markers of successful aging (Mollenkopf and Walker 2007: 6).

Wilhelmson *et al.* (2005: 585) report that social relations, functional ability and activities influence the QoL of the elderly as much as health status does. Lawton *et al.* (1999: 170) contends that the non-health-related areas of elderly people's lives may well override the negative aspects of chronic illness and poor health. QoL has been distinguished as a dynamic concept that has the ability to react with incredible fluidity as people's values and priorities change in response to life circumstances and certain life experiences.

Voyer and Boyer (2001: 274) considered the concept of QoL by comparing different types of QoL assessments in order to clarify the concept. This included the type of measure, type of evaluation and time factor. These authors further looked at QoL as a general sentiment of well-being, the satisfaction of needs, a favourable objective evaluation of life conditions and no mental disease symptoms.

Mallard (2007: 1) regards QoL in elderly people as challenging in that the well-being of elderly is not taken seriously for various reasons. The primary reason is that elderly people are taking care of the grandchildren due the fact that their parents are working far from home, or have died. An estimated six million children in sub-Saharan Africa are being looked after by elderly people.

Verma (2008: 110) demonstrated that the QoL in people living in urban areas is fundamentally better than that of those living in rural areas. Anecdotally, in rural areas, elderly people work continuously till their bodies get tired while in

urban areas, the elderly work for certain age limit as per their jobs, after which they suffer from economic insecurity, loss of power leading to low QoL. The elderly living in the urban area have significantly lower levels of QoL in the domains of physical, whereas rural elderly view their lives differently because of traditional ways of living. Verma (2008) goes on to say that the urban elderly are aware of their disease conditions and are more concerned about health problems while in rural area they simple overlook it considering it a natural process.

2.4.1 GLOBAL STUDIES CONDUCTED ON QoL

Nigeria

Gureje and Oyewole (2006: 56) conducted a study in Nigeria which looked at how QoL and social networks are dwindling. The study looked at the traditional family support which is diminishing due to urbanisation and relocation particularly of young members from the family. This social change influences the position of elderly people in the society and leads to the reduction in their social status which has an impact on their status within the community. All these components may influence the QoL of elderly people in the community.

Northern India

Barua *et al.* (2007: 147) conducted a study in Northern India on health related QoL and utilisation of health services. The QoL was observed to be better in males than females as far as physical, psychological, social and environmental well-being. There is a need to highlight the physical/medical and psychosocial issues that are being confronted by the elderly people and techniques for realizing a change in their QoL. The study found reluctance in caring for elderly people and the concept of QoL is not that prevalent in India.

Vietnam

Lim *et al.* (2007: 184) conducted a study in a rural area of Vietnam on the elderly and found imbalances in socio-economic, health status and QoL. The study

likewise found that a greater proportion of women reported poor health status and poor QoL compared to men.

New Zealand

Gabriel and Bowling (2004: 677) conducted a study in New Zealand on the perspectives of the elderly in low level home support. The elderly shared their perspective on having good people in their lives, being able to deal with their day-to-day activities and keeping healthy. Good health was identified as being a key constituent of QoL for elderly people.

United States of America

A study by Nilsson, Rana and Kabir (2012: 610) in the United States of America (USA) found that the global measure of health status in old age was considered critical because it was associated with mortality, QoL, and other important measures of health status. The study found that rural elderly people are more likely to rate their health poor because of their living conditions. This statement is in agreement as the study conducted in Vietnam on the QoL for elderly people, which focused on the health in general in rural areas (Lim *et al.* 2007: 184). There were limitations and poor access to health services which contributed to poor health status of elderly as reflected on the study. The findings were significant for the development of a QoL instrument that could be used for the comprehensive health promotion programmes in the country.

Australia

Lawton (1999: 181) found that the key QoL themes mentioned by community-dwelling elderly included psychological well-being and positive outlook, health, social relationships, leisure activities, neighbourhood resources, adequate financial circumstances and independence. However, elderly people's views of the key dimensions vary depending on circumstances and environmental influences (Lawton 1999: 181). Elderly with intellectual impairment face particular challenges in evaluating and expressing their QoL. However, a study by Abramson *et al.* (2012: 632) demonstrated that it is possible and appropriate

to measure QoL in elderly with cognitive impairment. According to the above, QoL in old age can be useful in evaluating ‘adding life to years’.

Italy

A study in Italy by (Bazzichi *et al.* 2005: 783) demonstrates that QoL ought not to be mistaken for the concept of standard of living, that is, based primarily on income and employment status. The emphasis should be on environment, physical, mental health, education, recreation, leisure time, and social belonging. Carta *et al.* (2012: 103) studied QoL by means of objective and subjective indicators. The authors concluded that features relating to the economic and social situation of a society are important for putting findings into their proper context, but the key is the subjective perception of wellbeing of an individual.

Iran

According to Levasseur, Desrosiers and St-Cyr Tribble (2008: 32), QoL is a total cognitive and emotional reaction experienced by individual in relation to achievements accomplished in the context of culture, values, goals, expectations, standards, and concerns. In this study QoL could not be measured in light of the fact that it had too many elements to evaluate.

China

Qin (2007: 73) sought to clarify the influences of personal and socio-environmental factors on attitudes toward aging with a focus on the individual’s adaptability to aging. The adaptation depended on the relationship between socio-economic, environmental determinants as well as the elderly’s QoL. The contention was that social resources are distributed unequally on the basis of gender, class, and race due to political and economic forces. The above have an influence which allows policy-makers to look at interventions that will improve QoL of older adults.

United Kingdom

A study conducted in United Kingdom observed that having good relationships with children, family, friends and neighbours were key factors to a decent QoL. Australia, Japan and Canada authenticate the argument that social support is a key component of elderly people's QoL (Chappell 2003: 127).

Dublin

A study conducted in Dublin, where elderly experienced abuse by community members taking or using their property without consent and even denied support by own children and neighbours has a significant threat on QoL (Naughton *et al.* 2010). Elderly experienced verbal abuse from their own children, grandchildren and children from the neighbours after alcohol consumption and returning home late hours of the night making commotion, which ends up awakening elderly people from their sleep. Another issue is the crime committed by the community members which goes unreported, notwithstanding when reported no action is taken, because they are not considered important, yet they are supposed to be respected and recognised by all (Naughton *et al.* 2010).

Berlin

A study in Berlin referred to elderly people encountering material abuse, where their personal belongings and possessions were vandalized and destroyed by community people. This implied that their property was used unlawfully. This type of harassment occurred primarily in the elderly's own homes and caused them a great deal of distress with an awful effect on QoL (Hightower, Smith and Hightower 2006: 205).

Northern Ireland

Scharf and Bartlam (2006: 251) conducted a study of rural elderly people who lived with their children. The elderly people lived on a small pension grant but were managing in spite of the fact that it was difficult. Those who were still

getting money from working on the farms were managing to support everyone at home to a certain extent. The study findings revealed that although there was some form of income, because the community was rural, they experienced financial challenges.

Summary of information from different countries

The information from the above different countries shows that there are similarities in that most of these countries used instrument which quantitative when the data was collected. Most of the authors looked at one or two aspects of QoL, for an example either the social or physical aspect of QoL. There were differences picked in terms of how the information was analysed, for instances QoL for the institutionalised, non-ambulant elderly people. Most of the studies in these countries were conducted in the rural communities which is similar to the study by the researcher. There were gaps identified by the researcher that gave reasons for developing a model to improve the QoL for the rural communities in South Africa, which was to focus on an elderly person holistically, meaning focus on physical, psychological, environmental and social aspects of an individual. The fact that there is no such a model in South Africa that brings together all the stakeholders in government and non-government organisation to improve the QoL of elderly people, especially in rural communities.

2.5 QoL AND NUTRITION

A study conducted at Sharpeville in South Africa focused on the socio-demographic and health profile of elderly residents, including their nutritional status (Van Rooyen *et al.* 2000: 780). The study found that the socio-economic status of the participants was poor. More than 80% of the respondents reported an occasional shortage of funds for basic household needs, which confirmed the presence of food insecurity. The health status of the respondents was also compromised. Although smoking and alcohol consumption were relatively low, environmentally this area suffers high pollution rates as it is an industrial area.

A large number of elderly persons taking chronic medication suffered from a number of disorders including painful joints, ear, nose and throat infections and chronic headaches. The findings of this study affirm that poverty, malnutrition (under nutrition and over nutrition), in addition to household food insecurity and poor health, were the major problems observed in this elderly community. These findings confirm the need to educate the elderly in the community (Van Rooyen *et al.* 2000: 783).

2.6 QoL AND HEALTH STATUS

A study by Xavier *et al*. (2003: 36) conducted in the rural areas of South Africa describe the well-being and functionality of the population aged 50 and above by assessing the flow of basic health status of elderly people. The findings of this study showed that women were 30% more likely than men to report a poor state of health.

2.7 QoL AND ENVIRONMENT

In Northern Ireland context, Cloke, Millbourne and Thomac (1997: 210) expressed the view that the elderly living in in the twentieth century experienced the worst living conditions yet. They were unsafe and had no proper facilities available within the community. The elderly who lived in the rural area of Ireland experienced poor living conditions, felt neglected and ignored on account of being old and living in rural areas, and felt that they were treated as second class citizens.

For the elderly to improve their QoL there were certain things that needed to be addressed either in the community or by government, which needed to incorporate enhance their living conditions, health status and environmental conditions. This study underpins the thought that QoL in elderly ought to be linked to good health, good family support, sense of security and belonging (Scharf and Bartlam 2006: 253).

2.8 QoL AND THE CARERS ASSOCIATION

The aim of the South African Council for Aged (SACA) is to improve the QoL of elderly people. The Association runs a series of practical support and training programmes and information sessions for those who care for elderly people within the communities. This is done through support groups that provide the carers with an opportunity to meet discuss and share problems and is a platform for them to express their views. The SACA focuses their attention on needs of the urban elderly as opposed to needs of the rural elderly people. According to SACA, elderly people value independence, financial security, emotional support and social integration. This is an essential point in considering the elements connected with the QoL of elderly people (Bowling *et al.* 2003: 269).

2.9 QoL AND NEEDS FOR OLDER PEOPLE

Pearson and Windsor (2012) propose the following point to improve the QoL of older people:

- The need to deliver what older people want rather than what the community think they want.
- Understand that there are individual differences in elderly people's wishes that need to be incorporated into service tailoring.
- Explicitly include QoL measurement and concepts in service evaluation and quality improvement.
- Help elderly people avoid and manage chronic illness. Promote meaningful social engagement.
- Improve self-perceptions of aging by valuing and promoting the contributions that older people make within their communities.

2.10 QoL AND THE AGING POPULATION IN SOUTH AFRICA

In South Africa, the elderly population (≥60 years) is expected to continue growing, which requires extensive social and economic planning (WHO 2012: 24). The availability of health related data to monitor the needs of elderly, and the extent to which these are being met, is still an area of requiring research. In

general, living conditions are worst for elderly Africans especially in the Eastern Cape, Limpopo and KZN. This is a result of the large non-communicable disease burden among the elderly, requiring comprehensive health care to manage the conditions and relevant health promotion programmes (WHO 2012: 22).

2.11 EFFECTS OF AGING

An understanding of the good life, as mentioned by Aristotle, is that each person values different things at certain times in their life depending on their situation, so is different for the elderly because for the most important thing for them is good QoL. An elderly person with ill-health wants to be healthy to enjoy a good life (Farquhar 1995: 1440).

For the elderly, QoL can change either positively or negatively throughout the lifespan. The elderly are more optimistic, view life more positively, and are more comfortable with themselves and their role in the community than younger adults. Contrary to the negative belief, aging brings increased happiness, according to a survey that was conducted with a sample of 2 969 elderly people of whom 60% were 65 years of age and older. The responses amongst respondents were positive as they indicated that they received more respect and felt less stress than when they were younger (Bryner 2010: 1). This was a good motivator for increased QoL.

Furthermore, the study showed that 50% of elderly people aged 80 years and older reported being happy, a larger proportion than that noted among young adults. Other factors to note in this survey were decreased life expectancy, where the elderly are positive in that that they focus on what made them felt good rather than dwelling on the negative. The benefits of old age included not having to work and having more time for hobbies such as traveling and volunteering. This was more applicable to urban setting.

The QoL may decrease with age, due to reduced ability to participate in physical activities which could be for many reasons such as physiology, personality,

emotional status, social support, vulnerability, personal beliefs about the health effects of age. This has a negative impact on the QoL of the elderly people (Stock *et al*. 2008: 1343).

Environmental circumstances directly affect the level of the elderly's activity participation. This is experienced more in institutions where factors which contribute to low QoL include isolation, loss of independence, and a risk of vulnerable adult abuse from other elderly people or staff. The dignity of elderly people is challenged by practices such as the use of bibs, publically visible labelling of their clothing, or failure to groom hair in a way that they prefer, (Levasseur, Desrosiers and St-Cyr Tribble 2008: 33).

QoL for elderly people is affected by many challenges in meeting health and social care needs, including advancing medical technologies and globalisation that has created international competitiveness, and thus a need to improve the QoL of communities in the hope of improving the country's social, economic and political profile (Henderson 2000: 221).

The study of well-being and QoL in old age is relevant because aging brings changes in personal capabilities, abilities and circumstances which can weaken an elderly person's well-being and challenges their everyday life. Adequate support from social and healthcare services has a positive impact on the QoL of elderly people (Vaarama 2008: 7).

2.12 FACTORS INFLUENCING QoL OF ELDERLY PEOPLE

There are a number of factors that influence QoL in elderly people which include chronic illnesses, social factors, environmental and health circumstances. The main threats to QoL in elderly people are chronic physical and/or psychological illness. Chronic illness affects elderly people and this becomes a major burden for them and their families. The Centre for Chronic Disease Prevention and Health Promotion in the USA (2011) stated that poor health is not an inevitable consequence of aging, but there should be effective public health strategies to help the elderly to remain independent longer and improve their QoL, which will

potentially delay the need for long term care (Browning, Heine and Thomas 2012: 60).

While chronic illnesses often drive the QoL in elderly people, behavioural, psychological, social, environmental and economic resources can moderate their impact. For example, health promoting behaviours can assist with the management of chronic illnesses and personal control over one's life activities and environment can influence perceptions of wellbeing in the face of illness (Mollenkopf and Walker 2007: 7).

Social resources, including social activities and social support, are key influences on QoL particularly in impoverished environments. Positive self-perceptions of ageing are important influences on wellbeing. Other characteristics, including social cohesion within a neighbourhood and safety, are also associated with wellbeing in late life (Pearson and Windsor 2012: 28).

Little is known about factors that determine the QoL of elderly people living in developing societies that undergo rapid social change. A study conducted in Nigerian on QoL for elderly people, using the WHO QoL instrument, evaluated major depressive disorder, physical conditions, social network, support and engagement showing how these factors have an influence on QoL of elderly people (Gureje and Oyewole 2006: 58).

Nilsson, Parker and Kabir (2004: 298) state that there should be deliberate planning of programmes to increase elderly people's social assistance, and improve medical, health and counselling services. They recommend that all stakeholders should consider their interactions with elderly people, and they should be prioritised in health promotion programmes and resource allocation. Formal care should be improved and strengthened health services reoriented both in the community and in homes for the elderly. Policy makers in developing countries should consider a new agenda and pay more attention to improving the services and financial support to improvement of the QoL of elderly people.

2.13 MEASURING QoL

Measuring health status, functionality and QoL at the population level in elderly people is important to understand the health, welfare and social support needs of this growing proportion of the population. It will become increasingly important for health and social services to adapt and improve in order to provide effective care for the elderly considering their significantly impaired functionality and other health problems.

Numerous measures of QoL include prosperity elements as well as functional components such as cognition, activities of daily living, independence, motor function, and socialisation (WHO 2004). Using the WHO estimation which includes functional, physical, psychological, satisfaction, and social elements, Kane (2003: 31) found that the QoL of rural elderly people was better in physical and psychological domains than the QoL in urban elderly people which was better in social relationship and environmental domains. This was a direct result of social resources and financial resources within the urban setting as compared to rural (Kane 2003: 31).

2.14 THEORIES RELATED TO THE STUDY

The following theories have been identified as relevant theories which influence the QoL of elderly people.

2.14.1 Hierarchical-compensatory theory

The hierarchical-compensatory theory focuses on the importance of elderly people's preferences (Messeri, Silverstein and Litwak 1991: 122). According to this theory, elderly people seeking help have an ordered preference based on the primacy of the relationship between the person offering help and elderly people. Elderly people lean towards the assistance from their own spouses if married. When this is not available, they turn first to children, second to relatives, third to friends or neighbours, and last to formal groups. This social network can be categorized in a hierarchical compensatory manner. These hierarchical-compensatory patterns are established in past relationships and

enacted when the elderly person needs assistance (Messeri, Silverstein and Litwak 1991: 124).

In some cases, elderly people have no one to turn to and this compromises the QoL especially when they are helpless. Friedman (cited in Chamorro 1985: 190) tested this model in older women with heart disease and found that the model appears to offer an explanation for the hierarchy of sources selected for only psychosocial support. In order to understand how informal caregivers affect the outcomes of elderly people, the effects need to be specified based on types of care that are given (psychosocial aspects *vs.* physical aspects). This theory focuses on ambulant, independent, elderly people, though most of them stay with their children and grandchildren and this renders this theory not ideal for the use in this particular study.

2.14.2 Theory on social gerontology

A set of propositions can be derived from social gerontology which aids in the understanding of the QoL of elderly people. These propositions presume that QoL of elderly people can be defined in a similar way to that of younger people in order for both subjective and objective elements to be included and for the heterogeneity of elderly people to be recognised. This theory is described as a network, as its component parts interact in order to characterise and assess QoL (Hughes 1990: 566). This theory does not indicate the specific needs of the elderly people, therefore not ideal for use in this study.

The above two theories were reviewed but were found to be inappropriate for the use in this particular study, as these do not focus on the specific needs of the elderly people, especially in rural communities.

2.14.3 Health related QoL

The concept of HRQoL and its determinants have advanced subsequent to the 1980s to encompass those aspects of overall QoL that can be clearly shown to affect health either physical or mental. On the individual level, this includes

physical and mental health perceptions and their correlates including health risks and conditions, functional status, social support, and socioeconomic status. At the community level, HRQoL includes resources, conditions, policies, and practices that influence the population's health perceptions and functional status. The construct of HRQoL encourages health agencies to address areas of healthy public policy around a common theme in collaboration with a wider circle of health partners, which include social service agencies, community planners, and business groups (Wilson and Cleary 1995: 61).

Health Related QoL questions about perceived physical and mental health and function have become an important component of health surveillance and are generally considered valid indicators of service needs and intervention outcomes. Self-assessed health status has proved to be more powerful predictor of mortality and morbidity than many objective measures of health. Health related QoL measures make it possible to demonstrate scientifically the impact of health on QoL. Health Related QoL has become an important public health issue in developed and developing countries, considering the aging of the population (Osborne *et al.* 2003: 140).

Distinctive measurements of social, physical and mental functions are considered in health related QoL. Since HRQoL provides a subjective diagram of the state of health of old people and is associated with higher mortality and morbidity rates, the utilisation of health care services, measuring existent HRQoL of elderly people could be helpful in planning health programmes (Guallar-Castillon 2005: 1229).

The HRQoL is a nonexclusive measure that can be used to assess elderly people at uThungulu district in a rural area. The dimensions of HRQoL include physical, psychological, social and spiritual. For elderly people, this has emerged as a critical construct to look at as it focuses on components of well-being, which are affected by progressive changes in health status, health care, and social support.

At an environmental level, HRQoL includes resources, conditions, policies, and practices that influence a population's health perceptions and functional status (CDC 2000). It is an important concept since it contributes to evaluating the appropriateness and effectiveness of both individual and system level interventions and outcomes. Data on the various spaces of HRQoL can inform decisions about innovative clinical practices, new technologies, and resource allocation for elderly people (Song *et al.* 2004: 371). The focus of this study is on a HRQoL at an individual level.

For the current study, a HRQoL instrument was selected and used to formulate the interview guide for elderly people in order to assess their QoL. The focus is on personal experience and on one's feeling of happiness and life satisfaction. Other aspects are related to income, housing, services and all other living circumstances.

2.14.4 Maslow's hierarchy of needs framework

The psychologist Abraham Maslow investigated how human needs influence actions, and developed a straight forward model to help predict motivation and behaviour. Maslow (1970: 62) identified five levels of need, each building on the other, from lowest to highest. This postulates a hierarchy of basic human needs, namely, physiological needs, safety and security, love and belonging, esteem, and self-actualisation. These can help to predict how elderly people benefit from improved QoL.

A framework derived from the work of Abraham Maslow helps to explain the observations about how elderly people perceive QoL (Maslow 1970: 64). There is evidence where Maslow's theory explains health-related behaviours in elderly people. Acton and Malathum (2000: 796) conducted a study of 84 community-dwelling elderly people based on Maslow's model. The study investigated the relationships between basic need satisfaction, health-promoting self-care behaviour, and demographic variables. Findings were that three types of needs (self-actualisation, physical, and love/belonging) accounted for 64% in health promoting self-care behaviour.

A study in Sweden on elderly people indicated that overall life-satisfaction is connected with meeting various levels of need, which fits with this model. It was found that healthy individuals have higher need satisfaction than those that are sick (Borg and Hallberg 2006: 610). This study has used Maslow's hierarchy of needs combined with HRQoL as a guide in order to develop a model that can be used in the rural communities such as uThungulu.

According to Maslow's hierarchy of needs, humans have basic needs that must be met first before the satisfaction of higher needs. Maslow's hierarchy of needs is based on the idea that the basics should be met first, so that a human being can be motivated to achieve other needs in life (Maslow and Lowery 1998: 60).

There are three sets of needs at the bottom of the pyramid which are called deficiency needs because they must be satisfied for the individual to be fundamentally comfortable and are the most important ones for elderly people in this study. The top two sets of needs are termed growth needs because they focus on personal growth and development which are not as important for elderly people (Maslow and Lowery 1998: 60).

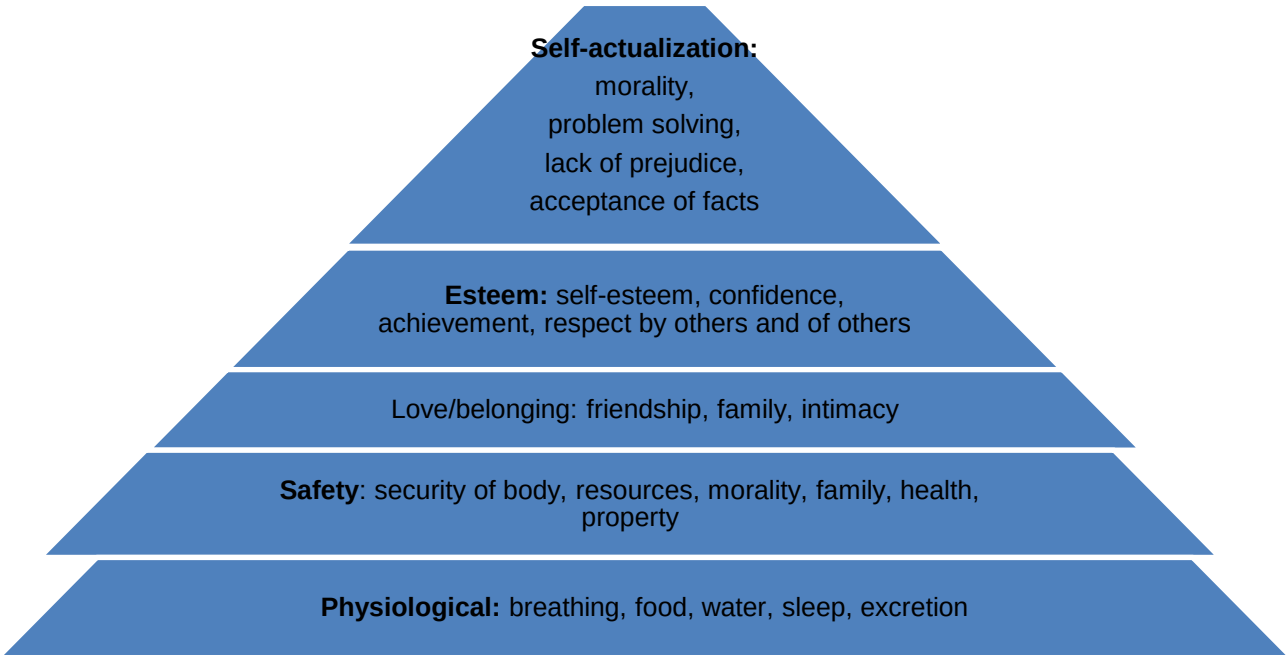

Figure 1: Maslow's hierarchy of needs

According to Maslow's hierarchy of needs, there are five levels of needs as depicted in Figure 1.

Level 1: Physiological needs

The motivation to acquire food, water and shelter is high, and behaviours that secure them are strongly reinforced. Most people do not require assistance in this process, but those with cognitive impairments may not be able to meet physical needs consistently. In terms of the QoL domain, reminders about how to prepare, or serve food, or how to return home, would be expected to offer immediate rewards to a person, and to be highly reinforced. The process of satisfying such elemental needs may be contrasted to health-related behaviours, such as brushing one's teeth, which is mainly undertaken to preserve long-term health. Taking medications can help to ensure a person's long-term well-being, however does not satisfy an immediate physical need, especially when the medications treat chronic disease. Maslow's model suggests that individuals' QoL can be improved by securing food or water differently than medication adherence (Wilson and Mitchell 2009: 212). The current study focused on physiological needs including food, medication, and health, care of own self.

Level 2: Safety and security needs

When physical needs are met, people seek protection from physical and emotional harm. Elderly people would be affected by this, especially as they worry a lot about their safety and security. This level of need has both short-term consequences, like staying away from dangerous environments, and long-term consequences, like trying to build a safer place. These are more abstract needs than food, water, and shelter, and require some projective reasoning in order to continue to seek them. While there is an innate understanding of hunger, thirst, or exposure to certain elements, it can be hard to recognise and adapt to threats to one's safety or security (Thompson and Thielke 2009: 315).

Treatments for chronic health conditions and diseases are intended to satisfy safety and security needs, since they promise long-term well-being or health.

From the health care provider's perspective, taking medications and managing vital physiological parameters like blood sugar or blood pressure seem to satisfy elemental physical needs. These steps often do not have any direct effect on how elders feel or evaluate their own health status, and may cause unintended negative effects (Osterberg and Blaschke 2005: 487). Medications are often expensive, and for those with few resources spending money on medicines can undermine financial security. There may also be competing needs around health maintenance: the poor control of blood sugar may occur when the short-term physical need of hunger overcomes the long-term safety goal of maintaining a healthy blood sugar (Mattke and Seid 2007: 670).

The need for physical and financial security types is considerably different than physical needs, because the rewards of getting food are immediate and visceral, but the need for security is generally known only when it is threatened or lost (Thompson and Thielke 2009: 316).

Level 3: Belonging and love needs

The next level of need is feeling loved and accepted by others. People desire communication and attachment, and seek out opportunities to relate meaningfully with others, especially family. The rewards around belonging and love are immediate and direct, and elderly people appreciate human contact, and, if deprived, show behavioural problems (Scholzel-Dorenbos and Meeuwsen 2010: 119).

Level 4: Esteem needs

People seek to have confidence and to be respected. Materially, this involves completing activities that an individual considers valuable. Restricting someone's agency for carrying out such activities can undermine her or his esteem. For example, elderly people often become upset if they are advised to move out of their own homes into assisted living or nursing facilities, where they will have fewer responsibilities but satisfaction of physical and belonging needs.

The reluctance to give up independence indicates that esteem may be a predominant need for these individuals. Although one might say that elderly people would appreciate assistance in their activities, research has shown that many people aging especially with disabilities seek to maintain independence rather than accept the care of others (Wilson and Mitchell 2009: 215).

Health promotion strategies often promise enhanced self-esteem as a beneficial consequence for participating in activities, such as exercising, managing blood sugar, or eating more healthily (Wilson and Mitchell 2009: 217). However, lower-level needs take priority, so, if one did not feel secured or a sense of belonging, self-esteem issues are not as important or do not make as much of an impact. This notion, which grows out of Maslow's hierarchical model, could explain why esteem on its own might fail to achieve benefits in health care related programmes.

Level 5: Self-actualisation needs

The highest level of human needs involves being true to one's own nature and seeking self-fulfilment through creativity. Self-actualisation can be achieved when all the other levels of need have been satisfied, by engaging in activities which give a sense of being truly alive or participating in something with broader meaning. In elderly people, group engagements, and hobbies are all ways of meeting this need (Maddux 1997: 331). The motivations for self-actualisation behaviours are, in Maslow's hierarchy, quite different than the motivations for behaviours directed towards other's needs, since they are not carried out in order to accomplish another end (e.g. food, water, belonging, a sense of security) (Maddux 1997: 332).

Human needs also provide part of the foundation for QoL and this can be an important influence on the theory (Bowling and Gabriel 2004: 10). Maslow's Theory of Human Motivation (1970) outlines a needs-based approach to measuring QoL that adopts a hierarchical stance. At the bottom of the hierarchy

are basic needs which are physiological, followed by safety and security needs. These needs are deemed to be essential for human survival and it is not until they have been fully satisfied that an individual will seek to fulfil higher level needs. When the physiological and safety needs have been gratified, then love, affection and belongingness needs will emerge. These include the need for affectionate relationships, for example with family and friends. When this need is satisfied, the individual will strive to fulfil esteem needs which include a feeling of self-respect and self-confidence and the gaining of the respect of others. Finally, Maslow maintains that even if all of these are met, an individual will not be at peace until they have fulfilled the need for self-actualisation that is "the individual is doing what he/she, individually, is fitted for" (Maslow 1970: 66). In other words, the individual must be able to realise and express her or his full potential, whatever the circumstances, which might be described as maximising capabilities.

2.15 SUMMARY OF THE CHAPTER

It can be concluded that there are physical, psychological and environmental factors affecting the QoL of elderly people. What is noticeable in the literature review is poor QoL among female elderly people. Another factor was poorer QoL for elderly people in rural communities compared to those in urban areas, especially regarding living conditions.

Maslow's hierarchy of needs assumes that individuals address one level of need at a time, and when one level is satisfied, they move to the next. The exploration of human needs indicates that there are things that would benefit those individuals who are striving to satisfy the level of need associated with physical health maintenance, namely the second of Maslow's needs, safety and security, which links Maslow's hierarchy and the QoL.

Maslow's hierarchy has been used in order to gain insight into the needs of elderly people which will help develop a model to improve QoL for elderly people especially in rural communities. Strategies aimed at improving and maintaining health and QoL for elderly people are beneficial to society as a

whole. Those efforts or strategies have the potential of preventing disability, reducing the costs of health care, and increasing elderly people's functional abilities and QoL. The domains are used in order to measure the QoL for elderly people which have the needs of human being that need satisfaction (Song *et al.* 2004:370). The model proposed in this study for improving QoL in elderly people has been formulated based on both HRQoL and Maslow's hierarchy of needs which aims at fulfilling the elderly people's' needs.

The next chapter (chapter 3) will present the research methodology adopted to study QoL for elderly people in rural communities of uThungulu district, KwaZulu-Natal (KZN) that will help improve their QoL.

CHAPTER 3 : METHODOLOGY

3.1 INTRODUCTION

This chapter presents the research design and methods utilised in conducting this study. The chapter also presents the methods of data analysis, ethical considerations and steps taken by the researcher to ensure trustworthiness of the research.

3.2 RESEARCH DESIGN

According to Burns *et al.* (2013:195), a research design is a detailed plan according to which the research is conducted. Mouton (1996: 107) describes the research design as a set of guidelines and instructions followed in addressing the problem. A qualitative, exploratory, descriptive design was used to achieve the aims and objectives of this study. This approach was chosen because of its naturalistic value, or its usefulness as a tool for the exploration of a full nature of the phenomenon that is related to knowledge development (Polit and Beck 2012: 16). It often informs clinical practice by raising questions and providing fertile ideas for improving quality of care and promoting additional research activities.

According to Burns, Grove and Gray (2013: 66) this type of research is indicated in the study of a specific population to understand their needs. This type of research identifies a gap in knowledge which can only be addressed by obtaining views from the people affected. The goal is to be able to formulate programmes or interventions that could be beneficiary to the researched population. This study will develop a model that will help improve the QoL for elderly people within the rural area of uThungulu district in KZN. Stommel and Wills (2004: 457) define qualitative research as research that eschews measurements and focuses on interpretive, non-numerical, narrative interpretations.

3.2.1 Qualitative research

Qualitative research aims to describe social phenomena and behaviours using rich contextual data that place an emphasis on the subjective experiences of social actors (Malta *et al*. 2005: 1424). While qualitative studies use open-ended questions, quantitative studies use closed-ended questions. Closed questioning does not provide in-depth information on the situation the participant is referring to (Chow *et al.* 2009: 435). These authors further elucidate that the open style of questioning in qualitative studies allows the participant freedom to comment on areas of care and quality of their lives and infers participant satisfaction (Chow *et al.* 2009: 436). In this study, questions were asked, to find out areas that affect the QoL of the elderly people (Chow *et al.* 2009: 438).

Stommel and Wills (2004: 458) maintain that the main characteristics of qualitative research are to explore the goal to understand behaviour or actions within their naturally occurring context, the tendency to focus on smaller samples, where the preference is for open-ended, standardised, reactive data collection procedures. Qualitative methods influence participants to bring out new areas of thought that could never be preconceived by a quantitative instrument. It was because of these merits of qualitative study methods that the researcher opted to use the qualitative approach in this study. Stommel and Wills (2004: 459) argue that although qualitative research is indispensable, it can be criticised for placing too much trust in the credibility and integrity of the individual researcher. The current study utilised a descriptive and exploratory design (Depoy and Gitlin 2011: 201).

3.2.2 Exploratory study

An exploratory study investigates the full nature of the phenomenon and the process by which the phenomenon has evolved or is experienced. This study aimed to explore the QoL in relation to elderly people in rural communities and how best this can be improved if challenges are found. By exploring the

phenomenon under study, knowledge development in this field is enhanced (Polit and Hungler 2004: 20).

3.2.3 Descriptive study

Polit and Beck (2012: 50) state that in descriptive research the main objective is the accurate portrayal of the characteristics of persons, situations, or groups and the frequency with which the phenomenon occurs. Descriptive research provides an in-depth description of participants' experiences in a narrative type description (Burns Grove and Gray 2013: 233). A descriptive qualitative research design is a non-experimental research design used to collect data in a form of in-depth interviews. In this study, the researcher met with elderly people persons at pension pay points to understand the situation that they find themselves in. Therefore, the study was also descriptive in the sense that it looked at the dimensions, variations and the importance of the phenomenon (Depoy and Gitlin 2011: 210).

3.3 TARGET POPULATION

The population that was targeted for the study comprised isiZulu speaking people and they were all from the uThungulu district of KZN. Polit and Beck (2012: 56) define a target population as the entire set of individuals having common characteristics sometimes referred to as a universe. Depoy and Gitlin (2011: 220) define the target population as a group of individuals from which the researcher is able to select a sample. This population comprised elderly people in the rural area of uThungulu district in the communities of uMhlathuze and uMlalazi sub-districts, KZN. These sub-districts are more populated compared to other sub-districts as shown in Figure 2. The population that was readily accessible to the researcher were those people gathering at pension pay points. Non-institutionalised elderly people aged 60 years and above were selected from these rural areas. Below is the distribution of the population in the district and the reason for choosing the two sub-districts for the study (Figure 2).

The next set of target population comprised of the District Programme Manager, the chairpersons of the two NGOs and the audits that were conducted at the chronic clubs in the presence of the NGO chairpersons and the community Care Givers (CCGs).

- The District Programme Manager employed by the Department of Health at district office was chosen as a respondent because that person's duties include issues of chronic illnesses and of old age people.

- The persons-in-charge of relevant NGOs were also selected because they are focussed on the needs of elderly people within the district of uThungulu. They are involved in the care and support of elderly people in the district.

- Chronic club audits were included in the study as they are active within the two sub-districts. The clubs were included because they are visited by elderly people in order to collect chronic medication.

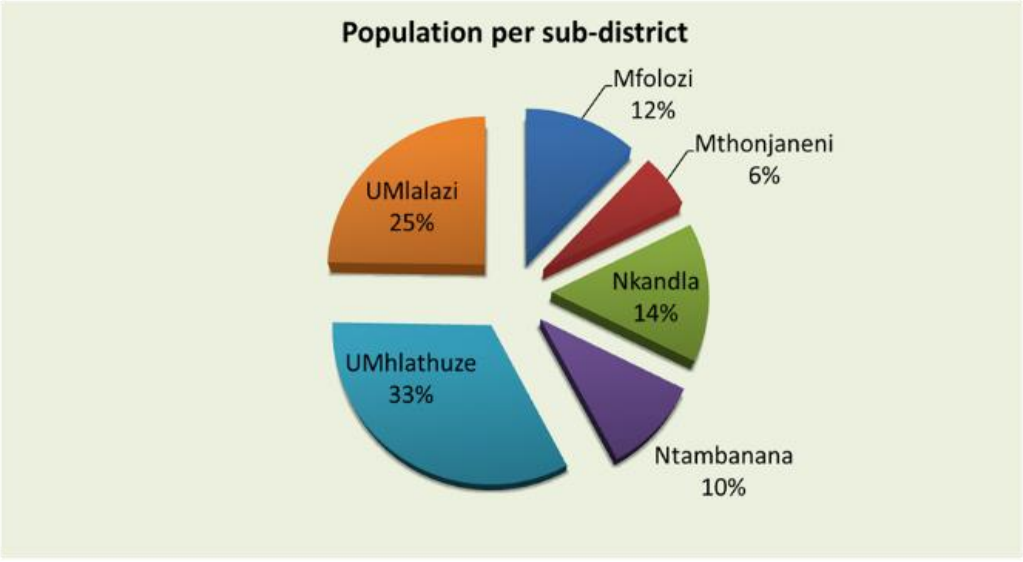

Figure 2: Distribution of people in each sub-district of the uThungulu district

3.4 RESEARCH SETTING

Polit and Beck (2012: 743) describe a setting as an environment where the data is collected for the study. Elderly people living in the uThungulu district of KwaZulu-Natal (KZN) were accessed for participation in this study. The uThungulu District Municipality is an area that occupies about 8,213.39 square kilometers of land, located in the northeastern part of the KZN Province of South Africa. It is bordered by a flat coastal region comprising the Natal Coastal Belt and Zululand Coastal Plain, and inland by the low-veld of Zululand to the northeast and the Eshowe block to the west, which are both hilly, whereas the northwest terrain has more extreme terrain with incised valleys. The Valley of the Tugela River bounds the district on the west. The uThungulu District Municipality has six local municipalities namely Mfolozi, uMhlathuze, Ntambanana, uMlalazi, Mthonjaneni and Nkandla (Figure 3). The study was conducted in the three villages of uMlalazi sub-district, namely, Ndlangubo, Gingindlovu and Nsingweni district and the three villages of uMhlathuze sub-district, namely, Nseleni, Mzingase and Matshana.

UThungulu District has a total population of 979 513 (48% males and 52% females) and approximately 80% of the population lives in rural areas, where rural poverty, rampant crime and the HIV/AIDS pandemic are major challenges. uMlalazi is the biggest sub district covering 2214km² with 25% of the population and uMhlathuze is the smallest with an area of 796km². Thirty three percent (33%) of the district population reside in uMhlathuze sub district. (StatsSA 2009) (Figure 2).

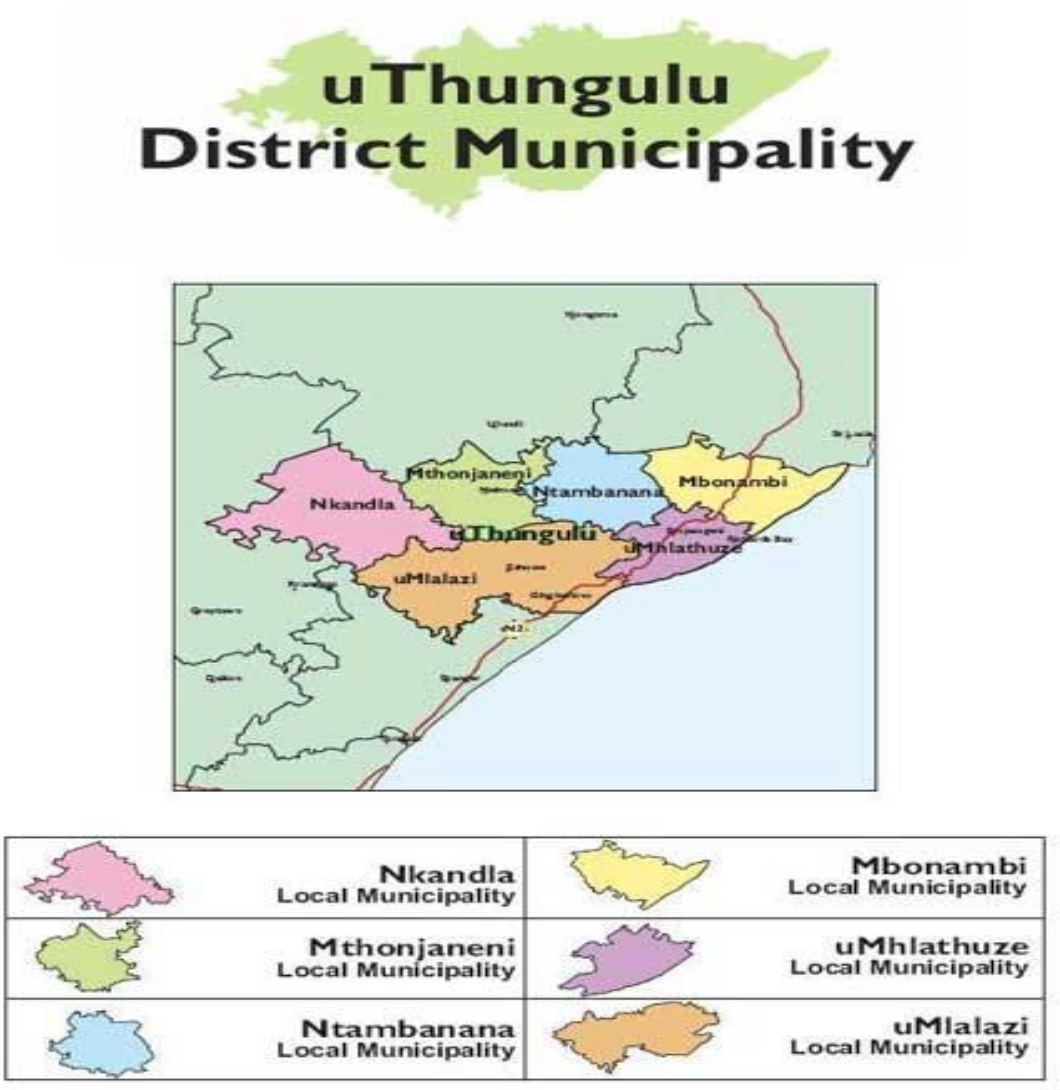

Figure 3: Map of UThungulu district showing the sub-districts

3.4.1 Health care infrastructure in the selected sub-districts

uMhlathuze Sub district: This sub district has nine provincial fixed clinics, two Local Government clinics and one Community Health Centre (CHC). Each clinic within this sub district services a population of 29 505 which is 4000 above the norm in urban areas.

uMlalazi sub district: This sub district has twelve fixed provincial clinics, one gateway clinic and one CHC. Each clinic serves a population of 17 212 per clinic. A gateway clinic is situated within the hospital premises, accessed by

community members who do not require hospitalisation but primary health care services only.

The population of this study comprised non-institutionalised elderly people who were between the ages of 60 and above, who were interviewed at the pension pay point in the two sub-districts.

These clubs are situated within the community where it is easy access to community members. The clubs are used by stable clients, who only visit the clinic biannually to be reviewed by the doctor. Elderly people also collect their medication at these clubs.

3.5 SAMPLING PROCESS

Random sampling was used to select the participants for the study. Random sampling refers to the selection of a sample such that each member of a population has an equal probability of being included in the study (Polit and Beck 2012: 56). Elderly people were selected whilst they were waiting to get their pension pay out. As the pension point was adjacent to the tribal court, a room was secured at the tribal court where interviews were conducted and in order to enable the comfort of elderly people during the interview. The researcher received support from the Community Care Givers (CCGs) who work closely with the community structures. The Department of Social Development (DSD) and South African Social Services Agency (SASSA) have scheduled dates that are shared with all communities in different districts, villages for pension pay out days. The pension pay outs are done on a daily basis in different areas from Monday to Friday.

For the rest of the participants within the study, purposive sampling was used for the selection of the District Programme manager, NGO persons in charge and chronic clubs. This technique selects information rich cases that can share a great deal about the focus or purpose of the study (Burns and Grove 2013: 365). The district level Programme Manager focuses on chronic ailments and

the elderly people programme. The NGOs deal with elderly people issues in their respective communities. An audit was conducted at the chronic clubs in the two sub-districts. This gave the researcher a better understanding of the gaps in ensuring QoL for elderly people.

Inclusion criteria

The researcher approached potential participants who met the following inclusion criteria and requested their participation:

- People aged 60 years and above living in the selected sub districts.
- Consenting participants who did not suffer from any mental condition as confirmed by CCGs because they have a better understanding of the elderly people in the two communities, and because they were not known to the researcher.
- Elderly people who collected their pension from the pay points in the selected two sub-districts.
- Non-institutionalised elderly people.
- The District Programme Manager responsible for chronic management and elderly issues in uThungulu district.
- The NGO chairpersons who are working closely with elderly people within the two sub-districts that are part of the study.
- The chronic clubs for audits fell under the two sub-districts for the study.

Exclusion criteria

- Elderly people who utilised other alternatives of collecting their pension money, for an example bank, post office, shops, relatives who collected pensions on their behalf.
- The District Programme Managers working in other environments within the district.
- The NGO chairpersons who are working in the district on different projects that do not involve elderly people.
- The NGO chairpersons working with elderly people in other sub-districts.
- The chronic clubs in different sub-districts, not involved in the study.

Those who met the inclusion criteria, and agreed to participate, signed a consent form.

3.6 DATA COLLECTION METHODS

The interview guide for the participants was formulated in English and isiZulu for the benefit of the elderly people who had no understanding of English (Appendices 3a and 3b). Questions were structured and included demographic data, social, health and environment issues. These were developed based on the objectives that have been outlined in chapter 1. The researcher asked questions based on the assumption was that some elderly people in these communities would be unable to read.

The second set of questions was formulated for the District Programme Manager who deals with the integrated chronic diseases management (ICDM) programme for uThungulu (Appendix 3c).

The third set of questions was directed to the NGO chairpersons dealing with elderly people issues within the district (Appendix 3d).

An audit tool was used to conduct an audit of the chronic clubs (Appendix 4). The clubs are linked to Municipalities in the district. The audit was done in order to get a better understanding of the services that are there to support the QoL of the elderly people. A summary of the data collection process is provided in Table 1.

Table 1: Summary of data collection process

Objective	Activity	Tasks	Expected outcome
Assess and review the QoL with a focus on health system of rural elderly people at uThungulu district, using a multidimensional approach that looks at both subjective and objective issues as stated in the interview guide for participants.	Review available activities for the elderly people. Review number of elderly people involved.	List of activities. List of clubs. List of support groups. Numbers participating.	Number of activities available. Number of elderly people within the population that are involved in the activities.
To determine and review the health status and the health seeking behaviour of elderly people aged 60 years and above, based on the health-related QoL tool.	Assess visits to the health facility.	Number of visits to the clinic per age group (DHIS). Frequency of visits.	% of elderly people accessing health care services. Number of visits.
Identify and re-work health indicators to be used to measure QoL by conducting an audit at the chronic clubs.	Review non-communicable diseases (NCDs) status for the elderly people. Review DHIS. Conduct an audit.	Number of NCDs according to age. Check indicator set. Using an audit tool to identify challenges in the chronic clubs. Interview a District Programme manager on indicators collected.	% of elderly people with NCDs. Have indicators that are relevant. As per Appendix 4. As per Appendix 3c.
Strengthen services and conduct an intervention through community structures and NGOs to improve the QoL for elderly people people.	Find NGOs dealing with elderly people issues within the community. Find out about their activities with the elderly people. Market the idea to the NGOs of QoL for elderly people. Schedule meetings with relevant platforms/ structures that deal with elderly people issues within the community.	Conduct an intervention for each of the NGOs. Types of activities per NGOs. Present at platforms like OSS. Present method to improve QoL for elderly people people at every encounter with relevant structures (DSD, DOH, and Municipality).	Review to check if intervention will work or not. Number of activities conducted per NGO. Number of participants at each encounter. Number of participants trained.
Objective	**Activity**	**Tasks**	**Expected outcome**

Development of a model of care that will improve the QoL along the health system of elderly people people in rural communities.	Collect information relating to participants, what set indicators are available on DHIS, Chronic clubs information and at District level. Identify where gaps are and using the information collected Do an analysis. Use the information collected to develop the model of care.	Step by step formulate a model of care for QoL for elderly people.	Improved QoL for elderly people of uThungulu.

Table 1: summarises the data collection process that was followed by the researcher in gathering information and the steps followed towards the formulation of the QoL model for this particular study.

3.7 PRE-TESTING OF THE DATA COLLECTION TOOLS

Polit and Beck (2012: 738) describe pre-test as a collection of data before the experimental intervention. Pre-testing of the data collection tool was conducted on elderly people within the targeted community to test the tool for interview before a full study was undertaken. This was to identify any mistakes about the chosen method of collecting data. The researcher identified elderly people for participation with the help of the CCGs who worked in the community. Entry was gained via the Ward Councillor, Indunas and/or the Chief of the area who were notified of the project as per the information note that was read to them (Appendix 2a). The CCGs helped in building awareness by sensitising the potential participants about the interviews so that by the time they went to pension sites, they were aware that they could be chosen for interviews. The data collection tool for the elderly people participants was tested in this community.

The changes that were considered on the data collection tool were on environmental issues and some questions were added. Some questions were moved from socio-economic issues to environmental issues, as they fitted well there. The changes were discussed with the researcher's supervisor.

3.8 DATA COLLECTION PROCESS

Information letters were distributed following requests of appointments to meet and discuss the study with the following:

- District Programme Manager in charge of ICDM and elderly people issues in the district (Appendix 2a).
- Traditional Leaders of uMhlathuze and uMlalazi through the Municipality offices.
- NGOs for uMhlathuze and uMlalazi sub-districts through the civil society forum based at the Municipality offices (Appendix 2a)
- Chronic clubs for uMhlathuze and uMlalazi sub-districts through the District Programme Manager.

Confirmed appointments were received telephonically. The researcher did the following in preparation for the data collection:

- Arranged who to meet first, as per availability.
- Explained to the traditional leaders the study and arranged a date for meeting with Izinduna for the two sub-districts and the villages where the participants came from. Meetings were held at the Tribal courts. This was an opportunity to inform Izinduna of the study and to disseminate relevant information to the respective communities.
- Meeting with the District Programme Manager to sensitise her on the study. A date was set with her for an interview. The Manager arranged a meeting with CCGs who the researcher was able to sensitise regarding the study and could request to disseminate information to the community. This made it easy for the selection of elderly people during pension days as they were aware of the study.
- The researcher also met with NGOs chairpersons of the two sub-districts, who were sensitised about the study and appointments were set for interviews.

- Chronic clubs were identified in the two sub-districts and meeting with the person's in-charge were arranged so as to sensitise them regarding the study and to set appointments for audits.

Before each interview with and elderly participant, the information letter was read, followed by reading and explanation of the consent form and signing thereafter (Appendix 2c and 2d). For participants who did not understand English, a translated information letter (Appendix 2e) and consent form (Appendix 2f) was provided. Participants who were unable to write were issued with a stamp pad and a right (R) thumb print was taken.

Interviews with elderly people

Interviews were semi-structured face-to-face interviews and were conducted using an interview guide to elicit information from the participants until the point of saturation had been reached. Interviews were conducted at the pension pay points whilst the participants waited for their pay-outs. One elderly person at a time was taken by the researcher to a space that was secured at the Tribal courts and in other instance a community hall. This enabled the comfort and privacy for the participants during the interview process. The participants were probed by the researcher to continue to obtain in depth information on the subject matter, until the saturation point was reached. This meant that when participants were saying one and the same thing on questions that were asked, the researcher realised that all the answers were the same, which meant that a saturation point had been reached. While the participants openly shared the information regarding their QoL, the researcher was at liberty to discover areas that affected their QoL in the following domains: health, social, and environmental well-being.

The interview material was collected using the health related QoL instrument and the interview guide was prepared in English (Appendix 3a) and isiZulu (Appendix 3b) and was used to guide the discussion. This was arranged by the researcher upon receipt of approval by all the gatekeepers.

The second set of interviews was conducted with the three categories mentioned earlier. This was to enable better understanding of the data elements and services offered by the districts to the elderly people and how these are evaluated in terms of improving the QoL.

Interview with the District Programme Manager

A consent form was read and explained to the District Programme Manager, after which it was signed (Appendix 2b). The interview guide (Appendix 3c) focused on finding out what was currently done to support the elderly people with their health and ways to improve the QoL for elderly people, what data elements are being collected and activities conducted by Department of Health in promoting QoL, and links with chronic clubs.

Interviews with NGO chairpersons

The NGO person in charge for each sub-district also signed a consent form after it was read and explained (Appendix 2b). Interviews were conducted with NGO person's in-charge to find out the type of services offered to elderly people that would help improve the QoL (Appendix 3d).

The interview used open-ended questions included follow-up questions which elicited appropriate responses about the interviewee's experiences of QoL. The duration was estimated at 30 minutes per interview and was conducted by the researcher. The interviews were recorded using a quality voice recorder while at the same time the researcher took notes to support the recordings (Creswell 2009: 185).

Audits conducted

Audits were conducted by the researcher at the chronic clubs to ascertain the type of services offered to the elderly people in general. The database of clubs is the responsibility of the municipality and is linked to the DOH. The information about clubs was sourced from both sub-districts and municipality offices and clubs were approached and sensitised by the researcher just before the audit was conducted (Appendix 4). A tool was formulated by the researcher to gather

information. This was then administered by asking questions from the person's in-charge of the chronic clubs.

The researcher determined what activities for the elderly were catered for by the clubs, how the clubs were formulated, the roles and responsibilities, special services for elderly people, the number of elderly people accessing services. This was done through observations and checking of records that were found in each chronic club. This gave a better understanding of what services were there to support the QoL of the elderly people. Currently chronic clubs are used by all patients with chronic communicable and non-communicable diseases to collect medication. The clubs have CCGs who distribute the treatment to all clients with chronic diseases in the community. This helps clients who sometimes miss their clinic appointments.

Data was captured by a recorder and transcriptions done. Data was collected for a period of five months, within the two selected sub-districts. The summary of the data collection process (Table 1) helped in understanding the current status. The information collected was analysed and this helped with the development of a model of care that may help improve the QoL for the elderly people of uThungulu districts.

3.9 TRUSTWORTHINESS OF THE STUDY

Trustworthiness is the extent to which a research study is that the outcome is worth paying attention to and worth taking note of (Lincoln and Guba, 1985: 100). These researchers identified a set of criteria that could be used to judge the qualitative work. They are credibility, transferability, dependability and conformability. Lincoln and Guba's work (1985) guided the strategies that were chosen to ensure rigour. The researcher conformed to the issue of trustworthiness, by informing the participants that the findings will be shared with them upon completion of the study.

3.9.1 Credibility

Credibility standards involve performing specific activities that increase the trustworthiness of the reported findings (Stommel and Wills 2004: 462). It can be enhanced through triangulation of data. Other techniques of addressing credibility include making segments of raw data available for others to analyse, prolonged engagement or the researcher's substantial immersion in the research process and the use of member checks in which respondents are asked to corroborate findings (Lincoln and Guba 1985: 101). In this study, the researcher thoroughly engaged with the research, established valid and meaningful relationships with participants and was open to the meanings that unfolded during the research process. The researcher also interacted with experienced research colleagues who provided guidance for research design, data collection and data analysis for the review and consensus on how to proceed. The results were compared with other data sources to examine and validate conclusions about meanings.

3.9.2 Transferability

Transferability, according to Stommel and Wills (2004: 463) is conceptually similar to generalisability (external validity) in quantitative studies, which refers to the extent to which findings can be generalized to other situations and target population. Lincoln and Guba (1985: 110) admit that generalizability is an appealing concept because it allows a semblance of prediction and control over situations. These authors suggest that the existence of local conditions makes it impossible to generalise. Stommel and Wills (2004: 464) recommend "thick description" which is a very detailed description of the nature of the participants, their reported experiences and the researcher's observations during the study. This provided sufficient detailed information for the study, such that interested others could gauge the extent to which the findings might apply in another population. To meet the criteria for transferability, the report of this study provided the discussions of the nature of the participants, their experiences/data obtained, and researchers' observations during the study, methods of data analysis and the interpretation of the research findings. The

researcher made references to the raw data, kept available for any interested person. This detailed information therefore renders opportunities to interest others to gauge the extent to which the study findings could be generalizable or transferable.

3.9.3 Dependability

Lincoln and Guba (1985: 115) propose a strategy which might enhance the dependability of qualitative research. That is the use of an “inquiry audit” in which reviewers examine both the process and the product of the research for consistency. Stommel and Wills (2004: 465) on the other hand, elucidate that dependability is most conceptually similar to the concept of the test-retest and internal consistency reliability in quantitative research approaches and refers to how stable or unstable the data patterns tend to be over time. To meet the criteria for dependability, the data and analysis were checked for comparability and similarity and discrepancies and resolved.

3.9.4 Conformability

Conformability refers to the degree to which the researcher can demonstrate the neutrality of the research interpretation (Lincoln and Guba 1985: 120). To meet the criteria for conformability, the researcher used audit trails in which approaches to data collection, decisions about data collection and decisions about the interpretation were carefully documented, so that another researcher can arrive at the same conclusion, and for the protection of the participants.

3.10 ETHICAL CONSIDERATIONS

The relevant ethical considerations of this study was observed, where ethical approval to conduct the study was obtained (Appendix 1) and informed consent forms (Appendices 2d and 2f) were provided for the participants to sign. Participants were informed that the interview would be recorded following their permission and that the researcher would take notes during an interview. The researcher ensured strict compliance with ethical standards, relevant to

protecting the rights of the participants as data was collected. Permission to conduct research was sought from the Durban University of Technology (DUT).

Information sessions / briefing of the participants about the research and written information were conducted by the researcher (Appendix 2c). For those participants who did not understand English, a translated letter of information was provided (Appendix 2e). Thereafter, each participant was required to sign the consent form (Appendices 2d and 2f). Those who were unable to write were issued with a stamp pad and a right (R) thumb print was taken. The study participants were given a choice to participate or not without any coercion and also to withdraw from the study at any point if they wished to do so. The District Programme manager gave permission to be interviewed by signing consent (Appendix 2b). The NGO chairpersons signed consent forms (Appendix 2b) which enabled the researcher to conduct interviews. Information letters were shared with the district and verbal permission was granted to the researcher to engage the District Programme Manager directly on issues concerning elderly people within the district, as she is responsible for the chronic clubs. The District Programme manager granted permission for audits to be conducted during the interview process.

The participants were informed of the study and reasons why it was done and why they were selected. A letter of information was shared with all concerned and for the elderly people who were unable to read, the letter was read to them in IsiZulu. Data collection tools were identified by numbers so that there was no link between the participants' identity. Completed data collection tools are kept under lock and key for a minimum of 5 years, and thereafter destroyed by shredding. Electronic data stored in a computer and secured with a personal secret password only known to the researcher and data wiped off after 5 years. Access to voice recordings would not be shared with anyone without consent.

In this study the researcher wanted the identity of the participant and promised to keep their identity confidential. This meant that the researcher was not going to share the information with anyone without the authorisation of the participant.

Participation on this study was done voluntarily and participants were not be coerced into participating which is why they signed a consent form before they were interviewed.

3.10.1 Protecting the rights of the participants

Non-discrimination

The researcher avoided discrimination against the participants on the basis of gender, race, ethnicity, or other factors that may jeopardise the validity and reliability of the study results. Equal opportunity to all participants that were at the pension pay out points to participate was given.

Beneficence

The researcher did no harm, refrained from exploitation of participants and promoted both individual and societal benefits that were directly related to the participation in the research. All study participants were assured that they would not be exposed to any physical harm during the study. Participants were given an opportunity to be part of the study or refuse if they did not want to or felt uncomfortable.

Respect for persons

The researcher respected the rights of the participants, both self-determination (autonomy) and the right to full disclosure (full informed consent for research participants). The rights of the elderly people to decide to participate in the study were respected based on the ethical principle of self-determination and the expected professional obligation to truthfully grant full disclosure of information relevant to the study. For participants to make an informed decision to participate in the study, a detailed explanation on the study including but not limited to the purpose of the study, consequences of participation or refusal to participate and any possible gains or risks associated with participating in the study was given. Participants were asked to voluntarily sign a written consent

form to participate in the study, which was witnessed and signed by the researcher.

Justice

The researcher respected the rights of the elderly people and other categories of participants included in the study to privacy and the right to fair treatment in the context of the research participation. The privacy of participants regarding any information relevant to them and their identity were maintained and safeguarded by the researcher. No section of the research report contained any information that could be used by any reader to be aware of the personal identity of the source of such information.

3.10.2 Scientific integrity of the research

Honesty

The researcher strived for honesty in all scientific communications, by honestly reporting data, results, methods and procedure and publication status after the thesis is accepted by the university. The researcher did not fabricate, falsify or misrepresent data.

Objectivity

The researcher strived to avoid bias in data analysis, data interpretation, peer review, personnel decisions, grant writing, expert testimony and other aspects of research where objectivity was expected or required.

Carefulness

The researcher avoided careless errors and negligence, and carefully and critically examined her own work. She kept a good record of research activities, such as data collected, research design and correspondence with supervisors or journals.

Respect for colleagues

The researcher respected her colleagues and treated them fairly. She acknowledged all who made useful contributions towards the success of this research study.

3.11 DATA ANALYSIS

Tesch's open coding approach was used for analysing the qualitative data, which entailed eight steps of analysis (Creswell 2009: 185-187). This includes:

- Reading through all transcripts to get a general impression of the collected data.
- Writing down in the margin thoughts that emerge from the data.
- Making a list of all topics. Similar topics were clustered together. These topics were preliminarily organised as major topics, unique topics and leftover topics
- Topics were abbreviated as codes which were written next to the corresponding segments of the data. Any other topics or codes that emerged were also written next to the appropriate segment of the text.
- The most descriptive wording for the topics was used and turned into sub-categories.
- Grouping together of the related topics and emerging list of categories.
- Preliminary analysis of data was done by assembling data that belonged to each category from which themes emerged.
- Existing data were recorded.

Qualitative data analysis started whilst the interviews were going on and thematic analysis used. Qualitative data was transcribed from the voice recorder into a written format and interpreted from isiZulu to English. The transcribed interviews were captured onto a master file through Microsoft Word. This meant that the researcher had to read through all transcripts to get a general impression of the collected data, writing down of margin thoughts that emerged from the data. This was followed by formulation of a list of all topics. The topics that were found to be similar were clustered together. The sequence

of topics was preliminarily organised as major topics, followed by unique topics and lastly leftover topics. The researcher then abbreviated topics which were then written next to the corresponding segments of the data. Other topics that emerged were also written next to the appropriate segment of the text. The most descriptive wording for the topics was used and turned into sub-categories. Related topics were grouped together. Data that belonged to each category where themes emerged was assembled and analysed (Creswell 2009:187).

Data analysis was done from the data as presented by the participants and not from a theory; the theory was used only to guide the study. According to Creswell (2009: 190), interpretive qualitative researchers rarely use a theoretical framework therefore, Maslow's' Hierarchy of Needs was not imposed on the themes that emerged from analysing the data. It was not used to identify the themes because that would have implied that the findings were pre-empted according to the theory. When data reduction was done, then the categories, themes and subcategories were discussed and supported by factors based on the interview guide. At the end, the findings were contextualised within Maslow's Hierarchy of Needs and discussed in relation to this theory. The analysis of the information gathered from the audits conducted was summarised on what was observed and records found at each chronic club.

3.12 SUMMARY OF THE CHAPTER

This chapter elucidated the subjective worldview that was utilised as a part of this study, where exploratory, enlightening and relevant outline was utilised. The chapter additionally shed light on the technique used to gather information from participants and methods of analysis. Moreover, the section depicted measures utilised by the researcher to guarantee strict consistence with ethical guidelines applicable to ensuring the privileges of the participants when information was gathered. The next chapter will focus on analysis and presentation of the data obtained from the participants.

The next chapter (chapter 4) will focus on the analysis and presentation of data obtained from the elderly people, District Programme Manager, NGO chairpersons and the audits that were conducted in chronic clubs within the two sub-districts of uThungulu district, KZN.

CHAPTER 4 : RESULTS

4.1 INTRODUCTION

The findings of the study are presented in this chapter. Data from each group has been described separately and regrouped at the end of the chapter for the formulation of the model. The study is guided by Maslow's hierarchy of needs as has been outlined in chapter 2 of the study. Data from the interviews are described around social, health and environmental issues of the elderly people. These clusters are pertinent to the QoL for elderly people and have been linked with the first three of Maslow's hierarchy of needs. The sequence in which data is presented is as follows: the elderly people group, as it was a large group, followed by the two NGO chairpersons together with audits that were conducted at the chronic clubs in the two sub-districts and lastly the Department of Health Programme Manager dealing with chronic illnesses. Quotes from the participants have been included to illustrate the analysis. Quoted text is found within inverted commas and it has been italicised.

4.2 DEMOGRAPHIC PROFILE OF THE PARTICIPANTS

Thirty elderly people from the two sub-districts (uMhlathuze and uMalazi) of the uThungulu district of KZN were interviewed. The interviews were conducted at the pension pay points in different villages as shown in Table 2. Table 2 shows a summary of the demographic data and the narrative of the descriptions below.

Table 2: Demographic data (n=30)

Topic	Description	Village	30(100%)
District	uMhlathuze	Nseleni	7(23%)
		Mzingase	6(20%)
		Matshana	5(16%)
	uMlalazi	Ndlangubo	4(13%)
		Nsingweni	4(13%)
		Gingindlovu	4(13%)
Age	60-70 years	Mhlathuze	7(23%)
		Mlalazi	8(26%)
	70-80 years	Mhlathuze	8(26%)
		Mlalazi	3(10%)
	80-95 years	Mhlathuze	3(10%)
		Mlalazi	1(3%)
Gender	Females	Mhlathuze	13(43%)
		Mlalazi	12(40%)
	Males	Mhlathuze	5(16%)
		Mlalazi	0
Marital status	Civil	Mhlathuze	4(13%)
		Mlalazi	4(13%)
	Customary	Mhlathuze	6(20%)
		Mlalazi	1(3%)
	Polygamy	Mhlathuze	2(6%)
		Mlalazi	0
	Divorced	Mhlathuze	0
		Mlalazi	1(3%)
	Separation	Mhlathuze	1(3%)
		Mlalazi	0
	Widowed	Mhlathuze	1(3%)
		Mlalazi	2(6%)
	Cohabitating	Mhlathuze	2(6%)
		Mlalazi	3(10%)
	Single	Mhlathuze	2(6%)
		Mlalazi	1(3%)

Topic	Description	Village		30(100%)
Number of children alive and dead & grandchildren staying with elderly.	Staying with both children and grandchildren.	Mhlathuze		11(36%)
		Mlalazi		12(40%)
	Not staying with either.	Mhlathuze		1(3%)
		Mlalazi		0
	Grandchildren only.	Mhlathuze		6(20%)
		Mlalazi		0
Type of houses & number of people in the house.	Block	Mhlathuze	3 rooms	8(26%)
		Mlalazi		5(16%)
		Mhlathuze	4 rooms	5(16%)
		Mlalazi		3(10%)
	Mud	Mhlathuze	2 rooms	4(13%)
		Mlalazi		3(10%)
		Mhlathuze	1 room	1(3%)
		Mlalazi		1(3%)
Number of times elderly eats a day.	Three times	Mhlathuze	8(26%)	
		Mlalazi	6(20%)	
	Two times	Mhlathuze	11(36%)	
		Mlalazi	3(10%)	
	Once a day	Mhlathuze	0	
		Mlalazi	1(3%)	
	No food	Mhlathuze	0	
		Mlalazi	1(3%)	

Topic	Description	Village	30(100%)
Chronic diseases.	Abdominal ulcers	Mhlathuze	2(6%)
		Mlalazi	2(6%)
	Arthritis	Mhlathuze	2(6%)
		Mlalazi	1(3%)
	Asthma	Mhlathuze	2(6%)
		Mlalazi	1(3%)
	Combination of HPT/Diabetes/Arthritis	Mhlathuze	6(20%) *
		Mlalazi	3(10%)
	Diabetes	Mhlathuze	2(6%)
		Mlalazi	1(3%)
	Epilepsy	Mhlathuze	1(3%)
		Mlalazi	2(6%)
	HIV	Mhlathuze	0
		Mlalazi	2(6%)
	HPT	Mhlathuze	7(23%) *
		Mlalazi	4(13%)
	TB	Mhlathuze	1(3%)
		Mlalazi	0
	No illness	Mhlathuze	3(10%)
		Mlalazi	2(6%)

**Participants who suffer from more than one chronic illness, majority has chronic illnesses, only a small percentage has no illnesses.

The majority of the participants in both sub-districts were female. The participants were between the age of 60 and 95 years. Some participants were married under civil law, some customary and others were in polygamous relationships. A few of the participants were cohabitating; a few were single, divorced and separated. The average duration for which the participants were married in any of the three forms was 30-40 years. One male aged 73 years of age indicated that he had paid the dowry for his girlfriend and was waiting for the wedding ceremony.

A number of participants indicated that they were staying with their grandchildren and different reasons were given for this. Most elders reported that they have both living and dead children, and those who had passed away left them with grandchildren. The elderly people were living under one roof with

their children as well as grandchildren. They reported this as having a big impact on their lives.

Some houses that were inhabited by the elderly people were built with blocks and some with mud. In some cases, as many as 10 people lived in a 2 bedroom mud house. They reported that they were still waiting for government to build them houses, which has not happened. The participants also mentioned the number of times that they ate a day which had an impact on them because they were taking medication for chronic conditions. Some participants had two meals a day and yet some had gone with no food for two to three days and that lead to malnutrition.

The most common chronic disease suffered by the participants is hypertension followed by a combination of hypertension, diabetes and arthritis. Some participants had TB and HIV which could be from caring for their children or grandchildren who suffered from these conditions and had not disclosed them. Some conditions reported were environmentally related due to industries in the vicinity that emit fumes that are dangerous to the community or cause chest problems.

4.3 QoL-THEMATIC ANALYSIS

A multidimensional approach was used to determine the QoL of the rural elderly people which looked at the social, health and environmental issues as per the interview guide. Table 3 presents the themes, categories, and subcategories that emerged from the findings as summarised from the interview transcripts.

Table 3: The presentation of themes, categories and sub-categories

No.	Theme	Category	Sub-category
1	Social well-being of elderly people.	Harassment of elderly people.	Lack of recognition and respect as an elderly people.
			Lack of understanding with regards to elderly people services in the community.
		Safety and security in the community.	Lack of safety for elderly people in the community
			Violence, crime and substance abuse in the community.
2	Physiological factors.	Finances.	Inability to provide for basic needs.
			Inability to pay for grandchildren's education
			Inability to improve living conditions.
			Unemployed children living with under one roof.
		Living conditions within the community.	Structural conditions and lack of resources.
			Lack and insufficient food supplies in the household.
			Provision of elderly people services.
			Health conditions.
3	Psychological factors.	QoL.	Belief that impact on living conditions and health status.
			Unpleasant environmental factors.
		Emotional experiences.	Feelings of hopelessness and helplessness.
			Feelings of stress.

4.3.1 Theme 1: Social well-being of the elderly people

The social well-being of the elderly people deals with two issues which are harassment of elderly people and threats to the safety and security of elderly people (Table 4). These are perceived as lack of recognition, respect and lack of understanding of the needs of elderly people for services within the community to contribute to their QoL. The threat to safety and security, elderly people felt unsafe in the community due to different reasons such as violence, crime and substance abuse.

Table 4: The categories and sub-categories under social well-being of elderly people

Category	Sub-category
Harassment of elderly people.	• Lack of recognition and respect as an elderly people. • Lack of understanding with regards to elderly people services in the community.
Safety and security in the community.	• Lack of safety for elderly people in the community • Violence, crime and substance abuse in the community.

Harassment of elderly people

Recognition and respect

Participants reported that they are not recognised or respected within the community by neighbours as well as their children. This contributes to their poor QoL, assuming that the community lack an understanding of how to take care of elderly people within their communities. The majority of participants felt that there is a high level of harassment of elderly people due to the issues mentioned above. For example, neighbours will go into an elderly person's property without permission or without consultation. Where a participant has a garden, the neighbours and their children would take what does not belong to them without permission. Property such as land would be taken away from them because they are old and unable to fight back. Quotes from participants with regards to harassment are given below.

"My neighbour will get into my house and take whatever he/she wants because he/she knows that I am old and there is nothing that I can do, I hates so badly. I feel I am being harassed."

"One of my neighbours took my plot without my permission to do her garden and we had a big quarrel about this, but she careless because she said I am old and there is nothing that I can do to her".

Understanding of elderly people's services

Participants indicated that they are not aware of the services that would help them in the community as old people and the community does not have knowledge of the services offered to old people. Most participants voiced out that they have never heard or seen any NGOs that are supporting the activities of old people in the community. Whatever is available, for instance the burial scheme is there to rip off the little pension money they get on a monthly basis. Even though participants have contributed for almost twenty years towards the scheme, when they pass on, the pay-out to the family for the burial is meagre. The participants felt aggrieved by the excuses that were made regarding the low pay-outs for example that some premiums were not paid, even though the money was withdrawn every month. The quotation below clarifies this point.

"*I have seen how the people from the scheme operate, they refused one old person's relatives in paying for the coffin and mortuary, saying the old person passed away having not paid her last few premiums, yet they were taking money from old people every time".*

Most participants informed the researcher that because their own children are unemployed and have resorted to drinking alcohol, they are harassed especially on pension days. These children demand the money to purchase alcohol, instead of food for the house. This affects their QoL and the participant stated the following:

"I have children that are unemployed and have resorted to drinking alcohol. They would come home in the middle of the night, making noise and I cannot sleep".

"My neighbour's children would go to taverns and come back in the middle of the night to disturb us whilst we are sleeping".

Safety and security

Experiences of crime and violence in the country and the fear for personal safety affect people's lives. These negative experiences impact negatively on participant's level of social well-being. This is not strange among the elderly people in the society due to high rates of crime and violence. Not only do they feel unsafe in the community, but also in their own homes, with their own children who abuse alcohol. Participants reported feeling unsafe in their own homes because of the children and grandchildren who keep the pension card and identification document so as to take all the pension money on the pension pay out day to use for alcohol. This is serious crime that participants experience and it has been reported several times to the authorities but nothing has changed.

Some participants expressed the following:

"….My *own child took my pension money and that of my husband without our permission and used it for his own things and this breaks my heart."*

"….My children and grandchildren took my identity document and my pension card to keep so that they take all my money when I get paid. At first I thought it was done in good faith, but later realised that they do not buy food with the money but alcohol. This makes me feel sad."

"….My children would accompany me to the pension point as if they care, but in actual fact, they want the money for the alcohol. This really disturbs me as I cannot buy household items, especially food. I have reported this matter to the Induna several times, but nothing is done".

Participants reported their frustrations about crime in the community, where neighbours steal goods from them, for an example fowls and house items like televisions. When an old person needs help from a neighbour, the neighbour would try and help but at the end the old person is subjected to abuse. This was reported by one participant, who had no refrigerator and asked neighbours to

keep perishable items for her and when a participant asked for meat that she bought, it was no longer there because the neighbour had used it without the permission and the participant went hungry. These are the things that impact negatively on QoL of elderly people. The following quote is related to this incident:

"I bought meat on the pension day and asked my neighbour to keep it in the fridge for me, as they always do, but every time when I want to cook I go and ask them to give me my meat and the neighbour will say she is sorry they have cooked the meat and I will go hungry".

Further frustration about, safety voiced out by a participant, was the fact that they were moved from one area to another. They currently have no stable place to stay and that brought about unsafe conditions. They do not have knowledge of the particular area resulting in uncertainty, damage and theft of their belongings which contributed to poor QoL. The following quote relates to this:

"….We were moved from one place to the other and I was scared for my life to go to a new place, as an old person that I will come across bad neighbours, well it happened. All my belongings were stolen and I was left with nothing. I sometimes feel unsafe with this movement, as I am not sure when they will move us again. I hope government build us houses now."

Crime, violence and substance abuse

One factor that relates to issues of safety and security in the community that participants cited was the use of substances like alcohol and dagga by children in the community. The participants mentioned that the level of noise from the taverns nearby where the children go and drink alcohol was too much. This affects the participants' QoL, as they reported difficulty in sleeping at night. This is illustrated in the quotations below.

"I hardly sleep at night because my house is next to a tavern and there is noise every time from the children in this community who drink and shout in the

middle of the night. It is very strange because we are in rural areas, such things we have seen in urban areas when we were young working there as labourers."

"The children in my community drink a lot and I always feel unsafe as an old person, because one old person was harassed in the middle of the night by drunkards. It's not safe anymore".

4.3.2 Theme 2: Physiological factors

These are the physical factors that affect the elderly people and are related to finances that make life difficult to fulfil individual basic needs, such as education of grandchildren and the category on improving living conditions (Table 5) below. Concerns regarding unemployment of the participant's children living in the same house also meant that they should be provided for their needs from the same pension money and this impact on the QoL for the elderly people.

Table 5: The categories and sub-categories under physiological factors

Category	Sub-category
Finances.	• Inability to provide for basic needs. • Inability to pay for grandchildren's education. • Inability to improve living conditions. • Unemployed children living with under one roof.
Living conditions within the community.	• Structural conditions and lack of resources. • Lack and insufficient food supplies in the household. • Provision of elderly people services. • Health conditions.

Finances

The participants' inability to provide for the basic needs of children and grandchildren, inability to pay for grandchildren's education, improve living conditions were identified as major financial factors that had a negative impacted on the QoL for the elderly people. Unemployment of participants' children was cited as a critical factor as it raised concern. This meant that the elderly people had to provide for their own needs plus those of their children with the little pension money that they get once a month.

One participant explained that she was struggling to survive on pension money, as it is used for buying food but now is also needed for paying for the grandchildren who are at school. The issue of unemployed children has continuously been mentioned, which had a negative impact on the finances. The majority of participants indicated that they have financial constraints which made them fail to meet their basic needs. All the above factors affect the elderly people QoL.

The words of a 75 year old single woman staying with six children and eight Grandchildren reflect many participants' feelings:

"I use my pension money to buy food, clothes, pay for household things, also pay for my grandchildren's education, as their parents (my children) have died and I have not received foster grant. All my children are staying with me and are not employed."

A further problem caused by unemployment of the children is that they end up all staying under one roof. Those children, who had odd jobs, were not paid much for the family to survive. This statement illustrates the views of some participants:

"…my children are staying with me and they are all not working, if they get something, it's only odd jobs which do not last for even a week."

Living conditions

This factor is in relation to structural conditions and lack of resources such as food supplies in the household and the provision of health services for elderly people also had an impact on the QoL. The structural conditions and lack of resources were noted as factors that affected the QoL of elderly people. Some participants were living in mud houses which showed signs of falling with leaking roofs. This is worse during rainy season, posing a threat to health and impacting negatively on the QoL. The following quotations related to this finding:

"I stay in a mud house and the roof is leaking, one side of the house is almost falling. This becomes worse when it rains and I am scared that the whole house will fall on us whilst we are asleep."

"The house is made of mud and there are holes because it's an old house. I always suffer from colds and flu because of the dust that comes through the holes."

"I stay with my children and grandchildren in this house. We are 10 in total in a two bedroom mud house that has a leaking roof."

"The house is too small for all of us, my grandchildren sleep on the floor every day and my children share a bedroom."

One other important fact is where a participant has to live under difficult conditions with no resources, for example where there is no proper way of disposing garbage, poor toilet facilities impact on their health status and compromise the QoL. The quotes below portray the results:

"We dig a hole that we use as a toilet and it is not safe."

"We use another hole to dispose of our garbage and we burn it."

A concern raised by participants was the lack of food supplies in the house. Most participants reported that food supplies were procured with pension money on the pension day and do not last for the whole month. This was the only source of income within the household and used for buying food and other household items and not enough to keep them throughout the month, as illustrated in this quote:

"My pension money is used to buy food which does not last for the whole month. I use the money to pay for other things for the house."

Elderly people need food to take their medication, yet sometimes they go without food for days and this leads to malnourishment. This has an impact on their health status. Those elderly people who reported that they eat only twice a day voiced out that they were saving the food items so that it lasts them for a month, which never ends up being the case because food gets finished mid-month. They eat left over meals from the previous night and nothing during the day and only cook in the afternoon. In a case where there is only one meal a day, it is because they want to take treatment and will only get another meal the following day. The following quotes relate to this finding:

"At home we only eat left over meals from the previous night and cook in the evening. We don't eat anything during the day."

"I eat once a day, in the morning so that I am able to take my pills and only get the next meal the following day."

"…Sometimes we go without food for days in my house when there is nothing to cook and eat. This is during the last weeks of the month before the next pension day."

The issue of a balanced diet was not heard of even though they mentioned different forms of food items. Secondly the person preparing the food, which was either an elderly person herself or the grandchildren were not worried about the health conditions of elderly people, as long as they cooked, it was fine. The following quotations related to this finding:

"I eat once a day in order to take my medication."

"I buy meat on pension day and other things like beans, cabbage, rice and mealie meal."

"I eat mealie meal with imifino or cabbage at times. I am not sure whether this is balanced or not, as long as I eat."

“I am responsible for cooking meals in the house. Sometimes my daughter cooks when she is at home.”

“My grandchildren prepare meals for the house. They cook whatever is available in the house.”

The following were cited as solutions to starving: elderly people getting food on credit from the nearest shops, borrowing food items from neighbours, waiting for the next pension day, waiting for the children to bring money home otherwise living on imifino (greens that grow from the garden on their own), as the quotes suggest:

“*When there is no food in the house, I go out and pick imifino in the garden and cook it with mealie meal.”*

“Once the groceries are finished, I ask neighbours for a bowl of mealie meal and get imifino from the garden and cook for me and my grandchildren.”

“I ask the shop owner to give me food items on credit and pay when I get my pension money.”

“My children would bring whatever they can from their part-time jobs so that we are able to eat.”

Another factor noted was about the provision of elderly people services for their health conditions. There are a number of factors that the participants raised about elderly people health services, including the waiting time at the health service that is too long, the health service is short staffed or nurses are taking long to see patients.

Services for the elderly people are included under chronic conditions which involve all age groups. The participants believe that there should be services dedicated to them as elderly people. The fact that they wait in the same queue with all patients suffering from a variety of ailments including infections has a

negative impact on their QoL. Where conditions are of the same nature, like diabetes, elderly people get mixed with younger patients who cause a delay in them being attended to on time. They voiced out that they need respect and dignity as elderly people. The Department of Health adopted an integration of services model, which offers a basket of all services in one space which makes services for elderly people to suffer as per the findings below:

"I wake up early to go to the clinic for my monthly treatment but I sit there till the afternoon as no one bothers whether I am hungry or not. We get mixed with all sorts of people, young and middle aged. There is no distinction between young and old in the chronic line I feel that we are not given the dignity and respect as senior people in the community."

Some of the challenges reported were travelling long distances to the clinic only to be told that there is no treatment. The use of little money they have to pay a taxi for nothing, contributes negatively towards QoL of an elderly people, as per the quote below:

"I pay R16.00 for the taxi to go to the clinic and when I get there to be told that there is no treatment. I get frustrated for using my money and also the fact that I will go for a week or two with no medication for my hypertension, it's very bad. This is because I get sick and sleep the whole week and not attend to my house chores."

A critical issue that impacts on the health status of elderly people is the belief in the use of traditional medicine. Most participants had a belief that using traditional medicine helps as they are old, yet they are not sure of the harm this can cause because the dose is not known and they sometimes forget the instructions. The other belief is that traditional medicine was there when their forefathers and foremothers were still alive, so they cannot live without traditional medicine and they use both traditional and clinic medication. The following quote portrays this finding:

"I attend the clinic on monthly basis to collect my medication for hypertension, but I also visit the traditional healer for traditional medicine because it's I believe in. My father taught me about the use of traditional medicine and I cannot live without."

Participants have indicated that if their clinic services are improved and become a stand-alone service and the way they are treated in the community improves, this will impact positively on their QoL. The participants voiced dissatisfaction about the way they get treated at the clinics, at times their blood pressures are not checked because the machine is either faulty or broken, yet they have travelled long distances to get to the clinic as per the quote below:

"I go to the clinic to collect my treatment for hypertension and only to be told that the machine is broken and I have already wasted money taking a taxi to and from the clinic, I really don't like this."

The services for chronic diseases are not well marketed within the community and even the participants indicated that they do not have or know of clubs in their communities. There are not aware of any NGOs available to support the activities of elderly people or where this is happening. Their observation is that NGO activities are arranged by people that are doing voluntary work which does not last for long and is not taken seriously. The following quote illustrates these results:

"I am not aware of any clubs in my community. I do not know what you are talking about."

"I am not aware of any NGO that help old people in my community, we sometimes go to the hall once in a while to play soccer, but those people who use to do that came for a short while and said they were doing this out of their good hearts to help us."

4.3.3 Theme 3: Psychological factors

The QoL and emotional experiences emerged as a category under this theme. Table 6 shows that QoL is related to and affected by the living conditions and the unpleasant environmental factors that affect the lives of elderly people in the community.

Table 6: The categories and sub-categories under psychological factors

Category	Sub-category
QoL.	• Beliefs that impact on living conditions and health status. • Unpleasant environmental factors.
Emotional experiences.	• Feelings of hopelessness and helplessness. • Feelings of stress.

QoL

Participants gave examples of poor living conditions, which included unemployed children and ill-health which had a significant influence on their QoL. The amount of money the participants' earned did not allow them to make ends meet. This is worse when the money gets taken away from them by their children who are unemployed, thus affecting them psychologically. The following quotes illustrate these findings of the study:

"This pension money is too little for me and my whole family and I am unable to make ends meet, as this is the only source of income."

"I get very sick every time I think of this, as my children are sitting at home, there are no jobs, this affects me dearly."

Emotional experiences

Participants explained their feelings of hopelessness, stress and helplessness as a result of a number of issues mentioned in the previous categories yet this affects them psychologically. Participants indicated that emotional stress is also caused by factors that include doing all house chores, yet there are children

and grandchildren who stay with them. The following quote illustrates the findings:

"I have a house full of children who sit and do nothing, they are not working, yet I still have to do house chores, this hurts me a lot…."

Another emotional factor that came out was the number of people that were staying under one roof and who sat and did nothing but waited to be fed with the pension money.

A 75 year old woman who lives with her children and grandchildren commented as follows:

"I stay with 10 people in a small house and everyone is supported with my pension money which is not enough for all of us and does not cover all my needs. My children sit and does nothing the whole day and I'm expected to feed them."

Another factor that contributed to emotional stress was when the pension money is used to buy alcohol and dagga and thus leaving a participant with no money, leading them to borrow from the neighbours or live on imifino.

A 65 year old woman who lives with her children that drink alcohol and smoke dagga expressed her feelings in the following words:

"My children would take my money and use it to buy alcohol and dagga."

The following quotes demonstrate participants' emotional experiences:

"*I end up with no money for food and live on imifino and also ask neighbours for food."*

"My life is very difficult because I can't make ends meet because of my children use my money for drinking and smoking. This is too much for me."

Stress is not unique to elderly people but and has a very negative effect on their QoL. Participants are affected by stress in many ways, it could be the environment where they live in, such as high level of noise in the middle of the night caused by the children who are drunk, as the following quote shows:

"I don't get a good sleep because of the children that come from taverns drunk and making loud noise."

The other stressful factor is the unemployment of the children that has come up many times and having to support the children and grandchildren and this affects their QoL, as the participants' own needs are not catered for. The elderly people also voiced that the responsibility of grandchildren whose parents have died, puts too much strain on their lives. The following quote demonstrates the participants feeling of stress:

"I support both my children and grandchildren, because my children are staying at home, not working."

"At my age, I am not enjoying life because it's difficult, I stay with all my grandchildren because their parents are no more and it is a full time job because I have to take care of them I am experiencing a lot of stress."

4.3.4 RESULTS FROM NGO CHAIRPERSONS

The results from the two chairpersons of the NGOs were based on the three themes that have been discussed which were the same as for the participants were as follows:

- Social well-being of the elderly people.
- Physiological factors.
- Psychological factors.

4.3.4.1 Social well-being of the elderly people

Harassment of elderly people

According to the chairpersons, it was important to point out that most of the elderly people still suffer a lot in terms of the lack of respect from their children and/or the community. One chairperson was quoted as follows:

"Old people in our communities still experience lack of being respected and harassment because their belongings like pension documents are taken by grandchildren and they end up not getting the money to themselves."

The chairperson continued to say that services for the elderly people within the community are not well advertised and it takes long for an elderly people to get support if he or she is in a crisis, as no one knows what to do or where to go in order to get help. This is where the NGO would act as a liaison between the elderly people and the clinic as well as with the community stakeholders in support of elderly people. The illustrative quote from the findings is as follows:

"We have a huge problem when an old person passes away and there is no one to bury her/him. The only thing we do as an NGO is to report the matter to the Induna, councillor through the war room, so that the municipality is informed and pays for the burial. This is because the services for elderly people are not well known to the community."

Safety and security

The chairperson informed the researcher that the elderly people are not safe in their own homes. The following quote demonstrates this point:

"As an NGO dealing with old people within this community, we still feel strongly about unsafe conditions of old people in the community, which is why we meet with tribal authorities to discuss issues of safety for old people in order for the community to take the initiative of protecting old people."

The other issue discussed related to crime in the community. The chairperson referred to the burial societies which are ripping off the old people of their pension money and they end up not paying for their burials when they pass away, as per the findings below:

"There are serious challenges with the burial schemes that operate at the pension points. They are ripping off the old people of the little money they get, because once an old person has passed away, they do not come forward and pay for the funeral and this ends up being a burden of the NGO and we report to municipality authorities. This matter has been taken to Indunas and Councillors several times."

4.3.4.2 Physiological factors

Finances

When the NGO chairpersons were questioned about this, they pointed out that old people have challenges in meeting their basic needs, as the money is too little to cover all their needs. The following quotes illustrate the findings:

"…We have noticed that old people do not enjoy their pension money, because the money goes towards paying for the needs of their grandchildren."

"The elderly people reported that the unemployment of their children contributes to the poor QoL, as they fail to fulfil all their needs and those of their grandchildren."

The chairpersons indicated that the socio-economic status of the elderly people is affected by their own children, who are not supportive, yet they have left the children to be cared for by the grandparents. The social grants available to the children are used up by their parents. The quotes below indicate the findings:

"The children of the elderly people get social grant but do not fulfil the needs of their children, leaving the burden with their parents. They take the money and spend it on boyfriends or vice versa."

"These children collect the grant money and leave home, not support to their children and their parents are left with the problem of attending to the needs of the grandchildren."

Living conditions

The participants' health conditions, unemployed children and the food supplies were an area of concern. This is indicated with the following quotes:

"As NGOs we get the chronic medication for the elderly people from the clinic and prepare it for collection on monthly basis, though it is not for old people only, but we try and separate from the young chronic patients."

"We collect the medication out of our own free will, this is supposed to happen constantly, as we have seen the need for it, but we do not know from Department of Health."

The fact is that there are insufficient food supplies within the home as a chairperson pointed out during the interview:

"Most old people go hunger in the community and as an NGO we give food parcels to alleviate the hunger, it is a big problem as they end up malnourished if they do not get any meals."

"Sometimes we find old people reporting that they have not had any meals for two days."

4.3.4.3 Psychological factors

QoL

The chairpersons reported that most elderly people come to them not only to access medications, but also for counselling as they have personal problems especially at home with their children and grandchildren. They were quoted as follows:

"One finds old people visiting us not for treatment collection, but to talk about their problems within the homes, especially unemployed children, grandchildren's' needs, food supplies. They always need someone to talk to. This is where we come in and give counselling."

The Chairperson pointed out that the participants are challenged by many things both environmentally and psychologically. The participants are exposed to environmental problems because some have houses built next to industries and they suffer from different ailments due to fumes. This has a negative impact on their health status. This is what the chairpersons said:

"Elderly people have problems of fumes from industries nearby and they end up with chest problems. Some are looking after grandchildren who are very sick and who have not disclosed what they are suffering from and this has a negative impact on the life of an old person."

The NGOs give support to elderly people by organising support groups where they meet to talk, exercise and play in an aid to improve their QoL. Also what is important is the support NGOs offer during the pension days where elderly people would stand in queues for hours waiting for their grant. Some will collapse because of the heat and hunger. They will bring marquees and chairs for elders to sit whilst they wait. The quotes below indicate the findings from the chairpersons:

"We want old people to have that sense of belonging, which is why we have support groups not for educating them, but where they have time to sit and talk to other old people, share stories and challenges."

"We have started games and exercise classes for old people, although this does not happen all the times, because old people are not used to this."

"My NGO has realised that some pension points have no shelter and old people would collapse due to heat and standing for long hours and having not eaten anything. We provide marquees and chairs for old people to sit comfortably."

Emotional stress

The other important factor under this theme is the emotional experiences of the elderly people, like stress caused by several issues. This has already been mentioned and it is related to a number of factors.

The elders discuss these matters amongst themselves especially during funeral gatherings.

"All my money gets taken by the burial society and I end up with nothing, yet these people do not pay your money back when you pass away."

The chairpersons also pointed out that the QoL for the elderly people gets compromised because old age services are not taken seriously. The community does not know about the importance of this.

"Old people suffer a lot because the community does not understand the services offered to elderly people and this way, elderly people are not taken seriously by community members."

4.3.5 AUDIT RESULTS OF THE CHRONIC CLUBS

The audit checklist was formulated based on what was required based on the Department of Health Information System, as currently there are no indicators for elderly people specifically. The indicators that appear on DHIS are for all chronic conditions and not specifying the age, especially the elderly people. The audits were conducted in the two chronic clubs in the sub-district. Table 7 shows the activities and the answers when the audits were conducted in both sub-districts. The NGOs act as links between the elderly people and the clinic and these NGOs are used as a chronic club sites where elderly people would collect their medication on monthly basis.

Table 7: Audit tool used in chronic clubs

	Question/Activity	Answers
1	Check if there is an existing club register.	The registers at chronic clubs are not the same as the one at district office. There is no consistency.
2	How often is it used?	This register is only used monthly, yet the chronic patients visit the club every second week for checks, the CCGs only record when treatment is issued, but not for regular checks. This means that the record is for the treatment only.
3	Activities taking place within the club to benefit elderly people.	Elderly people share experiences, pray together and do hand work. These activities are not recorded anywhere, yet are very important.
4	Check if names and addresses of the members completed.	The register is completed by a non-clinical person at the club (CCG).
5	How often is the register updated?	The register was found incomplete and not updated.
6	Look for the conditions that the individual filled.	There is no list of chronic conditions, only a space for patient to sign when they collect treatment.
7	Check If the information is updated, how often, is it weekly, monthly or not filled.	The information is not updated
8	The vital signs monitoring if it is done, i.e. BP, HGT, etc.	Reviews are done at the clinic every 6 months, no update on the register.
9	Check if there screening for complications related to each condition on the register.	There is no screening done or recorded.
10	What other information is captured in the register, e.g. (intersectoral collaboration).	Nothing besides the signature line.
11	Number of deaths recorded for the past year.	There is no record of the number of deaths.
12	Causes of deaths.	There is no record of the causes of death.
13	How many people have changed or stopped treatment in the past year because of improvement in their condition?	No record of people who either changed or stopped treatment when the condition improved.
14	How many people have changed treatment in the past year because of their condition getting worse?	No record of people who either changed or stopped treatment when the condition deteriorated.
15	Total number of geriatrics in the club in the past year.	The number of elders attending the chronic club was only noted by the signatures that were counted on monthly basis after treatment has been collected.

The clubs had no records of the activities conducted on elderly people, only name and medication collected was recorded. It was noted also that the clubs lacked resources and therefore elderly people were not checked for vital signs.

Resources, in terms of machines, for taking blood pressure, checking sugar levels and training for CCGs is a requirement. The register that was found was not helpful especially considering that it is the only indicator that is collected at district for chronic diseases.

4.3.6 RESULTS FROM THE DISTRICT PROGRAMME MANAGER

The programme manager is the only responsible person at district level for ICDM and non-communicable activities. The interview was based on establishing the activities conducted for the elderly people in order to improve their QoL. The researcher wanted to establish what is available, how elderly people services can be strengthened and what needs to be done if there is no support for the elderly people to enhance their QoL. Upon being asked about the services for elderly people, the programme manager indicated that the services were not consistent and not monitored because of challenges in the facilities. She was quoted as follows:

"Group activities / exercises are done if and when we can; sometimes this does not take place if we are pressed with time because the staff members are not enough to carry out the activities."

Some of the issues that were indicated by participants are reflected in the answers by the district programme manager, for instance the knowledge about chronic clubs which are not known to the participants and the community. The programme manager informed the researcher that the clubs are new and have recently been started. The clubs are supposedly to be run by Department of Social Development not the Department of Health. This has an important impact on the QoL for elderly people because if the clubs were well run, elderly people would not wait in long queues at clinics. They would collect their treatment at the nearby club. The programme manager was quoted as saying:

"Chronic clubs are fairly new and this model is still on pilot by provincial government, to see if they should be linked with Department of Social Development or Department of Health."

"Nurses fail to give preference to old people because they are short staffed and this leads to old people waiting for hours to be seen and to collect their treatment."

"The chronic clubs are new and there is still a need to register them with Department of Social Development so that there is compliance and be linked with clinics."

More information given by the district programme manager tallies with the results found by the researcher upon conducting audits at the clubs that were visited. The records that are filled by CCGs are not monitored, as per the quote below:

"There are lots of records that need to be filled and this is a big challenge for the CCGs and the records end up incomplete."

"The clubs are not monitored to check if they are functional or not."

When the district programme manager was asked about the main recipients of the service, she indicated that recipients are all those with both communicable conditions including HIV/AIDS, TB and non-communicable conditions in all age groups from a young age to old. This is a problem, as this meant that there are no stand-alone services for elderly people, which is a challenge.

The Department of Health has integrated services at the PHC level and therefore elderly people are not offered a service on their own. This brings about a challenge of collecting data relating to elderly people, as there is not even a single indicator about elderly people on DHIS.
The programme manager gave the following information when she was asked about how data for the old people services is kept. She said:

"Keeping of data is poor, there is nothing standardised. The collection of data is done differently by different clubs and or clinics."

"The record that is found at the club has a signature part only which is for the person receiving chronic treatment."

"There is no standardised form and procedure for data recording."

"There is a new tool that province said districts should pilot and this is an integrated chronic disease management tool (ICDM). As the district we have not yet started with the pilot."

Another issue raised by the district programme manager was feedback that the district receives from the elderly people who are utilizing the clubs. It was mentioned that elderly people were happy using the clubs, as this helped them save money to go the clinic and the fact that they were not waiting in long queues, as it happens at the clinics. The findings are as follows:

"*Old people are impressed in terms of waiting time which has been cut down and get home quicker, saving on transport."*

One negative issue that was pointed out by the district programme manager was the staffing at the chronic clubs with CCGs who were unable to check BPs and diabetes:

"Where the team that goes to the chronic club does not have a nurse, elderly people do not get their BP and sugar checked."

The discussions continued with the programme manager on the chronic clubs and the health outcomes. The chronic clubs were found situated within walking distances of elderly people, but the services are not well established which makes it impossible to describe the health outcomes. The quote below illustrates what the programme manager indicated to support the above:

"The department is still looking at improving the service because of compliance issues, though it will not be for old people only. Some of the people

do not want to go to the clinic, especially old people because of long queues and the issue of transport money."

She continued to say that the department conducts games and other activities for elderly people in the community, but there is no consistency. This is due to lack of funds and the department would end up working with NGOs. The following quote illustrates the findings:

"The Department offers what they call 'golden games' for old people to compete on different sports, which is a form of exercise, but it's not in all communities. There are also activities like hand work, sharing of personal issues and prayer, thou it's not done regularly. The Department at times works with NGOs that offer their services voluntarily."

The manager believes that there are platforms created for old people to meet and share ideas, but this happens mostly in urban communities. Limited numbers of outreach teams pose challenges in getting information about old people and areas without chronic clubs, as per the quote below:

"There is still a challenge, as the outreach teams are not in all wards and as a district person, I face challenges in getting information about old people where they are and if there are clubs in those areas."

The manager felt that there is still work to be done in order to improve the lives of the elderly people in the community, quoted as follows:

"A lot still needs to be done in promoting the lives of old people in rural communities, so that an impact is felt on what we do to support old people. It is still in the early days."

4.4 SUMMARY OF THE CHAPTER

Chapter 4 discussed the experiences of elderly people, comments from NGO chairpersons regarding the work they do in the community to promote QoL for elderly people as well as activities conducted by the Programme Manager in dealing with elderly people issues. The findings of the research study were supported by means of themes, categories and sub-categories that were explored and revealed. The majority of participants commented on several issues affecting their QoL, such as emotional stress, lack of respect, lack of food supplies, poor living conditions, looking after grandchildren with pension money, as their children are unemployed as well as lack of elderly people services in the community. Participants explained how these had a significant influence on the QoL. Living under difficult circumstances with shortage of resources was stressful for elderly people. These are the factors that contributed to QoL be it positively or negatively.

The next chapter (chapter 5) will address the discussion of the key findingas presented in this chapter.

CHAPTER 5 : DISCUSSION OF RESULTS

5.1 INTRODUCTION

In the previous chapter, the results were presented and this chapter focuses on the discussion of the results. The discussion of the findings is guided by the study objectives described in the first chapter, Maslow's hierarchy of needs, as well as the themes that emerged from the analysis of the elderly people, NGO chairpersons and the District Programme Manager. The researcher provided descriptions of what the participants indicated in the discussions and the quotes that were illustrative of the themes. There were comments regarding the new knowledge generated by the study which was provided by the researcher and included in promoting the QoL of the elderly people. The discussions highlighted the relationship between the evidence provided by literature review and the results obtained from this study. The researcher will now discuss the specific implications of the findings regarding the QoL of the elderly people, integration the implications to the existing literature, hence the credibility of the interpretations of the findings.

5.2 OVERVIEW OF RESEARCH DISCUSSIONS

The study sought to develop a model that will improve the QoL for elderly people living at uMhlathuze and uMlalazi sub-districts of UThungulu district, KZN.

In this study, three major themes were identified, namely:

THEME 1: Social well-being of the elderly people.

THEME 2: Physiological factors.

THEME 3: Psychological factors.

The findings in this study revealed that the factors contributing to either poor or improved the QoL for elderly people included what has been discussed under social well-being physiological, psychological and environmental. Elderly people as members of their own communities, interact with each other all the time. The negative experiences in their social interaction could be detrimental to their social well-being. As human beings who are holistic beings and have a combination of the above factors, it was apparent that given the opportunity to express their views, the elderly had definite opinions on what they thought constituted QoL, what mattered most and what both brought quality into their lives. This suggested that these elderly people were in fact the experts on their own QoL and ageing (Farquhar 1995: 1442).

The above finding agrees with research that was conducted in Limpopo, South Africa which indicated that QoL is dependent on physical elements, emotional factors, spiritual components and relationship with others (Murdaugh 1998: 59). The study noted that QoL is a function of the interplay and balancing of all the factors involved, especially those that are health related (Ferrans 1996: 293).

Hendry and McVittie (2004: 961) found that elderly people were clearly willing to talk about QoL matter. Participants in that study viewed QoL as being a good people, focusing on day-to-day life, trying to keep healthy, live with loss, looking at the future, and being the age they are. These views were closely interlinked (Hendry and McVittie 2004: 962).

5.3 SOCIAL WELL-BEING OF THE ELDERLY PEOPLE

5.3.1 Harassment of elderly people

The findings of the study as indicate that elderly people in this particular rural community feel that they are not well taken care of by either relatives or neighbours. They experience harassment where their belongings are taken from them without permission or their property taken without their consent. A study that was conducted in Berlin supports the above findings, where participants indicated they experienced material abuse where their personal

belongings and possessions were vandalized and destroyed. This implied that their property was sometimes used unlawfully. This type of harassment occurred primarily in participants' own homes and caused them a great deal of distress (Hightower, Smith and Hightower 2006: 205).

A study conducted in Dublin, where elderly people experienced abuse by community members taking or using their property without consent and even denied support by own children and neighbours is in support of the findings of this study (Naughton *et al.* 2010). Elderly people verbalised that they experienced verbal abuse from their own children, grandchildren and from the neighbours' children after alcohol consumption, coming home late hours of the night making noise, which disturbs their sleep. The above findings are suggestive of the lack of respect shown to the elderly people by the neighbours, their children and relatives. Besides the above, there is also crime committed by the community members and this goes un-reported. Even when elderly people report, no action gets taken, because they are not taken seriously, due to a lack of respect and recognition. These findings concur with those in the study by Naughton *et al.* (2010), that elderly people are being harassed by community members and do not have a platform for support.

A study in New Zealand showed a different perspective as neighbours take responsibility to care for elderly and their relationships are good (Wilhelmson *et al.* 2005: 585). A Singapore study also supports the fact that elderly people do receive care and support from their neighbours (Kau and Wang 1995:71). A positive perspective is also reported from a study in Northern Ireland, with a positive view of the care and support that is given to elderly people, as they feel valued by community members (Scharf and Bartlam 2006: 254).

Chappell (2003: 127) investigated the perception of QoL amongst elderly people in the United Kingdom and found that having good relationships with children, family, friends and neighbours, were the most frequently mentioned by the elderly people participants as key factors to a good QoL. This is also noted in places such as Australia, Japan and Canada which corroborates the

argument that social support is a key component in enhancing elderly people's QoL.

What emanated from the NGO chairpersons is that there is lack of respect shown to elderly people in the communities. They are aware of the harassment that happens to the elderly people and these incidents have been reported to the Chiefs, Indunas and Councillors in the community. The NGO chairpersons felt that there is a need to promote QoL for the elderly people by ensuring that there is a strong NGO support to promote the QoL of the elderly people in the communities and to work with all relevant community stakeholders.

Another finding from the NGO chairpersons was regarding poor understanding of elderly services by the community which led to poor support. Only a few people have information about the elderly services. The NGOs have taken an initiative to give support where they can, as long as funding is available. Northern Ireland talks about services that are available for the elderly people to promote QoL; their services in rural communities is far more advanced than what can be found in the rural communities of uThungulu (Heenan 2006: 380).

The findings regarding provision of elderly people services, were that community members are not aware or do not have knowledge of the services offered for the elderly people. This led to lack of support for the elderly people which contribute negatively to their QoL. There is also a need for elderly people services as indicated by a study that was conducted in Australia (Taylor 2006: 6). In that study the elderly participants also indicated that they are not aware of the services offered for them in the community, like NGOs that promote and support their activities. Some had knowledge, although it was not much. There is nothing done to support the elderly people and this compromises their QoL.
In conclusion it emerged from this study that the evidence generated from the work by NGO chairpersons will contribute to an informed decision regarding the need to improve QoL so that there is no harassment of elderly people and improved respect and recognition by society. The fact that there is lack of knowledge regarding the services available in the community for the elderly

people, led to NGO chairpersons taking a decision to strongly support elderly people within the communities in order to promote their QoL. This study is from Northern Ireland and can be used as the best practice from where elderly people have all the services in their rural communities as prescribed by their government (Heenan 2006: 378).

5.3.2 Safety and security

The findings under safety and security of the elderly people in the community refer to unsafe conditions within their homes because of unruly children, and neighbours that do not take notice of the elderly people. Elderly people felt unsafe in their own homes with their own children who drank, took their pension money and left the elderly people with no money for food and this impacted on their QoL. Elderly people who stayed alone experienced unsafe conditions, as they were subjected to terrible conditions.

The above findings are supported by a study that was conducted in Dublin, where elderly people were abused by their own children and neighbours who drank alcohol and abused them; they felt unsafe. The elderly people in Dublin blamed themselves for this, relating it to their upbringing, especially as a boy child (Hightower, Smith and Hightower 2006: 206).

Some of the elements mentioned are intertwined with a high level of unemployment, leading to abuse of alcohol, using the elderly people's pension money. All these contribute to poor QoL of elderly people. The findings could have been different and promote the safe conditions of elderly people as indicated in a survey that was conducted by Michigan University in Detroit, which looked at the safe conditions of elderly people and pointed out the importance of sustainable living within the aged in the community (Lehning, Smith and Dunke 2013: 80).

There are some positive findings from the NGO chairpersons about unsafe conditions and poor security of elderly people where the elderly people are in support groups where they report a number of challenges they face in their

homes and in the community. Counselling is offered to the elderly people during support group sessions. This is supported by a study in Dublin which highlights the barriers faced by elderly people in seeking help. Importantly the emphasis is on providing counseling and group support to elderly people who have been abused, or subjected to unsafe conditions. It is acknowledged that some elderly people may find difficulties in accessing support services because of the isolated rural areas they live in (Pritchard 2000:13). These issues should be brought to the attention of the district, for support for people in need of it.

The study is supported by the findings of a study which was conducted in Limpopo which explored the ability of support groups to attract people and their effectiveness especially for elderly people. The findings of this study revealed that the support groups helped to reduce isolation and improve QoL and should form part of essential health services especially for elderly people (Crook *et al.* 2005: 39). In conclusion, the NGO chairpersons felt that there is a need to formulate indicators that will help sustain the liveable experiences of the aging society in our country, as this is noted by the study conducted by Michigan University (Lehning, Smith and Dunke 2013: 82).

5.4 PHYSIOLOGICAL FACTORS

5.4.1 Finances

These are the physical findings relating to financial difficulties in rural communities and the pension money that is not enough is supported by studies that have been conducted by various researchers. This study found that elderly people are still responsible for educating their grandchildren, yet they are supposed to be taken care of. The grandchildren stay with elderly people they become their responsibility in terms of basic needs, as their own parents are unemployed and relying on the elderly people. The study conducted in Ireland supports these findings where the Irish community has high numbers of unemployed young people and elderly people are responsibility for everything in the household (Scharf and Bartlam 2006: 255). A study in Dublin supports these findings, as elderly people there are also subjected to financial abuse,

because their financial security is compromised due to abuse (Naughton *et al.* 2010).

The above factors contribute to poor living conditions, as elderly people fail to renovate their own homes mainly because they do not have enough money to do so. These factors impact negatively on the QoL of elderly people, as supported by a study that was conducted in Kosovo rural community by Moalla-Fetini *et al.* (2005: 1). The research was based on the socio-economic status of elderly people in the community which was low as the households were headed by pensioners. The experiences shared in the study are the same challenges as in uThungulu district communities where the current study has been conducted, that is, a high level of unemployment amongst youth, the pension money that elders receive is too small to cover all their needs, poverty levels that are very high *(*Moalla-Fetini *et al.* 2005: 1).

A study that supports the findings of this study was conducted in Sharpeville, South Africa and its focus was on the socio-demographic and health profile, which included nutritional status, of elderly people. The findings were that the socio-economic status of the participants was poor, 80% participants reported a shortage of funds for basic household needs and this confirmed the presence of food insecurity and inability to attend to the basic needs of their families (Van Rooyen *et al.* 2000: 780).

The findings from the NGO chairpersons' perspective indicate that elderly people have a burden of supporting their unemployed children with the pension money received on monthly basis. This is extended to grandchildren who are left with them. The sad thing is that these children collect the social grant meant to support their own children and use it for alcohol. This is a general problem for the elderly people in the sub-Saharan Africa, as currently close to six million children are being looked after by elderly people with their pension money (Mallard 2007: 1).

The above findings are supported by a study that was conducted in Northern Ireland with rural elderly people who lived with their children and were living on the pension grant and or those who were still getting money from working on the farms to support everyone at home which was a struggle (Scharf and Bartlam 2006: 256). A study conducted in Canada showed a different view as elderly people felt that if they provide support to children or grandchildren this reduces depression especially when a person has never been married (McMullin and Marshall 1996: 355).

Findings pertaining to malnourished elderly people because of poor nutrients were noted. A study in the Netherlands supports these findings stating that elderly people with poor nutritional status were likely to have more difficulties in functioning independently in the community. Poor functional ability not only affects their productivity, but also their QoL (Chilima and Ismail 2001: 11).

This study found that long hours spend by elderly people at the pension point waiting for pay in the hot sunny weather contributes to sweating and loss of power. The NGOs made provision of marquees, chairs and water at the pension points. The matter has been escalated to the councillors and Induna.

Another factor related to malnutrition was the lack of food supplies in the household. The elderly person left home in the early hours of the morning with no food, hoping to get the pension pay out, but the money gets taken by children or they are told to come back the following month because of problems with the system. The findings of this study are supported by the study that was conducted in Sharpeville, South Africa, which confirmed that poverty, malnutrition (both under nutrition and over nutrition), as well as household food insecurity and poor health were the major problems observed in this elderly people community (Van Rooyen *et al.* 2000: 783). There is a different view from Ireland, because elderly people in Ireland reported that they had enough food supplies and were offered a balanced diet. (Heenan 2006: 379).

Another contributory factor to the above is from a study conducted in China which showed that elderly women were more likely to have lower pensions than men after their retirement and thus had a higher risk of poverty. In 2004, the poverty rate for elderly females aged over 60 living in urban China was high compared to elderly people men (Yang and Wang 2010: 22). NGOs have arrangements to provide food parcels to those who need them.

5.4.2 Living conditions

The findings related to living conditions show that the lives of the elderly people are at risk through leaking and falling roofs. These were not conducive to QoL. The findings are supported by a Northern Ireland study where old people were concerned about the worst conditions yet in the twentieth century (Cloke, Millbourne and Thomac 1997: 210).

In areas like New Zealand elderly people indicated that they were relying on their children for financial support and on accessing financial support from government. This led to a public debate as this support was abused. There were concerns, as some had made little economic contribution to the country's social benefit scheme. However, some participants believed that they made an indirect contribution to the country by looking after their grandchildren and doing unpaid housework for their children's households (Bennett 2012:1).

Another finding under this topic was about house chores, where an elderly person would collect and burn garbage although grandchildren could help when they are back from school. In some instances this was reported as a form of exercise for elderly people and had a positive impact on QoL, but the elderly felt it was too much for their age especially on a daily basis (Mowlam *et al.* 2007: 42). Bowling and Gabriel (2004: 10) report that in Britain elderly people appreciated the practical help that grandchildren could provide.

The toilet facilities were found to be challenging and unsafe, as there were no proper toilets and a hole had to be dug and in most cases elderly people fall, injuring themselves. These findings show that rural elderly people experience

poor living conditions which contribute to poor QoL. This is supported by the comments from old people who live in the rural area of Ireland who felt neglected and ignored because they were old and lived in rural areas and were treated as second class citizens (Cloke, Millbourne and Thomac 1997: 219).

The only services that elderly people were aware of, was the burial schemes and stokvels which they reported to be helping them, although at times they were charged a lot of money. Instead of the scheme supporting the elderly people, although they felt that they were being abused by the people who were running the schemes. There are elderly people who have not benefitted from burial schemes, when they are being told they owed a lot of money towards the scheme, yet monthly they have been contributing.

The view from Ireland was that elderly specific services were being offered, such as bus rides for elderly people, transport being essential to meet their needs (Glasgow and Blakley 2000: 95). Another study that supports the services rendered for the elderly people was conducted by in the University of Michigan where a number of services were provided for elderly people, irrespective of whether they were from rural or urban communities (CDC 2003: 489).

Another finding relates to health conditions of elderly people which was important, as most elderly people suffer from chronic conditions. The types of chronic conditions are shown on Table 2 of Chapter 4, and can be as result of /made worse by stress and old age. The Dublin study by Naughton *et al*. (2010) showed that different forms of abuse led to elderly people suffering from health conditions such as high blood pressure and stress, which led a negative impact on QoL of elderly people. The findings of a study on age and health in America indicated that chronic conditions have a negative impact on the health of elderly people and diminishes the QoL for elderly people (Holtzman and Anderson 2012: 103).

Another support to the findings above is from a study by Gabriel and Bowling (2004: 676) to the impact of both positive and negative experience on the QoL of older people. Chronic health conditions among elderly people were noted as detracting from QoL in terms of decreased functional ability. However, the negative impact of either present or anticipated ill-health was mitigated to some degree by the positive QoL experiences in their lives. Participants that were exposed to exercise and soccer playing were highly motivated to keep healthy, which meant they were adopting a positive attitude to their old age. Having good health has been identified by researchers as being a key constituent of QoL for older people (Gabriel and Bowling 2004: 676).

In South Africa, the Department of Health developed chronic clubs in communities as part of the integrated chronic disease management (ICDM) programme to support people including elderly people who are taking chronic medication so that they continue to live long (Department of Health 2011a: 35). This is a new concept that has not taken up very well in the communities. Elderly people are not aware of this service and those who are aware are worried that the service is for all the people with chronic conditions including those of a young age. The concept is good but it is not helping elderly people, as they feel a need for a stand-alone service for them both at a health facility and community level. Developed countries already have stand-alone old age services that are called geriatric services which benefit old people in strengthening coordination and effectiveness of efforts to improve health and QoL for people with chronic conditions (Heenan 2006: 391).

In conclusion regarding the living conditions that affected the QoL of the elderly people, the matter was escalated to the community stakeholders and municipality through the platform called Operation Sukuma Sakhe (OSS). This platform is where all government departments, traditional leaders and councillors meet on a monthly basis to discuss community challenges and different departments address issues relevant to them. This helps in speeding up the activities including those of elderly people (KZN Flagship Project

Operation Sukuma Sakhe 2011).

5.5 PSYCHOLOGICAL FACTORS

5.5.1 QoL

The findings of the study are demonstrated by stories from elderly people that QoL is very much influenced by poor living conditions, poor socio-economic conditions, which include lack of finances, insufficient food items and poor health status. For the elderly people to improve the QoL there are certain things that need to be addressed either in the community or by government, which include improving living conditions, socio-economic circumstances, health status and environmental conditions. These are illustrated under HRQoL included in the interview guide. The study in Northern Ireland supports the notion that QoL in elderly people should be linked to good health, good family support, sense of security and belonging, as critical needs according to Maslow's Hierarchy of needs (Scharf and Bartlam 2006: 256).

Findings related to health status of the elderly people were found to be compromised because of issues, such as using traditional medicine which are not scientifically tested and of unknown dosage. Elderly people argue that these medicines were used by their forefathers and foremothers and it is difficult to let go of them, besides which they suffer from chronic conditions. These findings are supported by the Vietnam study on rural communities with the focus on health, socio-economic inequalities, health status and QoL of elderly people. Limitations were found on access to health services which contribute to poor health status of elderly people which led to poor QoL (Lim *et al*. 2007: 184). Also in Dublin, where elderly people had poor health status due to abuse, the impact on physical health as a whole affected the elderly people (Mowlam *et al.* (2007: 46).

The experience in Northern Ireland is instructive, where in rural communities, there are volunteers called home care workers who help the old people with basic needs, like washing, cooking and cleaning. The communities of old

people in Ireland rely on social security benefits because these offer old people delivery of meals and other benefits. This is not the case in South Africa, as the situation is different, as whatever help there is comes from NGOs as indicated in this study (Heenan 2006: 381).

The suggestions from the chairpersons of the NGO were a voluntary platform created to support elderly people. This would be ideal if the district can continue to strengthen the support to elderly people through support groups. These would include food parcels, physical activities in the form of soccer play for both males and females. This way QoL will be enhanced, especially in rural communities. Another suggestion that sought to improve the QoL by NGOs was the need for cooked meals offered to elderly people at pension points as most elderly people collapse whilst waiting due to hunger. It is important that departments communicate through OSS for service integration in order to uplift the standard of living of elderly people. This is indicated in the Integrated Development Plan of the district, implementation of services and monitoring to improve QoL for the community as a whole (KZN Flagship: 2011).

5.5.2 Emotional experiences

The contributory factors to this topic were feelings of hopelessness and helplessness, due to the high levels of harassment as mentioned in Theme 1, category 1. Furthermore, elderly people suffer the above because money gets taken away from them, the inability to support themselves, and the high level of unemployment and substance abuse by their children. A study conducted in Dublin supports the above findings where elderly people experience a feeling of emptiness and anxiety due to harassment by either neighbours or their own children (Naughton *et al.* 2010). A study that differs from this took place in Berlin which noted that old people with high QoL have improved social relations that have a positive impact on their emotional well-being (Bowling and Gabriel 2004: 35).

The NGO chairpersons shared the feeling that elderly people have lots of problems that are personal and some are addressed in the chronic clubs during

counselling sessions. NGOs offer a platform where elderly people are able to share ideas amongst themselves and give each other support. A study in Norway indicates that elderly people did not want to make demands on people. They wanted a constructive dialogue about their health (Brock 1993: 96).

5.6 AUDITS

The audits showed that there is a lack of training among the CCGs responsible for the clubs, and there is a need to develop indicators that will help improve the QoL of elderly people. These indicators around socio-economic, health and living conditions, to measure people's living conditions and life quality must consider the individual's own experience, as mentioned in a study conducted in New Zealand (Delhey *et al.* 2002: 161).

5.7 THE DISTRICT PROGRAMME MANAGER FINDINGS

The main reflection from the manager was on the chronic clubs that were not fully functional as per the ICDM. Currently clubs are not meant for elderly people only, but are used by all people with chronic conditions. There is a need for elderly people services to be exclusive in order to improve on the QoL, as mentioned earlier on this chapter. In as far as the indicators are concerned the manager, mentioned that there is nothing that is on DHIS with regards to the elderly people specific issues, only one indicator on the chronic illnesses which are grouped for everybody (Department of Health 2011a: 37). There is a need to formulate a working structure for the chronic clubs, link it to the health services, develop a model that is user-friendly and build a set of indicators that will address elderly people activities (Department of Health 2011a: 57). Through OSS, there should be promotion of services for elderly people and integration of services and feedback by the departments using the OSS platform and in this way the QoL for elderly people in rural areas will be promoted.

5.8 APPLICATION OF THE FINDINGS TO MASLOW'S HIERACHY OF NEEDS

Maslow's Hierarchy of needs was used as a point of departure in this study to establish some of the needs for elderly people that were unmet which impact negatively on QoL. For QoL in elderly people to be improved, there are a number of factors to consider, such as understanding that elderly people are individuals with a combination of physical, spiritual and social needs. The themes that emerged from the narratives were related to elderly people's physical, psychological and social well-being. It became clear that it was not a single need that influenced the participant's unmet needs but they are related to their holistic well-being which has an influence on QoL.

Maslow argued that human beings have innate desires to satisfy a given set of needs, which are arranged in a hierarchy of importance, with the most basic needs at the bottom of the hierarchy (Moorhead and Griffin 1995: 400). Maslow's hierarchy of needs is depicted on five levels (Figure 1 in chapter 2), where three sets of needs at the bottom are called deficiency needs because they must be satisfied for the individual to be fundamentally comfortable and are the most important ones for elderly people in this study. This has a bearing on QoL of elderly people as some needs are not met, thus affecting their lives. The top two sets of needs are termed growth needs because they focus on personal growth and development which are not that important for elderly people (Maslow 1998: 60).

The hierarchy of human needs includes physical, safety, social, esteem and self-actualisation needs. The theory posits that lower-level needs have to be satisfied before attention can be paid to higher level needs. In this study it was found that unmet needs on the lower level had an influence on QoL of elderly people. These were unmet physical needs which also impacted negatively on elderly people's psychological well-being (Hagerty 1999: 249).

5.9 SUMMARY

There is still a long way to go in improving the QoL of elderly people in rural communities. The Chronic Disease Model from Department of Health needs to be reviewed because it was done as a pilot but not fully implemented. The study will bring about a user-friendly model that will incorporate all the needs of the elderly people to be used for the whole country. The study will contribute immensely towards the support of rural communities on the health, social and environmental status of the elderly people.

The next chapter (chapter 6) show will give details on the model developed to improve the QoL for elderly people, especially in rural communities.

CHAPTER 6 : A MODEL TO IMPROVE THE QOL FOR ELDERLY PEOPLE LIVING IN A RURAL SETTING

6.1 INTRODUCTION

Upon completion of the analysis of the results and the discussions, the researcher gathered all the key notes that helped in formulating the model which will help elderly people in rural communities. This was despite the fact that there are model that have been developed in different countries to address QoL in general without focusing specifically at elderly people.

A model of QoL for elderly people has been proposed and developed using a multidimensional conceptual framework and is based on three elements. Each of these contain three sub-elements: physical, psychological and spiritual sub domains for being; physical, social and community sub domains for belonging; and practical, leisure and growth sub domains for becoming (Lawton *et al.* 1999: 169). What Lawton has indicated is not the same as the findings of this study, which is why there is a need to develop a model that will include all the needs of the elderly people, especially in rural communities. According to the authors, a person's QoL is determined by two factors linked to these domains: importance and enjoyment (Birren *et al.* 1991: 349). A study that was conducted on elderly people in Toronto found that the being domain had a disproportionate importance in the determination of QoL, particularly the physical sub domain (Raphael *et al.* 1997: 65). This shows that there is a need to improve on the QoL model for rural communities in South Africa.

6.2 MODELS DEVELOPED IN DIFFERENT COUNTRIES

There is a model that is only based on how people with long-term conditions will be identified and received care according to their needs as per the study conducted in England (Wagner 1998: 2). This author formulated a model called chronic care model which focuses on elderly people. This model has only been implemented in urban areas as its focus is on urban setting, yet rural

communities lack resources. Its focus is on chronic illnesses only not on QoL fully. It becomes impossible for rural communities such as South Africa to implement. He further worked on the expanded model, but the challenge with rural communities is still infrastructure and resources that are lacking. A model is needed that will fit with less resources and be formulated to meet the needs of elderly people (Barr, Robinson and Marin-Link. 2003: 73).

Another model called the public health model places emphasis on the determinants of disease, social, cultural and economic factors that impinge on quality of care and has elements which could make the chronic care programme succeed with being specific regarding elderly people issues only (Robles 2004: 194). This lacks specifics regarding the needs of elderly people which are mentioned by Maslow. Other models look at supporting elderly people only when they are terminally ill or when they are in nursing homes or hospitals (Feldman, Ploof and Cohen 1999: 111). The focus of this study is based on elderly people who were interviewed at pension points in the community, who are ambulant with an aim to improve the QoL within rural communities

Other models available in England, Scotland, and Wales, are found not to have descriptive or impact studies if compared to the frameworks used in other countries. Denmark, Italy, Germany and Netherlands involve remodeling institution-based long-term care into home-based and community-based services, but do not meet all the basic needs. (Stuart and Weinrich 2001: 474).

The WHO rates France's health system performance as number one out of 191 countries (Stuart and Weinrich 2001: 474). It has been suggested that France's attention to chronic care is one of the reasons that the country spends less than half the amount of the United States per capita on annual healthcare. The model used in France focuses on regional systems, population-based prevention, continuity of care, physician involvement in decision-making, and combining specialized medical care, assistive technology, and home support. These systems aim to make services more geographically accessible. However, it should be noted that the WHO's rankings are controversial, and a

number of features of the health care system in France are not consistent with other Models (Stuart and Weinrich 2001: 476). This is more reason that there should be continuous development of models to suit the needs of a specific country, for instance South Africa, for South Africans in rural communities.

The argument by Delhey (2002) on the composition of QoL model is that this should be approached in ways that are objective and subjective. The objective indicators assume that there are basic needs and that satisfying those needs determine one's QoL. Objective indicators include income, employment, social activity, housing ownership, health status, crime levels. (Boelhouwer, 2002: 113).

These indicators have been used in diverse disciplines. For example, Deiner and Seligman (2004: 2) used objective indicators for measuring the QoL of older people. However, measuring the QoL by using only these objective indicators can be criticized because "it can tell us only part of the story about the QoL" (Deiner, Lucas and Heliwell 2009: 315).

These days many scholars regard objective and subjective indicators as inter-dependent rather than mutually exclusive (Delhey *et al*. 2002: 164 and Deiner, Lucas and Heliwell 2009: 317). This means that it is apparent that QoL should be measured not only by objective but also subjective indicators, as per the research study that was conducted in Scotland by Hudler and Richter 2002: 217). Therefore, the multi-dimensional model of the QoL which comprises both objective and subjective dimensions as indicated above only focus on one or two of the needs without looking at the elderly person as a whole. The researcher noted this, thus the new model that is being developed will suit the needs of rural communities in South Africa (Katz and Lowenstein 2003: 131).

Therefore, it can be said that the indicators to be used for this model should be aligned to the themes and categories of this study in order to improve the QoL of elderly people in a way which meets the needs of elderly peoples and helps them attain what Maslow's hierarchy specifies.

An urban setting model raised an argument regarding QoL for elderly people that there are certain things that have been attended to, such as illness and disability, while important elements such as personal control and the potential for change and improvement have been ignored (Carp and Carp 1984: 336). Therefore, it is not advisable to use this model, because it is urban based and there is no integration of services to meet all the needs of the elderly people.

Bohland and Davis (1979: 95) developed a model of residential satisfaction to assess the contribution of safety, neighborliness, physical condition and convenience to neighborhood satisfaction. They also evaluated the stability of relationships across different age groups. For the elderly people, they found a weak relationship between the satisfaction of elderly people with their neighborhood, and safety which is just one aspect, yet this research is looking at a number of factors in order to improve the QoL for elderly people (Carp and Carp 1984: 336). This model does not provide or give perspective as per the needs of elderly people, which is why the researcher aims to develop a model that will take care of elderly people holistically and be rural based.

Italy uses a service delivery model that has a focus on care in nursing homes, and residential areas. There is no high quality evaluation of this service delivery model available, but reports suggest that there should be improved QoL, decreased dependence on private resources, and growth of voluntary services (Ricciardi 1997: 167).

Germany, also uses a service delivery model that is focussed on evidence based guidelines and data sharing, with disease-specific programmes. The country has legislation to provide incentives for care providers that will help develop approaches to coordinate care for people with long term conditions which include risk-adjustment mechanisms (Guterman 2005: 1).

In the Netherlands, the government implemented components of the Chronic Care Model for a period of 10 years after which, they conceptualised their own model. The model is called Trans mural Care Programme and aims to bridge

the gap between hospital and community care, but there is conflicting evidence about its effectiveness (Temmink *et al.* 2001: 280).

Quite a number of service delivery models have been tested in New Zealand. The current one being used is an 'outcomes intervention' approach which illustrates the relationship between aetiology, interventions, and outputs. This is based on a 'Life Course' Model. Service delivery models are also being developed in Asia (Wellingham *et al.* 2005: 327).

In Singapore, the government proposed a new chronic care framework because of the models used in America which are focussed on managed care and the country is worried that this may confuse healthcare professionals working in Asia. The framework emphasises primary care and self-care, but has less emphasis on linkages. The model seems not to be effective for the QoL for elderly people (Cheah 2001: 990).

6.3 AIM OF THE MODEL

The aim of developing a model for this study is based on good practices that were conducted in countries such as United Kingdom, which can be used in the rural communities of South Africa. These good practices have been implemented; though their shortfall is that they are specific to one programme; they are not using an integrated approach (Mechanic 2004: 3). The model that is developed aims at improving the QoL for elderly people especially in rural communities and it is specifically designed for community based systems with the focus on the three themes and inputs from the district programme manager combined with the results of the audits. The model has a focus on Maslow's hierarchy of needs, themes and categories generated during the analysis that will help generate information which will show improvement on QoL and which will be different from other generic models and the impact thereof. The researcher asked the following based on the themes:

- What type of model for elderly people based on the themes can be formulated and be used in rural communities?

- What evidence is there about the impact of the model?
- What approaches are to be adopted by the Department of Health?
- What would be the difference between this new model and the ICDM that was piloted in uThungulu district?

The model can be defined as an overarching approach that describes the different elements needed to care effectively for elderly people who have negative experiences related to their social well-being, physiological and psychological factors.

This model that is developed is based on the findings of the study and how best to improve QoL for elderly people. It will outline the factors in relation to the experiences of elderly people based on social well-being, physiological and psychological well-being. These experiences are linked to the Maslow's hierarchy of needs as per the categories that came out during the analysis

Maslow's needs hierarchy (Maslow 1970: 62) consists of different forms of well-being which are the result of the satisfaction of needs by available environmental resources. There are two levels of need: lower-order or life-maintenance needs, and higher-order needs. The satisfaction of both types of needs is dependent on the congruence (similarity) between the needs of the individual (based on competence, personality or life style) and the resources offered by the environment (Maslow 1970: 68).

Arising from the current study the researcher perceives that social well-being focuses on improved respect and recognition, safety and security, physiological factors focusing on finances, ability to cater for basic needs, improved health status and living conditions, and psychological factors looking at QoL and a stress free environment. Working with all structures in government through created platforms should be considered in a model for improving the QoL for elderly people, especially in rural communities. This applied approach is from a representative sample of uThungulu district in two sub-districts of elderly people aged between 60 and 95 years.

Based on the preceding section, a new model is being proposed (Figure 4) for three reasons. First, as it will demonstrate, the belief that it is conceptually useful to link the formulated themes and categories with Maslow's hierarchy of needs and relevant stakeholders in order for the QoL of elderly people to improve. This will help to clarify the ambiguities identified on the ICDM that currently has gaps in focusing directly on the needs of elderly people. Second, the belief that it is vitally important to recognize what was referred to earlier as the link between the experiences of elderly people on QoL and their needs as it can be seen in this developed model. Finally, and related to the previous concern, is explicit connection in the model between the themes and the aspects of QoL which other models have inadequately addressed (or omitted altogether).

In the following paragraphs, the researcher will present a model of QoL for elderly people in rural communities of South Africa with the focus on social, physiological and psychological well-being. The proposed new model attempts to resolve, among others issues, the ambiguity in the QoL of elderly people as per literature discussed in the earlier part of the study. The efforts for the model to improve the QoL for elderly people will be to consider the following:

- Integrate services within the government departments through OSS which are Human Settlements, Home Affairs, DSD, DOH, Agriculture, Sports and Recreation.
- Use the themes that emerged together with Maslow's hierarchy of needs so that elderly people are cared for holistically.
- Have a model that is community based but has a link with the Department of Health.
- Have indicators on the DHIS specifically for elderly people activities to be reported from the community level, not only on chronic illnesses and treatment.

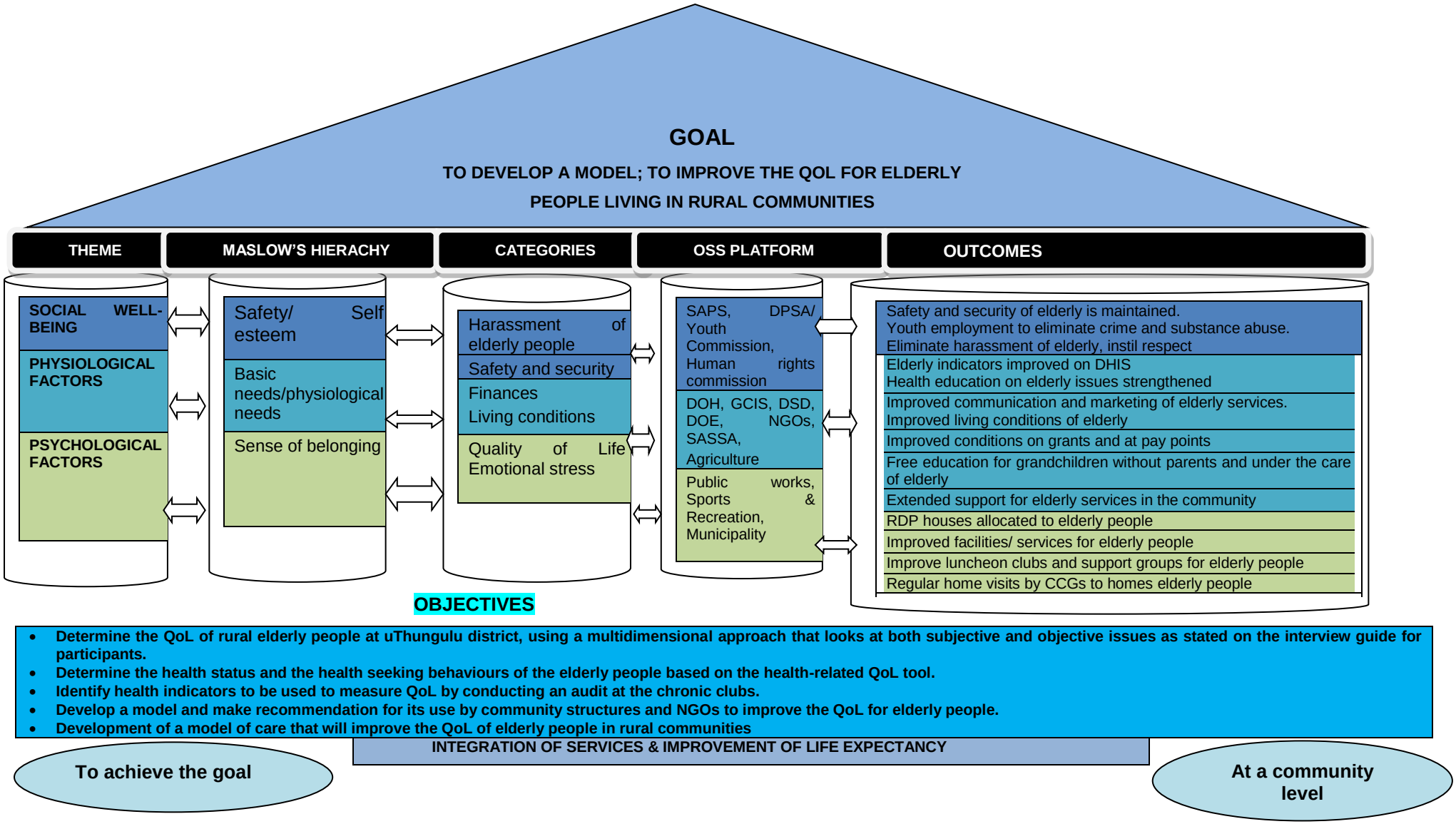

Figure 4: A model of care that will improve the QoL of elderly people in rural communities

6.4 MODEL IMPLEMENTATION

The implementation of the above model will be based on answering the questions as outlined in 6.3 of this chapter.

The model formulated has covered the social well-being, physiological and psychological factors of elderly people who are in the rural communities and the model can be used effectively by rural communities of South Africa. The multidimensional approach that looks at both subjective and objective issues for this study is stated originally in the interview guide for elderly people and consolidates the themes as mentioned.

Importantly, there is enough evidence to prove the importance of this model as one of the indications based on the safety elderly people, their health status, living conditions, and being able to cater for their own basic needs. The researcher looked critically at this because improved QoL is centered on a number of factors of which meeting basic needs leads to improved life expectancy of the rural communities.

For this model to work, certain approaches have to be used by DOH. The first one will be stand-alone services for elderly people, and to strengthen health education not just in relation to chronic conditions, but as a holistic package of services for elderly people. There should be health indicators to be used to measure QoL of elderly people and their use should be in both chronic clubs and health facilities. The provision of human resources that should be capacitated on issues affecting elderly people and their allocation at all service points in the communities.

This will help in addressing issues related to elderly people and improve on proper recording and submission to the district information system thereof. Currently the DHIS reports on just chronic conditions which are not age specific, yet there are a number of elderly specific matters that go unreported, such as living and health conditions, level of safety in the community, state of facilities and services required by elderly people.

6.5 SUMMARY OF THE CHAPTER

There are differences between the ICDM and this model, because the model is more on specific issues affecting elderly people, in rural communities as opposed to ICDM, which has a focus on chronic care in general irrespective of age. These are some of the gaps identified on the ICDM. What elderly people are experiencing regarding social well-being, physiological and psychological factors are important fixtures of this model and are specific to what affects elderly people with their daily living.

The model will therefore improve QoL with the consideration on the integration of services, improvement of life expectancy through the themes, Maslow's hierarchy of needs, working with different stakeholders, using OSS as the platform for different stakeholders in government and outside government.

Looking at the objectives, the activities and the expected outcomes in order to formulate indicators for DHIS, there was a need to assess and review the QoL of rural elderly people population at uThungulu district using a multidimensional approach as it has been considered in this study. Going forward, the activities reviewed, looking at the number of elderly people involved, number of clubs available to support activities of elderly people and the numbers of support groups were some of the important aspects that have been noted when the model was formulated.

The second objective of determining and reviewing the health status and the health seeking behaviour of the elderly people, the researcher was able to identify health indicators to be used to measure QoL which will then be used when conducting audits at the chronic clubs going forward. This way one is able to determine the elderly people with chronic conditions which are non-communicable, versus the communicable conditions.

Therefore there is a need to strengthen services for elderly people and conduct an intervention through community structures and NGOs to improve their QoL. This way the district will be able to monitor and tap on the NGO interventions as they

address elderly people's requirements, because of expanded resources, includes among those the CCGs training on elderly people activities and their presence in platforms such as OSS to report on the support rendered for the elderly people in the communities, as all government departments would be expected to do.

The next chapter (chapter 7) will focus on the conclusion, limitations and recommendations of the study.

CHAPTER 7 : CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

The previous chapter addressed the model formulation to improve the QoL for the elderly people. This chapter will focus on drawing conclusions. It will also describe the limitations of the study and recommendations for improving QoL for elderly people in rural communities. The conclusions, based on the research findings discussed in chapter 5 have been used towards the formulation of the model that will help improve the QoL for elderly people. Finally, the conclusions will ascertain whether the aim of the study, to develop the model that will improve the QoL for elderly people which was formulated in chapter 6, (Figure 4) was achieved.

7.2 LIMITATIONS

The findings of the study were limited by the fact that only 30 participants were interviewed. These participants were interviewed at pension pay out points only, not at their homes. The study did not include elderly people who are in the institutions. Participants were from rural communities in the two sub-districts of uThungulu district not the whole district because other sub-districts are semi-rural and others are urban. The majority of the participants were women than men, which is something to be considered for future studies to balance the numbers of the two genders. Therefore, the findings arising from the study cannot be generalised.

7.3 RECOMMENDATIONS

7.3.1 Recommendations for improving QoL for elderly people in rural communities

The following recommendations might improve QoL for elderly people especially those who are in rural settings, based on the model.

- Stand-alone geriatric services that are run by professional nurses, with the focus on elderly people only and offering all types of services not chronic care only.
- Linkages between the chronic clubs for elderly people with health facilities. The chronic clubs being specific to elderly people needs only.
- Improvement of data collection tools at community level for proper reporting at district level.
- Inclusion of indicators for elderly people activities on DHIS.
- More training is needed for nurses and other employees in essential services like social development, public works, agriculture on issues affecting the QoL of elderly people in the rural communities
- Strengthen training of CCGs in the communities to be able to help support elderly people, especially within the chronic clubs.
- Marketing of elderly people services in the community to improve life expectancy.
- Improve resources in the rural communities; suggestions as follows:
    - Safety of elderly people in the communities, work with Community Policing Forums and education of neighbours on the care of elderly people.
    - Regular visits by CCGs to the elderly people in their homes.
    - Support elderly people in financial education and skills to manage finances.
    - Improvement on infrastructure (Housing).
    - Improvement on health care for elderly people.
    - Provision of chairs and marquees at pension pay points or shades for elderly people for when it is hot and during rainy days.

7.3.2 Recommendations for further studies

A number of areas for further research have been identified as a result of the study. These are outlined below.

- A qualitative study on QoL for elderly people at institutions such as QoL for elderly people who are institutionalised in rural communities.
- A study of services offered at health centres to see if they are inclusive of the particular needs of elderly people.
- The best practice in linking government departments to support the care of elderly people in the community.
- Operation Sukuma Sakhe being the driver of integration of services for all government departments for improving QoL for rural communities.
- The QoL of elderly women in general
- The development of a model that will at the cultural perspective drawing on ethnographic approach.

7.4 SUMMARY OF THE STUDY

The aim of this study was to determine the QoL of the rural elderly people and ultimately to develop a model to improve the QoL for elderly people living at the uMhlathuze and uMlalazi sub-districts of the uThungulu district, KZN. The proposed model incorporates Maslow's hierarchy of needs especially those that affect elderly people and contribute to poor QoL if they are not met. The research produced information about social, economic, health and environmental factors in rural areas which will help in bringing issues of elderly people's QoL to public awareness. Themes emerged from the data analysis on the views of participants, NGO chairpersons and the district programme manager. This research will deepen the knowledge and skills of professionals on ageing issues, especially in rural areas/communities.

It was worth noting that services and programmes related to elderly people specifically should be in place in order to improve the QoL for elderly people. Finally, a model has been developed to improve the QoL through working with all stakeholders within and outside government to improve QoL for elderly people, especially in rural communities.

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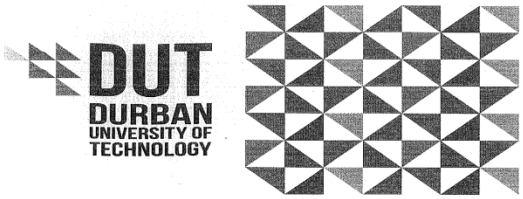
APPENDICES

Appendix 1: DUT Ethics clearance



Institutional Research Ethics Committee
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12 January 2015

IREC Reference Number: **REC 86/14**

Ms B A Ndlovu
No 9 Hyacinth Road
Ashley
Pinetown
3610

Dear Ms Ndlovu

A model to improve the Quality of Life for elderly living in a rural setting of uThungulu district, KwaZulu-Natal

The Institutional Research Ethics Committee acknowledges receipt of your final data collection tool for review.

We are pleased to inform you that the questionnaire has been APPROVED; you may now proceed with data collection on the proposed project.

Kindly ensure that participants used for the pilot study are not part of the main study.

Yours Sincerely

[redacted]

Professor J K Adam
Chairperson: IREC

Appendix 2a: Information letter for the District Manager and NGOs

Thank you for agreeing to participate in this study.

Title of the Research Study: A model of the quality of life for elderly people living in a rural setting of uThungulu district, KwaZulu-Natal.

Principal Investigator/s/researcher: Ms B.A. Ndlovu, M Tech: Nursing.

Co-Investigator/s/supervisor/s: Prof M.N. Sibiya, D Tech: Nursing (Supervisor), Prof T. Puckree, PhD (Co-supervisor).

Brief Introduction and Purpose of the Study: Quality of life for elderly people in rural communities is not taken seriously, especially their health status, as the South African government is trying its best to improve, but there are gaps. The purpose of the study is to develop a model of the quality of life for elderly people living at uMhlathuze and uMlalazi sub-districts at UThungulu district, KwaZulu-Natal.

Outline of the Procedures: I will ask you few questions on your experiences as a person that deals with elderly person issues. The interview will last between 20-30 minutes.

Risks or Discomforts to the Participant: There will be no risks involved.

Benefits: This will help improve the quality of life of elderly people living in rural communities. The research will deepen the knowledge and skills on ageing issues, become aware of the challenges of living in rural areas and add value in the training of health workers about factors affecting quality of life for elderly people focusing on their health status. This will eventually add value in the body of knowledge which will promote the quality of life hence improving the health status of elderly people in rural communities.

Reason/s why the Participant May Be Withdrawn from the Study: You are free to withdraw from the study at any time and there is no penalty that will be imposed on you.

Remuneration: There is no remuneration for participating in the study.

Costs of the Study: You will not bear any costs by participating in this study.

Confidentiality: All the information gathered during the study will be kept confidential. Your name will not be written on data collection sheets and the information that you give will be used for this study only. The paper based information will be kept in a locked cabinet and the electronic information will be secured with a private code that will only be known to the research.

Research-related Injury: There are no anticipated research-related injuries.

Persons to Contact in the Event of Any Problems or Queries:
Please contact the researcher, Ms BA Ndlovu (Tel no 082 461 1985), my supervisor, Prof MN Sibiya (Tel no 031-373 2606), my co-supervisor, Prof T Puckree (Tel no 031-373 2704), or the Institutional Research Ethics administrator on 031-373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031-373 2382 or dvctip@dut.ac.za.

Appendix 2b: Consent for the District Manager and NGOs

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Ms Busisiwe Ndlovu (name of researcher), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _____,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____	_____	_____	_____
Full Name of Participant	**Date**	**Time**	**Signature / Right Thumbprint**

I, _____ (name of researcher) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

_____	_____	_____
Full Name of Researcher	**Date**	**Signature**

_____	_____	_____
Full Name of Witness (If applicable)	**Date**	**Signature**

Appendix 2c: Information letter for the elderly persons in English

Thank you for agreeing to participate in this study.

Title of the Research Study: A model of the quality of life for elderly people living in a rural setting of uThungulu district, KwaZulu-Natal.

Principal Investigator/s/researcher: Ms B.A. Ndlovu, M Tech: Nursing.

Co-Investigator/s/supervisor/s: Prof M.N. Sibiya, D Tech: Nursing (Supervisor), Prof T. Puckree, PhD (Co-supervisor).

Brief Introduction and Purpose of the Study: Quality of life for elderly people in rural communities is not taken seriously, especially their health status, as the South African government is trying its best to improve, but there are gaps. The purpose of the study is to develop a model of the quality of life for elderly people living at uMhlathuze and uMlalazi sub-districts at UThungulu district, KwaZulu-Natal.

Outline of the Procedures: I will ask you few questions on your experiences as an elderly person. The interview will last between 20-30 minutes.

Risks or Discomforts to the Participant: There will be no risks involved.

Benefits: This will help improve the quality of life of elderly people living in rural communities. The research will deepen the knowledge and skills on ageing issues, become aware of the challenges of living in rural areas and add value in the training of health workers about factors affecting quality of life for elderly people focusing on their health status. This will eventually add value in the body of knowledge which will promote the quality of life hence improving the health status of elderly people in rural communities.

Reason/s why the Participant May Be Withdrawn from the Study: You are free to withdraw from the study at any time and there is no penalty that will be imposed on you.

Remuneration: There is no remuneration for participating in the study.

Costs of the Study: You will not bear any costs by participating in this study.

Confidentiality: All the information gathered during the study will be kept confidential. Your name will not be written on data collection sheets and the information that you give will be used for this study only. The paper based information will be kept in a locked cabinet and the electronic information will be secured with a private code that will only be known to the research.

Research-related Injury: There are no anticipated research-related injuries.

Persons to Contact in the Event of Any Problems or Queries:
Please contact the researcher, Ms B.A. Ndlovu (Tel no 082 461 1985), my supervisor, Prof M.N. Sibiya (Tel no 031-373 2606), my co-supervisor, Prof T Puckree (Tel no 031-373 2704), or the Institutional Research Ethics administrator on 031 373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031 373 2382 or dvctip@dut.ac.za.

Appendix 2d: Consent for the elderly persons in English

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Ms Busisiwe Ndlovu (name of researcher), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _____,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____ _____ _____ _____

Full Name of Participant Date Time Signature / Right Thumbprint

I, _____ (name of researcher) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

_____ _____ _____

Full Name of Researcher Date Signature

_____ _____ _____

Full Name of Witness (If applicable) Date Signature

Appendix 2e: Information letter for the elderly persons in isiZulu

Siyabonga ukuba uvume ukuba yingxenye yalolucwaaningo. Imininingwane mayelana nocwaningo ingenzansi.

Isihloko socwaningo: Indlela yokusiza kukhuphuke izinga lokuphila kubantu abadala abahlala emaphandleni kwisi funda saso Thungulu sigxile kwisimo sabo sezempilo.

Umcwaningi omkhulu: Busisiwe Ndlovu (umfundi weziqu zobu Dokotela kwezibuhlengikazi).

Abambekile: Usolwazi M.N. Sibiya (D Tech: Nursing) kanye noSolwazi T. Puckree (PhD).

Isingeniso esifishane kanye nenhloso yocwaningo: Ngizobe ngenza ucwaningo mayelana nokufuna indlela yokukhuphula izinga lokuphila kwabantu abadala kwisifunda saso Thungulu esifundazweni KwaZulu.

Inqubo yohlelo: Ngizokubuza Imibuzo embalwa ngezimo ohlangana nazo emphakathini,kwezeMpilo, kwimvelo. Imibuzo izothatha imizuzu ewu 20-30. Loku kuzikwenzeka ngesekhathi abantu abadala besalinde ukuhola imali yabo yomhlalaphansi ezikhungweni zokuholela. Loku kuzoba ezigodini zaseMhlathuze Kanye nase Mlalazi.

Ukungaphatheki kahle kwabangenele ucwaningo: Abukho ubungozi nokungaphatheki kahle kwabangenele lolucwaningo.

Inzuzo: Lolucwaningo luzosiza ekutheni kwenziwe izincomo ngendlela eningasizwa/nixhaswe ngayo ukukhuphula izinga lokunakekelwa kwabantu abadala ikakhulukazi emphakathini yase maphandleni.

Izizathu ezingenza labo abayinxenye yocwaningo bengabe besaqhubeka nocwaningo: Uvumelekile noma yinini ukuphuma ungabi yingxenye yocwaningo uma ufisa ukwenza njalo.

Inkokhelo: Ayikho inkokhelo etholakalayo ngokuba yingxenye yocwaningo, kanjalo nalabo abayinxenye yocwaningo akulindelekile ukuthi bakhokhe ukuze babe yingxenye.

Ukugcinwa kwemfihlo: Yonke Imininingwane iyogcinwa iyimfihlo, Igama lakho angeke libhalwe ezimpendulweni ozinikile, lezimpendulo ziyosetshenziselwa lolucwaningo kuphela. Wonke amaphepha aqukethe imininingwano ngocwaningo ayogcinwa ebhokisaneni elikhiyiwe bese kuthi konke okuwuhlelo lwamakhomputha kuvikelwe ngekhodi eyimfihlo eyokwaziwa kuphela ngumcwaningi.

Ukulimala okungenzeka ngenxa yocwaningo: Akukho ukulimala okungenzeka kuloluhlobo locwaningo.

Ongabathinta uma unemibuzo noma ofuna ukuchazelwa ngakho mayelana nalolucwaningo: Thinta umcwaningi, Nkk B.A Ndlovu (ucingo 082 4611985), umbhekeleli Solwazi. MN Sibiya (ucingo no 031-373 2606), osizana naye, Solwazi Puckree (ucingo 031-373 2600), or the Institutional Research Ethics administrator on 031-373 2900. Izikhalazo zingabikwa ku DVC: TIP, Prof F. Otieno on 031-373 2382 or dvctip@dut.ac.za.

Isongezo 2f: Isivumo

Isitatimende sesivumelwano sokuba yingxenye yocwaningo:

- Mina ngiyaqiniseka ukuthi ngitsheliwe futhi ngachazelwa lapho ngingaqondi khona ngakolucwaningo u Nkk B.A. Ndlovu (igama lomcwaningi). Ngiyaqiniseka ukuthi ngichazelwe ngohlobo locwaningo, usizo lwalo nokuthi abukho ubungozi engingabulindela ngalo, - Research Ethics Clearance Number: _____,
- Nginikiwe incwajana emayelana nalolucwaningo, ngayifunda futhi ngachazelwa ngayo.
- Ngiyaqonda ukuthi imiphumela yalolucwaningo uma isishicilelwa angeke kufakwe Imininingwane yami, ubulili, Iminyaka Usuku lokuzalwa noma isifo sami.
- Ngiyavuma ukuthi ulwazi oluzotholwa kimi luhlelwe ngohlelo lwama computer.
- Ngivumelekile noma yinini uma ngifisa ukungaqhubeki nocwaningo ukwenza njalo ngaphandle kokuthi kube nemiphumela emibi.
- Ngibenesikhathi esanele sokubuza futhi ngachazeleka kahle. Ngaleyondlela ngiyavuma ukuba yingxenye yalolucwaaningo.
- Ngiyaqonda ukuthi izinto ezibalulekile eziqhamukayo ngokuqhubeka kocwaningo ezithinta mina ngiyokwaziswa ngazo.

_____	_____	_____	_____
Igama lomcwaningi	**Usuku**	**Isikhathi**	**Sayina/ Isithupha sakhe**

Mina _____ (igama lomcwaningi) ngiyaqinisa ukuthi lo ocwaningwayo utsheliwe kabanzi ngocwaningo, nokuthi azikho izimo ezingaba yingozi kuye ngesikhathi socwaningo.

_____	_____	_____
Igama lomcwaningi	**Usuku**	**Sayina**
_____	_____	_____
Igama likafakazi (uma kunesidingo)	**Usuku**	**Sayina**
_____	_____	_____
Igama lombekeleil (uma kunesidingo)	**Usuku**	**Sayina**

Appendix 3a: Interview guide for the elderly persons in English

DEMOGRAPHIC DATA

1. Age:----------years
2. Sex: 1 Female, 2 Male
3. Marital status:
   1 Married, if so, how long have you been married? ----------
   2 Married (customary), if so how long have you been married? ----------
   3 Cohabitation, if so how long have you been cohabitating? ----------
   4 Single
   5 Widowed, if so how long have you been living alone? ----------
   6 Divorced, if so how long have you been divorced? ----------
   7 Other, what:----------
4. Number of children (total):----------
5. Number of children or grandchildren at home----------children----------grandchildren
6. Other persons at home (number, who):
7. Do you belong to any of the following groups?
   1 Spiritual community----------Name
   2 Support group----------Name
   3 NGO/CBO----------Name
   4 None
   5 Other, what
8. What activities do you do in each of the above groups?
9. How often do you do the above activities?

SOCIAL ISSUES

10. What are the challenges that you face in your community as an elderly person?
11. Would you say there are challenges that you have with regards to your social life, pertaining to income, respect, isolation / loneliness?
12. Are you in anyway involved in any form of a group within your community and what activities are you involved in /with?
13. Are there times when you do not have food at home, if so what could be the causes of this?
14. Who is responsible for preparing meals for you?
15. What type of food do you eat daily and how often?

HEALTH ISSUES

16. Can you elaborate on the type of illnesses that you are suffering from currently?
17. How often do you visit the clinic or traditional healer?
18. Are there challenges that you face when you visit the clinic?
19. Are you part of a support group within your community?

20. What is the type of support do you get from the group?
21. How do you find the chronic clubs in your community in terms of helping you?
22. Do you find helpful to be part of a chronic club and how?
23. In your community is there an NGO that helps the elderly?
24. How does the NGO help the elderly?
25. Do you think it's useful to have NGOs supporting the elderly in community? If yes, please elaborate.

ENVIRONMENTAL ISSUES

26. What type and size of the house have you got?
27. What are the means of getting clean water?
28. How do you dispose of garbage?
29. Do you dispose the garbage yourself or is there a person that helps you?
30. Please mention things that affect your health within the environment.
31. Is there enough room/space for the family members in a house you are living in?
32. How far is your house from the health services?
33. What are the means that you use to get to the clinic?

Appendix 3b: Interview guide for the elderly persons in isiZulu

ISENDLALELO SEMIBUZO

1. Iminyaka yokuzalwa.
2. Ubulili.
3. Isimo somshado:
   1.Ushadile, uma kunjalo, ingabe usushade iskhathi esingakanani? ----------
   2 Ushade umshado (wesintu), uma kunjalo ushade isikhathi esingakanani? ----------
   3 Unomasihlalisana, uma kunjalo isikhathi esingakanani? ----------
   4 Awushadile?
   5 Ungumfelokazi, noma ungumfelwa, uma kunjalo sekuyisikhathi esingakanani uhlala wedwa?
   6 Uhlukanisile, uma kunjalo sekuyisikhathi esingakanani? ----------
   7 Okunye, kungayini?:----------
4. Inani lezingane zakho (sezizonke): ----------
5. Zingaki izingane noma abazukulu ekhaya ---------- izingane ---------- nabazukulu
6 Abanye abantu ohlala nabo ekhaya (inani,bangobani kuwe?):
7. Ingabe uyangena kwelinye lama amaqembu ezilandelayo?
   1 Okuqondene nezomphefumulo ---------- Name.
   2 Iqembu elisizayo ---------- Igama.
   3 Ummutho ongatholi nzuzo ngokusiza umphakathi ---------- Igama.
   4 Akukho.
   5 Okunye, yikuphi?
8. Imiphi imisebenzi oyenzayo ngayinyekulamaqembu angenhla?
9. Kukangaki la wenze imisebenzi engenhla?

EZIPHATHELENE NEZO ZOMPHAKATHI

10. Iziphi izingqinamba obhekana nazo emphakathini njengomuntu osemdala?
11. Ungasho ukuthi unazo izingqinamba obhekene nazo mayelana nezezimali, ukuhlonipheka, isizungu noma umzwangedwa?
12. Kukhona inhlangano okuyona kumphakathi wakho ephathelene nezinto zabadala, nokuthii ikuphi okwenzayo?
13. Sikhona yini isikhathi lapho ungenakho ukudlla endlini, uma kunjalo ngabe isiphi isizathu?
14. Zikhona yini izinhlaka emphakathini wakho ezisiza abantu abadala?
15. Ubani omele ukukulungisela ukudla, futhi ukuthola kangaki ukudla ngosuku okuyinhloboni?

EZIPHATHELENE NEZEMPILO

16. Ungangichazele ngohlobo lezifo ezikuphethe?
17. Uyakangaki emtholampilo noma kumuntu olapha ngamakhambi?
18. Iziphi izingqinamba obhekana nazo uma usemtholampilo?
19. Ngabe uingxenye yombutho thizeni emphakathini?
20. Iziphi izinhlobo zosizo ozithola kulombutho?
21. Uzithola zinjani lezinhlelo ezakhelwe ukusiza abagula ngokufa isikhathi eside bedla amaphilisi,siyasiza kodwa?
22. Ukuthola kukusiza yini ukuba kulolu hlelo, kanjani?
23. Emphakathini zikhona yini izinhlangano ezisebenza zingenzi nzuzo, futhi ezingancikile kuhulumeni ezisiza abadala?
24. Uma zikhona zibamba liphi iqhaza?
25. Ngokwakho ukucabanga lezinhlangano kubalulekile yini ukuba khona kwazo ekusizeni abadal emphakathini, uma uthi yebo, sicela uchaze kabanzi?

OKUPHATHELENE NEZEMVELO

26. Indlu ohlala kuyo iluhlobo luni , futhi ingakanani?
27. Amanzi ahlanzekile uye uwathole kanjani?
28.Udoti uye uwulahle kanjani?
29.Uye uzilahlele ngokwakho udoti noma ukhona okusizayo?
30. Ngazise ngezinto ezikuhlukumeza impilo yakho kwezemvelo
31. Bangaki abantu ohlala nabo kulendlu?
32. Ukude kangakanani umtholampilo ukusuka endlini yakho?
33. Uye usebenziseni ukufinyelela emtholampilo?

Appendix 3c: Interview guide for the Programme Manager

1. What services are available for elderly people age 60 years and above?
2. Who are the main recipients of the services, in terms of age, gender and condition?
3. How often are these services provided?
4. In which sub-districts are these services available?
5. At which points of care are these services marketed?
6. How do you keep data for the recipients of these services?
7. Who collects and collates the data for the services?
8. How are the activities monitored?
9. What feedback do you get from the service users?
10. How would you describe the health outcomes for the people using the services?
11. For how long has these services been provided for?
12. What type of activities is conducted by department of health to improve the QoL for the elderly within the district?

Appendix 3d: Interview guide for the NGOs

1. What services are available for elderly people within your organisation?

2. How do you interact with elderly people?

3. How do elderly people get access to services within your organisation?

4. If you have not incorporated quality of life in your activities, what strategies do you have in place to promote quality of life for elderly people?

5. How is your organisation dealing with elderly issues; social, health and environmental?

6. What platforms within the district are available to deal with elderly issues, and what are they focusing on?

Appendix 4: Audit tool

1. Check if there is an existing Club register

2. How often is it used

3.Activities taking place within the club to benefit elderly people

4. Check if names and addresses of the members completed

5.How often is the register updated

6. Look for the conditions that the individual filled

7. Check If the information is updated, how often, is it weekly, monthly or not filled

8. The vital signs monitoring if it is done, i.e. BP, HGT, etc.

9. Check if there screening for complications related to each condition on the register

10. What other information is captured in the register, e.g. (intersectoral collaboration)

11. Number of deaths recorded for the past year

12.Causes of deaths

13. How many people have changed or stopped treatment in the past year because of improvement in their condition?

14. How many people have changed treatment in the past year because of their condition getting worse?

15. Total number of geriatrics in the club in the past year.

Appendix 5: Professional Editor's Certificate

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EDITING CERTIFICATE

Re: **Busisiwe Adelaide Ndlovu (DUT)**
Doctoral thesis: **A MODEL TO IMPROVE THE QUALITY OF LIFE FOR ELDERLY PEOPLE LIVING IN A RURAL SETTING OF UTHUNGULU DISTRICT, KWAZULU-NATAL**

I confirm that I have edited this thesis and the references for clarity, language and layout. I am a freelance editor specialising in proofreading and editing academic documents. My original tertiary degree which I obtained at UCT was a B.A. with English as a major and I went on to complete an H.D.E. (P.G.) Sec. with English as my teaching subject. I obtained a distinction for my M.Tech. dissertation in the Department of Homeopathy at Technikon Natal in 1999 (now the Durban University of Technology). During my 13 years as a part-time lecturer in the Department of Homoeopathy I supervised numerous Master's degree dissertations.

Dr Richard Steele
11 May 2016
electronic