EXPLORING ELDER ABUSE AMONG CLINIC ATTENDEES IN A SELECTED DURBAN HOSPITAL

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Masters in Nursing (Gerontology)

By

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DEDICATION

THIS DISSERTATION IS DEDICATED TO MY DAUGHTERS NONDUMISO AND ANELE,

MY SISTER SINDI, MY MOTHER AND MY HUSBAND

FOR ALL THEIR ENCOURAGEMENT, LOVE, UNDERSTANDING AND SUPPORT.

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To my family I also thank you for support and understanding during the years of my study.

DECLARATION

I declare that this is the researcher's original work and has not been submitted for a degree in this or any other university. All other sources cited in this dissertation have been acknowledged and referenced.

Signed:

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ABSTRACT

Background: Elder abuse is a relatively new phenomenon that has remained a hidden and taboo subject throughout history, not only in South Africa, but globally. It is however, emerging as a growing social problem. The problem of elder abuse remains hidden behind the non disclosure of family incidents and institutional incidents (Wolf, 1992). According to Beaulieu and Blanger (1995) elder abuse is a very complex issue with diverse definitions, types and names, has been very slow to capture the public eye and public policy. It is manifested at many levels including physical, psychological, legal and social levels and requires the involvement of different types of professionals.

South Africa is amongst countries with disproportionately large population of elderly adults. According to the Department of Health (2000) this situation is due to the impact of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome pandemic on members of the younger generations which has altered the age structure of populations in severely affected countries. South Africa is one such country with KwaZulu-Natal province reported to have an extremely high incidence of the disease. A 2002 report by the World Health Organization revealed that older people were taking on new roles by providing care and financial support to orphaned children and fulfilling child-rearing roles within their extended families.

Elder abuse is widespread in South Africa but the definition of abuse remains problematic. While some types of abuse fit with Western typologies, others (such as the rape of women by sons and grandsons to extort pension money, or accusations of witchcraft to seize assets) do not fit the Western typology hence an expanded typology is needed (Ferreira,

2008). In spite of the progress that has been made in explaining how and why elder abuse occurs, it still remains a poorly understood problem. The purpose of this study was therefore to explore the types and patterns of elder abuse and the extent of the problem in a selected hospital in Durban.

Research methodology: Guided by the positivist paradigm, a quantitative, descriptive and explorative design was adopted in this study. As a result, data was collected through a structured questionnaire and analyzed statistically using an SPSS package, version 15.0. The whole population of elderly patients (N=1000) in the selected setting was requested to participate in this study. A total of 150 elderly people were used as a research sample which is 10% of the population. All elderly who participated returned completed questionnaires, thus setting the response rate at 100%.

Results: The results indicated that the elderly experienced physical abuse more than any type of abuse. The most common types of physical abuse experienced by the elderly included pinching, force-feeding, hitting, biting and slapping, burning, kicking, prevention from access to food and medication, prevention from access to health aids such as eyeglasses, hearing aids and restraining. The abuse was most commonly committed by close relatives, loved ones and carers. It was also found that the elderly were abused financially. It also emerged that the elderly were treated like children and were sometimes accused of witchcraft and labeled within the community as witches.

Recommendations: This study recommends a multidisciplinary approach to elder care and management. Because of the growing number of elderly in our society and because they are a vulnerable group which needs special nursing care, it is recommended that the

nursing curriculum should include a detailed geriatric syllabus A future qualitative study is recommended that will explore the views of elderly on abuse. Further research that would explore each type of abuse as it occurs in the community is recommended, this will add on the existing limited literature. In South Africa there are national guidelines on the prevention of elderly abuse but these are frequently not implemented to safeguard the health and well being of the elderly. It is recommended that these guidelines should be disseminated to provinces and municipalities and the implementation of guidelines should be monitored and evaluated.

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ACRONYMS

AIDS: Acquired Immune Deficiency Syndrome

ALTCOP: Atlanta Long Term Care Ombudsman Programme

ANC: African National Congress

COPE: Congress of the People

DoH: Department of Health

HEAL: Halt Elder Abuse Line

HIV: Human Immunodeficiency Virus

HSRC: Human Science Research Council

JCPS: Justice Crime Prevention Cluster Safety

KZN: KwaZulu-Natal

NCEA: National Centre of Elder Abuse

NCOP: National Council of Provinces

NCPEA: National Committee for Prevention of Elder Abuse

NDPP: National Director of Public Prosecution

NGO: Non-governmental Organization

OPD: Outpatient Department

PMMH: Prince Mshiyeni Memorial Hospital

SA: South Africa

SABC: South African Broadcasting Cooperation

SACA: South African Council for the Aged

SAP: South African Police

SANGEA: South African National Guidelines of Elder abuse

VOTE: Voice of the Elderly

WHO: World Health Organization

CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 Introduction

Elder abuse, like other types of interpersonal violence, had remained hidden and taboo throughout history. According to Sijuwade (2008), elder abuse emerged after child abuse and domestic violence and only began to be discussed publicly in the 60's and 70's. This author further states that elder abuse was initially called "granny battering" which was then presumed to be a form of family violence. South Africa (SA) is amongst the countries with a proportionately large elderly population. According to the Department of Health (DoH) this is due to the impact of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) pandemic on the younger members of society (DoH, 2000). According to DoH (2006) HIV and AIDS related deaths are altering the age structure of populations in severely affected countries, including South Africa and the KwaZulu-Natal (KZN) province is reported to have a high incidence of the disease.

In developed countries with low levels of HIV and AIDS, most deaths occur among the very young and very old. However, AIDS primarily strikes adults in their prime working years. The deaths of people who were infected as adolescents or young adults, shifts the usual pattern of deaths and distorts the age structure in the country. Because of increasingly high AIDS mortality in South Africa, for example, people between the ages of 20 and 49 accounted for almost three-fifths of all deaths in that region between the years 2000 and 2005. This is a sharp increase from just one-fifth of all deaths between years 1985 and 1990 (DoH, 2006). Sijuwade (2008) highlighted the

fact that older people are caring for the sick, the dying and the children orphaned or made vulnerable by the HIV and AIDS pandemic. The older people, mainly older women but also including a good proportion of older men, are providing economic, social and psychological care and support for orphaned grandchildren (Sijuwade, 2008). They are doing so with very few resources and no recognition or support. A report by World Health Organization (WHO) (2002) revealed that older people have taken on new roles by providing care and financial support to orphaned children and playing child-rearing roles within their extended families. However, the idea that the role is 'new' is debatable. In many communities, older people, particularly older women, traditionally played an important role in the care and upbringing of children (WHO, 2002).

1.2 Background to the study

In SA, abuse in general, has become part of our daily lives. There are constant reports of abuse in the media (newspapers and television) and it is often experienced on the streets of our cities and towns. However, behind the closed doors of our homes, even more abuse takes place than society is willing to admit to (DoH, 2000). According to Wiehe (1998), social learning theory maintains that violence is learnt within the family. Wiehe further states that if a child has observed family abuse in the home, then physical abuse and emotional abuse become the strategies used to solve problems, even when they are faced with problems in the care of their parents (Wiehe, 1998.)

A statistical projection indicates that there are more elderly people nowadays than ever before. In October 1996 there were approximately 1.94 million aged people (65

years and above), of which 61.4% were females (South African Population Census, 1996).

Table 1.1: Statistical Projection of S A Population (Statistics SA, 2006)

Racial Category	Ethno-Racial Distribution
Blacks	79%
Whites	9.5%
Coloured	8.9%
Asians/Indians	2.6%
All races 65 yrs and above	**5.4%**

According to Statistics SA (2006), the South African population is 47.5 million of which 3.3 million is 60 years and above. This number constitutes 7.7% of the total population. The ethno-racial composition of the total population for Blacks is 79.3%, Coloured 8.9%, Asians/Indians 2.5% and Whites 9.3%. According to the WHO (2000), it is predicted that by the year 2025, the global population of those aged 60 years and older will more than double, from 524 million in 1995 to about 1.2 billion. Elderly people are living longer and their disabilities and dependencies increase in severity with their age (Brown and Herbert, 1997). Furthermore, these authors state that as elderly individuals grow older, they are more likely to require care from others. In this situation, adult children or other family members are most likely to provide the assistance required by the disabled or dependent elderly person (Brown and Herbert, 1997).

A United States study conducted in 2000, in which interviews were conducted with residents of nursing homes, found that 44% of the resident respondents considered they had been abused. In addition to this, 38% reported having seen other residents being abused, 48% had been treated or handled roughly and 44% reported having seen other residents being treated in the same manner (Atlanta Long Term Care Ombudsman Programme, (ALTCOP) 2000). Similarly, a survey done by Pillemer and Hudson (1993) of nursing assistants working in United States care homes, revealed that 17% admitted to pushing, shoving, or grabbing a resident, 51% stated that they had 'yelled at a resident in anger' during the previous12 months, whilst 23% said they had sworn at or insulted a resident during this period (Pillemer and Hudson, 1993).

As part of another research study relating to theft in Australian nursing homes by Harris and Benson (2006), it was found that just over a quarter of the respondents reported that they had either seen or suspected other staff of stealing from residents. Seventeen respondents reported that they had taken something or stolen from a resident, of whom the majority indicated that they had done so on more than one occasion. When asked about their colleagues, 58 respondents stated that they had seen co-workers stealing from residents, whilst 194 indicated that they suspected other employees of theft from residents (Harris and Benson, 2006).

A study conducted in North America by Reis and Nahmiash in 1997 aimed to improve the strategies for identifying and locating elders at risk and improve the indicators of abuse. Their study concluded that abuse could be identified with a valid tool, but experienced and trained professionals were required to conduct the interviews. While the abuse of older people was first described in British scientific journals in 1975,

scientific and legal action was, by and large, originally developed in the United States of America. In 1990, the first, and to date only, prevalence study on elder abuse was published in the United Kingdom and in 2004 a study was conducted in South Africa by Monica Ferreira of the University of Cape Town.

Harris and Benson (2006) view elder abuse as a complex problem, because for these researchers, it is easy for people to have misconceptions about elder abuse. Many people who hear 'elder abuse and neglect' think about older people living in nursing homes or about the elderly who live all alone and never have visitors (ALTCOP, 2000). Nevertheless, elder abuse is not just a problem of older people living on the margins of our everyday life. It is right in our midst and the majority of incidents of elder abuse do not happen in a nursing home. Occasionally, there are shocking reports of nursing home residents who are mistreated by the staff. Such abuse does occur but according to Stanley and Manthorpe (2004), this institutional abuse is not the most common type of elder abuse. At any one time, only about four percent (4%) of elderly adults live in nursing homes, and the vast majority of nursing home residents have their physical needs met without experiencing abuse or neglect (Stanley and Manthorpe, 2004).

The great majority of elderly people live on their own or with their spouses, children, siblings, and/ or other relatives, not in institutional settings. When elder abuse happens, family, other household members and paid caregivers usually are the abusers (Harris and Benson, 2006). According to Harris and Benson, although there are extreme cases of elder abuse, often the abuse is subtle, and the distinction between normal interpersonal stress and abuse is not always easy to discern. There is

no single pattern of elder abuse in the home. Sometimes the abuse is a continuation of long-standing patterns of physical or emotional abuse within the family. Perhaps, more commonly, the abuse is related to changes in living situations and relationships brought about by the older person's increasing frailty and dependence on others for companionship and for meeting their basic needs (Stanley and Manthorpe, 2004). Stanley and Manthorpe further state that it is not just infirm or mentally impaired elderly people who are vulnerable to abuse, those who are ill, frail, disabled, or depressed are at greater risk of abuse. Even those who do not have these obvious risk factors can find themselves in abusive situations and relationships (Harris and Benson, 2006; Stanley and Manthorpe, 2004).

In 1981, the South African Council of the Aged (SACA) reported on the abuse of the elderly and held seminars throughout the country (Eckley and Vilakazi, 1995). According to these researchers, SACA adopted a declaration on the Rights of the Elderly in 1993 and started to negotiate for an ombudsman. Furthermore, these authors recommended that in order to enable the communities to help the elder abuse victims, there was a need to understand the problem and develop detection, intervention and prevention strategies. The South African Broadcasting Cooperation (SABC) News (2009) reported that the young males who come back from traditional circumcision in the mountains, especially in the Eastern Cape, came back and raped elderly women in the belief that doing this would rid them of any bad luck. The elderly women in that province lived in fear of being raped by these young males (SABC News, 2009). At a workshop hosted by the Older Persons Forum (2003 to 2005), it was found that old people were victims of crime, and a number of sexual abuse and rape incidents were identified at the workshop (Older Person Forum, 2006). In some

communities it is also perceived or believed that males with HIV/AIDS will be cured if they have sex with an older person, specifically a woman.

The problem of elderly abuse has not received much attention from either researchers or policy makers. According to Wolf (1992), the problem of elder abuse remains hidden behind the reluctance of disclosure of family incidents and institutional incidents. Meeks-Sjostrom (2004) states that elder abuse is common in all socio-economic classes and among all cultural and ethnic backgrounds. Elder abuse has historically been defined as a social problem rather than a criminal problem (Payne, 2000; Wolf, 1992). In the democratic era, South African citizens demand solutions to crime. Government service providers such as police, doctors, prosecutors and other providers in the Justice Crime Prevention and Cluster Safety (JCPS) are required to render services to all 'victims' with an understanding of the victims' situations so as to eliminate secondary victimization (Payne, 2000; Wolf, 1992). The Joint Monitoring Committee on Improvement of Quality of Life and Status of Women and the Joint Monitoring Committee on Improvement of Quality of Life and Status of Children, Youth and Disabled Persons, National Council of Provinces (NCOP) 2006, reported that the elderly are often a forgotten vulnerable group. In their submission to the Human Rights Commission in 2006, this group reported that the elderly in South Africa tend to be largely unorganized in terms of their capacity to ensure that their concerns are placed on national agendas.

1.3 Problem Statement

There have been few studies examining the prevalence of elder abuse and neglect either at their homes settings or in hospital settings or other care settings (Martin,

1984; Stanley and Manthorpe, 1999). For these researchers, the reasons for this may include the nature of the population (frail, sick and/or vulnerable), their lack of access to communication and other health related difficulties; fear of retribution if concerns are raised; as well as a range of factors arising from specific organizational and cultural contexts (Stanley and Manthorpe, 1999). Elder abuse is widespread in South Africa but the definition of this abuse remains problematic. While some types of abuse fit with Western typologies, others (such as the rape of women by sons and grandsons to extort pension money, or accusations of witchcraft to seize assets) do not fit the Western typology, hence an expanded typology is needed (Ferreira, 2008).

In spite of the headway that has been made in explaining how and why elder abuse occurs, it still remains a poorly understood problem (Cooper, Selwood and Livingston, 2008). Elder mistreatment may take the form of an act of commission (abuse) or omission (neglect). It may be an intentional act that is, a conscious attempt to inflict suffering, or it may be unintentional because of inadequate knowledge, infirmity or laziness on the part of the person responsible (Cooper et al., 2008). Given that the elderly population is on the rise in SA, it is of paramount importance to examine the care of the elder persons.

Estimates of the prevalence of elder abuse have been difficult to capture because of a number of factors such as fear, stigma, and lack of trust prevent people from reporting incidents of abuse (Ferreira, 2008). Despite the difficulties in determining its prevalence, according to the WHO (2002) elder abuse in its many forms has been recognised as a growing concern. According to the WHO International Plan of Action on Ageing (2002), it is one of the two areas that require urgent action. Such concerns arise in part because of the negative impact which abuse has on the elderly. Not only

do the elderly have more difficulties in recovering from the physical injuries, but such treatment can also lead to problems such as depression, placement in a nursing home and an increased level of mortality (Ferreira, 2008).

According to Beaulieu and Blanger (1995) elder abuse is a very complex issue with diverse definitions, types and a name, which has been very slow to capture the public eye and public policy. Since it is manifested at many levels (physical, psychological, legal, social), it requires the involvement of different types of professionals (Sijuwade, 2008; Beaulieu and Blanger, 1995). Meeks-Sjostrom (2004) states that compared with other types of abuse against women and children, elder abuse and neglect have received little attention. This author further states that the lack of knowledge and information of elder abuse negatively affects the levels of awareness of and alertness to the problem among health care professionals. Therefore, the focus of this study is to determine the extent of elder abuse and its typology within the Durban Metropolitan areas of KwaZulu-Natal.

Motivation for the study

This study was conducted in a hospital outpatient clinic because this was where the elderly were easily accessible and available. Although they came for treatment they were requested to participate in the study, it was a good start for course work Masters to explore elder abuse. The scope did not allow for the use of elderly in their communities because it became difficult to trace and was time consuming. I felt that the population used in the study would represent and explain the experiences of elderly in general not specific to hospital setting.

1.4 Purpose of the Study

The purpose of this study is to explore the types and patterns of elder abuse and the extent of the problem in a selected hospital in Durban.

1.5 Objectives of the Study

The objectives of this study were to:

a) Explore the different types and patterns of abuse that the elder are exposed to in a selected Durban Hospital.

b) Describe the extent of elder abuse in a selected Durban hospital.

1.6 Research Questions

The research questions for this study were:

a) What are the different types of abuse that the elder are exposed to in a selected Durban hospital?

b) What is the extent of elder abuse in Durban metropolitan areas?

1.7 Significance of the Study

Since there is little scientific literature and evidence based information on elder abuse (Martin, 1984; Stanley and Manthorpe, 1999), this study may contribute to the body of knowledge and possible recommendations can be made to researchers, practitioners and policy makers for the detection, management and prevention of elder abuse. This then may contribute towards policy development in this area. This study aims to raise awareness among health professionals so that they can be empowered to identify and intervene appropriately in cases of elder abuse. By increasing awareness among healthcare professionals, home health care workers or carers, and others who provide

services to the elderly and family members, patterns of abuse or neglect can be broken, and both the abused person and the abuser can receive needed help. Furthermore, the results of this study may raise awareness about the issues and debates around elder abuse and identify what research and training is needed in order to advance knowledge among families and health care providers or carers of the elder people about elder abuse.

1.8 Conceptual Framework

A framework is the overall conceptual underpinnings of a study. Researchers undertaking a study should make the conceptual definition of their key variables clear, thereby providing information about the study‘s framework (Polit and Hungler, 2003). The conceptual framework guiding this study is adapted from the National Centre of Elder Abuse (NCEA) (1998). This model states that the elderly in the community or old age home are exposed to one or more different types of abuse. The types of abuse are physical, emotional, financial and sexual abuse. These types of elder abuse may occur in the community and/or old age homes. Elder abuse at old age homes fall into the same categories as those used to describe community and/or domestic abuse. Abusers of an elderly person can be anyone that the person depends on and/or meets. This can include family, neighbours, professional caregivers, friends, landlords and even strangers.

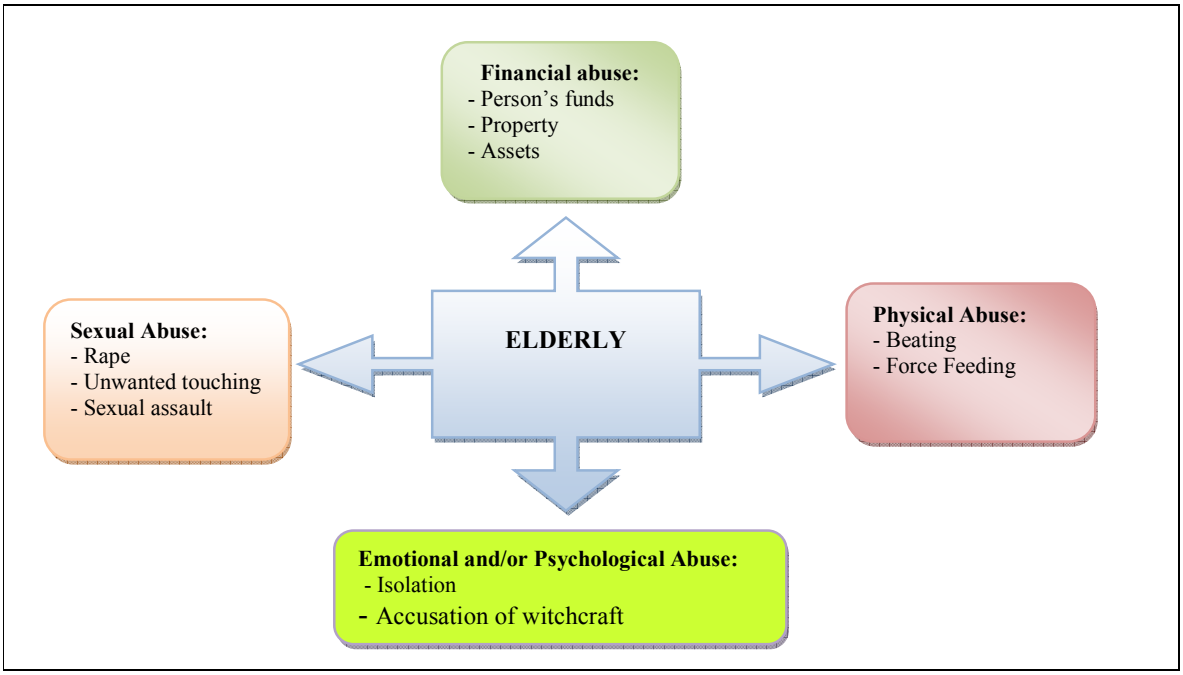

Figure1. The Typology of Elder Abuse (Adapted from the National Centre of Elder Abuse, 1998)

Physical Abuse

Physical abuse is defined as the use of physical force that may result in bodily injury, physical pain or impairment. It includes striking with or without an object, hitting, restraining, force-feeding, beating, pushing, slapping, shoving, kicking, pinching and burning (NCEA, 1998; Wolf and Pillemer, 1994). Signs of physical abuse include: sprains, dislocation, fractures and broken bones; burns from cigarettes, appliances, or hot water and skin problems, abrasions on arms, legs, or torso that resemble rope or strap marks; internal injuries characterized by pain, difficulty with normal functioning of organs, and bleeding from body orifices; broken eyeglasses or frames; noticeable dehydration or malnutrition, caregiver's refusal to allow you to see the elder alone (NCEA, 1998).

Furthermore, physical abuse can range from slapping or shoving to severe beatings and restraining with ropes or chains. According to NCEA (1998), when a caregiver or other person uses enough force to cause unnecessary pain or injury, even if the reason is to help the older person, the behaviour can be regarded as abusive. Physical abuse can also include hitting, beating, pushing, kicking, pinching, burning, or biting. It can also include such acts against the older person as over or under-medicating, depriving the elder of food, or exposing the person to severe weather, either deliberately or inadvertently.

Sexual Abuse

Sexual abuse is defined as non-consensual sexual contact of any kind with an older adult (NCEA, 1998). According to the Older Persons Act No 13 (2006), sexual abuse refers to any conduct that violates the sexual integrity of the older person. It includes unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity and sexually explicit photographing. Signs of sexual abuse include: bruises around breasts or genitals and around inner thighs; unexplained genital or sexual infections; unexplained vaginal or anal bleeding; torn, stained, or bloody underclothing; difficulty in walking or standing (NCEA, 1998). Sexual abuse can range from sexual exhibition to rape. NCEA further states that sexual abuse can include inappropriate touching, photographing the person in suggestive poses, forcing the person to look at pornography, forcing sexual contact with a third party, or any unwanted sexualized behaviour. It also includes rape, sodomy, or coerced nudity. According to NCEA (1998) sexual abuse is not often reported as a type of elder abuse.

Emotional and/or Psychological Abuse

Emotional and/or psychological abuse is defined by NCEA (1998) as the infliction of anguish pain, or distress through verbal or non-verbal acts. This type of abuse includes treating an older person like an infant, isolating the person from friends and family, or regular activities. Signs of emotional and/or psychological abuse include: behaviour that mimics dementia, such as rocking, sucking, or mumbling to oneself; confusion or depression without illness; unwarranted anger; unusual silence or sullenness; hesitation to talk openly; implausible stories; fear; withdrawal symptoms; threatening, belittling, or controlling caregiver behaviour that you witness (NCEA, 1998). Emotional or psychological abuse can range from name-calling or giving the older person the "silent treatment" to intimidating and threatening the individual. When a family member, a caregiver, or other person behaves in a way that causes fear, mental anguish, and emotional pain or distress, the behaviour can be regarded as abusive (NCEA, 1998). Emotional and psychological abuse can include insults and threats. It can also include treating the older person like a child and isolating the person from family, friends, and regular activities, either by force or threats, or through manipulation.

Financial abuse

Financial abuse involves the illegal or improper exploitation of an older person's funds, property, or assets. It includes cashing an elderly person's cheque without authorization; forging an elder's signature; improper use of power of attorney or guardianship; coercing or deceiving an elderly to sign any document such as a will (NCEA, 1998). Signs of financial abuse can include when the elderly person has no awareness of his or her financial affairs be it at home or in the care facility; his/her rent

is often overdue: other bills are late or unpaid; inappropriate activity of bank accounts; sudden change in the person's financial condition; items or cash missing from elder's household; suspicious change in wills, power of attorney, titles and policies; additional names to the elder's signature card; caregiver concerned that too much money is being used to provide resident with care and services (NCEA, 1998).

Financial exploitation can range from the misuse of an elder's funds to embezzlement. Financial exploitation includes fraud, taking money under false pretences, forgery, forced property transfers, purchasing expensive items with the older person's money without his/her knowledge or permission, or denying the older person access to his or her own funds or home. It includes the improper use of legal guardianship arrangements, powers of attorney, or conservatorships. It also includes a variety of scams perpetrated by sales people for health-related services, mortgage companies, and financial managers-or even by so-called friends.

1.9 Definition of Terms

Elderly person or Elder: According to Kallin et al. (2002) an elderly person is an adult aged 60 years and above. Most developed world countries have accepted the chronological age of 65 years as a definition of 'elderly' or older person, but like many westernized concepts, this does not translate well to the situation in Africa. While this definition is somewhat arbitrary, it is often associated with the age at which one can begin to receive pension benefits. While there is no United Nations (UN) standard numerical criterion, the UN agreed that the cut off is 60 years and above when referring to the older population (WHO, 2009). In this study the terms *elderly person*,

the elderly and *older person* will be used interchangeably to indicate a person 60 years and older.

Elder abuse: According to the WHO (2000) 'elder abuse is a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person'. The National Centre for Elder Abuse (1998) defined elder abuse as any of several forms of maltreatment of an older person by someone who has a special relationship with the elderly, such as a spouse, a sibling, a child, a friend or a caregiver.

A Clinic: A clinic (or an outpatient clinic) is a small private or public health facility that is devoted to the care of outpatients, often in a community, in contrast to larger hospitals, which also treat inpatients. Some clinics expand over time to become institutions as large as major hospitals, whilst retaining the name clinic. These are often associated with a hospital (retrieved from www.answers.com, 2009).

Clinic attendee: An attendee is the person who attends a certain clinic, for example, a particular clinic and in the context of this study, clinic attendees will be all elderly people who attend the chronic illness clinic at the selected hospital in Durban.

Hospital: A hospital is an institution where health care is provided and a patient is treated by specialized staff and equipment (www.answers.com (2009).

1.10 Conclusion

This chapter presented a brief background on elder abuse and a statistical projection of the spread of this social problem. The purpose, objectives, research questions and

significance of the study were presented. A conceptual framework guiding the research study was also presented.

1.11 Dissertation Outline

The envisaged chapter divisions are as follows:

Chapter One is the overview of the study. It orients the reader by presenting the background to the study in terms of its context, problem statement, purpose statement, objectives and research questions, the significance of the study and the conceptual framework underpinning the study.

Chapter Two is the review and analysis of the literature related to the phenomenon in the study.

Chapter Three presents the research paradigm and the design.

Chapter Four presents the analysis of data. The results and data analysis of the study are outlined in a manner which indicates how the objectives of the study were achieved.

Chapter Five presents the interpretation and discussion of the main findings.

CHAPTER TWO

REVIEW OF LITERATURE

2.1 Introduction

According to Polit and Hungler (2003), a literature review is a process that involves finding, reading, understanding and forming conclusions about the published research and theories on a particular topic. A comprehensive literature review was conducted in order to determine what research has already been done regarding the extent of elder abuse within our communities and in old age homes and to gain insight and understanding about what is already known about the topic in order to guide the research process. The search engines used were Google Scholar, Google Scholar Advanced, Pubmed, Ebscohost, Science Direct, CINAHL and Medline. The search terms used for the review were elder abuse, abuse in care settings, physical abuse, emotional abuse, sexual abuse, financial abuse, witchcraft and family violence. There is very scanty literature and most of the literature relates to developed countries and not current. Since the passing of Older Person's Act in 2006, there has been no significant research that has been conducted in South Africa.

2.2 Theoretical Basis of Elder Abuse

In attempts by researchers to explain the causes of elder abuse, several broad theoretical models have been drawn from psychology, sociology, feminism and the fields of child abuse and domestic violence. Like other types of domestic violence, elder abuse is extremely complex. It is a combination of many factors, from psychological to economic as well as the mental and physical conditions of the victim and the abuser. Very rarely do these factors operate in isolation. Instead, they tend to function as complex dimensions, interacting in ways uniquely dependent on the victim,

perpetrator and the situation. Research into elder abuse is in its early stages. However, a few theories are emerging that address the cause of elder abuse.

The Learning Theory

Learning theory or trans-generational violence theory is based on the belief that violence is a learned behaviour pattern. A child observes violence as an acceptable reaction to stress and then internalizes this as an acceptable behaviour. In cases of elder abuse, violent behaviour becomes cyclical: the abused (the child) becomes the abuser of the parent. It is also stated that an adult's behaviour relates to learned behaviour as a child, thus reverting to the same pattern in adulthood (McDonald, 1991).

The physical-mental dependence impairment theory

This theory is based on the belief that elderly persons who have a severe mental or physical impairment are most vulnerable to becoming abused. In relationships where one person is dependent and another person is the helper or caregiver, there is always the potential for misuse of power by the caregiver (McDonald, 1991).

The Pathologic Abusers Theory

According to Scogin (1992) *the Pathologic Abusers Theory* focuses on the fact that the abusers have personality flaws or character flaws that cause them to abuse others. Caregivers with drug and/or alcohol abuse or addiction and mental incapacitation or mental illness tend to be far more likely to be abusive. As caregivers, people facing these challenges often lack the decision making capacity to make appropriate judgments for the elderly people in their care. In spite of this, they are thrust into this role through circumstances. Caring for an older adult, especially one who suffers from

a mental or physical impairment is highly stressful which may cause the caregiver's own personality weaknesses to emerge (Scogin 1992).

The stressed caregiver theory

The stressed caregiver theory proposes that the mounting internal stress and/or external pressure that come with providing care for the elderly can erupt in violence. If a caregiver feels that there is no relief or escape from this stress, abuse may occur (Wolf and Pillemer, 1984).

Societal attitudes

Societal attitudes are based on the belief that certain societal attitudes toward older people make it easier for abuse to occur without remorse on the part of the caregiver. These attitudes can also reduce the likelihood of outside detection or intervention. Negative attitudes can lead to a devaluation and lack of respect for older people, who are often stereotyped as frail, incompetent and powerless. When perceived in this way, there can be a societal failure to recognize the importance of assuring dignity, support and safety for every elderly person (Boyack, 1997).

Feminist Theory

Feminist theory is based on domestic violence models, highlighting the imbalance of power within relationships and how men use violence as away to demonstrate power**.** It has become apparent that no single model or theory can explain such a complex issue because elder abuse research has never been able to validate them (Boyack, 1997).

Ecological Model

The Ecological Model explores the interaction between the individual and contextual factors. It considers violence to be a complex interplay between the person's individual characteristics (biology and personal history) close interpersonal relationship, characteristics of the community in which the person lives or works and societal factors such as policies and social norms. The ecological model allows elder abuse to be linked to broader social issues (Boyack, 1997).

2.3 Legal Aspect of Elder Abuse

There are many legal and policy documents and guidelines that underpin the legal aspect of the lives of the elderly and elder abuse. These will be briefly presented to give a broad view in the context of this study.

The Constitution of Republic of South Africa Act No. 108 of 1996, states that neither a person nor the state may discriminate directly or indirectly against anyone on certain grounds, including age. There are certain fundamental rights that have a bearing on specific groups of people. This constitution (Act No. 108 of 1996) has been designed to protect everybody and its provisions are wide enough to benefit all. The Bill of Rights contained in the Constitution targets the protection of personal rights and liberties and enshrines the rights of all the people in this country. There are however, certain fundamental rights, which have a bearing on specific groups of people. An indirect reference to the elderly can possibly be found in Section 9, the Equality Clause, where it states that a person (Section 9(4)) or the state (Section 9(3)) may not discriminate directly or indirectly against anyone on certain grounds, which include age (SA National Department of Justice, 1996).

The Public Protector Act, 1998 (Act 13 of 1998*).* The Office of the Public Protector is responsible for investigating matters and protecting the public against matters such as maladministration in connection with the affairs of government, improper conduct by a person performing a public function and an act or omission by a person performing a public function resulting in improper prejudice to another person (SA National Department of Justice, 1998).

The Human Rights Commission Act (Act 54 of 1994) is responsible for promoting the observance of respect for and the protection of fundamental rights, to develop an awareness of fundamental rights among all people of the Republic of South Africa and to undertake such studies for reporting on or relating to fundamental rights as it considers advisable in the performance of its functions. Section 7 of the Human Rights Commission Act, 1994, provides for the powers, duties and functions of the Commission. In terms of Section 7(1) (e), the Commission may bring proceedings in a competent court or tribunal in its own name, or on behalf of a person or a group or class of persons. Section 8 provides that the Commission may, by mediation, conciliation or negotiation endeavour to resolve any dispute or to rectify any act or omission emanating from or constituting a violation of or threat to any fundamental right. The Human Rights Commission can therefore be considered as a mechanism at the disposal of older persons in enforcing and exercising their fundamental rights (SA National Department of Justice, 1994).

The Older Person's Act,(Act 13 of 2006), aims at protecting the elderly from all forms of abuse, including accusations of witchcraft. The Act provides for anyone caring for the elderly to take steps to ensure their safety. Furthermore, this Act provides for

democratization of governance services and the compulsory notification of elder abuse and neglect. Every registered dentist, medical practitioner, nurse or social worker or any other person who examines, attends to or deals with an elderly person and suspects that the elderly person has been abused, or suffered from any injury shall immediately notify the Director General or Welfare. The Act defines the responsibility of the management committee. It also criminalizes elder abuse. The objectives of the Act are to:

- maintain and promote the status, wellbeing, safety and security of older person,
- maintain and protect the right of older person as stated in the constitution of RSA,
- shift the emphasis from institutional care to community based care in order to ensure that the elderly remains in his/her home within the community as long as possible and,
- combat the abuse of older persons (The Older Person's Act 13 of 2006).

According to Chapter 5 of this Act, the protection of older person includes:

- older person in need of care,
- notification of abused of older persons and
- keeping a register of abuse of older persons (SA National Department of Social Welfare, 2006).

Domestic Violence Act, 116 of 1998 offers protection to any victim of domestic violence who is in a domestic relationship with the abuser and provides for a protection order to be issued on behalf of the abused person with or without his or her consent. The abuser maybe arrested or evicted from the shared household and ordered to

continue to provide financial support to the victim. This Act also provides for intervention by the South African Police Service or anyone who suspects that the person is being abused. It includes physical abuse, sexual abuse, emotional abuse, economic abuse, intimidation, harassment, stalking and damage to property. According to this Act, an elderly person who has a relationship other than marital one with the abuser may seek redress under it. Furthermore, this Act comprises a substantial broadening of the limited scope of the 1993 Act and offers protection to any victim of domestic violence who is in a domestic relationship with an abuser. A broad definition has been given to “domestic violence’. Because this new Act extends its protection to all persons living in the same violent and hostile household as the abuser, an older person who has a relationship other than a marital one with the abuser may also seek redress under it. The Act also promotes an integrated service by the service providers involved in handling a complaint of violence. It provides for the assistance and support of victims by the various role-players (SA National Department of Social Welfare, 1998).

National Prosecutions Authority Act 32 of 1998 has a prosecution policy that contains directives which have a bearing on elderly abuse. The Act established a single national prosecuting authority in the Republic. Section 21 of the Act provides that the National Director of Public Prosecutions (NDPP) shall determine the prosecution policy and issue policy directives, which must be observed in the prosecution process. The prosecution policy came into effect on 1 November 1999. The prosecution policy contains directives, which have a bearing on elder abuse (SA National Department of Justice, 1994).

Recognition of Customary Marriages Act 88 of 1998 empowers elderly women who have been disadvantaged by the previous non-recognition of customary marriages, which made them perpetual minors without contractual capacity. This situation rendered them vulnerable to economic abuse in cases where their husbands would manage their joint estate in a manner that was financially prejudicial to them (SA National Department of Home Affairs, 1998).

The Nursing Act, 2005 (Act No.33 of 2005) provides for disciplinary action to be taken against any person registered or enrolled in terms of the Nursing Act for any improper or disgraceful action or conduct on their part. In principle, this provision may help to hold nurses and such professionals accountable for their actions and to ensure that they render good and professional services to patients. Sections 11(3) and (4) of the Nursing Amendment Act also allude to Section 28 of the Nursing Act, 1978 in their reference to the power of the Council to institute disciplinary proceedings against any person registered or enrolled under the principal Act, in respect of any act which constitutes improper or disgraceful conduct in terms of the principal Act, and which was committed before the date of the first meeting of the council. It is clear that these provisions are intended to guard against malpractice by encouraging good professional behaviour and conduct. It could be argued that they could prevent the abuse of patients, in this instance, elderly patients (South African Nursing Council, 2005)

Social Security Act No. 59 of 1992 provides entitlement to a social grant for any elderly person. It is the best example of poverty alleviation and improvement of the quality of

life of older persons existing within the legal framework of South Africa (SA National Department of Social Welfare, 1992).

United Nations Resolution No. 46 of 1991 states that the elderly person should:

- have access to adequate food, water, shelter, clothing and health care through provision of income, family and community support and self help,
- be able to participate in determining when and at what pace withdrawal from the labour force take place,
- have access to educational and training programme,
- be able to live in an environment that is safe and adaptable to personal preferences and changing capacities,
- be able to reside at home for as long as possible,
- be able to seek and develop opportunity for service to the community and to serve as volunteers in positions appropriate to their interest and capabilities,
- be able to form movement or associations of elderly persons, benefit from family and community care and protection in accordance with each society's system of cultural values,
- have access to social and legal services to enhance their autonomy, protection and care,
- have access to health care to help them to maintain or regain optimal level physical, mental and emotional wellbeing and to prevent or delay the onset of illness,
- be able to live in dignity and security and be free of exploitation and or mental abuse,

- be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and
- be valued independently of their economic contribution.

Halt Elder Abuse Line (HEAL), 2005, is a Non-Governmental Organization (NGO) providing a telephonic helpline for older persons and members of the public who suspect the occurrence of elder abuse. The organization receives an average of 160 to 170 calls per month. According to director Pat Lindgren, there has been an increase in the number of cases reported. However, Lindgren says it does not mean that elder abuse is on the increase. Elder abuse has always happened. It is just becoming more open due to greater awareness of the issue. HEAL deals with various forms of abuse. Physical abuse is the most common, but many cases of financial and sexual abuse such as rape by grandchildren, have been reported. HEAL telephone counsellors are available weekdays from 8.30 to 4.30. An answering machine takes messages after hours.

Voice of the Elderly (VOTE): The elderly are often victims of fraud, and this programme seeks to identify those who are robbing elder people of their dignity and money. It is an awareness-raising model including educating the elderly and the community at large how these frauds operate. Elderly people are invited to report e.g. any services charged for but not received, any medical visit charged for but when they were not seen by a doctor. According to Stats SA there are many examples where major legislation has been introduced to combat such activities, but the failure to commit sufficient funds for full implementation has rendered it ineffective. In the absence of support services, legislation can actually do more harm than good,

resulting in unnecessary institutionalization and premature separation of the older person from the care-giver.

2.4 Witchcraft Exploitation as Associated with the Elderly

According to HEAL (2005), elderly black people, mainly women, are sometimes identified as witches by others in the community, and as a result of the accusations, they and their possessions are set alight and burnt to death. It is reported that those identified as witches often have particularly wrinkled or darkened skins due to age, or are reclusive or independent and successful. It is also reported that one of the reasons an elderly person may be victimized in this way by the community might be the wish to obtain the elderly persons' property or possessions. The background to witchcraft in Venda was examined in 'Witch killing and the elderly', an article by Payze and Minaar (2001). The article states that at least 75% of women who appeared as the victim in witchcraft cases in Thohoyandou Magistrate's Court (Venda) were elderly. The physical appearance of old women lends itself to accusations of witchcraft. The above researchers suggested the following reasons for the elderly being targeted as witches:

- the elderly are often frail and less powerful than their assailants, they are therefore seldom able to resist attack,
- they are sometimes perceived to do no work for their share of the wealth. For example they may not yet be up and working when the youth leave early in the morning for school or other activities and they have completed their tasks when the youth return late in the day,
- there is a belief in Venda that women have many secrets and by the time they are old they know about many things. Hence the Venda have a saying that, "all women

> are the same and all women are witches." The City Press reporter, Elias Maluleka covered a story of Jessie Zikalala who was burnt to death in Bluebank, Ladysmith. The 65 year old Jessie was branded as a witch by the community sangoma and her sentence was death (City Press, 2007).

According to the Human Sciences Research Council (HSRC) (2004), accusations of witchcraft have been made against older women, which lead to stigmatization and ostracizing. The elderly are vulnerably to discriminatory cultural practices, which either exclude them or limit their inheritances within the family (HSRC, 2004). HSRC (2004) also pointed out that elderly black women living alone, who are wrinkled or who have darken skin due to age, or who are suffering from dementia, are branded as witches by their communities and blamed for any disaster occurring in the area such as storm, illnesses, deaths or crop failure. As a result, they are ostracized, sometimes physically abused and have been set alight along with their houses.

The killing of an elderly couple at Umlazi highlighted the dark side of different beliefs in supernatural powers by South Africans diverse communities. This elderly couple Robert Myeni (86 years) and his wife Nomathamsanqa Myeni (85 years) were attacked by an angry mob while sleeping in their two shacks in the early hours of Sunday morning (Maluleka, 2007). The elderly couple was first stabbed, wrapped in garbage bag and petrol was poured over them and around the house before being torched. Another elderly couple, Gwilile Ngcobo and her husband Mabona of Molweni, Durban, were accused of and arrested for killing five children for muti. The bodies of the children were found in an abonded car at their homestead. Amongst the bodies were two bodies of their grandchildren (Maluleka, 2007). However, the charges against them were dropped because the police investigation revealed that the cause of

death of the children was due to carbon monoxide inhalation. The Older Person's Act 13 of 2006, aims at protecting the elderly from all forms of abuse including false accusations of witchcraft. The Act provides for anyone caring for the elderly to take steps to ensure their safety and security.

According to the Ageing and Development (2000), in the United Republic of Tanzania, some 500 older women are murdered each year because of accusations against them of witchcraft. The problem is particularly serious in Sukumaland in the north of the country. Large numbers of older women are forced to leave their homes and communities in fear of being accused of witchcraft, and end up living destitute in urban areas. The belief in witchcraft has existed in Sukumaland for centuries, though the violence surrounding it has increased sharply in recent years. This may in part be due to increased levels of poverty caused by too many people living off too little land, as well as an overall lack of education. As poor and uneducated people try to explain the misfortunes that befall them such as illness and death, crop failures and dried-up wells, they search for a scapegoat, and witchcraft appears to explain events they cannot otherwise understand or control. Among some of the particular ways in this region of Tanzania in which women are accused of witchcraft are the land disputes which underline the cause of violence against widows.

According to inheritance laws, widows may continue to live on their husbands' land, without owning the property. When they die, the land becomes the property of their husbands' sons. Accusations of witchcraft are thus used to get rid of widows living on the land as tenants, and blocking the inheritance of others. Traditional healers are frequently urged by family members or neighbours to make accusations of witchcraft against women. One young boy killed his mother after a traditional healer told him that

she was the cause of his problems (Ageing and Development, 2000). Myths about the physical appearance of witches (that they have red eyes, for instance) also often give rise to accusations of witchcraft. The eyes of many older women are red from a lifetime of cooking over smoky stoves, or from medical conditions such as conjunctivitis (Ageing and Development, 2000). More recently during the election campaign in SA the Independent newspaper (2009), wrote an article in which Mr. Tokyo Sexwale, an ANC member of Parliament ,was allegedly quoted as saying that Congress of the People opposition party (COPE) was using older women for its campaign so that these women can bewitch the ANC. These recent accounts in the media of how people come to be branded witches and sorceresses is not exhaustive, yet this is reported almost every day and reflects the sordid state of affairs in the black South African community. The older persons that are accused of witchcraft usually belong to the lower class.

2.5 Criminal Exploitation of the Elderly

During the year 2003 to 2005, the Commission visited each of the provinces and conducted workshops on the Older Persons Bill. The issue of elder abuse was strongly highlighted (NCOP, 2006). Participants at these workshops gave examples of abuse:

- general intolerance of the needs and abilities of older persons. Older persons felt that officials did not always deal with them sensitively and that their complaints were often dismissed,
- bad treatment by health officials who complain that older persons are slow and therefore they deal with them in an irritated and dismissive manner,

- incidences in which older woman are burnt because they are accused of being witches,
- abuse by each other (especially in the old age settings),
- older persons are victims of crime and
- sexual abuse and rape as a result of the spoken 'older persons cleansing myth' in which it is believed that by having sex with an older person you will be cured of HIV/AIDS (NCOP, 2006).

The NCOP report (2006) further indicates that the social grant pay points provide a number of opportunities for criminals and unscrupulous people to target older persons and abuse them financially. In the Western Cape and Northern Cape, the report indicates that there were many incidents of these stolen pensions being used to fund drug and alcohol addictions. Stories were told of addicts dropping of older persons to collect their pensions, taking their pensions from them and then driving off not caring how the older persons would get home again. Furthermore, a severe lack of affordable accommodation places elderly in vulnerable situations. The older person's financial inability to afford a home of their own, results in many having to live in situations where they are abused. Some older persons live in situations where family members abuse them personally, emotionally and financially. However, the stress of having to participate in a criminal trial prohibits some older persons from reporting abuse to the police.

Older persons are induced into parting with pension money by scam operators of burial schemes. According to NCOP (2006), in the Eastern Cape, the report states that it was echoed that the elderly were vulnerable targets who were subjected to

exploitation in the giving of loans. It also is reported that there is mounting evidence that older persons who receive old age pensions become targets of financial exploitation by an array of persons and schemes that wish to obtain access to their money. There are a number of perpetrators who abuse the elderly in order to gain access to their pensions. Robbery and physical abuse are also common in order to make the older person give the money over, exploitation by families Hawkers and loan sharks target the elderly as clients, charging them exorbitant interest rates and they fall victim to corruption and abuse by officials. A shocking example of financial abuse was given in Limpopo. Hawkers sell false medicines to the elderly at pension pay out points. It is alleged that Stasoft was being sold in small bottles for a fee of R350 with the claim that it was an arthritis medicine. When this example was given at the Free State workshop, participants giggled and spoke of skin medicines that are sold in small tubs at their pension pay out points. This 'medicine' is in fact Jeyes fluid (p. 7). The issue of financial abuse at pension pay points was raised in all provinces (NCOP, 2006).

2.6 The Effects of Elder Abuse on the Health of the Elderly

The ageing process and chronic diseases magnify the problem of abuse. Older people generally do not have the same physical, psychological, and economical reserves as younger people, which means even minor incidents of mistreatment can have a devastating effect and can lead to a loss of independence, illness or even death (Wolf, 1992). A framework for estimating the impact of abuse on health, adapted from the WHO framework for violence, was developed for the South African situation. Exposure to community and family types of violence as well as issues related health outcomes were included in the framework.

The framework illustrated that mental health outcomes, behavioural consequences, suicidal attempts and sexually transmitted infections are the most likely casual outcomes related to community violence, but could not be quantified because of lack of sufficient evidence on their prevalence and hazards. Mental health, behavioural and reproductive long-term consequences of abuse were an important risk to health in South Africa and accounted for an estimated 6.7% of all deaths in South Africa in the year 2000 (South African Medical Journal, 2007). For older people, the consequences of abuse can be especially serious because their bones are more brittle and convalescence takes them longer. Even a relatively minor injury can cause serous and permanent damage (WHO, 1998).

HEAL recently investigated a case of a 75 year old man and his wife who were being abused by the man they stayed with. They had to pay him R1 000 per month and he took their identity books, bankbook and medical aid card. He withdrew their social grant each month, beat them regularly and did not give them food. The old man had to get up at 4am to collect and sell cardboard to get money for food. On a good day, he made R25 (HEAL, 2005). A social worker from the South African Council for the Aged (SACA) who investigated the matter further, found that the couple lived in an outside room attached to the house of a family member. Tearfully they told of how they were beaten and sworn at daily, locked out of the main house They showed the social worker their ‘food ration’ for the day: two teaspoons of coffee, sugar and powdered milk each. In the evening, they were given a small serving of food. The social worker immediately arranged for the couple to be accommodated in an old age home as an interim measure and laid a charge of elder abuse at the police station. After a year, the

couple moved into a flat of their own. In order to survive, people often deny that the abuse had taken place and try to block out memories of the events. Without help, some survivors struggle to come to terms with what has happened and may develop problems such as eating disorders, depression or substance abuse (HEAL 2005).

The immediate trauma caused by abuse contributes to a number of chronic health problems including chronic pain in any organ system, depression and alcohol and substance abuse (DoH, 2000). The DoH (2000) further states that some older women are classified as witches due to their dementia, this lead to stigmatization, exclusion and even death. Abuse deprives the elderly of necessary medical care while entrusting the life of the elderly to the caregiver. Withholding medication can be used as a death threat or a form of blackmail. According to the American Journal of Preventative Medicine (2009), the elderly who have experienced or witnessed child abuse have a higher incident of being a victim or the abuser. Furthermore, this researcher states that exposure to abuse causes emotional difficulties such as depression, decreased self esteem, cognitive difficulties, family distress, impaired life functioning, increased mortality, post-traumatic stress disorder which increases the person's risk for heart attach and autoimmune diseases such as arthritis, poor regulation of the nervous and endocrine system, adrenaline rush associated with exposure to trauma wear down the cardiovascular system.

According to the South African Police Service (SAPS) (1999), a large number of homicide-suicides are reported involving older married couples, typically with man killing his wife and then taking his own life. Furthermore, SAPS (1999), states that in about 30% of reported cases, there is a history of marital problems or domestic violence in the relationship. The common characteristic of these situations is the

husband's perception of an unacceptable threat to the relationship, such as a move to a nursing home, a real or perceive decline in health, or an increase in interdependency in the relationship. Wallace (1996), states that the effects of abuse can be long lasting and the victims may believe there is no further purpose in continuing to live or function. The victims often adopt a fight or flight response, which may even be associated with a chemical release in the brain.

2.7 Conclusion

This chapter presented reviewed literature for this study. The main themes reviewed were the theoretical basis of elder abuse, the legal aspects, witchcraft exploitation as associated with the elderly, criminal exploitation of the elderly and effects of elder abuse on the health of the elderly**.**

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

In this section, the research approach, research design, research setting, study population, sample and sampling procedure, data collection instruments, the methods of data collection, validity and reliability issues, data analysis and management are described.

3.2 Research Paradigm and Approach

Guided by objectivism, this study adopted a positivist paradigm and a quantitative approach. Objectivism according to Crotty (1998) is the epistemological view that things exist as meaningful entities independent of consciousness and experience, that they hold truth and meaning residing in them as objects. Objectivism allows for things to talk for themselves with no interference from the researcher. Babbie and Mouton (2002) describe a research paradigm as a basic orientation to theory and research, a fundamental model or scheme that organizes our view of something. As stated in Babbie and Mouton (2002), a paradigm shapes how one perceives the world. It reflects the beliefs the researcher holds in answering the question of interest in the study and the way the research is designed, how data is collected and analysed, and how the results are presented. As stated in Polit and Beck (2004), the positivist paradigm assumes that there is a fixed, orderly reality that can be objectively studied. Positivists believe that phenomena are not haphazard or random events, but rather have causes (Polit, Hungler and Beck, 2004

A quantitative research approach was adopted for this study. Quantitative researchers use deductive reasoning to generate hunches that are tested in the real world (Polit and Beck, 2004). According to Burns and Grove (2004) quantitative research is a formal, objective, rigorous, systematic process for generating information about the world and it is the investigation of phenomena that can be precisely measured and quantified involving a rigorous and controlled design (Polit and Beck, 2004). This approach enabled the researcher to explore the topic from the little that was known and the researcher was able to progress logically through a series of steps because of its systematic pattern. A quantitative design was chosen because the data was presented numerically by using tables and percentages.

3.3 Research Design

Research design is a set of logical steps taken by the researcher to answer the research questions (Polit and Beck, 2004). It forms the recipe for the study and determines the methods used to collect and analyze data and to interpret results. According to Burns and Grove (2004), the design is the overall plan for gathering data in a research study. The choice of the design depends on the expertise of the researcher, the purpose of the researcher and the research problem. The study design helps the researcher in planning and implementing the study to achieve the intended goal (Polit and Beck, 2004).

In this study, a descriptive exploratory design was adopted as the most appropriate because the purpose of descriptive studies was to observe, describe and document aspect of a situation as it naturally occurs (Polit and Beck, 2004). It is designed to get more information about characteristics within a particular field of study (Burns and Groove, 2001). Its methods therefore allowed for the types and extent of the elder

abuse to be determined. Rather than simply observing and describing, exploratory research investigates the full nature of the phenomenon, the manner in which it is manifested, and the other factors to which it is related (Polit and Beck, 2004), which was the intention of the researcher in this study.

3.4 Research Setting

The study was conducted at a specifically selected Durban hospital. This was a district hospital which contained of all the medical departments namely surgical, medical, maternity, paediatrics, theatre, including outpatient's clinics. One of the clinics in the outpatient department (OPD) is the chronic illness clinic. This clinic catered for all the patients with chronic illnesses including diabetes, hypertension, asthma and epilepsy. The clinic opened from 07H00 to 16H00 and from Monday to Friday. This clinic was chosen as the study setting. The number of elder patients attended per day was about ±150-200 (PMMH OPD Stats, 2009).

3.5 Study Population

The population is described as all the elements or subjects that meet the criteria for inclusion in the study (Burns and Grove, 2004). It comprises the entire group of persons or objects that the researcher is interested in studying and refers to the aggregate or totality of those conforming to a set of specifications (Polit and Beck, 2004). The population for this study was elderly people who were attending OPD chronic illness clinic at PMMH. The total number of the population for this study was 1000 (PMMH OPD Stats, 2009).

3.6 Sample and Sampling Procedure

Sampling is the process of making a selection of the study participants from the population (Burns and Grove, 2004). It is a subset of the population that is selected to represent the population. A systematic sampling was used in this study. According to Polit and Beck (2004), systematic sampling involves the selection of every *k*th case from a group. The sample was non-probability in nature. In this study, the targeted group was all the elder people coming to the clinic. The researcher systematically sampled every 5^{th} (fifth) elderly coming into the clinic until the desired sample of 150 participants was reached.

3.7 Data Collection Instrument

In this study, data was collected with the used of a questionnaire that was based on the National Centre of Elder Abuse (NCEA) (1998) conceptual framework. The items for the questionnaire were also selected based on an extensive literature research with regard to different types of elder abuse. The questions were modified to suit elder abuse in the South African context including questions on accusations of witchcraft and the labeling of elderly as witches. The instrument consisted of three sections:

- Section A: requested the participant to provide demographic data,
- Section B: requested the participant to provide living conditions data and
- Section C: attempted to elicit the nature and extent of abuse traits which the elder person might have experience at home.

3.8 Data Collection Process

The researcher allocated one week for selection of participants. Appointments were made with the hospital manager and the clinic operational manager to explain the

purpose of the study and its significance. The researcher then met the participants and explained the purpose of the study and their rights to participate or to refuse to give information. A letter clarifying the purpose and the importance of the study was attached to each instrument and was read for the participants. The researcher distributed the questionnaires. The researcher sat and asked each participant the questions on the questionnaire. This was done because some of the elderly people were slow and had tremors due to different diseases. The data collection process took a period of approximately two weeks to complete. The questionnaires were translated into isiZulu because most of the population's home language was isiZulu.

3.9 Validity and Reliability

The validity of an instrument is the determination of the extent to which the instrument actually reflects the abstracts concepts being examined (Burns and Grove, 2004). The different assessment approaches to validity are face validity, content validity, and criterion-related validity and construct validity. Content validity of the instrument in this study, was then ensured by asking experts to evaluate the contents the instrument to be used (Burns and Grove, 2004). The instrument was handed over to Gerontology research expert for analysis, corrections and the adjustments, which was done accordingly.

Reliability refers to the accuracy and consistency of information obtained in a study (Polit and Beck, 2004). Reliability was obtained by constructing simple questions to prevent misinterpretation and to construct different sections of the questionnaire in the same manner. The internal consistency of the questionnaire was measured using Cronbach's alpha coefficient and alpha was found to be 0.87 which is considered

satisfactory. Cronbach's α (alpha) is a statistic commonly used as a measure of the internal consistency reliability of a psychometric instrument (Polit and Beck, 2004).

3.10 Data Analysis

Data analysis refers to systemic organization and synthesis of research data (Polit and Beck, 2004). All data was analyzed using a computer statistical software package (SPSS version 15 for Windows). Frequencies were computed to determine the percentages for each item contained in the questionnaire.

3.11 Ethical Consideration

Permission for the Study: when humans are used as study participants, care must be exercised in ensuring that the rights of those humans are protected (Polit and Hungler, 2004). Ethical approval was granted by the University Of KwaZulu-Natal Faculty Of Health Sciences Research Ethics Committee. Permission to conduct the study at the selected hospital was requested from the KZN Provincial Department of Health and from the selected hospital manager.

Informed Consent: is defined as an ethical principle that requires researchers to obtain voluntary participation on the subject after informing respondents of possible risks and benefits (Polit and Hungler, 2004). Informed consent was obtained from each participant. A letter and informed consent form explaining the purpose and nature of the study was read and supplied to each participant. Participants were informed of their right to withdraw from the study at any time. Furthermore, all participants were assured that no information given by them would be shared with another person without their authorization. A letter explaining the purpose of the study was attached to

the questionnaire together with consent for participation. This letter requested the participants to give permission to do so freely, and to fill and complete the questionnaire.

Protection of vulnerable subject: as elderly are considered a vulnerable group, addition measures were taken, those elderly who were sick and confused were not requested to participate in the study. One Registered nurse in the clinic was identified whom the elderly can contact and report to if having any problems.

I, the researcher, am psychiatric trained, I would also offer counseling to those who are affected by the issues that can arise from the questionnaire.

Confidentiality: participants were ensured that the information would only be accessible to the researcher and that the information would only be used for the purpose of this research.

Anonymity: was assured by informing the respondents that their names were not be revealed and questionnaires would not be linked to names.

Benefits: the participants were assured that there were no potential, physical, psychological, social and legal risks to the participants. The researcher explained to the participants that there were no direct or any monetary benefits to them. However , the information they contributed was aimed at the enhancement and the improvement of health care provision for the elderly.

3.12 Conclusion

This chapter presented an overview of the study approach, design, setting and population that was used in this study. The data collection instrument and collection process were also presented. This chapter also depicts the ethical consideration including permission of the study, informed consent, confidentiality and anonymity.

CHAPTER 4

DATA ANALYSIS AND REPORTING

4.1 Introduction

This chapter presents the results of data that was obtained quantitatively. Quantitative data analysis was performed using the Statistical Package for Social Science (SPSS) version 15.0 which included frequency distribution, percentages and the use of tables and graphs as and when necessary. The objectives of the study were to:

- Explore the different types of abuse that the elder are exposed to
- Determine the extent of elder abuse in the Durban metropolitan areas.

4.2 Sample realization

The targeted total number of participants reached was 150. The questionnaire was distributed to all participants that were systematically chosen. A total of 150 responded.

4.3 Demographic characteristics and living conditions of participants

The participants were asked to respond to questions aimed at determining the conditions they were living under and their demographic data. Out of 150 participants in this study 69.3% (n=104) were between the ages 60 -80years old. The remaining 30.7% (n= 46) were above 80years. A total of 63.3% (n=95) of participants were elder females and 36.7% (n=55) were males. Most elderly were African 70.0% (n=105), followed by Asians 22.0% (n=33), Coloured participants were 7.0%,(n= 11), and Whites 1.0%, (n=1).

Most participants about 86.7%, (n=130) stayed in their own houses and 13.3% (n=20) stayed in institutions. The same number of participants who stayed in urban area were 86.7% (n=130) and 13.0% (n=20) stayed in rural area. In terms of marital status 60.0% (n= 91) of subjects were widowed, 29.0% (n=44) were married, 8.0% (n=12) were divorced and only 2.0% (n=3) were single. Most participants were pensioners, represented by 80.0% (n=120),employed full time 17.0% (n=25) and employed part time were 3.0% (n=5). The majority of participants 49.0% (n=74) provided the main income for their families, 43.0% (n=65) were provided by member living at home, 3.0% (n=4) provided by member living who returns monthly, and 4.7% (n=7) was other.

Table 4.1 Demographic Characteristics of Participants

Variable		Frequency	Percent
Gender:			
	Male	55	36.7
	Female	95	63.3
Age:			
	60-80yrs	104	69.3
	80yrs and above	46	30.7
Race :			
	African	104	70.0
	Asian	33	22.0
	Coloured	11	7.0
	Whites	1	1.0
Marital status:			
	Married	44	29.3
	Divorced	12	8.0
	Single	3	2.0
	Widowed	91	60.7
Place lived:			
	Own house	130	86.7
	Institution	20	13.3
Area lived:			
	Urban	130	86.7
	Rural	20	13.3
Employment status:			
	Employed full time	25	16.7
	Employed part time	5	3.3
	Pensioner	120	80.0
Main income provider			
	Self	74	49.3
	Member living at home	65	43.3
	Member living away returns monthly	4	2.7
	Other	7	4.7

Living conditions

Most participants were living with children 53.0%, (n=79), 24.0% (n=36) lived with partner, 14.0% (n=22) lived with grandchildren, 5.0% (n=7) lived with roommates., Almost half of participants 49.3% (n=74) lived in houses made of cement blocks, 36.7% (n= 55) of participants lived in houses made of mixed cement, 10.7% (n=16) lived in houses made of bricks, 0.7% (n=1) lived in houses made of sticks, mud and stones, 2.7% (n=4) were other types of houses. The water system of participants was 73.3% (n=110) piped inside, 26.7% (n=40) were piped-yard. Participants with flushed toilet made up 72.7% (n=109), VIP toilet 10.7% (n=16), chemical toilet 16.7% (n=25). The mode of cooking used by participants revealed that 69.4% (n=104) used electricity, 17.3% (n=26) used gas, 13.3% (n=20) used paraffin. Food for most participants was prepared by a family member living them as indicated by 68.7% (n=103), self 26.7% (n=40), care giver 2.0% (n=3), family member not living with them were 2.7% (n=4).

4.4 Abuse typology

The participants were asked to respond to questions aimed at determining the type of abuse that they might have experienced including physical abuse, emotional / psychological, financial abuse and sexual abuse. The other questions were on witchcraft since this phenomenon was highlighted in literature review. Participants were ask to choose from the three responses on the questionnaire which were *yes, no* and *not sure*. *Yes* meant that they were experiencing the type of abuse. No meant that the elderly did not experience that type of abuse. Not sure meant that the elderly was unsure if the experience fell under abuse or not.

4.4.1 Responses on Physical Abuse

Participants who were prevented from having food 13 (8.7%) and not prevented from having food were 91.3% (n=137). Participants who were prevented from having medication were 17.3% (n=26), not prevented from having medication 82.7% (n=124). No participants were prevented from having adequate living space. Participants who were prevented from having health aids such as eyeglasses, hearing aids and other were 21.3% (n=32) and 78.7% (n=118) were not prevented. Participants who were physically hurt, hit, bit, slap were 46% (n=69), 54% (n=81) were not hitten, bitten, slapped. Participants who were pushed 54.7% (n=82), the remaining 45.3% (n=68) were not pushed. Participants who were who were stroked with or without an object were 30.7% (n=46) those who were not stroked 69.3% (n=104). Participants who were kicked were 40.7% (n=61), not kicked were 59.3% (n=89). Participants who were shoved were 28% (n=42), not shoved were 72% (n=107, not sure 0.7%. Most participants were pinched (51.3%, n=77) not pinched were 48.7% (n=73). Some participants revealed that they were burnt (43.3%, n=63) not burnt were 56.7% (n=85). Half of the participants were force-fed (50%, n=75) not force-fed were 49.3% (n=74), not sure were 0.7% (n=1). Participants who were restrained were 35.3% (n=53), not restrained 62.7% (n=94), not sure 2% (n=1). Very few participants depended on someone for help with bathing as indicated by 22% (n=33), most of the participants did not depend on someone for bathing (76%, n=114), those who were not sure were 2% (n=3). Participants who depended to someone for help with shopping were 12.3% (n=19), those who did not depend on someone for shopping were 87% (n=130), not sure were 0.7% (n=1). A low number of participants depended or relied to someone for help with taking meals as indicated by 17% (n=26), most of the participants did not depend or rely to someone for help with taking meals (83%, n=124) Participants who

depended or relied to someone for help with taking medication were 32.7% (n=49), those who did not were 64.3% (n=97), not sure were 2.7% (n=4). Table 4.2 indicates the responses of participant on Physical abuse.

Table 4.2: Responses on Physical Abuse

Variable	Yes		No		Not sure	
Physical Abuse	**Freq.**	**Percent %**	**Freq.**	**Percent %**	**Freq.**	**Percent %**
Food	13	8.7	137	91.3	0	0
Medication	26	17.3	124	82.7	0	0
Clothing	52	34.7	98	65.3	0	0
Adequate living space	0	0	150	100	0	0
Health aids such as eyeglasses, hearing aids and other.	32	21.3	118	78.7	0	0
Has anyone at home physical hurt you including:						
Hit/bit/slap you	69	46	81	54	0	0
Pushed you	82	54.7	68	45.3	0	0
Strike with or without an object	46	30.7	104	69.3	0	0
Kicked you	61	40.7	89	59.3	0	0
Shoved you	42	28	107	71.3	1	0.7
Pinched you	77	51.3	73	48.7	0	0
Burnt you	65	43.3	85	56.7	0	0
Force fed you	75	50	74	49.3	1	0.7
Restrained you	53	35.3	94	62.7	3	2
Do you depend or rely most of the time to someone for help with basic daily needs including:						
Bathing	33	22	114	76	3	2
Shopping	19	12.3	130	87	1	0.7
Taking meals	26	17	124	83	0	0
Taking medicine	49	32.7	97	64.7	4	2.7

4.4.2 Responses on Emotional/Psychological Abuse

Questions were asked to determine if the participants were emotionally or psychologically abused or not.

Participants who usually felt lonely were 48.0% (n=72), those who did not feel lonely were 49.3% (n=74) and those who were not sure were 2.7% (n=4). Participants who were sad most of the time were 19.3% (n=29), most participants were not sad 76.7% (n=115). Participants who had someone who spent time with them were 20.7% (n=31), those who had nobody who spend time with them were 78.0% (n=117) and

those who were not sure were 1.3% (n=2). Participants who felt nobody wants them around were 15.3% (n=23), those did not feel that way were 82.7% (n=124) and those who were not sure were 2.0% (n=3). Over half of the participants trusted most people around them 52.7% (n=79) those who did not trust most people around them were 47.3% (n=71).

Participants who were treated like children were very few about 9.3% (n=14) those who were not treated like children accounted for a larger percentage were 90.7% (n=136). Participants who were upset because someone talked to them in the manner that made them ashamed or fearful were 8.7% (n=13) those who did not experienced this were 91.3% (n=137). Participants who had anyone talked to them in the manner they did not like were 6.7% (n=10), those who did not experience this were 93.3% (n=140). Participants who had anyone who made them especially sad were 11.3% (n=17), those who were not especially sad were 88.7% (n=133). Participants who had someone who yelled at them and felt ashamed were 16.0% (n=24), those who were not yelled at and felt ashamed were 84.0% (n=126). Participants who had someone who yelled at them and felt fearful were 10.0% (n=15), those who were not yelled at and felt fearful were 90.0% (n=135). Participants who were made upset for a long time 14.7% (n=22), those who were not made upset were 85.3% (n=128). Participants who sometimes felt unhappy were 38.7% (n= 58), those did not feel unhappy were 61.3% (n=92). Participants who sometimes felt anxious were 24.0% (n=36), those who did not feel anxious were 76.0% (n=114).

Participants who were prevented from doing things that were important to their wellbeing were 12.7% (n=19), those who were not prevented were 87.3% (n=131).

Very few participants had anyone who interfered with them being with people they wanted to be with 5.3% (n=8) a large number of participants had nobody interfering with them being with people they wanted to be with and were 94.7% (n=142) as indicated in Table 4.3.

Table 4.3: Responses on Emotional/Psychological Abuse

Emotional/ Psychological abuse						
Item	**Yes**		**No**		**Not sure**	
	Freq.	**Percent%**	**Freq.**	**Percent%**	**Freq.**	**Percent** %
Do you usually feel lonely	72	48	74	49.3	4	2.7
Are you sad most of the time	29	19.3	115	76.7	6	4.0
Do you have someone who spend time with you	31	20.7	117	78.0	2	1.3
Do you feel nobody wants you around	23	15.3	124	82.7	3	2.0
Do you trust most people around you	79	52.7	71	47.3	0	0
Has anyone treated you like a child	14	9.3	136	90.7	0	0
Have you been upset because someone talked to you in the manner that made you ashamed or fearful	13	8.7	137	91.3	0	0
Has anyone talked to you in the manner you did not like	10	6.7	140	93.3	0	0
Has anyone made you feel especially sad	17	11.3	133	88.7	0	0
Has anyone yelled at you and felt ashamed	24	16.0	126	84.0	0	0
Has anyone yelled at you and felt fearful	15	10.0	135	90.0	0	0
Has anyone made you upset for long time	22	14.7	128	85.3	0	0
Do you sometimes feel unhappy	58	38.7	92	61.3	0	0
Do you sometimes feel anxious	36	24.0	114	76.0	0	0
Do you feel uncomfortable turning to people for help	21	14.0	129	86.0	0	0
Has anyone prevented you from doing things that were important to your wellbeing	19	12.7	131	87.3	0	0
Has anyone interfered with you being with people you wanted to be with	8	5.3	142	94.7	0	0

4.4.3 Responses on Sexual Abuse

The participants were asked questions to determine if they experienced sexual abuse. Participants who consume alcohol were 39.3% (n=59), those who did not consume alcohol were 60.7% (n=91). Over half of the participants stayed with someone who consumed alcohol were about 54.7% (n=82), participants who did not stay with someone who consumed alcohol were 45.3% (n=68). Participants who had their private part touched were 15.3% (n=23), those participants whose private part were not touched were 54.7% (n=127). Participants who felt like someone has raped them

were 4.7% (n=7), most of the participants did not feel like someone has raped them 95.3% (n=143).

Very few participants were made to be nude forcefully as indicated by 2.0% (n=3), those who were not made to be nude forcefully were 98% (n=147). No participant had their pictures taken naked (0%). Participants who were sexually assaulted were 11.3% (n=17), participants who were not sexually assaulted were 86.7% (n=133). Participants whose relatives tried to rape them were 13.3% (n=20), those participants whose relatives did not try to rape them were 86.7% (n=130). No participants were forced to look at pornography (0%). Figure 4.1 depicts the responses of participants on Sexual abuse.

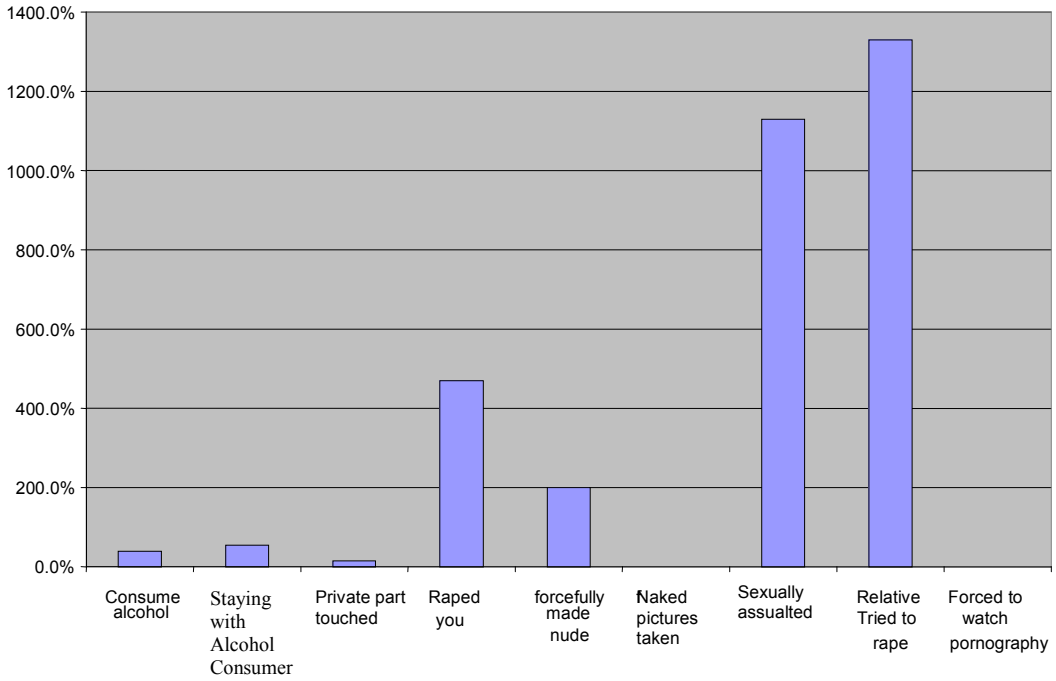

Figure 4.1 Depict Sexual Abuse of Participants

4.4.4 Responses on Financial Abuse

Participants were asked if they were financially abused or not. Participants who were forced to sign papers that they did not understand were 10.7% (n=16), those participants who were not forced to sign papers that they did not understand were 89.3% (n=134). Participants whose money was used against their will were 14.0% (n=21), and those whose money was not used against their will were 86.0% (n=129).

Participants who had someone that they trusted at home tried to use their money were 12.0% (n=18) and participants whose money was not used were 88.0% (n=132). Participants who had anyone who tried to use their property in ways they did not like were 9.3% (n=14), those whose property were not used in ways they did not like were 90.7% (n=136). Participants whose bills were paid on time were 61.3% (n=92), those whose bills were not paid on time were 16.0% (n=24) and those who were not sure were 22.7% (n=34). Participants who often found cash missing in their houses were 45.3% (n=68), those did not find cash missing in their houses were 54.7% (n=82). Participants who had anyone who tried to change their will were 8.0% (n=12), those whose will's were not changed were 92.0% (n=138).

Participants who had anyone who tried to make changes in their policies were 6.0% (n=9), those whose policies were not changed were 94.0% (n=141). Participants who anyone who tried to purchase expensive items without their permission were 12.0% (n=18), those that had nobody who tried to buy expensive items were 88.0% (n=132). Participants who had anyone who denied them access to their money were 29.3% (n=44), those who were not denied access to their money were 70.7% (n=106). Participants who had anyone who forced them to buy something they did not need or

want were 14.0% (n=21), those who were not forced were 86.0% (n=129). Table 4.4 indicates the responses of participants on financial abuse.

Table 4.4 Responses on financial abuse

Financial abuse						
Item	**Yes**		**No**		**Not sure**	
	Freq.	**Percent %**	**Freq.**	**Percent %**	**Freq.**	**Percent %**
Has anyone tried to force you to sign papers or documents that you did not understand	16	10.7	134	89.3	0	0
Has anyone used your money against your will	21	14.0	129	86.0	0	0
Has anyone that you trust at home tried to use your money	18	12.0	132	88.0	0	0
Has anyone tried to use your property in ways you did not like	14	9.3	136	90.7	0	0
Are your bills paid in time	92	61.3	24	16.0	34	22.7
Do you often find cash missing in your house	68	45.3	82	54.7	0	0
Has anyone tried to change your will	12	8.0	138	92.0	0	0
Has anyone tried to make changes in your policies	9	6.0	141	94.0	0	0
Has anyone tried to purchase expensive items without your permission	18	12.0	132	88.0	0	0
Has anyone denied you access to your money	44	29.3	106	70.7	0	0
Has anyone forced you to buy something you did not need or want	21	14.0	129	86.0	0	0

4.4.5 Responses on Witchcraft

Participants were asked questions to determine witchcraft allegations.

Participants who suffered from confusion were 18.0% (n=27), those did not suffer from confusion were 82.0% (n=123). Most participants suffered from forgetfulness and there were 66.0% (n=99), and those who did not suffer from forgetfulness were 34.0% (n=51). No one suffered from Dementia. Participants who were accused of witchcraft were 24.7% (n=37), and participants who were not accused of witchcraft were 75.3% (n=113). Participants who were labelled as witches were 14.7% (n=22), those who were not labelled as witches were 85.3% (n=128). Participants whose houses were burnt down were 14.7% (n=22), those whose houses were not burnt down were

85.3% (n=128). Participants who were chased away by the community were 10.7% (n=16), the remaining 89.3% (n=134) were not chased away by the community.

Participants to whom someone said they looked like a witch were 7.3% (n=11), those who did not look like witches were 92.7% (n=139). Participants who were blamed for illness in the family were 28.0% (n=42), those who were not blamed were 72.0% (n=108). Participants who were blamed for dying livestock were 6.0% (n=9), the remaining 94.0% (n=141) were not blamed for dying live stock. Participants who were accused of walking around at night were 18.0% (n=27), those who were not accused of walking around at night were 82.0% (n=123) as depicted by figure 4.2.

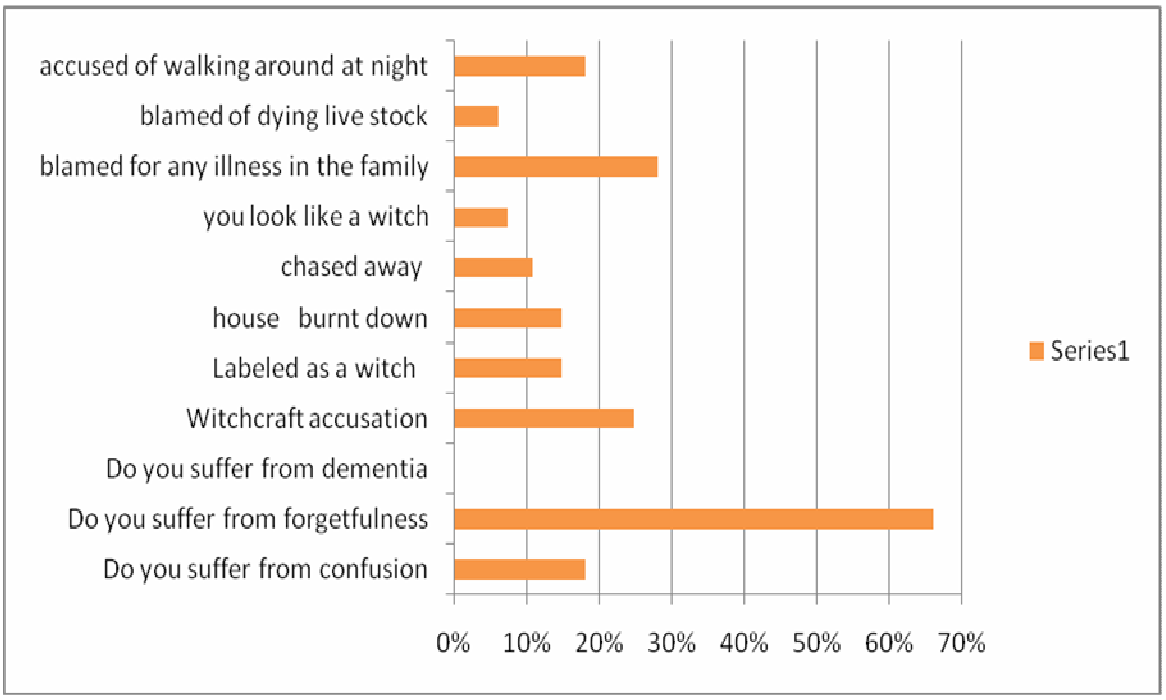

Figure 4.2: Responses on witchcraft

CHAPTER 5

DISCUSSION, RECOMMENDATIONS AND CONCLUSION

5.1 Introduction

This chapter presents a discussion of the most significant findings of this research study, the conclusion as well as the recommendations made for nursing and for further research. The purpose of this study was to explore the types and patterns of elder abuse and its extent in the Durban metropolitan areas in KwaZulu-Natal. The objectives of this study were to:

- explore the different types of abuse that the elder are exposed to; and
- determine the extent of elder abuse in the Durban metropolitan areas.

The findings will be discussed in relation to the research objectives and the conceptual framework used in this study as well as the literature and previous studies on elder abuse.

5.2 Summary of major findings

- It emerged from this study finding that the elderly experience physical abuse more than any type of abuse. The common types of physical abuse experienced by the elderly included pinching, force-feeding, hitting, biting and slapping, burning, kicking, prevention from having food and medication, prevention from having health aids such as eyeglasses, hearing aids etc and restraining. The main perpetrators of the abuse were close relatives, loved ones and carers.
- This study also revealed that elderly were abused financially. They were forced to sign papers that they did not understand, their money was used and property

taken, their personal bills were not paid on time, policies such as investments were changed, expensive purchases were made on their accounts without their permission and they were denied access to their money.

- The findings of this study revealed that the elderly were treated like children, were made upset because someone talked to them in manner that made them ashamed or fearful, they were made especially sad, felt anxious, felt unhappy, were yelled at and prevented from doing things that were important for their well being.
- Lastly, witchcraft emerged as a devastating and life threatening type of abuse. Findings revealed that the elderly suffered from forgetfulness, were chased away from the community, accused of witchcraft, labelled as witches and had their houses burnt down and were accused of walking around at night.

5.3 Discussion of Findings

5.3.1 Salient Features of the Participants

This study revealed that most elderly people experienced some sort of abuse. The most affected ones were older Black women who were widowed and living with grandchildren either in urban areas or in the rural area. This is in line with the study of Muzzy (2009), which stated that the victims of abuse are the elderly with physical impairments, dementia, substance abuse, emotional and financial dependence. But this study revealed that every elder person is vulnerable and exposed to any type of abuse irrespective of physical and mental impairment.

In this study most participants were females and widowed. The widows were pensioners living in their own houses and were the main income providers for their families. In line with these findings Perel-Levin (2008) is of the view that women were

living longer than men almost everywhere in the world so he states that these women become more likely to experience all types of abuse. However, the National Centre of Prevention of Elder Abuse (2009) argues that in their study carried out in America, victims of elder abuse were mostly White females who were frail and cognitively impaired rather than African American. The current study was conducted in an African dominated context in South Africa, thus African Black women accounted for the larger percentage of participants.

5.3.2 Physical abuse

This study revealed that most elderly experienced physical abuse in one way or another. Among the traits of physical elder abuse, pushing was the most common in this study, experienced by 54% of the respondents. The other types of physical abuse experienced by the elderly included pinching, force-feeding, hitting, biting and slapping, burning, kicking, prevention from having food and medication, prevention from having health aids such as eyeglasses, hearing aids etc and restraining. Many authors (NCEA, 1998; Wolf and Pillemer, 1994) define physical abuse as the use of physical force that may result in bodily injury, physical pain or impairment. It includes striking with or without an object, hitting, restraining, force-feeding, beating, pushing, slapping, shoving, kicking, pinching and burning. In line with the findings of the NCEA (1998) and Wolf and Pillemer (1994), the results of their studies revealed that physical abuse of elderly included pushing, shoving strike with an object and prevention from having medication.

The statistical scores which emerged for physical abuse ranged from 1- 11, with 11 being the highest score of physical abuse. It emerged that 11 represented gross physical abuse, most elderly scored between 6- 9. The higher the score the more

types of physical abuse the elderly suffered. According to this study, three out 150 participants scored 11 out of 11 on the physical abuse score. This means that all the participants in this study experienced or were exposed to more than five traits of physical abuse.

The South African National Department of Health (2000), (SANGEA, 2000) in their National Guidelines of Elder abuse, stated that physical abuse that had occur was 8.1% compared to other types of abuse. Supporting this, Jinjoo, Hesook and Diane (2006), in their study of elder abuse in Korea reported that physical abuse was least common among other types of abuse (Jinjoo et al, 2006). Furthermore Lindbloom and Brandt (2007) conducted a survey of elder abuse on family members living with elderly. Their survey revealed that 10% of family members reported that they had committed such acts themselves and 40% had observed other family members committing such acts.

5.3.3 Financial abuse

It emerged from the results of this study that financial abuse was second most common type of abuse. It is revealed that elderly who were forced to sign papers that they did not understand, their money was used or their property taken, bills went unpaid, policies such as investments and life insurances were changed, expensive purchases were made on their accounts and they were denied access to their money. In line with these findings, The South African National Department of Health (2000) confirmed that 53.8% of elder abuse occurs at home, 42% of elder abuse occurs in the community and 3.9% occurs in institutions. These institutions included hospitals,

Nursing Homes and retirement homes. SANGEA further states that financial abuse at home is about 35.6%.

According to a study conducted by Cardona, Meyer, Post and Schiamberg (2007), it was indicated that financial abuse occurred in families that were affected by unemployment, crowded living conditions and limited financial recourses. In line with Cardona et al. the current study revealed that the elderly were unemployed but were pensioners. According to the S.A. Labour Relations Act (2005), any female above age 60 years is entitled to be on pension, for males the age is 65 years and above. The South African Department of Social Welfare (1998) states that any female age 60 years and above is entitled to the Government Pension Grant, and males should be 65 years and above, even if they never worked before.

It also emerged in this study that the elderly had limited resources, they relied almost completely on the government pension grant, especially those who did not have professional jobs prior to retirement. In line with these findings Jinjoo et al. (2006) pointed out that a large number of elderly who were independent and were still supporting children and grandchildren were at high risk of being financially abused, followed by those elderly who had good jobs before retirement. Sijuwade (2008), stated that, despite being 70 years or older, 32% of participants were still working, due to economical necessity.

Sijuwade further stated that these people (above70yrs) were at high risk for financial abuse either by their employer or family members. The South African Department of Social Development (2009) stated in their training manual that financial abuse

accounts for 9.8% out of all abuse allegations. This department further stated that financial abuse may be at the hands of the family member who feels they are owed money in terms of an inheritance or as payment for their care giving duties, then the elder person become the victim.

In line with these findings the NCPEA (2009), revealed that the perpetrators of elder financial abuse were grandchildren and sons rather than the daughters of the elders. This was worsened by the problem of alcohol and drug abuse because the very same perpetrators were dependent on the elderly for their own shelter and finances (NCPEA 2009).

This study stated that the perpetrators had a sense of entitlement and believed that they had the right to the money of their parents or older relatives. These perpetrators often started with small crimes such as stealing small amounts of money and jewellery then moved to signing cheques, changing the will and liquidating the elder's assets (NCPEA, 2009).

5.3.4 Emotional abuse

In this study, emotional and or psychological abuse came third on the list following financial abuse, which is second and physical abuse as the most common one. It emerged that elderly felt that they were treated like children, they were upset because someone talked to them in a manner that made them ashamed or fearful, they were made especially sad, felt anxious, felt unhappy, were yelled at and prevented from doing things that were important for their well being. These findings were in line with Lueders (2010) who did a study on emotional and verbal abuse of the elderly. Lueders (2010) highlighted that emotional abuse included talking to the elderly in a manner that

she/he did not like, yelling at the elderly which made them ashamed and fearful, and controlling the elderly person's whereabouts. This researcher further stated that in emotional abuse the offender is usually the person that is taking care of the elderly such as the daughters or caregiver of the elderly. This form of abuse occurs during bath, feeding and medication time as indicated in this study. Lueders revealed that emotional abuse occurs most often to the elderly with the least power and resources.

It emerged that the people with the least power are females rather than male so females are more exposed to abuse than male. Emotional abuse does not leave any bruises, broken bones or scars so the elderly think it is not that serious, whereas it is very serious because it leaves the elderly withdrawn, ashamed, fearful, limited freedom of being with anyone they want to be with. They may also suffer from anxiety, high blood pressure, heart problems, digestive problems and chronic pain as (Lueders 2010) indicated.

In another study by McChristie (2010), it emerged that emotional abuse does not leave any black eyes or bruises but leaves serious scars on the person's self esteem. McChristie emphasized that as emotional abuse is frowned upon by outsiders, the abuser is very careful to save the scenes for home environment only as indicated in the results of this study.

5.3.5 Sexual abuse

It emerged in this study that elderly people in the community who either consumed alcohol and or lived with someone who consumed alcohol, reported that their private part were touched, they felt like someone had raped them, were made to be nude forcefully, were sexually assaulted, relatives tried to rape them. No participants were

forced to look at pornography and no subject had their pictures taken naked. It also emerged that elderly were less inclined to talk about it and reporting sexual abuse was even worse.

Sexual abuse of elderly occurs in the community dwellings more than anywhere else. Newspapers and television reports of elder abuse appear almost every week in South Africa. According to Meel (2008), of all rape cases reported in the community centre, elderly women accounted for only a small percentage compared to those age 11years to 20 years. Rape occurred because of poverty in his area of study and because people were living in crowded homes (Meel, 2008). Furthermore, Meel (2008) pointed out that the elderly were raped by relatives and by males known to the family.

In line with Meel's findings, Manesh (2007) revealed that Indian elders living with families were at high risk for sexual abuse. This researcher further stated that these elders were less inclined to report sexual abuse as it would bring shame to the family and they feared being rejected by their own family (Manesh, 2007). The Indian elders suffered sexual abuse due to their physically defenceless nature. Manesh (2007) indicated that Indian senior citizens had a fear of crime and that was why they did not report any form of abuse, especially sexual abuse.

On contrary, Pillemer and Rosen (2010) are of the opposing view to Manesh (2007). They argued that out of all types of elder abuse, most sexual abuse of elderly occurred in care facilities and the offenders were the staff. Pillemer and Rosen (2010) are of the view that sexual abuse victims in care facilities occurred because of the high level of dependency of the victim on the perpetrator and due to fact that some victims suffer from dementia (Pillemer and Rosen, 2010).

In line with the above findings Lindbloom and Brandt (2007) highlighted that most sexual abuse reported cases were from care facilities. These researchers pointed out that the victims of sexual abuse in the care facility presented with fear, confusion, loss of appetite and withdrawal as consequences of sexual abuse (Lindbloom and Brandt 2009). Furthermore Lindbloom and Brandt (2009), stated that most of the perpetrators of sexual abuse in the care facilities had a criminal record of rape or sexual abuse of residents.

5.3.6 Witchcraft as a typology of abuse

It emerged from this study that the elderly suffered from forgetfulness, were chased away from the community, accused of witchcraft, labelled as witches and had their houses burnt down and were accused of walking around at night. These findings were supported by a study of Makiwana (2004) which stated that accusations of witchcraft have been made against older women, which leads to stigmatization and ostracizing.

Witchcraft is defined by Makiwana (2004), as the alleged use of supernatural or magical powers, sometimes these powers are used to inflict harm upon members of a community or their property. The concept of witchcraft is normally treated as a cultural ideology, a means of explaining human misfortune by blaming it either on a supernatural entity or a known person in the community (Makiwana, 2004). Makiwana (2004), revealed that accusation of witchcraft have been targeted to older women. Furthermore Makiwana (2004), found that elderly black women living alone, who are wrinkled or who have darkened skin due to age, who are suffering from dementia, are branded as witches by their community and blamed for any disaster occurring in the area such as storms, illnesses, deaths or crop failures (Makiwana 2004).

The HSRC pointed out that the elderly are vulnerable to discriminatory cultural practices, which either exclude them or limit their inheritances within the family. As a result, they are ostracized sometimes physically abused and have been set alight along with their houses. Nhongo (2006) confirmed that elder people are accused of all forms of witchcraft, from causing deaths, HIV/AIDS, traffic accidents, too much or too little rainfall. They suffer unimaginable consequences such as being chased away from the community or even having their house burnt down (Nhongo, 2006). Moreover Nhongo stated that this happened to elderly who have no family members to defend them and most of the time they were living with grandchildren who could not protect them (Nhongo, 2006).

The findings of this study revealed that the elderly were accused of all forms of witchcraft. In line with these findings the Older Person's Act 13 of 2006, which aims to protect the elderly from all forms of abuse including accusations of witchcraft, provides for anyone caring for the elderly to take steps to ensure their safety and security. According to Ageing and Development (2000), in the United Republic of Tanzania, some 500 older women are murdered each year as a result of accusations of witchcraft against them. The problem is particularly serious in Sukumaland in the north of the country. Large numbers of older women are driven from their homes and communities in fear of being accused of witchcraft, and end up living destitute in urban areas. Belief in witchcraft has existed in Sukumaland for centuries, though the violence surrounding it has increased sharply in recent years. This may in part be due to increased poverty caused by too many people living off too little land, as well as an overall lack of education. As poor and uneducated people try to explain the misfortunes that befall them illness and death, crop failures and dried-up wells they

search for a scapegoat, and witchcraft appears to explain events they cannot otherwise understand or control (Ageing and Development, 2000).

5.4 Recommendations

Service delivery

This study recommends a multidisciplinary approach to elder care and management. In caring for and recognizing the problems facing the elderly in the community, a multidisciplinary approach is needed incorporating Social Workers, Police, Community Health Nurses and Doctors. An applicable referral system and home visits or follow up by the community based nurses need to be fully functional to attend to the elders.

Education

It is recommended that the nursing curriculum should include a detailed geriatric syllabus since there is a fast growing number elderly in our society and they need special nursing care as a vulnerable group. It should be incorporated in the undergraduate syllabus or Basic Nursing Sciences Degree as a subject on it own. Gerontology should be recognized as a specialty because our society needs specialist to deal with the elderly people's special needs.

Further research

In South Africa there is very little (few) research done on elder abuse. A qualitative study that will explore the views of elderly on abuse is recommended. Further research that would explore each type of abuse as it occurs in the community is recommended as this will add to the existing limited literature on the subject.

Policy

In South Africa, although there is the Elder Person's Act (No 13 of 2006), it is not implemented to the benefit of the elderly. It should be known to every citizen especially health care and social workers who deal with the elderly every day. This can be accomplished by means of awareness campaigns such as holding road shows in hospitals, clinics, schools and community centers, and making use of the media (newspapers and radios).

In South Africa there are National guidelines on the prevention of elderly abuse but these are not sufficiently implemented to safeguard the health and well being of the elderly. It is recommended that these guidelines be disseminated to Provinces, municipalities then communities and proper follow-on the implementation is carried out.

5.5 Limitation

Limitations according to Participants

The limitations of this study were that, because it was conducted in an area which was dominated by African racial group who attended a semi rural chronic illness clinic, it cannot be concluded that elder abuse affects African people more than any other race in South Africa. It was not feasible to trace the elderly in the community thus the researcher used the ones in the clinic.

Methodological limitations

Methodologically this study was limited by the number of participants attending the clinic. In addition, patients at a clinic setting are always in a hurry to see the doctor and fetch medication in the pharmacy then rush back home, therefore the sample may not be a true representation of all elderly.

5.6 Conclusion

The data showed that elder abuse is prevalent amongst the elderly, irrespective of gender, ethnicity, marital status and economic status. Elder people are living longer; and their disabilities and dependencies increase in severity with their age. This is why they are exposed to one or more types of elder abuse, the most common one being physical abuse. The abuse of elderly occurs in the home environment without anyone noticing it because it is usually hidden by the victims as well as the offenders in fear of stigmatization. The emerging type of abuse being witchcraft, elderly is accused of witchcraft almost every day and this affects their psychological and physical wellbeing. Health care workers need to be observant of elder abuse so as to report offenders as per the Older Person's Act (2006).

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APPENDIX 1

ELDERLY QUESTIONNAIRE

SECTION A: Biographic/Demographic Data

Instruction:

Please answer the following questions by ticking (√) the appropriate box.

1. What is your age?

60 – 80yrs	1	
80yrs and above	2	

2. What is your gender?

Male	1	
Female	2	

3. What is your Race?

African	1	
Asian	2	
Coloured	3	
White	4	

4. Where do you stay?

Own house	1	
Institution	2	

5. In which area?

Urban	1	
Rural	2	

6. What is your marital status?

Married	1	
Divorced	2	
Single	3	
Widowed	4	

7. Are you…..

Employed full-time	1	
Employed part-time	2	
Unemployed	3	
Pensioner	4	

8. Who is the main income provider in your home?

Self	1	
Member living at home	2	
Member living away returns monthly	3	
Other (Please specify)	4	
Don't know	5	

Section B: Living conditions

Please answer the following questions by ticking (✓) the appropriate box.

1. Who do you live with?

Alone	1	
With partner	2	
With children	3	
With room-mate	4	
With grandchildren	5	
With relatives	6	
With paid care-giver	7	

2. How many people live with you? ……..

3. What is your house made of?

Mixed materials	1	
Cement blocks	2	
Bricks	3	
Sticks, mud, stones	4	
Other	5	

4. How is your water system?

Piped- inside	1	
Piped- yard	2	
Piped- public tab	3	
Water tanker	4	
Other	5	

5. How is your toilet?

Flushed toilet	1	
VIP toilet	2	
Chemical toilet	3	
Bucket toilet	4	
Other pit latrine	5	
Other	6	

6. What do you use for food preparation?

Paraffin	1	
Gas	2	
Electricity	3	
Wood	4	

7. Who prepare food for you?

Self	1	
Family member living with you	2	
Family member not living with you	3	
Care giver	4	
Other	5	

SECTION C: Questions for Abuse Typology

#	Question	1 Yes	2 No	3 Not Sure
Questions about Physical Abuse:				
1	Has anyone prevented you from having needed things such as: 1.1 Food, 1.2 Medication, 1.3 Clothing, 1.4 Adequate living space, 1.5 Health aids such as eyeglasses, hearing aids, etc.?			
2	Has anyone physically hurt you, e.g.: 2.1 Hit/bit/slap you, 2.2 Pushed you 2.3 Strike with or without an object 2.4 Kicked you 2.5 Shoved you 2.6 pinched you 2.7 Burnt you or 2.8 Force-fed you 2.9 Restrained you			
3	Do you depend or rely most of the time on someone for help with your basic daily needs e.g.: 3.1 Bathing, 3.2 Shopping, 3.3 Taking meals 3.4 taking medicine			
4	Are you afraid of anyone at home? If yes, who……			
Questions about Emotional/ Psychological Abuse:				
5	Do you usually feel lonely?			
7	Are you sad most of the time?			
8	Do you have someone who spends time with you?			
9	Do you feel nobody wants you around?			
10	Do you trust most of the people around you?			
11	Has anyone treated you as child/infant?			
12	Have you been upset because someone talked to you in the manner that made you: 12.1 Ashamed or 12.2 Threatened/ fearful?			
13	Has anyone close to you unfairly yelled at you, or 13.1. Talked to you in ways that you did not like, or 13.2. Made you feel especially sad ... 13.3. Ashamed, 13.4. Fearful, or 13.5. Anxious in a way that left you upset for a long time?			
14	Do you sometimes feel: 14.1 Unhappy? 14.2 Anxious?			
15	When you need help, do you feel uncomfortable turning to people for help?			
16	Has anyone close to you made you feel that you were being taken advantage of, or 16.1. Prevented you from doing things that were important for your well-being, or 16.2. Interfered with you being with the people you wanted to be with? 16.3 Prevented you from being with your loved ones?			

#	Question	1 Yes	2 No	3 Not Sure
Questions about financial abuse				
17	Has anyone tried to force you to sign papers or documents that you don't understand?			
18	Has anyone used your money against your will?			
19	Has anyone that you trust: 20.1 Used or tried to use your money? …… 20.2 Used or tried to use your property in ways that you did not want?	……	……	……
20	Are your bills paid on time or late?			
21	Do you often find cash or money missing in your house?			
22	Has anyone tried to: 22.1 change your will? …… 22.2 made changes in your policies? …… 22.3 purchased expensive items without your permission?	…… ……	…… ……	…… ……
23	Has anyone denied you access to your money?			
24	Has anyone forced you to buy something you did not need or want?			
Questions about sexual abuse				
25	Do you: 26.1 consume alcohol? …… 26.2 stay with anyone who consumes alcohol?	……	……	……
26	Has anyone ever touched your private part without your permission?			
27	Have you felt like someone has raped you?			
28	Has anyone made you to be nude forcefully?			
29	Has anyone taken pictures of you naked?			
30	Has anyone sexually assaulted you?			
31	Has any of your relative tried to rape you?			
32	Has anyone forced you to look at pornography?			
Questions on witchcraft				
33	Do you suffer from any age related illness such as: 33.1 Confusion? …… 33.2 Forgetfulness? …… 33.3 Dementia?	…… ……	…… ……	…… ……
34	Has anyone accused you of witchcraft?			
35	Have you been labelled as a witch?			
36	Has your house ever been burnt down?			
37	Have you ever been chased away by the community?			
38	Has anyone ever said that you look like a witch?			
39	Has anyone blamed you for any illness in the family?			
40	Has anyone blamed you of dying livestock?			
41	Has anyone accused you of walking around at night?			

APPENDIX 2

INFORMATION SHEET

Date:	07 August 2009
Name of Research Student:	Nonhlanhla Phakathi
Address of Student:	AA1113 Umlazi 4031
Student Number:	208524307
Contact Number:	0833431363
Name of Supervisor:	Prof BP Ncama
Contact Number:	031-2602270
Name of Department:	School of Nursing
Name of Institution:	University of KwaZulu-Natal (Howard College Campus)

Dear Participant

I am completing a research project as part of the requirements for the Masters Degree in Nursing (Gerontology)

Title of the Research: Exploring elder abuse in the community and old age homes in the Durban area

Purpose of the Research: is to explore the types of elder abuse and its effects on the health status of the elderly that occur in the community and old age homes in the Durban area.

Description of the Procedure:

Your participation is requested as you are representative of the population under study. As part of the research process, you will be required to fill out a questionnaire. It will take you about 20 minutes to complete the questionnaire.

Ethical Aspects

Please note that your identity and information will be treated with the utmost confidentiality.

Please feel free to ask any questions you may have so that you are clear about what is expected of you. Please note that:

- you are free to *not* participate
- you are free to withdraw at any stage without repercussions
- your name will not be used nor will you be identified with any comment made when the data is published
- there will be no risks attached to your participation

Advantage to you as a respondent:

The findings of the study will be made available on completion.

Thank you,

Researcher: Nonhlanhla N. Phakathi

APPENDIX 3

INFORMED CONSENT FORM

Researcher: Nonhlanhla Phakathi

Student Number: 208524307

Contact Number: 0833431363

E-mail: nonhlanhla.phakathi@kznhealth.gov.za

Supervisor: Prof B.P. Ncama

Tel: 031-2602270

E-mail: ncamab2@ukzn.ac.za

DECLARATION

I …… (Full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

UNIVERSITY OF
KWAZULU-NATAL
University of KwaZulu-Natal
Research Office
Govan Mbeki Centre
Westville Campus
University Road
Chiltern Hills
Westville
3629
South Africa
Tel No: +27 31 260 3587
Fax No: +27 31 260 2384
E-mail :naidoos4@ukzn.ac.za

28 October 2009

Mr N N Phakathi
P O Box 72169
MOBENI
4060

Dear Mr Phakathi

PROTOCOL: Exploring Elder Abuse among Clinic Attendees in a Selected Durban Hospital
ETHICAL APPROVAL NUMBER: HSS/0770/2009: Faculty of Health Sciences

In response to your application dated 02 October 2009, Student Number: **208524307** the Humanities & Social Sciences Ethics Committee has considered the abovementioned application and the protocol has been given **FULL APPROVAL.**

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Professor Steve Collings (Chair)
HUMANITIES & SOCIAL SCIENCES ETHICS COMMITTEE

SC/sn

cc: Dr B P Ncama
cc: Mr S Reddy

UNIVERSITY OF KWAZULU-NATAL

School of Nursing

25 January 2010

The Director
KwaZulu Natal Department Health
Private Bag X
Pietermaritzburg

Dear Sir/Madam

Re: Request to Conduct a Research Study

I hereby request permission to conduct a research study at Prince Mshiyeni Memorial Hospital (Chronic out patient department). I am a student studying Masters Degree in Nursing (Gerontology) at the University of KwaZulu-Natal, School of Nursing, Howard College Campus. My ethical clearance number from the university is:

The title of my study is: Exploring elder abuse among clinic attendees in a selected Durban Hospital.
The aim of the study is to: is to explore the types of elder abuse and its effects on the health status of the elderly in the Durban metropolitan area.
I would like to commence data collection process by February 2010. Data will be collected from elderly clients attending the Chronic OPD Clinic during the working hours. The interview will behold confidentiality, anonymity, informed consent and freedom of choice.

Attached please find a copy of the proposal document and ethics permission letter for the University of Kwa-Zulu Natal, Faculty of Health sciences Ethics Committee.

Hoping that my request will meet your favourable considerations.

Yours faithfully,

_____

Ms NN Phakathi
Student number: 208524307
Contact Numbers: 0833431363 (Cell)

UNIVERSITY OF KWAZULU-NATAL

School of Nursing

15 February 2010

The Chief Executive Officer
Prince Mshiyeni Memorial Hospital
Private Bag X 10
Mobeni
4060

Dear Sir

Re: Request to Conduct a Research Study

I hereby request permission to conduct a research study at Prince Mshiyeni Memorial Hospital (Chronic out patient department). I am a student studying Masters Degree in Nursing (Gerontology) at the University of KwaZulu-Natal, School of Nursing, Howard College Campus. My ethical clearance number from the university is: HSS/0770/2009.

The title of my study is: Exploring elder abuse among clinic attendees in a selected Durban Hospital.
The aim of the study is to: is to explore the types of elder abuse and its effects on the health status of the elderly in the Durban metropolitan area.
I would like to commence data collection process by February 2010. This will be done at this institution during the working hours.
The interview will behold confidentiality, anonymity, informed consent and freedom of choice.

Hoping that my request will meet your favourable considerations.

Yours faithfully,

_____

Ms NN Phakathi
Student number: 208524307
Contact Numbers: 0833431363 (Cell)