



**Exploring the living arrangements of the elderly in the rural area of
Khambi village, Eastern Cape.**

**Masters Dissertation by
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i.

ABSTRACT

Living arrangements of the elderly people in rural South Africa are diverse and influenced by culture, politics and socio-economy. Elderly people in rural areas often face difficulties specific to their place of residence, low population density, geographic distance and difficulty accessing remote areas in particular which pose challenge for public transport service provision and community life. This study aims to shed insights into the living arrangements and living conditions of the elderly in Khambi village, Eastern Cape. Exploratory case study research design was used to elicit data from sixteen elderly participants who are 60 years and older using telephonic semi-structured interviews. The sampling technique used was snowball sampling and thematic analysis was used to analyse qualitative data. This study draws on the hierarchy of human needs theory to better understand living arrangements and conditions of the elderly. The findings of the study shows that living arrangements of the elderly are affected by limited social services with less support from their families, community and government. Further results indicated that rural elderly people are living in poverty with poor health status, limited access to healthcare services, unsafe environment and lack of basic care. Elderly people are suffering due to lack and limited resources in their residences. Support is inadequate and not always available when the need arose. There is a great need for efficient care for rural elderly people to improve their living arrangements.

Kew Words: Elderly people, living arrangements, rural areas, social development, social services.

ii.

COLLEGE OF HUMANITIES

DECLARATION ON PLAGIARISM

I, Sibongiseni Ntobongwana, declare that

1. The research reported in this thesis, except where otherwise indicated, is my original research.
2. This thesis has not been submitted for any degree or examination at any other university.
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Student's Signature

Date

iii.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CBD	Central Business District
EP	Elderly Participants
HIV	Human Immunodeficiency Virus
KSD	King Sabatha Dalindyebo
LMICs	Low Middle Income Countries
ORTDM	O.R Tambo District Municipality
SDGs	Sustainable Development Goals
UNDESA	United Nations Department of Economic and Social Affairs
UN	United Nations
WHO	World Health Organisations

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CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Ageing is an unavoidable phenomenon that brings physical, psychological, hormonal and social changes (Briley et al., 2019). These changes are expected to affect the quality of life of the elderly. In developing countries, demographic transitions have resulted in increasing life expectancy of elderly population (Prabowo, 2020). Living arrangements are the most immediate and proximate social environments that provide support for individuals (Alwin, Converse and Martin, 1985). Different living arrangements are associated with diverse family relations and distinct exchange patterns among family members (Liang et al., 2005). They are particularly important in old age, because the risks of physical and mental health problems increase with age. Living arrangements refer to the structure and composition of one's household, including the number of household members and their relationships with each another. Living arrangements include both single-person households (i.e. living alone) and multi-person households, including those comprised of persons with familial ties (e. g., living with a spouse or adult children) or those without familial ties (e.g. living with a partner or others related or unrelated) (Isengard and Szydlik, 2012). Living arrangements have also been examined in terms of intergenerational co-residence among older adults and their adult children – households that are often shaped by one's individual needs, family structure, and cultural contexts (Isengard and Szydlik, 2012). Living arrangements are important determinants of individuals' health and well-being in later life as well as significant predictors of the availability of informal care, the utilization of formal long-term care services and the institutionalization for the frail elderly (Kim, 2014).

In this study, the researcher focuses on living arrangements of rural elderly people aged 60 years old and above. An older person is defined by the World Health Organization (2013) as a person who is over 65 years of age. However, in the South African context, people aged 60 years and above are considered as elderly (StatSA, 2020). 'Rural' refers generally to areas of open country and small settlements, but the definition of a 'rural area' in both policy-oriented and in scholarly literature are often taken for granted or left undefined, in a process of defining that is often fraught with difficulties (IFAD, 2010). Ultimately, in developing countries as well as developed countries, rural is defined as the inverse or the residual of the urban (Lerner and Akin, 2010).

In the South African context, rural areas are used to refer to smaller towns and commercial farms as well as mostly mines. By extension, the definition of rural used here includes a number of small towns and relatively dense settlements. Living arrangements of elderly people in rural South Africa are diverse and influenced by culture, politics and socio-economy. According to the Older Persons Act 13 of 2006 an older person is used to refer to someone who is 60 years old or older. Many researchers, for example, Baltes and Smith (2003), suggest that we need to recognize two phases of human aging. The first stage is the socialization period which occurs in childhood and the second phase is in work and parenting (Laslett, 1989). There have been many ways to categorize the age of individuals in late adulthood. These categories are based on the conceptions of ageing including; biological, psychological, social, and chronological differences (Laslett, 1989). They also reflect the increase in longevity of those living to this latter stage. Laslett (1991) develops further precision by adding a third and a fourth age, building upon a dividing line which is not bound to actual age. The third age starts in retirement, where older adults usually still have good health and retain their physical and mental functions. The transition to the fourth age is not

bound to any actual age; it occurs when functions are impaired and the need for support and assistance arrive, something that varies greatly at the individual level (Palmér et al., 2019).

The ageing population in Africa is projected to increase dramatically over the next few years and the United Nations (2019) estimates suggest that population is likely to reach 2 billion by 2038. By 2030, older persons are projected to account for one in six people globally (United Nations, 2015). Although population ageing is more apparent in developed regions, it is increasingly gaining prominence in less developed regions. Two-thirds of the world's older persons live in the developing regions, where their numbers are growing faster than in the developed regions. In 2050, it is expected that nearly eight in ten of the world's older persons will be living in the developing regions (United Nations, 2017). Although currently the percentage of older persons is much higher in the developed regions, the number of older persons is growing more rapidly in the less developed regions over a shorter time period.

In 2015, the older population constituted more than one million in 11 African countries, including 5.6 million in Nigeria, 4.6 million in Egypt and 3.1 million in South Africa (Wan, Goodkind & Kowal, 2016). In Africa, over the next 20 years the population of older people will more than double in many countries. Interestingly, the number of the oldest of old people is also increasing rapidly with projections indicating that the number of people aged 80 or over worldwide will grow more than threefold between 2017 and 2050, rising from 137 million to 425 million and reaching almost 910 million by 2100 (United Nations, 2017). Older people in developing countries are more likely to be affected by diseases than in the developed world. For instance, two-thirds of people living with type-2 diabetes live in the developing world and older people in developing countries lose five times as many years from chronic lung disease and twice as many from stroke as in developed countries (UNFPA, 2012). In Africa, older people constitute an ever-increasing share of the population. However, there is a great deal of variation in population ageing in Africa by region. The vast majority

of the older populations are concentrated in the most populated regions of the continent, namely northern, eastern and western Africa. However, the elderly constitute a major share of the total population of less populated regions of the continent, namely northern and southern Africa. While developed countries have had long periods of time to adjust to this change in the age structure of the population, developing countries are forced to adapt to a rapidly ageing population more quickly with a wider population base (United Nations, 2012).

Statistics South Africa (2020) estimates the mid-year population of the country for 2020 is 59,62 million people, with approximately 5,45 million people aged 60 and over. In South Africa, the growth rate among the elderly (60 years and older) rose from 1,1% for the period 2002-2003 to 3,0% for the period 2019-2020 (Statistics South Africa, 2020). According to Statistics South Africa (2020) the provincial estimates shows that the highest proportions of elderly, those aged 60 years and above, are found in the Eastern Cape (11,4%). This shows that the Eastern Cape has the most elderly in the country and the majority reside in rural areas. In 2015 there were 3,1 million old age grant recipients and 80% were rural elderly. The Eastern Cape had 82,3% of elderly people who received the old age grant (Statistics South Africa, 2015). The majority of elderly people from the Eastern Cape depend on social grants. Elderly people are still affected by poverty and find it difficult to afford a healthy diet which would be more effective to prevent and manage common diseases experienced among the elderly. For treatment, some rely on traditional methods and this puts the majority at risk of dying because some rural areas does not have localised clinics and public transport is not always available to take them to healthcare centers (Indongo and Sakaria, 2016).

With improvement in access to services, a high number of young people from rural areas migrated to urban areas in search of access to services and employment opportunities leaving elderly people alone or with young children. This movement put older people at risk of living alone and vulnerable in terms of care as there are few or no young people to look after them

(Indongo and Sakaria, 2016). Therefore with the increase in migration of younger people, there is a need to understand the current living arrangements of the elderly who have been left behind in rural areas.

In South African context, rural areas are characterised by poverty, lack of sanitation, limited government services and poor infrastructure. Living arrangements of elderly people in rural South Africa are diverse and influenced by culture, politics and socio-economy. Older people living in rural areas often face difficulties specific to their place of residence. Low population density, geographic distance and difficult accessibility of remote areas in particular pose a challenge for public transport, service provision and community life. Due to these characteristics, comprehensive service infrastructures such as in urban areas, e.g. transport, health care, social services, education, retail and culture, are more difficult and expensive to create and maintain. The lower level of economic activity in rural areas also limits the choice of service providers. An urban-rural divide in access to services and activities is a consequence, putting older rural populations at a disadvantage across a number of dimensions (WHO, 2017). Urban-rural divide in access to needed services puts older people who have lived, worked and aged in rural areas at risk of experiencing the effects of accumulated disadvantage in their old age as compared to those living in urban areas. They may face higher risks of old-age poverty, poorer health status, less supportive environments in terms of access to transport services, opportunities for social participation, and access to health and care services (Camerero et al., 2009). In South Africa, particularly elderly women play a significant role in improving the wellbeing of those whom they live with (Munthree and Ngyende, 2017). With the limited resources available to elderly men and women, the presence of a pensioner in South Africa significantly reduces household reports of hunger, additionally children are more likely to be enrolled in school when there is an old age pension being accessed within the household (Case and Menendex, 2007).

A culmination of these numerous factors over time that has shaped the living arrangements of South Africans, including the elderly. Therefore, this research investigation sought to explore the living arrangements of the elderly people in the rural area of Khambi village in the Eastern Cape.

1.2 Motivation of the study

Concurrently, global rates of all rural-dwelling older adults are increasing (World Health Organization, 2015). Rural environments pose unique challenges and opportunities to health and wellbeing among older adults (Glasgow and Berry, 2013; Skinner and Winterton, 2018), with the rural communities of South Africa often excluded from other forms of development and these communities are filled with elderly people (Gopaul, 2006). There is either a very low level of infrastructure development or no development in the rural areas of South Africa to accommodate elderly people. Service delivery by government appears to be limited. These areas are characterised by low level of employment, poor housing conditions, low earnings and a generally low state of living (Gopaul, 2006). These problems also affect the living conditions of rural elderly people in South Africa.

As people live to a later age they are also more likely to experience health problems associated with the ageing process. One of the challenges is that the older population are not only living longer, but for some, living longer in poor health (Maharaj, 2020). This is likely to lead to an increase in demand for health services and residential care, as well as increasing support at home (Maharaj, 2020). The rural elderly in particular may have to spend money on transportation costs, walk long distances to get to a health facility, and even leave home early in the morning to spend most of the day sitting in a long queue so that they can be seen by a health professional. Once they meet with a health professional, older patients often face ageist stereotypes (Dionigi, 2015). Policies can be developed and implemented in order to

improve the living arrangements of older people in rural areas. Understanding their circumstances will provide insight on how best to improve their living conditions.

1.3 Statement of the problem

The oldest age groups are at greater risk of physical and cognitive disabilities, which is likely to have major adverse effects on their social and physical activities. They are likely to experience disruptions in normal daily functioning, which will probably affect their quality of life. As a result, there is an expanding need among the elderly for assistance (Maharaj, 2020). As people live longer there is likely to be a greater utilisation of health services, an increased need for long-term healthcare services as well as more assistance in carrying out activities of daily living (WHO, 2018). With improvement in access to services, a high number of young people from rural areas migrated to urban areas in search of access to services and employment opportunities leaving elderly people alone or with young children. This movement put older people at risk of living alone and vulnerable in terms of care as there are few or no young people to look after them (Indongo and Sakaria, 2016). Lastly elderly people are vulnerable to poverty; their capacity to work and earn an income diminishes which increases their risk of becoming poor. The inability to work results in older persons having to rely on their pension and others which is likely to influence their living arrangements. However, in many countries, pension funds are either not in place or are insufficient for the elderly to meet their needs; hence, older persons are more likely to live in poverty than younger age groups (United Nations, 2017). A major problem which the elderly encounter in rural areas of South Africa is limited social support systems. They are not informed of where they can go when they need social services as a result they become victims of fraud and corruption. Therefore with the increase in migration of younger people, the lack of assistance for older people in rural areas, poverty and poor health among elderly people highlights the

need to understand the current living arrangements of elderly people who have been left behind in rural areas.

1.4 Objectives of the study

The overall objective of this study is to shed insights into the living arrangements and living conditions of the elderly in Khambi Village, Eastern Cape.

The specific objectives are:

- To explore the perspectives and experiences of living conditions of the elderly living in Khambi Village, Eastern Cape
- To assess the challenges in current living conditions of the elderly living in Khambi Village, Eastern Cape
- To ascertain the opportunities and constraints for changing the current living conditions of the elderly in the rural area.

In order to explore the objectives of the study, the study has the following key research questions.

- What are the perspectives and experiences of living conditions of the elderly living in Khambi Village, Eastern Cape?
- What are the challenges in the current living conditions of the elderly living in Khambi Village, Eastern Cape?
- What are the opportunities and constraints for changing the current living conditions of the elderly in the rural area?

1.5 Theoretical framework

The theoretical framework that the researcher has used for this study is Maslow's hierarchy of needs. The hierarchy of needs theory proposed by Maslow (1943) consists of a five-tier model of human needs, including physiological needs (lowest level), safety needs, social needs, esteem needs, and self-actualization needs (highest level). Once human needs are satisfied at lower levels, people pursue higher-level needs, and the same is true of the elderly. Because of physiological functions, personal values, and preferences, elderly people's intrinsic demand may differ from those of younger people (Mertz and Stephens, 1986), for instance, elderly people's needs to maintain their health and economic stability become higher priorities regardless of where they live, whether in urban or rural areas.

Onah (2015) states that, Abraham Maslow, a renowned researcher in the study of human needs and motivation, came up with his hierarchy of needs theory with a proposal that people are motivated by five levels of needs namely: physiological, safety, belonging, esteem, and self-actualization. During adulthood, aged 60 to death, the way people fulfil their needs can change dramatically. While some people do age easily not having many issues, others have many issues such as health problems and lack of social support (WHO, 2015). The elderly often need assistance daily and this theory will help to analyse the living arrangements of rural elderly people looking at the hierarchy of human needs and integrate this with their current living.

Humans are a complicated creature which has moral and material motivation in every age. Motivation is a force which conducts the behaviour, i.e. behaviours form to meet human needs. The needs proposed by Abraham Maslow make up the hierarchy which are put in five distinct levels from basic needs to higher needs which are seen in Figure 1.1 below.

Physiological service needs such as food, clothing, housing, transportation, daily care, etc. In addition to the needs of the general human physiological needs such as clothing, food, housing, transportation, etc., the physiological needs of the elderly should also include the healthcare and daily care, due to their certain mobility disorders and cognitive impairments. In the home environment, all kinds of products should follow the cognitive and behavioural patterns of the elderly, and to ensure ease of use and safety, these devices should assist in maximizing the ability of the elderly. They should be able to overcome their physical and psychological barriers as well as enjoy an independent and safe life, thus, improving their overall quality of life (Fisk, Czaja, Rogers, Charness and Sharit, 2018).

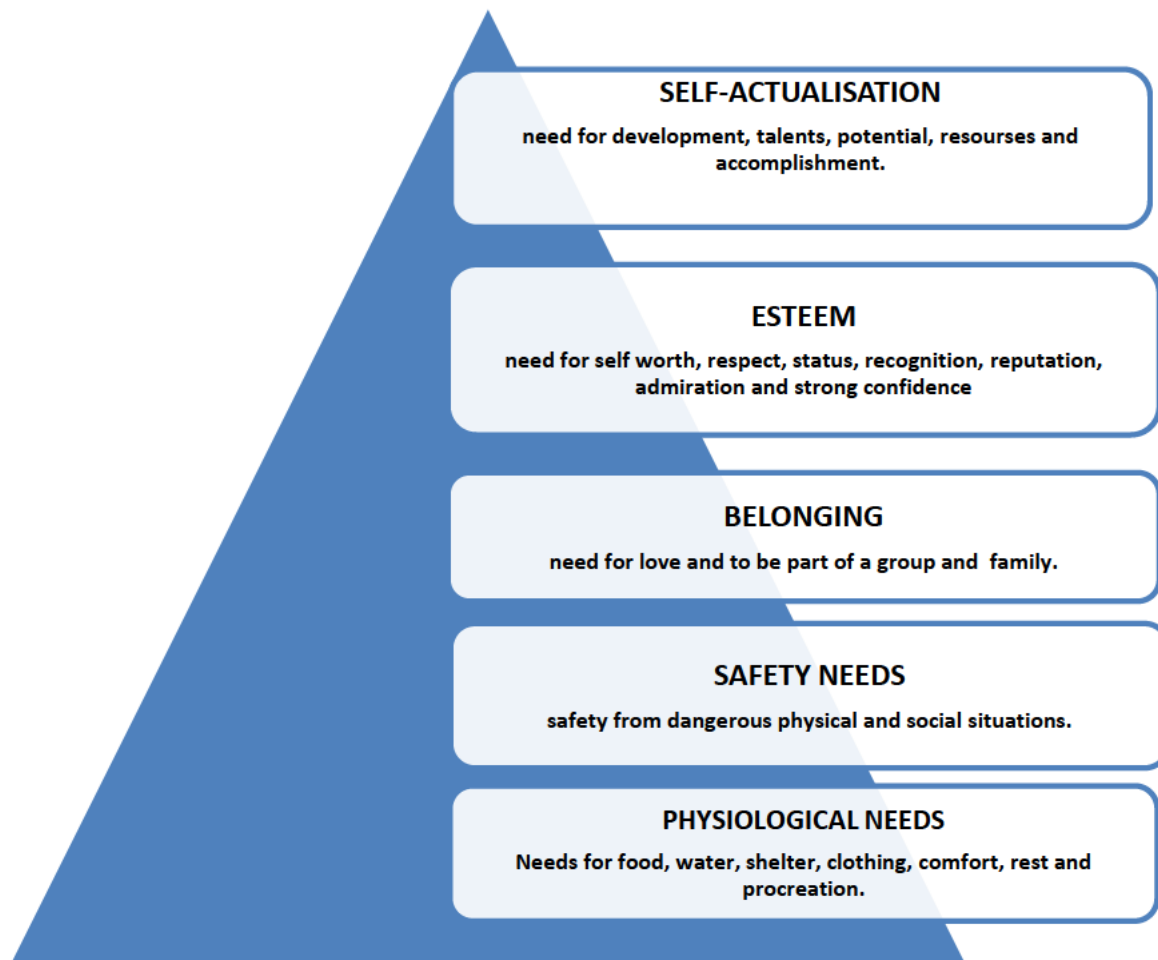
For the elderly, security needs are embodied in four aspects; namely life safety, property security, pension security and social security. Among them, the demand for life safety is embodied in the demand for health and medical security systems; property security and protection of their homes; pension security and public facilities that fully consider the special needs of the elderly. With increasing age, both physiological and psychological functions decline, therefore, there is a higher demand for medical and health services for older people (Hellström and Hallberg, 2001).

For the average person, emotional needs include two aspects, one is the need of love, including the need for friendships and companions; the second is the need of belonging, that is, to become a member of the group, and care for each other. Older people require relationships and interactions not only from their children, but also from their friends. Similarly, in order to give the elderly a sense of belonging, they should be given information about the social groups and religious beliefs that they care about, which can be disseminated through social media, and within the community (Van Baarsen, Snijders, Smit and Van Duijn, 2001).

Respect can be divided into internal and external. Internal respect refers to the individual's need for confidence and independence in their own strength; external respect refers to the individual's desire for external respect, trust and high evaluation. Combined with the analysis of the characteristics of the elderly, their respected needs are embodied in four aspects: self-affirmation, status in the family, status in the groups, and their general social status. At the service demand level, internal respect and external respect requires tools and information that separately rely on self-evaluation and social evaluation (Rosen and Jerdee, 1977).

Self-actualization is a component which includes knowledge skills and jobs. This is the highest level of need for the elderly. Older people need to master new skills and acquire new knowledge. This aids in realizing the ideals of their lifelong dreams or using their personal strengths to create value for society. Knowledge and experience of the elderly is a valuable social asset. Society should integrate a variety of resources to provide more opportunities to the elderly with job needs (Parasuraman, Zeitham and Berry, 1988).

Figure 1.1: The pyramid for elderly's needs based on Maslow's Hierarchy of needs



Source: Onah (2015)

1.6 Organization of the dissertation

This dissertation is divided into the following. *Chapter one* introduces the study and provides an overview of the intent and rationale of this study. It does so by presenting a general introduction and providing a brief motivation for conducting this study. This chapter defines relevant concepts to enhance the reader's understanding of the topic under investigation. The background in relation to the topic is also presented. It then discusses the significance of the study. This chapter also presents the aims and objectives of this study. It further discusses the significance of the study, as well as the theoretical framework used. *Chapter two* provides a

literature review of research relevant to the study. It includes an introduction to the literature that was reviewed, with particular reference to earlier studies that were conducted on a similar topic. *Chapter three* provides details of the research methodology relevant to the research. The interview schedule, sampling and sampling methods were described as well as the methods used in the data collection process. *Chapter four*, the findings of the research are presented, discussed in details and compared to the previous studies and *chapter five* provides a summary of the main findings, with an outline of the overall conclusions and recommendations. It also provides suggestions for further research into the living arrangements of the elderly people in South African rural areas.

CHAPTER TWO

LITERATURE RIVIEW

2.1 Introduction

Living arrangements are a critical aspect of older people's lives because how they live and who they live with undoubtedly affect their daily life, health and well-being (Trinh, 2020). Living arrangements represent an important social context in later life one that relates to opportunities for social integration, perceived isolation, health, and self-rated quality of life (Henning-Smith, 2016; Russell, 2018). Several concurrent trends are reshaping the global landscape of living arrangements in the twenty-first century, including rising incomes, declining fertility, and increasing longevity (Bloom and Luca, 2016). Living arrangements represent an important component of the social environment in later life and are intertwined with one's individual preferences, health and physical functioning, family structure, and availability of emotional and instrumental support (Gu and Dupre, 2019). The purpose of this chapter is to gain an understanding on the living arrangements of the elderly drawing on relevant literature. This chapter is composed of the importance of living arrangements among the elderly, factors influencing living arrangements, and consequences of particular living arrangements among the elderly.

2.2 The importance of the living arrangements among the elderly

Living arrangements affect and reflect family type and household structure among older people. These are in turn related to social support, inter-generational relations, health status, social isolation, satisfaction with life, and general wellbeing (Lee and Admonston, 2019). Older adults may not need as much space as that provided by the usual single-family home, so smaller housing units would be more appropriate (Lee and Admonston, 2019). Living

arrangements, including the availability of social supports within the home, have been shown to have implications for the ease with which one completes routine household activities and the extent that one experiences barriers to daily functioning (Russell et al., 2018).

2.3 Factors influencing living arrangements

2.3.1 Poverty

Globally populations are ageing. According to the United Nations Department of Economic and Social Affairs (UNDESA, 2015), in 2015 one in eight people worldwide was aged 60 years or older. According to Marchand and Smeeding (2016: p.906) “Poverty may take many forms across the ages distribution with young child, dependent upon the resources of his parents or guardian, which might not be sufficient to meet the needs of a number of individuals; to a working age adult lacking appropriate skills to find employment, whose unemployment benefits have run out weeks earlier; to an older widow in poor health, unable to maintain the lifestyle to which she was accustomed.”

The risk of impoverishment among the elderly is increasingly more prominent in less developed countries where social security is likely to be less inclusive and a large proportion of older people are reliant on extended family support (Rafeh, 2016). In 2015, global poverty among old people between the ages of 66 and 75 had widened to 10.9% compared to rates among those older than 76 years with poverty rates of 14.7% (OECD, 2015). In most instances elderly poverty rates are higher in developing countries than developed ones (Sumner, 2019). Between 2015 and 2019, an estimated 70% of the global population living in poverty, including the elderly were found in Africa, a number expected to increase to over 80% by 2023 (Kharas, Hamel and Hofer, 2018). Growing population numbers have fuelled elderly poverty in developing regions, in regions like sub-Saharan Africa, older female headed households regardless of their marital status (single, divorced or widowed) are more

inclined to poverty than households headed by older males, particularly in parts of the locale that are male centric (UN Statistics Division, 2015). In the case of South Africa, there appears to have been pervasive poverty increases at the same time, those already in poverty have continued to be worse off (Stats SA, 2017). Mncayi and Dunga (2019) in their study in South Africa found that being a female is associated with a greater likelihood of being poor.

Ojembe (2015) using secondary data from Global Age Watch Index Report for South Africa and Nigeria showed that the high incidence of old age poverty in Sub Sahara Africa is as a result of the inability of the policy makers to recognise and accept the fact that there is a global wind of change in population ageing which demands an immediate remedy. Differences in residence cause the emergence of differences in the physical, social, economic, psychological and spiritual aspects of the elderly that can affect their health status (Curl, Thompson, Alves, and Aspinall, 2016).

Research findings from sub-Saharan Africa show that households headed by older women, whether single, divorced or widowed, are more prone to poverty than households headed by older men, especially in parts of the region that are patriarchal (UNDESA, 2015). Similarly, in developed countries, older women living alone and/or in one-person households are more likely than men to be living in poverty (UN Statistics Division, 2015). In many countries, the survivor benefits paid through a husband's contributory pension are the only source of income for older women (UNDESA, 2015). The risk of increasing old-age poverty rates is serious unless policy changes are made. Over the next 35 years, the population aged 60 and over is forecasted to more than double its size reaching nearly 2.1 billion. In 2015, there were 602 million people aged 60 years or over living in developing countries, and 298 million older persons residing in more developed regions. Their numbers are projected to grow reaching 1 billion and 375 million respectively in 2030 – the target date for the Sustainable Development Goals (SDGs) (UNDESA, 2015).

2.3.2 Disability

According to data from World Population Prospects: United Nations (2015), the number of older persons has increased substantially in recent years in most countries and regions, and that growth is projected to accelerate in the coming decades. Between 2015 and 2030, the number of people in the world aged 60 years or over is projected to grow by 56 per cent, from 901 million to 1.4 billion, and by 2050, the global population of older persons is projected to reach nearly 2.1 billion. Furthermore, the higher disability rates among older persons, as a result of an accumulation of health risks across a lifespan of disease, injury, and chronic illness contributes to the higher disability rates among older people around the world, persons with disabilities face a number of obstacles including attitudinal, environmental and institutional barriers preventing their full and equal participation in all aspects of life. Often older persons with disabilities are among the most adversely affected, facing further age barriers in society (United Nations, 2015).

A study conducted in rural Haryana of India to assess functional disability among 836 elderly aged 60 years and over reported that the prevalence of functional disability was 37.4%. Disability has negative consequences on health and quality of life (Rahman, Guntupalli and Byles, 2018). Disability in later life was reported to increase elderly social exclusion and depression (Tobias and Mukhopadhyay, 2017). The prevalence of disability is likely affected by several factors. These main factors are demographic characteristics and socioeconomic factors including age, sex, race, education, and marital status (Hosseinpoor et al., 2016), income status and occupation (Mahmud, Clarke and Ploubidis, 2017), and living alone (Rahman, Guntupalli and Byles, 2018). A study conducted in Thailand to assess factors associated with the six types of disability (seeing, hearing, mobility, remembering and concentrating, communication, and personal care) for people 60 years old and above reported

that the presence of other comorbidities was found to increase disability prevalence (Khongboon, Pongpanich and Chapman, 2016).

2.3.3 Health status

The World Health Organisation defines healthy ageing as the process of development and maintenance of functional capacity that allows well-being at an advanced age (WHO, 2015; Michel et al., 2016). Functional capacity, in turn, can be understood as the combination of the intrinsic capacity of the individual, the relevant environmental characteristics and the interactions between the individual and these characteristics (WHO, 2015). Intrinsic capacity is the articulation of physical and mental abilities including psychosocial (WHO, 2015). Well-being is unique and permeated with subjective aspirations, including feelings of fulfilment, satisfaction and happiness (WHO, 2015). Indeed, in some countries in Africa, the population is ageing significantly amidst challenges such as the shortage of health infrastructure and services (Aboderin and Beard, 2015). Moreover, the focus on geriatrics and gerontology is often not adequately covered in health training institutions for medical personnel. Despite the greater demand for more health care in later life, older people are often confronted with healthcare that is financially inaccessible. In order to gain access to healthcare, older people in some African countries are required to pay user fees, making these services unaffordable (Maharaj, 2020).

In this context, older people are also likely to experience challenges in maintaining their social relationships and they may find themselves increasingly isolated and alone. Studies suggest that visual impairments and difficulties in hearing may affect communication and can contribute to social withdrawal and loss of autonomy, with associated anxiety, depression and cognitive decline (WHO, 2015). With advancing age, more people are likely to experience physiological changes associated with increased longevity and the risk of chronic diseases

risks which may require medication and sometimes even specialised treatment. By age 60, the major burden of disability and death arises from age-related losses in hearing, sight, movement and non-communicable diseases, including heart disease, stroke, chronic respiratory disorders and dementia (WHO, 2015). As people live much longer there is likely to be deterioration in health, leading to an expanded demand for assistance with daily tasks. This assistance may come in a variety of ways, at home, in the community or in various types of facilities, including assisted living facilities, adult day care, home care, hospice care and nursing homes. Elder care, sometimes referred to as long-term care, includes a wide range of services that are provided over an extended period of time to older people who need help to perform the normal activities of daily living (WHO, 2017a). In some instances, this care may also include training to ensure independent living in order to help older people adjust to or overcome many of the limitations that often come with ageing. Sometimes elder care may also include rehabilitative therapies, skilled nursing care, palliative care and social services, as well as supervision and a wide range of supportive care activities (WHO, 2017a). Traditionally in Africa, the main source of support and care for the elderly was the family. The family is often expected to constitute the long-term care workforce, with women often taking primary responsibility for caregiving activities of the elderly. Increasingly, however, families find themselves struggling, financially and physically, due to the pressure of caregiving, especially if the care is to be provided over long periods of time as life expectancy increases. Other reasons for the decline in family support may include the reduction in family size, greater geographical dispersion of family members as a result of migration and higher participation in the labour market often outside the home. A commonly held belief in many parts of Africa is that the elderly will be taken care of by their children, but with the AIDS pandemic and other factors there has been a reversal of intergenerational roles (WHO, 2017a). In many parts of sub-Saharan Africa, the elderly are often the providers

of care (Tanyi, Pelser and Okeibunor, 2018). They may offer a range of medical, personal care and assistance services with the primary objective of reducing or ageing the deterioration in health that often accompanies the process of ageing. These institutions are an important resource that will ensure that older people are cared for outside of the family system, especially when family care is no longer an option. However, they often are not widely available in many African countries as they usually come at a high cost (Kelly, Mrengqwa and Geffen, 2019).

The majority of older adults in sub-Saharan Africa utilise primary healthcare facilities for their health needs. Community clinics are the most commonly used providers of health services, while a small number of pensioners also access services from private general practitioners or traditional healers (Antimisiaris and Morton, 2017). Specialised geriatric services and specialist geriatricians are rarely available. As reported in 2017, there was only one geriatrician per 275 000 older adults in South Africa (Cassim, 2017). Transport is another major barrier to accessing healthcare, especially for the elderly in rural areas and in those with restricted mobility. Primary care health facilities in KwaZulu-Natal (KZN), South Africa, face resource constraints that present several challenges to geriatric patients. Older adults with physical impairments and urinary incontinence may be discouraged to attend health facilities with long queues and lack of accessible toilets. Despite policies to improve healthcare access for patients with disabilities, infrastructure at health facilities is still lacking (Vergunst, Swartz, Mji, MacLachlan and Mannan, 2015). Currently, the clinical guidelines endorsed for use by primary care providers in South Africa are designed for the management of single diseases, and they inadequately address the problem of multi-morbidity (Albashtawy, et al. 2016). Multi-morbidity, defined as the presence of two or more medical conditions, is more prevalent in the elderly people aged 60 and above than in people of other age groups (Chatterji, Byles, Cutler, Seeman and Verdes, 2015). As a consequence of multi-

morbidity and poor coordination of care, poly pharmacy in geriatric patients is common. A study conducted by Saka et al (2018) described the high prevalence of inappropriate drug prescription for elderly patients in Nigeria and South Africa (Saka, Oosthuizen and Nlooto, 2017).

2.3.4 Marital status

Many studies have shown that married people are healthier than unmarried people in later life. For example, married people tend to have lower risk of mortality and suffer from fewer chronic conditions (Wu et al., 2018). Being married is associated with better social engagement, social support, and social integration - all factors linked to better health and well-being including less physical frailty (Liu, Zhang, Choi, and Langa, 2020). A recent systematic review pooled 35 cross-sectional studies and finds being unmarried is associated with increased frailty (Kojima, Walters, Iliffe, Taniguchi and Tamiya, 2020). Three longitudinal studies also confirm the same results from Italy (Zambon et al., 2017; Bolzetta et al., 2016). While the association between marriage and frailty has been found, the role of marital status as a moderator in the relationship between social engagement and frailty remains unknown. Previous studies have shown that marital status plays a moderating role in the relationship between some factors and health in later life for example, Gyasi and Phillips (2018; 77) finds that the association between self-rated health and functional decline among older people are modified by marital status. Kail (2016) also finds that marital status moderates the relationship between depressive symptoms and chronic conditions on subsequent functional limitations among older people.

2.3.5 Widowhood

Widowhood in old age is a dreaded phase of life due to its influence on health and well-being (Perkins et al., 2016). Research from Mexico found that social integration can both mitigate and exacerbate depression among older widowed adults (Monserud and Wong, 2015). Widowhood seems to have mental, social, behavioural and biological consequences, consistent with a stress-inducing process. The meaning of bereavement, grief and mourning seems to differ across cultures, where most societies outline appropriate behaviours for those who are widowed based on socially constructed sets of norms (Robben, 2018). Cultural factors seem to influence health, and Lloyd-Sherlock, Corso, and Minicuci (2015) found variations in the prevalence and timing of widowhood across countries such as China, Ghana, India, Russia and South Africa, in addition to associations' between widowhood and being in the poorest wealth quintile of these countries. However, the evidence of the difference in impact across regions related to the cultural implications of widowhood on both individual and societal level is unclear. Widowhood is described as a cultural and gendered experience because the salience of different mechanisms linking widowhood to health may depend on local norms. Merz and De Jong (2016) investigated the role of family relationships through the lifespan in reducing loneliness among ever-widowed older adults (i.e., persons who experienced the death of a spouse at some time during their life). They found that older adults when losing spouses it causing a grief that decreases over time.

Currently, the proportion of older adults living alone increases with age. By age 65, almost 50% of women and 25% of men live alone due to divorce, death of a spouse, or lifelong single status. By age 85, about 80% of women and 43% of men live alone (U.S. Bureau of the Census, 2017). Although change in marital status is accepted as a normal life experience, the death of a spouse is a significant life event for older adults due to the associated changes in

roles, income, identity, housing, social contacts, and physical and emotional health status (Hooyman and Kiyak, 2015). For elderly people, transition to widowhood can be an extremely challenging time, which requires a tremendous amount of coping. Although the majority of people have the ability to bounce back from general adversity, the ability to demonstrate life satisfaction in widowhood varies greatly based on the breadth and depth of family and friend relationships. Although all widowed adults experience an emotional and physical loss, having frequent contact with family and friends can be the key to a successful show of life satisfaction to such losses. For example, frequent social relationships with relatives and friends may minimize emotional stress and depression while boosting psychological well-being (U.S. Bureau of the Census, 2017).

2.4 Abuse, Violence and Neglect among the elderly

Elderly abuse is defined as 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 (NCEA, 2005). Abuse, violence and neglect can affect a person's health, happiness and safety, and can occur at home, in the community, or in institutional settings. The increasing proportion of abuse, violence and neglect among elderly produces concern over health i.e. worsening health, security, shelter, longevity, and well-being at older ages (Chaurasia **and** Srivastava, 2020). Elderly domestic violence is a single, repeated act and lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm and distress to an older person (Killick, et al., 2015). Elder abuse is estimated to influence one out of six adults worldwide, has turned out as a growing public health challenge and requires more consideration by healthcare systems, research analysts and more evidence-based intervention (Dong, 2015; Yon et al., 2017). Initially it was seen as a social welfare issue, but today elder abuse continues to be a taboo which is mostly

underestimated and ignored by societies result in great deal of concern across the world. It is a complex phenomenon that can arise from several different reasons and often has roots in multiple factors.

Evandrou et al., (2017) examined the association between elder abuse and psychological distresses among older adults in India and Chaurasia et al., (2017), have examines the links between subjective well-being, social support through retirement (Chaurasia & Brajesh 2018; Evandrou et al., 2017). There was a study published by Raju and Gupta (2018) which examined elder abuse by rural-urban place of residence and men-women differentials but the study was confined to the state of Maharashtra (Raju **and** Gupta 2018). In a study that was conducted in India, Chaurasia and Srivastava (2020) find that abuse was highest among elderly people who were aged 80 and above. Elderly people who were single face more abuse than the elderly who were married. Respondents who never attended school face more abuse in comparison to those who ever attended the school. The respondents who belong to Hindu religion face less abuse than the respondents who belong to other religion. The prevalence of abuse was high among respondents who belong to other caste category. Elderly whose health status was poor faces more abuse than those who were having good or normal health status. The prevalence of abuse was high among those who belong to poorest wealth quintile. The respondents who work more than six months experienced more abuse. The prevalence of abuse was high among those respondents who were having any chronic morbidity than who do not have any chronic morbidity. Among both men and women, almost 50% of the elderly were facing physical abuse, while approximately 55% of women were facing verbal as well as economic abuse, respectively. 58% of women experienced disrespect, and 61% were being neglected. Physical violence, disrespect, and neglect among men and women showed significant association. In rural areas, approximately 80% of the elderly faced physical, verbal, economic abuse and also experienced disrespect and neglect in the society. Changing

the socio-cultural context and family relations are the major drivers of the increase in the occurrence of elder abuse in the state as most of the older people live in villages, experience poor socioeconomic status, are dependent on their families or relatives for both financial and physical support (Chaurasia and Srivastava, 2020).

2.5 Consequences of particular living arrangements among the elderly

2.5.1. Social isolation and loneliness

Wu (2020) found that social isolation and loneliness are major risk factors that have been linked with poor physical and mental health status: increased blood pressure, heart disease, obesity, diminished immune system functioning, depression, anxiety, poorer cognitive functioning, increased risk of Alzheimer's disease, and mortality. Social isolation has been associated with an approximately 50% increased risk of developing dementia, a 29% increased risk of incident coronary heart disease and a 32% increased risk of stroke (NASEM, 2020).

Loneliness is described as a state of feeling lonely where an individual's relationships may be perceived as inadequate (Ojembe and Kalu, 2018). Loneliness has been thought to be an important phenomenon especially among older people (Nzabona et al., 2016). Several studies show that there is a link between loneliness and quality of life among older people (Gyasi et al., 2020). Partly as a result of this notion, there has been a gradually growing interest regarding later life loneliness research in Africa (Gyasi et al., 2019; Nzabona et al., 2016; Ojembe and Kalu, 2018). Studies show that the causes of loneliness during later life are multifaceted. These include marital status, declining social networks, ageing associated events, and living arrangements among other factors (Berg et al., 2017; Theeke et al., 2015). Nzabona et al. (2016) reported that the death of a spouse meant the beginning of isolation from the society especially when spouses cannot be replaced. They further reported that being

widowed has a strong association with the feeling of loneliness, far exceeding that of being never married. In Nigeria, a qualitative study conducted by Ojembe and Kalu (2018) suggested that, retirement may also cause loneliness among older people. Their study further reported that older people seemed to have valuable work experience in certain fields in Nigeria but failed to even get positions on available volunteering duties after retirement. An impact of such a situation makes older people mostly idle and inactive during later life. Research suggests that when older people are alone, it does not necessarily mean they are lonely (Ojembe and Kalu, 2018). Nevertheless, their sustained act of living alone may be a predictor of loneliness (Nzabona et al., 2016; Ojembe and Kalu, 2018).

Older adults are more susceptible to adverse health consequences of loneliness and isolation (due to generally poorer health). Adults in later life who are socially isolated are typically among the oldest old, unmarried, male, have low educational attainment and low income (Szanton et al., 2020). Social isolation, defined as physical isolation, reduced size and diversity of social network or less frequent contact with family and friends, increases the risk of loneliness (Goat, 2018). Individuals who identify as LGBTQ or other groups in our society who tend to be marginalized are also more likely to report that they are lonely (Goat, 2018). Although prevalence varies across studies, in part due to different methods of measurement, the consistent finding is that both loneliness and social isolation are pervasive and significant problems across all age groups (Donavan and Blazer, 2020).

Social isolation and loneliness can also lead to psychiatric conditions such as depressive and anxiety disorders which can lead to social withdrawal and loneliness (Haro et al., 2019; Hyland et al., 2020), and reciprocally, social isolation, and loneliness can also lead to clinically significant depression and anxiety (Haro et al., 2019). Cross-sectional studies have frequently found associations of loneliness or lower measures of relationship quality and support with high depression (Rentz et al., 2016). Close relationships and social support may

be deficient or experienced as inadequate in those who are depressed because of the distress and disabilities imposed by their depressive state. Some depressed older adults experience broad deficits in social connectedness, including high loneliness, low social support, and fewer social connections (Rubio-Valera et al., 2017). Other elderly people with clinical depression or generalized anxiety report high levels of loneliness unrelated to structural measures of social network or support (Rubio-Valera et al., 2017; Narding P et al., 2015). In these cases, loneliness may reflect cognitive biases that impact social interactions more negatively lead to the perception of relationships as less rewarding (NASEM, 2020). Risk factors for social isolation and loneliness in elderly people also include cognitive deficits and dementia (Marx et al., 2015).

2.6 Summary

In summary, the purpose of this chapter was to gain an understanding on the living arrangements of the elderly people and debates relevant to this particular topic or area of study. The discussion highlighted the importance of living arrangements among the elderly. This chapter also highlighted the factors that influence the living arrangements of the elderly which focussed particularly on their status of poverty. This chapter also focused on the status of health among the elderly suggesting that many suffer from chronic diseases. They cannot afford better healthcare, and as a result their health status is very poor especially in Africa with lot of disability challenges. This chapter also discussed their independent living of the elderly which showed that widowhood is the cause of independent living and this group is vulnerable to different problems like poor health. This chapter also focused on the consequences of particular living arrangements like abuse, violence, neglect and loneliness. Lastly, it also highlighted their living in old age homes because of the lack family support or care from their families.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

Ageing in low middle income countries (LMICs,) and particularly in sub-Saharan Africa, is illustrating the adage of growing old before growing rich. LMIC socioenvironmental contexts are often marked by poverty, failing economic and political systems, and rapid emergence of the double burden of infectious and chronic diseases (Gyasi and Phillips, 2020; McCracken and Phillips, 2017). These conditions are increasingly evident in this century, and force many societies to confront the challenges of ageing. The life of the elderly has become a widespread concern of the society. As an important aspect of the lives of the elderly are different living arrangements that affect the quality of their lives (Xiong, 2018). The aim of this study is to shed insights into the living arrangements and living conditions of the elderly in Khambi Village, Eastern Cape. In this chapter the researcher focuses on the methodology which are the techniques used to collect and analyse the data in order to answer the research questions. This chapter encompasses the context of the study, the research approach, the type of method that was used to collect data, sample size, sample criteria as well as the research design to the limitations of the research, all of which contributes to the delivery of the information that leads to the conclusion of the study. This chapter also provides a clear idea of what was done by the researchers from the point of the conception of the research question to the problems and methods of data analysis.

3.2 The study area

Khambi village is an administrative area situated in Mthatha. Khambi village is dominated by Xhosa speaking people ruled by Chief Makaula. The village has elderly people, senior youth

and early youth. The majority of youth are uneducated, unemployed and committed to crime. There are few elderly people and the majority are living by social grants. In terms of development, the village has a clinic and a project called Ntinga whereby people are encouraged to plant crops. This village is part of Mthatha located in the eastern part of the Eastern Cape province of South Africa, (see map in figure 3.2.1) along the banks of Mthatha River. The city was founded as a military outpost in 1882 and was formally established as a colonial town in 1883. In the period between 1974 and 1994, Umtata was the capital city of the Bantustans State of Transkei (Cakata, 2017). Umtata is currently the seat of power of the King Sabatha Dalindyebo municipality which covers an area of 3,019km². It is the only major urban area in KSDM with the satellite towns being Mqanduli and Coffee Bay. These satellite towns depend on Umtata for employment, commercial and educational needs. Umtata is the capital town of the O.R Tambo District Municipality (ORTDM) which covers an area of 12,096km² (Figure3.2.1).

Figure 3.2.1: Map of the Eastern Cape showing Umtata



Source: Google Maps (2020)

Figure 3.2.2: Map of municipalities of the Umtata region



Source: Google Maps (2020)

The ORTDM is a majority rural district. The small towns of the local municipality are Tsolo and Qumbu. Umtata is located in the Eastern Cape. The population of the city of Umtata was

estimated 210, 783 (KSDCensus, 2019). Umtata covers an area of 73,6km² with a population density of 3,800/km². The urban form of Umtata is characterised by two key factors, namely the natural and human-made. The inner city, or the central business district (CBD) is defined by these two natural buffers. The city is ordered along two major roads. The N2 is the national road that transverse Umtata along a northeast and south-west axis. The N2 is a national route links Durban to East London and Port Elizabeth. The R61 is the major regional route that connects Port Saint Johns and Umtata on the south-west to Queenstown to the northwest connecting to the N2 national road that connects East London to Johannesburg. The R61 intersect in the middle of the CBD of Umtata. Umtata is surrounded by many rural settlements of significant population size (Figure3.2.3). Khambi village, Payne village, Ngaphezulu, Tyumbu and Sheshegu are example of rural settlements located in Umtata. The rural area like Khambi village depends on Mthatha as their urban centre (Firth, 2016).

Figure 3.2.3: Simple sketch of Umtata rural areas including Khambi village



Source: Google Maps (2019)

3.3 Research approach

This research used a qualitative approach. A qualitative approach is the systematic inquiry into social phenomena in natural settings. These phenomena can include, but is not limited to, how people experience aspects of their lives, how individuals and/or groups behave, how organizations function, and how interactions shape relationships (Teherani et al., 2015). The qualitative approach is a holistic approach that involves discovery. It is also described as an unfolding model that occurs in a natural setting that enables the researcher to develop a level of detail from high involvement in the actual experiences (Creswell, 1994). One identifier of a qualitative research is the social phenomenon being investigated from the participant's viewpoint. There are different types of research designs that use qualitative techniques to frame the research approach. As a result, the different techniques have a dramatic effect on the research strategies explored. What constitutes the qualitative approach involves purposeful use for describing, explaining, and interpreting collected data. Leedy and Ormrod

(2001) alleged that the qualitative research is less structured in description because it formulates and builds new theories. The qualitative approach can also be described as an effective tool studying individuals that occurs in their natural setting that enables the researcher to develop a level of detail from being highly involved in the actual experiences (Creswell, 2003). This method was used to elicit rich data about the living arrangements of the elderly in the rural area of Khambi village, Eastern Cape. Many studies that explored the living arrangements of the elderly people were quantitative in nature. However, the current study focused on the elucidation of qualitative data to obtain a deeper knowledge of the living arrangements of the elderly in the rural area of Khambi village in Eastern Cape.

There are some advantages and disadvantages when using this approach for example; Chalhoub-Deville and Deville (2008), argued that qualitative approaches are employed to achieve deeper insights into issues related to designing, administering, and interpreting language assessment. Secondly, there are some who argue that qualitative research approach (interpretivism) holistically understands the human experience in specific settings. Interpretivism argues that truth and knowledge are subjective, as well as culturally and historically situated, based on people's experiences and their understanding of them. Researchers can never be completely separate from their own values and beliefs, so these will inevitably inform the way in which they collect, interpret and analyse data (Ryan and Gemma, 2018). Denzin and Lincoln (2002), for example, mentioned that qualitative research is an interdisciplinary field which encompasses a wider range of epistemological viewpoints, research methods, and interpretive techniques of understanding human experiences. From the perspective of the epistemological position, any language assessment cannot be set apart from context, culture and values of where it was used (McNamara, 2001); and the language assessment researchers began to employ qualitative research methodology for focusing the issues that need an analysis of content-related variables such as the influences of test-takers'

characteristics on test performance, the strategies used to respond to assessment tasks, and so on (Tsushima, 2015). Thirdly, interpretivism is regarded as an ideographic research, the study of individual cases or events (Kelin and Myers, 1999); and it has abilities to understand different people's voices, meanings and events. So the source of knowledge in this approach is the meaning of different events (Richardson, 2012). In language testing, the qualitative techniques analyses the behaviour, interviewer behaviour, interlocutor behaviour, and cross-cultural influences on behaviour during the speaking tests (Lazaraton and Taylor, 2007). Fourthly, the qualitative research admits the researchers to discover the participants' inner experience, and to figure out how meanings are shaped through and in culture (Corbin and Strauss, 2008).

Silverman (2010) argues that qualitative research approaches sometimes leave out contextual sensitivities, and focus more on meanings and experiences. In terms of the research method, smaller sample size raises the issue of generalizability to the whole population of the research (Harry and Lipsky, 2014; Thompson, 2011). Lam (2015) observes that due to the small sample size the study results do not claim wider generalization to other contexts. Finally, the analyses of the cases take a considerable amount of time, and one can generalise the results to the larger population in only a very limited way (Flick, 2011). However, despite these shortcomings, the qualitative research becomes prominent in language testing research as it is a regular accompaniment with quantitative data analysis to which reports of standard setting are generally confined (Manias and McNamara, 2015).

3.4 Research design

According to Babbie and Mouton (2010: p.74), "a research design is a plan or blueprint of how you intend to conduct the research". The study employed exploratory case study research design. This approach assisted the researcher in allowing the participants to provide

extensive and rich information about their living arrangements in the rural area of Khambi village. This approach thus allowed the researcher to enquire in detail about their living arrangements in depth.

3.5 Data collection methods

Preparation of data collection is one of the most important aspects of research study. In constructing this study, semi-structured interviews were used to gather information from the participants. Semi structured interviews is a qualitative methods of inquiry that combines a predetermined set of open questions (questions that prompted discussion): with the opportunity for the interviewer to explore themes or responses further” (Henderson, 2009: p.135). The researcher used telephonic semi-structured interviews by formulating closed and open-ended questions to create a conversational interview by asking questions based on what a participant’s response and researcher is seeking for in depth information from the participants. The interview skills that were used are many: Rapport building according to Nicholas, et al (2010: 140) “rapport” is the relationship of trust between people and includes feeling of sympathetic understanding and having mutual understanding of the relationship”. “Listening skill which involves listening attentively and registering the information acquired”. (Counoyer, 2011: 112). “Seeking clarification is referred to attempt to elicit a more complete expression of the meaning of particular words or gestures” (Counoyer, 2011: 114). This data was collected telephonically. Frey (1983) defines telephone conversation as “an interactional sequence without the assistance of visual cues”. According to Hopper (1992), “the two parties must construct an encounter, setting the context only with their voices: they must identify each other and define the situation in which the dialogue will unfold”. Due to the global COVID-19 pandemic, the researcher was unable to physically go out into the field to collect data. This was to ensure the safety of the researcher and the

participants. The longest interviews took approximately 14 to 16 minutes and the shortest interview took approximately 6 to 9 minutes.

3.6 Process of data collection

The South African Older Persons Act, No 13 of 2006 defines an older person as a person who, in the case of a male is 65 years of age or older, and in the case of a female, is 60 years of age and older. Despite the differential male and female age specifications in the Act, South Africa has been moving towards making the age 60 for everyone (Makiwane, Alubafi & Gumede, 2020).

The researcher did not collect data from the entire population of the elderly people of Khambi village but only to those who agreed to participate in the study. Thus, the results of this research may not be regarded as representative of the larger elderly population and neither may the findings be generalised to the larger population because the sample size was too small. The total sampling size were sixteen (16) participants who aged 60 years and above. Establishing inclusion and exclusion criteria for study participants is a standard, required practice when designing high-quality research protocols. Inclusion criteria are defined as the key features of the target population that the investigators will use to answer their research question (Hulley et al., 2007). The study included both males and females. Racial and socio-economic criteria did not apply in the selection of the sample. In terms of selecting the research participants, the researcher used a non-probability sampling technique. Non-probability sampling technique uses nonrandomized methods to draw the sample. Non-probability sampling method mostly involves judgment. Instead of randomization, participants are selected because they are easy to access (Showkat **and** Parveen, 2017). Under non-probability sampling, the researcher used snowball sampling. Snowball sampling is a convenience sampling method. This method is applied when it is difficult to access subjects

with the target characteristics. In this method, the existing study subjects recruit future subjects among their acquaintances. Sampling continues until data saturation (Burns **and** Grove, 1996). As stated by Polit-O'Hara and Beck, this method, which is also called the "chain method," is efficient and cost effective to access people who would otherwise be very difficult to find. In this method, the researcher asks the first few samples, who are usually selected via convenience sampling, if they know anyone with similar views or situations to take part in the research. The snowball method not only takes little time but also provides the researcher with the opportunity to communicate better with the samples, as they are acquaintances of the first sample, and the first sample is linked to the researcher (Polit-O'Hara **and** Beck, 2006). This type of networking is particularly useful for finding people who are not willing to reveal their identities e.g., addicts and criminals (Hejazi, 2006). In another definition, snowball sampling may be less reliant on a reference sample, but it is still suitable to find unattainable populations. Generally, snowball sampling is a gradual process, and time influences the selection of samples. The risk of bias is low when the population is homogeneous in terms of the target characteristic under question, whereas in nonhomogeneous populations, this method of sampling has a higher risk of error (Abedsaeidi **and** Amiraliakbari, 2015). This helped the researcher to find participants when they were difficult to be located. The researcher used this technique since the sample size was small and not easily available.

When sampling these 16 participants, the researcher reached out to the younger generation in a form of advertisement via Facebook to assist with the recruitment of their grandparents. The advertisement explained the aim, purpose and population that are needed in the study. The recruitment was flexible since many rural elderly people had no Facebook and other social media platform such as Instagram or Twitter but their grandchildren and children were easily accessible on Facebook and referred the study to their grandparents for telephonic

interviews. The researcher contacted the targeted population via cell phone call and presented the purpose of the study to them. The researcher asked participants verbally if they were willing to participate to the study, the researcher conducted a pre-plan interview to make them familiar with what is expected. The researcher asked the participants to call them again for the main interview and asked them if they are going to give their consent to be recorded during the interview using a caller record application on the cell phone which records calls automatically. If they agreed the researcher recorded the interviews via phone calls in a quiet place. Prior to the interviews, the researcher explained again the purpose of the study and reiterated the importance of confidentiality. The participants were assured that the data and recordings would be stored safely and securely for only five years, after which they would be decimated. The interviews were conducted in IsiXhosa and translated into English.

3.7 Data analysis

Data analysis is a process of evaluating data using analytical and logical reasoning to examine each component of the data provided. Data from various sources is gathered, reviewed and then analysed to form some sort of finding or conclusion (Denzin & Yvonna, 2017). In this particular study, the data was recorded but the researcher used thematic analysis to analyze the qualitative data collected from participants' interviews. Thematic analysis as stated by Miller (2016) is an examination of themes which arise from the data that is collected. This analysis was important and useful to this research as it helped to identify the problem across a dataset that provided an answer to the research question being addressed. When analysing the data, the researcher focused on a number of stages, Familiarisation and immersion, the researcher familiarised himself with the data by listening to the recordings of the interviews over and over. After listening to the recordings the researcher then transcribed and translated the words that were used in isiXhosa into English. Lastly, the researcher made

notes of the important points to induce themes: In this process, the researcher created and organised the themes that emerged from the data. According to Terre Blanche et al. (2006), coding involves marking different sections of the data as being relevant to one or more of the themes. Therefore, the researcher took sections and marked them by using symbols. Elaboration, the researcher looked thoroughly at the coded themes to see if they fitted together by grouping them and creating subthemes where possible. Interpreting and checking, the last stage of the analysis process involves data interpreting and checking. During this phase the researcher reviewed all the data on elderly people especially how they live.

3.8 Ethical considerations

Ethics is a set of moral principles which is suggested by an individual or group, is subsequently widely accepted, and which offers rules and behavioural expectations about the most correct conduct towards experimental subject and respondents, employers, sponsors, other researchers, assistants and students (Strydom, 2011: 114). The ethical considerations ensured that there was no violation of privacy, anonymity and confidentiality. No identifying information and real names were disclosed. Strydom (2011), states that participants should be allowed to decide when, where, to whom and to what extent his or her personal information should be disclosed, participant's identity should be kept as a secret if they wish and also the some information disclosed to the researcher others should not be able to access some information disclosed to the researcher.

According to the rules of the University of KwaZulu-Natal, the researcher sent the proposal to the UKZN Ethical Committee and applied for ethical approval. The committee gave full approval for the study with reference number HSSREC/00002009/2020 appendix 3. The study was conducted under the approval of the university ethical clearance. Secondly, informed consent was provided which states that when providing information researchers must ensure

that participants are given sufficient details about the nature of the research and procedures involved, this should highlight the objectives of the study, potential risks and benefits and any alternative treatments must be made clear. Thirdly, voluntary participation which states that, participation should at all times be voluntary and no one should be forced to participate in a project and should be free to withdraw their participation in the study if they wish so. Lastly avoidance of harm that states that the researcher should ensure at all times that no harm befalls a research participant either directly or indirectly (Strydom, 2011). The researcher built a relationship with the participants and also told participants what the study is all about. It is important for the researcher to prepare so that the participants can be familiar with the method of data collection that is going to be utilised. An interview schedule which was written in English was translated into isiXhosa since the participants were Xhosa speaking. The researchers prepared the participants before the collection of data via a briefing where the researcher explained the process and the time frame of data collection.

3.9 Limitation of the study

The researcher found that the participants did not show up on time during the scheduled interview due to cellular network problems which hindered the process of data collection. Another challenge is that elderly were not accepting the calls and their phones were running out of battery life in the middle of an interview. This led to the delay of data collection as many appointments were postponed and lot of airtime was wasted. The data which was expected to be analysed as soon as possible was also delayed and this impacted the writing of chapter four of the dissertation. It was difficult to find participants as the majority of them had no cell phones.

3.10 Summary

This chapter outlined the research methods which were used to conduct this study. This research study employed the interview schedule; this method was regarded as appropriate in exploring the living arrangements of the elderly in the rural area of Khambi village, Eastern Cape. The ethical measures were taken into consideration during data collection without compromising the individual's identity was highlighted. It also looked at how the data was managed and results disseminated. The following chapter will give us an in-depth presentation of the analysis, findings and interpretations.

CHAPTER FOUR

RESULTS

4.1 Introduction

Living arrangements of elderly people in South Africa are diverse and influenced by culture, politics and socio-economic situation. The overall aim of the study was to explore the living arrangements and conditions of the elderly in Khambi Village. This chapter outlines some of the main findings of semi-structured interviews that were conducted with 16 male and female participants from Khambi Village, Umtata in the Eastern Cape. This chapter begins by exploring the perspectives and experiences of the elderly, thereafter findings which assess the challenges in their current living conditions are presented. The latter part of the chapter focuses on the opportunities and constraints in accessing healthcare services, as well as other aspects such as health status, basic care, and social support systems, income and safety of the elderly.

4.2 Study sample characteristics

Semi-structured, telephonic interviews were conducted with 16 older people. All were elderly people from Khambi Village, Umtata in the Eastern Cape. Their ages ranged from 62 to 76 years. Nine were females and seven males. The majority of the study participants are widows and social grant dependents. It is not surprising then that none were employed. There were 16 respondents, 9 were females and 7 were male. Most of the older people in this study were living with their grandchildren. These findings are displayed in Table 4.2.1 below.

Table 4.2.1: Study sample characteristics

Participant	Identifier	Age	Gender	Marital status	Employment status	Access to grant
1	EP1	65	Female	Widow	Unemployed	Yes
2	EP2	67	Female	Widow	Unemployed	Yes
3	EP3	62	Female	Married	Unemployed	Yes
4	EP4	69	Female	Widow	Unemployed	Yes
5	EP5	63	Female	Widow	Unemployed	Yes
6	EP6	66	Female	Widow	Unemployed	Yes
7	EP7	62	Male	Single	Unemployed	No
8	EP8	76	Male	Widower	Unemployed	Yes
9	EP9	67	Male	Married	Unemployed	Yes
10	EP10	72	Male	Married	Unemployed	Yes
11	EP11	64	Male	married	Unemployed	Yes
12	EP12	66	Male	Married	Unemployed	Yes
13	EP13	63	Female	Married	Unemployed	Yes
14	EP14	68	Female	Married	Unemployed	Yes
15	EP15	61	Male	Married	Unemployed	Yes
16	EP16	66	Female	Widow	Unemployed	Yes

4.3 Access to healthcare services

Access to healthcare services is shaped by both the individual characteristics of the patient such as their financial position; social capital, which gives individuals access to information and networks; level of education and physical and cognitive capability, as well as supply-side factors in the healthcare system. Supply-side factors include: the availability of equipment,

medicine and skilled human resources as well as facilities, policies, structures and processes (Ameh et al., 2016). Although much work has been done in recent years to improve the availability and quality of health services, the South African healthcare system remains a “stressed institution”, mired by healthcare worker shortages, poor leadership and improper resource allocation. Studies of healthcare quality and responsiveness in the public health sector have shown that elderly people face challenges in accessing adequate care in the public health system (Hasumi & Jacobsen, 2014).

The older people in this study were asked about their access to any public facilities. The majority of the elderly people mentioned that they have access to healthcare services. However, they have one public clinic in their village which makes it difficult for them to access services timeously because some of them live far from the clinic and have to walk long distances. Another issue was long waiting time, for participants, waiting for long periods to see a healthcare professional was an expected part of the process of seeking care but it was also tiring as they were elderly.

“Waiting long hours here are a norm, we are used to this and there is nothing we can do because when we are complaining we are told that nurses are busy attending other patients we must wait” (EP 10).

One of the participant also mentioned that it is difficult to access healthcare not because there is a shortage of staff in our clinic but the current staff nurses do not care. They know it is the only nearest clinic but they make it difficult for the elderly as they spend much time chatting without assisting patients. Sometimes they close early without attending some other patients and sometimes they do not come to work when it is raining with an excuse that the gravel road is wet which makes them unable to drive to the clinic. This delays the process of service as the number of patients’ increases

“I cannot say that there is a shortage of staff, I think they are enough but they are busy chatting and laughing without considering that we need their services so that we can go early to our homes”(EP 11).

Others mentioned that they do not have money to pay for transportation and as a result they have to cancel their appointments. This becomes challenging for them as it delays them from accessing healthcare immediately. They also mentioned that they do not have an appointment to visit their clinic because it is close to them. They have to join long queues in order to be attended to. When they receive no assistance they would then have to return the following day. This is difficult because it is not guaranteed that they will receive assistance when they return. They also do not get priority for treatment, irrespective of their age or healthcare needs. One elderly participant indicated that Khambi Village is isolated from town and if they needed to travel to the nearest hospital they would incur transportation costs. The participants mentioned that they do not have money to pay for healthcare services such as private hospitals because they are so expensive.

“We have a nearby clinic in our village; I always visit according to my schedule if I can although I will spend the whole day sitting there and get help later” (EP1).

One other participant also mentioned that they have a clinic but it is the only clinic they use and other surrounding villages also depend on their clinic. Appointments are not considered as there are many people and this makes it difficult for elderly people. They are expected to wake up early in the morning so that they can get services because there are long queues. Those who wake up late might not be seen by a health professional because after 13:00pm some nurses do not come back after lunch so they have to go back to their home without receiving any services. The participant also mentioned that she does not have a specific date to visit the clinic but it is important to wake up early in the morning to avoid long queues as

there are many people and some are coming from other villages that are far from Khambi village.

“Yes there is a clinic here, I do not have specific date to visit but it is wise to wake up early in the morning to avoid long queues and at the end of the day I get services”(EP2).

Many older persons face distinct challenges in accessing quality healthcare services. Moreover, most disparities in old age health are not random, but are associated with disadvantage that has accumulated over the life course. Those persons in the poorest health are the least likely to have access to the interventions they need.

4.4 Health status of the elderly

Aging is a highly individual process which influences the health status of older people; there is abundant evidence that health status is associated with a range of risk factors resulting in a decline in functional status, such as depression, comorbidities, cognitive impairment, high body mass index (BMI), low physical activity, increased medication use, smoking, and reduced social contact (Stuck et al., 1999). Health status encompasses physical, mental, and social health. Measures of disease, such as symptoms, signs, and physiological measures, and measures of illness, such as functional status, are included in the concept of health status, according to the report of the Society of General Internal Medicine Task Force on Health Assessment (Rubenstein et al., 1989).

One of the participants indicated that she is suffering from hypertension and diabetes. She mentioned that this illness affect her wellbeing as she is unable to participate in other social meetings in her community such as female initiation (intambo). Her health status is preventing her from attending even other social celebrations such as traditional weddings and

cultural customs of her family. This is affecting her social life as she is limited to attend or go to other places like nearest villages.

“I am diabetic and also suffering with hypertension which makes my living very difficult” (EP2).

One of the participants shared her story about how she became HIV positive. She mentioned that she did not expect to become HIV positive at her age. She married her husband when she was 50 years old and she did not bother to ask an old man about his health status as she believes that she contracted the virus from. Sometimes she gets sick and she cannot do much because she experiences pain and antiretroviral drugs (ARVs) makes her feel tired. She finds it difficult to do household chores as she is living with her sons who refuse to cook, clean and take care of their father who is also sick. . Living arrangement also mean that older people lives with their family but they do not get the support from them. This woman also mentioned that she accepted her status and she is participating in awareness campaigns in clinics and hospitals where she encourages elderly people who might have experienced similar situations to get help.

“I am HIV positive I got it from my husband he did not tell me that he is positive but I have accepted it but sometimes I am feeling well” (EP3).

The other participant mentioned that the pain in her knees is really affecting her as she is struggling to walk long distance and do her gardening. She is using a stick to support her so that she can walk better; there are some people in her village who are making jokes about her health condition and this is so offensive to her. The participant likes to do groceries on her own because her son who lives with her spends money on alcohol. The participant mentioned that being unable to walk properly because of pain is debilitating as she is unable to walk long distance and soon she will need a wheelchair or anything that will support her when she

needs to go somewhere or need to attend an event such as wedding. Her disability is likely to affect her dependence as she is likely to become more reliant on others as her health deteriorates.

“I am struggling to walk because of the pain in my knees; I cannot walk properly without my stick to support me so that I will not fall and slide because sometimes it is wet” (EP4).

4.5 Basic care

Traditionally, basic care for older adults has been the responsibility of family members and was provided within the extended family home. Increasingly in modern societies, care is now provided by state or charitable institutions. The reasons for this change include shrinking families, longer life expectancy and geographical dispersion of families (Ting and Woo, 2009).

The majority of the elderly people in this study are living with young children and others alone. This affects their living arrangements as they do not receive consistent care because they are the ones who provide care to young children. Those who are living alone are not different to those who are providing care to young children as they are also taking care of their households. This does not only affect their living arrangements but also their safety as there is no one to take care of them and vulnerable to criminals.

In most households elderly person it is expected that they would receive assistance with basic care because as they are ageing they become weak and they are unable to perform certain activities. One of the participants mentioned that most of them are looking after their grandchildren and they have to cook, clean and take care of all the household chores. This participant further indicated that being a widow also plays a major in creating stress for her

because some of the things she is doing would be taken care of by her husband such as to attending livestock. Many of the elderly participants revealed that their daily routine is overwhelming as they have many responsibilities to attend to. As the head of the family they expected to manage with these responsibilities without any assistance, even though there are other members in the household.

“I take care of everything because I have no one to assist me” (EP1).

The participant also mentioned that she has a daughter who is mentally challenged with disabilities that require special care. She is finding it difficult to attend to basic activities as she is also taking care of her daughter. Sometimes her daughter demands her grant and insults her. She mentioned that the last few months the grant was terminated and she had to renew it so that she can be able to attend their needs. The participant has also indicated that the child of her daughter is unable to walk. When she is going to town she leaves her with a friend who is also her neighbour.

“For example I am coming from Social Workers to renew a social grant of my daughter who is mentally disturbed” (EP1).

The other participant mentioned that she is struggling to take care of herself especially when she have to go to town for groceries she needs assistance because she is not educated and there are things she does not understand such as drawing money from the bank. People can take her advantage as they can see that she is struggling therefore basic care is a need as elderly people especial from rural areas as some elderly people are living alone or with grandchildren who are still in primary school.

“It is not easy for me to go to town alone, I need someone who can do groceries for me and at least help me when I need cash from the bank. I am living with my

grandchildren who are still in primary school so I take care of them; they are still young to take care of me” (EP4).

4.6 Social support system

Social support is defined as a fundamental form of human interaction central to the human experience. At various times in peoples' lives, individuals either seek or provide support. Social support includes interpersonal communication and interaction, love and understanding, caring and concern, affection and companionship, financial assistance, and respect and acceptance. Social support has an impact on mental and physical health throughout the life span and may be especially important later in life. Negative stereotypes of older adults and the elderly paint a picture of isolation and unwanted social interaction. In contrast, many studies over the last 30 years have shown that not only do the elderly want and seek social support and interaction, but also social support is complex and changes over the span of a person's life (Rausa, 2008).

Social support systems are important as they are needed by elderly people in their daily life to balance and manage stress and maintain a sense of wellbeing. Social support may be provided in the form of physical or practical assistance for example; transportation, assistance with chores and finance. It also includes assisting older people with resources and information sharing. There are other forms of support which includes emotional and physiological assistance. This refers to having someone who will listen to and encourage them. The main source of support that the participants from this study received was from their family. The participant mentioned that when she is in need of any type of support she ask her family to assist her such as financial support. She also mentioned that she does not

bother herself by seeking any support from the community because if someone from the community helped her she will then hear gossips about that.

“When I need support such as financial support or any kind of support I seek support from my family because I do not want people to gossip about my problems in this village” (EP13).

The other participant who is living alone mentioned that she is always in need of support as she is ageing and sometimes she finds it difficult to seek support from the community because she has a family. The community members are expecting her to get support from her family. The participant emphasized that she is in need of support such a maintaining her home because her children are in Cape Town and they only comeback home during December holidays like Christmas day. During the year they are absent and they do not support her.

“I always need family support because I am living with my two grandchildren who are still in primary school and sometimes I get sick and they cannot take care of me. I need my family to support me financial” (EP11).

The elderly people are always in of support because sometimes they may feel lonely especially if they live alone. The one participant mentioned that when he needs support he talks to his neighbours. However, he was not specific about what kind of support but he mentioned that he gets help and his neighbours support him. He also mentioned that his neighbours most of the time he talks to them and they understand him. In some cases it is not easy to approach his neighbours but they are ones who are mostly present for him when he is in need.

“I have a family but when I need support I get it from neighbours so I cannot say I get family support” (EP15).

4.7 Family support

As people get older, their social network tends to shrink and family support, as a vital component of elderly people’s social support, has been found to have greater importance than non-family support for elderly people (Merz and Huxhold, 2010). A large body of research has demonstrated the importance of family support for elderly people. Grundy and Henretta (2006) found that support stemming from within the family system may be of particular importance to well-being in older adults. Cheng and Chan (2006) suggested that support from family members is beneficial for the well-being of older groups. Zulfitri, Sabrian, and Herlina (2019) pointed out that family social capital, including family interactions, family relationships, family support, and family structures, has a significant impact on well-being at an older age.

Family support is that which is given by their families. The findings from the study indicate that most of the participants lacked family support as they are living alone or with young children. Their children are living in other provinces like Western Cape and this create a huge gap as they do not get support. Their living arrangements are affected by lack of family support. The other participants are living with their families but they do not get family support instead they are the one who support their families. One participant expressed that there are no family members who provides any form of support to them. Even if they seek help from family members they are referred to their neighbours or they are reminded of their children who are not in the village. Some believed that their own children abandon the responsibility of providing care for them by leaving the village.

The other participant mentioned that she does not bother herself by seeking any support from her family because she knows they will not help her instead some members of the family will refer her to other members. The participant also mentioned that she does not use cell phone to get hold of them, so she goes to their homes and it is not easy because she is also looking after her grandchildren and they are living far from her home. The participant indicated that she gets support from her neighbours and other people from the community.

“I do not bother myself by seeking any support from my family because they will not help me, instead they will refer me to other members of the family and I will end up did not receive the support I am seeking. I get help from neighbours and other members of the community” (EP14).

The other participant mentioned that he lost her wife and most of the time he is living alone, his children have their own places outside Mthatha and her granddaughter asked him to stay in her place. He finds it very difficult to leave his home and cattle behind. The participant mentioned that there are people who might steal his cows and vandalise his home so his family does not support him because of his refusal to stay at his daughter’s place. Currently he does not receive family support but he wishes that his family can support him when he needs support.

“I do not get support from my family because I told them I cannot leave home and cattle alone here, there are thieves here and they will vandalise my home” (EP8).

The family is best suited to meet the needs of each senior. Nowadays, when life expectancy got extended and retired people are in full possession of their faculties and physical strengths, they are people with considerable needs, wishing to retain contacts with the environment, the stereotype of old age being associated with diseases, dependency on others, the decline of the needs and opportunities are no longer the case (Mariola, 2014). Family life sometimes

imposes the situations of inevitable necessity, such as caring for a sick family member no longer able to care for themselves, care for the seriously ill or an infant. Grandmothers are often pleased to look after her grandchildren, left in her care, unless the care is too lengthy or too exhausting. Similarly, the grandfather happily fulfils the tasks undertaken for the sake of his children's family if he is in a position to do so (Mariola, 2014).

4.8 Community support

Elderly people are important members of society because they possess the skills, knowledge, wisdom and experience to contribute to society. The findings from this study suggest that the community provide support for elderly people by providing them with food and by assisting them to get to the hospital when they are sick.

According to Jansen van Rensburg and Strydom (2010: p.381) “community care should take place in a supportive and caring environment, and this also reduces the level of dependence on expensive institutional care, which is a major benefit for society at large”. Many of the elderly are now taking care of others, even though they themselves are already at an age when they could have expected to receive the care, respect and rest associated with old age (Boon, James, Ruiter, Van der Borne, Williams and Reddy, 2010: p.2). Older persons are currently made to assume both productive and child-raising duties with little or no support, and to endure the emotional, physical, financial and social costs that arise from their role as caregivers (Kakooza, 2004: p.6; Makiwane, Schneider and Gopane, 2004: p.14; May, 2003: p.54).

The study found that older persons in deep rural areas, who are often illiterate and without access to basic facilities, do care for people with chronic illness without any care-giving

training. Community based care and support service are programmes specifically designed to address the interests and needs of older persons in the community and also to assist them to cope with the difficulties of life. These services have both a health and social component (Timonen, 2008: p.109) and can be helpful to older persons if they are well implemented.

The findings from this study indicate that elderly people are receiving community support but the support is not always available and it means that community support is not reliable. Therefore elderly people cannot depend on community support as it is not permanent but occurs occasionally.

“I say the community provides support when we need it but the support is not enough because they do what they can do at that moment but their support is not reliable and you cannot depend on it. Sometimes they are available and sometimes they are not”
(EP12).

The other participant also mentioned that the community provides support but it is limited therefore there is a need for other support system like family. There are community support structures like formal home based-care; those structures are available in urban areas. In rural areas general support is provided at that particular moment when community member notices there is a need for support. The community will discuss the way forward and if they agree then the elderly will be supported.

“The support that is provided by the community is so limited and if there is no community member who have noticed you when you are in need of support, you might not get support but all I can say we are supported here although it not enough”
(EP11).

4.9 Source of income

The gradual erosion of the family support system and the use of their meagre incomes to bring up orphaned grandchildren results in an increasing number of older persons becoming actively involved in the struggle to earn a living (Makiwane and Kwizera, 2006). For the elderly, this brings new challenges and financial hardships, social isolation and risks to their own health (Madonsela, 2008). The majority of the older population in South Africa has never enjoyed access to employment in the formal sector owing to past discriminatory practices, so the elderly have no secure retirement benefits (Wachipa, 2006). They need state assistance in order to cope with their increased vulnerability and to live independent lives in the community (Wachipa, 2006).

In South African, the majority of elderly people typically depend on social grants and the minority on other sources of income. This is not surprising as sixteen participants have confirmed that they depend on the elderly social grant and this is their only source of income. It was mentioned that with the little money that they receive from the grant they use it to pay for funeral costs, to buy groceries and electricity and pay their debts that are accumulated in the middle of the month when they have run out of food. This leaves them feeling helpless because they cannot afford any groceries they become vulnerable to experiencing hunger. Some of the participants mentioned that they have to ask neighbours to assist them with food which is only sufficient for that day.

“I am a social grant dependent but it is not enough to cover up some of my needs and as result I run out of food in the middle of the month. I have to ask neighbours to assist me with food and sometimes they also run out of food” (EP5).

Elderly people, in comparison with other working age population, bear significantly higher risk of financial stress due to diminishing physical and mental ability (Erwin et al., 2017).

Some of the elderly people accumulate debt and as a result they are in debt and their SASSA cards and identity documents are taken away from them. They sometimes spend half of the month without electricity because they do not have enough money.

“I am running out of electricity before month end because I have I have no other source of income with social grant and this social grant is not enough. I have to pay electricity and I do not buy much so I run out of electricity before month end” (EP3).

One male participant indicated that he does not have any source of income and he survives by earning R100 per day by doing small tasks such as shepherding and doing gardens. He does not always get these small jobs because he has an injury to his knee so this makes it difficult. He mentioned that he has been applying for an elderly social grant but there were complications associated with his identity document. He lost his identity document and because of the small jobs he was busy with he had no time to do another identity document and as result when his social grant application was delayed. However, he believes that if all these issues were resolved and he manages to receive his social grant then it would make a difference in his life.

“I do not have social grant I live by asking for small temporal jobs and this is the only way of income and sometimes I do not get those small jobs but I have applied for social grant and it’s still on process” (EP7).

One participant mentioned that relying on social security grant is a challenge to her because even if she needs financial assistance from her children they tell her that she has a social security grant. They even ask what she is doing about the money she has because it should sustain her for the rest of the month. This has led her to stop asking financial assistance from them to avoid the conflict that might rise. The participant also mentioned that she was knitting African clothes and sells them but now she is no longer selling clothes because some

people were not paying her money. Her business was helping her a lot because she was not relying only on social grant as source of income and now she is struggling to maintain her health because she does not have enough money.

“I am depending on social security grant, I do not have other source of income and when I seek financial assistance from my children they ask me what I am doing with the money I have” (EP16).

The social grant is the only source of income for the majority of the elderly people in Khambi village. South Africans in rural areas are ageing in a complex context with high rates of income inequality, unemployment and an increasing burden of disease that includes endemic levels of HIV as well as a growing epidemic of non-communicable disease, particularly among those over age 50 (Nyirenda et al., 2012). In this context, social protection grants play a critical role in the survival and livelihoods of individuals and households (Twine, Collinson, Polzer and Kahn, 2007). However, the social grant does not cover all the living expenses of the elderly.

4.10 Safety of the elderly

Elderly people living in their homes, institutions, or communities are continuously integrated with their social and physical environment. The people and places that comprise their surrounding environments, the local shopping centre, the behaviour of elderly neighbours, the routine walk to the nearby bus stop, and the design and decor of their home, all influence daily life. However, being subjected to some incidents may restrict older adults' mobility and use of space and environment namely: abuse, risk for victimization, and fear of crime and victimization (Cozens, Neale, Whitaker, and Hillier, 2003). Older population are more likely to be victimized by strangers. However, known offenders of the elderly are more expected to be care givers (Bachman and Meloy, 2008).

Ensuring safety of older people is essential and improves their well-being. Some of the elderly participants mentioned that they did not feel safe and they are living in fear. This fear was influenced by young boys who are targeting elderly people especially those who are living alone or with children and take their items such as televisions, microwaves and sell them in the nearest villages cheaply so that they can buy drugs and alcohol.

“I not safe, I am scared because there is a group of boys here in our village that are targeting us and take our items and sell them because want to buy drugs and alcohol”. They do not care even if you know them, they are just doing these silly things and one of them was beaten up by community members” (EP5).

One of the participants has shared her story about her life and she said she feared being in danger. Participant mentioned that she is living with her son who is a thief and a criminal. The participant has been receiving several cases about the behaviour of her son who is accused of stealing in the village. The participant was told to talk to her son or move out of the village and live somewhere else. The participant was also threatened that the community will burn down her home if her son continues to steal and stab members of the community. The participant lives in fear of losing her home or being killed by community members who are angry. The participant is scared for her life that might be in danger.

“I feel like my life is in danger because my son has changed into something I do not know him so aggressive to me and not safe even outside because of him, community members are labelling me with many silly names and promising to burn down my home because I am protecting a criminal” (EP2).

One participant mentioned that there is a group of men near to her village who called themselves amavondo (vampires), these men are known for targeting elderly people and

children. This has created lot of fear even to elderly people of Khambi village as there were some case about rape and killing of elderly people by these so called vampires.

“I am not safe because I stay with my little grandchildren and there are vampires here who rape people and kill them so I am very scared” (EP6).

The other participant mentioned that they are living in an environment that is not safe and it is difficult to identify criminals as they are protected by their parents. There was a time where one of the elderly in the village was attacked by two men who wanted money. He told them that he does not have money and they beat him up. The participant reported the matter to the police but they were not identified because they were wearing masks that covered their whole face. It was not the first time a similar case occurred as one of the elderly was robbed but not harmed as she pleaded for her life. The participant also mentioned that he is not feeling safe as he cannot move freely during late hours because he might be robbed or harmed. Safe environments are those that allow free movement and have no risk or other types of threat to life and health.

“It is not safe here, we are living in environment that is not safe and we are not free to move during some late hours of the day because we know that our sons will rob us. We are living with fear” (EP15).

4.11 Summary

This chapter has presented results from the telephonic interviews that were conducted with elderly people from Khambi village, Umtata in the Eastern Cape. The age of the participants ranged from 62 to 76 years. The majority of the participants were females. The results suggests that there are several factors that are affecting the living arrangements of the elderly people which limit access to healthcare services as it was mentioned that they depend only

on those that serves the whole community and surrounding villages. The elderly people are struggling to access healthcare as it is limited due to poor services, limited equipment and lack of advanced machines. A poor health status was also a factor that has affected the elderly people with many suffering from hypertension, diabetes and HIV/AIDS. This has led elderly people to seek assistance that is not available. Another factor was basic care which was also lacking as the majority of the elderly are living with their grandchildren who are given care by them and this was a burden to the elderly. The social support systems were also discussed and it was noticed that the main social support systems of the elderly was both a family and community. The majority of the elderly mentioned that they receive support from the community because most of the time their families are not available when they need support such as financial support. However, the support from the community is always available. It was also noticed that the majority of the elderly are living in poverty as they are dependent only on the social security grant that is not enough to meet their needs as they are expected to pay funeral covers, groceries and electricity. Another factor was safety of the elderly, the findings has indicated that elderly people are living in environment that is not safe as some of them has been victims of crime such as robbery. Some of the elderly are living alone and others with their grandchildren who are still in primary school and they are the targets of criminals as they know that they are not protected. It is evident that these factors have not been considered yet as the situation is still the same.

CHAPTER FIVE

DISCUSSION AND CONCLUSION

5.1 Introduction

The study was an exploratory, descriptive and contextual qualitative study. The researcher adopted phenomenological approach to achieve the objectives of the study. Semi-structured, open, telephonic qualitative interviews were conducted with sixteen elderly participants from Khambi village in Umtata, who were purposively sample as participants. The interviews were conducted in English and phone recorded, then transcribed and analysed. This chapter integrates and compares findings to relevant literature. This chapter also provides recommendations and limitations of this study. The research study aimed to shed insights into the living arrangements and living conditions of the elderly in Khambi Village, Eastern Cape. The interpretation of findings of the study was guided by hierarchy of needs theory by Maslow.

5.2 Discussion

The study draws on the hierarchy of needs model developed by Maslow (1943) which looks at human needs. The theory explains that once human needs are satisfied at lower levels, people pursue higher-level needs, and the same is true for the elderly because of their physiological functions, personal values, and preferences. The elderly people's intrinsic needs may differ from those of younger people (Mertz and Stephens, 1986). For instance, elderly people's needs to maintain their health and economic stability become higher priorities. Onah (2015) has highlighted that people are motivated by five levels of needs namely: physiological, safety, belonging, esteem, and self-actualization. It was observed from the study that living arrangements of the elderly people are affected with so many challenges and these challenges are; limited access to healthcare systems, poor health status, lack of basic care, lack of social support systems from the family and community, limited source of income, and lack of security. The result from the study shows that the elderly people have

limited access to healthcare facilities as they have only one clinic with limited equipment to attend to their health needs. The elderly in this study also reported that they wait long times because the clinic is used by the whole village and there are poor healthcare services. This is supported by Young (2016: p.20), public healthcare facilities exhibit numerous shortcomings such as long waiting times, poor-quality healthcare delivery, old and poorly maintained infrastructure and poor disease control and prevention practices". According to Dunjwa (2016: p.1) and the South African Medical Association (2015: p.36), "most facilities had problems such as poor waste management, lack of cleanliness and poor maintenance of grounds and equipment". In a study by Nevhotalu (2016: p.138), "patients and staff confirmed that some departments had an unacceptable physical environment (e.g. dirty toilets) for delivery of quality health care. Interventions in this regard can include the provision of free or subsidized assistive devices, facility-based health care and regular outreach health care to older people in their homes. Another concern was the health status of the elderly people". According to the report of the National Working Committee on Aging in China (NWCA), the health status of 27.7% of the rural elderly was self-reported as "good" compared with the national average of 32.8%. This contradicts the findings from Khambi village as it was reported that the majority of the elderly people in the study have poor health status.

The elderly people in this study reported that they are in need of basic care and they are providing care for their grandchildren, which is difficult for them. In many areas of South Africa, there is a substantial care deficit state that are often limited to urban centers, and even where such provision exists, it may be inaccessible for many due to poverty (Schatz & Seeley, 2015). Consequently, most care provision for older people in South Africa is provided by informal carers the vast majority come from within the family. This is supported by Aboderin (2017), who suggested that care provided by families for elderly in South Africa

is limited. However, it was reported that the majority of the elderly people in this study are lacking basic care for example support for going grocery shopping and doing house chores are a challenge to them. These patterns of care and need are further modified by the impact of gender particularly with respect to the way that traditional societal roles place expectations on women as the main care providers in families, and also in how the loss of the male provider role as a result of activities of daily living impairment might alter care seeking or care receipt behaviour (Mugisha, Schatz, Seeley, and Kowal, 2015; Schatz et al., 2017).

Another major concern in the study was social support systems. According to Kim and Nakoaka (2016), social support usually comes from family members, neighbours, friends, and peers, who are important sources of social support. According to Animasabun and Chapman (2017), support can originate from family and friends as well as membership to community or faith based organizations. Although socio-demographic status had no significant relationship with social support, social support reportedly decreased with increasing age, due to a loss of a spouse, residence in a particular community for less than 10 years, low income, retirement status, or/ and minimal participation in faith-based activities. Another concern was family and community support and it was found that the majority of elderly people are lacking both family and community support due to younger family members migrating to urban settings. According to the United Nations (2015), it is suggested that family support decreases since younger family members migrate to urban settings for educational and employment opportunities. Factors, such as increasing social network, support and engagement, are increasingly more significant for elderly as social changes affect the structure of the traditional extended family and economic pressures lead to family members leaving for the cities. Cumulatively, these social factors are affecting the well-being

of elderly people as they are left behind with grandchildren in rural areas. This makes it difficult for the elderly people to receive care.

It was also found in the study sample that the majority of rural elderly people are social grant dependents and it is their only source of income. The South African government sponsors a formal system of support in the form of the old age pension which was extended to the Black population in the early 1990s. Currently, both men and women aged 60 and older are eligible to claim the pension (Ralston et al., 2015). In many African countries, older populations are less socio-economically advanced and live in poverty (Audain et al., 2017). According to the results of the study it was indicated that limited sources of income leads to vulnerability of the elderly people to poverty. This is supported by Gorman (2017), poverty is an underlying cause of food insecurity. Thus, the elderly is a vulnerable group due to their high poverty risk. A study conducted by Grobler and Dunga (2019) found that, based on the international poverty line of US\$1.90 per person per day, all members of this elderly community (Sharpeville) can be considered poor despite almost two thirds being food secure. Government initiatives targeting food insecurity involve social grants, including old age pension funds for elderly aged 60 years and older with no other income. This was evidenced by the majority of the households (60%) in the study that depended on the old age pension fund for purchasing food and other items. For 55% of the food secure households, the old age pension provided their only income, compared to 62% in the mildly and 80% in the moderately food insecure households (Grobler and Dunga, 2019). This is clear evidence that regardless of the old age pension fund that is provided it is not enough to meet the needs of the elderly as they are also vulnerable to poverty.

It was also indicated from the results that elderly are not safe and they are exposed to violence. Violence against the elderly can be in the form of physical violence, psychological violence, sexual violence, economic violence, neglect, or abandonment. According to the

World Health Organization (2018), one in six elderly people have been exposed to one type of violence. According to the results of a meta-analysis conducted by Yon, Mikton, Gassoumis and Wilber (2017) that included 52 studies from 28 countries, 15.7% of the elderly were reported to be exposed to violence. On the other hand, the results of a meta-analysis performed by Ho, Wong, Chiu and Ho (2017) that included 34 studies, 10.0% of the elderly were reported to be exposed to violence. In South African context there were cases of murder and rape of elderly in Eastern Cape (SAPS Media Report, 2021). This brings a concern about their safety as we can see from the literature that elderly people are not safe and this pose a challenge to our government about measures that needs to be taken to protect elderly people. According to Kalaycı and Özkul (2018), who suggested that the risk of violence against the elderly is affected by living in a large family or alone; low or high economic status; decrease in physical, psychomotor, perceptual, and cognitive abilities; the need for care; and being old. Many elderly people in the study are widows and they are living with young grandchildren. They are expected to provide care to these grandchildren without support from their parents and this affect their living arrangements as they are unable to manage their social life. This does not impact their social life only but also their well-being as they are living a contained life.

5.3 Recommendations

Understanding the living arrangements and living conditions of the elderly people in rural areas is pivotal. Rural living arrangements of the elderly people can be improved by addressing the striking problems facing them. There are still some barriers that are hindering elderly people's access to healthcare services. Building advanced healthcare centres in rural areas with the health professionals can improve access to healthcare services and health status of the elderly. Those experiences of health among older persons differ so greatly which

underscores the message that poor health in old age is not inevitable (WHO, 2015). Policies can influence some health determinants, such as access to care, risky behaviours and individuals' capacities such as health literacy, enabling persons to enter old age in a healthier state. Such types of policy responses, which should direct particular attention to people living in poverty and belonging to other disadvantaged groups, should be undertaken alongside broader efforts to better align health systems with the general needs and concerns of all older persons (WHO, 2015). These services should be free as the majority of the elderly are social grant dependants and might not afford to pay for healthcare. Basic care was also a striking problem that is faced by the elderly in this study as some of them reported that they need to be assisted. There is a need of the elderly care centres in rural areas to provide care to those older people who need special care as some of them are living alone or with grandchildren who are still in primary school. These centres can be managed by registered social auxiliary workers with support from social development. There is a need of permanent social support systems that will manage to maintain their well-being regardless of economic status. Adequate social support may represent a strategy for reducing the level of stress caused and, consequently, improving their living conditions.

Elderly people are living in fear as they are not safe in their environment and there is a need of some strategies to be implemented that will address the safety of the elderly in villages such as police patrol during the day and night. There is a need of safety measures that will protect elderly from robbery, murder, rape and other threats that are facing the elderly. The majority of the elderly are social grant dependants. However, they are living below poverty. All the above recommendations should be considered in order to improve the living arrangements and conditions of rural elderly people to live a harmonious life.

5.4 Limitations

The study noted several limitations that provide a solid basis for future research. Firstly, the study only focused on rural elderly people, it did not consider urban elderly people that might also face some similar challenges. Secondly, the study was predominately black elderly people, which limited the generalization of the findings to other elderly racial groups failing to reflect on their living arrangements. Thirdly, the study participants were more of the same age group, thus a research with a broader age range might be needed to examine the differences in perceptions/attitudes/experiences regarding their living arrangements and living conditions. Furthermore, due to Covid-19 the study used telephonic interviews that made it difficult to physically interact with participants as the rapport was not strong.

5.5 Conclusion

This study explored the living arrangements of the elderly people in Khambi village at Umtata in the Eastern Cape using telephonic semi-structured interviews. The overall objective of this study was to shed insights into the living arrangements and living conditions of the elderly in Khambi Village, Eastern Cape. The study had explored that living arrangements of the elderly are influenced by social and economic factors. The elderly people are struggling to access healthcare as it is limited due to poor services, limited equipment and lack of advanced machines. A poor health status was also a factor that has affected the elderly people such as hypertension, diabetes and HIV/AIDS. This has led elderly people to seek assistance that is not available. Another factor was basic care which was also lacking as the majority of the elderly are living with their grandchildren who are given care by them and this was a burden to the elderly. The social support systems were also discussed and it was noticed that the main social support systems of the elderly was both a family and community. The majority of the elderly mentioned that they receive support from the community because most of the time their families are not available when they need support such as financial

support. However, the support from the community is not always available. It was also noticed that the majority of the elderly are living in poverty as they are depending only social security grant that is not enough to meet their needs as they are expected to pay funeral covers, groceries and electricity. Another factor was safety of the elderly, the findings has indicated that elderly people are living in environment that is not safe as some of them has been victims of crime such as robbery.

According to the results of the study, rural elderly people are the most vulnerable age group who lives in poor conditions with many responsibilities of taking care of their families financial. This has been considered as a burden that makes their living arrangements stressful and fearful. The lack of care has been a major concern of the elderly because there are no elderly healthcare centres, caregivers and old age homes in the village. To get better healthcare services they need to go to town and it is expensive. Inequality in the distribution of services in both rural and urban has created a huge gap between rural elderly and urban elderly. Rural elderly are generally suffering and still living in poor conditions with little consideration of their living arrangements. The study concluded that living arrangements of rural elderly people are less considered and this makes them live in poor conditions with overwhelming burden of poverty.

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APPENDICES

Appendix 1: Ethical clearance letter



30 October 2020

Mr Sibongiseni Ntobongwana (220110810)
School Of Built Env & Dev Stud
Howard College

Dear Mr Ntobongwana,

Protocol reference number: HSSREC/00002009/2020

Project title: Exploring the living arrangements of the elderly in the rural area of Khambi village, Eastern Cape

Degree: Masters

Approval Notification – Expedited Application

This letter serves to notify you that your application received on 07 September 2020 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted **FULL APPROVAL** on the following condition:

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

This approval is valid until 30 October 2021.

To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

All research conducted during the COVID-19 period must adhere to the national and UKZN guidelines.

HSSREC is registered with the South African National Research Ethics Council (REC-040414-040).

Yours sincerely,



Professor Dipane Hlalele (Chair)

/dd

Humanities and Social Sciences Research Ethics Committee

Postal Address: Private Bag X54001, Durban, 4000, South Africa

Telephone: +27 (0)31 260 8350/4557/3587 Email: hssrec@ukzn.ac.za Website: <http://research.ukzn.ac.za/Research-Ethics>

Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville

INSPIRING GREATNESS

Appendix 2: Interview schedule



University of KwaZulu-Natal, Durban, South Africa

Topic: Living arrangements of the elderly: A case study of rural Eastern Cape

Biographical information						
Gender	Male	<input type="checkbox"/>	Female	<input type="checkbox"/>	Other	<input type="checkbox"/>
Age						
Educational level	Primary	<input type="checkbox"/>	High school	<input type="checkbox"/>	Tertiary	<input type="checkbox"/>

Living arrangements information

- Is this your home or is it the home of a family member and if it is of a family member who are they?
- Do you get an old age grant? What do you use this money for?
- Who do you live with and if you live alone –why is this so?
- Do you have a spouse? If yes do they live here? If not, where?
- Do you get help from your family members? What type of help? Financial, caregiving. Etc?
- Are you employed? If yes what kind of work do you do?.
- How do you earn an income?
- How long have you been living here?
- Where did you live previously and if not here why did you move?
- If you were not living here previously who did you live with?
- Do you have any illness that you are currently challenged with?
- Can you describe your living/home conditions to me?
- Do you have nearest clinic in your village or outside your village and how do you get there to access healthcare?
- How often do you get healthcare?

- What help do you need or kind of support?
- Do you face any challenges in your home? If yes explain.
- Who gives you support with your daily activities like cooking, cleaning, bathing etc?
- Do you feel safe or secured where you are currently living? Explain your answer.
- What changes would you like to happen in your home concerning your living conditions?

Appendix 3: Informed consent

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL

For research with human participants

INFORMED CONSENT

Dear Sir/Madam

Date: 21 July 2020

My name is **Sibongiseni Ntobongwana**. Student no: **220110810**. I am a Masters Candidate studying at the University of KwaZulu-Natal, Howard College Campus, and South Africa. I'm supervised by **Prof Pranitha Maharaj** from the department of Built environment and Development Studies. Her contact details are: Tel: **031-260-2243**, Email address: maharajp7@ukzn.ac.za

I am doing a study entitled:

“Exploring the living arrangements of the elderly in the rural area of Khambi village, Eastern Cape”.

You are being invited to consider participating in a study that involves research. I am interested in exploring the perspectives and experiences of your living conditions, to assess the barriers in your living conditions, and to ascertain the opportunities and constraints for changing the current living conditions. The aim of this research is to shed insights into the living arrangements of the elderly in rural areas. Your participation in this study entails consenting to participating in the interview. Before participating in this study please note the following:

Your confidentiality is guaranteed as your inputs will not be attributed to you in person, but reported only as a population member opinion. I will use telephonic interview and the interview may last for about 15 up to 20 minutes depending on your preference. Participating in this study is voluntary and you are allowed to withdraw in the middle of the interview if

you feel uncomfortable or do not want to continue. Any information given by you cannot be used against you, and the collected data will be used for purposes of this research only. When the researcher writes the report, your real name will not be used. Your participation is purely for academic purposes only and there are no financial benefits involved.

Request for an audio recording

The researcher requests to use an audio recorder during phone call interview for the purpose of ensuring trustworthiness of the study. The recording will be confidential and will not be used against you.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number_____).

In the event of any problems or concerns/questions you may contact the researcher at (provide contact details) or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001
Durban
4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

CONSENT (Edit as required)

I (Name) have been informed about the study entitled (provide details) by (provide name of researcher/fieldworker).

I understand the purpose and procedures of the study (add these again if appropriate).

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at 0718172936 or 220110810@stu.ukzn.ac.za

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

GOVAN MBEKI BUILDING

Private Bag X 54001
Durban
4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557 - Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Additional consent, where applicable

I hereby provide consent to:

Audio-record my interview / focus group discussion YES / NO

_____	_____
Signature of Participant	Date
_____	_____
Signature of Witness	Date
(Where applicable)	
_____	_____
Signature of Translator	Date
(Where applicable)	