



**Gender Disparities in Accessing Treatment for Age-Related Hearing Loss Among the
Elderly: A Study in Ngwaqa, KwaZulu-Natal, South Africa**

by

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DECLARATION - PLAGIARISM

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Signed

.....

Date

.....

DEDICATION

This study is dedicated to my grandparents and the other ARHL participants who spared time to share their experiences and knowledge. Their unwavering support and rich life experiences shaped my understanding of the world and inspired my pursuit of knowledge. Their participation in this study was a testament to their strength and resilience and paved the way for a deeper understanding of the challenges faced by older adults with ARHL in rural areas. I would also like to thank God, who has given me love, wisdom, and courage, and those have been my guiding lights. Finally, I would also like to dedicate this study to the loving memory of one of my grandmothers, who had so much belief in education that even on her deathbed, she was resilient enough to insist on participating and share her experiences. Her spirit continues to motivate me every day, and I hope to honour her legacy through the findings of this study.

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ABSTRACT

Age-related hearing loss (ARHL) significantly impacts quality of life, communication, and social integration among the elderly, particularly in rural South Africa. While both genders experience ARHL, evidence suggests that disparities exist in diagnosis, treatment access, and healthcare outcomes, compounded by socio-economic challenges and cultural beliefs. This study investigates these gender disparities in accessing treatment for ARHL and their implications for elderly individuals in Ngwaqa, KwaZulu-Natal. The primary objectives of this study are to explore cultural beliefs and attitudes of the elderly towards ARHL, examine gender differences in accessing healthcare services, assess the psychological well-being of individuals with ARHL, and understand the caregiving dynamics as experienced by the caregivers of the elderly. A phenomenological qualitative research design and a case study approach were employed to collect rich and in-depth data detailing the lived experiences of the elderly with ARHL. Data was gathered using participant observation and semi-structured interviews with 44 participants, including older men and women with ARHL, their caregivers, and healthcare professionals. Thematic analysis was utilized to identify key patterns, themes, and insights from the interview data. The findings reveal that women and men experience ARHL differently and have different experiences in healthcare settings. While some men reported feeling disrespected by healthcare workers, similarly, other women expressed frustration over being overlooked, dismissed, and having their symptoms downplayed. Conversely, other older men and women have positive and beneficial healthcare-seeking experiences. Participants also reported stigma, social isolation, and emotional distress as significant challenges associated with ARHL. Although access to hearing health remains limited, those who utilized hearing aids reported improved quality of life. Significant barriers to treatment access were identified, including financial constraints, transportation issues, and cultural stigma, which hindered timely diagnosis and intervention.

This study underscores the urgent need for gender-sensitive healthcare approaches to address the disparities in ARHL treatment access among the elderly. It highlights the importance of integrating cultural considerations and promoting community awareness to facilitate better health outcomes. Improving access to hearing healthcare and fostering social engagement can significantly enhance the quality of life for the elderly experiencing ARHL, advocating for policy reforms and public health initiatives tailored to these unique challenges.

Keywords: *ARHL, cognitive decline, elderly, access, treatment, gender disparity*

ACRONYMS

ARHL- Age-related hearing loss

CG- Caregiver

GAD- Generalized Anxiety Disorder

NIH- National Health Institute

QoL- Quality of Life

WHO- World Health Organization

GLOSSARY OF TERMS

Access to health care: The timely and affordable ability of individuals to obtain necessary medical services, including prevention, diagnosis, treatment, and follow-up care without facing financial, geographical, or systematic barriers (WHO 2023).

Access to health facilities: Access to health facilities refers to the ability to obtain and use medical services (Vitacare, 2021).

Age-related hearing loss: Refers to a gradual loss of hearing and diminished recognition commonly experienced by the elderly (Govender and Jongh, 2021).

Culture: Shared ideas, attitudes, beliefs, values, customs, and practices that shape the way a particular group of people understands and interacts with the world (Smith et al., 2006).

Disability: Reduced physical or mental capability from disease or injury (Leonardi, 2006).

Elderly: People aged 60 and over (Stats SA, 2022).

Gender: The socially defined roles, behaviors, activities, and expectations deemed suitable for men and women (WHO, 2021).

Gender disparity refers to the unequal treatment, opportunities, and outcomes between individuals based on gender (UNDP, 2021).

Health: “Human health is the biological and mental state of life” (Mondal and Das, 2022, p. 1).

Illness: The subjective experience of a person who perceives themselves as unwell.

Quality of life: Refers to an individual's overall well-being, encompassing physical, psychological, social, and environmental aspects that contribute to their satisfaction and happiness. (Teoli and Bhardwaj, 2020).

Stigma: The negative social attitudes, stereotypes, and discriminatory behaviors toward individuals or groups based on specific differences (Corrigan and Rao, 2021).

Treatment: According to the National Institute of Mental Health (NIMH), treatment refers to the medical or therapeutic interventions provided to individuals suffering from a physical or mental health condition to improve their symptoms, manage their condition, or prevent further complications.

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CHAPTER ONE

INTRODUCTION

1.1 Introduction

The social and cultural implications of age-related hearing loss (ARHL) are significant and can have a widespread impact on individuals and the communities to which they belong. Age-related hearing loss is a prevalent auditory condition in the elderly. It is characterized by declining hearing ability and speech comprehension (Govender and Jongh, 2021). This condition can significantly affect the quality of life for older individuals, including restricted communication, social isolation, and depression. Cheslock and Jesus (2020) assert that there is no treatment to reverse age-related hearing loss. However, the use of hearing devices can help relieve symptoms. This gradual hearing loss can still have extensive consequences for individuals and societies. Age-related hearing loss can have profound psychological effects on the well-being and quality of life of the elderly, especially in rural areas with limited access to healthcare and support services. Depression, anxiety, cognitive decline, social isolation, reduced independence, and overall decreased well-being are significant issues this population experiences (Gates and Mills, 2005).

Furthermore, ARHL affects individuals' ability to participate fully in various social settings and activities. Beyond the impact of hearing loss on daily life activities, hearing loss also impedes comprehension in group discussions, presentations, and public events, leading to reduced participation and potential discrimination (Jayakody et al., 2018). Therefore, ARHL can potentially affect cultural practices and traditions that heavily rely on oral or auditory communication. If people of a culture or community experience ARHL, their ability to engage and share practices, which involve speaking and listening or understanding sound, may be impacted. For example, attending religious ceremonies or cultural performances can become challenging. The inability to fully participate and engage with cultural practices due to hearing loss may lead to a loss of identity, feelings of exclusion, and reduced cultural integration (Saraceno, 2001).

Women in South Africa, particularly those in rural areas, have historically faced barriers to accessing healthcare services (Seidu, 2020). These barriers include a lack of transportation, limited financial resources, and cultural and social norms that prioritize the health and well-being of men over women. Ngwaqa is a community where females head one-third of all households. Connel et al. (2012) found that because of factors like a lack of education or experience, women in female-headed households are often forced to pursue low-paying, irregular, part-time, and marginal occupations. These jobs often offer little to no benefits. These jobs may be unstable or unpredictable. In this community, many households are headed by grandparents. In most cases, grandmothers are the sole providers who use their pensions. This issue can pose a challenge when traveling to and from the clinic or hospital. Given that they are

already old, there is also an issue of vulnerability, which plays a significant role in their health. Some receive assistance from caregivers, and others receive financial support from relatives. Most do not have such support structures because they came to settle in Ngwaqa so they could live with their in-laws and expand their families. Now that they are older, they are left alone. Other challenges include poverty, low socioeconomic status, and multiple responsibilities that make these women unable to maintain good health (Bayangani et al., 2014; Burstrom et al., 2005; Ozawa et al., 2011; Rahkonen et al., 2005). According to Coovadia et al. (2009), gender disparities in healthcare services in South Africa have been a long-standing issue.

Gender disparity refers to the unequal treatment, opportunities, and outcomes between individuals based on gender (UNDP, 2021). Women may face greater challenges in accessing hearing healthcare services compared to men, which can lead to delays in diagnosis and treatment, as well as poorer outcomes of rehabilitation (NASEM, 2016). This study addressed the need to understand the perceptions of the elderly with ARHL, its treatment, and the impact of gender disparity in health care access in a rural area of KwaZulu-Natal. It was intended to gather rich, detailed information about their well-being. Lastly, it aims to contribute to the growing literature on the elderly and their perceptions of illness, treatment, and access to health care. According to Peltzer and Phaswana-Mafuya (2009), in South Africa, the Zulu community has a longstanding history and deeply rooted cultural beliefs that shape how individuals perceive illness and seek treatment. Older Zulu adults understand their illness and treatment based on their cultural and belief systems. Their beliefs in spiritual balance, the influence of ancestors, and the use of traditional healing methods significantly impact their healthcare-seeking behaviors. Peltzer and Phaswana-Mafuya believed that acknowledging and integrating these beliefs and practices into healthcare delivery is crucial for culturally sensitive care.

1.2 Statement of the problem

Despite the prevalence of ARHL among older men and women, evidence suggests that a gender disparity exists in the diagnosis, access, and utilization of treatment options. Furthermore, the natural deterioration in hearing has harmed the social and personal lives of the elderly. This disparity raises concerns about the potential negative consequences on the quality of life, communication, and overall well-being of individuals affected by ARHL. Therefore, it is crucial to investigate the factors contributing to this gender disparity and understand its implications to develop targeted interventions and policies to ensure equitable access to treatment for all elderly individuals in the rural areas of South Africa.

1.3 The relevance of the problem statement within Anthropology

A conceptualization informed this study of anthropology. It is also part of the medical anthropology field and aims to contribute to understanding the social determinants of health. By addressing the needs and experiences of both men and women, this research aims to inform the development of more

equitable and effective healthcare interventions. Ultimately, the study seeks to improve the overall healthcare outcomes and well-being of the elderly population in uMzimkhulu, KwaZulu-Natal, and contribute to the broader literature on the elderly and their healthcare access. Brown and Closser (2016, p. 13) state that “medical anthropology is the anthropological study of health and healing.” Medical anthropology includes anthropological methods and anthropology's understanding of social, cultural, biological, and linguistic aspects to better understand the elements that influence health and well-being, significance, and use of multi-ethnic medical systems (Broom and Gardner, 2013). The most common hearing condition affecting the elderly population is age-related hearing loss. Fortunato et al. (2016) estimated that around 33% of people between the ages of 61 and 70 and more than 80% of those above 85 report hearing loss.

Reid-Cunningham (2009) postulated that the disciplinary boundaries between medical and sociocultural anthropology enhance a critical understanding of disability. He asserts that a broader understanding of social ecology and human behavior can benefit from anthropological interpretations of disability and their focus on “the other,” deviance, and stigma. The primary interest of this study is embedding a particular disability in social sensibility, especially the understanding of adults with hearing impairments. According to Yu et al. (2008), auditory deformity affects 15.4 million elderly adults, which makes up 34.59% of all deformities in people 60 years and older. Reid-Cunningham (2009) also observed that most families include members with disabilities who are unfamiliar to most societies. He argued that those with disabilities are often discriminated against, excluded, and alienated due to a lack of familiarity.

Furthermore, he noted that many communities fail to recognize individuals with specific disabilities as human beings. These individuals should be accorded the same rights, benefits, support, assistance, and recognition as others. Medical anthropological ethnography played a central role in understanding embodied differences in the lives of people with disabilities worldwide in the seminal work of disability in local and global worlds (Ingstad and Whyte, 2007).

Medical anthropology has not yet fully explored the potential of disability studies. As the global population ages and becomes more disabled, this will become more evident. Therefore, Battles (2011) suggested that in anthropology, which is fascinated by aspects of human development, disability must be studied as an integral part of cultures and its impact on families. Despite disability being a universally experienced condition, Rapp and Ginsburg (2012) argue in *Anthropology and the Study of Disability Worlds* that anthropology has not done enough to address disability. Although anthropology is founded on studying human diversity in all its aspects, this issue has been neglected. The authors questioned why anthropology does not seem to focus on disability issues. The authors argued for the importance of incorporating disability more centrally into the principles of anthropology on both epistemological and existential grounds (Inhorn, 2007).

1.4 Rationale and significance of the study.

Age-related hearing loss (ARHL) is a widespread and disabling condition that significantly impacts the quality of life, limiting communication abilities and social interactions for the elderly (Govender and Jongh, 2021). While research on ARHL is extensive, its prevalence and treatment access within specific populations, such as those residing in rural South Africa, remain underexplored. Therefore, this study holds great significance as it aims to shed light on ARHL in the context of rural South African communities, where access to healthcare is limited, and healthcare resources and cultural perceptions about aging and health differ extensively from urban settings. In the rural areas, cultural perceptions of aging often emphasize respect for elders as repositories of traditional knowledge and wisdom. However, hearing loss can be seen as a sign of decline and dependence, potentially diminishing an elder's social standing. Furthermore, traditional healing practices may be the first line of defense for many, with biomedical interventions viewed as a last resort or only when traditional methods fail, as well as the cost and logistics of accessing them.

Research suggests that gender disparities exist in the treatment and management of ARHL, with women often experiencing greater barriers (Heise et al., 2019). Understanding how these disparities affect the treatment of ARHL in the rural areas of South Africa is crucial for developing targeted interventions that can effectively address the unique challenges faced by the elderly to reduce health inequalities. The lack of resources and limited healthcare infrastructure in these rural areas are not simply logistical problems; they reflect historical patterns of marginalization and unequal distribution of resources rooted in colonialism and apartheid (Neely and Ponshunmugam, 2019). Socio-economic disparities are further reinforced by cultural norms around land ownership, access to education, and employment opportunities, particularly for women (Akinola, 2018; Choudhry et al., 2019). These factors shape the lived realities of elderly individuals with ARHL, influencing their health-seeking behaviors and access to information about available treatments.

Women often bear the primary responsibility for childcare and household duties, making it difficult to travel long distances to healthcare facilities, even if they are available. Economic dependence on male family members can further limit their ability to seek treatment, as they may require permission or financial support to do so. These factors, combined with limited access to information about ARHL and available treatments, create a complex web of barriers that disproportionately affect women. Therefore, examining gender disparity in ARHL treatment access is critical given the broader context of worldwide gender-related disparities in healthcare service delivery.

Recognizing and addressing these disparities can significantly impact public health outcomes and ensure equitable healthcare access for all individuals, regardless of gender. Given these disparities, a critical need exists to focus research efforts on understanding how gender influences the experience and management of ARHL in rural South Africa. This study aimed to address this gap by investigating

differences in access and utilization of healthcare services between men and women and any other disparities in the quality of care. It also aimed to contribute to the broader conversation around gender equity and healthcare access in South Africa.

Potential healthcare access and delivery inequalities in rural areas pose significant challenges in developing and developed countries (Scheil-Adlung, 2015). The KwaZulu-Natal province, which is comprised mainly of rural areas, is thinly populated as it has 21% of the South African population (Anon, 1996). Elderly residents in rural South Africa have reported significantly lower health status and overall quality of life than their counterparts in urban areas (Chen et al., 2015; Dong and Simon, 2010; Egbujie et al., 2016). Furthermore, Harris et al. (2011) found that urban residency was associated with improved healthcare accessibility, as indicated by higher rates of hospital admissions, access to private transportation for medical facilities, reduced travel distances to health services, utilization of private outpatient care expenditures, and a greater reliance on advanced public health facilities. The emphasis of the study was not only to learn about the experiences of all the elderly with ARHL, particularly those from rural areas.

Prior to the approval of this study, a preliminary literature search revealed that most available publications on presbycusis focus on health and medical research, but not on the disparities and social impacts. These studies focus on the effectiveness of the hearing aids they use and the severity of their condition. A gap exists in the experiences of adults living with ARHL where there is gender disparity in the diagnosis, access, and utilization of treatment options, especially in rural areas. This study draws on the anthropological concept of medical pluralism to understand how individuals in rural South Africa navigate both traditional healing practices and biomedical interventions for ARHL. By examining the interplay between these systems, we can gain insights into the cultural factors that influence treatment-seeking behavior and adherence to medical recommendations. Furthermore, this research contributes to a broader understanding of health disparities as social injustice, highlighting how gender inequalities and socio-economic marginalization create unequal access to care and perpetuate health inequities within this vulnerable population. Moreover, analyzing the rural dimensions of diseases that constitute a substantial global health burden, such as hearing loss, is the key to understanding and improving public health initiatives (Didczuneit-Sandhop, 2021).

1.5 Key questions:

1. How do socio-cultural beliefs and attitudes impact the elderly's understanding and perception of hearing loss?
2. How do gender differences in access to healthcare, social norms, and attitudes toward hearing loss affect the likelihood of receiving treatment?

3. What is the impact of ARHL on the psychological well-being and quality of life of elderly individuals?
4. How are the elderly with hearing loss treated by other family members within households?

1.6 Objectives:

1. To understand the cultural beliefs and attitudes of the elderly from Umzimkhulu, KwaZulu-Natal, about hearing loss and how these beliefs and attitudes impact their understanding and perception of their hearing loss.
2. To explore how gender differences interact with other factors, such as socioeconomic status and access to healthcare, to influence the likelihood of seeking treatment for hearing loss.
3. To explore and understand the impact of ARHL on the psychological well-being and overall quality of life of elderly individuals.
4. To identify and understand how caregivers and other family members support or treat the elderly with hearing loss.

1.7 Scope of the Study

Age-related hearing loss (ARHL) is a prevalent and often overlooked condition that affects millions of older adults worldwide. This gradual decline in hearing ability poses significant challenges to individuals and communities. In South Africa, geographic location profoundly influences healthcare access and quality, with rural communities frequently facing significant barriers. This study investigated the factors contributing to gender disparity in receiving treatment for age-related hearing loss at Umzimkhulu, Ngwaqa, in KwaZulu-Natal. This process involved examining access to healthcare services, socioeconomic status, cultural beliefs and attitudes toward ARHL, awareness, and perceptions of hearing loss among older adults.

The study also explored the impact of gender norms and roles on seeking treatment for hearing loss, as well as potential barriers to access, such as transportation, education, or awareness of available resources. Additionally, the research assessed the quality and availability of hearing loss treatment options in rural areas and identified potential strategies to address gender disparities in access to care. The study involved conducting interviews with healthcare workers, elderly individuals with age-related hearing loss, their family members, and their caregivers. It also included an analysis of existing literature on age-related hearing loss, how it impacts the quality of life and cognitive function of the elderly, gender disparities in accessing healthcare services, and healthcare-seeking behaviors between men and women.

1.8 Study Setting

The study was conducted in Ngwaqa, one of the villages in Ngwaqa, a rural community of Umzimkhulu, a Harry Gwala District municipality situated in KwaZulu-Natal, South Africa. The district borders Ugu

District to the east, Umsunduzi to the north, Lesotho to the west, and the Eastern Cape to the south. Umzimkhulu, formerly part of the Transkei, is a small town in KwaZulu-Natal that serves as the home of the Bhaca Nation. Umzimkhulu residents speak isiBhaca, a dialect of isiXhosa mutually understandable with isiZulu and siSwati, though it is not an officially recognized language in South Africa. While most residents are AmaBhaca, institutions such as schools, healthcare facilities, religious organizations, and government offices predominantly use isiZulu and isiXhosa. Hence, the interviews were conducted using isiZulu, isiXhosa, and English. Umzimkhulu is an isiXhosa and isiZulu name that means "Big/Great house" (Olivier, 2009). According to the Umzimkhulu Municipality Annual Report (2022), the municipality is divided into 22 wards, with traditional sites comprising 46% of the total land. Umzimkhulu's population resides across a sprawling area of 2,435.4 km². According to the KwaZulu-Natal Top Business (2022), around 90.8% of the population resides in rural parts of the province, with the remaining 9.2% residing in urban settings. In 2022, the census recorded that out of 220,620 people living in Umzimkhulu, 6.3% of that population is the elderly aged 65 and above.

1.9 Study Layout

Chapter 1: Introduction- This chapter comprises the study's research topic, background, and summary of existing research. It positions the researcher's approach, and the research problem is detailed.

Chapter 2: Literature Review and Theoretical Framework- This chapter examines concepts and case studies pertinent to the subject and highlights literature sources for this research study. It also describes the gaps in the literature identified for this study. This chapter also comprehensively reviews the theoretical framework, the two key theories that significantly influenced the development of topics and statements, and the study's objectives and questions.

Chapter 3: Description of Research Methodology- This chapter explains how the study was conducted. It provides a detailed and systematic description of the methods employed in collecting, analysing, and interpreting data.

Chapter 4: Presentation of Data- This chapter presents participants' demographic information in a structured format, using tables, charts, and graphs to make complex data more accessible. Moreover, it provides a foundation for the analysis and discussion chapter.

Chapter 5: Analysis and Discussion of Results- This chapter comprises the analysis and interpretation of the findings from this study, along with the generated themes.

Chapter 6: Summary and Conclusions- Following a discussion of the concepts and themes that came to the fore from the data gathered and analyzed, the chapter draws a clear conclusion and offers recommendations.

1.10 Conclusion

This chapter examined the social, cultural, and healthcare implications of ARHL in elderly individuals, mainly focusing on gender disparities in accessing treatment within a rural community in KwaZulu-Natal, South Africa. ARHL, commonly known as presbycusis, significantly affects the quality of life of the elderly, leading to challenges such as social isolation, communication challenges, and psychological distress. The literature referenced underscores the widespread consequences of ARHL, particularly in rural areas where healthcare access is limited. Factors contributing to this include socio-economic challenges, cultural beliefs, and gender norms. This chapter indicated that the understanding of ARHL and associated treatments must consider the cultural context, which is deeply rooted in the beliefs and practices of the elderly population, particularly among the Zulu community. Integrating these cultural aspects into healthcare delivery is emphasized to improve treatment outcomes.

The study has a clear problem statement focused on investigating the gender disparity in accessing treatment for ARHL and aims to uncover the ramifications of this disparity on individuals' quality of life and well-being. Key objectives include understanding cultural beliefs about hearing loss, exploring the interaction of gender differences in seeking treatment, assessing the psychological impact of ARHL, and identifying caregiving dynamics in households with elderly individuals experiencing hearing loss. The study's scope was limited to the rural area of Umzimkhulu, aiming to generate insights that can inform healthcare interventions and policies to address the inequalities faced by the elderly population. Overall, this chapter highlights the significant gap in the literature concerning the lived experiences of the elderly with age-related hearing loss (ARHL), emphasizing the need for a more nuanced understanding of the intersection between disability and gender in healthcare access.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Age-related hearing Loss ARHL among other health issues, among the elderly is an acknowledged, rapidly growing public health concern that “goes unidentified and untreated because of some variables including stigma, affordability, and accessibility issues” (Weinstein, 2019, p. 9). As the global population ages, ARHL has become a contributing factor to social isolation, cognitive decline, and reduced quality of life (Livingston et al., 2020). Scholars (Bainbridge and Wallhagen, 2014; Mamo et al., 2016) assert that while ARHL is a widespread concern, its impact is disproportionately severe in rural areas due to limited access to audiological services, socioeconomic disparities, and higher exposure to environmental noise from occupational hazards. Research suggests that rural women with ARHL are less likely to receive timely diagnosis and treatment compared to their urban counterparts, exacerbating health inequalities (Louw et al., 2018). In South Africa, where healthcare disparities coexist with socioeconomic and gender inequalities (Mtimkulu et al., 2023), women and men often have different barriers and experiences when seeking care for their hearing loss. This literature review provides supporting evidence for the research decisions that the researcher has made.

Good hearing and communication are essential to developing and maintaining relationships, emotional resilience, and overall well-being (McMahon, 2016). However, one of the most common chronic aging disorders has a significant impact on communication, adversely affecting socialization. Additionally, Tun et al. (2009, p. 7) highlight that those suffering from ARHL require more cognitive effort for verbal conversations, and thus, communication may suffer. Cacioppo and Cacioppo (2018) assert that interactions in group settings may become unpleasant and strain relationships. Those with hearing loss may feel like a burden to others as communicating with them requires patience and understanding (Hefferman et al., 2022). Furthermore, hearing loss has been linked to a decline in an individual’s sense of independence and confidence, making interactions with new and unfamiliar people difficult. This usually leads to isolation, disconnection, and less participation in gatherings and activities.

The World Health Organization (WHO, 2021) predicts that by 2050, there will be approximately 900 million people worldwide with hearing loss, underscoring the urgent need for targeted interventions to address hearing loss, particularly in rural areas where access to healthcare is often limited. In low-income countries, where 80% of hearing loss cases occur, women over the age of 60 are disproportionately affected by ARHL but are half as likely as men to afford assistive devices (Stevens et al., 2013; WHO, 2021). While ARHL is prevalent in men and women, some studies indicate that women also experience a high prevalence, particularly in older age groups (Cruickshanks et al., 1998; Gopinath et al., 2009). Nevertheless, it is significant to highlight that several studies often show a

slightly higher prevalence in men due to factors like occupational noise exposure (Nolan, 2020). Nonetheless, as supported by this study, women are not immune, and prevalence rates can be significant, especially in certain populations or regions.

A few authors (De Man et al., 2016; Peltzer, 2009) have recorded that healthcare providers in South Africa often overlook patients' preferences, autonomy, and socioeconomic status when delivering healthcare to the elderly. Similarly, Maphumulo and Bhengu (2019) maintained that cultural and economic factors also play significant roles in healthcare access and treatment in South Africa, leading to disparities in provision.

Socioeconomic disparities, including income inequality and education level, significantly impact access to healthcare services (Schneider et al., 2019). Kehler (2001) found that women in South Africa often face greater challenges in accessing healthcare due to financial constraints, caregiver responsibilities, and cultural factors that prioritize men's health needs. Additionally, gender bias among healthcare providers may enable disparities in treatment access and quality of care (National Academics of Science, Engineering, and Medicine, 2016). The gender disparity in the treatment of ARHL can be attributed to multifactorial causes, gendered ageism being one of them. *Gendered ageism* is “gender-related differences in the ageism that men and women face, with emphasis placed on the greater impact of ageism on older women” (WHO, 2021, p. 202). According to HelpAge (2023), in Kenya, Rwanda, and Uganda, older women report discrimination in healthcare, where they are often dismissed or denied adequate treatment. The WHO (2021) Report on Ageism in Health Systems reinforces HelpAge’s findings as it documents how gendered ageism reduces older women’s access to preventive care and rehabilitation services. It further highlights how older women face compounded discrimination due to intersecting age and gender biases, which restrict their access to adequate healthcare. The report underscores those assumptions about older women’s health needs being less urgent or their bodies as “less treatable,” which leads to neglect in medical systems.

The cultural perspective on healthcare services suggests that medical needs are determined by physical disease and cultural perceptions of illness (Marmot, 2005). Nayak et al. (2012, p. 61) assert that rural dwellers “have their own beliefs and practices concerning health and diseases”. The author argues that the validity of patients’ perspectives possibly affects their healthcare-seeking behavior; healthcare professionals need to acknowledge the presence of relativism in medicine. The author further maintains that the sociocultural differences between healthcare professionals and patients “can affect the nurse-patient relationship and quality of care provided.” However, to mitigate that and provide adequate care, Kamalam (2005) suggests that understanding the diverse needs and cultural influences on family priorities can improve the quality of care provided. Because, as Nayak et al (2012, p. 62) state, “even the smallest decisions of a person’s everyday life are influenced by culture, quality healthcare cannot be provided without a consideration of a patient’s cultural background.”

While existing studies have explored gender differences in the prevalence of ARHL, there is limited qualitative research that explores how gendered sociocultural norms, caregiving roles, and rural healthcare infrastructures shape women's and men's access to hearing loss treatment. Medical anthropological perspectives intersect with healthcare-seeking behaviors, particularly on how stigma, masculinity and femininity expectations, and economic barriers remain unresearched in this context. Most studies on ARHL focus on its prevalence, hearing aid usage, and risk factors (Gopinath et al., 2011), neglecting cultural narratives, lived experiences, and healthcare inequalities. While some studies combine biological sex with gender dynamics, this study briefly unpacks how socially constructed gender roles, especially toward women, influence treatment-seeking behavior.

Furthermore, limited public awareness about ARHL and its impact on women's lives perpetuates disparities in treatment access (Hussain, 2019). Addressing gender disparity in the treatment of age-related hearing loss has significant implications for societal well-being and individual quality of life. Promoting equitable access to healthcare services can improve early diagnosis, intervention, and outcomes for individuals with age-related hearing loss. This supports active participation in social activities, improves mental health, and enhances overall well-being for those affected.

2.1.2 Hearing Loss in the Elderly

As previously discussed, hearing loss among the elderly is a significant public concern, intensified by various socio-economic factors, healthcare access issues, and the aging population. The prevalence of hearing impairment in the population group is notably high, with studies indicating that it ranks as one of the most prevalent long-term health conditions among the elderly, following visual and physical disabilities (Kozáková et al., 2018; Malwafu et al., 2015). The World Health Organization (WHO) has recognized hearing loss as a pressing global issue, particularly in developing countries with limited resources for diagnosis and treatment (Malwafu et al., 2015; Pienaar et al., 2010). The aging population and the prevalence of ARHL are increasing in Africa. According to Stats SA (2020), the proportion of South Africans aged 60 and older has been steadily increasing, rising from 7,0% in 1996 to 9,8% in 2022. The impact of hearing loss has been recorded to extend beyond communication difficulties. It affects quality of life, social interaction, and mental health. Several studies have attempted to quantify the prevalence of hearing loss among the elderly in African countries; a systematic review by Kumar et al. (2015) highlighted that the prevalence of hearing impairment in sub-Saharan Africa is estimated to be between 25% and 60% among the elderly, significantly higher than in high-income countries. Abraham and Kahinga (2022) reported similar findings in a study conducted in rural Tanzania, where 52.8% of older adults exhibited varying degrees of hearing loss.

In South Africa, the audiological profile of the elderly reveals a wide range of hearing impairments, with studies showing that hearing loss can vary significantly, from mild to profound (Mtimkhulu, 2023). Mtimkhulu's research highlighted that on average, their participants were 67.8 years, with a substantial

portion of hearing impairment, yet only a small number presented with typical ARHL (Mtimkulu, 2023). This discrepancy suggests that while age is a contributing factor, other elements, such as environmental and lifestyle factors, may also play an important role in the etiology of hearing loss among the elderly in South Africa.

Access to audiological services remains a critical barrier for many older adults in South Africa. The public healthcare sector, which serves the majority of the population, is often under-resourced, leading to significant challenges in obtaining hearing aids and professional audiological care (Mtimkulu and Khoza-Shangase, 2023; Pienaar et al., 2010). Pienaar and his colleagues emphasized that many individuals with hearing loss cannot afford private audiological services, further exacerbating the situation (Pienaar et al., 2010). This lack of access is compounded by a shortage of trained hearing health professionals, limiting the availability of necessary interventions and support for hearing loss (Mtimkulu and Khoza-Shangase, 2023; Pienaar et al., 2010).

The socioeconomic context of South Africa is critical in shaping the experiences of elderly individuals with hearing loss. Many older adults live in peri-urban and rural areas with limited healthcare facilities, and the understanding of hearing impairment is often rooted in biomedical models that do not consider the broader socio-cultural factors influencing health-seeking behaviors (Mtimkulu and Khoza-Shangase, 2023). Mtimkulu and Khoza-Shangase's qualitative study revealed that most adults with hearing impairment seek help from formal healthcare providers. However, the barriers they face to accessing these services are profound (Mtimkulu and Khoza-Shangase, 2023). This highlights the need for a more integrated approach to healthcare that considers the unique challenges older adults face in different socio-economic contexts.

Moreover, hearing loss's emotional and psychological impacts on the elderly cannot be overlooked. Research indicates that hearing impairment is associated with increased feelings of loneliness and social isolation, which can significantly affect the quality of life for the elderly (Ciorba et al., 2012). The emotional burden of hearing loss extends to the affected individuals and their families as they navigate the challenges of communication and support (Kozáková et al., 2018). This emotional dimension highlights the importance of comprehensive rehabilitation strategies that address the audiological and psychological needs of elderly patients. Furthermore, the role of technology in managing hearing loss among the elderly is gaining recognition with positive results. For instance, Bhamjee et al. (2021) found that cochlear implants and hearing aids have improved the overall quality of life for individuals with extensive hearing loss. However, access to these technologies is often limited by financial constraints and the availability of services within the public healthcare system (Bhamjee et al., 2021; Pienaar et al., 2010). The disparity between urban and rural access to audiological services further complicates the landscape, as those in rural areas may face additional challenges in obtaining necessary devices and support (Louw et al., 2018).

2.1.3 Prevalence of Age-related Hearing Loss with Gender

The WHO (2021) estimates that approximately 466 million people, up to 5.3% of the global population, have hearing impairments, with older adults being the most affected. While the WHO does not explicitly provide gender-specific data on ARHL prevalence, it highlights the significant burden of hearing loss among older individuals worldwide. Nevertheless, there exists a considerable body of literature on gender-based prevalence of ARHL among the elderly. A study by Cruickshanks et al. (1998) examined the prevalence of ARHL among a cohort of men and women aged 48-92 in the United States. The results suggested that the risk of hearing loss increased with age in both genders, but higher rates were observed in men compared to women in all age groups (Cruickshanks et al., 1998). The study concluded that men were more likely to have ARHL loss than women, irrespective of age. In agreement with Cruickshanks et al.'s (1998) findings, Nolan (2020, p. 1705) also asserts that "it has long been known that age-related hearing loss (ARHL) is more common, more severe, and has an earlier onset in men than in women." The author further stressed that even without a possible cause like noise exposure, these gender differences in susceptibility to ARHL remain. Using level of education as a contributing factor, Stonkute and Vierboom (2025) also agree that ARHL is more prevalent among men; they further maintain that it is consistently higher among those with low levels of education. Taken together, these studies support the notion that men generally have a higher ARHL prevalence overall.

Although ARHL is often perceived as more prevalent in men, women experience a substantial burden of ARHL in their elderly years. While global data may suggest a slightly higher prevalence in men, epidemiological studies demonstrate that women are not exempt from ARHL, particularly beyond the age of 70, where prevalence rates frequently exceed 50% (Gopinath et al., 2009; Cruickshanks et al., 1998). Research also indicates that while ARHL onset in women may be delayed compared to men, the cumulative effects of aging, hormonal changes, and comorbidities such as cardiovascular disease contribute to its heightened prevalence in later life (Lin et al., 2011; Stevens et al., 2013). For instance, Gopinath et al. (2009) found that nearly 30% of women aged 50 and older had measurable hearing loss, increasing to over half in those aged 70 and older. Similarly, Lin et al. (2011) data revealed that 48% of women over 70 had clinically significant hearing impairment. These findings challenge the assumption that ARHL is predominantly a male concern, underscoring the need for gender-sensitive interventions, particularly as women's longevity exposes them to prolonged hearing loss.

According to Fransen (2003, p. 353), around 35% of people aged 60 to 70 experience ARHL, the most common sensory impairment associated with aging. The prevalence of ARHL, or age-related hearing loss, varies globally among different genders. Research has consistently shown an increased prevalence of ARHL in men compared to women. However, the exact factors contributing to these gender differences are not fully understood. These gender differences in the prevalence of ARHL may be attributed to various factors, including hormonal and genetic influences, as well as lifestyle and occupational differences. Intrinsic and extrinsic factors can cause physiologic and anatomic changes

with aging, such as hereditary components, hormones, intense noise exposure, ototoxic substances, previous ear infections, and specific underlying conditions (Nicolas-Puel et al., 2020).

2.1.4 Association Between ARHL and Cognitive Function by Gender

Research suggests that ARHL can directly contribute to cognitive decline, even without other factors. Specialists can assess these changes using a short test called the mini-mental state exam. However, growing speculations exist regarding the relationship between ARHL and cognitive decline (Uhlmann et al., 1989). ARHL is one health condition that has received much attention lately, because of its relationship with cognition and prevalence among the elderly. A person with ARHL is at a higher risk of experiencing depression and cognitive decline due to increased cognitive load and reduced social interactions (Rutherford et al., 2018). Fortunato et al. (2016, p. 155) assert that “long-term deprivations of the hearing inputs can lead to the impairment of cognitive performance and decreased quality of communication, which leads to social isolation and depression and facilitates the onset of dementia.” The author maintains that people with ARHL have a cognitive load that takes their working memory and other cognitive functions, which results in cognitive decline.

A study by Lin and Albert (2014) observed a linear relationship between the severity of ARHL and the progression of cognitive decline and the likelihood of cognitive impairment. Furthermore, the authors found that the risk of developing dementia similarly escalates with the degree of hearing loss. Building on the relationship between cognitive decline and ARHL, recent research has shown a potential connection between ARHL and cognitive decline, with some studies suggesting that the two may be linked through shared neurobiological pathways (Wayne and Johnsrude, 2015). Gender has been identified as a significant factor in ARHL and cognitive function, with some studies indicating that the association between the two may differ by gender (Wingfield et al., 2015). One study by Lin et al. (2011) examined the relationship between ARHL and cognitive decline in a large sample of older adults, finding that greater hearing loss was significantly associated with lower cognitive scores, particularly in women. The researchers suggested that the effects of ARHL on cognitive function may be more potent in women due to differences in brain structure and function between genders. Another study by Yamasoba et al. (2013) found similar results, with a stronger association between ARHL and cognitive decline in women than in men. A recent study by McCarrey et al. (2016) revealed that men experience a faster decline in some cognitive regions than women, though this trend does not apply to all domains. The scholars suggest that evolving social conditions may influence these gender differences by boosting women’s access to cognitive enrichment, economic stability, and better health. Inconsistent with Lin et al. 's (2011) suggestion on the effects of ARHL on cognitive function in women due to differences in brain structure and function, McCarrey et al. (2016) suggested that in as much as gender differences cognitive aging could be influenced by differences in brain structure and function, with women often experiencing more favorable outcomes later in life. This suggests that women are more resilient to age-related cognitive decline than men.

In contrast, a study by Loughrey et al. (2018) found no significant gender differences in the association between ARHL and cognitive decline in a sample of older adults. The researchers suggested that other factors, such as education level and overall health, may play a more prominent role in determining the impact of ARHL on cognitive function than gender. The researcher suggests a complex relationship between ARHL, cognitive function, and gender. Further studies are needed to understand these relationships better and identify potential interventions to improve cognitive outcomes in older adults with ARHL.

2.1.5 Age-related Hearing Loss and Cognitive Decline

Interest in ARHL has increased due to its prevalence and connection to cognitive decline. Swain (2021, p. 319) states that “long-standing hearing deprivation leads to a decline in cognitive performance,” negatively affecting communication, increasing social isolation and depression, and accelerating dementia. Similarly, according to Uchida et al. (2019), several epidemiology studies have confirmed a significant association between ARHL and cognitive decline. Mukadam et al. (2023) estimate that addressing mid-life hearing loss could lower the risk of dementia by 9% as hearing loss is a modifiable age-related factor. However, despite extensive research, the exact causal relationships between hearing loss and cognitive decline remain unclear. Swain (2021, p. 317) also found that “cognitive decline may be misdiagnosed if sensory abilities, such as hearing, are not properly assessed.

As mentioned in this study, hearing loss is strongly associated with increased isolation, depression, and frustration. Research shows that 60% of the elderly with hearing loss present signs of cognitive impairment (Nirmalasari et al., 2017). Additionally, growing evidence suggests that addressing hearing loss is crucial in slowing cognitive decline and dementia (Mamo et al., 2017). Early interventions, such as rehabilitation and screening for the elderly, may help prevent cognitive decline related to ARHL. Furthermore, research indicates that using hearing aids or cochlear implants improves communication, cognitive abilities, and emotional well-being, improving quality of life (Mulrow et al., 1990; Swain et al., 2018). Cognitive decline in the elderly significantly impacts the affected individual, their caregivers, and society as a whole. Therefore, Swain (2021) recommends using assistive hearing devices to support better cognitive function.

2.1.6 Hearing Loss and Possible Mental Health Outcomes

Although much of the existing literature has focused on depression, hearing loss has been linked to a higher prevalence of various psychiatric conditions (Blazer and Tucci, 2019). Notably, recent studies suggest a cross-sectional association between hearing loss and anxiety (Contrera et al., 2016; Cosh et al., 2018). Considering the frequent co-occurrence of depression and anxiety and the fact that the elderly with both conditions often experience worse outcomes (Pennix BWJH, 2015), comorbid psychiatric conditions should be considered when working with the elderly population. Furthermore, anxiety,

particularly in social contexts, may lead elderly individuals to withdraw from interpersonal interactions, exacerbating social isolation and potentially worsening the symptoms of depression.

Although hearing loss has never been associated with generalized anxiety disorder (GAD) (Cosh et al., 2018), older adults with vision loss show higher rates of social anxiety (van der Aa et al., 2015), and similar connections may exist for hearing loss due to communication difficulties affecting social interactions. Additionally, some findings suggest a possible predictive relationship between anxiety and hearing loss. A history of GAD has been associated with slightly increased odds of developing hearing loss (Cosh et al., 2018), and individuals with sensorineural hearing loss report higher past anxiety levels than those without hearing loss (Chung et al., 2015).

Hearing loss “is associated with impaired cognitive function, including poorer episodic memory” (Mahawani et al., 2018, cited in Cosh et al., 2018, p. 1475), accelerated cognitive decline (Lin et al., 2018), and incident dementia (Dawes et al., 2015; Lin and Albert, 2014). While the combined effect of depression and hearing loss on the risk of dementia remains unclear and understudied, existing evidence suggests that having both conditions may elevate the risk. Possible explanations for such risk may be the dysfunction of the neurobiological mechanisms (Rutherford et al., 2018) or due to “changes in brain volume in regions supporting auditory and cognitive processing” (Rudner et al., 2019, p. 1117). Correspondingly, Cosh et al. (2018, p. 1175) assert that “impairments in social communication from hearing loss and social withdrawal as part of depression might further increase the role of social isolation in dementia onset.”

2.1.7 Impact of ARHL on the Elderly, Their Families, and the Community

McMahon (2016) asserts that strong relationships are fundamental for emotional health and social well-being throughout life, and effective hearing and communication play a vital role in building and sustaining these connections. Several studies have examined how hearing loss affects individuals’ social and family relationships (Dalton et al., 2003) and quality of life (QoL) of individuals (Campbell et al., 1999; Mulrow et al., 1990). Building on this, researchers Lazzarotto et al. (2016) and McMahon (2016) have reported that the effects of ARHL involve challenges in understanding speech, which affects communication and socialising. These issues may contribute to cognitive decline, emotional distress, loneliness, and feelings of being stigmatized (Murray and Lopez, 1996).

Research has consistently shown that ARHL significantly impacts not only the daily lives of the elderly but also those of the family members, particularly the caregivers (Scarinci et al., 2009). This, according to Lazzarotto et al. (2016, p. 2280), is because caregivers “need to exert more effort to communicate with the hard of hearing individual, repeating themselves, speaking more slowly and loudly, and moving closer to them to be heard and obtain their attention.” As a result, these challenges contribute to heightened anxiety and stress among caregivers, along with verbal interactions, negatively affecting emotional closeness with the elderly (Hetu et al., 1993; Piercy and Piercy, 2002; Wallhagen et al., 2004).

Although existing literature highlights the benefits of hearing aids in improving speech, communication, and overall QoL, their utilization is relatively low in many countries. (Vona et al., 2016).

Gates and Mill (2005) asserted that the prevalence of ARHL is increasing as the population ages, and it can significantly affect the quality of life of millions of older people; furthermore, if ARHL is left untreated, communication becomes difficult, and social isolation and depression may result. This prevalence is supported by research by Rutherford et al. (2018), who discovered that behavioral processes may explain these associations. For example, adults may withdraw from situations where they may have trouble hearing and interacting, resulting in loneliness and isolation, which may result in loneliness and feeling isolated, which may then cause memory loss and depression. In contrast to Zarei's (2015) study on men and their delay in seeking health services, some studies, such as Carson's (2000) study, have found that women with ARHL tend to wait longer than men before seeking medical attention for hearing loss. This delay is due to several factors, including societal expectations that women should be more patient with age-related changes in hearing, gender differences in communication styles, and financial barriers to accessing healthcare services.

Additionally, Carson (2000) found that women are less likely than men to seek recommended treatments such as assistive hearing devices, which can further exacerbate the negative impact of hearing loss on their quality of life. Furthermore, the delay in the treatment can lead to greater hearing loss, communication difficulties, and decreased social participation, which can negatively impact the quality of life. Oral communication is vital for human interaction and is significant in various spheres, including oral history. The auditory effects of ARHL can pose challenges in capturing accurate and reliable oral history accounts. However, with appropriate accommodations and strategies, the impact of ARHL can be minimized, ensuring the preservation and dissemination of accurate historical information for generations to come.

2.1.8 The Importance of Oral Communication and the Effects ARHL has on Oral History

Oral communication is essential in human interaction, as it enables people to convey messages, share experiences, and pass on information from one generation to another. According to Sommer and Quinlan (2009), cited in Yow (2014, p. 1), oral history is "primary source material created in an interview setting with a witness to or a participant in an event or a way of life for the purpose of preserving the information and making it available to others." History has been revealed for analysis when one verbally explains events, daily life, or society as he or she sees it.

The time I spent with my grandmother, listening to her narratives, represents more than just an educational exchange. These intergenerational stories, passed from grandmother to granddaughter, are deeply embedded in a sense of familial duty, a duty that transmits culture, identity, and a fundamental sense of belonging. Through the accounts of my grandmother, her ancestors, and their lived

experiences, I understood the meaning of being a Dakota woman and the obligations, struggles, and dignity tied to this identity. Historians should recognize these oral traditions for their contributions to broader historical understanding and as a vital mechanism for cultural preservation (Wilson, 1996, p. 7).

This statement shows the importance of oral communication for the elderly as they serve as custodians of wisdom, sharing knowledge drawn from their life experiences (Handerson et al., 2017). In their community-based participatory research, where they studied the lives of Alaska Native grandparents raising their grandchildren in a rural setting, Handerson et al. (2017) observed that intergenerational knowledge transmission was deeply connected to their caregiving role. Seponski and Lewis (2009), Shoemaker (1989), and Weibel-Orlando (1997) found that these grandparents played a crucial role in preserving their grandchildren's cultural identity, language, and traditions.

According to Yow (2014), oral history relies on verbal communication to preserve and transmit historical knowledge and cultural traditions. However, age-related hearing loss (ARHL) can significantly impact the quality and effectiveness of oral communication and oral history. ARHL can make it difficult for affected individuals to hear and understand speech, especially in noisy environments or when interacting with multiple speakers. As a result, individuals with ARHL may struggle to actively participate in conversations, storytelling, or other forms of oral communication. The impact of ARHL on oral history is, therefore, particularly significant, as the preservation and transmission of oral historical knowledge often rely on personal narratives, firsthand accounts, and oral traditions.

2.1.9 Socio-Cultural Beliefs and Attitudes Toward Age-related Hearing Loss and Treatment in Rural Communities

A significant tension exists between biomedical approaches to health and more holistic understandings of well-being that are prevalent in many cultures (Frey et al., 2013). According to Bosire et al. (2022), biomedicine often emphasizes diagnosing and treating specific ailments, usually through targeted interventions, while potentially neglecting the broader context of a person's well-being. Bosire (2022) and her colleagues further assert that, in cultures where health is seen as a state of equilibrium, well-being encompasses more than just the absence of disease; it includes a sense of harmony within oneself and one's community and environment. Therefore, simply addressing a bodily issue may not resonate with patients who feel that their health is disrupted. They suggest such a disconnect may lead to a lack of trust in biomedicine.

Medical anthropology's biocultural framework broadens the traditional biomedical view, which defines health solely in biological terms. Instead, it recognizes that human health and illness emerge from the interplay between biological factors and different environments, shaped by cultural, social, and personal experiences that influence biological processes. By examining how culture affects health, healthcare

providers can gain deeper insights into health issues and the appropriate care required (Winkelman, 2008). Studies have identified culturally embedded factors that shape health-related behaviors (Triandis, 1994). “*Culture* refers to shared ideas, attitudes, beliefs, values, and practices influencing how people view the world regarding their choices, actions, and behavioral preferences” (Smith et al., 2006, cited in Zhao et al., 2015, p. 5). Consequently, it is important to examine cultural influences and their interplay with psychological factors in hearing-related behavior. Broader social determinants, particularly cultural dimensions, profoundly influence individuals’ health perceptions, behavioral patterns, help-seeking approaches, and engagement with healthcare services. Recognizing cultural differences is important and beneficial, as interpretations of health, illness, and overall well-being are culturally constructed (Rice and Liamputtong, 2023).

Bosire et al.'s (2022) study sheds light on the role of socio-cultural factors in how people perceive and understand illness and health, and how that influences their choices in attaining health and healing. They suggest that the recognition of the role played by socio-cultural nuances from prayer to ritual may improve physical outcomes and enhance mental health, especially for people with chronic illnesses. According to Peltzer and Phaswana-Mafuya (2009), in South Africa, the Zulu community has a longstanding history and deeply rooted cultural beliefs that shape how individuals perceive illness and seek treatment. Older Zulu adults understand their illness and treatment within the context of their cultural and belief systems. Their beliefs in spiritual balance, the influence of ancestors, and the use of traditional healing methods significantly impact their healthcare-seeking behaviors. Peltzer and Phaswana-Mafuya (2009) believed that acknowledging and integrating these beliefs and practices into healthcare delivery is crucial for culturally sensitive care. Collaboration between traditional healers and medical practitioners can bridge the gap between traditional and Western medicine, ensuring the best healthcare outcomes for older Zulu adults in South Africa.

In rural communities, where access to healthcare services may be limited, the prevalence of ARHL may be even higher. One study by Cho et al. (2018) explored the cultural beliefs and attitudes toward hearing loss among older adults in rural South Korea. The researchers found that many older adults in rural communities viewed hearing loss as a regular part of aging and were hesitant to seek treatment for their condition. Additionally, cultural beliefs around aging and disability often stigmatize hearing loss, leading to feelings of shame and isolation among those affected. Conversely, other rural communities may have more positive attitudes towards hearing loss treatment, seeing it as improving quality of life and maintaining social connections. These communities may also strongly emphasize traditional healing practices and holistic approaches to managing hearing loss.

Govender and Khan et al. (2017) argue that cultural traditions in South Africa significantly shape people’s belief systems and that they firmly believe in ancestors. When the authors assessed the mothers’ awareness and cultural perspectives on the risk factors for infant hearing loss, they found that a majority

of their participants believed that the condition was due to ancestral curses resulting from ancestral anger. Similarly, older adults in rural communities believed hearing loss was caused by supernatural forces or curses, leading to a reluctance to seek out medical treatment. Moreover, research by de Andrade and Ross (2005) documented that South African traditional healers believe that illness, including hearing loss, is associated with cultural beliefs, particularly the influences of ancestral spirits through witchcraft. Additionally, cultural norms around aging and disability also contributed to the stigma surrounding hearing loss in these communities. According to Bosire et al. (2022), people often think that witchcraft, curses, or punishment from a deity causes their illness. Additionally, people might favor non-medical professionals who are culturally familiar, speak their language, and are aware of the social concerns surrounding their illnesses. As a result, many people believe in treatments with a social or spiritual connection, like soothsaying, incantation, traditional herbs, or prayers.

Research suggests that cultural factors influence perceptions of health, disability, and illness differently across societies. As a result, people from various countries or regions may have different perspectives on hearing loss and using assistive hearing devices. Devins et al. (2010) examined how cultural beliefs and attitudes influence the relationship between illness, emotional struggles, and the lifestyle changes following the diagnosis of rheumatoid arthritis, which is a long-term, debilitating condition. Their findings indicated that elderly individuals with higher levels of horizontal individualism, a form of individualism emphasizing autonomy and equality within groups, demonstrated greater adaptability in managing the challenges imposed by the disease. The researchers proposed that those with strong individualistic tendencies were more inclined to perceive their condition as an opportunity to develop new coping mechanisms, leading to better adjustments and reduced stress levels in response to health-related changes.

Conversely, Chen et al. (2008) explored the connection between cultural values and the likelihood of seeking assistance from mental health professionals. Their research revealed that cultural background influences individuals' attitudes toward help-seeking behaviors when facing mental health challenges, as well as their perceptions of their conditions. The authors assert that people in collectivist societies tend to associate their mental health challenges with internal factors, whereas those from individualistic societies usually view them as stemming from a combination of personal and environmental influences. Chen (2008) and her team concluded that people shaped by individualistic values tend to seek medical assistance for their illnesses more than those influenced by collectivism. This highlights how cultural differences shape their perceptions of illness and the likelihood of seeking treatment.

Research on cultural beliefs and attitudes in ARHL is limited but suggests significant barriers exist to seeking treatment for hearing loss in these settings. There is a need for increased awareness and education about age-related hearing loss in rural communities and for healthcare providers to be sensitive to older individuals' cultural beliefs and attitudes when discussing treatment options.

2.1.10 Access to Healthcare Services and Facilities in Rural Areas

“Achieving equitable universal health coverage requires providing accessible and necessary services for the entire population without imposing an unreasonable burden on individuals or households” (Frenz and Vega et al., 2013, p. 31). Research on access to biomedical healthcare highlights that African rural areas face far greater challenges than urban areas (Obuaku, 2014), leading to heavy dependence on and use of the African healthcare system. Healthcare access remains a critical issue in rural areas across the globe, with rural South Africa being no exception. Access to healthcare services in rural South Africa is a multifaceted issue characterized by significant barriers stemming from historical, socio-economic, and infrastructural challenges. The disparities in healthcare access between urban and rural areas are distinct, with rural populations facing a higher disease burden and limited access to quality healthcare services. This is intensified by the uneven distribution of healthcare professionals, a critical factor influencing healthcare accessibility in these regions (Hatcher et al., 2014; Maphumulo and Bhengu, 2019; Ross et al., 2015).

One of the fundamental challenges is the shortage of healthcare workers in rural areas. Studies indicate that South Africa is experiencing a significant deficit in healthcare workers, particularly in rural settings, where the availability of medical professionals is markedly lower compared to urban areas (Maphumulo and Bhengu, 2019; Rensburg, 2014; Ross et al., 2015). This shortage is compounded by the historical context of apartheid, which has left a legacy of unequal resource allocation and healthcare infrastructure (Moodley and Ross, 2015; Silal et al., 2012). The lack of healthcare professionals limits the availability of services and affects the quality of patients' care, leading to poorer health outcomes for rural populations (Cleary et al., 2012; Kock and Pillay, 2016).

Additionally, geographical barriers play a crucial role in healthcare access. Rural residents often must travel long distances to reach healthcare facilities, making them less likely to seek necessary medical attention (Kahere et al., 2022; Vergunst et al., 2015). The physical infrastructure in these areas is frequently inadequate, with many healthcare facilities lacking essential resources and services (Price et al., 2019; Vergunst et al., 2018). This situation is particularly desperate for vulnerable populations, such as individuals with disabilities, who face additional challenges in accessing healthcare due to physical barriers and a lack of tailored services (Vergunst et al., 2017; Vergunst et al., 2018).

Economic factors also contribute significantly to healthcare access issues. Many rural households experience high levels of poverty and unemployment, which limit their ability to afford transportation to healthcare facilities, thus limiting access to healthcare services (Abrams et al., 2021; Gumede et al., 2021). This economic disadvantage is often combined with a lack of health insurance, worsening the barriers to accessing care (Moodley and Ross, 2015; Silal et al., 2012). Women, particularly those of reproductive age, are disproportionately affected, facing higher odds of encountering barriers to healthcare access compared to their urban counterparts (Seidu et al., 2020; Tamirat et al., 2020). A

combination of workforce shortages, geographical challenges, inadequate infrastructure, and economic barriers hinders access to healthcare services in rural South Africa. Addressing these issues requires comprehensive strategies that focus on hiring more healthcare professionals in rural areas and improving the overall healthcare infrastructure and economic conditions of these communities (Hatcher et al., 2014; Maphumulo and Bhengu, 2019; Ross et al., 2015; Silal et al., 2012).

2.1.11 Associations Between Gender Roles and Factors Affecting Access to Healthcare

Stigma and discrimination can hinder individuals from seeking treatment and accessing necessary care for medical conditions (Allen, 2014). Cultural norms and attitudes contribute to stigma and discrimination, particularly toward mental health, HIV/AIDS, and other infectious diseases (Airhihenbuwa et al., 2014). Economic factors, such as income inequality and poverty, heavily influence medical treatment and access in South Africa. Low-income individuals often struggle to afford private healthcare and depend on an overstretched, under-resourced public healthcare system. Additionally, transportation costs pose a significant barrier, especially for those in rural or low-income communities. Azad et al. (2020) explored health inequalities in Lilongwe, Malawi, exploring how gender prioritization, sociocultural norms, and household decision-making contribute to gender disparities. Their research revealed that health inequalities between genders stem largely from societal and personal biases that favor men's health while marginalizing women's well-being. Moreover, Ensor and Cooper (2004, p. 77) highlight that "in some communities, women have inferior access to resources and may be prevented from making their own choices, which has implications for health and all other aspects of an individual's lifestyle." These disparities have proven true for South African rural communities that still uphold tradition and culture. As Jayachandran (2015), cited in Msuya (2020, p. 46-47) states, "various traditional practices are based upon men's superior position in African culture, these practices where women have unequal access to health, education, employment, and wealth."

Gender roles in society have long been associated with differences in healthcare access and outcomes. Research has shown that social norms related to gender often intersect with other factors, such as socioeconomic status, race, and ethnicity, to influence an individual's ability to access healthcare services. One study by Laditka et al. (2003) found that women who adhere to traditional gender roles are more likely to experience barriers to healthcare access, such as a lack of insurance coverage and financial constraints. These findings are consistent with other research that has identified social norms around femininity, which may discourage women from seeking medical care or delaying treatment until their condition has worsened. In addition to societal expectations around gender, research has also highlighted the role of healthcare providers in perpetuating gender disparities in access to care. For example, a study by Bertakis et al. (2009) revealed that female patients are less likely to receive recommended preventive healthcare services than male patients due to gender bias among providers.

Socioeconomic factors, such as income and education, can intersect with gender roles, further complicating disparities in healthcare access. In their study, Artiga et al. (2020) found that they often face financial barriers to care, such as high out-of-pocket costs and limited access to affordable insurance options compared to men. This issue highlights the need for interventions addressing gender norms and structural inequalities to improve healthcare access for all individuals.

2.1.12 Gender Disparity and the Likelihood of Seeking Healthcare Between Men and Women

While age disparities in healthcare access among the elderly have been widely studied, gender disparities have received less attention. Qualitative research in South Africa shows that older clients face numerous challenges in accessing and receiving care at healthcare clinics, leading to communication gaps and frustrations. Globally, studies have reported gender disparities in hearing loss, with men having a higher prevalence than women. However, women are more likely to seek medical attention for their hearing loss, while men may delay treatment due to denial, stigma, lack of awareness, fear, cost, and accessibility barriers. The social stigma attached to hearing loss, particularly for men, can make them feel embarrassed or ashamed, hindering their help-seeking behavior.

Socioeconomic disparities, including income inequality and education level, influence gender disparity in access to treatment for ARHL. In South Africa, women face greater challenges in accessing healthcare due to financial constraints, caregiver responsibilities, and cultural factors. Gender biases among healthcare providers can perpetuate disparities in treatment access and quality of care (Govender and Penn-Kekana, 2007). Cultural norms and societal expectations often prioritize men's health, leading to delayed diagnosis and limited access to specialized treatment for women. Limited public awareness about ARHL and its impact on women's lives further perpetuates disparities in treatment access. Therefore, addressing gender disparities in the treatment of ARHL is crucial for improving societal well-being and individual quality of life. Promoting equitable access to healthcare services can enhance early diagnosis, intervention, and outcomes for individuals with ARHL. This supports active participation in social activities, improves mental health, and enhances overall well-being for those affected.

Gender disparities in hearing loss have been reported in a few studies globally. According to WHO (2021), hearing loss is more prevalent among men than women. However, women are more likely to seek medical attention for their hearing loss, whereas men are more likely to ignore it or delay seeking treatment. There are several reasons behind the delay in seeking treatment by men; these include denial, stigma, lack of awareness, fear, cost, and accessibility (Zarei et al., 2015). Men may refuse to admit that their hearing is degenerating, or they may downplay the severity of their condition, making it difficult for them to seek help. Also, hearing loss continues to carry a social stigma, especially among men. Unlike women, gender differences in the use of hearing aids in older adults, published in the journal

Audiology and Neurotology in 2015, revealed that women were more likely than men to use hearing aids, even after controlling for other factors such as age, hearing loss severity, and socioeconomic status. Some men may not be aware that they have a hearing problem, may not realize the signs and symptoms of hearing loss, or may assume that hearing loss is just a regular part of their aging (Wallhagen, 2015).

In conclusion, hearing loss is a significant worldwide public health concern, particularly among older adults. South Africa faces barriers in providing equitable access to healthcare, including gender disparities in the treatment of hearing loss. Stigma, economic factors, and cultural norms contribute to disparities in treatment access. Gender differences in seeking treatment and using hearing aids have been observed, with women being more proactive in seeking help. ARHL prevalence varies in different genders, with higher rates among men. Addressing gender disparities and promoting equitable access to healthcare services are important in improving the quality of life for individuals with hearing loss. Further research is needed on the lived experiences of older adults, especially in rural areas, to understand the social impacts of ARHL better.

There is a growing body of literature on gender disparities in the treatment of ARHL. Some research suggests that women are often less likely to receive timely and appropriate hearing loss treatment than men, possibly due to differences in health-seeking behavior, access to healthcare services, and provider biases (National Academies of Science, Engineering, and Medicine, 2016). Additionally, other studies have explored the impact of gender norms and roles on the experience of hearing loss and its management (Hetu et al., 1993).

2.1.13 Disparities in Healthcare Today

Disparities in health and healthcare are recognized as persistent and prevalent. The Heckler Report was the first to recognize health disparities that began over three decades ago. In 1985, the report highlighted persistent health inequalities that accounted for approximately 60,000 additional deaths each year, and simultaneously proposed comprehensive strategies to mitigate systemic inequalities in healthcare access and outcomes. “Rural-urban disparities in health and health care in Africa have been well described; yet they remain relatively less of a concern among many health and health care issues in Africa” (Oloyede, 2017, p. 36). These inequalities stem from multiple factors, with socioeconomic determinants, such as poverty, limited education, and harsh living conditions in rural areas, playing a predominant role. For instance, many rural communities face difficulties accessing clean water, as sources like rivers and streams are often distant and contaminated. Such disparities are evident in the quality of healthcare services, with rural residents experiencing significant barriers in access to biomedical treatment. In this regard, Oloyede (2017, p. 37) asserts that disparities exist in cardiac diagnostics, pain management, and treating chronic conditions like pneumonia and arthritis. Furthermore, research indicates that rural populations usually depend more on traditional African

healthcare systems than biomedical services, often integrating both approaches to manage illnesses (Obuaku, 2014).

2.1.14 Audiology Service Delivery and Socioeconomic Positions in South Africa

The contextual challenges influence the quality and nature of services provided in any healthcare setting (Lubinski and Frattali, 2001). If these challenges are left unaddressed, they can negatively impact audiology service delivery, underscoring the need for stakeholders to recognize and act upon them. In South Africa, where “untreated hearing loss is already a public health concern,” particularly in rural communities with access to audiological care (Mtimkhulu et al., 2023; Joubert et al., 2017). Barath et al. (2025, p. 9) highlight that the underestimation, underfunding, and undervaluation of audiological services in South Africa “contribute to a lack of awareness regarding the long-term consequences of untreated hearing loss.” On a national level, particularly in South Africa, as Swanepoel (2006) highlights, healthcare services are further influenced by other factors, including socioeconomic conditions and healthcare infrastructure. The author also noted that as a developing nation, South Africa faces additional challenges, including the pervasive effects of the HIV pandemic, which exacerbates existing barriers, especially for children. Moreover, it affects all the societal aspects of life in South Africa.

Economic factors also heavily influence medical treatment and access in South Africa. Schneider et al. (2019) asserted that the country has a high level of income inequality, and a large proportion of the population lives in poverty. Access to medical treatment is often determined by one's socioeconomic status (Phelan et al., 2010). Individuals from low-income backgrounds may struggle to afford private healthcare, leading to reliance on the public healthcare system, which can be overstretched and under-resourced. Moreover, the cost of transportation to healthcare facilities is a significant barrier for many individuals, particularly those residing in rural areas or low-income communities. The lack of affordable public transportation options makes it difficult for individuals to travel long distances to receive medical treatment, hindering their access to healthcare services (Schneider et al., 2019).

Several studies focus on age disparities in accessing health care faced by the elderly, and only a few studies have explored gender disparities. For instance, Motsohi et al. (2020) conducted a qualitative study in South Africa to evaluate the experiences of the elderly with healthcare delivery at two primary healthcare clinics. They found that older clients face several challenges accessing and receiving care at these clinics. Their holistic needs become more complex as they age, and age-friendly arrangements do not fully meet them. These challenges include communication gaps and frustrations of feeling unheard.

Socio-economic factors play an important role in shaping an individual's standard of living, access to health care, and education, which often determine the person's overall well-being. However, South Africa has an extensive divide, with a minority of the population enjoying ‘First world’ living standards, while the majority remains entrenched in ‘Third world’ conditions (Swanepoel, 2006). The author

asserts that due to low education levels, most rural communities lack sufficient awareness of disease causation, prevention, treatment, and disability management, which further exacerbates health disparities.

2.1.15 Existing Healthcare Policies in South Africa Addressing ARHL

Several South Africans have turned away from biomedicine due to past mistreatment by medical facilities and a lack of trust in clinical care. This scepticism stems from experiences of discrimination during apartheid, as well as ongoing systematic issues such as extended waiting periods, shortages of medication, insufficient equipment, and inadequate relationships between doctors and patients (Bosire et al., 2022). The issue of gender-based care in South Africa is a complex challenge that is deeply rooted in historical, socio-economic, and cultural contexts. Despite the progressive policies established post-Apartheid aimed at promoting health equity, significant disparities persist, particularly affecting women and marginalized gender groups (Malinga, 2016).

One of the primary frameworks for understanding healthcare access in South Africa is the National Health Insurance (NHI) initiative, which aims to provide universal health coverage. However, the implementation of NHI has been criticized for not adequately addressing the specific needs of vulnerable populations, including older women, who often face compounded barriers due to gender and age (Burger and Christian, 2018; Buisman and García-Gómez, 2014). Research indicates that while the NHI White Paper emphasizes a responsive healthcare system, the experiences of older women reveal ongoing issues with accessibility and acceptability of services (Burger and Christian, 2018). The intersectionality of gender and age significantly influences health-seeking behaviors and outcomes, with older women often experiencing higher rates of morbidity and mortality due to inadequate healthcare access (Harris et al., 2011).

Socio-economic factors further exacerbate gender inequality in healthcare. To corroborate that, Harris et al. (2011) assert that women in South Africa are more likely to experience poverty, which limits their access to healthcare services. This economic disadvantage is linked to broader systemic issues, including the patriarchal structures that persist in society, which often prioritize male health needs over those of women. The research by Marx et al. (2018) highlighted that despite the existence of policies aimed at promoting health rights, many women, particularly the elderly, continue to face health and rights violations due to entrenched gender inequalities. This systemic bias affects access to healthcare and influences the quality of care received, as healthcare providers may hold implicit biases that affect their treatment of female patients (Spencer et al., 2017).

The role of non-governmental organizations (NGOs) and community-based initiatives is also vital in bridging the gap in healthcare access for older women. NGOs often provide essential services that address the specific needs of marginalized groups, including the elderly. However, the effectiveness of these organizations is sometimes undermined by a lack of coordination with government policies and

insufficient funding (Marx et al., 2018). The research by Harris et al. (2011) emphasized the need for a comprehensive approach that integrates the efforts of various stakeholders to enhance healthcare access and equity for older women.

In conclusion, while South Africa has made progress in establishing policies aimed at promoting health equity, significant gaps remain in addressing gender-based healthcare inequalities among the elderly population. The intersection of gender, age, and socio-economic status creates a complex landscape that requires targeted interventions and a more inclusive approach to healthcare policy. Future research should focus on evaluating the effectiveness of existing policies and exploring innovative solutions that can better meet the needs of older women in South Africa.

2.1.16 Conceptualization of ARHL in Medical Anthropology (Disability, Disease, Disorder, and Impairment)

ARHL is recognized as a complex, multifactorial condition influenced by genetic, environmental, and health-related factors. It is primarily attributed to the deterioration of sensory and neural elements in the auditory system, similar to other age-related sensory disorders such as macular degeneration in vision (Roth et al., 2011). The condition is not only a physiological decline; it is intertwined with cognitive functions, where studies have shown that ARHL is associated with increased risks of cognitive impairment and dementia (Lozupone et al., 2018; Panza et al., 2015). For instance, a meta-analysis highlighted the correlation between ARHL and various cognitive domains, including memory and executive function, suggesting that untreated hearing loss could exacerbate cognitive decline in older adults (Wang et al., 2022)

Moreover, the social ramifications of ARHL are profound. Individuals with hearing loss often experience social isolation due to communicative difficulties, leading to a diminished quality of life for themselves and their caregivers (Lazzarotto et al., 2019). This social deprivation is compounded by the stigma associated with hearing loss, which may deter individuals from seeking necessary interventions, such as hearing aids. Alarmingly, only a small percentage of those with mild hearing loss utilize hearing aids, suggesting a broader issue of underdiagnosis and undertreatment (Golub et al., 2020). The relationship between ARHL and mental health is another critical aspect of its conceptualization. Research indicates that ARHL is linked to increased rates of depression and anxiety, further complicating the health trajectory of older adults (Sharma et al., 2021). This relationship highlights the need for a holistic approach in addressing ARHL, where healthcare professionals must recognize the interconnectedness of auditory health, cognitive function, and mental well-being (Sardone and Lozupone, 2020).

From a medical anthropology perspective, it is essential to consider how cultural perceptions of aging and disability influence the experience of ARHL. The stigma surrounding hearing loss can lead to a reluctance to engage with healthcare systems, thereby perpetuating a cycle of neglect and worsening

health outcomes (Sardone and Lozupone, 2020). Furthermore, the lack of awareness and education about ARHL among healthcare providers and patients contributes to the underutilization of available treatments and support systems (Chern et al., 2022). The conceptualization of ARHL in medical anthropology must encompass its biological, psychological, and social dimensions. Understanding ARHL as a disorder that transcends mere auditory impairment allows for a more comprehensive approach to treatment and support, emphasizing the importance of early diagnosis, effective communication strategies, and the integration of hearing health into broader healthcare practices.

2.1.17 Conclusion

The literature review highlights the multifaceted nature of age-related hearing loss (ARHL) and its profound implications for individuals, particularly the elderly, their families, and society. As ARHL is recognized as one of the most prevalent sensory impairments among older adults, especially those aged 75 and older, its significance cannot be overstated, particularly within the context of an aging population. The review highlights the disproportionate impact of ARHL on quality of life, social engagement, and cognitive function. Key findings illustrate that ARHL is not solely a medical issue but intersects intricately with social, psychological, and economic dimensions. The challenges faced by older adults with hearing loss are exacerbated by gender disparities, with men generally experiencing higher prevalence rates. However, women often face obstacles in seeking diagnosis and treatment because of societal norms, financial constraints, and cultural beliefs. These disparities extend to healthcare access, where socioeconomic factors contribute significantly to treatment availability and quality inequities, particularly in resource-limited settings such as South Africa.

Additionally, the connection between ARHL and cognitive decline emerges as a significant concern, highlighting the need for healthcare professionals to adopt a holistic approach to treatment. The treatment should consider that auditory, cognitive, and mental health are intertwined. The emotional and psychological implications of hearing loss, including increased rates of depression and anxiety, further strain the well-being of the affected individuals and their caregivers. Cultural attitudes and beliefs are crucial in recognizing and managing ARHL, particularly in rural communities.

The stigma often associated with hearing loss can deter individuals from seeking necessary interventions, leading to a vicious cycle of neglect and worsening health outcomes. Therefore, addressing cultural perceptions, raising awareness about ARHL, and promoting accessible healthcare services are crucial to mitigating these challenges. In conclusion, addressing ARHL requires a multifaceted strategy encompassing medical intervention, social support, educational initiatives, and policy reform for equitable healthcare access. Future research is essential to explore the lived experiences of older adults with ARHL, particularly in rural contexts, to create tailored interventions that respect cultural beliefs and promote inclusive healthcare practices. Through a comprehensive understanding of ARHL's implications, healthcare systems can enhance the quality of life for affected

individuals, fostering their engagement in social activities and improving overall mental health outcomes.

2.2 THEORETICAL FRAMEWORK

The theoretical framework refers to a structured system of ideas and theories directly related to the studied phenomenon. It plays an important role in delineating the research's theoretical boundaries and helps researchers formulate and analyze their research topics, problems, and questions (Du-Plooy et al., 2014). Additionally, the theoretical framework helps establish a study's theoretical, knowledge-based, methodological, and analytical foundations (Grant and Osanloo, 2014).

Understanding the complex disparities in access to treatment of age-related hearing loss (ARHL) through the lenses of the biopsychosocial model and access theory provides a comprehensive framework for comprehending the individual biomedical aspects of the condition and the social determinants that influence treatment-seeking behaviors among the elderly. This study aims to explore gender disparities in accessing treatment for ARHL among the elderly in Ngwaqa, KwaZulu-Natal, South Africa, utilizing the biopsychosocial model and access theory. Furthermore, this study aims to fill gaps in the literature regarding gender disparities in healthcare access and contribute significant insights and potential policy implications for enhancing hearing care for underserved populations. Applying these two theories is central to this anthropological study as anthropology seeks to investigate and comprehend humanity within its cultural and environmental context. This includes understanding the lived experiences of individuals, the social structures that shape their lives, and the impact of illness and healthcare on these aspects.

The access theory, which centres on how resource limitations influence human behavior, social organization, and well-being, assisted the researcher in analysing the effects of limited or no access to resources. On the other hand, the biopsychosocial model offers a valuable tool for understanding the intricate connection between biological and social factors in the development and experience of diseases. It can be employed to study various health conditions, including age-related hearing loss (ARHL). By utilizing the biopsychosocial model, researchers can gain knowledge on the contributing factors to gender disparities in the treatment of ARHL and develop more effective interventions to improve the lives of both men and women with this condition. This theory thus aided in investigating how psychological, biological, and social factors converge to influence treatment-seeking behavior and experiences of older men and women. Specifically, it examines how societal expectations and roles may lead to disparities in treatment uptake. By situating this study within medical anthropology, we acknowledge that health and illness are not solely biological phenomena but are deeply embedded in cultural meanings, social structures, and power dynamics.

2.2.1. Anthropological Perspective & the Biopsychosocial Model & Access Theory

From a medical anthropology perspective, ARHL is not merely a physiological condition requiring audiological intervention. Instead, it is a lived experience shaped by cultural beliefs about aging, gender

roles within the Ngwaqa community, and the available resources within their social and environmental context. This study uses the biopsychosocial model and access theory to unpack these culturally mediated experiences and understand how they contribute to disparities in treatment seeking.

2.2.2. Foundational literature on the theories

According to Adanu & Johnson (2009) and Mumtaz & Salway (2009), gender disparities adversely affect women's health through more than just biological factors. Fikree & Pasha (2004) highlight those practices, such as female infanticide and negligence of girls under five, which lead to inadequate nutrition and delayed healthcare, highlighting the social, cultural, and structural disadvantages faced by girls and women. A structural illustration of these disparities is seen in hospital admission rates. In high-income countries, the gender ratio for overnight stays and emergency admission is nearly balanced (Conway et al., 2017). However, in low-and middle-income countries, women are less likely to seek medical attention, with studies showing male-to-female ratios of 2:2 for surgeries and 1:4 for general admissions (GlobalSurg, 2016; Reid et al., 2019). Research indicates that even when disease prevalence is similar for both genders, socially constructed gender roles and beliefs contribute to health inequalities. (Forrester et al., 2017; Forrester et al., 2012). Traditionally, barriers of access to healthcare, such as distance from health facilities and the base cost of healthcare access, are generally found to affect both genders in similar ways (Rutherford, 2009; Kruk, 2009). However, sociocultural factors such as gendered societal expectations, personal autonomy, and influence over decision-making have been suggested as additional obstacles that may disproportionately hinder women's healthcare access. Despite these observations, empirical studies examining these gendered disparities remain scarce (Adams et al., 2002).

The biopsychosocial approach is increasingly recognized in fields focusing on medical issues, yet discussions about gender differences in health often emphasize biomedical factors, like men's reluctance to seek medical help, and psychological factors, such as toxic beliefs and norms (Courtenay, 2000). This perspective overlooks the cultural, economic, and social influences that shape men's health behaviors and outcomes (Evans et al., 2011). Additionally, research on men's health has frequently concentrated on the negative impacts of masculinities and gender expressions on health disparities among men. In contrast, the nine articles in the special issue of Behavioral Medicine on men's health critically examine the reasons and mechanisms behind these health factors. Together, these studies enhance the understanding of men's health by identifying various factors, many not exclusive to men, that still significantly impact their health. These findings reveal a crucial connection between gender disparities and access to healthcare. To address this, this study investigated how gender disparities affect access to healthcare and treatment for ARHL.

2.2.3. Biopsychosocial Model

The biopsychosocial model is a framework that seeks to “understand the complex interplay between psychological, biological, and social factors in the development and experience of disease” (Engel, 1977, p. 129). It argues that disease is not simply the result of biological factors but is also influenced by social factors such as gender, race, ethnicity, socioeconomic status, and culture (Engel, 1977). This study not only focuses on ARHL but also addresses ARHL's impact on the social side and the psychological well-being of the elderly in rural areas. In the context of this condition, the biopsychosocial model would argue that gender disparities in the treatment of this condition are not simply due to biological differences between men and women but are also influenced by social factors such as gender roles, gender stereotypes, and gender discrimination. In turn, they influence the psychological well-being of the ARHL patients. For example, research has shown that women are more likely than men to report hearing loss but are less likely to seek treatment for this condition (Carlson et al., 2022; Knoetze et al., 2023). This may be because women are more likely to be primary caregivers for children and elderly relatives, and they may feel that they do not have the time or resources to seek treatment for their hearing loss.

Additionally, women may be more likely to experience gender discrimination in the healthcare system (Belgrave, 1994), which may make them less likely to seek treatment for their hearing loss. From an anthropological perspective, these factors are not simply individual-level constraints but reflect broader cultural norms and power imbalances. For instance, the prioritization of women's caregiving roles over their own health reflects a cultural valuation of women's contributions in the domestic sphere, often at the expense of their well-being. Understanding these cultural dimensions is essential for developing culturally appropriate interventions that address the root causes of disparities. The biopsychosocial model argues that these social factors need to be considered in order to understand and address the gender disparities in accessing treatment of ARHL (Manchaiah et al., 2013). By understanding the complex interplay between biological and social factors, we can develop more effective interventions to improve the treatment of this condition for both men and women.

2.2.4. Access Theory

The access theory, proposed by Penchansky and Thomas (1981), seeks to understand how individuals obtain healthcare and other services, focusing on five key dimensions: availability, accessibility, accommodation, affordability, and acceptability. In this study, the theory was employed to examine various aspects, including the availability of specialized healthcare facilities, accessibility for both genders, accommodation of various elderly patients' needs and preferences, affordability of treatment options, and acceptability of specific interventions across genders. In the context of medical anthropology, access theory offers a framework for analysing the structural barriers that limit healthcare access, highlighting how social inequalities are embodied in health outcomes. It allows us to move

beyond individual-level explanations and consider the broader social, economic, and political factors that shape healthcare experiences. The availability dimension of this theory focused on the presence of healthcare within rural areas. In the context of age-related hearing loss treatment, it is important to assess the availability of audiologists, clinics, and hearing aids in Ngwaqa. Gender differences in access to these services can be explored to understand the disparities in availability. For example, an anthropological perspective would consider how historical patterns of resource allocation and infrastructure development in Ngwaqa may have favoured certain areas or groups, leading to uneven distribution of healthcare services.

The accessibility dimension stresses the physical proximity and transportation options for individuals to reach healthcare services. Gender disparities in access to treatment for age-related hearing loss can be studied by examining the distance to hearing clinics, transportation barriers faced by women compared to men, and the availability of telehealth options for remote consultations. The accommodation dimension emphasizes the fit between healthcare services and the individual's needs and preferences. Gender differences in accommodation for age-related hearing loss treatment can be explored by assessing the availability of gender-sensitive care, flexible appointment scheduling, and communication preferences for women and men. An anthropological lens would examine how healthcare facilities are designed and operated with respect to the cultural norms and values of the community. For example, the gender composition of healthcare staff, the language used in consultations, and the cultural sensitivity of treatment protocols can all impact the accommodation of healthcare services for elderly individuals in Ngwaqa.

The affordability dimension highlights the financial barriers that individuals may face in accessing healthcare services. Gender disparities in affordability for age-related hearing loss treatment can be analyzed by examining the cost of hearing aids, insurance coverage for hearing healthcare, and the financial burden of treatment for women compared to men. Finally, the acceptability dimension focuses on the individual's willingness to seek and receive healthcare services (Burger & Christian, 2018). Gender differences in treatment accessibility for age-related hearing loss can be investigated by assessing cultural beliefs, social norms, and stigma surrounding hearing loss and treatment-seeking behavior for women and men in rural areas. The access theory posits that access is a critical concept in health policy and services research, enabling researchers to understand factors that facilitate or hinder access to healthcare at the time needed by users or beneficiaries (Penchansky and Thomas, 1981). From an anthropological perspective, acceptance is deeply intertwined with cultural beliefs about health, illness, and the body. For example, the stigma associated with hearing loss may vary by gender and cultural group. Understanding these culturally specific meanings is essential for designing interventions that are not only accessible but also acceptable to the community. By utilizing the access theory, the researcher could analyze all dimensions of healthcare access, drawing on the experiences of the elderly,

caregivers, and healthcare workers, and considering other social disparities that may contribute to difficulties in accessing healthcare facilities.

By utilizing this study's biopsychosocial and access theories, the researcher understood the barriers and facilitators that impact access to healthcare services. This approach allowed the researcher to uncover the complex interplay of individual, social, and environmental factors contributing to the disparities in treatment access. Moving forward, policymakers and healthcare providers need to consider these intersecting factors to develop targeted interventions that address the specific needs of individuals experiencing gender disparities in treatment for age-related hearing loss in rural areas.

2.2.5. Alignment of research questions with the underlying principles of the frameworks

Research question 1: How do socio-cultural beliefs and attitudes impact the elderly's understanding and perception of hearing loss?

This question aligns with the biopsychosocial model by emphasizing the significance of socio-cultural factors in shaping perceptions of health and disease. Cultural beliefs and attitudes impact the elderly's psychological understanding of hearing loss, reflecting the interplay between social and psychological elements in health experiences. The question can also relate to the acceptability dimension of access theory, as socio-cultural beliefs may influence how acceptable specific rural communities view hearing loss treatments. From an anthropological standpoint, this question explores the emic perspective on hearing loss within the Ngwaqa community, recognizing that local understandings of health and illness are culturally constructed and may differ significantly from biomedical models.

Research question 2: How do gender differences in access to healthcare, social norms, and attitudes toward hearing loss affect the likelihood of receiving treatment?

The question fits well with the biopsychosocial framework, particularly concerning how gendered social norms and psychological factors can deter or encourage treatment-seeking behavior amongst the elderly. Moreover, it directly aligns with the dimensions of access theory by illustrating how these factors collectively shape the paths the elderly individuals take toward seeking treatment for their hearing loss. Each dimension is critical in determining whether individuals perceive healthcare as available, accessible, affordable, and acceptable, ultimately influencing their health-seeking behaviors. An anthropological perspective views gender not as a binary construct, but as a fluid and culturally contingent set of roles, expectations, and power relations. This question seeks to understand how these gendered dynamics influence healthcare access for elderly individuals in Ngwaqa.

Research question 3: What is the impact of ARHL on the psychological well-being and quality of life of elderly individuals?

This question is central to the biopsychosocial model, as it addresses the psychological ramifications of a physical condition (ARHL) on the quality of life, thus highlighting the interconnectedness of biological hearing, psychological well-being, social dimensions, and overall quality of life. Medical anthropology would explore how ARHL affects an individual's social roles, participation in community activities, and sense of belonging. This requires understanding the cultural context in which aging and disability are experienced.

Research question 4: How are the elderly with hearing loss treated by other family members?

This question explores the social dynamics of the family environment and how these dynamics influence the elderly's experience with hearing loss. The psychological support from family members and social perception can significantly affect individuals' coping mechanisms. While not directly related to healthcare access, the treatment by family members can indirectly influence the acceptability and accommodation of healthcare decisions for elderly individuals with hearing loss. For example, how does the family support or undermine treatment-seeking? An anthropological approach would emphasize the cultural values and kinship systems that structure family relationships in Ngwaqa. It would examine how traditional roles and responsibilities within the family influence the care and support provided to elderly members with hearing loss.

The biopsychosocial model serves as a common grounding for understanding the multifaceted nature of hearing loss among the elderly, incorporating psychological and cultural aspects. On the other hand, access theory complements the inquiries by providing a structure to analyze healthcare access and treatment disparities based on social norms, gender differences, and perceived suitability of care options.

2.2.6. Conclusion

This study adopted a comprehensive approach by employing the psychosocial model and access theory to investigate gender disparities in accessing treatment for ARHL among the elderly in Ngwaqa, KwaZulu-Natal. By integrating the psychosocial and access theoretical frameworks, the study emphasizes the complex interaction of biological, psychological, and social influences that shape the treatment-seeking behaviors of elderly individuals, considering gender dynamics and sociocultural influences. The biopsychosocial model emphasizes the importance of understanding how gender roles, societal expectations, and psychological well-being intersect to shape the experiences of individuals dealing with ARHL. Simultaneously, access theory provides a robust framework for analysing various dimensions of healthcare access, enabling a nuanced examination of barriers and facilitators that influence both men and women in seeking treatment. However, this study goes beyond simply applying these theories. By adopting a medical anthropological lens, this research aims to understand how the cultural context of Ngwaqa, KwaZulu-Natal, shapes these factors. The study seeks to uncover the local

meanings of health, illness, aging, and gender, and how these meanings influence healthcare-seeking behaviors.

The alignment of research questions with these frameworks underlines the significance of socio-cultural beliefs, gender-based disparities, and the psychological impacts of ARHL on the quality of life for elderly individuals. Through this multifaceted exploration, the study aims to fill critical gaps in the literature and offer insights that can inform policymakers and healthcare providers in developing targeted interventions. Addressing the specific needs of the underserved population in this rural setting, the findings may contribute to enhancing access to hearing care, ultimately promoting equitable healthcare outcomes for both genders. As the research reveals, understanding the complexities behind healthcare access and gender disparities is vital in fostering inclusive and effective healthcare strategies that respond to the challenges faced by the elderly with ARHL. Ultimately, this study aims to contribute to a deeper understanding of the cultural and social dimensions of ARHL and to inform culturally sensitive interventions that promote the well-being of elderly individuals in Ngwaqa.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

A methodology analyzes and collects methods utilized in a particular field to simplify the research process (Pressman, 2001). Research can address knowledge gaps by providing solutions to unknown issues. Therefore, the purpose of research studies is to explain and understand the essence of a phenomenon. The methods employed for gathering the study's data are described in this chapter. It is one of the most important sections of any anthropological study. It enables the researcher to provide a detailed account of the study techniques to the reader and all the encounters recorded by the anthropologist during data collection.

3.2 Ontological and Epistemological Considerations

This research investigated a social reality where gender disparity exists in healthcare access and treatment. It acknowledged that this disparity is not just a statistical anomaly but a reflection of broader social, cultural, and institutional structures. The study identified various entities, including elderly individuals with age-related hearing loss (ARHL), healthcare workers, family members and caregivers, gender identities and roles, socioeconomic status, and healthcare systems and policies. These entities have relationships that shape the experiences and outcomes of different genders in receiving treatment. The research recognized that individual experiences of age-related hearing loss and treatment differ significantly based on gender. Personal, social, and cultural factors could have influenced this subjectivity. Regarding social constructs, gender disparity is considered a social construct influenced by societal norms and values that dictate access to healthcare and treatment options.

Epistemology studies knowledge, its nature, sources, limitations, and validity. In the context of this study, knowledge about gender disparities in treatment access is constructed using both qualitative and quantitative research methods. Interviews as a qualitative data collection method provided behavioral insight into personal experiences, while the statistical analyzes of treatment access as quantitative data revealed treatment-seeking behavior patterns and correlations. This study also relied on theories to provide a lens through which knowledge is interpreted and understood. Biases that could have affected both data collection and interpretation were considered. These included biases related to gender stereotypes and cultural and systemic inequalities within healthcare. Epistemologically, the voices and experiences of the elderly affected by ARHL are central. Therefore, the study aimed to centre these perspectives to ensure that the findings reflected lived realities rather than merely institutional narratives.

The exploration of gender disparity in receiving treatment for ARHL engages with both ontological and epistemological questions. It seeks to understand the nature of the disparities and the knowledge

surrounding them while considering the subjective experiences and social contexts that influence these disparities. This holistic approach was critical for developing effective interventions and efforts to address gender disparities in healthcare access and treatment outcomes.

3.3 Research design.

Malagon-Maldonado (2014) asserts that qualitative research is an important methodological approach when investigating topics with limited existing knowledge and when the primary objective is to understand participants' lived experiences. The author highlights that in qualitative research, there are various approaches, many of which share the common goal of exploring, describing, and interpreting different phenomena experienced by individuals, groups, and cultures. This study adopted a dual-method qualitative design to achieve an in-depth understanding, integrating a phenomenological study design with a case study approach.

The phenomenological qualitative research design focuses on the study of the lived experiences of individuals. Lester (1999) defined phenomenological research as qualitative research mainly focused on studying the lived experiences of individuals. The participants' actual sensations, understanding, and content of the investigated phenomenon were captured using the phenomenological methodological approach (Husserl, 1970). At the same time, a case study approach allows for an in-depth investigation of the specific context, in this case, the context of South Africa, where cultural, social, and economic factors significantly influence healthcare access. By focusing on a particular setting, as a researcher, I can uncover nuanced insights about gender disparities that broader qualitative studies may overlook. A case study design enables a holistic exploration of the lived experiences of elderly individuals, particularly focusing on the intersection of gender, socioeconomic status, and health service accessibility.

The study's overall objective was to explore gender disparity in accessing treatment for age-related hearing loss (ARHL) and understand the lived experiences of adults living with ARHL in Ngwaqa, Umzimkhulu, in KwaZulu-Natal. Semi-structured interviews and participant observation were used to collect data. Data collected through this study provided in-depth insights into the lived experience of the elderly with ARHL. This study used a reflexive thematic analysis technique to analyze and frame data, emphasizing perspectives on human experience. Bryman (2016) states that qualitative research is significant because it allows researchers to facilitate different interpretations before participating in fieldwork. This research offers an in-depth grasp of the lived experiences and perspectives of the elderly living with age-related hearing loss at Ngwaqa, uMzimkhulu, in KwaZulu-Natal.

3.3.1 Study Setting

The study was conducted in Ngwaqa, one of the villages found in Umzimkhulu, a Harry Gwala District Municipality town in the South African province of KwaZulu-Natal. *Umzimkhulu* is an isiXhosa and

isiZulu name that means "Big/Great house" (Olivier, 2009). According to the KwaZulu-Natal Top Business (2022), around 90.8% of the population lives in rural areas, with the remaining 9.2% residing in urban areas. In 2022, the census recorded that out of 220,620 people living in Umzimkhulu, 6.3% of that population is elderly, aged 65 and above. Since I am also a resident of uMzimkhulu, it was easy for me to collect data (Municipalities.co.za, 2025). Being a resident of my research setting provided unique advantages that contribute to the ease and effectiveness of data collection. It also allowed for a deeper understanding of the context, enabling better resource access. As a resident, I had the flexibility to adjust my data collection strategies in response to unexpected developments or changes in my research setting. This adaptability was, therefore, crucial in addressing all challenges that arose during the data collection process. Out of this 5.5% of the elderly population, more than 4% have either a hearing problem or an eyesight problem, primarily due to their age. The healthcare workers were interviewed at the Malenge Clinic in Umzimkhulu, KwaZulu-Natal. The Malenge Clinic in Umzimkhulu was chosen as the healthcare facility for interviews with healthcare workers.

Below are two maps showing the Ngwaqa village, the Malenge area. The clinic does not appear on Google Maps as the areas are very rural, but the pinned location is in the coordinates of the Malenge Clinic. The third figure shows the distance traveled from Ngwaqa to Malenge on foot and by car. It takes approximately 10 minutes to drive to Malenge and 1 hour to walk. The distance between the two areas is approximately 4.4 km.

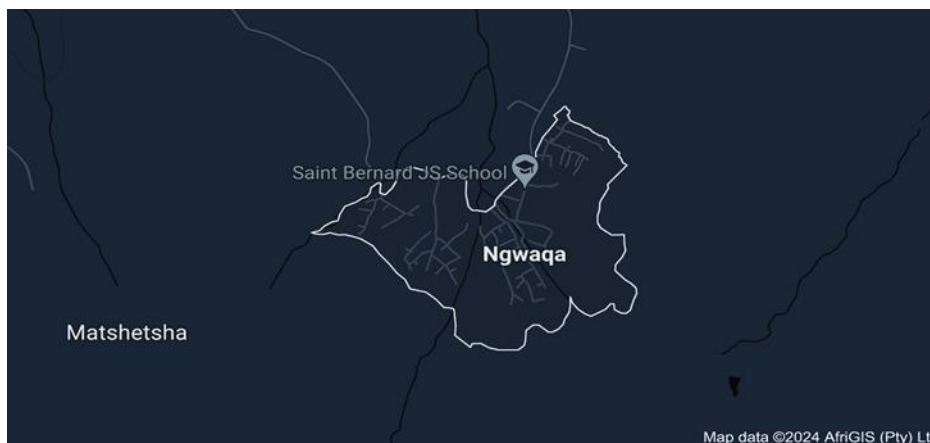


FIGURE 1.1: Map of Ngwaqa Village. (https://www.google.com/maps/place/Ngwaqa/@-30.1691525,29.648335,16z/data=!3m1!4b1!4m6!3m5!1s0x1ef44d20f51ca5a7:0xc3297c13f40cca52!8m2!3d-30.1706318!4d29.6513178!16s%2Fg%2F1t15_gfb?entry=ttu)

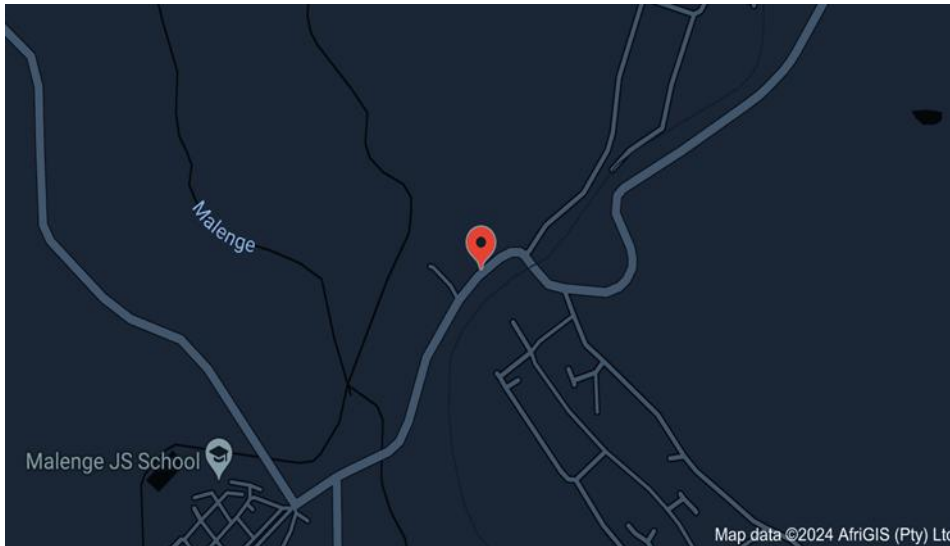


FIGURE 1.2: Map for 30.14801° S, 29.62297° E (Coordinates for the Malenge Clinic).

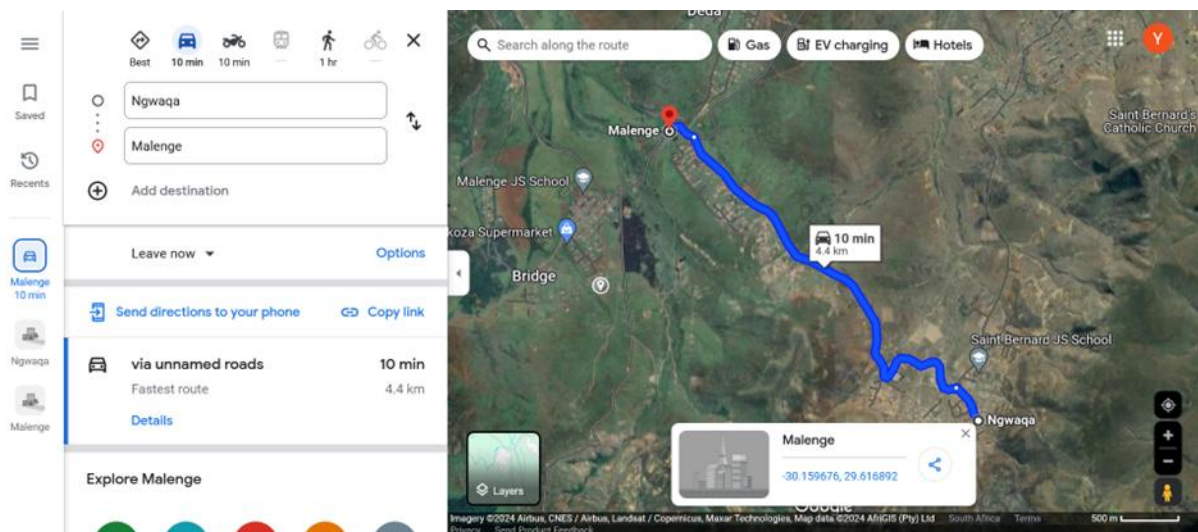


FIGURE 1.3: Map illustrating the distance and the time it takes to drive or walk from Ngwaqa to Malenge Clinic.

3.3.2 Study Population and Sample Size.

The sample size for qualitative research must be determined at the design stage (Valdecasas et al., 2010). Polit and Beck (2010) asserted that qualitative researchers should choose the largest one available to ensure their sample represents the target community. For this reason, the researcher aimed for a sample size of 20 participants, made up of 10 older adults, six caregivers, and four healthcare workers. However, as the snowball sampling approach was adopted, more participants were more than 20. The study had 44 participants, including 26 elderly individuals, twelve caregivers, six healthcare workers, four qualified nurses, one visiting doctor who is a general practitioner, and one audiologist from the closest clinic and hospital for this study. The study focused on elderly female and male participants at Ngwaqa in Umzimkhulu, who are 65 years and older. They had to be diagnosed with

ARHL for at least two years to ensure that they had a stable level of hearing impairment. ARHL is a progressive condition that develops gradually over time, and individuals may experience fluctuations in their hearing abilities during the early stages of the condition. Therefore, by requiring participants to have a diagnosis of ARHL for two years, researchers can be more confident that the participants' hearing loss has stabilized and is not due to temporary or reversible factors. The goal was to have equal numbers of males and females. This method ensured that the study was representative of the community, which enabled the study to identify any gender disparities in the treatment of ARHL.

The researcher used this age range because people who are 65 years and older are reported to be the ones living with ARHL; they were, therefore, appropriate for this study on the impact of gender disparities in accessing treatment for ARHL. The reason for this sample selection was that my two grandmothers, who are sisters, have ARHL, and a majority of the elderly population in my hometown, Umzimkhulu, are living with ARHL. At Umzimkhulu, older men and women living with ARHL were requested to participate in the study. To ensure that the interview questions were heard and interpreted clearly, the caregivers of the elderly and family members were asked to be present during the interviews. The caregivers were family members and individuals explicitly employed to care for the elderly. This is because people with hearing problems communicate differently; some read lips, and it is easier to read the lips of those they are used to talking to. Some ask you to speak directly to their ears; some ask you to speak louder.

3.3.3 Sampling

This study was carried out using purposive and snowball sampling techniques. The purposive sampling method allows for the selection of different groups as participants. In this study, the researcher interviewed adults with ARHL and healthcare workers, including nurses, A medical doctor, and an audiologist. Including an audiologist was important to this study because they directly treat hearing loss in older adults. Audiologists are trained professionals who specialise in diagnosing and treating hearing loss. They were able to help explore how gender might influence the perception of hearing loss, the willingness to seek treatment, and the effectiveness of different treatment options. They were also able to shed light on gender-specific attitudes towards hearing health, which can also affect access to care.

The participating nurses provided insights into the state of hearing healthcare services and potential barriers to providing equitable care. Adults with age-related hearing loss shared their lived experiences and differences in accessing healthcare services and any challenges they may have faced due to gender disparities. This information can help inform recommendations for improving hearing healthcare services for older adults in South Africa. Snowball sampling is one of the sampling procedures used when the statistical concept of randomness does not determine the picked elements (Kirchherr and Charles, 2018). They are called non-probability sampling methods. In snowball sampling, the researcher begins by non-randomly picking beginning participants, and these people determine how the final

sample is constituted. The author further claimed that snowball sampling allows researchers to reach out to hidden and socially stigmatized populations to analyze current problems within these populations. The chain referral recruiting strategy is better suited for research involving or focusing on rare qualities (Kirchherr and Charles, 2018).

The snowballing technique was helpful in this study, given the challenge of locating participants before identifying the 20 participants that constituted the study's population. The researcher approached the tribal councillor of the village (*uSibonda*) to assist with recruiting participants needed to fulfil the research goals. Given that the councillor usually calls a monthly meeting, inviting all the village members to discuss the community's issues and make announcements. I requested that my study be added to his agenda. In the meeting with the community members, I explained my research interest further and what it entails for them. I then asked for volunteers who wanted to participate in the study. Most elderly individuals do not attend these meetings due to various health conditions. However, because caregivers and family members attend, I asked them to relay the message. When the elderly agreed, I made house visits to reiterate and explain my research interest with the assistance of the caregivers and family members, as they know how to communicate with each older person with ARHL.

3.3.4 Ethnographic Technique

Dutta (2016, p. 69) describes ethnography as “a social science methodology, by and large a 19th-century enterprise anchored in the discipline of anthropology.” Ethnography fundamentally relies on immersive fieldwork conducted within a geographically defined setting. This methodological approach commonly incorporates participant or nonparticipant observation, supplemented by individual and group interviews and focus group discussions (Madison, 2005; LeCompte and Schensul, 2013). This approach is valuable because the power of ethnography lies in its ability to describe people and places, creating ‘conversations’ that enhance cultural awareness (Jagganath, 2019). In this study, ethnographic fieldwork was conducted by engaging with the elderly individuals experiencing ARHL, their caregivers, and healthcare workers through semi-structured interviews.

Karatsareas (2022, p. 99) states, “interviews are among the most widely used methods of data elicitation in the social sciences.” Kvale and Brinkmann (2018, p. 3) define the semi-structured format of interviews as “an interview to obtain descriptions of the life world of the interviewee in order to interpret the meaning of the described phenomena”. Before visiting this study's participants, I had a set of predetermined questions to guide the conversation, and I was prepared to adjust as the interviews progressed. With luck, all the participants responded accordingly. Semi-structured questions revealed rich and detailed information about the participants' perspectives and experiences.

Mannik and McGarry (2017) state that effective communication relies heavily on language, which fosters interviewee comfort and facilitates open dialogue. They also state that the sequencing of

questions significantly influences rapport-building and conversational coherence, enabling deeper reflection and sustained engagement throughout the discussion. “Without rapport, even the best-phrased questions can fall flat and elicit brief, uninformative answers” (Leech, 2002, p. 665). The interview questions were written in both English and IsiZulu. These two languages were used because the elderly participants are native Zulu and Bhaca speakers, while the healthcare workers and caregivers, including family members, could switch between the two languages. The caregivers asked for the interviews to be conducted in IsiZulu to make it easy for them to process questions and respond even on behalf of the elderly when needed. Some healthcare workers requested that questions be asked in English so they could easily respond in either language. This made all the interviews easy and comfortable for me and the participants.

In this study, I started with neutral questions as they allow interviewees to decide how they will answer a question. More sensitive questions, or questions I felt might evoke emotion, were asked toward the end of the interview. Given that this study involved a vulnerable population (the elderly), it was crucial to prioritize their well-being. However, the questions were not overly controversial or sensitive, and I experienced no problems.

DeWALT and DeWALT (2002, p. 7) define participant observation as a process that enables researchers to “learn about the activities of the people under study in the natural setting through observing and participating in those activities.” They also state that it establishes the framework for creating sampling protocols and interview tools. Some scholars contend that, in a way, all parts of social research involve elements of participant observation because “we cannot study the social world without being part of it” (Hammersley and Atkinson, 1983, p. 248). This study also employed participant observation to gain deeper insights into the social dynamics surrounding ARHL. Another poignant instance that exemplified this approach occurred during the funeral of one of my grandmothers, who passed away during the course of my research. The preparation for the funeral provided a unique opportunity to observe interactions and attitudes within the community regarding elderly individuals, particularly those who struggle with hearing loss. As part of the family, while I participated in the preparations for the funeral, I witnessed the deep respect and reverence the community and the family members held for the elderly, regardless of their hearing impairments. I also noted that almost everything was asked of the elderly, as they remain the leaders of the families and know more about our culture and the way of doing things. Moreover, I observed interactions between younger and older family members, where the younger generation approached the elderly with affection, engaging them in brief conversations. Despite the hearing challenges, the elderly would respond with warmth and humor, and the community’s efforts to bridge the communication gap were evident. During the funeral, community and family members gathered closer to the elderly, ensuring they were not isolated or overlooked.

The participant observation technique allowed me to witness nuanced interactions and emotional expressions not conveyed through verbal communication alone. Before the interviews began, I observed the participants in their natural environments; some were in their workplace, while others were in their homes. I noticed the demeanor of the elderly participants; many exhibited cautious body language, with hunched postures and slow movements, indicating the physical challenges associated with their ARHL.

Another notable observation was how caregivers displayed a mix of supportive gestures; some were kneeling to establish eye contact, while others gently placed a hand on the shoulder of the elderly participants. This physical touch seemed to bring comfort, as many elderly participants appeared more relaxed when their caregivers and family members were nearby. Throughout the interviews, I paid close attention to the body language and facial expressions. Facial expressions are particularly telling, as Schmitz (2012) states that non-verbal on-verbal communication is a process of generating meaning using behavior other than words. Furthermore, Sathik and Safia (2013) assert that facial expressions serve as the primary means of transmitting emotional information, providing insight into an individual's inner feelings. This form of non-verbal communication allows humans to communicate different emotions without needing verbal articulation. Elderly participants often expressed frustration when discussing their hearing difficulties. They would, for instance, shake their heads in disbelief or cover their ears, which suggested a desire to disconnect from negative past experiences.

After the interviews concluded, I took a moment to reflect on the change in the room, and the emotional aftereffects lingered. Many elderly participants took a moment to catch their breath, visibly relieved to share their stories. Others remained reflective, with soft smiles indicating a sense of validation from being heard. I also noted the immediate reactions of the caregivers after the interviews; some engaged their elderly participants in soft, reassuring conversations, while others appeared pensive, perhaps contemplating the challenges presented during the interview.

The voices of the elderly participants carried distinct qualities that reflected their hearing challenges and lived experiences. A few of them leaned forward closely and spoke softly, as if compensating for auditory uncertainty. Some of them spoke in their usual and firm tones. Some participants had a louder, almost forceful tone, a habit they developed over the years of their hearing decline. **Participant 20** mentioned that she speaks that way because she also wants to hear herself. The voices of the elderly participants revealed not just the auditory decline but also adaptive strategies, emotional resilience, and social challenges. Combining interviews with participant observation allowed me to capture nuances that data collected from interviews might miss.

This experience reinforced the idea that while hearing loss can create barriers, the cultural values surrounding respect for the elderly persist. My observation at the funeral highlighted not only the prospects of ARHL but also exposed an underlying resilience within the community that affects access

to treatment. It illustrated how respect and care could provide support, encouraging further exploration of factors contributing to gender disparity in treatment accessibility.

3.3.5 Research Paradigm

Bhengu (2005, p. 61) stated, "as opposed to interpretivists/constructivists, who want to comprehend and reconstruct, positivists and empiricists try to make predictions, command, and explain." Therefore, this study employed an interpretivist paradigm. According to Thanh and Thanh, "an interpretive paradigm enables researchers to perceive the world through the perspectives and lived experiences of participants" (2015, p. 24). This paradigm leans more toward using qualitative approaches and emphasizes the existence of realities. The interpretive paradigm is used by the researcher who is looking for answers to build and interpret their understanding from the data that has been collected. Interpretivism allows researchers to learn more about the world through interpreting how people think. This study seeks to examine the experiences of adults living with ARHL and how gender disparities in receiving treatment for ARHL impact them. Therefore, the findings of this research relied on in-depth descriptions as they help explain the situation being studied.

3.3.6 Researcher's positionality

Positionality refers to an individual's worldview and perspective on a research topic and its social and political context (Foote & Bartell, 2011; Savin-Baden & Major, 2023; Rowe, 2014). The individual's worldview, often known as 'where the researcher is coming from,' includes ontological, epistemological, and human nature and agency beliefs (Bahari, 2010). Positionality "reflects the position the researcher has chosen to adopt within a given research study" (Savin-Baden & Major, 2023, p.71). It is known and discussed that a researcher's positionality impacts qualitative research. This positionality can affect all elements of the research process, including study design, key research questions, data collection, and analysis (Wilson et al., 2022). Within qualitative research, it is important to keep in mind that the researcher's "subjectivity and positionality" could influence how they interact with the study participants, as well as their emotional experience and the interpretative lens they employ (Alvesson & Sköldberg, 2000; Dean, 2017).

In this study, the researcher approached the research within Ngwaga from the complex and contested position of an "insider." While offering advantages regarding access and rapport, this insider status also presents significant methodological and ethical considerations, particularly relevant to anthropological research (Narayan, 1993). My familiarity with Ngwaga, stemming from my upbringing and ongoing familial connections within Ngwaga, allowed for a relatively smooth entry and negotiation of access through established community structures and local leadership. This eased the initial stages of ethnographic engagement, fostering trust and openness during interviews, and facilitated the collection

of rich qualitative data. This insider perspective and my understanding of local cultural nuances allowed for a deeper understanding of the participants' experiences than possible for an outside researcher.

However, the notion of being an "insider" has its challenges. As Narayan (1993) argues, the concept of "insider" is not a fixed or monolithic identity but rather a fluid and relational one, shaped by the specific context of the research. While my pre-existing knowledge of Ngwaga offered advantages, it also carried the risk of taking certain cultural assumptions for granted, potentially overlooking subtle nuances or power dynamics that might be more readily apparent to an outsider. Furthermore, the very act of research, even when conducted by someone perceived as an "insider," inevitably alters the social landscape and introduces a degree of intervention. This raises ethical questions about the potential impact of my presence and research on the community, a concern central to the ethics of "doing anthropology at home" (Messerchmidt, 1981). To mitigate these potential drawbacks, I consciously employed several strategies. First, I practiced constant reflexivity, questioning my assumptions and biases throughout the research process. This involved maintaining a detailed research journal, documenting my evolving understanding of the research topic, and critically analyzing my interactions with participants. Second, I sought diverse perspectives within Ngwaga, ensuring that my sample included individuals with varying social positions, experiences, and viewpoints. This helped guard against the risk of relying solely on perspectives aligned with my pre-existing knowledge. Third, I employed the principles of "thick description" (Geertz, 1973), striving to provide detailed and nuanced accounts of the social context in which the participants' experiences were embedded. This involved recording what people said and did, and paying close attention to the meanings and interpretations attached to their actions.

Moreover, I was aware of the potential for my insider status to create power imbalances within the research relationship. Even though I share a cultural background with the participants, my position as a researcher inevitably conferred a degree of authority. To address this, I prioritized transparency and informed consent, ensuring that participants were fully aware of the research aims, their right to withdraw at any time, and how their data would be used. I also actively sought participant feedback on my interpretations of the data, allowing them to challenge my assumptions and ensure their voices were accurately represented. While my insider status in Ngwaga offered valuable opportunities for gaining access and building rapport, it also presented complex methodological and ethical challenges. By engaging in critical self-reflection, employing rigorous research methods, and prioritizing the participants' perspectives, I aimed to mitigate these challenges and ensure that the research was conducted responsibly and ethically.

3.3.7 Data Collection

Parahoo (2006) states that qualitative data are gathered to categorize and define the population's characteristics, habits, and activities. According to Robson (2007), a researcher should not gather more

data than is necessary and should employ the most straightforward method possible to gather the data to answer the study questions. Considering these circumstances, this study used semi-structured open-ended interviews to collect participant data. This format allows for a degree of structure, ensuring that important topics are covered, but also allows for spontaneity and the opportunity to explore more deeply into specific areas. Semi-structured interviews are commonly used in qualitative research and can provide rich, in-depth insights into the interviewee's thoughts and experiences (Bryman, 2016). The researcher went to the elders' homes and asked them to participate in the study. The researcher read the Study Information Sheet and Consent Form. The researcher asked for consent and asked the participants to sign the forms before participating in the interview. The researcher also went to the closest clinic and requested healthcare workers and doctors who treat hearing loss to participate. The researcher audio-recorded all the interviews and transcribed them verbatim because verbatim transcripts are more detailed (Rutakumwa et al., 2020). The interviews were conducted using IsiZulu and Bhaca languages, the most spoken languages in Umzimkhulu, Ngwaqa. Each participant had a 45-minute to an hour time limit with 10 open-ended interview questions.

3.3.8 Data Analysis

The research utilized open-ended questions from a semi-structured, in-depth interview. As a result, the data was analyzed using a codebook thematic analysis (CTA) approach. A codebook thematic analysis is a type of theme analysis that uses organized codebooks and specified codes. It is conducted using a deductive technique (Crosley, 2020). A deductive technique is a top-down strategy in which a codebook is created using codes derived from research questions or examined data (Saldana, 2009). The codebook enables a more precise, focused, and efficient analysis of the raw data from the interview transcripts. The codes were then categorized into themes, each reflecting a relevant data pattern. Verbatim descriptions of participants accompany the results. The interpretivist technique used in the current study is strongly tied to thematic analysis. The interpretation of the data is the main emphasis of both thematic analysis and interpretative methods. Similar to an interpretive method, thematic analysis derives reality from the participants' perceptions, personal history, and experiences. Additionally, by emphasizing participant perceptions and experiences, the two techniques help researchers comprehend the world (Schwartz-Shea and Yanow, 2013).

3.2.9 Trustworthiness

The trustworthiness model proposed by Guba was used to ensure the maintenance of validity and reliability during the study. To address the validity of my investigation, I altered Lincoln and Guba's (1989) model. I chose data analysis techniques that aligned with the activities Lincoln and Guba describe for researchers (1989). In order to ensure validity in my work, I concentrated on three areas: reliability, credibility, and transferability. Credibility is trust in the veracity of the results. The "truth" in phenomenological research refers to a realistic model or representation of the underlying commonality

of participants' lived experiences. Using extensive, diversified field expertise and the interviewing procedure helped to ensure credibility (De Vos et al., 2014). Quotations were utilized to preserve the accuracy of the information collected.

Reliable research practices are those that are systematic and rigorous. (Liamouttong, 2011, p. 278). The methodological strategies I chose for this study included precisely defined and well-structured research protocols. Dependability was maintained by keeping field notes during the interview and paying attention to nonverbal signs. An impartial coder also helped me to analyze and understand the data. According to Korstjens and Moser (2018), transferability demonstrates how well the results can be used in different situations. Similar to generalizability in quantitative research, this idea reflects how qualitative findings can be applied or adapted to other contexts, settings, or populations. Phenomenological research aims to identify and describe a phenomenon's universal structure. The results are not anticipated to apply to other occurrences because the phenomenon under study is singular. Nevertheless, if the phenomenological researcher was effective, anyone with "lived experience should be able to identify the model or description" (de Chesnay, 2014), cited in Barrow (2017, p. 104). Using multiple data collection techniques, including interviews, field notes, and tape recording, further enhances transferability (Grove and Burns, 2012, p. 585).

3.4 Ethical Considerations

During the study, standard ethical practices were considered. Participants were provided with information sheets that gave them detailed information about the study. All participants were provided with written consent forms before participating in the study. They were informed about their voluntary participation and their right to withdraw from the study if they wished to do so. Study participants were informed that they would not receive any monetary compensation. Records identifying all participants will remain confidential and anonymous. The researcher maintained confidentiality and anonymity of records, identifying all participants in the study. The researcher used pseudonyms for illustrative quotes. I ensured that the demographic data collection adhered to ethical standards and respected participants' privacy and confidentiality. The researcher ensured that a gatekeeper's letter was obtained from the ward councilor and that ethical clearance was obtained from the University of KwaZulu-Natal and the Department of Health. All authors used in this study have been acknowledged with the use of the Harvard referencing style.

3.5 Study Limitations

This study had a small sample size of adults with age-related hearing loss, family members, and healthcare workers. Therefore, the findings cannot be generalized to a larger population. This study relied on the interview data from the participants, and it would have been beneficial for the study to incorporate observations of the gender inequalities at play when adults with hearing loss seek treatment for their condition. The elderly population being investigated was frail during the interviews. Also, some

responses might not be reliable, hence the inclusion of family members and caregivers in the study sample. The presence of caregivers during ARHL study interviews potentially impacted the validity and accuracy of the information obtained from the participants. Caregivers provided input or influenced the participants' responses, which could have led to biased data. Another limitation was the reliance on self-reported data, which may come with social bias. Participants could have provided responses they deemed socially acceptable, potentially leading to an underrepresentation of existing gender disparities. To mitigate these impacts, the researcher clearly explained the purpose of the study and the importance of obtaining independent and unbiased responses from the participants without external influence.

3.6 Conclusion

In conclusion, this chapter has meticulously detailed the methodological framework employed to investigate the lived experiences of adults facing gender disparities in accessing treatment for age-related hearing loss (ARHL) in Ngwaqa, Umzimkhulu, KwaZulu-Natal. By adopting a phenomenological qualitative research design, the study captures its participants' subjective realities and perceptions, illuminating their intricate nuances. The selection of semi-structured interviews as the primary data collection method enables an in-depth exploration of participants' thoughts and feelings. At the same time, the reflexive thematic analysis empowers a thorough interpretation of the rich qualitative data gathered. The intentional choice of purposive and snowball sampling strategies ensures that diverse voices, including those of healthcare workers and caregivers, are represented, providing a comprehensive understanding of the systemic barriers elderly individuals face with ARHL. Moreover, the ethical considerations adhered to throughout the research process aim to protect participant autonomy and confidentiality, ensuring their experiences are represented with integrity and respect. While acknowledging the study's limitations, including the potential challenges of a small sample size and the subjective nature of self-reported data, this chapter sets a solid foundation for the forthcoming analysis. By unraveling the complexities surrounding gender disparities in healthcare access, the research aims to inform targeted interventions and policies, ultimately improving hearing healthcare services for older adults in South Africa. The subsequent chapters will discuss the findings derived from this methodological approach, enriching the broader discourse on health equity and gender issues in the context of age-related hearing loss.

CHAPTER FOUR

PRESENTATION OF DATA

4.1 Introduction

Demography is an academic discipline that systematically analyzes measurable population statistics (Vogt and Johnson, 2011). Such statistical data enables researchers to categorize distinct population subgroups and assess their characteristics within a defined temporal context. Key demographic variables frequently examined include age, gender, ethnicity, educational attainment, disability status, employment, socio-economic standing, and other attributes relevant to specific research inquiries (American Psychological Association, 2009). In this study, demographic information serves as a foundation for understanding the complexities of accessing ARHL treatment within the context of gender disparities in Ngwaqa. Rural areas often experience different socio-economic challenges. Therefore, capturing demographic data can help contextualize findings by considering how socioeconomic status influences health outcomes, including access to ARHL treatment. Moreover, a detailed account of participants helps readers and researchers assess the applicability of study results to broader populations and facilitates comparisons between replicated studies. It also provides essential data for meta-analysis and secondary research (Bein, 2009).

4.2 BASIC DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS (ELDERLY WITH ARHL)

Hammer (2011), cited in Masego et al. (2024), states that demographic data on research participants is essential to evaluate whether the participants in a specific study are a representative sample of the target population for generalisation purposes. The study included 26 participants diagnosed with ARHL. Participants were aged 65 and older and recruited from Ngwaqa in Umzimkhulu. The following table presents the demographic characteristics of the elderly participants, including age, gender, and ethnicity.

Participants	Age (Years)	Sex	Ethnic group
Mrs. P1	68	Female	African
Mrs. P2	76	Female	African
Mr. P3	75	Male	African
Mr. P4	77	Male	African

Mrs. P5	71	Female	African
Mrs. P6	77	Female	African
Mr. P7	81	Male	African
Mr. P8	82	Male	African
Mrs. P9	65	Female	African
Mr. P10	84	Male	African
Mrs. P11	96	Female	African
Mrs. P12	85	Female	African
Mrs. P13	66	Female	African
Mrs. P14	83	Female	African
Mr. P15	76	Male	African
Mr. P16	74	Male	African
Mrs. P17	74	Female	African
Mr. P18	80	Male	African
Mrs. P19	70	Female	African
Mrs. P20	72	Female	African
Mr. P21	80	Male	African
Mr. P22	87	Male	African
Mrs. P23	73	Female	African
Mr. P24	72	Male	African
Mrs. P25	89	Female	African
Mrs. P26	81	Female	African

Table 1. From the table above, each participant was assigned a unique participant number for confidentiality and anonymity, ranging from 1 to 26. The second column lists the participants' ages, ranging from 65 to 96 years, reflecting a range of early to late senior citizens. The third column identifies the participants' gender, with entries indicating male or female. The table balances representation across both sexes. Finally, the last column provides insights into the ethnic backgrounds of the participants, with only an African category, which prevented an understanding of diversity within the sample. Future studies should aim for greater ethnic diversity, allowing them to generalize their findings.

4.2.1. Gender Distribution of ARHL participants

The following pie chart is a descriptive demographic element and a foundational checkpoint that informs the study population's representation and the interpretation of results. This representation will help assess if the results can be generalized to both genders and if the findings are skewed toward one gender group.

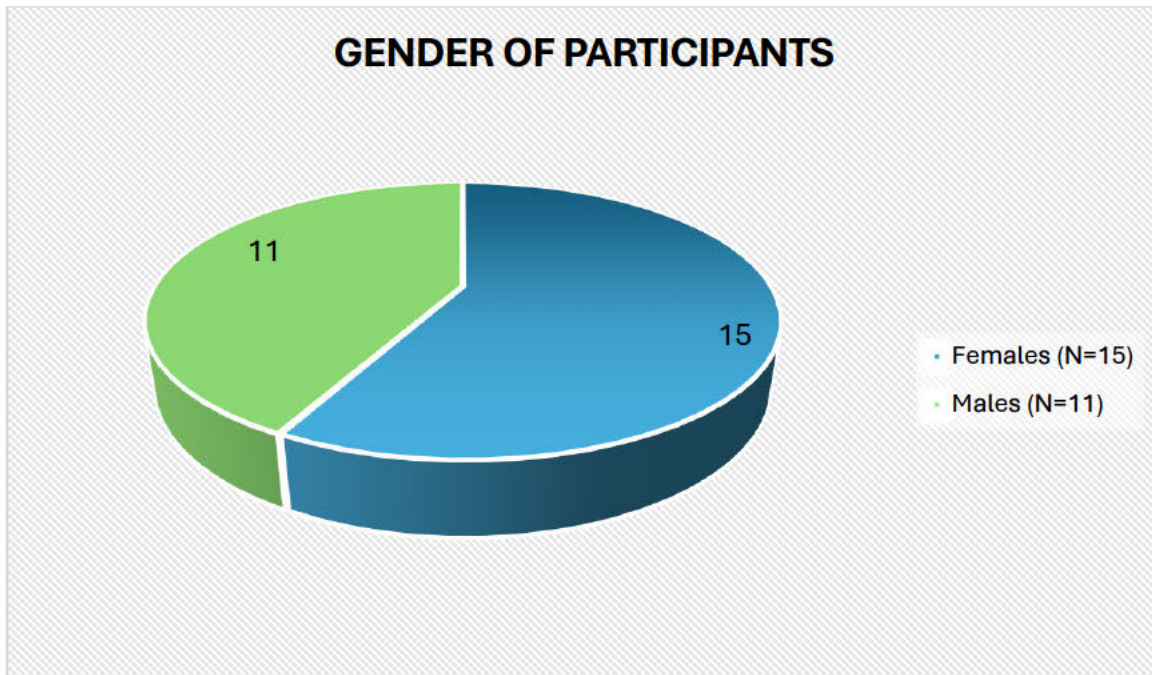


Figure 1.4 above illustrates the gender distribution of the elderly participants with ARHL, consisting of 26 individuals, 11 males and 15 females. Females slightly outnumber males in the study, representing 57.7% of participants. This gender difference may be attributed to several factors that influence the prevalence and development of ARHL. Research indicates that men are more susceptible to ARHL due to certain environmental factors (Nolan et al., 2009). This study presented contrary findings, as it had more women than men living with ARHL from the age of 65. However, it does not provide any causal relationship between biological or environmental factors and ARHL's prevalence, mainly because it investigated the lived experiences of the participants with ARHL aged 65 and older.

The following table serves as an analysis of the age distribution among the 26 elderly participants with ARHL.

4.2.2 Age of Participants

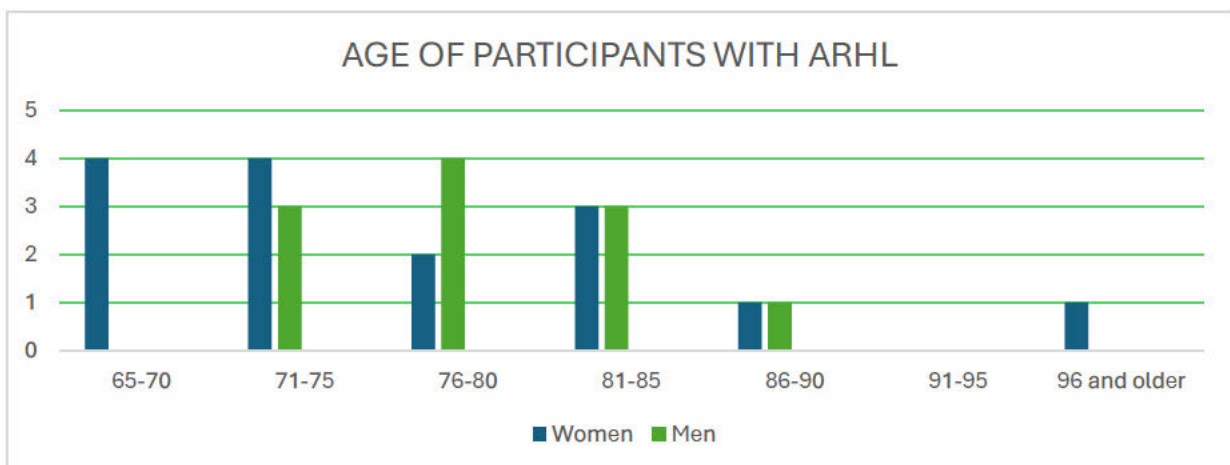


Figure 1.5 represents the distribution of elderly individuals living with ARHL across different age groups and by sex.

The chart does not show a clear upward or downward trend in prevalence across age groups, suggesting that while ARHL affects individuals at various ages, there is no consistent increase or decrease across these groups. Most individuals with ARHL appear to be female, especially in the younger elderly age groups (65-75), though the ratio becomes more balanced in the older categories. The age groups were categorised into 6-year intervals:

Age group 65-70: There are four older women in this age range with ARHL; notably, there are no males. This possibly reflects a trend where women may be more likely to experience ARHL at this age.

Age group 71-75: This group has six individuals, four females and three males. The higher number of females continues from the previous age group, suggesting that ARHL remains more prevalent or is diagnosed more frequently in females.

Age group 76-80: This age bracket has a balance of genders, with two females and four males. The increase in male representation may indicate that ARHL affects males more significantly in this age range or that they are more likely to be diagnosed.

Age range 81-85: The trend shows three females to three males in this age group. The ratio is equal to that of previous groups, suggesting a more even impact of ARHL among the two sexes as their ages increase.

Age group 86-90: With one female and two males, this group shows an almost equal representation, which could reflect that ARHL affects aging males and females similarly in the oldest age brackets.

Age group 91-95: No individuals were in this age bracket.

Age group 96 and older: There is one female and no males.

There was an underrepresentation of the oldest age groups due to deaths, hence a higher number of widows, as recorded below.

4.2.3. Marital Status

MARITAL STATUS	NO. OF PARTICIPANTS	PERCENTAGE (%)
Single	3	11%
Married	9	35%
Widowed	13	50%
Divorced	1	4%
Total	26	100%

Table 2 above is a marital status table based on the information the elderly participants provided. There are three single participants, constituting 11% of the total participants in the study. Most of the participants, nine individuals, are married, making up 35% of the total. The largest group comprises thirteen widowed participants, representing 50% of the elderly population. Lastly, 1 participant is separated, accounting for 4% of the participants.

This table provides a clear overview of the marital status distribution among the elderly participants, highlighting that the widowed category represents the highest percentage, while the single and separated categories have the lowest representation. According to Heylen (2010), loneliness is often associated with old age. Weinstein (2019) asserts that ARHL has been identified as a risk factor for loneliness in the elderly. This table is, therefore, significant to the study as it gives some insight into the companionship of the elderly.

Family roles involve dynamic expectations and responsibilities that evolve throughout life. These roles are often closely associated with co-residence patterns, including whether individuals live with a partner or independently and their marital status. Furthermore, research indicates a significant correlation between the living arrangements of the elderly and their overall health and well-being (Sereny, 2011).

4.3 SOCIO-ECONOMIC STATUS

4.3.1. Elderly's Sources of Income

Ensuring the elderly have adequate access to healthcare services is essential for sustaining their quality of life. Barriers such as geographic isolation, financial limitations, or insufficient healthcare systems can adversely affect their well-being (Zhang et al., 2018). Research has consistently emphasized that accessible and cost-effective medical care supports healthy aging (Izadi-Avanji et al., 2024). In the context of Ngwaqa, accessibility, availability, and the affordability of healthcare are particularly critical, given the challenges related to transportation and treatment accessibility. The figure below is a record of different income sources among the elderly. Including this recorded information is important in this study as it helps understand the elderly's economic situation, determining their affordability and access to healthcare services and treatment for their hearing impairment.

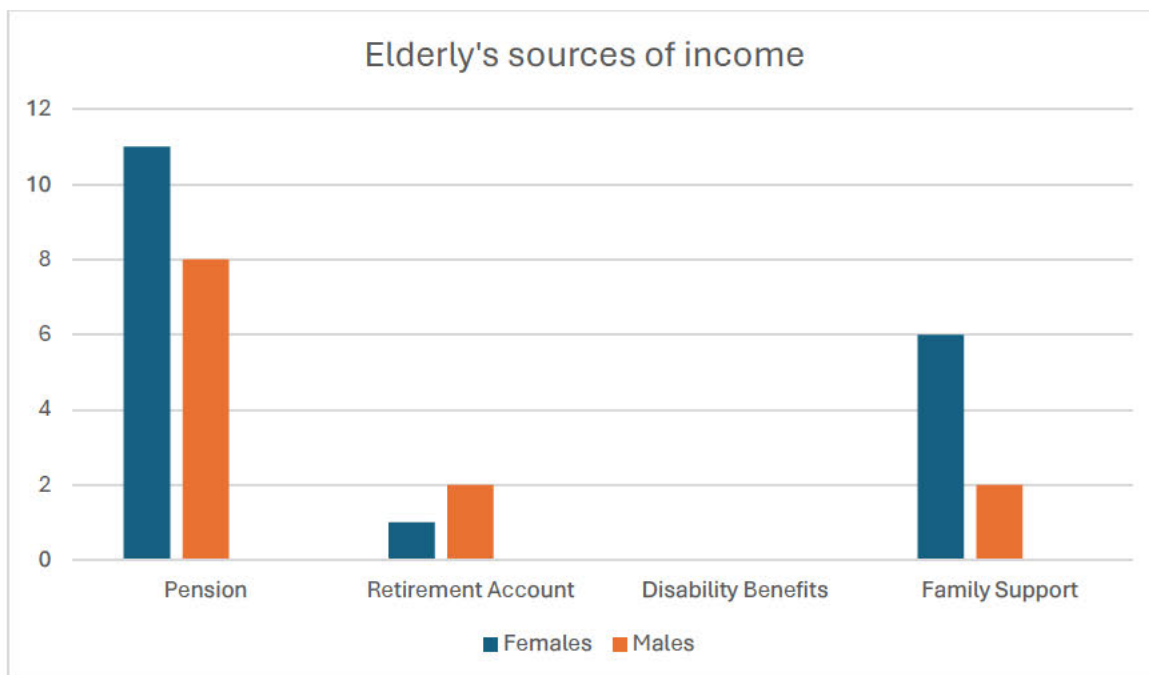


Figure 1.6 above highlights differences in income sources by gender, with women receiving more support from pensions and family than men. This was generally because there were more women than men in the study, as more women aged 65 and older lived in the Ngwaqa community. Regarding retirement benefits, the chart indicates that only one woman and two men are receiving income from this source.

The sources of income illustrated in the figure above inform accessibility to and affordability of hearing healthcare and hearing loss treatment, which will be assessed in the table below.

4.4. ASSESSMENT OF HEARING LOSS, ACCESS, AND AFFORDABILITY

The table below aims to show how individuals with hearing loss aged 65 and older are impacted by their socioeconomic status in accessing hearing loss treatment and hearing aids. Research indicates that socioeconomic status significantly influences an individual's ability to obtain hearing aids (Mumford, 2024). Moreover, according to Gates and Mills (2005), untreated hearing loss has been associated with adverse physical and psychological health outcomes, including cognitive decline, impaired balance, and exacerbation of hearing-related symptoms. Conversely, surgical treatment and hearing aid use have demonstrated substantial benefits, including slower cognitive deterioration, decreased risk of falls, and a 50% reduction in income loss attributed to hearing impairment (Mumford, 2024).

Participants	Can they afford hearing aids? (Yes/No)?
Mrs. P1	No
Mrs. P2	No
Mr. P3	No
Mr. P4	No
Mrs. P5	No
Mrs. P6	Yes
Mr. P7	Yes
Mr. P8	No
Mrs. P9	No
Mr. P10	Yes
Mrs. P11	Yes
Mrs. P12	No
Mrs. P13	No
Mrs. P14	Yes
Mr. P15	No
Mr. P16	Yes
Mrs. P17	No
Mr. P18	Yes
Mrs. P19	No
Mrs. P20	Yes
Mr. P21	No
Mr. P22	No
Mrs. P23	No
Mr. P24	No
Mrs. P25	No
Mrs. P26	No

Table 3 above is a visual tool that presents the affordability of hearing health services among elderly individuals with ARHL in Ngwaqa. From the figure above, only four females and four males have hearing aids; 18 elderly individuals do not. The figure shows that the majority of the elderly population cannot afford hearing health services, which makes it hard for them to have access. This is because they depend on government pension support, which is R2310 and R2330 if you are 75 years and above (www.gov.za, n.d.). While hearing a hearing test and hearing aids cost R7999 at Specsavers (Specsavers.co.za, 2025).

Hearing loss treatments such as hearing aids are costly for most older people and solely depend on their pension. It is one of the reasons why the elderly do not seek treatment for their hearing loss. Figure 1.7 below details the utilization of healthcare services by the elderly in Ngwaqa.

4.4.1. Utilization of Healthcare Services by the Elderly

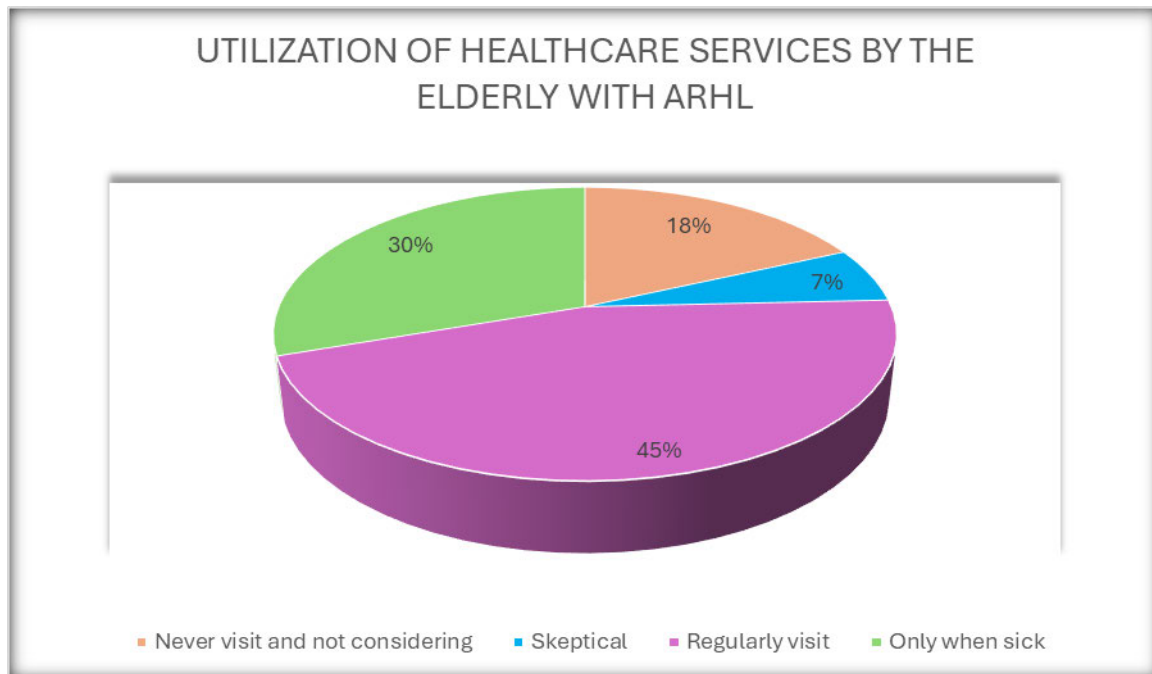


Figure 1.7 above shows the utilization of healthcare services by the elderly participants with ARHL in Ngwaqa. The chart shows that not all participants visit the healthcare centers. Although a high number (45%) of participants regularly visit the healthcare centers, 30% only visit when sick. While 7% of the participants are skeptical, 18% never visit and do not even consider visiting. There are a few reasons for the non-utilization of healthcare services by the elderly: they consider loss of hearing as a regular part of aging, healthcare centres are too far, not affordable, and there is no one to accompany them. Scepticism among other participants is because of their lack of faith in Western medicine. Most elderly participants in this study reported on self-diagnosed hearing loss, substantiated by the data above.

The figure above initially assesses healthcare-seeking behaviors among the Ngwaqa elderly population with ARHL. Understanding their access and attitudes toward healthcare helps frame the study's relevance. The demographic data presented here is descriptive and shapes the entire framework of this study. It exposes healthcare access, directly impacting early detection of hearing loss and outcomes. Without this insight, this study's findings could misrepresent the real ARHL burdens in rural areas like Ngwaqa.

4.4.2. Types of Households

Female-headed households in South Africa are frequently seen as a marker of financial struggle (Pashapa and Rivett, 2018). Such households often consist of single mothers, widows, or women whose

partners are absent due to rural-urban migration, employment, or death. In the case of Ngwaqa, the households are headed by women who are widows, as shown by the high number of widows in the marital status table above.

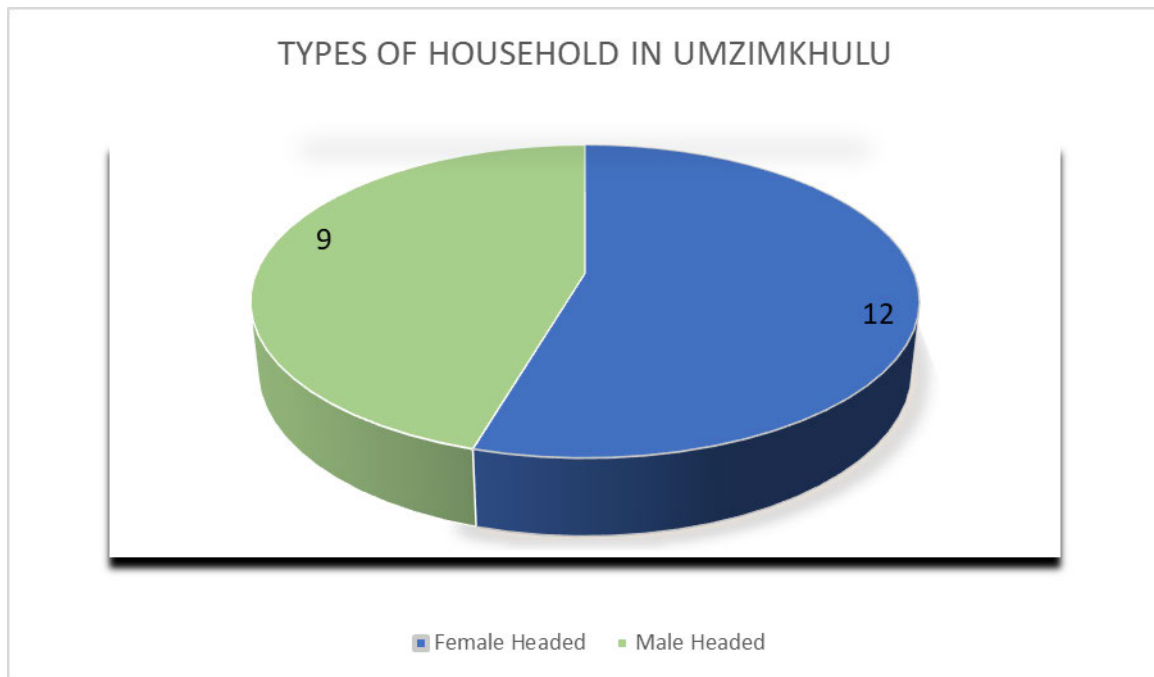


Figure 1.8 The figure above represents the number of male and female-headed households in Ngwaqa. There seem to be more female-headed households than male households, which corroborates Stats SA (2021) results indicating that “KwaZulu-Natal has the second largest female-headed households in South Africa, with an estimated 1,5 million people (48,3%) living in this province.” The types of households in which the elderly participants reside provide important context for understanding their living conditions and the support systems that surround them.

Several studies have consistently shown that household structures and support systems are crucial in determining an individual’s access to healthcare services (Story et al., 2012; Silverstein and Bengtson, 1994). Both male and female-headed households can face challenges in accessing healthcare, although the nature and extent of these challenges may vary.

The types of households in which the elderly participants reside provide important context for understanding their living conditions and the support systems that surround them. Family caregivers within households have become an integral part of the healthcare system. Attending to the elderly’s needs has become a crucial nursing responsibility that can improve patient and caregiver outcomes (Schumacher et al., 2006). The demographic characteristics of family and professional caregivers supporting the elderly are summarised in the table below.

4.5. DEMOGRAPHIC INFORMATION (CAREGIVERS/FAMILY MEMBERS)

Caregivers/Family members	Age	Gender	Relationship to the elder	Educational level	Employment status	Duration of caregiving
Zolile	27	Male	Grandson	Grade 11	Unemployed	2 years
Athandwa	31	Female	Caregiver	Diploma	Employed	4 years
Siyabonga	26	Male	Grandson	Grade 12	Employed	7 years
Zimele	30	Male	Grandson	Diploma	Employed	4 years
Zinhle	25	Female	Granddaughter	Grade 12	Unemployed	4 years
Nombuso	25	Female	Granddaughter	Grade 11	Unemployed	2 years
Pearl	33	Female	In-laws	Bachelors' Degree	Employed	3 years
Ntokozo	27	Male	Caregiver	Diploma	Employed	3 years
Aya	30	Female	Caregiver	Diploma	Employed	1 year
Pamela	66	Female	Wife	Grade 11	Retired	4 years
Calvin	29	Male	Grandson	Bachelors' Degree	Employed	5 years
Nobuhle	25	Female	Niece	PGCE	Employed	3 years

Table 4 above represents the caregivers' and family members' basic demographic characteristics in caring for elderly individuals with ARHL. The care resources for the elderly mainly come from three sources: family, institutions, and the community. There is quite a high level of family caregivers and support in extended family households in rural areas.

Arokiasamy et al. (2012) assert that traditional multi-generational households have historically represented an intricate social network system that ensures care for older adults from within the family or their extended social network. Even when opting for formal care, such as in times of medical need, family and extended family decide to go for formal care (Fox et al., 1999).

Family-based support systems are as important as the support provided by health care systems. Below is a table indicating the healthcare workers involved in supporting the elderly.

4.6 BASIC DEMOGRAPHIC INFORMATION (HEALTHCARE WORKERS)

Healthcare workers	Ages	Gender	Educational background	Profession	Years of experience	Work setting
Dr. Victor	34	Male	MBChB	General Practitioner	11	Hospital/Clinic
Audiologist	30	Female	B Audiology	Audiologist	6	Hospital
Nurse Ntombi	36	Female	Diploma in Nursing (R171)	General Nurse	9	Public Clinic
Nurse Sibusiso	23	Male	B Nursing (R174)	Professional Nurse	2	Public Clinic
Nurse Thobile	44	Female	B Nursing (R174)	Professional Nurse	18	Public Clinic
Nurse Khaya	31	Male	B Nursing (R174)	Professional Nurse	9	Public Clinic

Table 5 above represents basic demographic characteristics of the healthcare workers involved in the study. Healthcare professionals involved in treating elderly patients consisted of 1 medical doctor, one audiologist, and four nurses. Their demographic characteristics provide insight into the healthcare delivery framework of this study.

4.7 Conclusion

Overall, the demographic information presented in this chapter establishes a foundational understanding of the challenges faced by elderly individuals with hearing loss and the crucial roles that caregivers and healthcare workers play in their lives. This chapter has provided a detailed overview of the participants' demographics, shedding light on the important characteristics of the elderly experiencing ARHL, the caregivers in their care, and the healthcare workers. The demographic characteristics presented in this chapter provide valuable context for understanding gender disparities related to the treatment of ARHL. These findings highlight a pertinent pattern whereby women appear more frequently affected by ARHL in the early elderly age group (65-80). This finding aligns with existing literature indicating that presbycusis, or ARHL, tends to manifest more profoundly in women aged 65 and above (Gopinath et al., 2009). However, as participants age (especially past 80), prevalence converges between men and women, suggesting that both genders experience ARHL as an inevitable aspect of aging. The findings also suggest that some elderly individuals who rely on pensions and their family's financial support do not have access to hearing health and hearing aids, which will be further explored in the following chapter of this study.

CHAPTER FIVE

ANALYSIS OF DATA AND FINDINGS

This chapter examines the impact of gender disparity in the context of receiving treatment for age-related hearing loss (ARHL). This study conducted a thorough investigation into the prevalence of ARHL among men and women, as well as the extent to which gender influences access to and utilization of treatment options. The analysis used qualitative data gathered from interviews and existing literature. Through the analysis of data collected from semi-structured in-depth interviews, this chapter presents key findings that provide a comprehensive understanding of how gender influences the accessibility, uptake, and outcomes of treatment for individuals affected by ARHL.

This study employs two key theoretical frameworks, the biopsychosocial model and access theory, and a medical anthropology perspective. The biopsychosocial model examines the interplay of biological, psychological, and social factors in the development and treatment of ARHL. At the same time, access theory focuses on how individuals obtain healthcare and services, framing them within availability, accessibility, accommodation, affordability, and acceptability. This framework allows for an expansive investigation into the social disparities in access to treatment, especially concerning gender differences among the elderly in Ngwaqa. The medical anthropological perspective emphasizes the importance of understanding health and illness within their cultural context. Its integration helps explore how cultural beliefs, social structures, and power dynamics shape the experience of elderly individuals with ARHL in Ngwaqa.

The findings from this study reveal significant differences in the experiences of men and women regarding the prevalence, perception, treatment, and social implications of ARHL. These disparities are observed across various dimensions, including socio-cultural beliefs, healthcare access, utilization of services, and affected individuals' perceived quality of life. The discussion integrates these findings with existing literature, highlights implications for healthcare practice, and suggests areas for future research. The findings in this chapter aim to fill the gap in the literature on gender disparities in healthcare and provide valuable insights for healthcare providers and policymakers in addressing the needs of individuals with ARHL.

5.1. THEMATIC ANALYSIS OF DATA

The following steps provided a structured approach to conducting thematic analysis while allowing for flexibility and creativity in interacting with the data collected. The method emphasizes the importance of reflexivity and transparency throughout the analysis process, making it critical to know my positionality and how it may influence my interpretations.

Step 1: Familiarization with the Data

To familiarize myself with the data I had collected, I immersed myself in gaining a deep understanding. I re-read the interview transcripts and took notes on initial impressions and recurring themes related to gender and experiences.

Step 2: Generating Initial Codes

This step identifies interesting data features related to the research question. To achieve this, I systematically coded the data by highlighting segments related to gender disparity in receiving treatment.

Step 3: Searching for Themes

This step is essential in collating codes into potential themes. I reviewed the codes and grouped them into broader themes that captured significant aspects of the data collected. For instance, themes included “gender differences in diagnosis and treatment,” “the role of culture,” and “treatment-seeking experiences.”

Step 4: Reviewing Themes

In this step, I refined the themes to ensure they accurately represented the data and the research question. Each theme was evaluated against the coded data. The themes were coherent and distinct. I ensured that each theme had enough supporting data.

Step 5: Defining and Naming Themes

In defining and naming the themes, I clearly defined each theme and the aspects of the data it captured.

Step 6: Writing the Report

The analysis and findings of the study were presented in a meaningful way. There is an introduction to the research topic and its significance. A methodology section, a findings section, and a presentation of each theme with supporting quotes from participants to illustrate the findings are included. Then follows a discussion section connecting the themes to the literature on gender disparities in healthcare access and treatment, as well as implications for practice policy. Lastly, recommendations for future research will be made based on my findings and the literature gaps identified during the study.

5.2.THEMES GENERATED

5.2.1. Theme One: Social Isolation

ARHL is a deterioration in the status of the elderly, which deprives them of communication and encourages social withdrawal associated with self-degradation (da Ponte, 2021). Lotfi et al. (2009, p. 368) also found that “hearing loss can lead to communication problems, familial discontentment, alienation, isolation, and a drop in social activities.”

This theme explores the social isolation experienced by elderly individuals with ARHL. It will be analyzed through the lens of the Biopsychosocial Model, focusing on the psychological consequences of isolation, and Access Theory, examining how barriers to social participation contribute to this isolation. A medical anthropology perspective will help us understand the cultural meanings of social isolation in Ngwaqa and its impact on the well-being of the elderly.

Most elderly individuals experience hearing impairment, often making comprehending speech amid background noise challenging. These difficulties can lead to an increased need for listening effort and heightened fatigue. As a result, social engagements may become less enjoyable, and ARHL is linked to social isolation and related adverse effects on mental and emotional well-being. However, the exact nature of the relationship between ARHL and social isolation is poorly described.

The inability to hear well may lead older people to depression, or they may be socially withdrawn from others due to frustration and embarrassment about not hearing what is being said. Sometimes, due to their poor hearing, they are misinterpreted as being confused, inattentive, or unpleasant (NIH, 2018). Some elderly participants reported that they self-isolate to avoid being excluded from conversations; others alluded that stigma plays a huge role in their decision to isolate themselves.

Some caregivers and family members interviewed mentioned that their elderly sometimes avoid social gatherings or become withdrawn due to difficulty in hearing and communicating with friends and family. **Nobuhle, Mrs. Participant 12's** niece, reported that *Malumekazi (Aunt) does not attend imbizo or ceremonies anymore; we attend on her behalf because she does not enjoy being around many people and fails to engage*. On the other hand, **Zolile** mentioned that **Mrs. Participant 1** *said she would continue attending social gatherings and ceremonies, but just for appearances. When invited, I took her to that ceremony, and we stayed for a while; she made it a point to greet the hosting family so they could see she came. However, shortly after that, we leave. I asked the reason for that, and she responded by saying that the hosting family can support her when she needs them to, rather than not going and expecting them to understand why she did not come*.

As much as hearing loss has been reported to affect communication, socialization, and the elderly's overall quality of life, two elderly participants reported that their hearing loss only affected their ears and nothing beyond that. **Mrs. Participant 2** mentioned that she did not allow aging and its sicknesses to affect how she lived her old age. She said, *I want to be around people at all times because I am old and might depart very soon, so I do not isolate myself because of my hearing difficulties or sore knees (Mrs. Participant 2)*.

The other participant mentioned that at their age, anything can happen anytime. Therefore, she wants to live life to its fullest. *You cannot choose to isolate yourself in your last days. I want to be everywhere and do everything with everyone for as long as possible. It is not like I cannot hear; I can, just not as loudly as I used to. (Mrs Participant 19)*

I know that ARHL can significantly affect communication, leading to social isolation. When individuals struggle to hear, they may withdraw from conversations, resulting in them feeling lonely and depressed. However, I personally do not think our elderly here are self-isolating. Maybe the educated ones or the other races; other than that, I think they learn to live with the new status of hearing (Nurse Ntombi).

Many older adults may feel embarrassed or frustrated about their hearing difficulties. This emotional strain can lead to anxiety and affect mental health, impacting their overall well-being. There is this thing I grew up thinking was normal, but it is not always normal. This is seeing our elderly talking to themselves but making no sound. That is also a side effect of some sort. (Nurse Khaya).

5.2.2. Theme 2: Treatment Seeking Experiences

This theme explores the various experiences older adults and their caregivers encounter when seeking diagnosis and treatment for the elderly's hearing loss. The elderly and their caregivers recounted positive and negative experiences when visiting the healthcare facilities. Participants shared their experiences recognizing the need to seek assistance with their hearing loss. Many sought help after noticing that their hearing loss affected their daily lives, leading them to consult with healthcare professionals. Some were encouraged by their friends and families to seek medical intervention, and some reported having their family members take them to the clinics and specialists.

When **Mrs. Participant 17** was asked when she sought diagnosis and treatment for her hearing loss, she stated,

I started noticing problems with my hearing a few years ago, but I did not think much of it until it became difficult to follow conversations. I finally sought help about a year later because it was frustrating, especially during family gatherings. I approached my doctor, and he was quite dismissive initially. It felt like he assumed I was getting older and did not think it was a serious issue (Mrs. Participant 17).

Because the question had two parts, she recounted a mixed experience, as she reported that the audiologist was polite, but overall, she felt overlooked.

At the clinic, I felt overlooked, to be honest. The audiologist was polite but focused more on the technical aspects rather than addressing my emotional concerns. I expected more empathy, especially as a woman who had always been vocal about my health. The clinic environment did not encourage questions, and I wished I had been taken more seriously (Mrs. Participant 17).

Another female participant, who is a proactive seeker, reported having a negative experience when she mentioned her hearing issue during her routine check-up consultation. She mentioned that she felt her concern was dismissed, and the overall experience was unpleasant. Fortunately, that did not stop her from actively seeking treatment.

I went in for my routine check-up and mentioned my hearing issues. It felt like my concerns were dismissed at first because there is a stereotype of older women being more concerned about their looks than their health. It was disappointing, and it made me feel invisible at times. Eventually, it took a friend's encouragement to get me to follow up and really push for a hearing test (Mrs. Participant 25)

Regarding her experience at the clinic, **Mrs. Participant 25** reported that her experience was uncomfortable and unpleasant. *When I arrived at the clinic, I felt uncomfortable. Most men were in the waiting area, and the doctors seemed to focus more on the clinical parts than on my personal experience. I found myself having to advocate for myself more than I expected. I realized how many women struggle to be heard in these situations. I went to that clinic for my hearing and eyes once, and I never went again. I only go to Pietermaritzburg for ukuyokwekwa amehlo (cataract surgery). What is even better now is that your aunt is in this programme where they collect our medicines on our behalf and bring them to us. So now I do not have to experience the disrespect from those young nurses (Mrs. Participant 25).*

In contrast to most of the elderly ARHL female participants' responses on when they started to seek diagnosis and treatment, and their experiences at the healthcare facilities, some males who have sought a diagnosis had positive experiences to share. However, a few, like women, had unpleasant experiences.

When asked about when the participants started to seek diagnosis and treatment for their hearing loss, it was clear that at first, males hesitated to visit healthcare facilities regarding their hearing decline. However, they eventually went, and either their wives or family members insisted on the importance of consulting about the matter, or when they finally decided on their own. **Mr. Participant 4** had this to report: *I first noticed my hearing loss when my wife pointed it out. It took me a few years to finally realize and admit that I also needed help. I went to see a specialist after she insisted. It initially felt like a sign of weakness, but I eventually realized it was necessary (Mr. Participant 4).*

Mr. Participant 15, who was also hesitant at first, reported *that I have always been strong in my family, so asking for help was hard. I asked my daughter to take me to the clinic, but I kept second-guessing whether I needed to check, so I would make excuses and end up not going. I finally went after not being able to hear the TV properly. Maintaining my 'manly' image was crucial, so it was a humbling experience to realize that I needed assistance.*

I noticed that when our makoti (daughter-in-law) took my wife and me to the audiologist, the nurses and the audiologist gave me a more thorough assessment than they did with her. After my assessment, I remember telling my sons we would still wait longer, but I was surprised to see her walking out of the room within a few minutes of sitting down (Mr. Participant 7).

Both genders mentioned that the attitudes of healthcare providers toward them often left them feeling uneasy during their visits. Men, in particular, emphasized the need for healthcare workers who were

respectful, patient, calm, and friendly. They criticized other healthcare workers for treating them demeaningly and failing to ensure that the elderly leave their facilities with a positive experience; nonetheless, they recognized and complimented certain healthcare workers who were supportive and accommodating toward everyone.

Additionally, **Mr. Participant 24** complained about the healthcare worker's disrespectful attitude towards the elderly. *Times have changed and so have the nurses. Back then, nurses were very friendly, patient, and helpful. However, when it comes to these youngsters, I think they chose the wrong jobs because they are disrespectful and impatient with us. Because they know that we cannot hear properly, they sometimes say things you should never say to your elder.*

I have seen firsthand how hearing loss can contribute to frustration and helplessness in our elderly. This emotional burden can affect their interaction with us, sometimes leading to misunderstandings and inadequate care. I always try to ask them to bring along someone younger than them, and some have, but some insist that they are fine alone (Nurse Sibusiso).

From the other healthcare workers' responses, one can tell that they frequently observe that elderly patients with hearing loss may struggle to understand crucial information and instructions, impacting their ability to adhere to treatment plans and leading to poor health outcomes. A comparison of the results obtained from men and women reveals that when the healthcare worker participants were interviewed regarding the question on age-related hearing loss (ARHL) diagnosis and treatment differences between men and women, they had varied responses, which were all informative and essential.

5.2.3. Theme 3: Challenges in Support and Care

The effects of ARHL include diminished physical and social functioning and difficulty in understanding speech sounds, which often contribute to a decreased capacity for communication. Cognitive impairments, mood swings, social isolation, and stigmatization may result from this (Murray and Lopez, 1996). Several writers have written about how hearing loss affects people's social and familial lives (Dalton et al., 2003; Salomon, 1986) and the QoL of individuals. ARHL has been shown to impact relatives' daily functioning (Scarinci et al., 2009), particularly the primary family caregiver. They must make more effort to communicate with people with hearing loss; they must repeat themselves, speak more slowly and louder, and stand closer to them to be heard and get their attention. The caregivers' quality of life was negatively impacted by their elderly hearing loss, which also caused them to experience stress and anxiety, limit their ability to communicate verbally and intimately with their relatives, change their social activities, avoid social situations, and feel alone, frustrated, resentful, and guilty (Hetu et al., 1993; Wallhagen et al., 2004).

Caregivers discussed difficulties such as misunderstandings, lack of resources, or the emotional burden of supporting someone with hearing loss. They also reflected on the complexity of caregiving roles and responsibilities.

Aya reported the misunderstanding she has noticed daily, leaving her with a feeling of doubt, like she cannot do her job correctly.

Absolutely, there are misunderstandings almost every day. Gogo often misinterprets what I say because she cannot hear me clearly. This leads to conflicts over simple things. I try to repeat myself, but sometimes it is tiring for both of us, and it makes me feel like I am not doing my work properly when I cannot communicate more effectively, as she depends on me when we have visitors. (Aya)

Aya's response highlighted the communication barriers posed by hearing loss.

Mrs. Pamela, who takes care of her husband, **Mr. Participant 10**, who has been living with ARHL for over four (4) years, reported on the lack of resources:

There is a severe lack of resources in our community and Umzimkhulu at large for elderly individuals with hearing loss. I have struggled to find affordable hearing aids or support services that specialize in age-related hearing difficulties. I want to help my spouse more effectively, but finding the right tools has been a major obstacle. We are navigating this alone without adequate support (Mrs. Pamela).

Ntokozo, Mr. Participant 8's caregiver, reported on the complexities of caregiving. *The role of a caregiver is more complex than I initially thought. Beyond just managing his hearing loss, I have to address his feelings of inadequacy and frustration. Sometimes, he refuses to wear his hearing aids, insisting he does not need them. On top of that, balancing work, my own family, and caregiving responsibilities is overwhelming. It is a daily juggling activity.*

Nobuhle, Mrs. Participant 12's niece, reported on the stress and fatigue brought by taking care of her elderly grandmother with ARHL:

I have definitely faced challenges supporting Khulu (grandmother) with her hearing loss. It is emotionally draining, especially when I have to constantly remind her to pay attention or when I have to repeat myself multiple times. There are days when I do not feel like being around her, which I know is very wrong. Some days, the stress can wear me down, and I feel guilty for getting irritated when she wants to be included and understood.

Zinhle, Mrs Participant 5's granddaughter, reported on her elderly grandmother isolating herself. *One of the toughest challenges is her social isolation. Since her hearing has worsened, I have noticed that she has become more withdrawn, which frustrates me a lot. Not so long ago, there was a umgqababovu (coming-of-age ceremony) at our next door, and she did not want to attend; if it were not for our neighbour, who knows more about Khulu's situation, her name would have been dragged and made bad*

for not attending a ceremony at her neighbour's. I see how much she misses socializing with friends, but she often feels embarrassed to participate because of her hearing struggles.

Nombuso further sympathetically reported that “it is hard to see her elderly miss out on things” and that she feels so “impotent” to change *Khulu's* situation.

I have had to learn new ways to communicate, like using more body language or speaking more slowly. This can feel stilted and unnatural, which adds another layer of complexity to our interactions. Not only do I need to be a caregiver, but I also have to be a communication coach. It is challenging, especially when time is limited, and patience wears thin. She reported on the communication technique she had to adopt to make their interaction easier and more engaging (**Nombuso**).

5.2.4. Theme 4: Coping Strategies and Techniques

This theme examines the various coping strategies and techniques elderly individuals employ to manage the impacts of ARHL. Like any disorder, ARHL can be challenging. Common strategies include hearing aids, assistive listening devices, and environmental modifications to facilitate communication. The elderly reported various coping mechanisms that are helping them to manage the impact of ARHL on communication and daily living. Coping strategies are vital for managing ARHL and promoting better communication and social interaction. Speechreading, visual cues, and assistive listening devices can enhance conversation understanding.

Participants reported relying on visual cues such as lip-reading and maintaining eye contact during conversations to enhance understanding. Some revealed that expressing their needs to family and friends helped foster better communication experiences, while others noted the importance of family support in managing their condition.

Mrs. Participant 25, who self-advocates for her hearing loss, reported her openness and clearly communicating her needs and preferences to aid understanding. *I have learned to notice people's facial expressions when they talk to me. I let my family and friends know I can follow along better if they make eye contact. I have noticed that if I tell people about this prior to having any conversation, our communication becomes easier. It helps me feel like I am fully part of the discussions, which is important for my happiness, especially now that I am this old.*

*Before retiring, I was a teacher for a very long time, so we were constantly learning about new things, even when they were meant for learners, but we would attend for some knowledge or to assess what was being taught to our learners. When I first noticed that my hearing in one ear was changing, I went for a consultation and thought it was just an infection. Only to find out the time had come for me to feel old. I freaked out upon finding out and told everyone in the family and everyone I knew. Then I decided to find out more about this. Understanding that my situation is common among older people has helped me accept my condition. The more I learn about it, the less afraid I feel (**Mr. Participant 22**).*

As discussed in another chapter, ARHL can significantly impact the individual's quality of life, and family support has been found to play a crucial role in coping with this condition. Family support provides emotional, practical, and social dimensions that can enhance an individual's ability to manage the condition effectively, ultimately improving their overall quality of life. Other participants said they cope better with ARHL as they have family support.

I think I can cope with my hearing because of my family. They are more supportive now than when I was fresh and my husband was still alive. My daughters visit very often, and they bring my grandchildren along whenever they visit because they know the little ones are never tired of talking, which helps me to keep engaging. We talk openly about my hearing challenges, and they help me by repeating things if I do not hear right away. All of the things they are doing for me reassure me that I am not a burden (Mrs. Participant 11).

Mrs. Participant 2 reported on her strong support system. Her caregiver, **Athandwa**, advocates for her needs in various settings other than their community, as people in her community know how to communicate with her.

I have a great support system, starting with my caregiver, whom I refer to as my daughter; she is very patient with me. I take her wherever I go because I know I quickly get irritated when I have to explain that I cannot hear properly, and a person communicates with me like a normal person, and I have to tell them repeatedly. She helps me when I converse when I cannot hear, read their lips, or ask them to speak closely and slowly. People here in Ngwaqa know about everyone who cannot hear properly, and they know how to communicate with us. (Mrs. Participant 2).

Athandwa added that *when we are in unfamiliar settings, I ensure that her hearing loss is considered and appropriate accommodations are made.*

Mr. Participant 21 mentioned using distractions while keeping busy to mitigate the emotional challenges associated with his hearing loss, although concerns about safety during nighttime remained prevalent.

I like to keep myself busy by fixing things or checking my dogs for fleas. I noticed that I hardly think about this problem when I am busy because I have not fully come to terms with my new self. So, when I am working, I forget a bit. The problem starts at night when my wife and everyone are sleeping, and I am wide awake thinking about how I will never be able even to hear intruders while I should be the one to protect my household (Mr. Participant 21).

Like others, **Mr Participant 18** shared a very different yet positive response. *One thing about my hearing is that it is not constant; today, I can hear you without using my hearing aids. Later or tomorrow, I might need to use them. However, that does not worry me; it makes me feel like I have not lost it all. Because even when I have my hearing aids on, I sometimes forget that it is assistive hearing.*

So, whenever I feel the worry slowly coming on me, I insert my hearing aids and focus on other important things because I can always hear (Mr Participant 18).

Coping strategies utilized by the elderly participants underscore the applicability of both theoretical frameworks.

5.2.5. Theme 5: Gender Differences in Diagnosis and Treatment

This theme explores how accessing healthcare for ARHL can differ based on gender. People residing in rural areas often face several barriers to accessing healthcare, including distance to health facilities, transportation issues, and a lack of specialized healthcare providers such as audiologists. These barriers impact both genders differently. For instance, women usually have less mobility due to caregiving roles, whereas men, in most cases, have less social support.

Barriers to healthcare access affected men and women differently, with women often experiencing less mobility due to caregiving responsibilities, while men may have less social support. Some healthcare providers noted implicit biases in the diagnosis and treatment approaches toward genders, impacting timely care and interventions.

My observations have led me to believe that there is an implicit bias in the way we diagnose ARHL in men versus women. I find that women are sometimes underestimated regarding their level of hearing loss. When they report symptoms, they are often not perceived as severe as when men report the same symptoms, which can lead to delays in effective treatment for women. (Audiologist Cynthia)

There is a notable difference in how men and women respond to treatment. While both genders benefit from hearing aids, women are generally more proactive. They tend to embrace assistive technologies faster and see the value in social engagement. Men, however, can be more resistant to wearing hearing aids due to perceptions about masculinity or societal norms. (Nurse Ntombi)

Nurse Thobile stated that *compared to women, this might be linked to occupational noise exposure, as many men work in louder environments. Consequently, their diagnosis tends to occur sooner, and they often seek treatment more promptly. In contrast, women may experience a more gradual onset and sometimes delay seeking help until their hearing loss impacts their daily life significantly.*

The healthcare workers' contradicting or varying responses may be because they have prior working experience in other facilities. The pronounced gender disparities echo existing literature, reinforcing the access theory's assertion that different access experiences affect healthcare outcomes. **Nurse Ntombi** and **Audiologist Cynthia** highlighted this. The underestimation of women's symptoms highlights issues of acceptability and denotes an implicit bias, corroborating previous findings on healthcare inequalities (Adams et al., 2002). This theme advocates for modifications to existing theories to better account for gendered experiences within healthcare contexts

5.2.6. Theme 6: The Role of Socio-cultural Beliefs and Attitudes

Cultural attitudes are crucial in shaping individuals' experiences of age-related hearing loss. They significantly influence how individuals perceive age-related changes, including hearing loss. Cultural beliefs also affect individuals' willingness to seek help for hearing loss. However, individuals may be more inclined to pursue diagnosis and treatment in cultures that openly discuss health issues.

Cultural beliefs framing treatment perceptions and decisions add a critical layer of understanding to the biopsychosocial model by revealing how social and psychological dimensions can impact health-seeking behavior. A study by Bess et al. (2020) found that cultural beliefs can create barriers to accessing hearing aids and other treatments, particularly in cultures favouring traditional medicine or where medical interventions are less trusted. The intersection of culture and ARHL perceptions suggests that access theory must incorporate cultural factors. Such an insight opens avenues for exploring culturally tailored interventions. To find out how socio-cultural beliefs impact the elderly's understanding and perception of their hearing loss, the elderly expressed a variety of responses that reflected their individual experiences, cultural backgrounds, and personal beliefs.

In my culture, there is a belief that aging naturally comes with inevitable losses, including hearing and blindness. However, there is this unspoken acceptance of it. It took me time to break away from that mindset and to consider treatment as a valid option rather than something to be embarrassed about. (Mr. Participant 22)

Older people seem to have different views about hearing loss than younger generations. I have noticed that the younger folks are more open and understanding. They are quick to adapt and use technology to help communicate with me. (Audiologist Cynthia)

Some people in my community believe that hearing loss is a test of faith or a sign of aging, and that is just how the circle of life goes. I have heard some sermons at church about embracing our challenges, which have helped me look at it as just another stepping stone. Such belief gives me solace, but does not change the fact that I struggle sometimes. (Mrs. Participant 17)

There is an expectation that if you have hearing loss, you should deal with it quietly. Since all of my sisters are losing their hearing ability as well, when we all meet, we discuss it, and I can see that it has helped us understand how to cope with it. (Mr. Participant 7)

There is a fear in my community about isolation as we age, especially with hearing loss. Some believe it might mean losing touch with society, which is disheartening. Nevertheless, I try to make others understand my condition and its difficulties so that I bridge the gap. (Mrs. Participant 25)

In my culture, there is still a stigma around hearing loss. People often think you are losing your mind when you cannot hear. That has made it hard for me to talk about my hearing problems openly to anyone other than immediate family members and our caregiver. (Mrs. Participant 12)

Our clinic is in a rural area, and most of our staff are from surrounding rural communities where culture is more important than anything else. Since we understand that and are also heavily cultured, sometimes cultural perceptions about hearing loss affect patients' willingness to seek treatment, complicating our efforts to provide care. (Nurse Thobile)

5.2.7. Theme 7: Quality of Life (QoL)

Quality of Life (QoL) is a term used to determine an individual's overall well-being and the psychological, social, and environmental aspects that contribute to their satisfaction and happiness (Teoli and Bhardwaj, 2020). According to Felce and Perry (1995), there is considerable agreement regarding the idea that the evaluation of QoL is multidimensional as it includes physical, material, social, and emotional well-being. Several authors have also reported that hearing loss in adults is directly linked to reduced quality of life as it significantly impacts their daily lives by impairing the exchange of vital and general information. Alongside these reports, there are reported effects of ARHL on quality of life, emotional reactions, including isolation leading to loneliness, increased dependence, frustration, depression, anxiety, embarrassment, and guilt. Moreover, cognitive changes, such as dementia, loss of focus, communication disorders, decreased self-esteem, and confusion, may occur.

Elderly participants have also reported how their QoL deteriorated due to ARHL. Caregivers also shared their observations of emotional responses in elderly individuals, such as frustration, anxiety, or depression, regarding their hearing loss. Some elderly participants, especially those who had varying responses, and most of those who do not use hearing aids, had varying responses, and most of those who do not have similar responses in terms of how ARHL affects their QoL. The audiologist's perspective on the impact of ARHL on the elderly's well-being and quality of life was

Throughout the years of treating older adults with deteriorating hearing, we have noticed growing evidence to suggest a link between untreated hearing loss and cognitive decline. The brain may become less engaged when not receiving auditory stimuli, affecting memory and cognitive function over time (Audiologist Cynthia).

Mrs. Participant 13 reported that *sometimes it feels overwhelming. I get frustrated when I cannot hear what others are saying or when I struggle to follow along. These moments affect my mood and make me less confident in social situations.*

Mr. Participant 3 also responded by saying, *I find myself feeling more anxious and sometimes even stressed because I cannot hear what is going on around me. I miss the little moments and the sounds of*

everyday life. This is why I stopped attending ceremonies and church; my grandchildren are now my representatives.

Mrs. Participant 11 reported that she does not take it to heart in most cases, even though it sometimes gets to her; she said *I have learned to laugh about it. My family, especially my children, teases me about my hearing, and I joke back. It is a part of my life now, and while I struggle sometimes, I have decided to focus only on what I can still enjoy.*

Mr. Participant 4 reported on how ARHL has impacted his simple daily activities. He stated that *simple things like watching TV or talking on the phone have become more challenging. With the phone, I always have to put it on speaker to hear properly, even in public, which feels like losing a sense of privacy. Moreover, I often find myself frustrated with the TV and constantly needing to adjust the volume. (Mr. Participant 4)*

Meanwhile, participants with hearing aids had varying positive, neutral, negative, and mixed responses that illustrated their individual experiences and sentiments regarding the impact of ARHL, along with the use of hearing aids. Each participant emphasized different aspects based on their circumstances. Starting with the positive responses from the elderly with hearing aids. They reported on improved social engagement, enhanced independence, and mental health benefits.

Since my children got me these things I used to hear, I feel I am back to my younger self. I stopped isolating myself and can now be part of conversations with my family and friends again. I think this has improved my well-being because I no longer overthink or feel the need to be around people. (Mrs. Participant 11)

Using hearing aids has given me back a sense of independence. I can hear the phone ring, the gate opening, my cows and dogs, and I enjoy watching TV without relying on the writing on the screen at my tender age. Even with you, you can see by yourself; you do not have to repeat yourself. (Mr. Participant 16)

I am not sure if I should say it is this technology helping or thank myself for not being afraid to embrace my hearing loss as part of aging. However, I can agree that, although I am wearing them, although uncomfortable, I feel relaxed knowing nothing will catch me by surprise. (Mrs. Participant 26)

Mr. Participant 7 and **Mrs. Participant 14**, a married elderly couple living with their granddaughters and caregiver, had a neutral response to the question of how ARHL has impacted their overall well-being and quality of life, as they have hearing aids. **Mr. Participant 7** reported on his experience trying to adjust to wearing hearing aids to hear. *At first, I found adjusting to hearing aids challenging. While they definitely help a lot, there are still times when I struggle to understand people, especially in noisy environments. I think I can say, little by little, I will get there. (Mr. Participant 7)*

On the other hand, his wife reported the inconsistent impact of the assistive devices. **Mrs. Participant 14** stated that *the impact of my hearing aids on my life is different every day. Some days, I feel great, and other days, I still feel the weight of my hearing loss. I can say that it is not the perfect solution, but it has helped.*

Two participants had negative responses to the question. **Mr. Participant 8** reported on how he feels based on perceptions from others.

I can tell that people sometimes underestimate my capabilities because of my hearing loss. This affects the way I often view and feel about my masculinity. It makes me feel less valued in social and family settings. This is why I never wanted to age. (Mr. Participant 8).

Even with hearing aids, I still find it exhausting to keep up with conversations. I often feel mentally drained after social gatherings or even if a friend or relative comes to visit me, which takes a toll on my quality of life (Mrs. Participant 6).

Some participants reported how ARHL has affected their independence and the stress it has brought as they now have to rely on others. They also reported feeling like they have become bothersome to their family members, which makes them uncomfortable.

Mrs. Participant 23 complained about how stressful life has become for her, especially at night, as she must wake up now and then and ask whoever is in the rondavel with her if they have not heard any strange sounds or dogs barking to alert them of danger.

You know, having dogs means you are protected because, at night, they alert you when there are intruders, but now that I can hardly hear them, and when I do, it is as if they are barking from a distance, I cannot rely on them. Now, I need to always ensure that I am not alone at night; I do not enjoy bothering people, and I like doing things myself, but now I have to wake them up and ask if they have not heard anything strange or the dogs barking. (Mrs. Participant 23)

As the head of the family, I am asked everything. Since I have accepted that I do not hear as I used to, it still has not been as easy as I would like. But at least I am still respected at home and in Ngwaqa (Mr. Participant 24).

5.2.8. Theme 8: Key Dimensions of Access Theory

This theme discusses various barriers elderly individuals face in accessing healthcare services for hearing loss, including availability, accessibility, affordability, and acceptability. The dimensions of access theory are vividly illustrated through the experiences detailed within this theme, particularly regarding availability and accessibility to healthcare services. The following findings indicate that

barriers are prevalent and disproportionately affect women, thus reinforcing existing claims within health literature (McLuaghlin and Wyszewianski, 2002).

a) Availability

“Availability measures the extent to which the provider has the requisite resources, such as personnel and technology, to meet the client's needs” (McLaughlin and Wyszewianski, 2002, p. 1441). ARHL affects communication and diminishes the overall quality of life. Despite effective diagnostic and therapeutic interventions, many adults in rural areas face considerable barriers and delays in accessing necessary care (Powel et al., 2019). The healthcare providers were asked about the availability of hearing loss treatment in their facilities. Their responses showed that they have limited resources at the closest clinics.

The patients would have to go to hospitals that offer speech and audiological services to get tested on the severity of their hearing loss. We offer basic hearing services like screening, but for more advanced treatments or hearing aids, patients have to go to the surrounding hospitals that offer hearing services or to audiologists directly (Nurse Thobile).

With the resources we have, we can only check if they can hear or not, and then we refer them to audiologists at St Andrews Hospital, Murchison Hospital, and Pietermaritzburg, where they check them thoroughly and treat them if it is still treatable (Nurse Sibusiso).

So, we conduct certain tests to assess each patient's hearing loss severity accurately. The only treatments available for hearing loss are hearing aids and cochlear implants. The problem is that we can only offer them free tests, but when it comes to treatment, they have to pay for that. Sadly, most cannot afford it, and I believe something should be done with that (Audiologist Cynthia).

b) Accessibility

Accessibility refers to “geographic accessibility, determined by how easily the client can physically reach the provider's location” (McLaughlin and Wyszewianski, 2002, p. 1441). Access to audiologists and hearing specialists is often limited in rural areas. Elderly individuals, particularly in rural regions, often encounter difficulty accessing specialized healthcare services. Though essential screening may be available, comprehensive treatments requiring audiologists may necessitate traveling to distant facilities, creating logistical issues for many.

While we do have those few resources available, getting oGogo (older women) and oMkhulu (older men) to the necessary appointments can be challenging due to the costs of transportation (Nurse Khaya).

I can only go to the clinic, which is not close as well, but at least a van is more affordable than a taxi to Harding or Pietermaritzburg (Mrs Participant 5).

Calvin reported that he took his grandmother to specialists, and they suggested hearing aids as a treatment for her and advised him to take her to the clinic or hospital as often as possible for check-ups. *I try by all means to be consistent in taking her to check-ups, but because of the distance, she is too old to travel with these vans on uneven roads, and the clinic is far, so it is not easy (Calvin).*

Another caregiver reported inconsistency in taking her in-laws for check-ups. *I think it would be easy for me to take them to the clinic if there were audiologists there, but now, because the nurses do not have any specific machines to check the elderly's hearing, I do not see the necessity of making them travel a long distance for nothing (Pearl).*

Pearl's reasoning was based on the lack of resources. She highlighted that it discouraged her from making her in-laws travel a long distance for the treatment they receive at the clinic.

c) Affordability

Affordability poses another critical barrier, as many elderly individuals cannot afford hearing aids and related services due to limited pension and financial support from their families.

No, I do not have hearing aids. Our pension money is insufficient for me to afford them and groceries at once, and I believe they need to be changed like everything else. I do not see our money being enough to cover that (Mr. Participant 11).

Mr. Participant 4 reported that *because we do not get them at the clinic and hospital, I once asked around and found that they are costly and might need to be changed after some time. I would get them if they were a lifetime thing. Another thing is that seeing doctors is not free like in clinics, and we cannot always go to the clinics because they are not as helpful as one would think. They do not have this thing of prioritizing us; we need to queue like everyone else. Maybe we receive such treatment because it is free.*

Economic factors often play an important role in healthcare decision-making, with cost as a primary determinant for some individuals, even influencing whether they seek treatment altogether. In the context of hearing healthcare, expenses encompass both services and assistive technologies. Moreover, these costs are recurrent, as patients may need to sustain, replace, or upgrade devices and services over extended periods to preserve the benefits of auditory rehabilitation and related interventions (Liverman et al., 2016).

Yes, I have hearing aids. My children bought them for me. They took me to this doctor who deals with ears in Maritzburg when everyone in the family complained about the severity of my hearing because I was starting not to respond when people were talking to me. It did not bother me, but my wife insisted we take it seriously, and they agreed. They then took me to Maritzburg, where this doctor checked and checked and then said I should wear the hearing aids; he even wrote down which kind. I do not even

know where they bought them and how much they cost; I can hear almost properly with them on (Mr. Participant 10).

I have them, but Mkhulu does not want them. Although, as we told you, when speaking to him, you have to stand closer, at least he can still hear with one ear. As for me, I have lost hearing in both ears, not completely, because when a sound is too loud, I can hear it, but not people. I asked my children to get them for me because I still want to hear my grandchildren when they visit (Mrs. Participant 20).

Maybe if my husband and his family allowed me to work, I would be able to afford this treatment. He used to work in Johannesburg in the mines, dust killed him, and he left me with nothing in this world. Whatever money I get from the government, I feed my grandchildren and myself and pay masincwabisane (funeral policy) (Mrs. Participant 23).

d) Acceptability

Acceptability reflects the extent to which patients feel comfortable with the healthcare they receive (McLaughlin and Wyszewianski, 2002), which can vary based on demographic factors. Healthcare workers emphasized the importance of tailored approaches to treatment that consider individual needs and circumstances while aiming for equitable care across different genders and age groups.

I have come to accept that my hearing is not what it used to be. This loss of hearing to us aging is just part of getting older for me, and I have learned to read lips and watch their facial expressions. (Mrs. Participant 25)

At this age, and especially with hearing loss, my child and I think more and talk less. What can we say? There is no going back. After all, it is all part of natural aging. It does not bother me because I have taught everyone at home how to communicate with me; even in Ngwaqa, they know. (Mrs. Participant 17)

Our clinic strives to provide equitable treatment for all patients, regardless of their age or gender. Our protocols are based on the severity of hearing loss and patients' specific needs rather than on demographic factors. By that, I mean our approach is to assess each patient individually. Age and gender do not dictate the type of treatment they receive; we focus on the clinical evidence and their personal circumstances (Nurse Ntombi).

The visiting Doctor's response concurred with Nurse Ntombi's, stating that they follow specific guidelines prioritizing factors like hearing loss severity and comorbidities over gender or age. Therefore, while not everyone receives the same treatment, it is based more on clinical judgment than any demographic factor. He further emphasized that they have protocols in place, but sometimes they are adjusted based on the patient's or support systems, which can vary with age and gender.

While we aim for fairness, we do consider gender and other individual factors in treatment decisions. Older female patients may have different needs or responses to treatment, and our goal is to tailor interventions accordingly. Therefore, some gender differences might influence our discussions, particularly around communication styles and support networks, but ultimately, diagnosis and treatment plans are built around individual assessments (Doctor Victor)

I have noticed that sometimes younger patients may receive more aggressive treatments, possibly because of the perception that they have more to gain in terms of life quality. There can be unconscious biases where men might receive different recommendations than women, especially in how hearing loss impacts social interactions differently. We participate in regular training to ensure we are aware of potential biases in treatment. She emphasized that it is important that all patients feel they are receiving the best possible care, irrespective of their gender or age (Nurse Sibusiso).

The study's findings affirm the relevance of the biopsychosocial model and access theory, revealing gaps that must be addressed. While social determinants and gender biases emerged as critical factors, individual characteristics and resilience also significantly shaped treatment-seeking behaviors. Importantly, this study contributes to the theoretical landscape by advocating for a holistic understanding that integrates health's biophysical, emotional, and social dimensions. Additionally, the findings indicate that societal perceptions and roles influence how gender affects the diagnosis and treatment of ARHL. Women often experience healthcare provider scepticism when reporting hearing difficulties, with healthcare providers sometimes underestimating the severity of their condition. This can delay diagnosis and treatment, creating an inequitable healthcare experience (Bess et al., 2020). In contrast, men face unique stigmas associated with masculinity, where seeking help for hearing loss is often perceived as a weakness, and has psychological implications that deter timely treatment seeking.

The theme of social isolation emerges as a significant factor affecting older adults with ARHL, particularly among women who often refrain from social gatherings due to communication barriers. Social isolation is associated with numerous adverse health outcomes, including exacerbated mental health issues (Cuddy et al., 2018). Notably, individuals who reported a willingness to engage socially often experienced improved well-being and enhanced quality of life, echoing findings from previous studies that suggest social engagement mitigates feelings of loneliness (Holt-Lunstad et al., 2010). This suggests that interventions encouraging social participation among this demographic could enhance overall health outcomes.

The barriers to healthcare access identified in this study reflect a broader public health issue, particularly for elderly individuals in rural areas. Transportation challenges, limited availability of specialist services, and financial constraints collectively contribute to the reluctance and inability of elderly individuals, especially women, to seek timely care (O'Rourke et al., 2021). These barriers highlight the critical need for policy interventions addressing spatial and financial access to hearing healthcare

services. Furthermore, applying access theory, precisely the dimensions of availability, accessibility, affordability, and acceptability, provides valuable insights into developing targeted strategies for improving ARHL service delivery. By enhancing accessibility through mobile health services, integrating hearing assessments into routine care, and addressing affordability via community support initiatives, healthcare systems can significantly improve outcomes for both genders.

The findings related to socio-cultural beliefs provide an important lens through which to view ARHL. Cultural perceptions around aging, health, and hearing loss can significantly inhibit patients' willingness to seek help and adhere to treatment (Xie et al., 2020). Both men and women experienced cultural stigma around aging and hearing loss, yet the nature of this stigma differed. For example, some women felt discouraged due to cultural expectations that aging should be accepted quietly, while men were afraid of facing ridicule associated with the loss of masculinity. Understanding these cultural dimensions is essential for healthcare providers to engage effectively with elderly patients, fostering a more inclusive and respectful clinical environment. Tailoring educational outreach and care approaches to acknowledge and respect cultural views may enhance the acceptability of treatments and encourage individuals to seek help sooner.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

This study has explored the complex and multifaceted dimensions of ARHL among the elderly, focusing on gender disparities in healthcare access for treatment in the rural community of Ngwaqa, KwaZulu-Natal. As the findings have illustrated, ARHL is not merely a sensory impairment but a significant factor impacting social interactions, psychological well-being, and overall quality of life for older adults. Given the increasing prevalence of hearing loss in aging populations worldwide, it becomes crucial to understand how social, cultural, and healthcare-related factors intersect to shape individuals' experiences with this condition.

This research has highlighted several key points. Firstly, gender disparities are evident in the prevalence and treatment of ARHL. While both men and women are affected, cultural perceptions and social roles often shape their experiences differently. Women tend to face more barriers in accessing treatment, partly due to societal norms that prioritize the health needs of men and discourage women from voicing their health concerns. Also, the stigma associated with hearing loss often leads to social isolation between both genders, as they may withdraw from social gatherings due to communication difficulties.

This study contributes valuable insights to the literature on aging, health disparities, and gender in the context of ARHL. The intersection of cultural beliefs, social roles, and healthcare access profoundly influences the treatment experiences of older adults facing hearing loss. By emphasizing a holistic, interdisciplinary approach to ARHL, this research advocates for an inclusive healthcare framework that promotes the well-being of all elderly individuals regardless of gender, enabling them to maintain their identities, relationships, and quality of life as they age. Future research should continue to address these disparities by exploring innovative solutions and assessing the effectiveness of interventions to support the aging population in managing ARHL.

6.1 Recommendations

ARHL is increasingly recognized as a significant public health concern due to its prevalence and adverse effects on health outcomes. Despite its impact, ARHL frequently remains undiagnosed and untreated, influenced by factors such as social stigma, financial constraints, and limited access to healthcare. Research indicates that ARHL is a modifiable risk factor for cognitive decline, falls, and social or emotional isolation, underscoring the importance of early detection in preserving speech comprehension, communication efficacy, social participation and involvement, and overall healthy aging. Proactive measures such as assisting the elderly with ARHL navigating public spaces and promoting timely referrals can mitigate this growing public health issue (Weinstein, 2019). Addressing ARHL through early detection, proper management, and social support can improve QoL outcomes for

the elderly. Therefore, continued research and awareness-raising are essential to ensure that intervention strategies are implemented effectively to support the aging population facing hearing loss.

The findings of this study underscore significant implications for healthcare policymakers and practitioners. Gender-sensitive healthcare training is vital to ensuring equitable treatment. Policies should advocate for education, recognizing the different sociocultural and psychological factors influencing treatment-seeking behavior among men and women. Moreover, establishing support groups and community programs designed to de-stigmatize hearing loss and promote social engagement can create a more supportive environment for affected individuals. Additionally, promoting research into gender disparities in ARHL treatment should be a priority, funded by both government and non-governmental organizations. Continued investigation into the specific barriers faced by varied gender cohorts can inform tailored interventions that effectively address the unique experiences of men and women.

6.1.1 Increased awareness campaigns: The need for increased awareness and education regarding hearing health is paramount, as many individuals may not recognize the signs of hearing loss or understand the importance of seeking help. Launch awareness campaigns targeted by gender. (Objective: Raise awareness about ARHL and the importance of timely treatment among both genders. (Action: Develop and implement community outreach programs specifically designed to educate older adults about ARHL, emphasizing that both men and women are at risk and should seek diagnosis and treatment. The target audience should be men and women with tailored messages for each gender to address specific misconceptions.

6.1.2 Enhance accessibility to hearing healthcare services: Improve access to hearing assessments and treatments for the elderly in rural areas. This can be done by establishing mobile clinics that travel to rural areas, providing hearing assessments and follow-up treatments, and reducing the need for travel to centralized healthcare facilities. This can be achieved by collaborating with existing health clinics to integrate hearing assessments into routine check-ups, ensuring they are accessible to the elderly. This will increase the number of elderly individuals receiving hearing assessments and timely treatments and reduce travel barriers, leading to higher treatment rates in rural areas.

6.1.3 Gender-sensitive healthcare training: Train healthcare providers to address gender disparities. Addressing age-related hearing loss is a crucial component of holistic care. It is not just about hearing aids but also about creating an inclusive environment where elderly patients feel respected, heard, and engaged in their care, contributing significantly to their overall well-being. This objective could be achieved by creating a training curriculum that includes gender sensitivity and awareness of ARHL, focusing on how gender can influence perceptions of health and accessibility of services. Training workshops could be organized for healthcare workers focused on

communication styles, cultural competence, and personalized care for elderly patients, addressing their unique concerns. This will help healthcare workers be more equipped to address gender-specific barriers to treatment. Additionally, it will create a more inclusive and understanding healthcare environment, leading to increased patient satisfaction.

6.1.4 Promote research and data collection: Encourage further research on gender disparities related to ARHL. Advocate for funding opportunities from government and non-governmental organizations to support research initiatives focusing on age and gender disparities in hearing health. Partnerships should be formed with universities and research institutions to design studies that analyze prevalence, access to care, and the effectiveness of treatment among different gender groups in rural settings. Disseminate data by sharing collected data with community leaders and stakeholders to inform policy development and community health initiatives. This will produce a comprehensive understanding of the impact of gender on ARHL treatment access.

6.1.5 Policy advocacy: Advocate for policies that address disparities in healthcare access for elderly individuals suffering from ARHL. Coalitions could be built with healthcare advocacy groups, local government officials, and community leaders to push for legislation supporting hearing health initiatives and funding for rural areas.

6.1.6 Support groups and community programs: Establish gender-specific support groups for men and women to share their experiences regarding ARHL, providing a safe environment to discuss challenges and coping strategies. Developing community programs incorporating social activities focused on hearing health would foster interaction and destigmatize hearing loss.

This study contributes valuable insights to the growing body of literature highlighting the persistence of gender and other social inequalities in healthcare. The disparities revealed in this study underscore the urgent need for systematic change. The implementation of the aforementioned recommendations will not only improve the QoL of the elderly but will also foster a healthcare environment that prioritizes the needs of all individuals.

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APPENDIX 1: TURNITIN REPORT

YS FINAL SUBMISSION

ORIGINALITY REPORT

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SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

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APPENDIX 2: UKZN ETHICAL CLEARANCE LETTER

16 May 2024

Yonela Sibiya (219095064)
School of Social Sciences
Howard College Campus

Dear Y Sibiya,

Protocol reference number: HSSREC/00006738/2024

Project title: Exploring gender disparity in the treatment of age-related hearing loss at Umzimkhulu, Ngwaqa in KwaZulu-Natal.

Degree: Masters

Approval Notification – Expedited Application

This letter serves to notify you that your application received on 06 March 2024 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**.

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.

Incidents of adverse events and serious adverse events (AEs and SAEs) should be reported in writing to HSSREC, the study sponsors, and any regulatory authority (where appropriate), within 7 working days of the occurrence for local sites and 14 days for all other South African sites.

This approval is valid until 16 May 2025.

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.

HSSREC is registered with the South African National Health 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 3: GATEKEEPER CONSENT LETTER

169 Main Street
Private Bag 53
Umzimkhulu
3297



Email: info@umzimkhulu.gov.za
Tel: (039) 259 5000/5300
Fax: (039) 259 0427

OFFICE OF THE SPEAKER

PROVINCE OF KWAZULU-NATAL
KZN 408

Date: 23 October 2023

Dear Mrs. Sibiya

RE: PERMISSION TO CONDUCT RESEARCH

Gatekeeper's permission is hereby granted for you to conduct research at uMzimkhulu, under the Harry Gwala District in KwaZulu-Natal, towards your Masters' studies at the University of KwaZulu-Natal provided Ethical clearance has been obtained. We note the title of your research is as follows:

"Exploring gender disparity in the treatment of Age-related hearing loss in Umzimkhulu, KwaZulu-Natal."

I understand that by this permission I am granting you the use and ownership of the data that you will collect from your participants using structured in-depth interviews provided that they voluntarily participate in your study.

I understand that you will write up the results for your degree and disseminate the findings at the University of KwaZulu-Natal. I therefore give permission for you to go ahead and conduct interviews with your participants.

Yours sincerely,


Mr. LM Damoyi

[Ward Councillor]

Cell: 081 470 1105

APPENDIX 4 INFORMATION SHEET AND CONSENT FORM (ENGLISH)



Fieldworker: Yonela Sibiya

Contact details: [REDACTED] 8

Supervisor: Dr. Gerelene Jagganath

Contact details: 031 260 7332

JagganathG@ukzn.ac.za

Dear Participant,

My name is Yonela Sibiya, I am a Masters candidate studying at the University of KwaZulu-Natal, Howard College. The title of my research is: *Exploring gender disparity in receiving treatment for Age-related hearing loss in Umzimkhulu, KwaZulu-Natal. The aim of the study is to explore gender disparity in accessing treatment for ARHL and to understand the lived experiences of adults living with ARHL in uMzimkhulu, KwaZulu-Natal.* I am interested in interviewing you so as to share your experiences and observations on the subject matter.

Please note that:

- The information that you provide will be used for scholarly research only.
- Your participation is entirely voluntary. You have a choice to participate, not to participate or stop participating in the research. You will not be penalized for taking such an action.
- Your views in this interview will be presented anonymously. Neither your name nor identity will be disclosed in any form in the study.
- The interview will take about (how long?).
- The record as well as other items associated with the interview will be held in a password-protected file accessible only to myself and my supervisors. After a period of 5 years, in line with the rules of the university, it will be disposed by shredding and burning.
- If you agree to participate, please sign the declaration attached to this statement (a separate sheet will be provided for signatures).

Additional consent, where applicable

- I hereby provide consent to:

	Agree	Disagree
Audio-record my interview/focus group discussion		
Video-record my interview/ focus group discussion		
Use of my photographs for research purposes		

I can be contacted at: School of Social Sciences, University of KwaZulu-Natal, Howard College Campus, Durban. Email: yonelamjuqu6@gmail.com;

Cell: [REDACTED]; [REDACTED] 13

My supervisor is Dr. Gerelene Jagganath who is located at the School of Social Sciences, Pietermaritzburg Campus / Howard College Campus, Durban of the University of KwaZulu-Natal. Contact details: email [REDACTED]@m Phone number: 0312607332

The Humanities and Social Sciences Research Ethics Committee contact details are as follows: Ms Phumelele Ximba, University of KwaZulu-Natal, Research Office, Email: ximbap@ukzn.ac.za, Phone number +27312603587.

Thank you for your contribution to this research.

DECLARATION

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

I understand that I am at liberty to withdraw from the project at any time, should I so desire. I understand the intention of the research. I hereby agree to participate.

I consent / do not consent to have this interview recorded (if applicable)

Signature of Participant

Date

**Signature of Witness
(Where applicable)**

Date

**Signature of Translator
(Where applicable)**

Date

APPENDIX 5: INFORMATION SHEET AND CONSENT FORM (ISIZULU)



UNIVERSITY OF
KWAZULU-NATAL™
INYUVESI
YAKWAZULU-NATALI

Fieldworker: Yonela Sibiya

Contact details: [REDACTED]

Supervisor: Dr. Gerelene Jagganath

Contact details: 031 260 7332

JagganathG@ukzn.ac.za

Mhlanganyeli othandekayo,

Igama lami ngingu..... Ngingumfundi we-Masters ngifunda eNyuvesi yaKwaZulu-Natal, eHoward College. Isihloko socwaningo lwami sithi: Ukuhlola ukungalingani kobulili ekutholeni ukwelashwa kokulahlekelwa ukuzwa okuhlobene nobudala eMzimkhulu, KwaZulu-Natal. Inhloso yocwaningo ukuhlola ukungalingani kobulili ekutholeni ukwelashwa kwe-ARHL kanye nokuqonda ukuphila kwabantu abadala abahlala ne-ARHL eMzimkhulu, KwaZulu-Natal. Ngingentshisekelo yokuxoxisana nawe ukuze ngabelane ngolwazi lwakho kanye nokuphawulile ngesihloko.

Sicela uqaphele ukuthi:

- Ulwazi olunikezayo luzosetshenziselwa ucwaningo lwezifundo kuphela.
- Ukuhlanganyela kwakho kungokuzithandela. Unokukhetha ukubamba iqhaza, hhayi ukubamba iqhaza noma ukuyeka ukubamba iqhaza ocwaningweni. Ngeke ujeziswe ngokwenza isenzo esinjalo.
- Imibono yakho kule nhlolekhono izokwethulwa ngokungaziwa. Igama lakho noma ubuwena ngeke kudalulwe nganoma iyiphi indlela ocwaningweni.
- Inhlolokhono izothatha cishe (isikhathi esingakanani?).
- Irekhodi kanye nezinye izinto ezihlobene nenhlolokhono zizobanjwa efayeleni elivikelwe ngephasiwedi elifinyeleleka kimina kuphela nabaphathi bami. Ngemuva kweminyaka emi-5, ngokuhambisana nemithetho yenyuvesi, izolahlwa ngokusikwa nokushiswa.
- Uma uvuma ukubamba iqhaza sicela usayine isimemezelo esinamathiselwe kulesi sitatimende (iphepha elihlukile lizonikezwa ukuthi lisayinwe).

Imvume eyengeziwe, lapho kufanele

	Vuma	Angivumi
Rekhoda ngomsindo ingxoxo yami/ingxoxo yeqembu engigxile kuyo		
Rekhoda ngomsindo ingxoxo yami/ingxoxo yeqembu engigxile kuyo Rekhoda ngevidiyo ingxoxo yami/ingxoxo yeqembu		
Ukusebenzisa izithombe zami ngezinjongo zocwaningo		

Ngingathintwa kwa: School of Social Sciences, University of KwaZulu-Natal, Howard College Campus, Durban. I-imeyili: [REDACTED];

Iselula: [REDACTED]; [REDACTED]

Umphathi wami uDkt. Gerelene Jagganath ofunda eSikoleni Sesayensi Yezenhlalakahle, eKhampasi yaseMgungundlovu / Ikhampasi yaseHoward College, eThekwini eNyuvesi yaKwaZulu-Natali. Imininingwane yokuxhumana: i-imeyili [REDACTED]

Inombolo yocingo: 0312607332

Imininingwane yokuxhumana neKomidi leZimilo loCwaningo lweHumanities and Social Sciences imi kanje: UNksz Phumelele Ximba, waseNyuvesi yaKwaZulu-Natal, Ihhovisi Locwaningo, i-imeyili: ximbap@ukzn.ac.za,

Inombolo yocingo +27312603587.

Siyabonga ngegalelo lakho kulolu cwaningo.

ISIMEMO

Mina..... (amagama aphelele ababambe iqhaza) ngalokhu ngiyaqinisekisa ukuthi ngiyakuqonda okuqukethwe kulo mbhalo kanye nohlobo lombhalo. iphrojekthi yocwaningo, futhi ngiyavuma ukubamba iqhaza kuphrojekthi yocwaningo.

Ngiyaqonda ukuthi ngikhululekile ukuhoxa kuphrojekthi noma kunini, uma ngifisa kanjalo. Ngiyayiqonda inhloso yocwaningo. Ngiyavuma ukubamba iqhaza.

Ngiyavuma / angivumi ukuthi le nhlolokhono irekhodwe (uma ikhona)

ISIGOMELO

Mina..... (amagama aphelele ababambe iqhaza) ngalokhu ngiyaqinisekisa ukuthi ngiyakuqonda okuqukethwe kulo mbhalo kanye nohlobo lombhalo. iphrojekthi yocwaningo, futhi ngiyavuma ukubamba iqhaza kuphrojekthi yocwaningo.

Ngiyaqonda ukuthi ngikhululekile ukuhoxa kuphrojekthi noma kunini, uma ngifisa kanjalo. Ngiyayiqonda inhloso yocwaningo. Ngiyavuma ukubamba iqhaza.

Ngiyavuma / angivumi ukuthi le nhlolokhono irekhodwe (uma ikhona)

Isignesha yombambiqhaza

Usuku

**Isignesha ka fakazi
(lapho kudingeka khona)**

Usuku

Isignesha yomhumushi

Usuku (lapho kudingeka khona).

APPENDIX 6 : PARTICIPANT'S DEMOGRAPHIC INFORMATION

RESEARCH PARTICIPANT'S DEMOGRAPHIC INFORMATION FORM

PARTICIPANT CATEGORY:

DATE:

A. FOR ELDERLY PARTICIPANTS

Surname:		First Name		Title:
Age.:		Gender:		
Marital status:		Ethnicity:		
Living Condition:		Transportation:		
Contact No:		Email Address:		
Marital Status	Single	Married	Divorced	Widowed
Affected ear: Left/right/both				
Source of income:				

B. FOR CAREGIVERS/FAMILY MEMBERS

Surname:		First Name		Title:
Age.:		Gender:		
Marital status:		Ethnicity:		
Qualification:		Occupation:		
Contact No:		Email Address:		
Relation to the elderly	Child	Grandchild	Relative	Caregiver

C. FOR HEALTHCARE WORKERS:

Surname:		First Name		Title:
Age.:		Gender:		

Qualification:		Occupation:		
Experience (Years):		Position:		
Contact No:		Email Address:		
Marital Status	Single	Married	Divorced	Widowed

APPENDIX 7: INTERVIEW QUESTIONS (ENGLISH)



Fieldworker: Yonela Sibiya

Contact details: [REDACTED]

Supervisor: Dr. Gerelene Jagganath

Contact details: 031 260 7332

JagganathG@ukzn.ac.za

EXPLORING GENDER DISPARITY IN THE TREATMENT OF AGE-RELATED HEARING LOSS AT UMZIMKHULU, NGWAQA IN KWAZULU-NATAL. (45 minutes – 1 Hour)

Interview Questions (ARHL Patients)

1. When and how did you first notice that your hearing was degenerating?
2. When did you seek a diagnosis and treatment? And what was your experience at the clinic or hospital?
3. Do you have hearing aids? (If yes, how, and why? If no, why not?)
4. What is your understanding and perception about ARHL and how do socio-cultural beliefs and attitudes impact your understanding and perception?
5. Can you briefly describe your personal experiences with hearing loss?
6. How do you think gender differences in access to healthcare, social norms, and attitudes towards hearing loss affected your likelihood of seeking and receiving treatment?
7. Apart from gender, what other social disparities do you believe limit your access in receiving treatment for your hearing loss?
8. How do family members in your household show support and understanding towards you? What specific behaviors do you observe?
9. How has ARHL impacted your overall sense of well-being and quality of life?
10. Can you share any coping strategies or techniques you have developed to manage the psychological impacts of ARHL? How effective have they been in improving your well-being?

Interview Questions (Healthcare workers)

1. Can you explain your understanding of age-related hearing loss and its impact on individuals' quality of life?
2. In your experience, have you observed any noticeable differences in the way age-related hearing loss is diagnosed or treated between men and women?
3. Do you believe that gender-related attitudes toward hearing loss are linked to the likelihood of treatment? Why or why not?
4. What do you think contributes to the gender disparity in receiving treatment for ARHL?
5. In your opinion, how does the level of support and understanding from family and friends affect an elderly person's acceptance and management of their hearing loss?
6. In what ways do you think age-related hearing loss can affect one's emotional state and mental health?
7. In your opinion, what are the main social disparities that contribute to limited access of ARHL treatment in rural areas?
8. Are there any cultural or language barriers that affect the accessibility of ARHL treatment in rural communities?
9. In this clinic, do all ARHL patients receive the same treatment regardless of the severity of the condition? If not, how do you decide who gets a hearing aid and who does not?
10. Are there any specific strategies or interventions that you believe could be implemented to address these disparities in receiving treatment?

Interview Questions (Family members/Caregivers):

1. Can you describe any changes you have noticed in the elderly's hearing abilities over time?
2. How has ARHL impacted your elderly's daily life and communication with family members?
3. What steps have you taken to help your elderly to manage their hearing loss, such as using hearing aids or modifying their environment?
4. How has ARHL affected your elderly's social life and relationships with friends and family members?
5. Have you noticed any emotional or psychological effects of hearing loss on your elderly, such as frustration or feelings of isolation?
6. How do you communicate with your elderly in a way that accommodates their hearing loss?
7. Have you experienced any challenges or difficulties in supporting your elderly with Presbycusis?
8. In what ways do you think healthcare providers could better support individuals with Presbycusis and their families?

9. Can you tell me about your experiences in seeking treatment for ARHL for your elderly family member?
10. How do you think attitudes towards hearing loss in older adults could be improved in society?

APPENDIX 8: INTERVIEW QUESTIONS (ISIZULU)



Fieldworker: Yonela Sibiya

Contact details: [REDACTED]

Supervisor: Dr. Gerelene Jagganath

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ISIHLOKO SOCWANINGO: UKUHLOLA UKUNGAHLUKANA KOBULILI EKWELASHWENI OKULAHLEKELWA UKUZWA OKUDALA EMZIMKHULU, NGWAQA KWAZULU-NATAL.

Imibuzo Yengxoxo (Iziguli ze-ARHL)

1. Waqala nini futhi kanjani ukuthi ukuzwa kwakho kuyehla?
2. Ufune nini ukuxilongwa nokwelashwa? Futhi kwaba yini isipiliyoni sakho emtholampilo noma esibhedlela?
3. Ingabe unazo izinsiza-kuzwa? (Uma kunjalo, kanjani, futhi ngani? Uma cha, kungani kungenjalo?)
4. Kuyini ukuqonda kwakho kanye nombono wakho nge-ARHL futhi izinkolelo zezehlalo namasiko nezimo zengqondo zikuthinta kanjani ukuqonda kanye nombono wakho?
5. Ungakwazi yini ukuchaza kafushane okuhlangenwe nakho kwakho siqu ngokulahlekelwa ukuzwa?
6. Ucabanga ukuthi umehluko wobulili ekufinyeleleni ekunakekelweni kwezempilo, ezinkambisweni zomphakathi, kanye nesimo sengqondo mayelana nokulahlekelwa ukuzwa kuwathinta kanjani amathuba akho okufuna nokuthola ukwelashwa?
7. Ngaphandle kobulili, yikuphi okunye ukuhlukana kwezehlalo okholelwa ukuthi kukhawulela ukufinyelela kwakho ekutholeni ukwelashwa ngenxa yokungezwa kwakho?
8. Amalungu omndeni wakho akhombisa kanjani ukukweseka nokukuqonda? Ikuphi ukuziphatha okuqondile okubonayo?
9. Ngabe i-ARHL ibe nomthelela onjani umuzwa wakho wenhlalakahle kanye nezinga lempilo?

10. Ungakwazi ukwabelana nanoma yimaphi amasu okubhekana nesimo osuwenzile ukuze ulawule imithelela yezengqondo ye-ARHL? Basebenze ngempumelelo kangakanani ekuthuthukiseni inhlalakahle yakho?

Imibuzo Yengxoxo (Abasenzi bezempilo)

1. Ungakwazi yini ukuchaza ukuqonda kwakho ukulahlekelwa kwezindlebe okuhlobene neminyaka kanye nomthelela wako eqophelweni lempilo yomuntu ngamunye?
2. Kokuhlangenwe nakho kwakho, ingabe uwubonile umehluko obonakalayo endleleni ukungezwa okuhlobene neminyaka okutholakala ngayo noma ukuphathwa ngayo phakathi kwabesilisa nabesifazane?
3. Ingabe ukholelwa ukuthi izimo zengqondo ezihlobene nobulili ngokulahlekelwa izindlebe zihlobene namathuba okwelashwa? Kungani noma kungani kungenjalo?
4. Ucabanga ukuthi yini enomthelela ekungalinganini kobulili ekutholeni ukwelashwa kwe-ARHL?
5. Ngokubona kwakho, izinga lokwesekwa nokuqonda okuvela emndenini nakubangane likuthinta kanjani ukwamukela nokuphatha komuntu osekhulile ukungezwa kwakhe?
6. Yiziphi izindlela ocabanga ukuthi ukulahlekelwa ukuzwa okuhlobene neminyaka kungathinta isimo somuntu somzwelo nempilo yengqondo?
7. Ngokubona kwakho, yikuphi ukuhlukana okukhulu kwezenhlalo okunomthelela ekufinyeleleni okulinganiselwe kokwelashwa kwe-ARHL ezindaweni zasemakhaya?
8. Ingabe zikhona izithiyo zamasiko noma zolimi ezithinta ukufinyeleleka kokwelashwa kwe-ARHL emiphakathini yasemaphandleni?
9. Kulo mtholampilo, ingabe zonke iziguli ze-ARHL zithola ukwelashwa okufanayo kungakhathaliseki ukuthi isimo sinzima kangakanani? Uma kungenjalo, unquma kanjani ukuthi ubani ozothola insiza yokuzwa futhi ubani ongayithola?
10. Ingabe akhona amasu athile noma ukungenelela okholelwa ukuthi kungasetshenziswa ukubhekana nalokhu kuhlukana ekutholeni ukwelashwa?

Imibuzo yengxoxo (Amalungu omndeni kanye nabanakekeli)

1. Ungakwazi yini ukuchaza noma yiziphi izinguquko ozibonile emandleni okuzwa asebekhulile ngokuhamba kwesikhathi?
2. Ngabe i-ARHL ibe nomthelela kanjani empilweni yansuku zonke yabantu abadala kanye nokuxhumana namalungu omndeni?
3. Yiziphi izinyathelo ozithathile ukuze usize asebekhulile ukuba balawule ukungezwa kwabo, njengokusebenzisa izinsiza-kuzwa noma ukulungisa indawo abahlala kuyo?
4. I-ARHL iyithinte kanjani impilo yomphakathi yabantu abadala kanye nobudlelwano nabangane namalungu omndeni?
5. Ingabe uke wayiqaphela imiphumela engokomzwelo noma engokwengqondo yokungezwa kubantu abadala, njengokukhungatheka noma imizwa yokuhlukaniswa?
6. Ukhuluma kanjani nabantu asebekhulile ngendlela evumelana nokungezwa kwabo?
7. Ingabe uke wahlangabezana nanoma yiziphi izinselele noma ubunzima ekusekeleni abantu abadala nge-Presbycusis?
8. Yiziphi izindlela ocabanga ukuthi abahlinzeki bezempilo bangabasekela kangcono abantu abane-Presbycusis kanye nemindeni yabo?
9. Ungangitshela mayelana nolwazi lwakho lokufunela ilunga lomndeni wakho osekhulile ukwelashwa kwe-ARHL?
10. Ucabanga ukuthi izimo zengqondo mayelana nokungezwa kubantu abadala zingathuthukiswa kanjani emphakathini?