THE EXPERIENCES OF OLDER PERSONS LIVING WITH CHRONIC DISEASES IN GA-DIKGALE, LIMPOPO PROVINCE

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Declaration

I, declare that **THE EXPERIENCES OF OLDER PERSONS LIVING WITH CHRONIC DISEASES, GA-DIKGALE, LIMPOPO PROVINCE** is my own work and that all the sources that I have used, or quoted have been indicated and acknowledged by means of complete references and that it had not been previously submitted by me for a degree at this or any other University.

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Sedrose Ndivhuwo Tshishonga Date

[redacted]

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Abstract

The deterioration of health associated with chronic diseases such as hypertension and diabetes mellitus often leads to psychological problems especially among ageing older persons. The aim of the present study was to explore the lived experiences of older persons living with chronic diseases in Ga-Dikgale community in the Limpopo Province. Specifically, the study sought to determine the subjective meanings that older persons living with chronic diseases attach to their conditions; to establish older persons' causal explanations of their chronic diseases; and, to determine the psychological strategies that older persons use to manage their conditions.

A qualitative approach, and in particular, the phenomenological method was used in the present study. Ten older persons living with the experiences of chronic diseases (male = 3: female = 7), aged between 60 and 90 were selected through purposive sampling and requested to participate in the study. Data were collected using semistructured interviews and analyzed using the Interpretive Phenomenological Analysis (IPA) method. The themes that emerged from the study included the following: a). The subjective explanations by older persons living with a chronic disease; b). Manifestations of chronic diseases; c). The psychological coping strategies used by older persons; d) The management of chronic diseases. The findings of the present study further suggest that the participants understand their illnesses as chronic conditions that require long-term management. A number of psychological strategies are utilised by the participants to cope with their chronic conditions. These include passive/active coping and cognitive reappraisal coping strategies. With regard to the management of chronic conditions, most participants were of the view that medical treatment received from the clinic is appropriate for the treatment of their conditions. Some of the participants were however of the view that the nurses did not give them enough information about their chronic condition. The study is concluded by making a number of recommendations that among others include calling for more studies that should be conducted on the impact of chronic diseases on the family structure.

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CHAPTER 1

INTRODUCTION

1.1 Background to the study

According to the World Health Organization (2008), about 69% to 70% of deaths in the African continent alone in 2006 were attributable to chronic diseases. Complicating this picture was the fact that African countries, including South Africa, have a shortage of health care resources to cope with the increase of infectious and chronic diseases (Aikins, Unwin, Agyemong, Allotey, Cambell & Arhinful, 2010). Underdeveloped health care systems, poor governance and inadequate financing are some of the factors that led to this increase in deaths related to chronic conditions (Aikins, Arhinful, Pitchforth, Ogedegbe, Allotey & Agyemang, 2012). The World Health Organization (2006) has suggested that chronic diseases such as chronic inflammatory pulmonary disorders (related to cardiovascular diseases and musculoskeletal diseases) are the third largest leading cause of death that imposed a greater burden on the health care systems of countries globally. The common risk factors are air pollution, aging, respiratory, infections, bronchial asthma (BA), low socio-economic status and smoking (Mirrakhimov, 2012).

According to Aikins et al*.,* (2010), Africa's chronic disease burden is attributed to multifaceted factors including increased life expectancy, changing lifestyle practices, poverty, urbanisation and globalisation. A study by Steyn, Fouri and Temple (2005) has suggested that the majority of the South African population had moved extensively along the epidemiology transition towards disease profiles that are more related to western lifestyles. However, the diseases of poverty, which are related to infectious and maternal disease, still contribute significantly to the overall burden of chronic diseases in South Africa (Steyn, Fouri & Temple, 2005). This epidemiological transition is motivated by people adopting, or being forced into unhealthy lifestyles, which relate to tobacco use, unhealthy nutrition, and lack of regular aerobic physical activity.

Globally there is an awareness of the increasing burden of long term conditions as the population ages (World Health Organization, 2006). The aging population is a worldwide phenomenon, and with this are increasing social, cultural, biological economic and political concerns about the health and care needs of individuals in later life (Lowe & Macbride-Henry, 2012). Studies have suggested that older adults can expect to live with at least one chronic illness during the later part of their lives (Penrod, Gueldner & Poon, 2003; Lowe & Macbride-Henry, 2012). Based on these findings, it is therefore important to explore the experiences of older persons who live with chronic diseases.

1.2 Research problem

The deterioration of health associated with chronic diseases often leads to psychological problems among ageing older persons (Kagee, 2010). Chronic diseases create additional stress that requires older persons to develop new ways of coping (Morris, Moore & Morris, 2011). For example, a study by Wikman, Wardle and Steptoe (2011) found that being diagnosed with a chronic disease leads to distressing experiences that impact the individual's affective well-being. Another study by the National Institute for Health and Clinical Excellence (2011) found that people diagnosed with chronic hypertension tend to have increasing high hypertension levels which is a major causative factor in conditions like stroke, chronic kidney disease, cognitive decline and premature death. Studies by Kagee (2010) and Kagee and Martin (2010) also found that older persons who live with chronic diseases and chronic hypertension are expected to adjust to the diagnosed condition and adhere to the treatment that also included psychological care.

Whilst there are studies that point to a number of psychological factors that were associated with chronic diseases, there are few studies that have been done to explore the experiences of individuals in rural South African communities who are living with chronic diseases (Mokaila, 2008). In view of the paucity of studies in this regard, the present study sought to investigate the experiences of older persons living with chronic disease in a rural community context in Limpopo Province.

1.3 Purpose of the study

1.3.1 Aim of the study

The aim of the present study was to explore the lived experiences of older persons with chronic diseases in Ga-Dikgale community, Limpopo Province.

1.3.2 Objectives of the study

The present study sought to address the following objectives:

- To determine the subjective meanings that older persons living with chronic diseases attach to their condition;
- To establish the causal explanations that older persons living with chronic diseases attribute to their condition; and to;
- To determine the psychological strategies that older persons living with chronic diseases use to manage their conditions.

1.4 Operational definition of concepts

- **Experiences:** This is any event through which one has lived. It also refers to personal and subjective phenomena experienced by an individual (Reber, Allen & Reber, 2009). In the context of the present study, experiences will refer to the events that older persons have lived through.
- **Older persons:** According to the Older Persons Act Number 13, of 2006, an older person is a person who is 65 years or above for males (and 60 years and above for females) (Department of Justice, 2006). For the purpose of the present study, older persons will be understood to be individuals (both male and female) who are over the age of 60 years and are living with one or more chronic diseases.
- **Chronic disease:** Chronic diseases will be understood to mean conditions that lasts a longer period of time (at least 3 months) and maybe accompanied by residual functional impairment that necessitate long term management. Chronic diseases include arthritis, diabetes mellitus, blood pressure, HIV-AIDS, cancer, kidney disease and chronic pain (Cavanaugh, & Blanchard-Fields, 2015). In the present study, the concept chronic disease will carry the meaning as above.

1.5 Outline of the dissertation

Chapter one provides the background to the study including an outline of the research problem. The aim and objectives of the study, including the operational definition of concepts were also presented. In chapter 2, relevant literature on the subject of chronic diseases, particularly in relation to the ageing population is reviewed. Two theoretical perspectives pertaining to how individuals perceive and deal with chronic diseases are presented. This is followed by a presentation of an Afrocentric perspective as a lens through which the lived experiences of older persons living with chronic diseases can be understood. The methodology that was used in the current study is presented in chapter three. Topics such as the research design, sampling, data collection and the analysis of data are also addressed here. The quality criteria that guided the investigation, including the ethical issues that were used in conducting the study are highlighted. Chapter four presents the findings of the study. In chapter five the findings of the study are discussed in the context of existing literature, whilst chapter six provides the conclusion, limitations and recommendations for future research.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter starts by focusing on chronic disease and the older person. This is followed by a presentation of the coping strategies that are often mobilised to cope with the debilitating chronic conditions. The impact of chronic diseases on the health-related quality of life is presented in the next section. Two theoretical perspectives pertaining to how individuals perceive and deal with chronic diseases are presented. This is followed by a presentation of an Afrocentric perspective as a theoretical framework through which the lived experiences of older persons living with chronic diseases was interrogated.

2.2 Chronic diseases and the older person

The World Health Organization (2008) states that diabetes mellitus and high hypertension are major public health problems that are estimated to cause a million premature deaths globally every year. In South Africa, population-based studies have also reported higher hypertension among urbanised black elderly African females compared to other race groups (Mkhonto, Labadarios & Mabaso, 2012). The prevalence of hypertension is also increasing among elderly individuals in rural areas (Mkhonto, Labadarios & Mabaso, 2012).

Older persons are faced with the risk challenges that occur with functional impairment and chronic illness. This occurs when a person grows older, or when the illness that comes with old age advances (Moe, Hellzen & Enmarker, 2013). Amongst the general population of older persons, impaired physical function and morbidity are strong predictors of hospitalization, disability, institutionalization and death (Painter & Marcus, 2013). Chronic conditions are associated with the predicament of continued long term periods of illness and sadness in an individual. These responses are associated with fatalities, fatigue, maladaptive behaviours and disability of an individual living with a chronic condition. There are also psychological symptoms found in an older person with a chronic illness which may include loss of relationships, loss of autonomous life, loss of roles, loss of activities, loss of identity, loss of life imagined and loss of uplifting emotions (Weingarten, 2012).

According to Cooper, Harding, Mullen and O' Donnell (2011), management of chronic conditions such as hypertension requires earlier diagnosis. This is even more important in the case of African older persons, more especially in rural African societies, who may be less aware of their illness conditions. The older person's knowledge in most major parts of African societies are considered to be poor with their health beliefs deeply rooted in the prevailing sociocultural knowledge systems in their communities (Aikins, Boynton & Antaga, 2010).

2.3 Coping with a chronic disease

Older persons learn to live with chronic illnesses by managing them through psychological strategies that include 'problem focused coping' and 'emotion focused coping (Folkman, Lazurus, Schetter, Christine & Gruen, 2012). Problem focused coping involves attempts to tackle problems head on by taking medication to treat the chronic illness an older person is diagnosed with. Emotion focused coping involves dealing with one's feelings about the chronic illness by allowing the older person to express anger or frustration towards the long term illness (Cavanaugh & Blanchard-Fields, 2015).

The psychological strategies used to cope with chronic diseases include the affective aspects of well-being in an older person. These may be assessed by clinicians through a number of measures which — among others — include scales of perceptions of control, autonomy, self-realization and pleasure aspects of quality of life (Weingarten, 2012). Older persons with chronic diseases often live with chronic disappointment. According to Weingarten (2012), such psychological consequences of living with a chronic condition may be ameliorated through a number of activities that include social participation. For example, an older person living with a chronic disease may be encouraged to have more significant relationships with spouses and family members or multiple health care professionals.

One of the primary goals for older persons living with chronic illnesses is to have a high quality of life. Quality of life is a multidimensional concept encompassing biological, psychological and sociocultural domains in the life cycle that an older person living with chronic diseases experience. Quality of life amongst older persons living with chronic illnesses is a subjective judgment understood in the context of adult development and aging. Health related quality of life includes both physical and mental health (Cavanaugh & Blanchard-Fields, 2015). In the context of the present study, quality of life will focus on chronic disease amongst older persons.

Fatigue is an overwhelming and distressing experiences that constraints capacity for physical function and social participation. Fatigue is a key component of frailty syndrome that is related to an increased aging process. Pain in chronic illnesses is disruptive, saps energy, negatively affects quality of life and can lead to over intensifying cycle of pain, anxiety and anguish (Egerton, 2013). The frailty syndrome is described as a constellation of characteristic representations, including loss of muscle mass, weakness, weight loss, low exercise tolerance or energy and low activity. Physical therapists play an important role in rehabilitation following many chronic diseases and the promotion of increased physical activity in the population of older persons who are disabled. These physical therapists are found in primary health care facilities in rural areas and in hospitals (Egerton, 2013).

2.4 Impact of chronic disease on health-related quality of life

The World Health Organization defines quality of life as an individual's perception of their position in life in the context of culture and value systems in which they live and in relation to their goals, standards and expectation (Baernholdt, Hinton, Yan Rose & Mattos, 2012). The goals for effective management for older persons with chronic diseases (chronic pulmonary disease) include symptom relief, prevention of disease progression, exercise, tolerance and health status improvement (Yong Kil, Oakoh, Jin Koo & Hyun Suk, 2010). The quality of life is defined as an older person's life that is a holistic determined evaluation of satisfaction with issues important to the person. Significant impairment on health related quality of life involves limitation in activities of daily living; social functioning and recreational activities that makes a patient withdraw from daily living. Pathophysiological problems of patients with chronic diseases must also strive to cope with physiological changes and problems

such as depression and anxiety. These abnormalities have been characterized as having a higher prevalence of depression than normal individuals (Yong et al., 2010).

Older persons hospitalized with conditions like diabetes mellitus are likely to have comorbid conditions contributing to sub-optimal health related quality of life. Health related quality of life is a general self-related concept regarding one's own mental, physical and social functioning that represent major outcome of diabetes mellitus management interventions. Psychosocial factors have been cited as barriers that achieve quality of life through personal illness perceptions (Koliopaulos, Bleich, Rapp, Wang, Hoffman & Raghuwanshi, 2012). According to self-regulation theory, illness perceptions include the beliefs about the causes, timeline, identity (symptoms and understanding), controllability and consequences of a schematic view of one's illness (Bameister & Vohs 2007). Collectively these schematic view results in illness perception that is either threatening or nonthreatening which is associated with risks for developing diabetes mellitus-related complications such as amputations, wellbeing and health related quality of life.

2.5 Theoretical perspectives

A number of theories have been advanced to explain how individuals perceive and deal with chronic diseases. What follows below is a presentation of two popular theories (namely: theory of learned helplessness; and theory of person environment interactions) on how people relate to chronic conditions, including the theoretical framework that will be used to guide the present study.

2.5.1 Theory of learned helplessness: Learned helplessness is a theory that was developed by Martin Seligman in 1965 (Seligman, 2006). According to Barlow and Durand (2009), learned helplessness occurs when humans encounter situations such as stress in their lives, of which they have no control. People can function well if they learn to cope with these stressful events by doing something to avoid them. When human beings learn that their behaviour has no effect on the environment they may become helpless.

The theory further maintains that people become depressed if they cognitively decide or think that they can do little about that specific stressful event (Barlow & Durand, 2009). Therefore, people make attributions that they have no control over their stressful situations, and this leads to their depression. The learned helplessness theory of depression shows that depression may follow the state of hopelessness when there is a need to cope with difficult life events. The attribution that bad things will always be my fault remains within an individual (Barlow & Durand, 2009). This is when individuals attribute negative things in life to internal, stable and global factors. Essentially, it means the person feels as if change is not possible since there is a pervasive and unchangeable personal problem. It has a universalizing effect in that the attributions traverse a variety of issues within the individual. Helplessness is apathy in doing anything to avoid punishment, and this can lead to general passivity, withdrawal, fear, depression and accepting whatever happens (Derhami, 2013).

The theory of learned helplessness relates to this study through the subjective experiences (which are a positive and negative impacts) of living with chronic diseases such as high hypertension levels and diabetes mellitus. These subjective experiences are observed in exhibited behaviour of each particular individual in terms of coping with the chronic disease. This is shown in the themes of chronic disease as a result of neglect and manifestations of chronic diseases. This theory is related to this particular study by focusing on behavioural reactions that older persons living with hypertension and diabetes mellitus show through the impacted lifestyle of the chronic diseases. The behavioural reactions in older persons living with chronic diseases are the results effects of cognitive reactions which occur through psychological manifestations, such as learned helplessness.

2.5.2 Theory of person-environment interactions: This theory posits that behaviour is a function of both the person and the environment. The relationship characterized by person-environment interactions is described by competence, environmental press, and congruence. Competence is the theoretical upper limit of an older person's capacity to function (Brent-Trofle, 2009). It involves domains such as biological, health, sensory perceptual functioning, motor skills, cognitive skills and ego strength. These domains are thought to underlie all other abilities and they are life-long. Environmental press is defined when environments are classified on the

basis of the varying demands they place on a person. Environmental press involves demands such as interpersonal, physical and social demands (Cavanaugh & Blanchard-Fields, 2015).

According to Lawton and Nahemow (1973), behaviour is a result of the person of a particular competence level acting in an environment of a specific press level. Therefore behaviour is placed on a continuum from positive to negative, and is thought to be manifested on behaviour and affect levels (Sirriyeh, Lawton, Gardner & Armitage, 2010). Adaptive behaviour and positive affect result from many different combinations of competence and press levels. When change occurs in a press level behaviour becomes more negative. The limits on individual freedom can result from age related declines in competence. Lazarus' theory of stress, appraisal and coping (Lazarus & Folkman, 1984), states that older persons evaluate situations to assess their potential threat value. When older persons realise they have a chronic disease, they establish a range of coping responses that they have learnt to live with the chronic illness. The outcomes of coping responses are positive or negative depending on many contextual factors (Cavanaugh & Blanchard-Fields, 2015).

This theory is related to the study by observing emotional reactions of older persons living with chronic diseases through interaction within their environment with their significant others. This was observed in the study when older persons interact with other people in their community as adaptive coping strategies that resulted with good effects of their wellbeing.

2.5.3 Theoretical framework: The Afrocentric perspective

In the present study, the researcher used Afrocentric perspective as a lens through which the lived experiences of older persons living with chronic diseases would be understood. The Afrocentric perspective, propagated by scholars like Asante (1995) and Mazama (2003), seeks to deal with the questions of identity and experience from the perspective of African people as centred, located, oriented, and grounded. According to Asante (1995), the many years of colonialisation have decentred and dislocated Africans in many social spheres. According to Mkabela (2005), to say that Africans are decentred means essentially that they have lost their cultural footing and have become disoriented.

Afrocentricity as a paradigm and a method of research is intended to serve as a liberating intellectual movement that allows for multiple perspectives in research. As a research methodology, it operates within African ways of knowing and existence and results in the implementation of principles, methods, concepts, and ideas that are derived from the African people's cultural experiences (Mazama, 2003). The researcher in the present study considered Afrocentricity to be the most suitable framework since the aim of the study is to gain insight into the experiences of a group of African older persons living with chronic diseases.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the research methodology employed in this study. It describes the research design as well as the setting where the study was conducted. Issues such as sampling, data collection instruments and the methods followed in data analysis are presented and motivated. The chapter also highlights the ethical issues that guided the research.

3.2 Research design

In this study, the qualitative research method was considered and, in particular, the phenomenological research design was used. According to Terreblanche, Durrheim and Painter (2006), qualitative studies seek to understand subjectivity through the personal and social realities of the participants, empathically. Specifically, the researcher sought to understand and describe the lived experiences of older persons living with chronic diseases in a rural community. Phenomenology grants the researcher access to the world of the individual participant's experiences, thereby observing participant's behaviour in real life situations. The data obtained from the phenomenological research process are subjectively emphasized in a narrative form and analysed by the researcher following the experienced conversations that occurred between the researcher and the participants.

Description is the most commonly used word in phenomenological research. The aim of the researcher was to describe the researched phenomenon in the most accurate manner as possible. Therefore, the researcher had to refrain from any pregiven framework, yet still remain to the true aspects of the facts. The critical qualitative aspects of research are the subjective meanings and perceptions of the participants, and it was the responsibility of the researcher to access these. This study aimed to explore the experiences of older persons living with chronic diseases in Ga-Dikgale, of which the researcher saw that it would be appropriate to use a qualitative research method, specifically the phenomenological process (Groenewald, 2004).

3.3 Background and setting

3.3.1 Background

This study formed part of a bigger research project that was undertaken by Dr J Makhubele and Prof T Sodi under the auspices of the University of Limpopo (UL) and Vlaamse Interuniversitaire Raad – Institutional University Cooperation (VLIRIUC) Partnership Programme. The programme was a multidisciplinary comprehensive package that supported and integrated five project clusters whose overarching theme was: “Human wellness in the context of global change – finding solutions for rural Africa”. The bigger research project by Dr Makhubele and Prof Sodi entitled “The impact of lifestyle behaviours on chronic diseases: The case of

Ga-Dikgale Communities”), is located in Cluster 2. The aim of this research project (also known as Project 2) was to explore and describe various lifestyle behaviours and chronic diseases in Ga-Dikgale community (Limpopo Province). The study population would thus be limited to older persons drawn from Ga-Dikgale in the Polokwane Local Municipality (Capricorn District, Limpopo Province).

3.3.2 The setting: Ga-Dikgale

Ga-Dikgale is a rural community located within the Polokwane Local Municipality in the Limpopo Province. This small rural community is located in the north eastern side of the University of Limpopo, which is about 45 kilometres away from the University of Limpopo (Figure 1). According to the recent census data collected in Ga-Dikgale, it has been estimated that there is an approximate population of 36,000 people living in Ga-Dikgale (Statistics South Africa, 2012). There is low rate socioeconomic status, unemployment and education amongst older person and the young people living in the area (Statistics SA, 2012).

Figure1. Map of Ga-Dikgale, Limpopo Province (Kanjal, Alberts, Byass & Burger, 2010).

3.4 Sampling

Purposive sampling was used to select the participants for this study. As Babbie and Mouton (2012) suggest, only cases that have some features that are of interest for a particular study are identified and selected to take part in this study. Similarly, the researcher in the present study opted to select only the older persons who were living with chronic diseases in the Ga-Dikgale community. The participants were all drawn from the existing database of the UL-VLIR partnership research programme. Patton (2002) asserts that there are no rules for the size of the sample in qualitative inquiry. The sample size depended on what the researcher wanted to know: the purpose of the inquiry, what was at stake, what was useful, what had credibility and what needed to be done with the available time and resources. Although, the aim was to select ten (10) older individuals living with chronic diseases, sampling did however continue until data saturation occurred. This meant that additional analysis of the data brought redundancy and revealed no new information (Patton, 2002).

The inclusion criterion for the participants in this study was any older person in Ga-Dikgale community who is suffering from high hypertension levels and diabetes mellitus. The researcher had defined a chronic disease to be the type of disease which is not curable, but treatment of which may reduce some symptoms of the disease and prevent mortality amongst the population of older persons in Ga-Dikgale.

3.5 Data collection

The researcher used semi-structured interviews in order to collect data from the participants (**Appendix 1a: Interview guide – English version**; and **Appendix 1b: Sepedi version**). During the interview process the researcher, after seeking permission from each participant, used an audiotape to record all data. In order for the researcher to validate the data through trustworthiness and credibility of the research process, a triangulation method was used, by taking field notes.

Hermansen, and Miller (2008), have pointed out that semi-structured interviews allow the participants to speak about their subjective experiences in their own perceived meaning, at the same time this still maintained the structure to the interview. Data was collected within the homes and houses of the participants. Before data was collected, each participant was asked to give consent to participate. During the interview process there were new questions asked by the researcher which came about as a result of the answers that were given by the participants. These questions emerged during the interviews and were directed at the subjective experiences, feelings and beliefs of the participants. The language used during the interview sessions was Sepedi, which is the language commonly spoken in Ga-Dikgale community. The interviews were all recorded on an audiotape. The interviews were later transcribed and translated by a language expert into an English version, while still ensuring the accuracy of data.

3.6 Data analysis

Interpretive Phenomenological Analysis (IPA) was used as a method to analyse the data. According to Smith and Osborne (2007), IPA helps the researcher to learn more about something that concerns the psychological world (social and personal experiences) of the participants. This occurs either in the form of beliefs and constructs that are suggested by the participants during the interview sessions or when the researcher analyses the information by merely focusing on the identity of a certain participant. The aim in IPA is for the researcher to try and understand the content and complexity of those meanings. Through the use of IPA, the researcher was able to identify the essential features and relationships that existed in the themes that emerged from the data (Coffey & Atkinson, 1999).

The researcher followed the five steps of IPA as elucidated by Reynolds and Kamphaus (2003) to analyse the data. These consisted of the following:

- **Step 1 - Familiarization and immersion:** After data was collected, the researcher immersed herself in the data which was in the form of field notes and transcripts in order to develop an understanding of the phenomenon that was under investigation in this study.
- **Step 2 - Inducing themes:** When going through the transcripts and field notes, the researcher was able to develop general rules and to also generate themes.
- **Step 3 - Coding:** During this step, the researcher marked the different sections of the data that were relevant to the themes by labeling sentences or paragraphs through identification by virtue of their contained materials that pertained to the themes that the researcher considered.
- **Step 4 - Elaboration:** The researcher differentiated extracts grouped together under a single theme and other sub-issues that came to the fore during the analysis process. In other words, elaboration implied the researcher had to explore the themes more closely in order to capture the meaning not captured by original coding.
- **Step 5 - Interpretation and checking:** During this step, the researcher had to put together the interpretations that were written of the phenomenon being studied using thematic categories from analysis as subheadings. The researcher had to use a “fine-tooth comb” to try and fix weak points such as contradictions, over-interpretations and prejudices. Apart from these considerations, the researcher in the present study used this step as an opportunity to do reflections on her own in data collection (Terreblanche et al., 2006).
- **Step 6- Writing up:** During this step, the researcher had to write up the final statements and outline the meanings which were inherent to the subjective experiences of the participants. In this step the researcher had to translate the themes into a narrative account where themes were explained, described and nuanced. The table of themes was used by the researcher as a basis of account of the responses of the participants that took place in the form of narrative argument which is seen through the extracts from the transcripts to support the

cases. The researcher had to carefully distinguish between what the respondent said and the analysis interpretation of the responses (Smith & Osborne, 2007).

3.7 Quality criteria

The researcher adhered to the following quality criteria as recommended by Krefting (1991) in order to ensure the truthfulness of the data:

3.7.1 Truth value

During the process of undertaking the study the researcher had to oversee the truth of the findings and context from the participants. This occurred when the researcher asked questions during the interview process to get responses from the participants. This helped the researcher to establish the truth of the findings based on the phenomenological research design that was used in this study. The truth value in this study was obtained through observation by the researcher of the subjective experiences as they were lived, narrated and perceived by the participants during the research interview process.

3.7.2 Credibility

Credibility in this study was established when the researcher had to identify and document recurrent characteristics of analysis that involved patterns, themes, and values in phenomenological qualitative research. The emphasis on this recurrence suggested the need to spend sufficient time with the participants in order to identify the repetitive patterns. Therefore credibility in this study occurred when the researcher observed the accurate interpretations by spending 2 months with the participants whilst collecting the data in Ga-Dikgale. In this study, it was older persons living with the experiences of chronic diseases (Krefting, 1991). During the interview process the researcher had to probe to get more insights about the older person's subjective experiences to find appropriate themes guided by the research questions of the interview guide.

3.7.3 Applicability

Applicability refers to the transferability as a criterion against the applicability of the phenomenological data to be assessed. This study meets the criterion where the findings fit into the context of the data outside of the study situation that are determined by the degree of similarity that fits both contexts. This occurred after the researcher presented this study with sufficient interpretative data to allow such comparison.

3.7.4 Consistency

This criterion of trustworthiness considers the consistency of the data. This was observed by the researcher when the findings of this study were consistent with the participant's subjective experiences in a similar context. The key role in phenomenological research is for the researcher to learn from the participants. In this study, the participants and the researcher were critical assessors of consistency.

3.8 Ethical considerations

3.8.1 Permission for the study

Ethical clearance for the present study was obtained from the University of Limpopo's Research and Ethics Committee (Appendix 4: Turfloop Research Ethics Committee Clearance Certificate). Since the present study formed part of a bigger research project that was undertaken by Dr J Makhubele and Prof T Sodi under the auspices of the University of Limpopo (UL) and Vlaamse Interuniversitaire Raad – Institutional University Cooperation (VLIR-IUC) Partnership Programme, there was also ethical approval obtained for this bigger study.

3.8.2 Informed consent

According to Neuman (2006), research participants are entitled to be informed about the reason, aims, and purpose about the investigated phenomenon of the study during data collection process. The participants in this study were briefed about the collection of data process and what will occur to the data that was collected afterwards. In relation to the ethical principle of this study, the researcher described the purpose, significance and aim of the study before collecting data from the participants **(Appendix 2a: Informed consent letter) – English version, and (Appendices 2b: Informed consent letter – Sepedi version).** After, the researcher had described the purpose of

the research, a consent form was given to the participants (also explaining to the participants the use of a consent form), which was then signed by both the researcher and the participant **(Appendix 3a: Informed consent form) – English version, and (Appendix 3b: Informed consent form – Sepedi version)**.

3.8.3 Anonymity and confidentiality

According to Neuman (2006), anonymity and confidentiality are some of the critical ethical principles that should be observed in research. In line with this principle, the researcher ensured the confidentiality of the participants by assuring them that their real identity and names will not be revealed in the research report which will be produced by the researcher.

3.8.4 Aftercare for participants

Given the nature of the phenomenon which was investigated, some participants had experienced emotional discomfort during the interview sessions. Good ethical practice required the researcher to be mindful of the psychological welfare state of the participants who had shown some emotional reactions as they took part in the study. In this regard, the researcher ensured that the psychological welfare state of the participants was taken care of by referring these affected participants to psychologists and social workers in the nearby hospital for counselling sessions. Only three participants had emotional reactions such as relieved experiences of past distressing events and painful events of physical impairments (particularly participants with high hypertension levels).

CHAPTER 4

FINDINGS OF THE STUDY

4.1 Introduction

In the first part of the chapter (Part A), the researcher presents the demographic profile of the participants. This is followed by the phenomenological explication of the data that was obtained from the participants (Part B). The themes and subthemes that have resulted from the phenomenological reduction of the data are presented and described. In this regard the following themes emerged from the phenomenological accounts of the participants: a) The subjective explanations by older persons living with a chronic disease; b) Manifestations of chronic diseases; c) The psychological coping strategies used by older persons; and, d) The management of chronic diseases. The above four themes yielded further subthemes that are also presented.

PART A: DEMOGRAPHIC INFORMATION ABOUT THE PARTICIPANTS

4.2 Demographic profile of the participants

The table below shows the demographic details of the participants that include factors such as age, gender, and the type of chronic disease that an individual has been diagnosed with.

Participant	Age	Gender	Duration	Form of chronic disease	Occupation	Residential area
1	60	Male	3 Years	Diabetes Mellitus	Retired	Ga-Moshate
2	79	Female	+-10 Years	High hypertension levels	Pensioner	Ga-Moshate
3	86	Female	5 Years	High hypertension levels	Pensioner	Ga-Moshate
4	71	Male	3 Years	High hypertension levels	Retired	Ga-Moshate
5	62	Female	2 Years	High	Pensioner	Ga-Moshate

				Hypertension levels		
6	81	Female	17 Years	Diabetes Mellitus	Pensioner	Ga-Moshate
7	90	Female	8 Years	High hypertension levels	Pensioner	Ga-Moshate
8	77	Female	11 Years	High hypertension levels	Pensioner	Ga-Moshate
9	75	Male	8 Years	Diabetes Mellitus	Retired	Ga-Moshate
10	64	Female	6 Years	High hypertension levels	Pensioner	Ga-Moshate

Table 1 Demographic details

PART B: PHENOMENOLOGICAL EXPLICATION

The table below depicts the main themes and the subthemes that emerged from the explication of the accounts by the participants. These themes and subthemes are briefly discussed in the results and discussion chapters.

Theme number	Main theme	Subthemes
1	4.2 The subjective explanations by older persons living with a chronic disease	4.2.1 Understanding of a chronic disease
		4.2.2 Aging
		4.2.3 Chronic diseases as a result of neglect
		4.2.4 The effect of lifestyle changes
		4.2.5 Cultural explanations for chronic diseases
2	4.3 Manifestations of chronic diseases	4.3.1 Cognitive reactions
		4.3.2 Fatigue
		4.3.3 Behavioural reactions

3	4.4 The psychological coping strategies used by older persons	4.4.1 Managing emotional reactions
		4.4.2 Passive coping strategies
		4.4.3 Active coping strategies
		4.4.4 Cognitive reappraisal coping strategies
4	4.5 The management of chronic diseases	4.5.1 Western medical treatment of chronic diseases
		4.5.2 Views about clinic treatment
		4.5.3 The role of the significant others

Table 2: Themes and sub themes

4.3 The subjective explanations by older persons living with a chronic disease

4.3.1 Understanding of a chronic disease

The findings suggest that the participants had some understanding of what it means to live with a chronic disease. The participants had to explain in their own words what it means to live with a chronic disease. The following extracts illustrate this:

> *"This disease is a long term condition and it needs one to treat it with care like visiting the clinic regularly to get medication" {**Participant 5}.***
>
> *"Chronic diseases are long term conditions which are very dangerous, when it comes to an older person's ill health" **{Participant 1}.***
>
> *"High hypertension is not curable" **{Participant 4}.***
>
> *The disease seems to be a long term illness and it will never be cured, you have to live with it for the rest of your life **{Participant 8}.***

*"I treat my condition by eating healthy and managing it, because they say it is not curable **{Participant 5}**.*

Based on the above extracts, it can be suggested that the participants did understand their illnesses as chronic conditions that require long-term management. Most participants were able to identify and describe the different symptoms associated with their chronic conditions. These, among others, included persistent stomach aches, high or low body temperature levels, ulcers, headaches and insomnia. This is reflected in the following extracts:

*"The nurses told me that I have high hypertension levels, which I discovered after having a lot of stomach aches then I went to the clinic" **{Partcipant 3}**.*

*"One suffer from diabetes mellitus, because the older person is not able to control their diabetes mellitus levels in their body" **{Participant 1}**.*

*"Older persons with diabetes mellitus have after effects were their legs can be amputated and also blindness" **{Participant 1}**.*

*"I lost my sight after which the doctor told me that I have diabetes mellitus" **{Participant 6}**.*

*"I was not feeling well I went to the clinic and they told me that I was suffering from high hypertension levels" **{Participant 7}**.*

Based on the above extracts, it can be suggested that living with a chronic disease has both long term physical and psychological impact on the individual experiencing the condition. The results of the study further indicated that there are different forms of chronic conditions that are found in elderly persons. These persons mentioned chronic diseases that they live with during their personal experiences which affect their lifestyle. In this study, the persons observed exhibited an understanding of some other different chronic conditions that were existent in some other elderly person who live with them in the same community, revealing that an elderly person may have the occurrence of more than one chronic disease. This was revealed as shown in the following quotes:

"High hypertension levels, asthma, ulcers is caused mostly by salt levels in an individual's body, all individuals suffering from it all end up in hospitals" ***{Particpant 1}****.*

"*Yes it is only the high hypertension level chronic disease that I suffer from*" ***{Participant 3}****.*

"I understand this disease, because in almost every hospital you visit, you are likely to find older persons who have diabetes mellitus" ***{Participant1}****.*

"*I am suffering from diabetes mellitus and also from osteoporosis, I say this because my bones are very weak"* ***{Participant 9}****.*

Looking at the above quotes by the participants, it is observed that there is an occurrence of more than one chronic disease in older persons such as diabetes mellitus, osteoporosis, high hypertension levels, asthma and ulcers. This study has shown that some older persons do not realise that besides other psychological problems they experience because of trauma, the chronic diseases they suffer from might have been as a result of old age.

4.3.2 Aging

The findings of this study reveal that some of the participants believed chronic diseases are caused by aging. In their view, aging factors include the increase in chronological age which induces certain changes amongst elderly persons. In the psychological perspective, subjective age refers to the years of an elderly person's individual experiences, compared to their chronological age. Globally, most elderly people experience some psychological changes simply as a function of aging. Behaviours mediated by the central nervous system slow down as the body of a person ages. These take the form of slow motor reactions, reduced capacity to process information, decreased efficiency in memory as well as learning of new behaviours (Bootzin & Acocella, 1989). Most chronic diseases in older persons were caused by aging, which brought the most stressful changes in the person's life. These subjective explanations were observed in the extracts below:

*"Yes, as old as I am, you can see that I am coping well, even though the chronic disease (diabetes mellitus) took my sight. I can wake up and walk into the sitting room to just sit by myself" {**Participant 6}**.*

*"It has been a long time ever since I have been living with high hypertension, and as I grow older I consistently feel tired" {**Participant 3}**.*

*"The nurses just provides us with pills, all they say is they are preventing the effects of the chronic disease without really telling us the major cause, all they tell us is to reduce the high level amounts of eating salt because we are old people" {**Participant 7}**.*

The above findings were emphasized by the participants as they blame aging as the cause of their chronic diseases. They feel that aging brings psychological distresses which induce chronic diseases.

4.3.3 Chronic diseases as a result of neglect

Some participants tend to understand and interpret their chronic conditions as a result of neglect that older person experience from their family members or care givers. There were a few other participants who felt that as older persons, if their quality of life was not neglected they would not be having the critical conditions brought about by their chronic diseases. These are shown by the following quotes:

*"My grand child is very young and negligent of my chronic illness, but I can still walk and go to the clinic by myself" **{Participant 3}**.*

*"The people I live with in my community, may either accept your chronic conditions or like you…….and have the willingness to help or may not have the willingness to help the older person. While others may not accept your chronic conditions and are very much ignorant or negligent of my chronic condition" **{Participant 8}**.*

*"I do attend funerals and functions where a lot of people gather in one place, even though I cannot stand for a long time because my conditions becomes worse when I stand for a long time and other people do not even mind my conditions" **{Participant 9}.***

"It does not bother me when people do not like me and have ugly notions towards my chronic condition……..I have neglected my chronic conditions for a while, so I just have to live amongst other people with my chronic disease and do what others do" ***{Participant 10}****.*

"I have seen that there are supportive family members and friends who are trustworthy which will offer you help as primary caregivers who helps to take care of me during my chronic illness and there are those who are negligent" ***{Participant 7}****.*

"As you can see I am her only daughter, I have to take care of her because she cannot do all things by herself……. This enforces me not to sleep outside the home, as I have to prepare her food, give her medication and accompany her when she goes to the clinic, so she does not feel neglected" ***{Participant 2}****.*

As can be seen from the above extracts, some of the participants feel abandoned and tend to blame the family structures, nurses and the primary caregiving structures for their predicaments.

4.3.4 The effect of lifestyle changes

Findings from this study revealed that lifestyle changes were some of the perceived causes of chronic diseases. These included retirement, loneliness, withdrawal from interpersonal relationships, fatigue as well as low socioeconomic status. These factors, revealed by a few participants, showed that low socioeconomic status in the community is a factor that affects the living conditions of older persons and it contributes to the large number of victims of chronic diseases such as diabetes mellitus and hypertension amongst older persons. These participants have shown that:

"A person who suffers from this disease probably once had a lot of struggles in life" ***{Participant 1}****.*

"She was once was faced with a lot of problems and challenges in her life, this is the reason she got sick" ***{Participant 2}****.*

"As a human being in life you come across experiences that are either positive or challenging" ***{Participant 7}****.*

"I once had a lot of problems in my life, I used to worry and think a lot which caused my stroke attack" ***{Participant 8}****.*

The absence of adequate self-management in an older person is another cause of diabetes mellitus for most of the participants. Stress suffered by these persons in their younger age was also highlighted as the cause of chronic conditions.

4.3.5 Cultural explanations for chronic diseases

Almost all the participants believed that there was a cultural reason for their chronic diseases. These participants believed that as older persons, the chronic diseases were caused by ancestral spells, witchcraft spells, and other negative spiritual forces. These reactions suggest that some of the participants understood their conditions to be a result of ancestral actions. In some cases, jealous behaviour by a community member was perceived as a cause of the chronic disease. Based on these cultural explanations, a traditional healer is understood as the most appropriate person to help treat such a chronic condition. The following statements by participants reveal this:

"*She became sick for a long time, until she consulted a traditional healer who diagnosed her traditionally, but the problem was that the very same traditional healer liked money more than the life of my wife, and he did not care or even think about her even when she was in critical pains"* ***{Participant 1}****.*

"I have been consulting the traditional healers as well" ***{Participant 4}****.*

"Onetime in the clinic, someone told me to also consult traditional healers to find help, and I never forgot so I did go and consult a traditional healer to find out what was my problem" ***{Participant 10}****.*

"I have visited traditional healers, but my condition gets worse every time" ***{Participant 8}****.*

The above extracts suggest that some older persons have determined the causes of their chronic diseases as related to their own cultural beliefs. This study has revealed that these older persons have an understanding that it is a subjective experience to be a victim of witchcraft or ancestral spells for ill health to occur in an individual.

4.4 Manifestations of chronic diseases

4.4.1 Cognitive reactions

Cognition refers to the mental process of perceiving, recognising, conceiving, judging and reasoning. Cognition is also defined as a mental process that includes emotion, thought, expectation and interpretation by an older person living with a chronic disease. Therefore the cognitive characteristics of ageing, chronic diseases amongst older persons included a depressed mood, loss of pleasure or interest in usual activities, sleep disturbance, feelings of worthlessness, and difficulties in memory and recurrent thoughts of death, these are shown by the following quotes made by the participants:

> "Yes, she lives a normal life with her chronic condition, but she is psychologically affected by loneliness and hopelessness as well as difficulty in remembering things" **{Participant 2}**.
>
> *"Wishing to be cured is the thing of the past. Right now I am only just waiting to die" {**Participant 4}**.*
>
> *"What would I say, all I want is to die because it has been a long time since I have been struggling from this chronic disease (high hypertension levels), therefore it is better if only one dies" {**Participant 7**}.*
>
> *"Yes, I see all the time that she worries a lot. I stay with her most of the times that's when I see her worry behaviour all the time. I am also her daughter, so I stay with her in this house. At times you hear her say that she wants to go home (die)" {**Participant 2}**.*

The above statements have emphasized that older persons suffer helplessness and hopelessness as a result of depression while living with chronic diseases. Through impaired mental processes most participants in this study have shown hopelessness through recurrent thoughts of death because they had lost hope for living after being diagnosed with the chronic disease.

4.4.2 Fatigue

Fatigue is an overwhelming and distressing experience that constraints capacity for physical function and social participation. Fatigue is a key component of the frailty syndrome that is related to an increased aging process. Pain in chronic illnesses is disruptive, saps energy, negatively affects quality of life and can lead to an intense cycle of pain, anxiety and anguish (Egerton, 2013). This physical impairment, which was observed by the researcher in the participants, is caused by aging and chronic diseases such as high hypertension levels and diabetes mellitus. The participants emphasized the impacts of these impairments through the following quotes:

> *"I started by having a stroke, after which my relatives took me to the clinic. There nurses gave me pills and told me I am suffering from high hypertension levels"* ***{Participant 8}****.*
>
> *"The challenges I face are on the side of the body that is affected by the stroke, which is very painful and which worries me a lot" {****Participant 8}****.*
>
> *"At times during the night you will find her getting physically disturbed, having sleep disturbances, having put away her blankets and just sitting down and starring around the room"* ***{Participant 2}****.*
>
> *"I started by having stomach aches, then my body had physical complications in such way I was not able to eat food"* ***{Participant 1}****.*
>
> *"I had a problem of falling down most of the times which will give me bruises and swollen legs when I went to the clinic I was told I have high hypertension levels"* ***{Participant 4}****.*

"I once fell down while working in a building site, the doctor gave me a letter to regularly go to the clinic and get medication of diabetes mellitus," ***{Participant 9}****.*

One older person had experienced physical fatigue as a result of a stroke while two other male participants who fell down while at work, developed traumatic experiences that may have led to their chronic conditions. The findings suggest that most participants were affected psychologically by their different chronic conditions which resulted in physical fatigue and changes in their thought process. The participants were able to express a wide range of subjective experiences of having to deal with the consequences of living with a chronic disease. Therefore, ageing and physical fatigue may cause social impairments in an older person that are seen through behaviour deficits caused by the chronic diseases.

4.4.3 Behavioural reactions

Older persons living with chronic diseases react to these life experiences by either having a positive or a negative behaviour. Some older persons living in Ga-Dikgale who had experiences of chronic diseases were found to manifest some emotional tension about their environmental situations, which were not compatible with the behaviour for a good quality life. Behaviours of older persons living with chronic diseases are determined by self-reinforcement, which are thought processes that have modelled the individual's unique behaviour from a young age. This type of behaviour is learned through the impacts of rewards and punishments to gain self-approval and criticism. Maladaptive behaviours in older persons living with chronic diseases are behaviour deficits that result in the individual impairment of social interaction and intellectual skills. Social withdrawal affected older persons living with chronic diseases as they felt other community members made them feel unwanted at interactions during community activities. Some participants felt their chronic condition hindered them to be around other people within the community.

"She got affected by high hypertension levels chronic disease. She became blind, and before she had all these problems she had never had an unhealthy condition" ***{Participant 2}****.*

*"Yes, for me to know ,I was not feeling well, then I went to the clinic and the nurses told me that I am suffering from high hypertension levels…..I did not deny because I was instructed, even though I could not understand the reasons" {**Participant 7}**.*

*"One gets stressed by children who are not disciplined. When I tell my children and grandchildren not to do something and they do not listen, it stresses me a lot" {**Participant 7}**.*

"*You know what, she is always alone, while at times her only friend comes around to visit her" **{Participant 2}**.*

*"Yes, it is true, the individual lives amongst other people but most of the time the older person always behaves as a lonely individual with a lot of boredom, because he or she thinks too much about the way other people are always enjoying their lives while he or she is suffering, you find that loneliness or boredom occurs in the individual, because they are always feeling pains" **{Participant 1}**.*

The above quotes show that learned behaviours in the older person are primary appraisal of determined coping strategies that are passive or active in order for the older person to live with a chronic disease. The maladaptive behaviour affects the functioning pattern of an older person through loneliness, denial, boredom, social withdrawal and constant worries over living with the chronic disease. The older persons have also shown that their impairment impacts on their functioning, thereby reducing the changes of lifestyle in behavioural reactions.

4.5 The psychological coping strategies used by older persons

4.5.1 Managing emotional reactions

Emotions influence how older persons respond to situations of living with a chronic disease and help them to organise their thoughts and actions which will guide their behaviours. Finding meaning and purpose is an important process of hope especially towards individuals living with chronic diseases. The process of searching for meaning amongst older persons living with chronic diseases involves reflecting upon what is important to them and the self-regulation of their values and priorities. This may impact

older persons by helping them to return to their normal state of life, maintaining positive health outcomes, and maintaining relationships with their significant others. Coping strategies for some older persons in the community was to live their lives as best as they could before death occurs. It was discovered that the males coped better than the females by engaging in community activities such as traditional courts, or attending weddings and funerals as well as other functions within the community. The main reason in having a good quality of life is to positively interact with other community members rather than withdraw from the significant others. This was emphasized through the following quotes:

> *"I do not see or worry about people that cannot help me, I smile and walk away……pretend as if I am not seeing anything. "One must not always be angry, sad and just treat the chronic disease with simplicity"* ***{Participant 5}****.*
>
> *"Once you have long term critical headache, you must know that your worries have affected your mental state of mind and emotions"* ***{Participant 10}****.*
>
> *"People do not like me very much I am not originally from here I only came by marriage rights, so when other people in the community do not appreciate me I do not waste my time by getting angry instead I laugh with them"* ***{Participant 5}****.*
>
> *"I do not know the cause of my high hypertension chronic disease, at least you have education so you should know* ***{Participant 7}****.*
>
> *"For the first time I was told that I have diabetes mellitus chronic disease I was powerless and I was unable to stand on my own two legs"* ***{Participant 9}****.*

The above quotes revealed that the participants were affected by emotions and maladaptive behaviours as a result of living with chronic diseases. Their emotions range from feelings of anger, fear, anxiety and stress. Participants indicated that they were stressed and depressed, adding that these feelings do not bring about changes in the older person's health because they always have to worry about their state of wellbeing. Anxieties about what might or might not happen and the hope of early death only added to their psychological distress level that had a great impact on the quality of their lives.

4.5.2 Passive coping strategies

Passive coping involves avoidance where escape is correlated with reports of greater depression, greater pain and flare up activity, greater functional impairment and lower general self-efficacy. The participants show maladaptive behaviour impairment in the functioning of the wellbeing. The denial mechanism of living with a chronic disease impacts the older person's way of living. This is the refusal to acknowledge that the older person individual is living with the experiences of high hypertension levels and diabetes mellitus.

> *"She has not yet accepted that she now leaves with high hypertension chronic disease". And another participant has also shown that, "Yes, I have accepted…….only because they (nurses) say that I have high hypertension levels" {**Participant 2}.***
>
> *As an older person you still live in the denial perception state of being diagnosed with the chronic disease, because you can never understand why this is occurring" {**Participant 3}.***
>
> *"I do not go to functions and places where people gather in large numbers. I do not go even if I would like to go, because it seems some people define my chronic disease as a problem and they do not accept my blindness condition" **{Participant 6}.***
>
> *"There is nothing I can do, at least I can still wake up and walk even if I am still living with diabetes mellitus" {**Participant 9}.***
>
> *"I was amazed when I went to the clinic and they told me that I have diabetes mellitus, it was a big shock" **{Participant 10}.***

From these extracts above, these participants show feelings of helplessness. Although they have accepted their own chronic condition, they feel that there is nothing more they can do as older persons, except to live with the chronic disease. This is understandable as they were told that their condition is chronic and permanent.

4.5.3 Active coping strategies

One of the most frequently used concepts of dealing with chronic diseases is adaptation strategies. Active coping involves problem solving where the collection of information and re-focussing on the emotional response is aroused by a stressor. It is associated with less pain, less depression, less functional impairment and higher general self-efficacy. The older person accepts their chronic condition and finds adaptive ways to live a quality life in spite of the chronic disease. The older persons accept their chronic condition by focusing behaviour on self-management skills, social and emotional support from family support structures.

> *"When you are the older person who is living with a chronic disease, as an individual you must accept the condition irrespective of the consequences that comes with the illness" {**Participant 1}**.*
>
> *"Once a person lives, gets old (ages) he or she is bound to get sick, these chronic diseases come with aging" **{Participant 10}**.*
>
> *"I have accepted the chronic conditions by relying on the guidance of good spirituality hoping that one day the situation will get better" **{Participant 5}**.*
>
> *"It has been long since I have been living with this chronic disease…… I have accepted and I live with it irrespective of the challenges I face" {**Participant 7}**.*
>
> *"I have accepted that I am living with a chronic disease as an older person, therefore I have to behave well and treat it because it is not a curable disease" **{Participant 5}**.*
>
> *"The chronic disease seems to be a long term condition and one may never be cured from it for the rest of their lives, you just have to accept and live with it" **{Participant 8}**.*

The quotes above show that the older persons who use adaptive active coping strategies empower themselves by acquiring relevant self-management skills to deal with their problems. This shows the will power to live, even when the older person experiences a chronic condition. This level of resilience seems to provide hope for the

older person and family supportive structures whilst at the same time reducing the level of stress in the individual.

4.5.4 Cognitive reappraisal coping strategies

Cognitive reappraisal coping strategies is when the older person living with a chronic disease evaluates his or her physical changes through their own memories, beliefs, and expectations before reacting to their experiences. This is an internal process that accounts for a wide difference in individual responses to the chronic condition. Therefore, the older person responds by becoming anxious, perspiring, and stumbling in the process of dealing with the situation. This mechanism can be applied through a variety of ways, such as seeking social support during bereavement, reappraising the stressor in a positive light after losing a spouse, accepting responsibility, using avoidance, exercising self-control, and distancing. The focus of this coping mechanism is to change the meaning of the bereavement stressor or transfer attention away from it. This coping strategy is emphasized by the quotes below:

> *"There are so many things of life that hurt a person. I have children, my daughter got married far away from home and she died. Of the three children I had I have two left, it is not easy, and this led to the cause of diabetes mellitus chronic disease"* ***{Participant 10}.***
>
> *"Aging and bereavement may be the cause of chronic diseases in older persons. "My child died… and I have been mourning her, immediately after the death I began to worry a lot, this chronic condition has been caused by the death of my child"* ***{Participant 5}****.*
>
> *"My wife was diagnosed with diabetes mellitus chronic disease since 2014 and she died in May of 2015 this year……..She lived a difficult life, and it was not easy because her leg was swollen" {***Participant 1}*,.*
>
> *"I have been taking pills of high hypertension levels. It has been long since I have been taking this pills, people I know people of my age group who have passed away long ago…….which bothers me"* ***{Participant 7}****.*

The above quotes have shown that the participants reduce their feelings of fear, depression and anxiety caused by perceived thoughts that affected the behaviour of the older person. This influences the older person to determine a specific meaning of living with the chronic disease through responses of the individual interpretation of the chronic condition.

4.6 The management of chronic diseases

4.6.1 Western medical treatment of chronic diseases

The findings of this study revealed that most participants show that medical treatment received from the clinic is appropriate for their treatment as persons living with chronic diseases. This is a huge disadvantage as the government has a shortage of health facilities and medications for older persons living with chronic diseases in the Ga-Dikgale rural area. The older persons have shown that when they go to the clinic, there is usually a shortage of medication. Nonetheless, these older persons still believe that medications in form of pills and injections was a way to reduce the pain they feel in their body, thereby helping with the maintenance of healthy status in the individual. Behavioural medicine amongst older persons living with chronic conditions is the recognition of their way of living and state of mind that affects their wellbeing. This is accumulated wisdom regarding emotional and intellectual functioning that contributes to the treatment of physical illness (Bootzin & Acocella, 1989). Another participant who was affected by stroke also mentioned that, although she used the medication from the clinic, she has also decided to put her trust in God to change her situation because she has lost hope of living with the chronic condition.

> *"No, there is no progress even when I use the clinic medication. The pills and injection* medication only reduces the high levels of my hypertension temperature" **{Participant 3}**.
>
> *"I use pills and eyes drip drop medicines that I receive from the doctor and clinic" **{Participant 6}**.*
>
> *"I have visited doctors who injected me…….I have also visited traditional healers but my condition does not get better". I have become a Christian now and have decided to put everything in God's hand" {**Participant 8}**.*

Even though there are individual factors affecting the use of clinic medication, some older persons still fetch medications from the clinics every month because it brought about significant improvements in each of the participants:

> *"In clinics we are given medication, for high hypertension which helps to reduce temperature levels"* ***{Participant 4}****.*

From the quote below, the older persons still use the medication because they feel it is their only way to reduce pain suffered from fatigue.

> *"It has no use, all the time we go to doctors and clinics to get medication and there are no other adjustments that we rely on besides pills and injections"* ***{Participant 3}****.*

Based on the findings of the study, it does appear that some of the participants have lost hope in taking the medication. For them, it is a routine they are used to. They feel it is just another unnecessary duty to use medications for chronic conditions as instructed by the clinics.

4.6.2 Views about clinic treatment

Nurses who attend to chronic disease sufferers are expected to have effective communication skills about the diagnosis and ways to live a good quality life. These older persons need effective communication or education from nurses in order for them to understand the impacts of chronic diseases like blood pressure and sugar diabetes. Therefore, behaviour therapy allows for self-understanding and self-acceptance in an older person living with a chronic disease. The goal of behaviour therapy is to teach the older person living with high hypertension levels and diabetes mellitus to gain skills they require to live with these chronic conditions. This study has revealed that these older persons will look for treatment that will help with treating the symptoms of their chronic diseases. Therefore, older persons living with chronic diseases in Ga-Dikgale need to find better coping strategies.

> *"I have told you I do not know, when I arrived at the clinic I was told I have high hypertension levels, because I had a stroke and they only gave me pills and injections"* ***{Participant 8}****.*

"I will appreciate it very much if I can get better, because nurses only tell us to come regularly to fetch pills. Maybe if I go to the doctor he or she will tell me what is my problem" ***{Participant 7}****.*

"*There is no good relationship between me and nurses, they do not tell us the kind of medication we should use, sometimes I mistakenly use wrong medicine for my eyes as you can see I am old and blind"* ***{Participant 6}****.*

"I have been visiting traditional healers because in the clinics and hospitals all they give you are pills and injections for high hypertension levels and no other assistance" ***{Participant, 4}****.*

Based on the above extracts, it can be suggested that the participants have shown that the nurses do not give them enough information about their chronic condition. Instead, they feel that the nurses just tell them to constantly come back to fetch medication on a regular basis from the clinic.

4.6.3 The role of the significant others

The psychological interventions of older persons living with chronic diseases included primary and secondary interventions. This study has emphasized that primary interventions include cognitive restructuring of mental processes such as mental imagery, modelling procedures and therapy by a psychologist or a social worker. The research has revealed that Western medication of pills and injection will induce maladaptive behaviours, emotional disturbances and irrational beliefs within the older persons living with chronic diseases. Secondary interventions involve putting older persons living with chronic diseases in hospitals and primary caregiving institutions. These older persons need constant assessment of their physical changes and impaired cognitive behaviour within these institutions.

"One should not only rely on one form of assistance, but you must go to a hospital such as Mankweng where you will find social works who will also help you" ***{Participant 10}****.*

*"No, I do not know about psychologists, where will we find them, here in our rural areas we only know about nurses in the clinic… maybe if there were this psychologists you are talking about we will find more assistance" {**Participant 9}**.*

*"I have used many things to get help some I forgot, maybe if we had people like social workers in the community to advise us" **{Participant 8}**.*

The study has shown through the quotes above, that the older persons where requiring detailed information about the causes of their chronic conditions and ways of living with the experiences of high hypertension levels and diabetes mellitus in Ga-Dikgale. These older persons hoped that if they knew a lot about their own chronic conditions, they would be able to gain self-management skills to live with high hypertension levels and diabetes mellitus.

4. 7 Summary of findings

The present study comprised of 10 participants (older persons) living with chronic diseases and were drawn from Ga-Dikgale's Ga-Moshate villages. The participants' ages ranged from 50 to 65 or older. The key findings of the study are as follows:

- The participants understand their illnesses as chronic conditions that require long-term management.
- The chronic diseases were understood by the participants to be manifesting in many ways. The manifestations of chronic diseases, among others, include cognitive reactions, fatigue and behavioural reactions.
- A number of psychological strategies are utilised by the participants to cope with their chronic conditions. These include passive/active coping and cognitive reappraisal coping strategies.
- With regard to the management of chronic conditions, most participants were of the view that medical treatment received from the clinic is appropriate for the treatment of their conditions. Some of the participants were however of the view that the nurses did not give them enough information about their chronic condition.

CHAPTER 5

DISCUSSION

5.1 Introduction

This chapter discusses the findings of the present study in the context of existing literature. In this regard, the findings will be discussed in accordance with the themes that emerged from the results of the study. The themes that emerged from this study are the following: a). The subjective explanations by older persons living with a chronic disease; b). Manifestations of chronic diseases; c). The psychological coping strategies used by older persons; and, d). The management of chronic diseases. The findings of the study will also be discussed in the context of the Afrocentric theoretical framework which was adopted as a lens to understand the older persons' experiences of chronic diseases.

5.2 The subjective explanations by older persons living with a chronic disease

The results of the present study have indicated that participants tend to understand chronic diseases as long term conditions that require proper management and treatment. This finding lends support to previous studies that have also indicated that older persons tend to understand their chronic diseases as long term conditions that require lifelong care. For example, a study by Marcos and Cuesta-Benjumea (2014) found that older persons did understand that their chronic disease required long term treatment. This suggests that older persons need to work closely with the health professionals and family members to manage the symptoms associated with the chronic disease (Corbin & Strauss, 1991).

Previous studies have also indicated that older persons living with chronic diseases are more likely to report interference with activities in multiple areas of their lives as a result of maladjustments due to greater pain and lower perceived control over their functionality in their everyday lives (Chan, Hadjistovropoulos, Carleton & Hadjistovropoulos, 2012). Similarly the results of the present study did indicate that some participants tended to complain of persistent pain that significantly interferes with their functioning.

A number of participants did acknowledge that some of their chronic conditions were closely associated with aging. This seemed to confirm the results of previous studies which have shown that most of the chronic diseases experienced later in life are closely linked to aging (Kralik, 2002). According to Roy and Giddings (2012), chronic conditions are a dynamic transition that needs flexibility and acceptance by older persons of the typical challenges that occur during the ageing process.

5.3 Manifestations of chronic diseases

The findings of this study suggest that most participants were affected psychologically by their chronic conditions. The participants were able to express a wide range of feelings and experiences of having to deal with the experiences of living with a chronic disease. In that respect, there were a variety of responses ranging from physical, cognitive, behavioural and emotional reactions. The findings of this study are consistent with the results of a study by Korabel, Grasbski, Dudek, Jawarek, Gierowski, Kiejna, Wojas and Pelc (2013) which states that persons with chronic diseases tend to show a wide range of responses that may include a number of physical, cognitive, behavioural and emotional responses.

5.3.1 Fatigue, depression and other psychological conditions

The results of the present study suggest that older persons do experience high levels of emotional, psychological, and physical distress that at times disrupt their ability to function normally in day-to-day life. The results of the present study lend support to previous studies that have shown that fatigue, depression and other psychological conditions are common in older persons who experience chronic diseases (Foley, Ancoli-Israel, Britz, & Walsh, 2004).

5.3.2 Cognitive and behavioural reactions

Through impaired mental processes most participants in this study have shown hopelessness through recurrent thoughts of death because they had lost hope for living after being diagnosed with the chronic disease. Previous studies have also indicated that older persons living with chronic diseases tend to show a number of cognitive reactions (Brenda, Ferruci, Eleanor, Dorly & Robert 1998; Kring, Johnson, Davison & Neale, 2010). Other studies have indicated that some older persons living

with chronic diseases show behavioural tendencies that are cognitively determined. One such cognitively determined behaviour is denial. Denial is a specific kind of avoidance coping that is determined by both cognitive and behavioural aspects. Denial is linked with psychosocial factors such as lower social support, higher perceived stress, poorer medication and adherence to the chronic disease. This, in turn, impacts on the quality of life of an older person living with a chronic disease (Kamen, Taniguchi, Student, Kienitzi, Giles, Khan, Lee, Gore-Felton & Koopman 2012).

In this present study, participants showed behavioural reactions like social withdrawal and avoidance caused by maladaptive behaviours with regard to older persons living with chronic diseases. Some of the participants indicated that, as an older person living with chronic diseases, you perceived life experiences by either a positive or a negative behaviour. Denial is a specific kind of avoidance coping that is emphasized by both cognitive and behavioural aspects. Cognitive dissonance has diverged into the interpretation of denial in the context of psychological adjustment and chronic diseases. The behavioural aspects point out that the different conceptualizations of denial related behaviour has led to an inconsistent interpretation of the usefulness of denial as a coping strategy. Denial is linked with psychosocial factors such as lower social support, higher perceived stress, poorer medication and adherence to the chronic disease. This, in turn, impacts on the quality of life of an older person living with the experiences of a chronic disease (Kamen et al., 2012).

5.4 The psychological coping strategies used by older persons

Consistent with previous studies, the present study found that older persons living with chronic diseases tended to use a number of psychological strategies to cope with their conditions. These included passive and active coping strategies as well as cognitive reappraisal strategies.

5.4.1 Passive coping strategies

It was found in the present study that some of the participants opted to use some passive strategies to deal with their chronic diseases. The passive coping strategies are understood as the ego defense mechanisms and defense styles that occur without active or conscious effort. This is reflected in internal psychological states that may result in altered denial perceptions of living with the chronic disease. One such passive coping strategy is reaction formation which entails engaging in the repressing of feelings of living with a chronic disease. Denial is another form of passive coping that was found to be used by older persons in the present study. The older person living with the chronic disease may deny the reality of their circumstances by pretending that they do not have the condition. Such an approach may only create a difficult situation for the individual to cope with the chronic conditions that results from the refusal of the existence of the chronic condition (Albuquerque, Eduardo, Lopez, Marques, Macedo, Pereira, Hyphantis & Carvalho, 2011). Other previous studies reveal that passive coping strategies may also be described as a way that the participants suppress involvement in competing activities in order to concentrate fully more on the challenges of living with a chronic disease. Suppression of competing strategies refers to the older person putting aside self-regulation cognitive process that will help them deal with the challenges (Carver, Weintraub, & Scheier, 1989).

5.4.2 Active coping strategies

This adaptive coping strategy refers to the participants taking active steps to try to reduce the negative effects of living with chronic diseases (Carver et al., 1989). In the present study, some of the participants were found to be engaging in active coping strategies like trying to remove the negative thoughts of living with a chronic disease. This is reflected in actions like seeking emotional support from significant others. This is related to other coping strategies such as focusing on venting emotions which is a tendency for the older person to focus on the psychological distress in order to ventilate the feelings (Lazarus & Folkman, 1984). Previous literature showed that managing emotions and actively trying to cope with a chronic disease improves the wellbeing of the older person living with a chronic disease. (Tesser, 1995). On the other hand, negative emotions were found to increase the chance of the older persons'

chronic condition becoming worse (Kring et al., 2010). Acceptance of the reality of living with a chronic condition was found to be an adaptive active coping strategy (Cohen & Lazarus, 1973).

5.4.3 Cognitive reappraisal coping strategies

In the present study, it was found that some participants tended to empower themselves by adopting a more relevant and positive attitude towards their chronic conditions. They tended to accept their conditions by applying competency skills such as good self-management, interpersonal understanding, behavioural and self-confidence skills towards their chronic disease condition experiences. Behavioural flexibility (that is, the tendency for a person individual who lives with a chronic disease condition to adjust one's coping behaviour) was found to be a common coping strategy (Mayo, Kakarika, Pastor & Brutus, 2012). These cognitive reappraisal strategies are believed to decrease physiological arousal that in turn help to improve the well-being of older persons living with chronic diseases (Brozovich, Goldin, Lee, Jazaieiri, Heimbeg & Gross, 2014). Therefore, cognitive reappraisal tends to provide an excellent opportunity for an older person to better cope with their chronic condition (Brozovich, et al., 2014).

5.5 The management of chronic diseases

With regard to treatment and management, the participants were found to have various ways of treating and managing their conditions. Older persons preferred using medication because they were provided with pills and injections which reduced the amount of excessive pain caused by physical fatigue. They believed that, it would probably make a difference in their chronic condition if they had the opportunity to see a doctor rather than go the clinic all the time.

Literature shows that older persons living with chronic diseases have traditionally received little attention from health authorities, clinicians and researchers. Disaggregated statistics on older persons by the type of disability, chronic diseases, sex, age, population group, employment status, educational attainment and their general living conditions provide key indicators essential for assessing demographic trends, needs, challenges, and designing effective policies that contribute to improving lives of the older persons. Results indicate that most older persons in the larger population of South Africa (that is an average of about 90%) had no difficulty or

limitation that prevented them from carrying out certain functions at the time of census, in spite of living with chronic conditions (Statistics South Africa, 2012).

Chronic diseases in older persons are difficult to diagnose and treat and there is often a lack of appropriate health services, skilled health professionals and effective treatment options. Many chronic diseases are complex and associated with physical, intellectual or neurological disabilities. Health education should focus on implementation of programs as well as the designing and developing of programs that are grounded in theory and systematically targeted towards meeting the concerns of older persons in the community (Millard, MacDonald, Elliot, Slavin, Rowell & Gidler, 2014). Despite the many South African government programmes that are aimed at educating individuals about healthy lifestyles, it has been noted that older persons living in rural areas are often unable access these services. Accessibility has often been cited as the reason for the lack of access to these services.

5.6 Implications for theory

As it has already been pointed out, the present study used the Afrocentric perspective as a lens through which the experiences of older persons in a rural community were understood vis-à-vis their chronic diseases. As was pointed out earlier in in the literature review, the Afrocentric perspective, propagated by scholars like Asante (1995) and Mazama (2003), seeks to deal with the questions of identity and experience from the perspective of African people as centred, located, oriented, and grounded. According to Asante, the many years of colonization have decentred and dislocated Africans in many social spheres. According to Mkabela (2005), to say that Africans are decentred means essentially that they have lost their cultural footing and have become disoriented.

Based on the responses of the participants, it can be argued that the older persons tend to embrace both the traditional and Western explanations for their chronic diseases. For example, on the one hand the participants did indicate that their conditions were a result of a number of factors that, among others included aging, neglect (by family members or caregiver) and lifestyle changes. In this regard, the participant considered as appropriate, the use of Western methods of disease management like the use of medication and consultation with nurses in the clinics. On

the other hand some of the participants considered that their conditions are a result of external factors like ancestral spells, witchcraft spells, and other negative spiritual forces. In some cases, jealous behaviour by a community member was perceived as a cause of the chronic disease. Based on these cultural explanations, a traditional healer is understood as the most appropriate person to help treat such a chronic condition.

What is suggested above is that the Afrocentric perspective has relevance in explaining the experiences of the older persons with chronic diseases. In other words, in the context of the African community where the study was conducted, it can be considered normal for someone with an illness to accommodate both the Western and African perspectives in explaining and responding to their illness conditions. Similar findings have been made in previous studies (Berg, 2003; Bojuwoye & Sodi, 2010; Mojalefa, 2013). For example, in a study that sought to understand health seeking pathways followed by patients receiving mental health treatment in a rural hospital in Limpopo Province (South Africa), it was found that African patients will simultaneously access the services of Western and traditional healers for the same symptoms based on the cultural conception that an illness is both physical and spiritual.

5.7 Concluding remarks

In this chapter, the results of the present study were discussed in the context of existing literature. The results tended to lend support to previous studies that have mainly found that an individual's reaction to and management of a chronic condition is dependent on a range of factors. The study further suggested that the Afrocentric perspective does have merit in explaining the experiences of chronic diseases by older persons in the rural community that include personal and a wide range of chronic manifestations.

CHAPTER 6

SUMMARY AND CONCLUSION

6.1 Summary

The aim of the present study was to explore the lived experiences of older persons with chronic diseases in Ga-Dikgale community in Limpopo Province. Specifically, the present study sought to address the following objectives:

- To determine the subjective meanings that older persons living with chronic diseases attach to their conditions;
- To establish the causal explanations that older persons living with chronic diseases could have attributed to their condition; and to;
- To determine the psychological strategies that older persons living with chronic diseases use to manage their conditions.

Based on the findings of the study, the following four themes emerged: 1)The subjective explanations by older persons living with chronic diseases.; 2). Manifestations of chronic diseases; 3). Coping strategies used by older persons; 4). The management of chronic diseases using western treatment. The four themes were further broken down into subthemes. The results are discussed in the context of the emerging field of African psychology in comparison to the western psychology within the spectrum of chronic diseases in older persons and the calls for greater recognition of the management of high hypertension levels and diabetes mellitus chronic illnesses through care provision of lifestyle changes (self-management skills) within clinics and primary caregiving homes in developing countries like South Africa. From the findings of this study it does appear that chronic diseases are perceived by the participants as a result of a number of factors, with witchcraft as another cause. This suggests that chronic diseases in Ga-Dikgale may also be a culturally conceptualised condition that is perceived to be brought about by external agents like supernatural factors and evil intentions of others. This causal explanation of chronic diseases appears to compare the popular Western notion of mental illness that tends to perceive this condition as a result of the individual's inner psychological forces. Generally, the participants perceived chronic diseases as a condition that is associated with aging, neglect and effect of lifestyle changes in their social context.

The findings of the present study further suggest that the participants do not have an elaborate understanding of psychological manifestations of chronic diseases that distinguishes between the different types of cognitive and behaviour impairments. Instead participants are able to identify the names to their illnesses such as high hypertension levels and diabetes mellitus, and also tended to describe the illness based on what is perceived as the cause. In view of the above findings, it can be suggested that both traditional medical interventions and western medical management procedures of chronic diseases are used to treat chronic illnesses. This suggests that an indigenous healing is perceived as another significant treatment playing the role of medical practitioner and psychologist in a traditional setting, in contrast there other older person that perceives to use the western treatment of the management of chronic diseases in their communities.

6.2 Limitations

The following were some of the limitations of the present study:

- Firstly, the nature of the investigation required the researcher to use purposive sampling to obtain the required number of participants. This approach made it difficult to get the required number of older persons in the research site to participate in the study.
- Secondly, the interviews were conducted in Sepedi and were later translated into English by a language expert. This process may have resulted in some of the cultural nuances that are embedded in language being lost in the process of transforming the data from one language to another.
- The sample used comprised older persons drawn from a small rural community in Ga-Dikgale in Limpopo Province. Given the sample size, it is therefore not possible to generalise the findings of the present study to the bigger Northern Sotho community of Limpopo Province or the South African population.

6.3 Recommendations

Based on the findings of the present study, the following recommendations are made:

- More studies should be done on the experiences of older persons living with chronic diseases. Such studies should focus on specific chronic diseases instead of looking at the general notion of chronic diseases as the present study has done.

- More studies should be conducted about the impact of chronic diseases on the family structure. This recommendation is made in the light of the evidence that some participants received little social support family, friends or community members.

- Since there are indications that older persons may be lacking adequate information about chronic diseases, it is hereby recommended that awareness campaigns be rolled out to target older persons, particularly in rural communities like Ga-Dikgale.

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ANNEXURES

Annexure 1 (a): A semi-structured Interview guide

1. What do you understand to be a chronic disease
2. Share with me what you understand to be the chronic disease that you are living with.
3. Can you explain to me how you have lived with the chronic condition from the time when it was diagnosed up to now?
4. Can you explain to me the lifestyle behaviors you have adopted while you are living with a chronic disease?
5. Can you explain to me what you understand to be the cause(s) of the chronic condition?
6. Can you describe to me the ways that you have used all these years to manage the chronic condition that you have lived with?

Annexure 1(b): A semi- structured Interview guide – Northern Sotho version

Koketšo 1 (a): Temošo ya dipoledišano

1. A o kwišiša eng go ba bolwetši bjo bo sa folego?
2. A re boledišane go ya ka moo o kwišišago ka gona go ba bolwetši bjo bo sa folego bjo o phelago le bjona.
3. A o ka nhlalosetša ka moo o phetšego ka gona ka bolwetši bjo bo sa folego go tloga mola o hlahlobiwago ka gona go ba go fihla ga bjale?
4. A o ka nhlalosetša ka moo o kwišišago gore leemo la bolwetši bjo sa folego le gore bo hlolwa goba bo bakwa ke eng?
5. A o ka nhlalosetša mekgwa yeo o e šomišitšego mengwaga ye ka moka go laola bolwetši bjo bo sa folego bjo o phelago ka bjona?
6. Ka kgopelo, a o ka nhlalošetša mokgwa wa bophelo bjo o bo amogetšego ge o le gare o phela ka bolwetši bjo bo sa folego

Annexure 2(a): Informed Consent Letter

Department of Psychology

University of Limpopo

Turfloop (Campus)

Private Bag X 1106

SOVENGA

0727

17 March 2014

Dear Madam/ Sir

Thank you for showing interest in this study that focuses on the experiences of older persons living with a chronic disease at Ga-Dikgale, Limpopo Province.

Your responses to this interview will remain strictly confidential. The researcher will attempt not to identify you with the responses you gave during the interview or disclose your name as a participant in the study. Please be ensured that your participation in this study is voluntary and if you decide to withdraw at any stage there will be no penalties.

Kindly answer all the questions with integrity and honesty. Your participation is greatly appreciated.

Thank you for your time.

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Sedrose Ndivhuwo Tshishonga Date

Masters Student

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Prof. T. Sodi Date

Supervisor

Koketšo 2(b): Lengwalo la Boitlamo

Kgoro ya Saekholotši

Yunibesithi ya Limpopo

(Khamphase ya Turfloop)

Private Bag X 1106

0727, SOVENGA

17 Matšhe 2014

Mohlomphegi

Ke a go leboga go bontšha kgahlego mo go thuto ye e lebeleletšego maitemogelo a batho ba bagolo bao ba phelago ka bolwetši bjo bo sa folego mo Ga – Dikgale, Profense ya Limpopo.

Dikarabo tša gago mo poledišano ye e tla ba sephiri sa mannetennte.

Monyakišiši a ka se tsoge a go amantše le dikarabo tšeo o tla mo fago tšona ge a ntše a go botšiša goba a bololla (utolla) leina la gago bjalo ka motšeakarolo mo thutong ye. Hle, o tshepišwa gore go tšea karolo gaga go mo thutong ye ke go ithaopa, ge o nagana go ikgogela morago goba go se sa tšwelapele le go araba dipotšišo go ka se be le kotlo yeo e tla go amago.

Ka kgopelo, araba dipotšišo ka moka ga tšona ka potego (bothaga) le ka botshepegi.

Go tšea karolo ga gago go lebogiwa kudukudu.

Ke leboga nako ya gago

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Sedrose Ndivhuwo Tshishonga Letšatšikgwedi

Moithuti wa ‘Masters’

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Prof. T. Sodi Letšatšikgwedi

Annexure 3 (a): Informed consent Form

I hereby agree to participate in the study of the experiences of individuals living with a chronic disease at Ga-Dikgale, Limpopo Province. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop this interview at any point should I not want to continue and that this decision will not in any way affect me negatively.

The purpose of the study has been explained to me, and I understand what is expected of my participation. I understand that this is a research project whose purpose is not necessarily to benefit me personally.

I understand that this consent form will not be linked to the; Interview guide and that my responses will remain confidential.

I understand that, **if at all possible,** feedback will be given on the results of the completed research by dissertation.

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Signature of the participants	Date
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Researcher	Date

Koketšo 3 (b): Foromo ya Boitlamo

Ke dumela go tšea karolo go mo go thuto ya maitemogelo a motho yo a phelago ka bolwetši bjo bo sa folego mo Ga – Dikgale, Profense ya Limpopo. Ke kwišiša ga botse gore ke tšea karolo ntle le go gapeletšwa. E bile ke kwišiša gape gore nka emiša dipoledišano tše nako ye nngwe le ye nngwe ge ke se sa nyaka go tšwelapele, e bile sepheto seo se ka se ke sa nkama ka mokgwa woo o sa kgahlišego.

Maikemišetšo a thuto ye a hlalošitšwe e bile ke a kwišiša gore go hutšwa (letetšwe, tsomega) eng go nna ge ke tšea karolo. Ke a kwišiša gore, se ke projeke ya dinyakišišo yeo maikemišetšo a yona ga se gore nna ke holege.

Ke a kwišiša gore foromo ye ya boitlamo e ka se amagantšwe le, temošo ya dipoledišano le gore dikarabo tša ka ka moka di tla ba sephiri.

Ke a kwišiša gore, **ge go kgonega,** ke tla fiwa dipoelo ge dinyakišišo di fedile.

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Mosaeno wa Motšeakarolo Letšatšikgwedi

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Monyakišiši Letšatšikgwedi

Annexurex 4: Turfloop Research Ethics Committee Clearance

University of Limpopo
Research Development and Administration Department
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 2212, Fax: (015) 268 2306, Email:noko.monene@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE CLEARANCE CERTIFICATE

MEETING:	05 March 2015
PROJECT NUMBER:	TREC/19/2015: PG
PROJECT:	
Title:	The experiences of older persons living with chronic diseases in Ga-Dikgale, Limpopo Province
Researcher:	Ms SN Tshishonga
Supervisor:	Prof T Sodi
Co-Supervisor:	Dr C Burman
Department:	Psychology
School:	Social Science
Degree:	Masters in Psychology

PROF TAB MASHEGO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031.**

Note:
i) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.**
ii) **The budget for the research will be considered separately from the protocol.**
PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.