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A QUALITATIVE STUDY OF THE MEANING FOR OLDER PEOPLE OF LIVING ALONE AT HOME IN RURAL GHANA

By

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Abstract

Many people live alone in old age, often with significant health and other challenges. Living alone may contribute to social isolation, with this concept understood as loneliness that has negative influences on health and wellbeing. Alternatively, living alone could be salutogenic (or positive). An interpretive-descriptive study explored the meaning for older adults of living alone at home in rural Ghana, a developing African country. After purposive sampling, multi-day observations and repeated interviews of 10 individuals occurred until data saturation was achieved. Three themes emerged: (a) how they came to be living alone, (b) their variable ability to competently and comfortably live at home alone in old age, and (c) fears associated with living alone in old age. Most of the participants interviewed indicated that living alone was not a choice. Many difficulties with living alone were present, including fears about personal safety and the need to cope with health and income issues. As such, new considerations for old age social isolation were identified. With accelerating population aging, more older people will be living alone, making it essential for health and social policies to be designed in rural and urban areas of each country that address local cultural and economic realities.

Keywords: qualitative research, social isolation, loneliness, seniors, older people, rural, aging

Nearly 1 billion people worldwide are 60 years of age or older now, with this number expected to increase to 2 billion by 2050 in keeping with continued low fertility and late-life mortality trends (United Nations, 2013). Two of every three older persons today live in developing countries, and by 2050 this proportion is expected to be 8/10 (United Nations, 2013). The most rapid population aging in the world is taking place in African countries (United Nations, 2013). Most African countries have developing economies that are being challenged by global economic and other trends (African Development Bank Group, 2015). Another major consideration for current and future population aging is that rural areas typically have a higher proportion of older persons as compared to urban areas (Global Action on Aging, 2004); with this a concern for older people as rural areas normally have fewer health and social services

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(Wilson et al., 2009). In the Republic of Ghana, people aged 60+ years constitute 7% of the population, a rate that is low compared to Japan, the "oldest" country where 1/4 citizens are elderly, but one of the highest of all other African countries (United Nations, 2013).

With population aging, it is both ethically and practically necessary to ensure the needs of older people are understood and solutions found to prevent or reduce the significant challenges accompanying aging. Social isolation is a common challenge for older people (Constanca & Ribeiro, 2009), with living alone identified as the most important reason for social isolation in old age (Lillyman & Land, 2007; Tsegai, 2004; WHO, 2004). Although negontrophic or negative views of living alone in old age are prevalent (Lillyman & Land, 2007; Tsegai, 2004; WHO, 2004), more salutogenic or positive and health promotive views of living alone in old age are also possible and should be considered (Antonovsky, 1996).

Method

Although population aging is occurring rapidly in Africa, no studies could be located that focused on old age social isolation in Africa or what it is like for older persons to live alone in rural Africa. As more older people live in rural areas, it is particularly important to focus on these persons, as they could be most at risk for social isolation. Consequently, a qualitative study was designed to answer the question: "What is the meaning for older people of living alone at home in rural Ghana?" Interpretive description was chosen as the qualitative research method, as it aims to generate credible and meaningful insights (Thorne, 2008). Research ethics approval was gained in advance of this study from a Canadian University Research Ethics Board and then Ghana's Noguchi Memorial Institute of Medical Research.

Data were subsequently collected in three rural areas of Eastern Ghana; areas mostly inhabited by the Akan people whose language is Twi. Eastern Ghana is a typical rural African setting, far from any cities and with long-standing social customs and traditions still very much in evidence. The principal researcher speaks Twi, with this a considerable advantage as it avoided the need for an interpreter and thus possible cultural issues, as well as communication and language translation misinterpretations. This researcher also helped make this study possible, as rural people in Ghana are more likely to talk with someone who looks and speaks like them.

Care was taken to obtain the right participants. All needed to be 65 years of age or older, living alone in a rural area, willing to report being socially isolated or lonely, had lived in Ghana all their lives, were good communicators in Twi, and willing to participate in a study with at least two formal interviews and extended observations of their home and immediate community. To find participants, study information was first presented to the elders of each of the three villages

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selected for inclusion since these villages could be reached periodically by bus. This initial step of contacting elders was required for the researcher to gain permission to enter their communities. Once village elder permission was obtained, as it was in all three cases, each elder was asked to identify all potential participants, as they knew which older community members live alone and where. The village elders were not informed as to which persons were approached and which ones agreed to take part in the study. After contacting potential participants, the researcher explained the study verbally in the local language to each and provided a letter of information that was read to them. Informed consent was obtained from a total of 10 persons, with 3, 3, and 4 participants in the three communities respectively who remained in the study to its completion. The researcher stayed in each community for a few days at first to gather information about that community and the life of the people there through open observation of community life and dialogue with the local people. This dialogue was not about the older participant who was living alone in their community; it was about what it is like to live in rural Africa now. The researcher had lived in a rural Ghanaian community some years before. The researcher visited each participant a number of times on her first visit to their community, with these visits amounting to almost an entire day per person. A second similar visit to the participants and their communities 1-2 months later was done to confirm findings and ensure a valid understanding of what it means to live alone in old age in rural Ghana. This field work was undertaken January through March, 2012.

Face-to-face open-ended unstructured interviews of participants at home was the primary direct data collection method; along with observations of them, their homes, and their communities. Each formal interview lasted around 40 minutes, with these recorded and transcribed verbatim as soon as possible to enable an ongoing analysis of data. Field notes were written prior to, during, and after each data gathering episode. Data analysis after each formal interview was done by manually coding the interview and field note data, as Internet connections were intermittent. The findings for each participant and community were compared with those gained from previous participants and communities in a constant-comparative basis. As is common with qualitative research analysis methods, coded data were grouped into categories and then themes as data saturation became evident. The three themes were: (a) how they came to be living alone in old age, (b) their ability to competently and comfortably live alone in old age, and (c) fears associated with living alone in old age. All research steps and findings were reviewed with a second researcher, with the themes developed by the two together and key quotes also selected by this research team.

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Results

The 10 participants were mostly female (7/10), ranged in age from 65 to 100, and all lived alone in a house within or outside a small Ghanaian rural village. Their dwellings varied in amenities and condition; the smallest one-room homes had no toilet, electricity, or running water while all of the multi-room homes did. All participants reported and appeared to have a number of health issues, with two needing help to walk.

Theme 1. How They Came to be Living Alone in Old Age

It quickly became evident that it was essential to understand why older people came to be living at home alone in rural Africa, so as to gain an understanding of what it is like to live alone in old age. Five primary reasons for living alone were identified: (a) no children live at home, (b) death of children and/or spouses, (c) failed marriages, (d) unwillingness to burden or bother their children, and (e) neglect.

No children live at home. Most of the participants lived alone because their children had migrated to cities in Ghana or elsewhere. One said “All my children have travelled in search for employment” (#03). She received intermittent financial support from her children, with this child to parent “tithing” a tradition in Ghana. Another stated: “I live alone, as all my children have travelled” (#06). She got some financial support from her children, but she was concerned that the people in her community were not pleased with her as she asked their children to fetch water and perform other chores for her. She did not get enough financial support from her children to be able to pay them, but she still needed their assistance. Not only was she lonely for her children, but she was in a precarious position in her local community as she depended on neighbors to live at her home in that community.

Death of children and/or spouses. The death of children and spouses was another common reason for living alone in old age. These deaths were highly problematic for many different reasons, as illustrated by one participant who said “my three children are dead; death destroys the home” (#09). Another said “after delivery, my child died” (#01). She was still very sad that she had lost her only child, as children are the "source of hope in life" (#10). After her child died, her husband divorced her and she could not bear another child although she tried with several men and used medication to try to get pregnant. As such, these participants lived alone through the tragic loss of children, a major issue as large families are the norm in Africa.

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Spousal death was another common reason for living alone. One participant, when asked why she lived alone, responded "Death has brought all this about; I was married (twice). I had four children with my first husband and he died; I had two children with my second husband and he died" (#07). Another participant blamed spousal death for her current poor living predicament as she has no spouse to help her financially (#02). She was also actively grieving her "beloved" husband who had been killed only a few years before while working in another country (#02). Bereavement was thus discovered as a factor that often accompanies living alone and perhaps also social isolation.

Failed marriages. Some lived alone because of failed marriages. One said she left her husband because he was a bad man; she chose to live alone without him (#08). Another participant whose husband had divorced her because she could not get pregnant stated "If I had a man who did not care about children, I would have someone to live with now and be happy" (#01). For her, living with a spouse was considered much more preferable to living alone.

Some indicated their failed marriages had caused wounds that would not heal, while others had no regrets that they were no longer married. Most indicated directly however that living alone was "full of pain" for them. Living at home alone in old age was understood by all of them as not being in keeping with African traditions. Living alone was therefore not expected, recognized, approved, or assisted other than if they were fortunate enough to have children providing financial or other support to them.

Unwillingness to burden or bother their children. Two participants indicated they lived alone because they did not want to burden or bother their children (#04, #10). For instance, one said "My adopted child asked that I come to stay with her in the city, but I want a life of my own" (#10). Some additional information indicated though that there was very little room for her in her adopted child's home and her living there could jeopardize the marriage of her adopted daughter. As such, her decision to live alone was not simply one of preferring to live alone.

Neglect. Although some participants said they were visited periodically by church members and friends, and some said they got financial support from children and/or small gifts of food or money from community members; "neglect" by family members, friends, and/or neighbors was commonly and clearly evident. Neighbors were often seen passing by their homes without stopping. Most had no visitors day after day, and many did not leave their homes much, if at all. All participants were consequently alone much of the time, and so needed to largely if not entirely fend for themselves. Each needed to care almost independently for their own home, and shop and prepare all of their own meals, and undertake all other activities of basic and instrumental activities of daily living on their own. For instance, one stated: "I was admitted to

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hospital but was never even visited there by any of my family members" (#01). This hospital was in a city where some family members lived. Another reported "My main worries are that my children do not visit me" (#5). He had completely lost contact with them after they moved away. As such, family and community "neglect" became apparent as a factor for social isolation in old age.

Theme 2: Variable Ability to Competently and Comfortably Live Alone in Old Age

The ability to live alone comfortably and competently varied greatly among the participants, with this variability chiefly a result of their: (a) economic state, and/or (b) health state.

***Economic state*.** The economic state of most participants was very poor, with little to no income for even everyday necessities. None had savings and some worked part time in petty jobs, but their main source of income in old age was financial support from children (if alive and able to do this) and occasional gifts from other people. One participant was grateful that "my adopted child supports me with an amount of $27 (Canadian) a month," as well as "gifts of other people that enable me to buy food to eat" (#10). Another, who received some periodic financial support from her children, asserted that without gifts from other people, it would be difficult for her to survive (#03). She said "Although my children can sometimes support me financially, it is not enough to take care of me; the elders here sometimes bring me food" (#03).

This lack of sufficient and dependable income was problematic in many ways. One participant said living alone was the only option for her as "the little I get is what I spend on food; if I lived with someone, it would be difficult to provide for them" (#04). Another remarked "I could not afford to let someone young live with me because there is no money for school fees" (#06). Another said "I do not have money, it makes me feel hopeless" (#05).

Some had small businesses to raise income, but these businesses and the work associated with them were problematic. For instance, one participant reported "People buy on credit, but cannot pay. I am tired from working long hours; I come home and sleep" (#07). Another periodically rents rooms in her house for a small income; as "when you see people coming here, it means that there is a funeral, and people want a place to rent for that short time. I rent a room for a token" (#08).

None of the participants had enough funds to live comfortably and worry free. Inadequate income had many impacts on their daily lives. One common and highly obvious impact was dirty and decaying homes. Some participants were not bathed, wore dirty and torn clothing, and were

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untidy in appearance. Another common impact was inadequate food intake and with concern then for subsequent impacts on health.

Health status. The experience of living alone and the meaning of living alone for all participants were clearly impacted by their health. Most reported being ill and all were observed as unhealthy. Some of the many reported health problems were aches and reduced functioning of limbs from broken bones, abdominal pains, dizziness, blindness, and chronic diseases that rendered them weak. One participant noted “I am not too strong; I had a car accident so I walk with this stick” (#10). Another said that soon after moving to the rural area, **“**I developed diabetes and I fell into coma;” she is often weak and dizzy now, saying "I have not been able to sweep my room because I cannot bend down my head” (#01). Another said: “My waist and knee are so painful, it worries me a lot” (#06). She could do little for herself in the home, and she could not go far outside her house because she could not walk unaided. Even when assisted to walk, she said “I feel so much pain when walking so I do not take delight in it” (#06). Another participant, who had once been an active member in her church, could no longer go to church to ring the church bells or sing there. She had stopped going as her family asked her not to walk to church along the roadside because of her bad eye sight, as she risked falling or being struck by a vehicle, and she had agreed (#09).

Local healthcare services were limited, another factor explaining poor and at times worsening health. Most indicated their ill health was physically and mentally problematic for living alone. Not only was it physically demanding to live alone without help, but negative psychological health impacts of living alone were evident, as revealed by this statement “living alone is pain; it is hard; it is mind bugging; it is tears” (#01). As such, poor health was a contributor to social isolation in old age and also an outcome of living alone in old age.

Theme 3: Fears Associated with Living Alone in Old Age

The experience of living alone in old age in rural Ghana was also understood as a time of fear. Three common fears were discovered as associated with living alone in old age, each with distinct actions and/or outcomes: (a) fear of night, (b) fear of illness, and (c) fear of crime.

Fear of night. All but one participant (a male who lived in a home in his village) reported fearing the night and taking actions to address that fear. For instance, one female indicated "there are lots of fears; sometimes I will be sleeping then someone will knock hard on my gate; then I am afraid, especially when I know it is a male. Only God knows what happens at night" (#01). Her home’s geographic isolation outside the village was a factor as she worried about getting assistance at night, as “on whose door will you knock for assistance?” (#01).

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All took precautions to be safe at night. One participant explained: “Here, the windows are all intact, so it is a bit safe" and she barred the door, but she was still concerned for her safety (#03). As such, fear of the night was a common factor associated with living alone in old age, with rural living contributing to this fear.

Fear of illness. All were concerned about becoming ill and incapacitated. Some visited a city hospital for regular check-ups as a result. Others without the financial means and strength to go for check-ups managed their own lives to remain as healthy as possible. Despite this, all feared what would befall them if they became ill. One commented “I always pray that I do not fall sick. Who will look after me?” (#03). This woman was particularly worried about being sick at night when no one could see or hear her calling for help; for her, "sickness at night is the problem” (#03).

Fear of illness was also impactful in other ways. One said “the worry of sickness has rendered me hopeless that I could not even go anywhere; you cannot visit anybody for the fear of falling sick” (#01). Another was uncertain about what would happen to him; as “I have little money to take care of myself when I fall sick; I may be dead before my children come to my aid” (#05). Few had the physical strength and ability to readily do the ordinary and necessary activities of daily living on their own and all were concerned that they would not be safe if they became ill as they had no one to look after them.

Fear of crime. Fear of crime was common across all participants. A high sense of security awareness was also obvious, with actions taken by all to safe-guard their lives and property. One said “All you will hear about is stealing; by God’s grace it has not happened to me. If you leave your door ajar, that is when the evil one can enter to harm you” (#05). Another said “In this community, there are a lot of thieves; if you do not lock your door they will harm you” (#08).

Daily lives were affected in other ways by this fear of crime. One said “I cannot attend church service because I am afraid that someone will break in when I am not around” (#01). Another had experienced theft several times. She noted being vulnerable in her community because everyone there knew she lived alone and was old, stating "if I go out and do not lock my door, all my belongings will be stolen. Sometimes when I dry my washed clothes on the line, they are stolen; thieves really take advantage of me" (#03). As such, fear of crime was a factor associated with living alone in old age and it contributed to social isolation as well.

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Discussion

This study highlights diverse reasons for living alone in old age, the variable ability among these participants to competently and comfortably live at home alone in old age, and fears associated with living alone, with some unique considerations in relation to living in a rural area. This study largely revealed negative effects of living alone in old age, with these effects including social isolation as a result of limited contact with other people. Living alone contributed to feelings of despair, poverty, and other impacts; some of which are distinct to rural Africa and other impacts that are likely to be common everywhere for older people living alone, such as a fear of crime, a fear of illness, and having few if any helpers when or if needed on a daily basis and continuously during times of illness. Many findings from this rural African region are thus relevant to a broader appreciation of the impact of living alone in old age.

Living alone in old age appears to be a time of much risk for older persons. This risk was largely managed by the participants, and in salutogenic or health promotive ways (Antonovsky, 1996); such as precautions taken at night to protect themselves, and some having a business for income purposes. These businesses would also gain them company, and provide structure and purpose in life. For many, however, ill health, dependency needs, and low income were exceeding their capacity to independently live alone competently and comfortably.

This is not the first study to find health problems in old age were responsible for unmet social and other needs, and therefore loneliness (Russell, Cutrona, & Wallace, 1997). Loneliness has also been shown to reduce physical functioning (Perissinotto, Cenzer, & Covinsky, 2012), with this a revolving problem as ill health can cause social isolation and social isolation leads to or contributes to ill health. Health problems in old age erode independent functioning, and dependency on others is an issue as it precipitates frustration and fear, which are concerns as they can lead to depressive episodes, more loneliness, and increased social isolation (National Institute on Aging, 1990). The importance of good health into and throughout old age is thus emphasized. For many years, nurses and others have been concerned that enhanced health should become a greater focus of healthcare systems over the much more expensive current illness care focus.

Although few supportive services were available to the participants of this study, as Ghana is a developing country, a wide range of relatively low-cost services can be designed and provided to support living at home alone in old age; ones that are culturally and economically possible. Most developed countries have long ensured these services such as old age pensions exist to support older people, and now more recently to support the widely-popular old-age policy of aging-in-place (Wilson, Osei-ware, Hewitt, & Broad, 2012). Developing countries will

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need to notice many older people live alone, and need income and other help to remain at home.

However, consideration must also be given to the issue when living alone in old age is no longer appropriate. Living in habitually dirty, unmaintained, and unsafe homes is an indication of this concern, as well as a permanent inability to independently manage activities of daily living at home. Another indication is when family caregivers become ill from providing extensive ongoing home-based care (Bevans & Sternberg, 2012; Stajduhar, 2013). Although nursing homes do not generally enjoy a good reputation, they provide security, food, and supportive care for those needing these basic necessities. However, few nursing homes and other communal seniors' care options such as lodges exist in developing countries. Over time it is likely that these will be developed. In the meantime, there are other ways of addressing the current needs of older persons living alone in old age in developing countries. All such ways need to be in keeping with long-standing cultural traditions which emphasize children as caregivers of their parents, such as providing a small grant to children who provide a residence for their parents. Other creative solutions are needed in rural areas to address the need for local health and social services, and to address regional poverty as well. For instance, neighbors could be paid a stipend for providing services to older people living nearby in their community.

One additional consideration arising from the findings of this study is that other researchers have found physical and functional limitations reduce the ability of older people to form new social contacts and maintain old ones (Civi & Tanrikulu, 2000; Pinquart & Sorensen, 2003; Theeke, 2009). Relocations are never easy, but moving before advanced physical and functioning limitations occur as a result of undernutrition, malnutrition, falls, and other outcomes of unsupported living alone could be salutogenic or health promotive.

It is of concern that most of the participants of this study were clearly lonely. Ryan and Patterson (1987) believe the most important reason for loneliness in old age is a lack of contact with one's children. In Ghana, a country where the age-old tradition is to live with or near your children, many participants were lonely because their children had died or moved away and contact with them by telephone or other means was limited. Their loneliness could be assuaged however through contact with other people; such as church group members, neighbors, and customers. As such, social isolation cannot simply be attributed to having limited contact with children or living alone.

Loneliness and social isolation was more evident among the participants with failing or poor health. Hawton et al.'s (2011) study indicated that dependence on others as a result of physical weakness or illness results in social isolation. For older rural Ghanaians, a need for assistance with fetching water and groceries or other necessities posed a multi-faceted problem.

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If their income was adequate for their needs, they would be able to pay for assistance and thus not fear being shunned by their neighbors as a burden that these neighbors are not supposed to be responsible for, as children then and now are responsible for the care of their older family members. Income security thus appears to be a key factor for successfully living alone in old age, and thus also for helping to prevent social isolation.

It is important to reflect that most Ghanaian participants lived alone as a result of life circumstances, most often the outmigration of children, and/or the death of children and spouses. These factors are not isolated to rural African. An American study by Adams, Sanders, and Auth (2004) found both loneliness and depression resulted from the death of a spouse in old age. Other researchers have similarly found depression is common in old age in response to and then ongoing after the death of significant others (Chou, Ho, & Chi, 2006; Mui & Burnette, 1994). McInnis and While (2001) indicate death "fractures" significant caring relationships, often leaving major gaps in a person's life. The impacts of death are also of concern, as the inability to share daily thoughts and concerns with a spouse has been shown to have major negative outcomes among older people (Smith, 2012). Older women are most at risk, as women typically outlive their male spouses (Oksuzyan, Juel, Vaupel, & Christensen, 2008).

Not having a spouse in Ghana has additional cultural and practical implications to consider, however. In the context of that country's tradition of women occupying a lower socio-economic status as compared to men, widowhood exacerbates their low status and widowhood then precipitates feelings of loneliness. Another Ghanaian tradition is problematic for older females; when a husband dies and there is no will, his extended family inherits the property. The loss of a home and other lands upon which to raise goods for sale or to sell immediately places them in perpetual poverty. However, a recent interstate succession law was designed to protect widows whose spouses did not make a will leaving his estate to her (Gedzi, 2009). This law ensures widows have the right to inherit their husband's property. Yet, widows in Ghana today often do not take advantage of the law to avoid the risk of being marginalized by society for going against tradition; they are still then without his assets and thus without needed income for life in old age.

Not having children alive and living nearby was also highly problematic in rural Ghana for many practical and cultural reasons. In the Ghanaian tradition, children are expected to provide economic security for their parents. With globalization and urbanization, younger people often migrate to cities (Tsegai, 2004; United Nations, 2013; WHO, 2004). Ironically, one of the main motivations for young people in Ghana migrating from rural areas is to seek employment elsewhere to provide financial support for their aging parents (Tsegai, 2004). Although this "travelling" could be thought of as a major factor for older person loneliness, the strong family

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bond tradition that continues to exist in Ghana means children are supposed to maintain contact with their parents after migrating, in addition to providing financial support for them. Only 1 of the 10 participants felt the correspondence and financial support received from her children was sufficient. In light of this expectation, it may be necessary to determine why children are not able to provide financial and emotional support as expected. It is possible they are not doing well economically, or that familial bonds weaken after moving. Some years ago, Mason and Lee (2003) found the role of the family and extended family has declined everywhere. This gap has led other researchers to raise the question of "who" will provide care for an increasing number of older persons (Kelley, 2005). This question is of major importance as "abandonment" of older people by their children, other family members, and community members could be a major reason for social isolation in old age.

In any country such as Ghana where there is no pension to eliminate old-age poverty, personal income greatly impacts physical and emotional health. As indicated, most participants depended on financial support from their children in keeping with filial traditions, augmented with cash or food gifts from people in their community. Although this may appear a problem confined to developing countries (Kelley, 2005), a study in a developed country (the United States of America) revealed older people with higher incomes could buy the ability to live alone comfortably, as they could purchase needed assistance (Gustavson & Lee, 2004). In Ghana, most participants reported persistent serious financial difficulties as their income was intermittent and inadequate overall for meeting their needs. Similarly, a study done by Okumagba (2011) in Nigeria found the financial support received by older people from their family was neither regular nor adequate. Inadequate and irregular financial support puts the health status of older people at risk; it also increases old-age vulnerability to stress and depression, and therefore social isolation. A monthly old-age pension, even if small, is likely to be a critically important income and health requirement for older people in need.

The issue of health challenges was also paramount, as illnesses and disability at all ages limit involvement in communal activities and other social contacts (Murphy et al., 2006; Pennington & Knight, 2008). Any loss of social contacts can have a profound influence on the mental and emotional health of older persons. Murphy et al. (2006) observed that older adults with visual and auditory impairments have communication difficulties leading to loneliness. Six of the ten participants had auditory and/or visual impairments. Birkeland and Natvig (2009), and Pettigrew and Robert (2008) both report older people with physical disabilities cope by engaging in activities that do not require physical strength. This coping mechanism could result in a solitary life at home, however.

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Conclusion

This is not the first study showing older adults who live alone can be socially isolated, which is a concern for older people in both developed and developing countries. Clearly, the absence of anyone to interact with on a daily basis and to turn to in times of need can be major issues for older people, particularly those with health and income limitations. Living alone in old age does not by itself ensure loneliness or other aspects of social isolation; instead it appears a cascade of contextual as well as direct and indirect factors related to and resulting from living alone in old age are significant for social isolation, and are thus of concern and consideration for policy and service developments tailored to each country, ones that are culturally and economically appropriate (Kelley, 2005).

Acknowledgement: The researcher would like to thank her team for helping with this study, which includes her Supervisor, Dr. Donna M. Wilson, and her thesis committee members: Dr. Herb Northcott, Dr. Beverly O'Brien, and Dr. Norah Keating.

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