UNDERSTANDING SOCIAL SUPPORT AND DETERMINANTS OF HEALTH IN OLD AGE IN SOUTH AFRICA USING A MIXED METHOD APPROACH

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DECLARATION – PLAGIARISM

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Signed 

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DEDICATION

To my father, Maurice Bifilu;

My wife, Doudou Mukuna;

My sons, Believe, Hogradi and Chris;

and

My daughter, Allmerry Kosse.

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ABSTRACT

The study attempted to understand social support and determinants of health of people aged 60 years and older living in South Africa and provide a comprehensive definition of the concept of old. This research was motivated by the fact that South Africa has witnessed an increase in the proportion of older people. They have to live with threats inherent in the demise of the extended family, their traditional support networks as well as the risk of being marginalised as a result of modernisation and urbanisation. In the absence of alternative social support, the elderly are left to fend for themselves. For decades, population aging has been overlooked and there is nearly no empirical evidence on factors that affect health in old age in Africa, let alone South Africa. Furthermore, there is no consensus on the concept of old among scholars.

The study made use of both qualitative and quantitative methods to explore the issue at hand. For this study, both descriptive and explanatory research designs were used, drawing on 18 in-depth interviews from a primary study among participants in an old age home and a nationally representative quantitative sample of publicly available data. The motivation for this methodological approach was to improve the outcome of this study since strengths of one data source will compensate for the weaknesses in the other source. A total of 3545 respondents aged 60 years and older who took part in NIDS wave 5, conducted in 2017, were included in this study.

The findings from the in-depth interviews seem to suggest that the current concept of old was flawed and irrelevant. Old age cannot be described using a one-size-fits-all approach, instead, it is heterogeneous and depends on some factors including lifestyle. Old age was well explained according to others and health played an important role in this regard. An older person was regarded as a sickly individual who depended on others for performing activities of daily living. In terms of gender, men and women were believed to age differently. Moreover, from a cultural standpoint, the elderly were those who have procreated and lived long enough to see their children becoming mature and independent members of the community.

The elderly reported having at least one monthly medical appointment. The frequency of visits to health care facilities was dependent on the number of medical conditions. It was

found that older people were affected by several conditions uncommon at younger ages and some have been on medication for more than a decade. Despite the multiplicity of these medical conditions, many older people were not living healthy.

Old age pension was found to be the main source of income of the households headed up by the elderly. In becoming recipients of old age pensions, the elderly were able to keep their medical appointments as they were able to afford taxi fare. The likelihood of receiving emotional and instrumental support was higher than gifts and other donations. Adult children, notably daughters and sons were the main source of support for their parents. It turned out that childless older parents were less likely to receive gifts. Working adult children or family members were more supportive than their unemployed counterparts. Social support was associated with improved well-being and better health. This study could not confirm the abandonment of the elderly highlighted by the modernisation and aging theory.

A great deal of ill-health in old age can be prevented by raising awareness about the positive impact of a healthy lifestyle. Providing health care workers with adequate training and making them knowledge about health challenges in old age is likely to change their perception and care of older patients.

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AIDS:	Acquired Immunodeficiency Syndrome
BMI:	Body Mass Index
DRC:	Democratic Republic of Congo
HIV:	Human Immunodeficiency Virus
MDS:	Minimum Data Set
NGOs:	Non-governmental organisations
NIDS:	National Income Dynamics Study
NPOs:	Non-profit organisations
OECD:	Organisation for Economic Cooperation and Development
SDGs:	Sustainable Development Goals
STI:	Sexually Transmitted Infection
UK:	United Kingdom
USA:	United States of America
WHO:	World Health Organisation

CHAPTER 1: INTRODUCTION

1.1 Background

Within less than a century, the world's population has increased exponentially from 2.5 billion in 1950 to 7.6 billion in 2018 and this trend is predicted to continue for further decades to come (Population Reference Bureau, 2018). The proportion of people aged 60 years and above will account for 22% of the global population by 2050 (Bacci, 2017; Population Reference Bureau, 2018). This rapid growth is referred to as population aging, defined from the standpoint of the relative importance of the share of the aged to the younger population, it is a rise in the number of older people and a decline in the number of younger people (Jain et al., 2010). It is worth noting that the twenty-first century has witnessed a profound change in the demographic landscape of the world's population. Aging is viewed as a result of combined declines in mortality and fertility. The low level of fertility and mortality entails a decline in the proportion of children accompanied by a subsequent increase in the population aged 60 years and older. In most developed countries, the level of fertility has shifted from above 2.1, the replacement rate that helps maintain a balance between different age groups of the population structure and gives rise to a stable population, to below or far below the replacement level. Although aging has become increasingly widespread, its magnitude and pace vary. The most developed regions were the first to witness these demographic patterns, while in less developed countries it is a recent trend. Currently, developed countries are home to the most aged populations while developing countries have the largest share of people aged 60 years and older. Because of the heightened pace of aging in the less developed regions, the likelihood of having the highest concentration of people aged 60 years and older becomes increasingly evident (Population Reference Bureau, 2018; United Nations, 2013).

To be more specific, a rise in life expectancy is witnessed in a substantial number of countries (Population Reference Bureau, 2018; Statistics South Africa, 2018). Factors such as medical advances, access to water and sanitation, reduced family size, and family planning, as well as better food distribution and quality are put forward as those that have led to an increase in life expectancy and fuel this demographic growth (Maharaj, 2013). It is argued that because of a lack of preparation Africa cannot sustain a substantial increase in the number of people aged 60 years and older (Bremner et al., 2010). It deals with many

challenges and aging is less likely to be on the priority list. Yet the experience of the current demographic trends is not unique to Africa, Europe witnessed the same pattern towards the middle of the twentieth century. The main difference seems to lie in the pace of aging which is believed to be faster in the developing world. Furthermore, aging is coupled with rapid urbanisation as a result of rural-urban migration. The combination of both rapid urbanisation and population aging is thought to weaken the extended family which was entrusted with the care of the sick and the aged (Jackson et al., 2010). Hence, the demise of the extended family and the migration of young adults in search of green pastures could represent a threat to the well-being of people aged 60 years and older (Makoni, 2008). Traditionally, multi-generational households were instrumental in the support of the aged, any deficiency inherent in social security systems was allegedly offset by these living arrangements (McKinnon et al., 2013).

It appears evident that using old age to describe the last developmental stage of an individual remains contentious because of a lack of consensus about the definition among scholars (Orimo et al., 2006). For the purpose of this study, older people or elderly applies to every male and female who has reached the chronological age of 60 years or older. Although this chronological age is used as a basis for operational purposes, it is worth noting that the elderly differ in terms of income, health, and culture as any other age group of the population (United Nations Population Fund, 2012). The issue of population aging has been overlooked for decades by almost all stakeholders in Africa because of the youthful nature of the population (Makoni, 2008). The recent demographic trend has compelled scholars to conduct more research on aging. Unlike the more developed world, older people living in Africa can be referred to as a hidden population since there is a dearth of research on old age issues. Besides, they are more affected by health challenges and infectious diseases than other major regions of the world (de-Graft Aikins et al., 2010). The multiplicity of these challenges lead to the perception of vulnerability in old age.

The concept of vulnerability is understood as the fact of being “defenceless, liable, imperfect, unprepared, frail, susceptible, weak, helpless, open to, exposed, in danger” (Schroeder and Gefenas, 2009, p114). Vulnerability in old age appears to be a result of various concurrent factors occurring in the elderly’s life. Currently, sub-Saharan Africa experiences intersecting epidemics of HIV and non-communicable diseases (Clark et al., 2015; Mayosi et al., 2009; Nojilana et al., 2016). While the elderly living in the developed world are more likely to

become disabled and develop non-communicable diseases than infectious conditions (National Institute on Aging, 2011). The deterioration of the immune system with age increases the vulnerability of the elderly. The presence of one chronic condition or infectious disease weakens the system and makes room for additional infectious diseases. For instance, in old age, type 2 diabetes and tuberculosis are well-documented conditions associated with serious health risks (Workneh et al., 2016). From a social standpoint, the elderly are regarded as vulnerable because of their limited ability for self-determination and they may struggle to defend their interests (Barbosa et al., 2017). They are more likely to lack power, knowledge, education as well as resources. Poverty in old age is another factor that intensifies the amount of vulnerability (Tanga, 2015). Although some older people may be fit and able to take care of themselves, others may be more vulnerable and need assistance with activities of daily living (Tong, 2014).

The issue of vulnerability in old age was acknowledged some decades ago in the developed world while it was overlooked by policymakers in the developing regions. Currently, the aging debate in developed countries revolves around pension reforms. These pensions were put in place right after the Second World War when the fertility rate was high and the proportion of prospective retirees or older people was less substantial (Drucker, 2017). However, the rise in the number of the aged and the decline in fertility have rendered the pay-as-you-go public programmes unsustainable. Faced with the prospect of a sharp increase in the proportion of the aged and a rise in social welfare spending, many developed countries have already started cutting their “generosity” towards older people (Ebbinghaus, 2015). In developing countries, the main concern is still the growing vulnerability of older people. The fast pace of aging without adequate policy development remains one of the main challenges since there is not enough time to put in place a modern public welfare state system (Bengtson, 2018).

Furthermore, the outbreak of the AIDS epidemic some decades ago has highlighted the vulnerability of older people. Notably, with millions of people living with HIV/AIDS worldwide, many older people and other non-infected family members have been hard-hit by this condition (UNAIDS, 2013; UNAIDS, 2018). Older people face twofold challenges in sub-Saharan Africa. On one hand, they are affected as parents or family members by the death of their loved ones as a result of AIDS. On the other hand, they are part of millions of people who have contracted the epidemic but are denied the status of people living with

HIV/AIDS. They are neither included in the statistics nor targeted by awareness campaigns (HelpAge International, 2014). The provision of social support is one of the better ways of tackling old age vulnerability. Therefore, the elderly who are unable to live independently or perform activities of daily living may be able to improve their well-being. Studies have described 'social support as the perception every member of the community has of the quality of social bond and the availability of care and support received' (Cobb, 1976; Schwarzer and Knoll, 2007). Any assistance provided for the elderly aiming at easing their burden is referred to as social support, it can be private or public.

The last few years have witnessed an increase in scholarly writings on aging in Africa. However, there is almost no research that focuses on the impact of social support and determinants of health in old age, that is, among people aged 60 years and older. This chronological age is crucial since it seems to be associated with several health problems (Paula et al., 2010). Moreover, South Africa is home to the largest AIDS epidemic in the world, the elderly have made substantial contributions to mitigate its impact on the households. Conducting this research could help to assess the factors that influence their health. It should be noted that older people run into several problems such as poorer health and heightened poverty. The study attempts to understand social support and determinants of health of people aged 60 years and older living in South Africa and provide a comprehensive definition of the concept of old from the perspective of the elderly.

1.2 Problem statement

With an estimated 8.5% of the population aged 60 years or older, South Africa has one of the fastest-growing aging populations in sub-Saharan Africa (Statistics South Africa, 2018). Over the next few decades, the proportion of the elderly living in developing countries is expected to increase drastically and match the pattern of the more developed world (United Nations, 2015b). The onset of this demographic pattern in the more developed regions some decades ago challenged their financial stability and was associated with enormous social and economic costs (Ogura, 1994). Prior to a rise in the proportion of the elderly, these regions witnessed a change in factors such as improvement in standards of living, higher income levels, better coverage and provision of health care services, increased rates of vaccination for the youth, availability of antibiotics, improved hygiene and substantial increase in survival at younger age (Jakovljevic et al., 2017). In contrast, in the developing world,

particularly in sub-Saharan Africa, population aging occurs in the context of unstable or weak political institutions, high HIV prevalence and large burden of diseases, inadequate health infrastructures and systems, conflict and heightened poverty (Maharaj, 2013). Moreover, many governments and policymakers are still reluctant to address the issue of population aging to provide effective responses.

Population aging has become an issue in the developing world because of the pace at which it is occurring and the 'demise' of the extended family that was often seen as responsible for the care of older people (Zimmer and Dayton, 2003). Traditional old age support has been weakened by rapid urbanisation, which has led to younger members of the population migrating to cities in search of a better life and more opportunities. The burden of older people is also worsened by challenges such as lack of mobility and disability, chronic illnesses, lack of access to health care among others (Dhemba and Dhemba, 2015). Besides, they are also affected by the loss of their adult children as a result of AIDS. Older people are also involved in the caregiving activities of people living with AIDS and take on the parenting role of AIDS orphaned children (Kalomo and Liao, 2018; Kasedde et al., 2014).

The current concept of old is based on one feature, chronological age, any person who reaches the age of 60 years is regarded as an older person. Demographic characteristics such as gender, level of education, and socio-economic status are ignored. Chronological age is believed to be the feature that describes old age most effectively (Spector-Mersel, 2006). Once labelled older, the elderly are denied opportunities and resources, they become all of a sudden second class citizens. The executive order made by the German Chancellor over 100 years ago setting the age of retirement at 65 years still stands out as the commencement of old age (Bauernschuster et al., 2018). Furthermore, the fact that the elderly are able to live long, independent, and in good health is overlooked.

1.3 Rationale of the study

The multiplicity of challenges experienced by older people has not only made them more vulnerable but it is also more likely to worsen their health. There is almost no research that seeks to understand social support and determinants of health in old age in South Africa, let alone Africa and there is no comprehensive definition of the concept of old. Most studies look at policy development, the negative impact of the aging population on economic growth

and the health care system, the increase in the number of the aged and the demise of the extended family. This study seeks to fill the gap by investigating barriers to access health services in old age. A further attempt will be made to fuel the debate on the definition of the concept of old.

A gradual increase in the proportion of the elderly experienced in South Africa over the past decades appears to require an investigation. Conducting research seems to be the starting point as it will provide first-hand information on how it can be dealt with. The youthful nature of the South African population cannot be taken for granted to the extent of overlooking challenges inherent in old age. Given that old age is associated with increased vulnerability and frequent ill-health, understanding social support and determinants of health in old age remains a crucial feature that needs to be addressed to allow the elderly to live independently. Thus, this research is important as it provides insights into health in old age and informs policymakers on ways of improving the well-being of the elderly.

1.4 Objectives of the Study

The overall objective of the study is to understand social support and determinants of health of the South African population aged 60 years and older provide a comprehensive definition of the concept of old.

The specific objectives of the study are:

1. To obtain a deeper understanding of the concept of aging from the elderly's point of view.

The aim is to obtain a better understanding of the concept of old from the perspective of older people. It is a crucial concept for the elderly, they cannot be left out of issues that deal with their future.

2. To identify the source and type of support which are perceived by the elderly as an important determinant of health in old age.

This objective attempts to explore the source of support in old age, notably emotional, material and financial. Support received from the government such as old age pension as well as from others including friends, relatives and non-governmental organisations (NGOs) needs to be assessed in line with its contribution to the well-being of the elderly. It would be erroneous to focus solely on financial contributions or gifts and leave out some impactful contributions of human interactions on the well-being of the elderly.

3. To investigate the reported health status of older people and identify their main health problems.

This objective focuses on the description of the elderly's health; features inherent in their self-reported health status and the diagnosis made by health workers are highlighted. Furthermore, challenges encountered by older people in their attempt to access health care, the type of treatment received and the overall experience of their visits at health care facilities are explored. Also, practices that are conducive to healthy living, as well as risky behaviour, are investigated.

1.5 Theoretical framework

The research adopts a model, termed modernisation and aging theory, used by Burgess (1960). This theory argues that as 'societies westernise' and nuclear families replace extended families, older people are losing their status and support over time. The model consists of two distinct but related propositions. The first proposition depicts the aged experience in the more developed world and the second provides the reasons that have led to the current lack of support.

In the words of the inventor of this theory,

> "the older person… can no longer count as a matter of right and of moral and legal obligation on economic support by his children. He is less and less likely, if needed, to be offered a home by a son or a daughter. If ill, particularly with a chronic ailment his children are more and more likely to shift his care to a hospital rather than to provide a bed in their home. If lonely, he must more and more look elsewhere than to his descendants to provide companionship and sociability. In short he must seek

> elsewhere for the satisfaction of his needs – financial, health and social. In Western cultures he turns to the government or other organisations" (Burgess, 1960, p17).

This theory stirred heated debate over the role of the family in the support of older people in the more and less developed world. The controversy was over the perception of abandonment, according to O'Rand (1990), there was a decline in the amount of support but the way it was portrayed was not a true reflection of the situation on the ground since there was not uniform societal development as posited by the theory. The evidence gathered from the developing world highlighted that many elderly were living in poverty and there was a decline in their material support (Aboderin, 2000; Apt, 1997; Barrientos and Lloyd-Sherlock, 2002).

There is not a valid reason that explains the decline in the support of older people. It transpires that the demise of the traditional pillar of support, notably the extended family, and the loss of the role and status of the aged are put forward as catalysts (Aboderin, 2004). However, some studies have provided more light on this issue in pointing out the failure of the traditional norms that were binding family members. The illustration is given in the following quote:

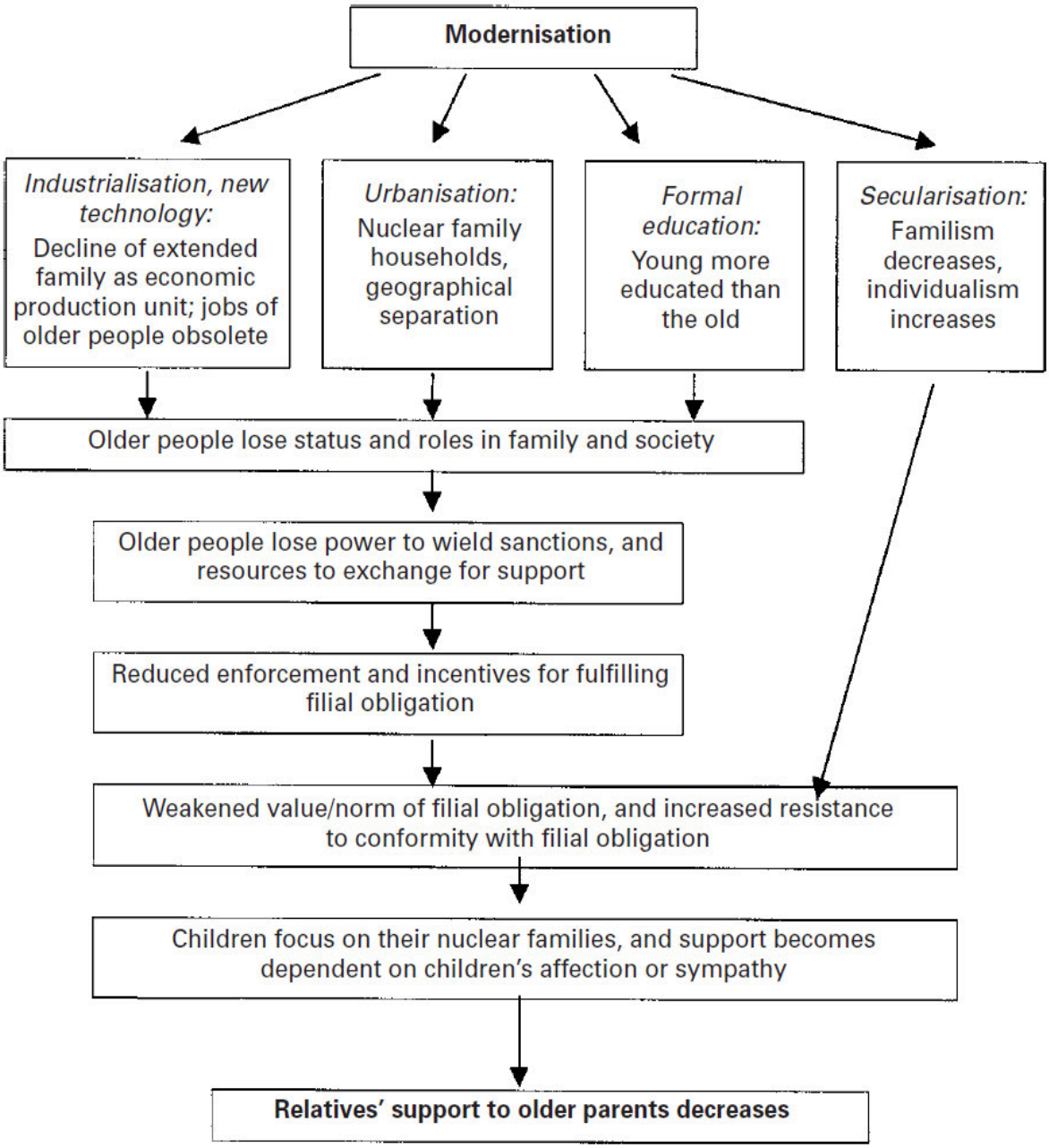
> "In all societies there is evidence of mutual obligations and responsibilities between aged parents and their adult children, but these obligations appear to be less clear and less binding in modern societies … there is considerable resistance to it, and state insurance and assistance programmes have been instituted as partial substitutes for such filial responsibility" (Cowgill and Holmes, 1972, p307).

The decline in the children's willingness to support their aging parents is more felt in cities, it highlights the weakening of familial attachments and sentiments (Burgess, 1960). The gradual increase in the values that relate to modernising societies and secularisation is seen as the consequence of the decline in the support of the aged by the younger generations. From the prospect of the most developed world, the decrease in the traditional old age support is viewed as a result of the erosion of the 'force of custom' which failed to play its role of enforcement by using economic, familial and religious punishments (Burgess and Locke, 1954; Simmons, 1945; Simmons, 1946). The potency of this tradition is explained by the fact that the elderly were in positions of authority and could easily compel other family members

to comply with the norms. This is to say that old age support was not a direct outcome of affective sentiment but a result of fear of sanctions and exchange of services such as household chores, advice or other help. The role played by older people was very crucial as it ensured that children fulfilled their family obligation of supporting their parents. The modernisation theory implies that there is a link between the decline in the support of older people and the loss of their roles and status.

The loss of the economic, religious or social privileges of the elderly due to education, urbanisation and technological advances entails the absence of both exchange resources and power to compel children to fulfil their filial obligation and norms. The theory suggests two factors that are believed to cause a decline in the support of the elderly, notably individualism and secularisation, which lead to the erosion of traditional norms of filial obligation, decrease the extent of enforcement and compliance with family obligation norms (Figure 1.1).

Figure 1.1: Modernisation theory's explanation of the causes of decline in family support for older people



Source: Burgess (1960)

Over time, children have become more interested in taking care of their nuclear families, and support for elderly parents depends more on the extent of attachment between adult children and parents. In other words, the decision to provide old age support is dependent on the

ability and willingness of children which implies that many parents are less likely to receive support from them (Grundy and Murphy, 2018).

Another theoretical framework used in this research is referred to as social support. It is based on the existence of a positive correlation between social support and psychological health outcomes. In theory, the model could be achieved through two distinct processes (Cohen and Wills, 1985). One feature of this model focuses on the
support of persons who experience stressful events, it is termed the buffering model since it seeks to minimise any potential negative influence of these events. The other feature, termed main effect model, argues that social support has always a positive outcome whether it is during stressful events or not.

It is believed that stress arises when there is no appropriate response to a situation regarded as threatening (Lazarus and Launier, 1978). Sells (1970) sheds light on this issue by pointing out that this situation requires an immediate and appropriate response which may not always be available. Furthermore, the ability to cope with difficult situations is challenged by several stressful events. The fact of experiencing persistent difficult events may result in a serious disorder and strain the coping mechanism. Cohen and Wills (1985) reveal that the psychological definition of stress associates the appraisal of stress with the perception of feelings of helplessness and the potential loss of self-esteem. Yet the loss of self-esteem can lead to self-blame or the perception of being responsible for own misfortune.

Figure 1.2 below depicts how social support buffers stress. The buffering effect takes place at two points that link stress to illness (Cohen and McKay, 1984; Gore, 1981; House, 1981). On one hand, support may take place right after the occurrence of the stressful event or expected stress to mitigate or prevent a stress appraisal reaction. In a sense, the assistance provided by others is perceived effective enough to help the subject to cope with imposed demands, and thus avoid making a particular event to become perceived as highly stressful. On the other hand, support may take place before the beginning of a pathological outcome, right after the occurrence of a stressful event, to buffer or stop the reaction to stress. Support may negate the influence of stress appraisal by solving the problem or by alleviating its perceived magnitude.

Taking care of the elderly has been one of the major roles and functions of the family. However, many recent developments challenge this traditional way of caring for the aged.

For instance, it is argued that the death of adult children, as a result of AIDS has led to the formation of skip-generation households. The death of young adults may nullify the likelihood of receiving support from loved ones (Dayton and Ainsworth, 2004; Knodel and Im-Em, 2004). Migration and urbanisation of young adults are also part of the reasons that might reduce the amount of support for the aged (Makoni, 2008). In contrast, the elderly who co-reside or live in the same area with their adult children are believed to benefit from better support than their peers with different living arrangements.

For this study, two main support resources will be used. Firstly, esteem support which means that a person is esteemed and accepted (Cobb, 1976; Wills, 1985). "Self-esteem is enhanced by communicating to persons that they are valued for their worth, experiences and are accepted despite any difficulties or personal faults", it is called emotional support (Cohen and Wills, 1985, p313). The concept of emotional support is extended to informational support and social companionship. Informational support entails providing explanations that can bolster understanding and coping mechanisms for dealing with difficult events, it is also referred to as appraisal support and advice. Social companionship entails spending time with others in outdoor activities or leisure. This type of support may be useful since it takes the focus away from worrying issues and provides carefree moods. Secondly, instrumental support involves the provision of required services, financial assistance, and material resources. This kind of support may assist in alleviating stress by solving instrumental problems or allowing the recipient to allocate sufficient time to other activities or rest.

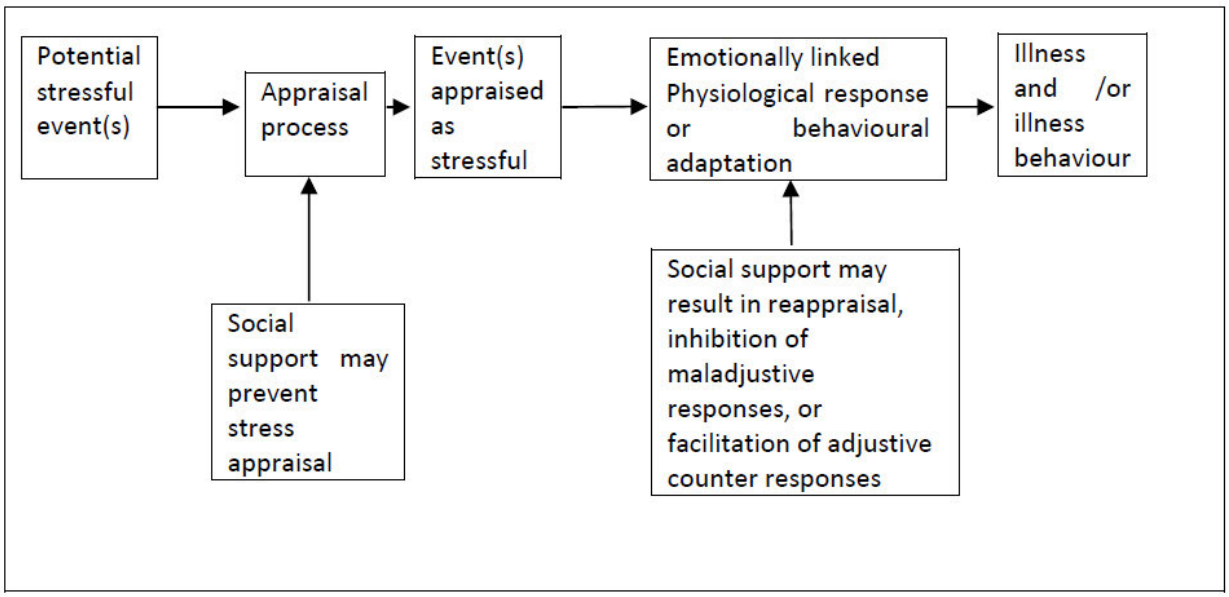
The mitigation of stressful events takes place as follows: it is assumed that the fact of perceiving events as stressful is more likely to lead to feelings of helplessness and represent a threat to self-esteem (Cohen and Wills, 1985). Esteem support may offset the effect of threats on self-esteem that usually takes place as a reaction to stress appraisal. Informational support, that is designed to provide adequate coping responses, would offset an appraised lack of control. Thus, informational and esteem support are expected to respond to different stressful events. However, companionship support and instrumental support are seen as appropriate and involve the provision of assistance for dealing with a particularly stressful event. For instance, if stress comes from a loss of companionship, then social companionship would be appropriate for its mitigation. If financial problems have led to stress, then instrumental support would be the right solution for reducing its effect. Although stressful events may

result in several resources, it is argued that specific events cause particular ways of handling them (ibid).

The modernisation and aging model is used to investigate the amount of old age support received from adult children living in the same or different areas. In other words, it helps understand the impact of migration and urbanisation on the support for the aged. The social support model is instrumental in assessing the role played by social networks, notably adult children and friends, on the health of the elderly. Social support networks are expected to be frequently supportive to reduce the effects of events appraised and even provide a direct solution to some problems.

Both models are useful since they help explore different factors that impact health in old age, they seem to overlap and complement each other. The social support theory explores issues that relate to health while the modernising and aging model unpacks the impact of migration and urbanisation on old age support. Concerning the second tool of investigation, notably the social support model, it is has been intensely used in previous quantitative studies, however, its theorising shows that it can apply to the current study and helps ensure a greater understanding of the synergy between social support and health.

Figure 1.2: Two points at which social support may interfere with the hypothesised causal link between stressful events and illness.



Source: Cohen and Wills (1985)

1.6 Organisation of the Thesis

This thesis consists of seven chapters. The first chapter has provided an overview of the study by highlighting the problem statement and rationale, the objectives and the theoretical framework guiding the analysis. The second chapter unpacks the existing literature on social support and health in old age. The third chapter outlines the research methodology and details the step-by-step process employed during data collection. The next three chapters outline the main findings from the quantitative and qualitative data analysis. The final chapter discusses in detail the main findings from the study as well as recommendations for future investigations and the major conclusions.

CHAPTER 2: REVIEW OF LITERATURE

2.1 Introduction

The rise in the proportion of the aged was regarded as a European concern since it was first experienced in the western world, towards the mid-twentieth century, where it resulted in a profound change in the population age structure. This "exotic" issue was overlooked in Africa because of a perception of "invulnerability" to the greying of the population (Makoni, 2008). There was a tacit agreement between African scholars and policymakers to neglect or pay less attention to it. This lack of interest resulted in a paucity of scholarly publications on gerontology as well as few people trained in this discipline (ibid). For instance, developed countries use chronological timing to define population aging while this concept fails to explain meaningfully old age in less developed countries (Maharaj, 2013; Makoni, 2008). The difference between these two societies makes it difficult to find common ground. Finding a consensus on this concept may be regarded as a complex undertaking because of the heterogeneity of the global population. The scarcity of data as well as of a body of research into population aging appears to be a culmination of several challenges. Besides the lack of data on the aging population, researchers do not always have access to adequate data. Under such circumstances, it is almost impossible to conduct any satisfactory research (Maharaj, 2013; Makoni, 2008). Additionally, although the Demographic and Health Survey conducted in the developing world encompasses substantial information on health, older people are usually left out.

At present, advocacy for actions against challenges faced by older people in different regions of the world has become recurrent. One of the most prominent calls for actions was made by the then United Nations Secretary-General, Ban Ki-moon, during the commemoration of the 25th anniversary of the International Day of Older Persons under the theme" Leaving No-one Behind: Promoting a Society for All" (United Nations, 2015a). Mr. Ban Ki moon acknowledged the contribution made by older people to global development and described them as an enormous asset to society.

At present, this call to action seems to be heard by researchers in Africa as numerous studies attempt to unpack different challenges experienced by the elderly; aging in Africa (Makoni, 2008); health status and quality of life (Mwanyangala et al., 2010); morbidity profiles (Jain et

al., 2010); dietary diversity of women caregivers (Oldewage-Theron and Kruger, 2011); hypertension and associated factors (Peltzer and Phaswana-Mafuya, 2013); aging and health in Africa (Maharaj, 2013); social networks and health (Moore et al., 2018); intergenerational care (Harling et al., 2018; Schatz et al., 2018). The recent interest in researching population aging is prompted by a set of issues that can be broken down as follows: a rise in the proportion of people aged 60 years and older, the demise of the extended family, the outbreak of HIV/AIDS, changes in morbidity patterns and increasing migration.

This section provides a critical review of literature that helps to understand social support and highlights the determinants of health in older people. It looks at some empirical evidence on challenges inherent in the health of the aging population and outlines the definition of the concept of old. Furthermore, it highlights some determinants of health and unpacks the role played by relatives and friends in their attempt to tackle challenges that come as people grow older. It also discusses some practices or behaviours regarded as risky or acceptable that may have an impact on the well-being of the elderly.

2.2 The concept of old

Several attempts have been made to describe the concept of old but there is not a single definition universally accepted among gerontologists. By convention, the term elderly is used to describe any person who is 65 years or older. The age group elderly is broken down in two parts; those who belong to the 65-74 sub-age group are referred to as “early elderly” and from 75 upwards are “late elderly” (Orimo et al., 2006). Nevertheless, this definition does not stem from any empirical evidence. It is believed to date back to the reign of Prince Bismarck, the then German Chancellor who set 65 years as the minimum chronological age at which every citizen would be eligible for a pension. When this executive order was made, turning 65 was nearly impossible as a lot of people were more likely to die early (Bauernschuster et al., 2018). At present, given medical and health advances and gains in life expectancy experienced over recent decades, this definition does not hold true anymore since it lumps together everyone who is 65 years or older into the elderly age group (Klenk et al., 2016). Unlike during Bismarck time, a substantial number of people aged 65 years and older are now able to live long and healthy lives.

From the perspective of the United Nations, old age begins at age 60. This means every person who turns 60 can be referred to as the elderly (United Nations, 2013). Defining old age using chronological age as a key factor has one advantage; it allows the United Nations, for instance, to compute easily and consistently the world population. When using fixed chronological age as an indicator of old age, it is assumed that there will be no change in factors such as disability rates and life expectancy at 65. This assumption does not hold true since many characteristics associated with age do not remain fixed instead they are subject to change. It can be noted that in 1950 and 1955, women aged 65 years old were expected to live an additional 5.7 years on average in Japan. Fifty years later, their life expectancy increased by 15.6 additional years and a further increase is predicted (Klenk et al., 2016). The number of years spent in good health or disability-free life expectancies has witnessed the pace of increase similar to the pattern of life expectancies. These gains have reduced the rates of disability in old age (Sanderson and Scherbov, 2010).

Because of the complexity of defining old age by using the timing approach, an attempt to avoid this conventional measure was made by Ryder (1975) who was followed by others. However, despite having some advantages in terms of the computational process, this attempt was associated with challenges that would impede further investigations. Firstly, aging was not seen as a serious issue until recently. Secondly, there were neither available life-expectancy adjustments in consistent and acceptable format for all countries nor enough trained people to use them (ibid). According to Orimo et al. (2006), a better chronological definition should take into consideration regional, historical and social aspects. A survey conducted in Japan reveals that many Japanese believe the term elderly should be used for people who are aged over 70 or 75 years and unable to perform activities of daily living (ibid).

Governments, in developing countries, define old age from the perspective of developed countries, that is, taking into consideration retirement age as a basis. However, given that the largest share of older people in the less developed regions lives in rural areas, they are neither formally employed nor entitled to formal retirement or its benefits, this imported definition does not hold true. Furthermore, the current concept assumes that there is no difference in terms of life expectancy between more developed and less developed regions. Applying this definition to regions with relatively lower life expectancy may not help capture the real meaning of old age (Kowal and Dowd, 2001).

In Africa, the chronological definition of old age seems to be irrelevant since it overlooks several regional differences. For instance, this concept fails to embody many key realities that describe better old age. Firstly, because of the absence or inefficiency of vital registration, many elderly are unable to provide their exact dates of birth, instead, they refer to some events that might have happened during the year of their birth to determine their ages. Secondly, there is a difference in the perception of the concept of old in Africa. It is associated with the amount of achievement in life, the number of children and wives, properties and possessions, grandchildren, etc. Thirdly, visible features (such as wrinkled face, grey hair, etc.) are viewed as characteristics of old age. Fourthly, the amount of knowledge on major events, rituals, history, initiations, and other traditional practices is seen as a feature of seniority. Finally, the retirement age cannot be used as criteria since it is flawed and ranges from 45 to 65 years (Nhongo, 2004).

Despite these inconsistencies, the Organisation of African Unity Policy Framework and Plan of Action on Aging advocates for Africa to align itself with the definition of the United Nations. Embracing the United Nations definition will, of course, simplify understanding but it will not capture its real essence. Defining this concept in this way is more likely to leave out many older people whose identity documents indicate that they are younger than the age of legal retirement. Thus, the fact of including the chronological, functional and social components of this concept would capture the full meaning of old age in Africa (Kowal and Dowd, 2001; Nhongo, 2004).

A study among older people in Nigeria found that the chronological age at which an individual was considered old was 76.8 years for males and 64.2 years for females (Togunu-Bickersteth and Togonu-Bickersteth, 1988). Because of this, three points seem to stand out from this definition. Firstly, it is more liberal than the official concept that sets the retirement age at 60 years for every citizen and 65 for the judges of the high court. Secondly, the official definition does not make a distinction between male and female. Finally, regarding the number of challenges faced by older people in Africa, this chronological age might be very high. On the other hand, its gendered aspect seems to provide a clear picture of the concept that blends in the African context by including features such as a decrease in the vigour or inability to assume the role of provider and childbearing for male and female respectively (ibid).

Gorman (2017) points out that the concept of chronological age is irrelevant in a significant number of developing countries. Instead, there are other definitions accepted by societies that are better at explaining old age from the role played by the elderly. The inability or weakness to perform societal roles can be used as a basis for describing old age. In fact, in most developing countries, old age is believed to begin when people become unable to contribute actively to society or family. According to the World Health Organisation (2000), Harare hosted the Minimum Data Set (MDS) workshop that aimed at recognising the United Nations definition of 60 years as the commencement of old age; however, a large share of participants came to the conclusion that this concept does not reflect the real condition of older people in the less developed world. One year later, another MDS workshop hosted in Dar es Salaam agreed to set the commencement of old age at 50 years instead of 60 years (World Health Organisation, 2001). Nevertheless, despite the recommendations made at these workshops, it is difficult to compare data from countries around the world.

Ayokunle et al. (2015) argue that the traditional definition of old age varies across countries, regions, and settings and seems to match the chronological timing of 50 to 65 years in Africa. It should be noted that the official or chronological definition of old age does not always match its traditional component. Yet, the age of legal retirement has turned out to be the default definition of old age. In general, anyone aged 50 years and older should be referred to as an elderly person (Collins and Lienhardt, 2014). In Nigeria for instance, in 2017, life expectancy at birth was approximately 52.8 years and 55 years for males and females respectively (Central Intelligence Agency, 2018). To be more inclusive and appropriate, the Nigerians suggest that an old person is recognisable by various characteristics including their inactivity, illness, respect, physical appearance, blessedness, inability to handle tasks (Ayokunle et al., 2015; World Bank, 2012). In other words, an older person is anyone living in Nigeria aged 50 years and older (Akanbi, 2014).

2.2.1 Old age as a social construct

The gain in terms of extension of human lifespan did not occur suddenly and there is not much change in the length of human life. The only significant change that seems to challenge cultural norms is the number of people who survive into old age (Carstensen, 2011). The rise in the number of people who live into their 80s and above is creating a discrepancy between

observed cultural norms and the length of their lives. Human life revolves around culture; the age for getting educated, marrying, starting families, being active and retiring is determined by culture (Riley et al., 1994). The sudden increase in life expectancy has caught off guard the contemporary cultural norms, used to distinguish different developmental stages in life, which are still set at halfway of the lifespan of older people. Even the life course used as an indicator is also culturally designed. Two hundred years ago, the stage of life in human development referred to as "adolescence" did not exist. The age of 65 was not associated with more significance than 55 or 45 (ibid). Cultures and societies are youth-oriented since infrastructures and social environments are designed to be used by young people (Davey, 2017). This assertion seems to apply to medical science, a crucial part of a culture, which mostly focuses on curing infectious and acute conditions while ignoring the elderly's health (Ng et al., 2010).

2.3 Factors impacting health

2.3.1 Health disparities

A study conducted among older people in Tanzania found that higher quality of life and good health status correlated with the fact of being married and having a higher level of education (Mwanyangala et al., 2010). Enstrom and Breslow (2008) outline some factors experienced in life at a younger age are more likely to impact health in old age. Notably, people with middle to high levels of education were more prone to better health in old age. This entails that individual health depends on the level of education attained. Educated people tend to be more knowledgeable about healthy behaviour and have more control over their life (Mirowsky, 2017). For instance, ignoring or being unaware of the World Health Organisation guidelines on the prevention, assessment, and management of cardiovascular risk may result in heightened health risk of developing this condition (World Health Organisation, 2007).

A multi-country study (China, Ghana, India, Mexico, Russia, and South Africa) reveals that Russia accounts for the highest proportion of people who are aware of the risk of hypertension (72%) while none of the other countries neared 50%. Other factors associated with awareness are age, gender, urban residence, overweight and obesity (Lloyd-Sherlock et al., 2014). A study by Liu et al. (2017) highlights that older women living in urban areas in China were more aware of hypertension than their male counterparts as well as other older

women living in rural areas. The urban residence appears to be associated with more exposure to the media which results in more awareness. In terms of gender, women outlive men in developed and developing countries, however, they are likely to spend a substantial time of their lifespan in poor health (Kinsella and He, 2009).

Regarding the relationship between health and standard of living, a positive correlation was found between quality of life in old age and household wealth (Mwanyangala et al., 2010). Islam et al. (2010) point out that income-related health inequality is maintained over time and increases as people age. Unlike the poor, people of high socioeconomic statuses seem to have the privilege of choosing health care services at their convenience. Asada et al. (2014) argue that historical and social reasons are more likely to impact health inequalities associated with some socio-demographic characteristics. Countries with a history of discrimination such as the United States tend to experience health disparities.

Also, regardless of the level of socio-economic development, non-communicable diseases remain the leading causes of death in old age in both poor and rich settings. It is revealed that the elderly living in developing countries tend to develop chronic conditions and die earlier than their counterparts in the more developed world (Beard et al., 2016). A study carried out in Scotland argues that people living in poor settings are more likely to develop non-communicable diseases 10-15 years earlier than their counterparts in wealthier areas. Similarly, the prevalence of non-communicable diseases is higher in people of low socioeconomic status than in high-income earners (Ibanez-Gonzalez and Norris, 2013; Marengoni et al., 2011; Mayosi et al., 2009; Nojilana et al., 2016). Given the amount of health vulnerability associated with old age, the plight of the elderly living in the less developed regions is worsened by the combined effects of non-communicable and communicable diseases. Disparities in terms of lifespan and health seem to be dependent on the socio-economic level of countries. Also, Kinsella and He (2009) found that the elderly living in the more developed regions tend to outlive those in the less developed regions and also spend a substantial part of their lives in good health.

Several other socioeconomic factors are believed to be responsible for health inequalities in older people. Yet a substantial share of ill health in older persons in Africa seems unjust as it highlights their exclusion from the provision of health care (Wyman et al., 2018). The elderly experience worse health than younger adults while their utilisation of health care services is

substantially lower. This contrast highlights possible inequalities in accessing health care services between these two age groups (Aboderin and Kizito, 2010). In sub-Saharan Africa, the largest proportion of older people live in rural areas where most formal health care facilities are very rudimentary (United Nations Development Programme, 2016). Accessing health care services is difficult for many older people since they face various barriers such as user fees, compulsory co-payments, long distances, waiting times, transport costs, inadequate health facilities, lack of adequate information, inadequacy or unavailability of required services in public health institutions (Aboderin, 2010; Beard et al., 2012). This practice has deterred older people from attending health care services even when vulnerable groups are exempt from paying. A survey conducted in Ghana reveals that numerous older people could not seek health care although they were entitled to free access (Beard et al., 2012). Studies in the Democratic Republic of Congo (DRC) list some reasons such as high costs, the inadequacy of health care facilities and long distances as factors that impede the elderly to seek medical treatment, especially in rural areas. Ill-health is also put forward as a deterrent to health seeking behaviour in frail older people. They are less likely to seek health care than their non-frail counterparts (Zihindula and Maharaj, 2013). By the same token, Beard et al. (2012) argue that even when they have access to health care facilities, the service is either of low quality or unaffordable. More importantly, few older people living in developing countries are covered by medical aid.

2.3.2 Lifestyle

Unlike most infectious illnesses that are curable, chronic conditions are costly and require long-term care in all sufferers. The elderly are more affected than younger adults because their immune systems weaken with age, they become prone to develop more chronic conditions than at younger ages. Adopting a healthy lifestyle is regarded as a better way of circumventing the trap of chronic conditions across all age groups and particularly among the elderly (Simon et al., 2015; World Health Organisation, 2015). Physical inactivity has become one of the major causes of death with 6% of cases globally (World Health Organisation, 2010). In contrast, regular participation in physical activity decreases the risk of developing conditions such as breast and colon cancer, coronary heart disease, diabetes, stroke, hypertension, and depression. It should be noted that physical activity is an important component of a healthy lifestyle as it is essential to weight maintenance and weight loss (Swift et al., 2014).

The level of physical inactivity is high in old age, with a study conducted in five developing countries revealing that around 21% of older people in South Africa meet the World Health Organisation (WHO) guidelines on physical activity, the highest proportion was 59% registered in China and Ghana (Gaskin and Orellana, 2018). WHO recommends that every individual aged 18 years and older spend 150 minutes or more a week engaging in moderate to vigorous physical activity (World Health Organisation, 2010). A longitudinal study in Jerusalem reveals that physical activity extends survival rates and delays functional loss in the oldest old (Stessman et al., 2009). Similarly, the gap in terms of the positive effect of physical activity on well-being widens between physically active and sedentary older people with advancing age. Additionally, the protective effect of physical activity is also observed in individuals who have been active throughout their life as well as those who start exercising in old age. The protective effect seems to be dependent on the intensity of physical activity, even a dose below the current WHO guidelines on physical activity result in improved survival (Hupin et al., 2015).

Educated people are more likely to have a different lifestyle than their uneducated counterparts as a result of their higher income, increased knowledge and access to information. Studies have found a link between socio-economic status and health. According to Haas et al. (2012) and Hurst et al. (2013), educated older people, as well as those living in wealthier households, have a significantly stronger grip and faster gait than those with lower socioeconomic status. Furthermore, a balanced or healthy diet made up of cereals, fish, fruits, legumes, nuts, olive oil, seeds, and vegetables is believed to be associated with a better quality of life and an improved health status (Milte and McNaughton, 2016). In contrast, an unhealthy lifestyle in mid-life tends to be associated with negative health status in old age. The consumption of tobacco is regarded as one of the important risk factors that lead to non-communicable conditions such as cancer and hypertension and it has a substantial impact on premature mortality (Lafortune et al., 2016). A significant amount of mortality and morbidity is attributed to alcohol consumption. Despite being credited with some form of protection from ischaemic heart disease as a result of alcohol consumption in women, these positive effects are outweighed by the risk of cancer, communicable disease, and injuries associated with alcohol consumption (Griswold et al., 2018).

2.3.3 Qualifications of health care workers

The risk of developing non-communicable diseases increases with advancing age. Providing better health care to the elderly requires special knowledge and skills imposed by the complexity of their health needs (Ferris et al., 2018). Despite the availability of treatments that could improve the well-being of the elderly suffering from some non-communicable diseases, they were simply turned down on the grounds of suffering from less severe conditions. For instance, studies reveal that older people suffering from depression were denied treatment by health care workers (World Health Organisation, 2012). In the same way, many older people suffering from dementia were denied the status of "sick" since their condition is viewed as a result of aging. This reaction may raise serious questions about the competency of these health care workers to deal with older patients since they believe that chronic conditions in the elderly are a result of the normal aging process (World Health Organisation, 2012; World Health Organisation, 2017). This perception does not seem to hold true since age does not cause pain but only extreme old age can restrict bodily function (World Health Organisation, 2012).

2.3.4 Attitudes of health care workers

The attitude of health workers towards older people is also believed to be one of the reasons that decreases health seeking behaviours in the elderly. Any discriminatory attitudes affect both the quality of services and access to health care (Rubinstein et al., 2017). For instance, older people have been frequently discriminated against by mental health services in the United Kingdom (UK) and by health care systems in Africa (HelpAge International UK, 2017). Apt (2013) highlights that in Ghana older people complain about a lack of respect, consideration, and ill-treatment. The elderly report being treated like a waste; they are advised to remain quiet, to obey without voicing their frustration about the quality of health care. Any disobedience can be severely punished, they are repeatedly told that taking care of them is worthless because they are going to die (Rubinstein et al., 2017).

Some older people believe the attitudes of health care workers towards them may be explained by a lack of motivation as a result of their meagre salary (Rubinstein et al., 2017). A study in South Africa by Haskins et al. (2014) points out that some health care workers did not like their profession, they ended up working in the health sector because of a lack of

opportunities in their career of choice. In contrast, knowledge of gerontology and preference to work with the elderly appear to have a positive impact on the health care workers' attitudes towards the elderly. Liu et al. (2012) found that education in gerontology and better clinical experiences are more likely to improve the interaction between health care workers and older patients.

2.3.5 Policy and old age

The elderly seem to be an invisible population since they are more likely to be omitted from public debate. The exclusion or omission of older people, on the part of African policymakers, translates into a lack of responsiveness towards the elderly. Thus, the largest share of the health budget is allocated to services for age groups that fall under the Sustainable Development Goals (SDGs), notably, children, mothers as well as those who suffer from tuberculosis and HIV/AIDS. The needs of older people are overlooked since other competing priorities are deemed more urgent and important.

It is argued that a rise in the proportion of the aged will put much strain on the health care system and social security. A significant increase in health spending is expected to take place since old age requires intensive utilisation of health care services (Keehan et al., 2017). Nevertheless, evidence points out that the involvement of multiple stakeholders such as policy makers, planners, innovators, and scholars will enable countries to come up with better responses to the challenges of population aging and meet their basic health needs (Cloos et al., 2010; Walker and Maltby, 2012; World Health Organisation, 2002). The reform of the health system can also help to lower the health spending of the aging population (Kelley et al., 2013).

2.3.6 Poverty and vulnerability

The well-being of the elderly is challenged by factors such as vulnerability and poverty. In a sense, they are more inclined to be at risk of chronic poverty as a result of the culmination of disadvantages accumulated from younger ages (United Nations Development Programme, 2014). According to Ku and Kim (2018), South Korea records one of the highest levels of poverty in old age among the Organisation for Economic Co-operation and Development (OECD) countries with slightly over 40% of the population aged 65 years and older. On the

other hand, the rate of poverty in old age is low in 11 OECD countries. The United Nations (2015b) argues that the public pension scheme has led to a substantial decline in poverty in old age.

The developing world witnesses a higher level of poverty in old age compared to the general population, especially in countries that do not provide the elderly with pensions (United Nations, 2015b). Their vulnerability is exacerbated by ill-health and a lack of economic opportunities. In general, there is a systematic disadvantage of older people compared to younger adults in terms of access to health and wealth. The proportion of poor older persons is higher than their younger counterparts in both rural and urban areas. This highlights the relationship between old age and poverty in African settings. The lack of social justice results in the combination of four factors that make the aged more vulnerable as argued by Aboderin (2012). Firstly, physical and mental impairments make it difficult to take up well-paid jobs, which is worsened by the lack or limited opportunities for securing employment. Secondly, the traditional "safety net" or the extended family is waning in magnitude. Young adults tend to migrate to other areas in search of opportunities and better living conditions. Thirdly, they are compelled to fend for themselves following the death of their adult children as a result of AIDS. Finally, a lack of old age pension in most countries in sub-Saharan Africa makes it difficult for the elderly to be financially independent (Aboderin, 2012; Apt, 2012). These factors highlight the impact of urbanisation and nuclearisation of the family as posited by the modernisation and aging theory (Burgess, 1960; Makoni, 2008).

The research adopts a model, termed modernisation and aging theory, used by Burgess (1960). This theory argues that as 'societies westernise' and nuclear families replace extended families, older people are losing their status and support over time. The model consists of two distinct but related propositions. The first proposition depicts the aged experience in the more developed world and the second provides the reasons that have led to the current lack of support.

The poorest households in north-eastern KwaZulu-Natal are believed to be headed by older people (Aboderin, 2010). Several studies have highlighted various issues confronted by these households such as poor health, a lack of basic necessities and deficient nutrition (Oldewage-Theron and Kruger, 2011). For instance, any additional increase in the household size is more likely to put a strain on the elderly as primary breadwinners (HelpAge International, 2010).

Similarly, in the Democratic Republic of Congo (DRC), older people live in dire poverty and blame their ill health on food scarcity rather than age (Zihindula and Maharaj, 2013). It is worth mentioning the existence of differences in terms of vulnerability between males and females. Given that women tend to live longer, they experience heightened poverty and vulnerability. Moreover, women's lower socio-economic status due to their lack or limited level of education is an additional challenge. Women are often expected to juggle childcare and work, as a result, they are more inclined to be employed in the informal sector (United Nations Development Programme, 2014). Marital status plays an important role in their socio-economic status in later life. Married older women are more likely to have a higher socio-economic status than those who are not. Minicuci et al. (2014) reveal that in Ghana married older women had better health outcomes than their widowed counterparts.

The vulnerability of older women is enforced by discriminatory practices against widows in some countries. For instance, in countries such as Ethiopia, Honduras, and Rwanda, widows are not legally entitled to have any share of their husband's property, savings or pension. Instead, a brother or son of the deceased inherits every asset and is not obliged to support the widow (Beard et al., 2012). In general, the elderly are stereotyped and marginalised because of their age. Forcing them to retire is regarded as a form of marginalisation and it can be perceived as a message to potential employers that they are no longer fit for taking up any job. The elderly are often described as forgetful, frail, helpless, past their sell-by date, senile, unproductive and worthless. These depictions are likely to result in negative attitudes towards the elderly. For example, younger people may be tempted to prevent them from taking part in the daily activities of the community (World Health Organisation, 2012).

2.3.7 Culture

According to Goodenough (1981), culture can be understood as a set of values, practices, and symbols that influence the behaviour of every community member. The concept of "cultural frame" can help to shed light on the influence of culture on individual behaviour, values, and beliefs. It provides more insights into the way culture shapes experiences, beliefs, and interactions that are perceived to be common to every community member (Dilworth-Anderson et al., 2012). Barriers to health care or a healthy lifestyle inherent in culture can be well understood by looking at practices, values and belief systems. Many people's actions and beliefs regarding health are rooted in their cultural perspective

(Alexander et al., 2012). Any cultural practices that accommodate risky behaviour can be deemed dangerous for health. For instance, in Bolivia, being a sex worker is culturally accepted and viewed as a beneficial economic activity among Ayoreo people despite the heightened risk of contracting HIV and STIs associated with it (López-Entrambasaguas et al., 2013). Dilworth-Anderson and Gibson (2002) reveal that cultural practices and values do not only influence the perceptions different communities assign to dementia but also prevent them from seeking help from non-relatives.

On several occasions, culture is put forward as a factor that has serious implications on health outcomes (Singer, 2012). Culture plays an important role in influencing human behaviour in every society. It is believed that the combination of culture with historical, geographical, political and social factors influences people to adopt a healthy lifestyle. A study conducted among migrants highlights the impact of culture on both the pattern of morbidity and lifestyle (Fejerman et al., 2008). While investigating the pattern of asthma among people of African descent, the highest rates were found among African-Americans in the United States, the diaspora living in Caribe came in second position and individuals residing in Africa recorded the lowest rates (Akosile et al., 2018). According to Asada et al. (2014), social reasons influence significantly the health outcomes of different populations in the USA and UK. Similarly, a study conducted among American older people reveals that, besides Asians, all minority groups were more likely than whites to report poor health such as inability to conduct activities of daily living, sensory limitations, several health symptoms and poor mental health (Ng et al., 2014).

2.3.8 Labour and income

Labour income is an important source of revenue for older people. Several countries encourage older people to continue working after retirement. It is perceived as one of the ways of alleviating challenges inherent in population aging and providing much-needed experience and skills (International Labour Organisation, 2017). In a sense, an increase in the labour market participation of older people is likely to be fuelled by factors such as the demise of the extended family and weak pensions systems, the prospect of raising the retirement age and better health and a rise in the labour participation of women (International Labour Organisation, 2018). Working after retirement age is also regarded as a way of

supporting at least part of their spending in the absence of formal social security schemes (International Labour Organisation, 2017).

For the age group 65 years and older, the proportion of income earners decreases sharply, especially in developed countries and some developing countries in Latin America that have extensive social security schemes. For instance, in countries like Austria, Finland, and Germany, people aged 65-69 years support their consumption with less than 10 percent of their labour income while the elderly living in developing countries can support theirs with up to 45%. In general, from the age of 70 onwards, their contribution tends to decline in both developed and developing regions. Furthermore, at this age, the elderly face several challenges such as declining productivity, accessibility to labour markets, employability and health. Only a few older persons can still rely on labour income to finance a significant part of their consumption (United Nations, 2013).

In many OECD countries, over half of income among people aged 65 years and older stems from public transfers. This is inclusive of public sector pensions and minimum income schemes. The largest share of income comes from the public sector with 60%, employment based-pensions accounting for 20% and other sources such as private investments and private pension schemes accounting for nearly 20% (OECD, 2015). Unsurprisingly, these proportions vary across different countries. For instance, in Belgium, Hungary, Slovakia, and France public sector pensions account for 80%, in Finland and the Republic of Korea their share drops at 15% and slightly over 33% in the United States. It appears that public benefits play a crucial role in poverty alleviation among older people in OECD countries, the extent of need would be much higher if public pensions were not part of the mix (United Nations, 2017b).

Unlike other countries, OECD countries have achieved better levels of pension coverage. The incidence of poverty in Latin America and the Caribbean depends on the level of coverage and generosity of the pension system. Data from 12 countries of this region reveal that 30% of people aged 60 years and older do not benefit from any type of pensions and even over 50% for the Dominican Republic, Colombia and El Salvador (United Nations, 2017b). Outside OECD countries, the coverage is very low and averages 44% in Eastern Asia, 34% and 32% in the Middle East and Northern Africa and Latin America and the Caribbean respectively. It even drops further in Southern Asia with 13% and 6% in Africa (ibid).

With close to 90% of coverage, South Africa has one of the most extensive cash transfer schemes in Africa. Unlike the majority of more developed countries, in Southern Africa, the pension system is non-contributory because almost all eligible recipients are not formally employed. The pension scheme is essentially an anti-poverty measure aiming at providing the elderly with a source of income allowing them to meet their household needs (Madhavan et al., 2017). Financially speaking, every pension recipient has become less dependent on family members and friends and can take care of himself or herself. In terms of age, the eligibility criterion was 65 years for men and 60 years for women but was equalised to 60 years in 2008 for all recipients (ibid).

2.3.9 Social support

Social support is believed to be a key feature that impacts the amount of well-being and is an important determinant of health. The elderly experience numerous life-changing events such as retirement, illness, and death. Although these events cannot be avoided, their impact on health and well-being can be managed (Smith et al., 2017). For instance, while asked about factors that make their life better, approximately 81% of a group of 999 people aged over 65 years living at home in Britain reply that social interactions and social support had a positive impact on their well-being (Bowling et al., 2003; Siedlecki et al., 2014). Having satisfying relationships is more likely to be associated with frequent happiness and less frequent sadness. Research reveals that happy people who tend to be friendly and cooperative, generous, live longer than those who are unhappy, they have larger social rewards as well as better immune systems (Siedlecki et al., 2014). Social support seems to play an important role on psychological health outconmes of the elderly as highlighted by the theory (Cohen and Wills, 1985).

A study by Smith et al. (2017) reports a high likelihood of being physically active in the elderly who receive greater support from family members. Likewise, a positive relationship was found between social support and physical activity. Marital status can be equated with social support as it has a substantial impact on emotional health. Also, social support works as a buffer against the risks associated with some diseases and even offset the negative effect of chronic conditions on well-being (Heinze et al., 2015). In contrast, a lack of social support is more likely to be associated with negative health outcomes for the elderly. An estimated

20% of older people living in Botswana are relatively isolated. With no helping hands, they are compelled to perform activities of daily living even when their ailing bodies struggle to cope with it. Their inability to perform these basic activities combined with poor health, impaired mobility, solitary eating may have a negative consequence on their longevity (HoltLunstad and Uchino, 2015).

On the other hand, research conducted in developed and developing countries fails to support the notion of abandonment of older people by younger generations as a result of development as highlighted by the modernisation and aging theory (Burgess, 1960). Evidence shows that family ties have been maintained, have superseded social change and adjusted to economic hardships. Although they are less likely to co-reside as it used to be in the past, family members still provide financial assistance to any loved one in need through private transfers (Kim et al., 2015). This type of transfer is important in settings where formal old age pension schemes are either inexistent or weak. It is worth mentioning that support from family members is not always consistent or adequate. Instead, it is unpredictable, informal and the value of transfers depends on the ability to provide of the remitters who are, to a greater extent, subject to market fluctuations and instability such as labour income and unemployment (United Nations, 2013). The United Nations (2011) argues that even if parents and adult children do not live under the same roof or in the same area, many other ways can be still used to provide support.

Depending on their health status, the elderly living in the United States are cared for in three different environments: home, assisted living residences and skilled nursing homes (Tong, 2014). A substantial proportion of the elderly live in their own homes or are accommodated by family members. They live independently or receive minimal support offered free of charge or at a cost. Some of these elderly are active, productive and healthy, live longer and work part-time to avoid feeling bored or in order to earn an income. This type of older people is outspoken about their independence and successful aging (Jakovljevic and Laaser, 2015). In terms of care, nearly 65% of home care provided is unpaid and women account for the largest proportion of caregivers. The average amount of time required to assist the elderly varies from one to four years. To ease the burden of their tasks, some families hire the service of an independent caregiver (Adkisson et al., 2011). On the other hand, assisted living residences accommodate the elderly without relatives or friends who can take care of them as well as those who are uncomfortable with the home environment. Their willingness to live in

these residences may not be sufficient since they must be able to pay the professionals who will care for them. Assisted living residences in the United States support the elderly with housing, health care and recreational activities (Tong, 2014). Regarding, skilled nursing homes, the decision can be made by caregivers or the elderly. It is mostly when a caregiver is no longer able to cope with the demand for caregiving or a care-recipient does not want to burden her or his family members with continuous repetitive tasks (Klenk et al., 2016).

It is estimated that the cost of unpaid care provided by adult children is equivalent to ten dollars for every dollar spent on family caregivers in the United States. In China, old age support is referred to as the 4-2-1 problem as one child is expected to take care of two parents and four grandparents (United Nations, 2011). Traditionally, African older people rely on the extended family for support but because of conflict, rapid urbanisation, HIV/AIDS pandemic, and other humanitarian crisis, many elderly have become heads of the households (United Nations, 2013). Old age or retirement homes are still scarce in sub-Saharan Africa and are perceived as alternative accommodations by the elderly without family members (Pype, 2018).

South Africa has few institutions that take care of people in old age. The majority of the elderly like living at home with their adult children or grandchildren until their death. Financially, they do not represent a burden to their families as they receive the state pension from the age of 60 (Madhavan et al., 2017). The prospect of co-residing with working adult children is slim for a large proportion of older people because of high youth unemployment. In this sense, the elderly are less financially vulnerable and the focus of their support is placed more on being cared for properly until death (Ismail and Kollamparambil, 2015).

2.3.10 Living arrangements

In the more developed regions, multigenerational living is somewhat more frequent in Eastern and Southern Europe and Japan than in the Northern and Western parts of Europe. In the developing world, multigenerational households are more widespread in Africa and Asia than in Latin America and Caribe. Yet it is still a common practice in several countries of the developing world. An estimated 30% of older people live with their adult children in every emerging economy. This proportion is above 50% in Brazil, Chile, Mexico, and India, while in most developed countries, it falls under 20% and even and below 10% (United Nations,

2017c). An exception to the rule is noticed in countries such as Italy, Spain, and Japan where nearly 28%, 37% and 44% of multigenerational households were recorded respectively (Jackson et al., 2013). Multigenerational dwelling is viewed as one of the better ways of curbing challenges inherent in population aging by allowing other co-residing family members to take care of the elderly (ibid).

Traditionally, multigenerational households have provided a good platform for mutual support and sharing of resources among family members in need. Unlike the developed world where children are more likely to leave their parental home, in developing countries, it is common that parents live with at least one adult child until their death. In contrast, older people tend to live as a couple or alone after the death of a spouse in developed countries. In most cases, the surviving person in the more developed world is the wife who ends up living alone until death. Although countries that belong to the same geographical region tend to follow a given pattern, there are significant variations between countries of each region (United Nations, 2017c).

In developing countries, financially dependent or independent older people live in multigenerational households, they often play the role of caregivers for the younger generations. They are involved in community activities or taking care of children or doing some household chores. The elderly take on the parenting role of their grandchildren who rely solely on them for maintenance (United Nations, 2017c). Globally, approximately 50% of older people were living with a child or children aged 25 years and older in 2017. The proportion of the elderly living with their grandchildren in skipped-generation households was around 30%. Asia recorded the highest proportion of older people living with adult children, followed by Africa, Latin America and the Caribbean (United Nations, 2017c). The size of the multigenerational-household is variable, Mwanyangala et al. (2010) reveal that in the rural settings of Tanzania there were on average 10 members of the extended family living together while in South Africa, an estimated 6,7 members were recorded (Schatz et al., 2015).

The formation of skip-generation households is not a new phenomenon in Africa, research in the developing world highlights the importance of these types of living arrangements (Evans and Palacios, 2015). Unlike the developed world where senior citizens rely on the combined

support of private and public sources, in Africa, this support is achieved through co-residence or extended families because of the weak institutional security systems.

In traditional Western society, the concept of family revolves around father, mother, and children, in Africa people usually live in extended families. However, this traditional concept of the family appears to be challenged as Kautz et al. (2010) found an uncommon pattern of extended families without young adults. A substantial proportion of older people, throughout sub-Saharan Africa, live in skip-generation households with at least one grandchild as a dependent. This pattern was regularly associated with countries hard-hit by HIV/AIDS (ibid). The proportion of the elderly taking on the parenting role of their grandchildren varies across countries and follows the pattern of HIV prevalence. A study conducted in countries such as Rwanda, South Africa, Ghana, Uganda, Ethiopia, Zambia, and Zimbabwe revealed that between 20% and 33% of women aged 60 years and older were involved in these living arrangements (Knodel, 2014).

Globally, 17% of women and 9% of men aged 60 years and older live alone. In Europe, the proportion of older women living alone (36%) is twice as high as their male counterparts (17%). In Africa, the rate of solitary living is on average 13% and 6% for women and men aged 60 years and older respectively (United Nations, 2017c). It may appear that a significant proportion of older people who live alone do not have major health problems and are active in the community, yet they are more vulnerable than those who co-reside (United Nations, 2015b). These older people are less likely to seek or access help in case of serious illness, they are inclined to experience frequent health problems, mainly depression with nearly no social interactions (ibid).

2.4 Health in old age

2.4.1 Causes of morbidity and mortality

The most common illnesses in old age are hearing loss, mental disorders, arthritis, and visual impairments. Conditions such as dementia, cerebrovascular, and chronic obstructive pulmonary diseases are particularly common among the oldest old. It is possible that, as time goes on, many of these physical, sensory and mental impairments may worsen and impede their independent living (United Nations, 2015b). Furthermore, despite the scarcity of reliable

statistics on depression in the developing world, it remains a widespread condition in old age. A significant proportion of older people are affected by anxiety, depression, and loneliness. Depression occurs in conjunction with major life-changing events such as the passing away of a loved one or a severe decline in health. The combination of depression and conditions such as cancer, dementia, diabetes, stroke, compromise the well-being of the elderly (Lloyd-Sherlock, 2010).

It is argued that non-communicable diseases are responsible for an estimated 63% of deaths worldwide. Some of the diseases or disorders such as chronic obstructive pulmonary disease, ischaemic heart, and stroke emerge as the leading causes of mortality (World Health Organisation, 2016a). Globally, hypertension represents a serious challenge to public health and it has become one of the major causes of disability and death (Murray et al., 2013; Stephen et al., 2017). While in developing countries, the leading causes of illnesses and death in rural areas are still related to poverty and preventable conditions (Maher and Sekajugo, 2011). There is a general agreement that the rate of non-communicable disease is on the rise and its surge is led by cancers, diabetes, chronic lung diseases, and cardiovascular diseases. These four diseases constitute the largest share of morbidity and death (World Health Organisation, 2011).

The likelihood of developing a chronic condition increases with age and people aged 65 years and older are more likely to experience multiple morbidities (Hung et al., 2011; Pirani and Salvini, 2015). Older people living in Africa are more likely than the youth to have impaired function and suffer from more diseases (Aboderin, 2010). It is argued that as people age, they are expected to be sicker than the younger age groups since the functional capacity of the human system decreases gradually (Aboderin, 2010). On the other hand, the availability of antiretroviral therapy has allowed many people living with HIV to extend their life span and turned the AIDS epidemic into a chronic disease. This treatment has resulted in a substantial increase in the number of people suffering from more than one chronic condition (Prados-Torres et al., 2014).

2.4.2 Double burden of disease

Many less developed countries are experiencing a rapid epidemiological transition with an increasing number of non-communicable diseases (Di Cesare et al., 2013; Vellakkal et al.,

2013). The epidemiology of older people in the developing world seems to follow a pattern different from their counterparts in the more developed world. The epidemiological and demographic transition occurred at the same time in developed countries. Following this transition, there was a shift in the leading causes of death and illness from infectious diseases, inadequate hygiene and nutrition to road accidents, stress and chronic disease (Coovadia et al., 2009; Frenk, 2010; Tollman et al., 2008). However, in less developed countries, the epidemiological pattern is complex and sometimes labelled "incomplete epidemiological transition" because of its two distinct patterns (Maher and Sekajugo, 2011). Both communicable and non-communicable diseases are on the rise, even in poor countries (Kuate Defo, 2014; Moran et al., 2013). This situation is in contrast with the agenda of WHO with very little spending on chronic diseases, around US$0.50 per diseased person while disbursing US$7.50 for major infectious diseases (ibid).

An increase in the proportion of older people represents serious challenges to the health system of many developing countries. Several countries are still struggling to prevent and control infectious and communicable diseases. For instance, in Indonesia, the health system is still involved in fighting infectious diseases such as dengue fever, malaria, tuberculosis, diarrhoea, and no resources are made available for helping older people to deal with chronic diseases (Ng et al., 2010). A study in Ghana found that the elderly were not only afflicted by chronic conditions such as diabetes, arthritis and heart disease but also by cataracts and edentulism. The elderly living in Ghana were unable to access adequate treatment for chronic conditions. For instance, there was no match between the prevalence and available treatment for hypertension (Minicuci et al., 2014). Other studies carried out in South Africa and Senegal have highlighted the same unmet need in treatment (Peltzer and Phaswana-Mafuya, 2013).

2.4.3 Disability

Aging is associated with a continuous decline in ability to function independently as well as challenges such as limited mobility, increased hearing difficulties, loss of eyesight (Makoni, 2008). Disability among older people is increasingly becoming a public health concern. It is a costly condition that can lead to poor quality of life and heightened dependence in old age (Beard et al., 2012). The likelihood of developing a disability increases with age as studies have highlighted that people aged 65 years and older tend to experience impairment and

disability (Hung et al., 2011; Pirani and Salvini, 2015). According to the United Nations (2017a), an estimated 46% of people aged 60 years and older are disabled and over 250 million have moderate or severe disabilities across the globe. Developing countries account for more than 40 million elderly living with a disability. A study conducted in Latin American and Caribbean cities revealed that around 19% of people aged 60 years and older were living with a disability (Medici, 2011). Furthermore, back and neck pain, chronic obstructive respiratory disease, dementia, depressive disorders, diabetes, falls and osteoarthritis are identified as major causes of years lived with disability in the elderly (World Health Organisation, 2016a).

2.4.4 HIV/AIDS challenges

Researchers seem to be unanimous in their agreement that caregiving is disruptive and distressful to the life of care-providers (Beard et al., 2012). Caregiving is associated with a lack or decrease of social support, family conflict and restriction in social interactions. It may also result in social isolation as the opportunities for socialising with people outside the home are restricted (Lee et al., 2010). Some studies, conducted among grandmothers who assume the parenting role of their grandchildren, in the United States found that primary caregivers were more likely to report poor health, psychological distress and stress inherent in caregiving. In addition, the physical and emotional well-being of primary caregivers was poorer than other grandmothers who were partial, supplemental or non-caregivers (Kelley et al., 2010).

Globally, the number of AIDS orphaned children over the last decade was around 13 million (UNAIDS, 2016). A significant proportion of these orphans were living in sub-Saharan Africa and taken care of by their grandparents (Atobrah, 2016). In most cases, caregivers are older women who experience serious challenges for playing this role later in life. Although men are actively involved in caregiving, the tasks they perform are more inclined to the gender division of labour, there is also a trend towards playing roles that transcend the traditional responsibilities of providers (Munthree and Maharaj, 2013). The AIDS epidemic has increased the burden on the elderly who take on the parenting role of AIDS orphaned children. Taking care of a large number of orphans puts much strain on older people when they already struggle to make ends meet. This situation causes frustration, depression, trauma and psychological stress in caregivers (Nankwanga et al., 2013).

Caregiving is associated with many demands since it ends up straining household resources. It was found in South Africa that elderly caregivers of HIV infected persons were helpless, frustrated and desperate because of the enormous burden inherent in caring for the sick. A substantial proportion of caregivers were not highly educated and were unemployed, they were relying on public cash transfers to meet the needs of the household and were overwhelmed by the demand placed on them (Munthree and Maharaj, 2013). Having a sick relative or young adult would lead the elderly to shift priorities, more resources may be allocated to medical expenses than food and this can have a negative impact on health. Living in the household with an HIV-positive adult child and being under financial constraints may increase the vulnerability of the elderly.

The availability of antiretroviral treatment has led to an increase in the number of older people living with this epidemic (Nakagawa et al., 2013). In Swaziland, it was found that 13% of men and 7% of women aged 60-64 years were living with HIV. A study in the province of Mpumalanga in South Africa found an HIV prevalence of about 20% among men and 13% among women aged 60-64 years, while the 65-69 age group accounted for 17% among men and 10% among women respectively (Gómez-Olivé et al., 2013). Despite the extent of infection and unsafe sexual practices, older people are not targeted by prevention campaigns since they are perceived to be a no-risk group (HelpAge International, 2014; UNAIDS, 2014).

In general, most people aged over 60 were often not exposed to HIV when they were dating and may overlook it thinking that only younger people are at risk of infection. This perception may lead them to engage in unsafe sex if they have to start dating again after divorcing or following the death of a partner. For instance, using condoms may be disregarded if the partner is no longer of childbearing age since there is no more risk of falling pregnant (Negin et al., 2016). Seeing things from this perspective is dangerous since the risk of HIV transmission in postmenopausal women is heightened by vaginal thinness and dryness (Roberson, 2014).

One of the major setbacks for older people living with HIV is that they might become aware of the diagnosis at an advanced stage of illness since they are perceived as a no-risk group (Cardoso et al., 2013). The diagnosis is likely to take place when their health has severely

deteriorated and it may be difficult to reverse the course of the illness. Furthermore, the provision of antiretroviral treatment for older people requires special care, especially, if they have other chronic conditions. An emphasis is placed on the diet of people on antiretroviral treatment, failure to comply with this requirement may result in poor health (Abioye et al., 2015).

2.4.5 Self-reported health

A study conducted in South Africa on self-reported health reveals that the elderly report being fairly good, having low levels of daily activities and a significant decline in fitness with advancing age. Although the female participants acknowledge having slower gait speed than men, they all witness similar age patterns regarding activities of daily living. The elderly living alone are less dependent on others and less likely to report activities of daily living limitations. Furthermore, the level of education does not seem to have an impact on the activities of daily living limitations (Payne et al., 2017). Despite rating their health as good, the elderly in a South African study have lower physical performance (gait speed and grip strength) than other sister studies carried out in low and middle-income countries (Latham, 2014; Saenz and Wong, 2016).

In an Agincourt study, the participants report having a good quality of life and rate their health as good or moderately good. However, they were also diagnosed with conditions such as hypertension (31%) and musculoskeletal pain (42%). While measuring their blood pressure, the prevalence was much higher (57%) than reported (Gomez-Olive et al., 2013). In a sense, a large share of the study participants are unaware of their condition. A study on the prevalence of depression in people living with HIV reveals that those who report suffering from depression tend to rate their health as poor. The likelihood of reporting poor or moderate health status was higher in the HIV-positive elderly who were not on antiretroviral or had been on treatment for less than three months as well as those living with an HIV-positive relative (Nyirenda et al., 2013).

Regardless of their age, place of residence and country, women tend to report poorer health than men (Boerma et al., 2016; Hosseinpoor et al., 2012). Factors such as education, employment, income, and marital status are put forward as responsible for self-reporting poor

health in women. Furthermore, social, cultural, economic and biological factors appear to have a significant impact on the reporting of women compared to men. For instance, men and women are not affected by the social determinants of health in the same way. Men and women who had never married are more likely to have a better health status than those who had married, divorced, cohabitated or widowed. A substantial share of inequality in health status between men and women appears to come from the differential distributions of social determinants of health and age (Hosseinpoor et al., 2012).

2.5 Aging and gender

It is highlighted that women outlive men by 4.5 years on average, as a result, they make up the largest share of older persons in the world, especially among people aged 70 years and older (Zarulli et al., 2018). The gender gap in life expectancy is not static, instead, it varies. The advantage in terms of longevity of women has risen from 2.8 to 4.4 years worldwide between 1950-1955 and 2005-2010 respectively. This varies across different regions; it either narrows or widens. During 2005-2010, the lowest gap was recorded in Africa and the highest in Europe, it was approximately 2.4 and 8 years respectively. There were 66 million more women than men in the world in 2009 (United Nations, 2015c). According to Beard et al. (2012), the proportion of women in the 60 years and older age group is around 55%, it rises to 64% and then 82% for people aged 80 years and older and those aged 100 years and older respectively. Life expectancy at birth for women is higher than men in the more developed regions.

Women's longevity over men results in their higher proportion among people aged 85 years and older. Reaching this age is more likely to result in an increased burden of chronic conditions. Unlike their male counterparts, a larger proportion of older women live with disabilities (Mwanyangala et al., 2010). In other words, the advantage that women have over men in terms of "healthy life expectancy" or the number of years spent in good health seems smaller (Beard et al., 2012). Older women are the most afflicted by medical conditions that prevail in old age while their male counterparts suffer from conditions that require limited hospital stays. The over-mortality of males restricts the pool of those who reach late old age as well as those who undergo long-term care.

Being a woman and living in the less developed regions is associated with numerous challenges. In most cases, causes of mortality and morbidity are inherent in the countries they live, rich or poor. A substantial number of health issues experienced by older women can be traced back to their childhood; adequate nutrition is an important health determinant for the rest of their life. Attitudes towards women transpire from the structures that shape policies and determine their role and contribution to society (World Health Organisation, 2009). Gender norms imposed on older women to take on caregiving roles rather than older men. It is commonly accepted that older women care for others even if they are disabled or have other conditions that require care. On the other hand, the proportion of older women who live alone is higher while men are more likely to marry or remarry (Beard et al., 2012).

2.6 Healthy aging

From a demographic point of view, Africa will experience a twofold challenge inherent in aging. Firstly, the number of older people will rise from currently 56 million to 716 million by 2100. This increase is steeper than what has been witnessed in any other major region of the world. Secondly, the longevity of older people has been extended. People aged 60 years older are expected to live for 16 and 18 additional years for men and women respectively (United Nations Population Division, 2009). The number of years lived after turning 60 is substantial and cannot be overlooked. Although there is still a gap in terms of life expectancy between developed and developing countries, this difference tends to become marginal over time (United Nations, 2015c). Given these predictions, having a substantial number of people who reach old age can be celebrated as an achievement but aging in poor health does not seem to make old age worth living.

Given the multiplicity of medical conditions, it is possible that the elderly experience some health states that are not captured by normal disease classification. Having functional older people is an important determinant of survival than assessing the presence or absence of diseases (Beard et al., 2016). The WHO model argues that functional capacity, during the course of life increases gradually and reaches its highest level in the early stage of adulthood before decreasing drastically as people age. As the decline takes place, the disability threshold can be reached over time. The pace of decline varies from one person to another. It can be affected either by factors inherent in each individual such as physiological changes associated with aging, impairments, and disease or by economic, social and behavioural

factors (World Health Organisation, 2001). Although this process cannot be avoided, it may be delayed with behavioural changes and an adequate lifestyle (Stessman et al., 2009; Vellas et al., 2018). Thus, with some targeted interventions, the decline in functional capacity can be delayed with a subsequent positive advantage of extending disability free-life in old age.

In an attempt to address these unavoidable physiological and psychological changes inherent in old age and allow the elderly to enjoy healthy aging, the current WHO programme focuses on the concept of intrinsic capacities. Described as the composite of all physical and mental capacities that an individual can draw upon at any point in their life, the concept of intrinsic capacity entails that healthy aging is regarded as a process that can be achieved even in sick older people. The priority should be set on maintaining intrinsic capacity across different stages of life (Vellas et al., 2018). Another important determinant of their capacity is the environments they live and the way they interact with them. These environments can be user-friendly or restrict the type of activities a person with impaired mobility might be willing to undertake. Having access to a walking stick, scooter or wheelchair and living in the neighbourhood of a shopping centre or affordable disabled-access transport might allow an older person to run errands unaided. The combination of intrinsic capacities, relevant facilities and the interactions between the elderly and these facilities make up what is referred to as their functional ability. Regardless of their health status, the synergy between these features is useful for determining what the elderly can do.

2.7 Summary

The literature review section has revealed a paucity of empirical evidence on the factors that impact health in old age in Africa and South Africa in particular. It is worth mentioning that literature on population aging in Africa seems to be growing over time and there is increased awareness about this issue which was until recently regarded as “alien” or non-African. In contrast, there is a limited number of scholars who are interested in conducting investigations on aging as well as the absence of gerontology as a major discipline of interest. The lack of consensus on the concept of old is an additional challenge.

Traditionally, older members of the community were dependent on the younger generations for support. However, the gradual demise of the extended family coupled with increased migration, the rise in the proportion of the elderly and the emergence of the HIV/AIDS

epidemic have put much strain on this traditional “social security system”. The present level of empirical knowledge does not help to capture the extent to which these changes impact the health of the elderly. Unlike the more developed world where aging has benefited from extensive investigations, research on population aging in Africa is quite nascent and less documented. It may be misleading to rely on studies conducted elsewhere, notably, in the developed regions to understand challenges experienced by the elderly living in Africa. This comparison seems to be made impossible by the complexity of the different contexts. This literature search highlights the importance of carrying out studies that seek to understand the health challenges of population aging using data from the African continent.

Currently, there is a growing interest in researching aging in Africa. This willingness to dig deep to understand this demographic pattern can be well captured by the amount of effort made across the African continent. Academics are more involved in sensitising policymakers and governments on the challenges of population aging. The existing empirical research on population aging in Africa has addressed issues such as aging in Africa; health status and quality of life; morbidity profile; dietary diversity of women caregivers; hypertension and associated factors; aging and health in Africa. However, research that seeks to explore the combined effect of social support and other determinants on the elderly’s health seems to be more advanced in the more developed world than in the less developed world. In Africa, the amount of empirical evidence gathered is still limited and this prompts the need to investigate this issue.

CHAPTER 3: METHODOLOGY

3.1 Introduction

This research aims at understanding social support and determinants of health that affect men and women aged 60 years and over and provide a comprehensive definition of the concept of old. Given that the concept of old is contentious, an attempt is made to contribute to the debate by engaging with the elderly on this issue. This section highlights the procedure used to develop the tools of data collection to gather sufficient information to answer the problem statement stipulated in the introductory chapter. It begins by providing an overview of the study setting, the Republic of South Africa as well as the city of Durban, before outlining the context in which older people live. It then looks at the methodology used which is broken down into the following sub-headings: research context, research methods, study design, qualitative and quantitative components, data analysis, ethical considerations, validity, reliability and rigour, and study limitations. The data analysis section provides insights into data analysis. The validity, reliability, and rigour of the study are addressed under a separate sub-heading. The section on ethical considerations highlights all the steps followed to ensure that the study participants are not harmed during the research process. The study limitations highlight weaknesses and strengths that the approaches used may have on the research outcomes.

3.2 Research context

With a total land area of 1219 602 squared kilometres, South Africa is the third-largest country in Africa after Algeria and the Democratic Republic of Congo (DRC). It is located on the tip of Southern Africa and shares borders with five countries, namely, Botswana, Mozambique, Namibia, Swaziland, and Zimbabwe. The sixth neighbouring country is Lesotho, a landlocked kingdom located in the south-east of South Africa. The Republic of South Africa has 3000 kilometres of coastline of both the Atlantic and Indian oceans. In 2018, the mid-year population of South Africa was estimated at 57.7 million people with 51% made up of females. As far as diversity is concerned, South Africa is a multicultural society and is referred to as “the Rainbow Nation”. The majority of the population is Black (80.9%), followed by Coloureds with approximately 8.7%, nearly 7.8% of Whites and Indians or Asians constituting around 2.6% (Statistics South Africa, 2018). The share of people aged 60

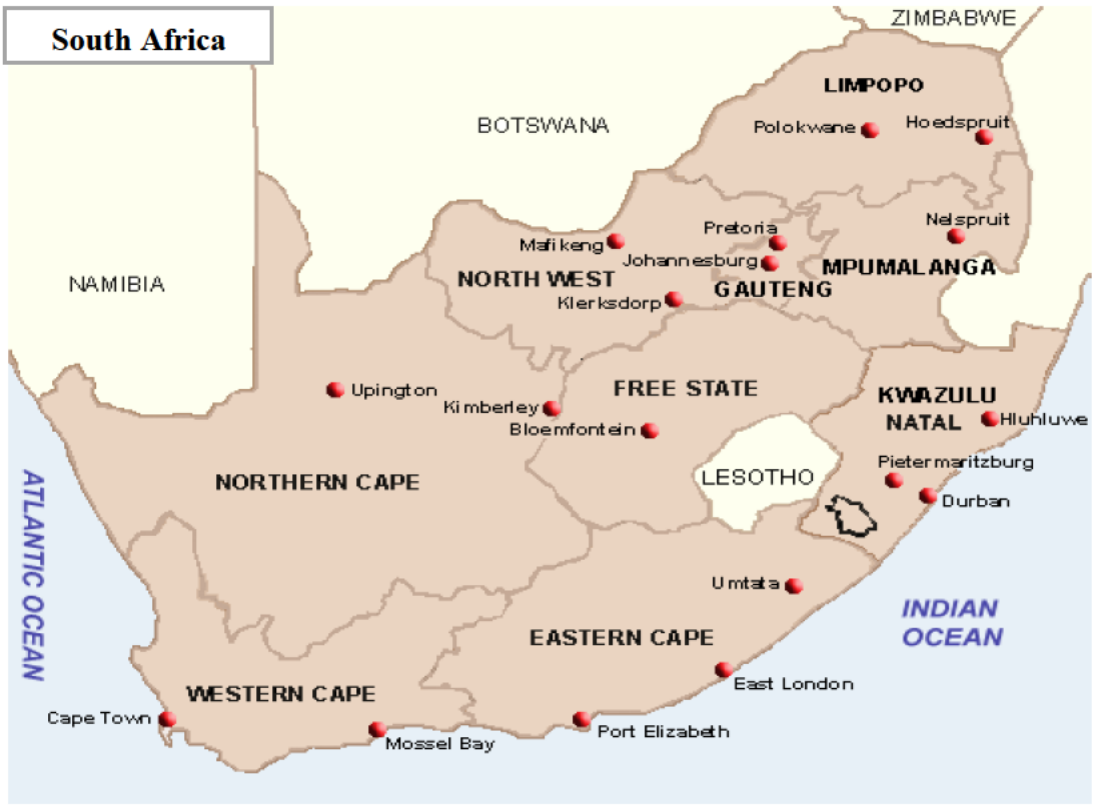
years and older has risen from 8% in 2015 to 8.5% in 2018 (Statistics South Africa, 2015; Statistics South Africa, 2018). In terms of life expectancy at birth, the age gender gap seems to have widened, at 64.3 years and 60.6 years for women and men respectively (Statistics South Africa, 2018). There are currently 11 official languages in the country: Afrikaans, English, isiNdebele, isiXhosa, isiZulu, Sesotho sa Leboa, Sesotho, Setswana, Siswati, Tshivenda, and Xitsonga. English is the second largest language in terms of the number of people who share it as a medium of communication although it is the mother tongue of about 9.6% of the population. Administratively, this country is divided into nine provinces, namely Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Limpopo, Mpumalanga, Northern Cape, North West, and the Western Cape.

A substantial proportion of the South African population has a religious affiliation. It is that estimated 85.6% of South Africans perceive themselves as Christians. These statistics depict a pattern that highlights the importance of Christianity in the country. There is approximately 5.6% of those who claim to have no religious affiliation while a further 5% reveal to observe animist tribal, ancestral or other traditional religions. Nearly 2% are Muslims, they are largely found in Gauteng, KwaZulu-Natal, and Western Cape. Also, Hindus account for 1% of the population and around 3.9% of the residents of KwaZulu-Natal (Statistics South Africa, 2018).

South Africa is the second-largest economy in Africa after Nigeria, it has a GDP of $349,817 million and ranks 33rd in the world (World Bank, 2015). According to the purchasing power rankings of the World Bank, it is among the upper-middle-income countries of Africa along with Angola, Botswana, Gabon, Libya, Mauritius, Namibia and Tunisia (ibid). Despite this ranking, the economy stagnates with an estimated 2% growth rate. South Africa is characterised by high levels of inequalities between the rich and poor (Masie, 2015). These inequalities are experienced in every sphere of socio-economic life. For instance, the health care system in both the public and private sectors is pro-rich. A significant proportion of the population relies on the publicly funded health care system. The public sector is overburdened by a large number of users and limited resources. The only pro-poor services are primary care provided by district hospitals, community health centres, and clinics, however, when the services sought require the highest levels of health care, poor people are excluded (Ataguba and McIntyre, 2012). In terms of health service benefits, the share of rich people is greater and equates their relative needs in both the private and public sectors

(Ataguba and Alaba, 2012). An additional challenge is a geographic divide, urban health care facilities receive more funding than those in rural areas. Figure 3.1 provides insights into the geographical location of South Africa.

Figure 3.1 Map of South Africa



Source: SA Places (2017)

On the other hand, it is argued that sub-Saharan Africa has witnessed a growing interest in social protection over the last decade. Social protection is widely viewed as a better way of tackling poverty among vulnerable groups. Despite this consensus in the region, only a few countries located in Eastern and Southern Africa have succeeded in expanding their social protection schemes (Niño-Zarazúa et al., 2012). South Africa is one of the few countries whose social welfare institutions have substantial funding. Initially, the introduction of social pension schemes in South Africa took place in the late 1920s and was aimed at protecting the white population from old age poverty (MacKinnon, 2008). Population groups such as Asians/Indians and Coloureds became the first recipients and later, in the late 1940s, the policy was extended to the black population. However, all racial groups were not entitled to the same amount of benefits. The extension of social pensions to the African elderly in the

1970s and 1980s was intended to provide some source of income and restrict urbanisation. The fall of apartheid led to the implementation of equitable policies (Niño-Zarazúa et al., 2012). The pension scheme is means-tested, tax-funded and transferred to around 3 million people. It covers approximately 80% of people aged 60 years and older and about 100% of the African population group (International Labour Office, 2016). The minimum age for receiving a pension in South Africa is 60 years for both men and women (Hunter and May, 2013). Barrientos (2012) reveals that the South African cash transfer programme was designed to supplement the income of poor households. Besides the high level of poverty, other serious challenges plague the country.

HIV/AIDS is one of the serious health issues, with a prevalence of approximately 13.1% in 2018 (7.52 million). Young adults (aged 15-49) are the most hard-hit with an estimated 19%. Globally, South Africa tops the list of countries hard hit by the HIV/AIDS epidemic. Although the national statistical service does not provide the HIV prevalence among the elderly, it is believed to be substantial, the scaling up of the antiretroviral therapy has resulted in extended life expectancy and an increase in the number of people who survive into old age (Bor et al., 2013). The HIV prevalence among older people is overlooked because of the belief that they are not exposed to the risk of being infected (HelpAge International, 2014; UNAIDS, 2014). According to Gómez-Olivé et al. (2013), Agincourt records one of the highest prevalence, around 20% and 13% for males and females aged 60-64 years respectively.

3.3 Methodology

3.3.1 Research methods

The present research used mixed method research or mixed research. There is not a definition that is universally accepted, the following definition was widely approved by methodologists from the 1980s to the mid-1990s:

> "Mixed methods is the type of research in which a researcher or a team of researchers combines elements of qualitative and quantitative research approaches (e.g. use of qualitative and quantitative viewpoints, data collection, analysis, inference

techniques) for the broad purposes of breadth and depth of understanding and corroboration" (Johnson et al., 2007, p123).

Using this method is associated with some advantages as highlighted by Bryman (2006). Firstly, it is used for the sake of triangulating data, as a result, weaknesses inherent in quantitative and qualitative methods are cancelled out while their strengths are used to improve the validity of the results. Secondly, the result obtained from one method can provide insights into the other method. Finally, alternatively, one method can fit in another method to provide more insights at a different stage of analysis.

This research relied extensively on the triangulation of quantitative and qualitative methods. Also, several techniques were used with each methodological component for data collection and analysis. After data collection, the quantitative component was analysed before unpacking the qualitative one.

3.3.3 Study design

The study was conducted in two phases: qualitative and quantitative. The quantitative component was investigated before the qualitative component, notably, the data collection and analysis of quantitative data. In terms of procedure, the results obtained from quantitative analysis were used to modify the qualitative interview guide and enable one-on-one interviews.

3.3.4 Quantitative component

The quantitative component of this study relied on the nationally probabilistic sample drawn from National Income Dynamics Study (NIDS). The first survey of NIDS dated back to 2008, it had 10367 dwellings that were selected from 400 primary sampling units across the Republic of South Africa, 491 were found to be multi-household dwellings. Out of 10858 households eligible for the study, 7296 were interviewed and 31144 persons were identified as household members. However, 2918 non-residents residents were excluded from the study which brought down the number of sampled residents to 28226. The study defined a resident member as every person that spends at least four nights a week at the dwelling. The NIDS

questionnaire provides a range of questions that help investigate a significant number of social issues.

The NIDS project is a longitudinal study with the aim of assessing changes that take place in the well-being and living conditions of the respondents. The second wave was successfully carried out in 2010 and recorded a slight increase in the number of successful interviews. This research uses the recent survey, wave 5, which took place in 2017 and resulted in an increase in the number of households interviewed, 10842 and more investigations conducted than during the previous waves, 37368 residents interviewed.

An attempt was made to assess the impact of chronic illnesses and infectious diseases on the well-being of older people as well as the amount of support they receive. The health component of the NIDS survey provides information such as self-reported health status, health conditions, recent health consultations, activities of daily living, chronic conditions and medication, smoking, exercise, alcohol use and coverage by medical aid. The NIDS dataset provides sufficient information on health that can help explore the link between the amount of support and health in South Africa. There are various questions on the adult component that allows for the construction of the depression index. Furthermore, height, weight, waist circumference and blood pressure are measured during the course of the survey.

3.3.5 Sample characteristics

The quantitative sample is made up of 3545 people aged 60 years and older who took part in the NIDS survey Wave 5, conducted in 2017. The Sort Command of SPSS was used to select the respondents who meet this criterion, every individual born after 1957 was left out of this investigation. It was assumed that the youngest respondents, notably every study participant born in 1957 turned 60 by the time the interview was carried out. Regarding the oldest respondent, she was born in 1907. Although NIDS is a panel study, this research makes use of cross-sectional data. The data of this study are weighted to account for the attrition of respondents (Brophy et al., 2018). The design weight corrected for non-response used in this study is w5_dwgt as provided by NIDS Panel User Manual (ibid). The largest proportion of respondents is made up of older women with approximately 67.4% and nearly 75.5% of those aged 80 years and older are female. Further insights are provided in Table 3.1 below.

At 60-69 years of age, it is slightly more than 65.7% of older women who receive pensions, this proportion increases to 75.7% for people aged 80 years and older. There are more female recipients (71.6%) than their male counterparts (28.4%). More men are either married or living with partners (56.4 %) than women (43.6%).

Table 3.1: Percentage of respondents by gender and some socio-demographic characteristics

Statement	Men %	Women %	N
Age in years			
60-69	34.3	65.7	2103
70-79	32.1	67.9	1048
80+	24.5	75.5	394
Total	32.6	67.4	3545
Recipient of state pension			
Yes	28.4	71.6	2751
No	42.5	57.5	794
Total	32.6	67.4	3545
Marital status			
Married	56.4	43.6	1406
Never married	37.1	62.9	73
Total	56.4	49.9	1764

** Using NIDS weighted data, wave 5, year 2017*
**Although 3545 respondents took part in the survey, some skipped certain questions in this section.*

3.3.5 Qualitative component

3.3.5.1 Overview on in-depth interviews

An in-depth interview or a face-to-face interview is one of the methods of data collection in qualitative research in which investigators asks a series of questions to participants. It often takes place in an environment conducive to self-disclosure (Johnson, 2002). The conduct of in-depth interviews is interesting since it allows other concurrent observations to take place. While interviewing, some important information sent out by the respondent such as body language, and intonation in line with the issue under investigation might be observed as well. It is worth mentioning that during this investigation process, the interviewee does not have much time to think and is likely to give spontaneous answers while the interviewer is expected to listen to the answers and prepare his or her next questions. Furthermore, the

interviewer is expected to take notes and record the interview. Depending on the quality of recordings, transcribing can be time consuming and the conduct of interviews costly if the respondents are scattered in an immense area (Opdenakker, 2006). It is also essential to notice that unlike other investigation techniques, face-to-face interviews have the advantage of allowing the interviewer to probe for more insights into any important issue being investigated. The interaction between interviewers and interviewees can help unveil some unanticipated issues (McCullough, 2011).

3.3.5.2 Conduct of interviews

The study participants were made up of older males and females living in old age homes in Durban. Respondents were selected on a purposive basis and individual in-depth interviews were used as the technique of data collection. Initially, their caregivers were asked to assist in the selection of potential interviewees. After conducting a few interviews, the interviewer started selecting the study participants. Furthermore, the sample size was not determined in advance, it was stipulated that the investigations were going to be conducted until saturation occurs and this point was reached after 18 in-depth interviews. Before proceeding with the fieldwork, a thorough documentary research search was conducted to understand the context in which older people live. This included all older people, particularly those living in South America, Asia, Middle East and Africa.

The age 60 years and older was chosen because it coincides with the pensionable age (Hairault et al., 2010), it is an age at which a significant proportion of people is likely to retire. Older people are vulnerable, they experience discrimination in the job market because of their physical appearances and ill-health (Chepngeno-Langat et al., 2010). Furthermore, 60 years and older seems to be the right cut off point as it marks the onset of some conditions that are mostly found in this age group (Beard et al., 2012).

3.3.5.3 Data collection instruments

This research made use of two types of data, primary and secondary data. Firstly, the researcher drew on the existing dataset, the NIDS quantitative information, in an attempt to answer the research question. Secondly, data collected from in-depth interviews helped to fill

in the gap left by the first type of data explored. A Zulu speaker was recruited and trained to administer the interview guide to all participants who chose to be interviewed in this language. Before this stage, the interview guide was translated to isiZulu to accommodate respondents to choose the language of their convenience as recommended by the Ethical Committee. The fieldwork took place between July and September 2016.

3.3.5.4 The interview guide: Construction and design

The interview guide for in-depth interviews was designed from a combination of the review of South African and global literature on the challenges posed by population aging. Although the interest in aging is nascent and not yet sufficiently explored, some numerous insightful articles and publications assisted in shedding light on this research and also, helped in the design of the interview guide. Some insights were received from colleagues and friends while engaging in the challenges of the elderly. The interview guide underwent several changes and modifications until it covered the most important issues for which it was designed. Additional and crucial contributions were made by the researcher's supervisor and reviewers. Before proceeding with fieldwork, a series of pilot studies were initiated with older people living in and around Durban to ensure that it is fit for the task it was designed for. Every attempt was made to include every population group in the study sample. After the pilot study, the interview guide was amended to make the administration process smooth and straightforward. Some sections were dropped, incorporated, reworded or modified to fit in the context.

One of the main concerns expressed during the discussions was that the elderly, especially females, might feel intimidated to deal with a male researcher who might look like a stranger. Although the concern sounded genuine, its impact would be mitigated since the interviews were not going to take place in the wild but in old age homes where the elderly would be under the watchful eyes of their caregivers. Getting the elderly to sign informed consent forms was challenging since some would not be able or did not know how to do it. This problem was circumvented since provision was made for them to choose between signing, using a thumbprint or putting a cross. The elderly who took part in the pilot study did not participate in the study and were not living in old age homes. The interview guide was structured in such a way that it would begin with broad and general questions to make the respondent comfortable before addressing issues that were more specific and personal.

To accommodate English and Zulu speakers as well as to ensure that the interviewer would use consistent wording during different investigations, the interview guide was made available in these languages. This technique was crucial as it was meant to help bridge the gap between the interviews conducted by the principal investigator and the interviewer. It is commonly agreed that there is no right or wrong answer in an interview since respondents share their personal experiences (Doody and Noonan, 2013). However, carrying out successful research requires on the part of the investigator to ensure that the research question is answered. The synergy between these two facts was achieved through probing since it allowed the respondents to share their experience in line with the research. Respondents were indirectly incentivised to talk about their experience relevant to the current study. Besides taking notes, provision was made for recording all interviews provided every participant consented to it.

3.3.5.5 In-depth interviews

The in-depth interviews expanded on six different sections: the first part focussed on background information and helped the interviewee and interviewer to settle and build trust. The second section explored the concept of old among the elderly. The third section assessed the general health of respondents as well as their medical history. The fourth section dealt with the nutritional status of respondents. The fifth section highlighted health seeking behaviour, its deterrents as well as some practices or lifestyle that may have a significant influence on health. The last section attempted to highlight some of the types and sources of support received. This research made use of semi-structured interviews for data collection. According to Holloway and Wheeler (2010), it is a type of interview that requires the use of questions determined in advance and the investigator is free to probe to obtain clarification. The use of an interview guide helps both investigator and study participants to provide the same type of data that is in line with the research.

Using interviews as a method of collecting data is associated with a given set of advantages and disadvantages. In terms of benefits, conducting interviews provides an opportunity for the participants to explain what is important to them. It is a better way of generating stories and quotes that enable the researcher to draw a rapport. While conducting interviews, the researcher is offered the opportunity of listening to the responses as well as observing the

body language to generate more information. Likewise, the participant can seek clarification to a question and enquire about its purpose in the research project or ask any question about the study. The researcher can probe further to obtain adequate and accurate information, engage with the study participant on more complex issues that cannot be addressed easily. Interviews offer a platform for the study participant to provide detailed responses and gain some personal benefits as a result of sharing one's experience. Interviews can provide light on the reasons that prompt participants to act in a certain way and their understanding of events. It is a better way of getting insight from some groups, notably those who cannot read or write. Another important feature of interviews is that participants are given the opportunity of exploring and discovering themselves (Doody and Noonan, 2013).

According to Doody and Noonan (2013), conducting interviews is associated with several setbacks. Interviews are thought to be costly and time-consuming since the researcher is expected to design them, to travel to conduct fieldwork, to transcribe and analyse the data. Interviews may sometimes be seen as intruding on participants and may require more expenses in comparison with other types of investigations. Some interviews should be handled with care, especially, if they deal with intimate or personal subject matters, which can arouse strong feelings. Interviews can be easily biased since there are instances that the study participants may be willing to please the researcher by telling him what they think he is willing to hear or by aligning themselves with an official point of view instead of expressing their own opinion. The bias can also stem from an attempt on the part of the study participants to give a good impression rather than providing honest answers. Furthermore, the study participants are urged to say something even if they have nothing to mention on a topic. On the other hand, the researcher can influence the responses of the participants.

3.3.5.6 Fieldwork

Data for the research was collected between July and September 2016. The fieldwork took place in South Beach and around Durban CBD. The principal investigator was assisted by a female Zulu speaking interviewer who was trained on how to conduct interviews and to deal with personal issues. Every effort was made to provide as much information as possible to the interviewer to deal with any issue that might arise as a result of the interviews. Although some clinics and hospitals were identified for a referral but considering that the elderly were living in old age homes, it was incumbent on their caregivers to have a last say on the matter

should any critical situation arise. It was agreed that counsellors would be available to assist every person affected by their participation in the study. The fieldwork interviews were conducted by two persons; the principal investigator and an interviewer.

After this preliminary arrangement, the principal investigator was the first to conduct interviews. The study participants without a mental disability were selected purposively by caregivers. Upon agreeing to take part in the study, they were informed about the research aim and the voluntary nature of their participation. It was clearly made that any study participant had the right to skip or refuse to answer any question, that all information provided is confidential and will be used solely for the sake of the study, that their names would not be mentioned at any moment and nothing would identify them with the interview; the section on data analysis would be done on an anonymous basis. Furthermore, the participants were briefed about the length of the interview and were also told that no payment would be made. On the other hand, they were urged to share their personal experiences relating to the issue under investigation. Before proceeding with the interviews, they were asked to sign, thumbprint or put a cross on informed consent forms as required by the research ethics committee. This procedure was repeated and respected everyday spent on the research site for both English and isiZulu interviews. Investigations in English were made by the researcher in the absence of the interviewer, every person who consented to take part in the research using isiZulu as a medium of communication was identified to be interviewed the next day.

The sample size of the qualitative component was not specified in the research protocol, it was however stipulated that investigations would be conducted until saturation occurs. After interviewing 18 older people, it became clear that they were repeating themselves and the decision was made to end the data collection stage. Regardless of the statistical considerations of the South African population, every effort was made to include every racial group in the sample and benefit from their multicultural background. Regarding the gender composition, there were more females than males who took part in the research, 6 males and 12 females. This imbalance was partially explained by the willingness to include in the study, nearly, the same number of the early and late elderly. In other words, there were more female older people in the “late elderly” age group than their male counterparts, as a result, they ended up being overrepresented in the sample. The racial composition of the sample is provided in Table 3.2 below. The age of respondents ranged from 63 to 84 years.

All interviews took place as scheduled and the response rate was 100% in all old age homes. In terms of length, it varied between 25 and 45 minutes. This rate might be because the investigations were conducted at the respondents' "home", in an environment conducive to self-disclosure. Seemingly, the elderly had expressed the trust they had in their caregivers and were very accommodating. Also, they gave the impression of being very enthusiastic upon hearing that some people are interested in researching old age issues. Finally, there was on the part of some respondents the impression of feeling relieved after sharing their experiences, challenges and daily struggles.

Table 3.2 Gender and population groups of respondents

Statement	Africans n	Coloureds n	Asians/Indians n	Whites n	N
Gender					
Men	1	2	1	2	6
Women	2	3	3	4	12
Total	3	5	4	6	18

Regarding the selection of the study participants, at first, a member of staff of the old age residence was involved in identifying them. This assistance was crucial as it helped select residents who met the requirements in terms of cognitive ability. This first stage was quite smooth since none of the residents approached objected to the interview, instead, they availed themselves and were ready to engage in various issues covered by this research. Over time, this member of staff was no longer available, while approached for assistance her colleagues told the principal investigator to find another way of making it work. The principal investigator was told to approach all residents for the study besides those living on the first floor, referred to as a frail care unit. This floor accommodates sufferers of dementia as well as other similar conditions that affect their cognitive ability. At this stage, it became quite challenging on the part of the principal investigator as he had to convince the elderly to take part in the study. At first, they were suspicious, thinking of dealing with a spy sent by the management to help identify potential outspoken people to evict. Some people refused to avail themselves for the study while others were reluctant. It was only after they were briefed on the nature and purpose of the project that some of them started to open up. Unsurprisingly, it was much easier to approach people who had been interviewed in the past as they would

not be suspicious of any setup. Also, others regarded their participation as a form of assistance to the principal investigator in his attempt to carry out successfully this research.

Several insightful and impactful interviews were made on the daily struggles of the elderly. They shared their experiences, expectations, and disappointments. Although they knew their challenges would not be subsequently addressed, they were excited to make their voices heard. It should be noted that no promises were made to the elderly in exchange for their contribution, instead, they were informed of the academic nature of the research. After the interviews, some respondents expressed their excitement about the investigation, they found it relevant and thought-provoking. Some respondents became emotional after being asked questions that reminded them of painful life experiences. When suggested if they were willing to go for counselling, they objected to it and were willing to continue with the investigation provided they were given some time to get composed.

The excitement was also visible on the face of others as they were able to share their painful experiences and expectations for the future. Even if no positive outcome would come from the interaction, the fact of talking to an attentive ear about their worries was heart-lifting and cheerful experience. There was an impression that their challenges have prompted researchers to investigate and inform others. With a limited prospect of receiving a guest, the visit of the researcher seemed to be most welcome, as it would help break loneliness and offer a platform for voicing their frustration. To highlight their excitement, some respondents were even tempted to offer snacks to the researcher. Additionally, depending on the availability of the principal investigator, the interviews were conducted once to twice a week, from July to September 2016.

3.3.6 Data analysis

The research made use of both qualitative and quantitative research methods to benefit from the insight offered by each tool of investigation. This approach allowed the researcher to switch between two analytical tools for thorough investigations.

3.3.6.1 Qualitative data analysis

In-depth interviews were very instrumental in the analysis of the qualitative data. After fieldwork, all interviews were translated and transcribed in English before any further analysis. The qualitative data were analysed thematically. According to Braun and Clarke (2014), thematic analysis is viewed as "a method for identifying, analysing and reporting patterns within data". It is an independent qualitative method that helps describe the issue under investigation and provides further insight to researchers by enabling them to conduct various types of qualitative analysis. This approach can be broken down into six distinctive steps, notably, familiarising with the data by reading transcripts several times and noting down initial ideas; generating interesting features in the dataset in a systematic way by gathering relevant data; gathering all data into potential relevant themes; ensuring that all the themes are coded consistently throughout the entire dataset; generating relevant definitions and names for every emerging theme and writing the research report as a result of thematic analysis and interpretation. Moreover, some relevant quotes extracted from in-depth interviews were incorporated in the result section of the study.

Unlike other approaches used in the qualitative analysis that can be referred to as methodologies since they are associated with theoretical frameworks and provide insights on data collection and analysis, thematic analysis is just an approach that only aims at informing the researcher on the procedure to follow for coding and generating themes. This is to say that this approach is more flexible and can be used for data analysis in almost all qualitative research projects. Thematic analysis can be used for research that covers a large range of issues such as personal lived experience and social constructions of meaning. It is relevant for analysing primary and secondary qualitative interviews and for the analysis of data collected from homogeneous and heterogeneous datasets as well as suitable for any size of samples (ibid).

The flexibility and straightforwardness of the thematic analysis approach were instrumental in its attractiveness for this research. After this stage, all transcripts were read several times to familiarise the researcher with the data as informed by thematic analysis. To ensure the confidentiality of participants was maintained, pseudonyms were used to replace names. Then all emerging themes were coded using NVIVO software. The process of analysis was not only limited to listening to the recording but also extended to scrutinise the body

language of respondents. Any important details that could help understand the universe of the elderly were written down right after the interview to keep a good record of it. This process was referred to as "delineating units of meaning" by taking into consideration their importance and relevance (Saravanan, 2013). Some descriptive themes were generated from thematic analysis which led to analytical themes after interpretation (Barnett-Page and Thomas, 2009). Clusters of themes such as living arrangements, private and public support, safety nets, dependency, abuse, well-being were generated. Relevant quotations from respondents were included in the data analysis section to back up the themes. In most cases, the analysis of the qualitative component was performed after the quantitative component to assess the outcomes of both methods.

3.3.6.2 Quantitative data analysis

The quantitative component used the NIDS data which is the first national panel study conducted in South Africa. The first wave took place in 2008 and provided a starting point for exploring change occurring in the well-being of the sampled population over time. There were 28226 sampled people from 7296 households who took part in wave 1. The second wave took place in 2010 with 28551 sampled households and gave rise to 6787 successful interviews. The present project explored Wave 5 which was held in 2017.

The NIDS dataset was designed and collected to meet international standards and is useful to the researchers and policy community. The better quality of data was achieved through the combination of the Computer Assisted Personal Interviewing (CAPI) software and the development of computer-assisted procedures assessing the quality of data. The NIDS dataset is designed to meet the "six fit for use criteria", notably, accessibility, accuracy, coherence, interpretability, and relevance. Every effort has been made to meet these requirements from the first to the successive wave. The NIDS data were designed to be used in the following formats R, S-Plus, SPSS, and Stata. The analysis of quantitative data was conducted with the Statistical Package for the Social Sciences (SPSS). Two sets of variables were used notably: independent and dependents variables (self-reported health and high blood pressure).

The independent variables that were more likely to impact health in old age were as follow: gender, lifestyle, living arrangements, recipient of gifts, old age pension recipients, and marital status. Frequencies and percentages were used in tabulations to associate respondents

with a given category of responses and cross-tabulation tables were provided for frequencies and percentages between two different categories. The cross-tabulations of gender, marital status, age, state pension recipients were investigated. Furthermore, to explore the factors that impact the health of older people, dependent variables such as self-reported health status and other features inherent in emotional well-being were investigated as well. It is worth mentioning that only respondents aged 60 years and older were included in the study. Logistic regression was also run for independent variables such as marital status, receipt of the state pension, living arrangements. At first, the univariable model was used to determine whether there were significant differences among variable outcomes using the chi-squared test. Thereafter, the multivariable model for dependent variables self-reported health and high blood pressure were included in the final model. Moreover, the results obtained from the quantitative analysis that followed a given pattern were singled out and fed into the interview guide for further investigations.

3.4 Ethical considerations

During the course of investigations, every effort was made to abide by generally accepted ethical considerations and to ensure that there is no prejudice caused to any person that took part in the study. To comply with the university "Code of Conduct for Research", approval to conduct research was sought from the Humanities and Social Sciences Ethics Committee of the University of KwaZulu-Natal, the Protocol reference number HSS/1513/014D (See the Ethical Approval letter in Appendix). Before this approval, permission to collect data was sought and granted by old age homes and the gatekeeper's letter was provided as evidence to the Ethics Committee. There was no particular concern on the part of the management of old age homes regarding the research project. In contrast, they were enthusiastic and looking forward to its outcomes as it is hoped to provide insight into their contribution to the well-being of the aged under their care.

After this administrative stage, the researcher explained the aim of the research project and the anticipated outcomes to the participants. All participants were briefed about their right to skip or refuse to answer as well as to withdraw from the study at any time. They were informed that their participation was done voluntarily. Every respondent was asked to sign, thumbprint or put a cross on informed consent forms before interviews. The names of respondents were not written on anything to ensure that their confidentiality and anonymity

were guaranteed during data collection. The recorder would be switched on after the initial phase of introduction for those who did not object to it. All completed interview guides and notes taken were first stored in a filing cabinet.

3.5 Validity, reliability and rigour

Validity can be understood as the extent to which a research project measures what is aimed to. The validity of the research outcomes implies the accuracy or 'precision' with which the analysis and interpretation are made. This concept often encompasses two distinct aspects, namely, internal and external validity. Internal validity seeks to ensure that the researcher is doing the type of investigations he claims to undertake. The other aspect of this concept, external validity aims at assessing the extent to which the research assumptions apply to other individuals in the larger population or other settings. There is a potential 'conflict' between the ability to generalise and external validity, these two concepts overlap and can easily trap the discussion on generalisation. This discussion is crucial as it raises questions on the extent to which the applicability of research can be extended (Lewis and Ritchie, 2003; Ritchie et al., 2013).

The concept of reliability usually deals with the replicability of the research outcomes to predict whether the same study would result in the same findings if it were conducted in another setting using the same methods. The replicability of qualitative research is perceived as questionable by some social scientists because of a given number of reasons. Firstly, it is argued that there are several realities to capture which in return render replication difficult. Secondly, every reality is complex since it depends on the context of its setting. Finally, qualitative investigations can only be carried out successfully in response to a given reality. A better way of dealing with all these concerns is to have a clear picture of the features that are likely to be consistent and inclined to replicate. It is the collective aspect of the reality revealed by respondents and its representation that might replicate (Lewis and Ritchie, 2003; Ritchie et al., 2013).

Internal validity is relevant to this study as it seeks to determine the impact of socio-economic factors on the health of older people. External validity focuses on the generalisability of scientific research. The quantitative component of this research was based on nationally representative data. It is believed that the results would be externally valid as

they were obtained from a random sample. On the other hand, to ensure reliability in the qualitative component was attainable, the interview guide was pre-tested on a small sample that met the requirement of the study. The rigour of the qualitative component was enhanced by probing to help the participants to remember the events that took place a long time ago. The respondents were encouraged through probing to relate their current or recent experiences to the incidents that impacted on them. The rigour of this study was also ensured through audio-taping, transcribing and coding all the interviews.

3.6 Limitations

Unlike the quantitative component, the findings of the qualitative component of this research are neither representative nor generalisable. They are however intended to provide insights into the factors that impact the health of older people in the region that is not 'prepared' to deal with an increase in the proportion of its senior citizens and highlight the necessity of conducting further investigations. Moreover, rather than seeking the generalisability of the results, the qualitative component was designed to explore issues that could not be addressed with quantitative data.

This limitation goes beyond the scope of the methodological challenges of this research. Far from questioning the quality of the NIDS dataset, other interesting investigations could not be carried out because of a substantial number of missing values in some variables. However, there was sufficient information that would help address the research problem.

3.7 Summary

This chapter expanded on the methodology used in the research project to collect data. This study employed a mixed-method approach and used two different sets of data in its analysis and interpretation; qualitative and quantitative. The quantitative data came from a nationally representative sample drawn in South Africa and the qualitative component was based on in-depth interviews conducted among the elderly living in old age homes around the city of Durban. The research participants were made up of males and females, aged 60 years and older and representing the multiculturalism of this country. SPSS 25 was used to analyse quantitative data whilst NVIVO was very instrumental in the analysis of the qualitative

fieldwork. The following chapter investigates and discusses the challenges of population aging as well as the concept of old from the perspective of older people.

CHAPTER 4: UNDERSTANDING THE CONCEPT OF OLD

4.1 Introduction

Until recently, population aging was regarded as a challenge unique to the more developed world since there was a small share of older people in the less developed regions. Currently, the proportion of older people is on the rise in every region of the world. It is believed that the age structure of the population in the developing world will match the pattern of the most developed world (Ramírez and Palacios-Espinosa, 2016; Shetty, 2012). However, despite the existence of the agreement on the issue of population aging as well as its challenges, defining the concept of old fails to gather a consensus around it.

The concept of old is a social construction that views aging as a process associated with a decline in cognitive behaviour. This concept is widely interpreted and its understanding depends on society and culture. For those who live in the mountainous regions of Peru, an older person is expected to be in his eighties and involved in hard physical labour (Ward, 1984). From a Japanese perspective, a senior citizen is expected to live alone and is provided with housing by adult children as a sense of family duty. While for the Chagga tribe of Mount Kilimanjaro in the Republic of Tanzania, an older woman is entitled to live with a grandchild to help her with some domestic tasks (ibid). This viewpoint is also shared by American Indians living in the Southwest. An older woman is recognisable in many societies by her caregiving responsibilities such as babysitting or food preparation.

Old age is constructed as a category, once identified as “old”, the elderly are no longer regarded as active and useful members of the community or society. The “old” is constructed as a uniform group, differences are either blurred or ignored since aging stands out as a common identity (Spector-Mersel, 2006). The arbitrary definition of chronological age that fixes old age at sixty-five has succeeded in creating a class of people who are denied opportunities and resources that others benefit from, they are denigrated and stereotyped. The decision to create the category of older people was made without consulting with them. Bytheway (2005) reveals that although a group of English older people agreed that age statuses stem from chronological age, they vehemently oppose the application of this classification to themselves. The old age identity is defined by others who have nothing to do with it. When taking into consideration several differences in old age such as education,

income, socio-economic status, political affiliation, degree of participation in community and health status, being “old” appears to be a pointless basis of identity.

In western countries there is a consensus that the age 60-65 years represents the onset of old age, however, at an individual level, this consensus does not necessarily seem to hold true. It happens that people who are older than this chronological age do not want to be labelled “old” or “elderly”. A study conducted in the United States reveals that only 20% of people aged 60-69 years accepted the label “old” or “elderly” (Ward, 1984). Even 30% of people aged over 80 years were comfortable with being described as middle-aged or young rather than “old”. It emerges that seven factors were put forward as identifying the onset of old age notably medical conditions, retirement, physical or mental illness, chronological age, restricted cognitive functions, change in social contacts and widowhood (ibid).

The South African government aligns itself with the United Nations chronological definition that set 60 years as the cut-off point for the onset of old age. This age coincides with the pensionable age in South Africa. While, in most developed countries, old age begins at 65 years (World Health Organisation, 2016b), in Lesotho, the commencement of old age is variable and fixed at age 70 years for men and 66 years for women (Cherry et al., 2013; Drewes et al., 2011; French et al., 2012; Pigliautile et al., 2011). On the other hand, Tanga (2015) believes that growing older should be associated with the amount of psychological, social and physical experiences accumulated overtime rather than chronological age.

Grignon and Spencer (2015) interrogate the current concept of old and argue that social programmes should be ageless because of the amount of gains made in life expectancy over several decades. It is pointless to maintain static age markers that designate the passage of different life events such as early years, schooling age, working years and old age. Life expectancy is believed to keep on rising for a few decades to come. The one size fits all approach that sets old age at a fixed age is not realistic. There is substantial heterogeneity in the population, instead, old age should be independent of chronological age. The concept of “old” should take into consideration people’s aspirations. For instance, the fact that a person is unemployed and willing to benefit from employment insurance or has retired and is seeking to be on pension benefits instead of lumping into the old age group everyone who reaches a predefined chronological age.

This section expands on the understanding of the concept of old from the perspective of those who are referred to as the "elderly". Such insight is useful as it helps contribute to the ongoing debate on population aging as well as the place or role of the elderly in society. It is crucial to explore this issue since the share of older people is more likely to witness a substantial increase (Grignon and Spencer, 2015; Ramírez and Palacios-Espinosa, 2016). It appears that a shift in the social involvement and contribution of the elderly needs to be rethought thoroughly to avoid leaving out the ever-growing share of the population. This chapter explores the definition of the concept of old since there is a little consensus on this matter.

4.2 Chronological age

The concept of chronological age was mentioned to describe "old", although it was different from the one used by the United Nations or most governments around the world. Seemingly, chronological age represents more of a number used to substantiate an argument rather than a cut-off point or commencement of old age. Several suggestions regarding the beginning of old age were made and differ from one another depending on the chronological age of the respondent. Being old appears to be well explained when reference is made to others. This highlights the relative nature of the concept, the following respondents provide more light on this issue:

> *There is a lot of people who are older than me, I am still a baby compared to them. You can see it as I told you we have a lot of people who are 90 here when people reach 90 you can say they get old, they are here today and gone tomorrow (Female, 66 years).*

> *Certainly, one who is older than I am, age-wise, let us say, somebody who is 80, they will be older (Female, 73 years).*

> *I do not know what to say of the government definition, like me now I am going to be 70 in October, we talk and have fun together, I cannot say I am old. An older person is anybody older than me, for instance, there is a lady here, she is older than me (Female, 69 years).*

For some respondents, the fact of being able to interact with others is regarded as uncommon in old age. In a sense, the ability to interact is believed to be in contrast with isolation and loneliness experienced in old age. There is an attempt to highlight differences from stereotypical older people and those who do not display old age behaviour. Although they do not claim openly to be younger, the fact of being referred to as older makes them feel uncomfortable. The fact of lumping everyone who turns 60 in the old age group leads some respondents to question their seniority. There is a perception that chronological age does not describe better their age since some people are much older than others.

Chronological age appears to be one of the features that should be taken into consideration to describe old age. However, using chronological age alone may not help provide a better definition of this concept. The extent of knowledge and experience acquired over the years is regarded as an important factor for becoming a senior respected member of the community. The combination of both chronological age and knowledge is believed to offer the well-balanced concept of old since an older person needs to have lived for a significant number of years. The following respondent provides insights into this concept:

> *I think an old person is somebody who is at least 65, I am 63, I do not know it is a minor condition on some people, you know some people get old quickly because of health when they get a certain age but others do not. I think an old person is anybody who has been around for quite a long time, has knowledge and should be respected by the younger generation (Female, 63 years).*

While using chronological age as a marker of the beginning of old age, every respondent attempts to avoid being labelled old. Instead, they argue that old age begins between 65 years and 90 years of age. The beginning of old age depends on the chronological age of respondents since those who are 60 years old believe that 65 years heralds the onset of old age, while septuagenarians suggest 80 years and even 90 years of age. It seems clear that there is no agreement on the cut-off point among respondents. Regardless of their chronological age, no one dares to refer to himself or herself as old.

Old age is also perceived to be associated with isolation and loneliness. This means every person who is not withdrawn and has a social life cannot be regarded as old. Interacting with others is thought to be uncommon in old age, instead, older people are believed to be unable

to have fun and spend quality time with their colleagues or peers. Chronological age is not regarded as a reliable basis for labelling or assigning age groups to people. It transpires that using chronological age as the sole criterion to describe old age is regarded as flawed, other features are required to capture its full meaning.

4.3 Ill-health and activities of daily living

The respondents appear to be more inclined to equate old age with physical ability than chronological age. There is a discrepancy between the official concept of old and the description of the study participants. Being 60 years old or older is not enough for belonging to the age group "old" but it must also be associated with some degree of limitations in activities of daily living. This is to say every person who can move around, bath, cook, dress, and perform other personal tasks daily should not be lumped together with those who rely heavily on others. There is a clear desire for making a distinction between people who may represent a burden to others and those who can contribute to their society. An older person is seen as a person who cannot live independently but relies on others for a different type of support.

> *I can say someone who is over 60 and perhaps has some degree of frailty and is dependent on other people for help either financially, physically even emotionally (Male, 65 years).*

> *A man is old when he cannot work anymore, cannot do things for himself and has some degree of frailty. For instance, he cannot move around as before and this can be accompanied by memory loss. I would describe a male as being old when he shows symptoms of that (Male2, 65 years).*

> *For me, an old person is my brother, is older than me and very sickly (Female, 70 years).*

> *Somebody who does not walk too well and who is older than I am. We are all old here, I cannot say because they have grey hair, we cannot say that here and that is not a genuine answer (Female, 73 years).*

Health appears to be the most important factor that marks the commencement of old age or makes people old. A healthy and chronologically older individual is not regarded as an older person. The absence of a crippling medical condition is believed to delay the commencement of old age. Chronological age is perceived as a number that cannot make anyone old, this is in contrast with the official definition that sets 60-65 years of age as the commencement of old age. In other words, there is a discrepancy between chronological aging and functional aging. An individual can be chronologically young but functionally old and vice versa. Using chronological age as the only basis to describe old age appears to be misleading since it fails to capture an important feature that is health status.

The inability to work or generate an income, the fact of relying on others for activities of daily living is put forward as one of the characteristics of old age. The elderly are those that have features such as frailty and other crippling conditions which make it difficult for them to fulfil any commitment. The absence of disabilities is regarded as an important feature since it restricts the likelihood of relying on others for instrumental support or being a burden. On the other hand, people who are forced into retirement because of their chronological age cannot be viewed as older when they are still physically, mentally and emotionally able to continue working for some time. Once one of these features is affected, it may become difficult for an individual to be efficient. For instance, memory is believed to be one of the conditions that make people old. Developing such a condition is more likely to impact the ability to work and be productive. This entails that people aged 60 years and older affected by memory loss may be inclined to forget and even become unable to perform their duty as expected. Understandably, memory loss rather than chronological age can be listed as one of the conditions that make people aged 60 years and older unemployable and unfit for work.

The interviews suggest that the concept of old cannot be described by a single feature such as chronological age because the old age group is not homogeneous. The elderly differ in terms of physical appearance, fitness, and health. The fact of turning 60 or 65 years, which is the official retirement age in most countries, does not make everyone look the same. Older people are exposed to different risk factors and environment. They are less likely to develop the same medical conditions at a fixed chronological age.

4.4 Independent living

Regardless of how old an individual might be, chronological age is seen as a feature that does not impact the ability to do anything in life. Being able to conceive and carry out a plan is seen as uncommon to older people. In other words, it is believed that older people lack the ability and commitment to do things for themselves, conceiving plans unaided is regarded as uncommon in old age. Despite being in her early seventies and a wheelchair user, one of the study participants likens herself to a teenager. Her ability and commitment to achieve her goals without representing a burden to others or requiring assistance prompted her to make this statement. The quote below sheds more light on this issue:

> *Actually, what is what they think and how they act, as for me, as I told you, I am a 73-year-old teenager. It all depends on the individuals, what they want to do and what their capacity is like. There is nothing to stop anybody from anything they want to do and if they have the ability and the capability, so go ahead, is not that so? (Female, 73 years)*

Some respondents have made it clear that the concept of old is complex and should be inclusive of features that impact the life of the elderly. Older people are described as those who live in an old age home and who are unable to take care of themselves. This means they have not only retired from active life but are dependent on others for fulfilling activities of daily living. In other words, living in an old age home itself does not make anyone older, it must be coupled with a loss of independence. This viewpoint shows that every retiree is not an older person and old age is well described at the individual level since people age differently. In a sense, assuming that everyone who reaches a given chronological age becomes an older person seems to be a wrong perception of reality. The following respondent illustrates this viewpoint better in the quote below:

> *One who is gone over age, over 60 years old, one who went to live in an old age home and cannot take care of himself or herself anymore. Sometimes they are ill and need care (Female, 64 years).*

Old age should be about the way people feel, if a person is still mentally healthy and physically able to lead his or her life before being chronologically classified as “old”, there is

no need for that person to be lumped together with those who cannot take care of themselves anymore. For the same chronological age, some people are frail and willing to retire while others are still active and committed to being productive and generating an income for a substantial number of years after the age of legal retirement. It is worth noting that some older people are more likely to end up being forced into retirement against their own will. In a sense, the current concept of old seems to be blamed for creating financial dependence. The following respondent falls under this category and he sounds bitter about his retirement experience as expressed in the quote below:

> *I believe a person is as old as he feels. For a person who is mentally and physically fit, I do not think that he should be put in the same category as the one who is disabled somewhere because of old age. I think he should continue because he is a major ballplayer in society, he can contribute in a lot of areas. For instance, I have been an IT specialist. All my life has been IT programming and analysing systems, things like that. But all of us have been put off work, I was quite prepared to continue working but I was told stop. So that is where I stand now and I feel older people that can continue working should be given a chance to do so (Male, 65 years).*

A 75 years old person is alluding to another old age home resident as an older person because of his inability to walk independently, especially, going upstairs or downstairs. This highlights the difference in ability to perform activities of daily living among people who are expected to belong to the same age group, display similar characteristics and experience the same challenges. Understandably, although this individual may be classified as an older person because of his chronological age, there is on his part a feeling of being imposed a particular age category that he does not fit in. Some people feel the concept is not representative of their age group or does not apply to all of them because it is solely based on chronological age. It assumes that there is no difference in the process of aging among people of the same chronological age. Important features such as fitness and health are left out. Regardless of chronological age, a healthy and fit person is more likely to live independently. The quote below provides more insights into this aspect:

> *An old person battles to go upstairs, I help him because he cannot make it (Female, 75 years).*

It appears that chronological age does not affect everyone in the same way. This means, for every age group, there are always people who are stronger than others. It is irrational to assume there is no difference in terms of health and ability in a birth cohort. Independent living is one of the essential features for having a social life and being productive. Regardless of the absence or presence of a medical condition, an older person is believed to be an individual who cannot live independently.

More importantly, it appears that lumping fit and healthy 60 years and older people together with those who are bed-ridden or crippled seems unfair. Similarly, forcing into retirement an active 60 years old based on the assumption that his or her chronological age makes him or her unproductive seems to highlight the obsolescence of this concept. It is essential to make a distinction between people who are referred to as elderly who may represent a burden and those who can live independently. This means that an independent septuagenarian may not be regarded as an older person while a dependent sexagenarian may be declared older despite their substantial margin in chronological age. Health is viewed as an important feature in the description of old age since the loss of independence is a result of a crippling condition that prevents older people from taking care of themselves.

4.5 Physical appearances

Physical appearance is usually regarded as one of the prominent symptoms of aging since older people tend to have more wrinkles. However, using physical appearance to describe old age can be sometimes false and it may not be a true reflection of chronological age. Some people may look younger than their chronological age. The discrepancy between appearance and chronological age is not static but varies from one another. Some older people can look ten years younger than their chronological age, especially, when they have no disability and can perform a given number of tasks late in life. This perception can be picked up from the statements made below by some respondents:

> *Some are over 60 but they still walk like the 55 years old, the only handicap can make you old (Female, 67 years).*

It is weird, when you live in an old age home and you see a person in their sixties sometimes, they are fit and yet you see another person in their fifties they are very old. So I think, aging affects different people differently (Male, 65 years).

The elderly look younger these days now and they do lots of things. You cannot see that they are old but they are young old. Some people do not act old at all, some people are 92 and they look 82, you cannot say that they are old (Female, 69 years).

Someone is old when he looks old, it depends but mostly young people look older now that is why they do not like me, they say I am a child and they call me a thief. Others like the black woman who came here early, they say I do not look like I am seventy (Female, 70 years).

There are old people here, there is an old lady, she is ninety-eight and she is still fit and strong, she is tiny and tall (Female, 75 years).

Some respondents argue that a new trend has emerged and it consists of having older people who look young while chronologically young people look old. This viewpoint seems to question the conventional wisdom that young people should look younger than their elders. In other words, it entails that younger people who are expected to be productive, energetic and fit look much frailer than those who are forced into retirement. The current concept of old gives the impression of discriminating against a group of people since it is not based on any empirical evidence. In a sense, depending on the retirement age of each country, it is assumed that everyone who reaches the retirement age becomes suddenly frail, wrinkled and no longer fit for work while there are other younger people with worse conditions who may remain on the job. Health status is thought to have an impact on the physical appearance of some people. For instance, a sickly person is more likely to look older than his chronological age.

Besides the fact of looking young as mentioned in the section above, some respondents reveal that physical structure makes them feel young. Unlike a typical older person who is expected to be frail and has slow motion, some older people are fit. These features make them feel uncomfortable to be referred to as elderly when they do not have much in common but still carry the label of old. The following respondent speaks about his experience as expressed in the quote below:

I always hear people saying that I am old but I have a young person's body, what is not about you, how old are you? But how do you feel? A lot of people come and ask what are you doing here? (Male, 68 years).

Often, people born to a recent cohort are expected to look younger than their elders, this common perception seems to be challenged by the sight of some chronologically younger people who appear to be older than their counterparts born some years before. The extent of discrepancy between physical appearance and chronological age is believed to be as high as 10 years. This perception contrasts with the current concept of old which assumes that people aged 60 years and older are no longer fit enough to remain active, instead they should retire. It also sounds paradoxical to argue that a chronologically young and sickly person is deemed more productive than a fit and healthy individual aged 60 years and older.

4.6 Signs of seniority

Signs of old age have been put forward by some respondents. These signs are believed to describe the visible and physical features of the concept of old. Features inherent in conditions that are more prevalent in old age such as visual impairment, chronic medication as well as those that cannot be explained by aging. Some of the features put forward do not represent a health threat such as the greying of hair and can be found in almost all older people. Understandably, other signs are associated with non-health threatening features since they are a stereotypical depiction of the way old age is perceived. A given number of features that prevail in old age are mentioned. In a sense, every older person is expected to have all or at least one of these features. The following respondents have highlighted several features as worded in the quotes below:

We have our medication, we have elderly medication with our pills, what can I say, when they have "pills and glasses" (Female, 69 years).

An old man looks drawn, he cannot walk properly while an old woman can be recognisable by the way she walks and her hair looks grey (Male, 84 years).

When you see he cannot walk properly and he is getting grey like I am getting grey. He is slack, when he cannot walk and talk properly then you can see that he is getting old (Female, 81 years).

According to some respondents, getting older is a process that is experienced over time, the more years go by the more it becomes evident. This implies that old age cannot be pinpointed or there is not a cut-off point but changes in physical appearance become more visible with age. Furthermore, while using signs of seniority as an assessment tool, it seems difficult to predict with accuracy the chronological age at which old age commences since the onset of these features may be early or delayed in some individuals. It is worth mentioning that the features of old age range from less to more severe as well as other crippling conditions. It happens that a feature may be severe in a younger person and minor or inexistent in an older individual. The following respondents elaborate on this issue in the quotes below:

Each year you are older brings more change in features of seniority (Male, 76 years)

You can see even symptoms of old age like changing hair colour, wrinkles on the face, physical features, fitness, the way of talking changes, the voices are changing and the disability (Male, 70 years).

The concept of "old" can also be described from physical features that are believed to be characteristics of older people. Numerous signs associated with old age have different causes and influences. Some are minor and do not have an impact on the quality of life while others, such as physical disabilities, are more likely to affect the ability to perform activities of daily living and even deprive the elderly of their independence. The loss of independence is seen as the commencement of old age rather than the existence of signs in an individual. Besides the link between features and old age, some viewpoints expressed seem to stem from stereotypes rather than the effect of aging. The fact of being disabled and having conditions that require chronic medication cannot be solely perceived as a result of aging.

4.7 Aging as an attitude

Being old or young is not only about chronological age, capability or physical appearance but also about feeling. Some people can be chronologically older but they do not feel old.

Seemingly, they have nothing in common with older people since their viewpoint, lifestyle and even perception of life is different from other individuals of their birth cohort. A typical older person is expected to think and behave in a way that is common to those who belong to his or her cohort. This implies that his or her reaction can be predicted based on the experience with other peers who confronted the same challenge. In other words, outsiders or non-older people are not entitled to decide on who is "old" or "young", instead, they must engage with older people. The following respondents have expressed this viewpoint below:

> *People that I know now, they are not acting like old people they are still young at heart, it is not they are old, they are young at heart still (Female, 69 years).*

> *You are as old as you feel (Female, 67 years).*

Some people are thought to be chronologically young but old in mind while others can be chronologically older but having a younger mind. In other words, "some elderly" can think, feel and perceive things like the young. For instance, young people are expected to continue working and be independent while the elderly are likely to be inclined to retire. This widely accepted perception can be challenged by the elderly who are young in mind as they may be willing to continue to work while some younger might be pleased to retire and become dependent on employment-based pensions or other social welfare schemes. Furthermore, some people may be chronologically older but their ability and action do not match that of a typical person of their generation. Older people tend to be conservative while the youth are inclined to be progressive and risk-takers. A person who is young in mind can be keen to take on challenges that are less widespread in his age group. Regardless of their chronological age, people who are young in mind do not want to be referred to as the elderly as a result they can be attracted by the youth fashion and even feel more comfortable to befriend them. The following respondent has made this point:

> *You can on the sort of cut of date of 60 years age, you can do that way but old is also very much in the mind. I mean I know a young 80 years old, how many of them? There are a lot and I know an old 40 years old and that is all in the mind which most people do not use enough (Female, 68 years).*

Although some people may look older, they act young and some are young but act old. A typical older person is expected to behave and perceive life in a predictable way that is believed to be representative of the entire age group. This perception may not hold true for every older people since some act young and feel young in mind. To prove this point, some older people are willing to have a lifestyle that is in contrast with their generation, they may seek to age healthy and enjoy independent living. A person who is "old in mind" struggles to accommodate changes that may result in poor performance and misunderstanding, however, a person "young in mind" may make a substantial contribution to the community.

Being older is a personal matter which may require the contribution of the elderly for further light and understanding. Most policymakers appear to depict the elderly from a stereotypical point of view and lack sufficient insights on their ability. For instance, some chronologically older people may still be willing to be active and prove wrong those who portray them as forgetful, incompetent and backwards. It is believed that old age impacts the ability to adjust to change and achieve goals, this can be proven wrong by having a positive attitude and self-esteem. Furthermore, they may not use old age as an excuse for being a burden to others but work around their inability to come up with a better way of tackling their challenges and remain independent.

4.8 Aging and gender

The current concept of old assumes that everyone ages in the same way. This perception seems deceptive since people are different and cannot grow older in the same way. It is possible to find a significant number of people who may become nonagenarians and even centenarians in the same birth cohort with those who die early. The pace of aging appears to be influenced by lifestyle; in addition, healthy living is thought to have a positive impact on the aging trajectory. People who choose to live healthy at a younger age are likely to reap more benefits than those who do it at a later stage. Similarly, different lifestyles can also be equated with various levels of exposure to risk factors. For instance, two healthy living people working in two different sectors of the economy are less likely to age in the same way since they are exposed to different occupational hazards. The heterogeneity of the old age group makes it difficult for everyone to age according to a predictable trajectory. The following respondent makes this point as outlined in the quote below:

It depends on what kind of life you have been living, I believe. If it has been active life throughout, you will find the ratings are a bit slower because there are things you can do (Male, 65 years).

Aging affects men and women differently, some tend to look older than they are while others appear to be younger than their chronological age. It seems that health plays an important role in the way people look. A healthy older person may look younger than the one who is sickly chronologically young. Even within the same birth cohort, sickly people tend to look older than others. Chronological age does not make people frail or unfit but poor health and an unhealthy lifestyle can do so. Furthermore, older women tend to outlive their male counterparts. The following respondents have mentioned some of the factors responsible for differences in the aging trajectory:

I have noticed women outlive men but I do not know why. Somebody says it is because men pay bills and women just stay at home. That is the reason men die quicker (that is just a joke anyway). Even here in the old age home you will find a lot of women, they are 90 and they are still living (Male, 65 years).

I do not think so, I do not think a man is old until he cannot work anymore. Maybe he does not have his ability you know maybe he has lost his strength to put on his maximum capacity, maybe then he is old. I suppose it is the same thing when she cannot do things for herself when she is unable to do what she was able to do at an early age, once you cannot help yourself to full capacity I will say you are reaching old age but not me (Female, 73 years).

When she cannot take care of herself anymore, she is taking a lot of tablets, she is ill (Female, 64 years).

We age differently, I think men surely age later and women tend to look older than men. I think the same applies to what I said about women (Female, 63 years).

It appears that the trajectory of aging differs from one another but there is no agreement on the gender that ages earlier. Men are believed to age early or when a man turns 65, he can be referred to as an older person while for women, old age begins at age 70. On the other hand,

women are thought to age earlier than their male counterparts without providing any cut-off point. More importantly, for every man and woman, old age is not automatically acquired by reaching this chronological age, it must be accompanied by dependence. The inability to live independently and/or generate an income is put forward as one of the determinants of old age.

Besides the inability to take care of themselves put forward as characteristic of old age by other respondents, being older can also be described by the way people deal with their issues. Human interactions are part of daily life occurrence; it can be friendly, cold or antagonistic. It is believed that when a man reaches old age, he becomes wise and humble while his female counterpart tends to be aggressive and moody. This viewpoint seems to highlight some misconceptions about the other gender group and has nothing to do with old age. Some physical features that are believed to be characteristic of old age are also found in women. The following respondents express this stance in the quotes below:

> *An old woman is very touchy, if you do not say the right way she will attack you while an old man is humbler, men are always humble (Male, 68 years).*

> *A woman becomes old when her flesh is wearing out (Male, 70 years).*

The concept of old cannot be understood and described in the same way for everyone since people age differently. These differences can also be expanded to gender because it is believed that men and women do not follow the same aging trajectory. Although there is no consensus on which of the gendered groups - men and women – ages earlier, it is however agreed that aging is part of human life. Furthermore, within every age group as well as across generations, the trajectory of aging seems to be different from one to another. It depends on lifestyle and the extent of exposure to risk factors. The combination of lifestyle and determinants of health dictates how people should age. Therefore, it may be possible that some chronologically young people end up looking older than their chronological seniors.

Health remains an important factor that is claimed to make a man or woman old and the inability to perform activities of daily living is seen as a main (major) catalyst. Besides features inherent in physical appearances and health, stereotypes are also put forward as factors that determine the onset of old age. This may result in having some chronic or avoidable conditions in the elderly overlooked because of the belief that it is caused by aging.

If aging were an illness, its symptoms would have been found in every chronologically older person. However, the fact of using stereotypes seems to be an easy way of shifting the blame on the cause of a condition or something that cannot be explained rationally.

A lack of knowledge of conditions in old age has given rise to many stereotypes. For instance, older people are often portrayed as forgetful while this might be a result of dementia or other conditions. The viewpoint that implies that older people are not fit for taking on any responsibility can be proven wrong. To be more specific, a large number of government officials are entrusted with more responsibility while they are over 60, even over 70 years. Furthermore, most features used to describe old age are either demographic such as chronological age or biological such as health and physical appearance. The concept of old can be better explored by using these two features since they are measurable or based on fact, while, stereotypes are socially constructed and vary across the world. Stereotypes are often baseless and pointless and cannot help understand the concept of old.

4.9 Old age and culture

Being an older person is not only about reaching a given chronological age decreed by governments around the world at the onset of old age but it also has cultural significance. Culturally, an older person is described in terms of achievements rather than chronological age. The most important achievement is raising children to an age they become able to fend for themselves. After reaching old age, parents can either live independently or rely on adult children for meeting their day-to-day needs. Although the elderly may not always depend on adult children, they expect their support when health deteriorates or they face challenging issues. In addition, older people can be recognisable by the type of respect given to them by younger generations. The following respondents share their opinion on this issue as quoted below:

> *In my culture, old age starts when you retire from your children, growing them up and they care for themselves then you are free yourself, you are going to be independent or you depend on them. That is what I live for, I do not depend on anybody, just be independent as I was. But in the event of, I do not know, I get older, if I collapse or something, it is going to be the children or something else, I do not*

know but I have good children. I do not go to them, I raised them, I did what I could do for them now it is their way of living. They are all doing well (Female, 70 years).

In my culture, if you are old, people respect you (Female, 75 years).

According to some respondents, the concept of old is described in terms of reproduction. An older person is viewed as the one who has succeeded in procreating. Although no mention was made regarding the size of descendants, it appears that what matters the most is to have successfully taken on the parenting and grand-parenting role. An emphasis is placed on reproduction or the role played by any individuals in ensuring the survival of the community and culture left behind after their passing. It appears that becoming an older person is not only an honour but also a legacy that aims at encouraging others to leave behind people who will replace them in the reproductive role. The following respondent makes this point in the quote below:

Seniority is when you are a great-grandmother, great-grandfather that is older in my culture (Female, 73 years).

Culturally speaking, older people are those that are looked after by their children. It appears that, from a cultural perspective, having children benefits both the elderly and the community. The survival of the community is assured through reproduction while the elderly will be cared for by their descendants. This reciprocal dependence plays a crucial role in the well-being of older people and the community. However, this cultural responsibility seems to be challenged in the contemporary society where the elderly live or are expected to live in old age homes because of the demise of the extended family as well as traditional structures that were supposed to cater for them. This point seems to emerge from the following quote.

When the mother and father get very old, their children must take care of them. I must thank God since we can have access to shelters and food regardless of our old age (Female, 68 years).

From a cultural point of view, older people are viewed as valuable members who have made a significant contribution to the survival of the community. This implies they will leave behind descendants who are going to ensure that the future of the society is not in jeopardy as

their replacement is provided by younger generations. There is more pride for older persons to live and see their grandchildren, great-grandchildren as well as other generations that will follow. In return for their contribution, the elderly expect to be honoured with the support of their family members when they become unable to provide for themselves. The reciprocal relationship of dependence between the elderly and their descendants is viewed as the basis of old age support. Initially, it was believed that the amount of old age support depends on the number of descendants, currently, some contemporary issues such as migration, urbanisation, and unemployment are thought to challenge this traditional support net. Families tend to be less involved in the support initiative while new structures of support such as old age homes have emerged. One of the ways of honouring the elderly is through the respect they earn from their descendants and other members of the community.

4.10 Opportunities

The fact of getting old deprives some older people of the ability to benefit from their possessions or undertakings. This can be more detrimental if it is accompanied by the loss of a partner, especially, who was dealing with the daily running of the business entity. The widowed elderly might find another partner in replacement of the deceased and entrusted him with everything and hope that he is going to be reliable and trustworthy as the first one but the outcome may be disastrous. Old age seems to be equated with the end of financial independence and limited living conditions. The onset of old age takes away opportunities since the elderly are no longer active or are compelled to retire because the concept of old is solely based on chronological age. However, having a roof over their heads and a source of income seems to result in a positive attitude and improve the well-being of the elderly. In a sense, old age is equated with the feeling of self-contentedness and gratefulness. The following respondent expands on this in the quote below:

> *You know we live in a world where you should have things when you get older but for some people, life is never the same, it takes away opportunities. If you are in the wrong place at the wrong time you meet the wrong people so what I have at the moment. When my husband died, I met somebody who took all my money. For the moment, I can say what I should have had, I do not have it that is why I am on the state pension, at least I have a roof over my head. One day you got it and in a blink of an eye, you can lose it (Female, 63 years).*

Old age may coincide with some important events at the individual level which seems to revolve around the loss of independence, especially income. For a stay at home person, the onset of old age can be equated with the passing of a partner who is also the main income earner or the main breadwinner. The deprivation of opportunities is seen as an important factor at a time older people are less likely to provide for themselves or undertake income-generating activities allowing them to live independently. The lack of opportunities should also be seen from the perspective of being excluded from the job market because of the retirement rules dictated by chronological age. Any individual who has reached the retirement age does not benefit from the same opportunities as younger generations. The prospect of improving living conditions seems to be restricted or nullified since older people are believed to be no longer fit for work. To some extent, older people become compelled to live in poverty and rely on pensions for meeting their needs.

4.11 Summary

This chapter presented several features of the concept of "old" which are explored to come up with a comprehensive definition. The interviews also reveal that there is no consensus on the age at which old age commences since all respondents, regardless of their chronological age do not want to be referred to as older people. This lack of consensus highlights the complexity of the issue which is also found in academic literature (Maharaj, 2013; Makoni, 2008). The commencement of old age is believed to occur around 65 years. However, the fact of reaching chronological age alone does not seem to make people older, it must be accompanied by features such as limited or complete loss of mobility, inability to earn an income, poor quality of life, lack of social life and loss of self-esteem. There is on the part of the elderly, regardless of their chronological age, a tacit desire of remaining or being referred to as a non-older person especially in the absence of a crippling health condition. People aged 65 years and older or over the age of legal retirement were not comfortable to be described as elderly, this fact was documented by past studies (Ward, 1984).

Health appears to be an important factor that determines the onset of old age. The absence of a serious health condition is regarded as one of the factors that delay the commencement of old age. The ability to live a normal life leads the elderly to question the fact of being classified as senior citizens or older people. The current concept of old does not make any

distinction between people who live independently and those who rely on others for performing activities of daily living. Any person who reaches the age of legal retirement is referred to as an older person. This concept seems biased since it overlooks other features and assumes that chronological age is the most important component. It appears that the description of old age is shallow and does not capture its full meaning. Some elderly question this concept since it is not representative of their age group. Likewise, Rowland et al. (2018) argue that the concept of old should be made of two distinct features, notably chronological and functional aging. This is to say an individual can be chronologically young and biologically old. The aging process does not happen at the same pace, some people tend to experience a slower pace of aging in comparison to those who belong to the same chronological birth cohort (Sternäng et al., 2018). Besides highlighting this inconsistency in this concept that is widely used by many governments around the world, several features are also put forward to provide a comprehensive definition.

An older person is described as anybody who relies on others for performing activities of daily living. The ability to live independently is seen as an important feature that distinguishes the elderly from non-elderly. An increase in life expectancy witnessed over the last decades has affected the way old age is experienced. Goldman et al. (2018) argue that the elderly do not only live longer but also independently. It appears that old age is not described solely based on chronological age but an emphasis is placed on the extent to which people can take care of themselves.

It is believed that some of the elderly tend to look younger than their chronological age. In terms of physical appearance, they can be compared to people who are 10 years younger. Facial aging is more likely to be caused by an unhealthy lifestyle (Morita, 2016; Seitz et al., 2012). It is argued that older people are those who suffer from conditions such as frailty and have slow mobility. On the other hand, regardless of their chronological age, individuals who are fit and able to move around like youngsters should not be referred to as older people. The aged who experience healthy aging are not regarded as older people because of their good quality of lives and relatively good health (Whittaker et al., 2019). Health is seen as an important feature in the concept of old as it impacts physical appearance, sickly people often tend to look frailer and older than healthy individuals who belong to the same birth cohort with them.

The combination of commitment and ability to live independently is seen as uncommon in old age. This entails that older people are not able to conceive plans and execute them on their own without being a burden to others, any chronologically older individual who can live independently should not be referred to as an older person. It is argued that chronological age is less likely to reflect cognitive aging since it increases steadily from one year to another in middle age while cognitive performance remains almost unchanged (Rönnlund et al., 2005). Instead, an increase in functional biological age is more likely to impact cognition in adults. Functional biological age is believed to be a better indicator of aging than chronological age (Sternäng et al., 2018). Furthermore, older people are described as those who live in old age homes and rely on others for assistance. This means that living in an old age home itself does not make someone older as long as there is no care involved. This viewpoint seems to highlight the fact that the decision to live in an old age home is imposed on some people by the loss of income as a result of retirement. Besides the issue of physical fitness, mental health is also evoked as an important feature. It is argued that any person who is mentally healthy and able to live independently should not be classified as "old".

Despite their chronological age, some people still feel confident, able and willing to continue working for some time. In interviews, there is a clear recognition that people who belong to the same birth cohort may not necessarily look the same in terms of physical appearance and medical history. McPhee et al. (2016) argue that even though they may have the same chronological age, the elderly experience considerable variability in terms of individual health since some are very healthy while others are disabled, weak and frail. In other words, it seems unfair to lump together those who are frail and willing to retire in the same category as those who are willing to live an active life just because they have the same chronological age. As a result of the arbitrary concept of old, some people are, against their own will, forced into retirement since it is assumed that they are no longer fit and able to contribute to society. The beginning of old age is equated with the marginalisation of the elderly. Unlike young adults, older people are deprived of several opportunities, they are perceived as unemployable and unproductive just because of their age. The loss of opportunities in old age is often worsened by the death of a partner. The worst scenario is the loss of the breadwinner which would make it difficult for the partner left behind to generate an income to meet the household needs. Regardless of their skills, older people are taken off the job market and have no prospect of improving their living conditions. This is to say that old age is more likely to coincide with the end of financial independence. Research suggests that employers

in the developed world attempt to be flexible as far as retirement age is concerned but they still believe that reducing the number of older employees is economically viable since it helps reduce costs. This results in vulnerability for old workers as they are less likely to be employed (Baruch et al., 2014).

Regardless of their chronological age, the ability to perform activities of daily living is seen as an important determinant of old age. The elderly who live independently do not want to be referred to as older people, instead they label their peers as old. This means the inability to live independently is a result of the aging process rather than chronological age. Chronological age alone should not be used to determine old age since people may belong to the same birth cohort but differ in terms of physical fitness and independent living. There is a clear attempt to dissociate the elderly who experience healthy aging from those who rely on others for performing activities of daily living (Whittaker et al., 2019).

The concept of "old" focuses solely on chronological age to describe old age and leaves out some interesting features. For instance, despite their chronological age, some people do not identify themselves as older because the concept does not reflect their perceptions and experiences. It is often believed that people who belong to the same generation tend to perceive life differently from others. To be more specific, this means that their perceptions are shaped by the sense of belonging to the same age group. This viewpoint is made by Leach et al. (2013) who argue that the baby boomers dissociate themselves from the label old. Their lifestyle and consumption motivate them to reject the old age identity since they match the description of a typical older person (Gilleard and Higgs, 2005). The issue of self-identity is overlooked in the description of old age. Restricting the concept of old to chronological age is flawed, simplistic and fails to capture its complexity. The current concept is challenged, old age is not only about reaching the age of legal retirement but also the way people think. This means every person who thinks like the elderly should be regarded as older since he is likely to behave like a typical older person despite being chronologically younger. It is believed that perception has an important influence on performance.

Old age is likened to an ongoing process which is difficult to pinpoint but which becomes evident overtime. This implies that setting a cut-off point of commencement of old age may be unattainable since poor health increases with age. Research suggests that the timing of the onset of chronic conditions differs across and within regions (Engelgau et al., 2011; Robinson

and Hort, 2012). Reaching old age can be associated with various features that are believed to be common among older people such as grey hair, wrinkles, slackness, impaired sight, and chronic conditions. The inability to live independently stands out as the main determinant, it may be a result of a disability that restricts mobility. On the other hand, as far as gender is concerned, the fact of getting older for men and women is believed to be accompanied by changes in behaviours. Older men are expected to become wise and humble while older women are perceived as more aggressive and moody. It is worth highlighting that the gendered description of old age seems to be social and does not have any medical or biological evidence since it is based on perceptions or stereotypes rather than a rational argument. The concept of old seems to be described in the same way for every country around the world since it is assumed that the aging trajectory is similar for everyone. Old age is not a one size fit all approach, people age differently. Even within the same society, it is believed that biological differences between men and women may have an impact on their aging trajectory. From biological standpoint, it is revealed that men and women experience age-related declines in muscle functioning and strength which result in limited mobility, disability and low walking pace in old age; the rate of decline is more pronounced in midlife in women than men (Musumeci et al., 2015; Sipila et al., 2006; Sipilä et al., 2013). Furthermore, features such as lifestyle and the extent of exposure to risk factors have a substantial impact on the way people age. These differences still hold true among people exposed to a similar risk factor and environment since their respective systems cannot respond in the same way. The impact of lifestyle on the aging trajectory appears to be substantial as reported by other studies (Gobbo et al., 2015; Lafortune et al., 2016)

From a cultural perspective, being an older person is seen as an achievement. Older people are viewed as those who earn the respect of others because of the amount of experience accumulated over the years. An older person is an individual who has succeeded in bringing up his or her children until they become productive and independent. Therefore, the elderly can continue to live independently or rely on their offspring for support, this viewpoint is also shared by others (Ward, 1984). On the other hand, in case of challenges that may make the elderly unable to handle or develop a coping mechanism, the support of adult children becomes a necessity and a moral duty. The elderly are regarded as people who deserve a double honour. Firstly, they are honoured for their procreation role since they succeeded in leaving behind their descendants who will ensure the survival of their community. Secondly,

an older person is not only someone who has raised his or her children to adulthood but also has lived long enough to see other generations that descend from him or her.

When people get older, they expect to be taken care of by their adult children but this type of support is no more available for every older person. Increasingly, they are cared for in residential homes for the elderly. This change is believed to be a result of the inability of the extended family to assume its responsibility for providing for the elderly. The demise of the extended family appears to be responsible for the lack of social support in old age. It is believed that factors such as a decrease in family size, the death of young adult as a result of HIV/AIDS, increased migration and urbanisation are believed to have impacted the ability to provide for older people. These issues about the inability to provide for the aged experienced by the traditional support net were also mentioned by Alambo and Yimam (2019).

People aged 65 years and older are referred to as senior citizens. This concept is not only nominal or used for classification purposes but it is also an indicator of the exclusion from productive life. This is to say any person who reaches this chronological age is expected to retire willingly or forcefully. The implications of this in the life of the elderly are very substantial since it results in deprivation of opportunities, marginalisation and fuels poverty. Describing the concept of old should be handled accordingly since it has an impact on the living conditions of the elderly, notably, their identity and retirement age. The current definition of old age is questionable and does not take into consideration the change in the population age structure that is taking place over time. It is worth mentioning that when the concept of chronological age was made legal, turning 65 was almost uncommon (Bauernschuster et al., 2018). At present, there is a gradual increase as a large proportion of people tend to live long and in good health (He et al., 2016). The current concept is not representative and fails to capture the complexity of the issue in various regions of the world, particularly in Africa.

CHAPTER 5: OLD AGE AND SOCIAL SUPPORT

5.1 Introduction

Recent decades have witnessed declining fertility and a rise in the share of the older population. This trend is common to almost all the regions of the world and it is associated with several challenging issues. The prospect of a substantial increase in the proportion of the aged seems to raise some questions. In the more developed world, there are attempts to mediate the economic impacts of aging and below-replacement fertility. While in the less developed world, there are growing concerns over the demise of old age support since families tend to nuclearise and reduce their size. In the absence of reliable public welfare, the well-being of older people is likely to be in jeopardy (Ezeh et al., 2012; Yasuda et al., 2011).

It is argued that the elderly experience an increase in the burden of chronic conditions that tend to turn them into medication dependents for life (Prasad et al., 2012). This frequent episode of ill-health and reliance on medication occurs at a moment they are confronting other stressful events such as loneliness and loss of social networks (Cacioppo and Cacioppo, 2014). Social support appears to be one of the better ways of mitigating the effect of stressful events in life. The type of assistance provided by relatives or family members is various and can include emotional, financial, material and physical support (Shor et al., 2013). While individuals who do not benefit from family support are likely to experience ill-health such as depression, low level of self-esteem, elevated risk of disease and mortality (Shor et al., 2013; Thoits, 2011). The contribution of family members to well-being is often in old age (Shor et al., 2013). Studies reveal that individuals who benefit from social support are well equipped to cope with stress than those who are not (Awasthi and Mishra, 2007; Roohafza et al., 2012).

South Africa has witnessed a rising number of older people in a difficult socio-economic context of inequality, high HIV prevalence and a growing chronic disease burden (Kahn et al., 2012; Nyirenda et al., 2012). The high level of poverty in old age makes precarious the living conditions of many older people. Furthermore, the endemic nature of HIV/AIDS to Southern Africa appears to represent a serious threat to the extended family as a source of old age support since many young adults are affected. The death of adult children as a result of AIDS increases the vulnerability of the elderly and compels them to live in skipped-generational households surrounded by orphans without other income earners. The demise of

the extended family renders nearly inexistent any traditional support for the elderly (Karimli et al., 2012; Kautz et al., 2010).

In South Africa, older people have become part of essential providers of caregiving to vulnerable children as a result of the government-sponsored old age grant. It is means-tested and remains one of the most extensive pension schemes in Africa, a direct way of redistributing resources to the vulnerable households in a highly unequal society (Ralston et al., 2015). This scheme is perceived as a way of extending the income-generating life in a society that experiences a high level of youth unemployment. Every recipient of old age pension has become income earners and providers of their households (Schatz et al., 2015).

Old age is associated with increased vulnerability and several health challenges. Besides requiring support in line with their failing health, material deprivation and limited sources of income, the elderly also confront emotional challenges. Some studies have looked at the dwindling nature of intergenerational support in Africa (Kowal and Dowd, 2001), social support and well-being in the United States (Nhongo, 2004), a literature review on health, social isolation and loneliness in old age (Togunu-Bickersteth and Togonu-Bickersteth, 1988). There are nearly no studies in Africa and South Africa that explores the interaction between social support and determinants of health in old age. The present research attempts to fill this gap by attempting to understand these features and highlight different types of support the elderly receive as well as its source.

5.2 Analysis of social support

Respondents were asked about the type of assistance they receive from various sources including family members, the community, the government as well as non-governmental organisations (NGOs). Social support is defined as the availability and the amount of care generously offered by all these stakeholders. To assess the extent to which they were assisted, respondents were asked the following questions: “What kind of support do you receive?”; “What kind of food do you eat?”; “What are your eating habits?”; “Where are your relatives located?”; “What should be done to improve your living conditions?” These qualitative questions were complemented by some relevant sections of the NIDS survey. It is worth noting that the type of assistance received is not restricted to money but any kind of contributions received as well as support.

5.3 Emotional support

The participants who took part in the NIDS survey were asked about their likelihood of feeling of loneliness in the last 30 days, the categories of responses ranged from almost never (less than a day) to seven days (most of the time) a week. This is cross-tabulated with marital status to explore its impact on their emotional well-being. It appears that marital status plays a role in the likelihood of feeling of loneliness among the elderly. Table 5.1 highlights that men and women living with their partners tend to report feeling less lonely all of the time (1%) while those who are not married seem to be the most affected as they record the highest proportion of feeling of loneliness with approximately 4%.

Table 5.1: Percentage of respondents by marital status and likelihood of reporting loneliness

Statement	Almost never %	Sometimes %	Most of the time %	N
Marital status				
Married	77.3	21.6	1.0	1406
Not married	64.3	31.7	4.0	357
Total	73.8	24.4	1.9	1763

** Using NIDS weighted data, wave 5, year 2017*
**Although 3545 respondents took part in the survey, some skipped certain questions in this section.*

The fact of living together or away from their children appears to influence the feeling of loneliness in respondents. Table 5.2 reveals that the elderly who co-reside with their children tend to be less affected by this problem since nearly 31.2% report feeling lonely all of the time compared to their counterparts (68.8%) who do not live with them. The same trend is observed in all older people who live with their children, as well as, those who do not co-reside.

Table 5.2: Percentage of respondents by living arrangments and likelihood of reporting loneliness

Statement	Not living with children %	Living with children %	N
Likelihood of feeling of loneliness			
Almost never	56.4	43.6	1438
Sometimes	58.7	41.3	761
Most of the time	68.8	31.2	81
Total	57.9	42.1	2280

** Using NIDS weighted data, wave 5, year 2017*
**Although 3545 respondents took part in the survey, some skipped certain questions in this section.*

The respondents who took part in the in-depth interviews spoke about the diverse sources from which they received emotional support. The amount of support depends on the level of interaction of every individual in the community. A great deal of emotional support comes from their peers living in the old age residence as they always meet in the dining room or other parts of the building. Family members provide emotional support on the telephone or during their visit. Also, faith based-organisations such as churches come to the rescue of some respondents to help them get going. The following respondents provide more light on this issue.

> *I do get support telephonically but most of the emotional support comes from people who live here, in this building because I am closer to them, my family is in the Western Cape, they are far away (Male, 65 years).*

> *Well, my friend encourages me a lot, I like phoning, my money goes on airtime and I have a lot of church sisters and brothers that I go to for weeks. I just came there from Cape Town, from my son then I went two weeks to Newlands East, two weeks to Reservoir Hills and they are always phoning me. So I am happy (Female, 64 years).*

> *I receive emotional support from my family and we have a very good relationship (Female, 67 years).*

I have a very good friend that I have known for many years and now and then she will take me out for lunch, we talk and laugh about all those things, emotionally here, yes they do help (Female, 63 years).

Other respondents reported drawing on their inner strength. For instance, approaching a person regarded as emotionally weak was not acceptable; instead, self-talking was seen as a better way of obtaining emotional support and confronting personal challenges. Self-talk is a valuable tool for increasing self-confidence and curbing negative emotions. Seeking support from others can also be seen as a bad initiative since it is likely to result in a negative outcome, especially if the person is not emotionally well-balanced. For instance, a broken-hearted person cannot assist others, instead, he will pass on his bitterness to others. The following respondent talks about her experience in the quote below:

That is the tough one, mainly from myself, I do a lot of talking to myself and this has nothing to do with the hospital or government. In general, people who are emotionally broken tend to drag you down. I stamp on them, I am not going down there, you think I am a tough old bird (Female, 68 years).

Other older people manage to avoid stressing by keeping themselves busy since finding reliable support may be difficult and even challenging. In the absence of any entertaining activity, some respondents attempt to take their mind off their worries by spending time reading books, novels or newspapers. Loneliness and boredom have an adverse effect on frustration that can lead to emotional instability. This may compromise the well-being and put the health of the most affected in jeopardy. The impact on health can be more severe in those who did not get emotional support at any point in time. The following respondent speaks about his coping mechanisms and experiences in the quote below:

If I need support, I read good books to get my mind off crazy things. Sometimes, older people get bored and annoyed because there is nothing to do, no one to talk to but I read a lot. Therefore, I am covered in that way (Male, 65 years).

Some respondents used their social networks to access emotional support. The nature of expected support determines the type of people they are likely to approach. This highlights the various challenges that the elderly confront as well as their social networks. Older people

confront personal, social or relational issues that would lead them to seek emotional support from other residents or any reliable person. The nature of challenges facing the elderly dictates the person to approach, for instance, legal matters require the assistance of those who have special skills. Besides the conventional way such as face-to-face interaction, telephonic conversations, and even mails, electronic mails are some of the ways they use to keep in touch with social networks to receive emotional support. The quotes below provides further light on this point:

> *Well, it depends on people I socialise with because we share ideas and if I know that I need something like counselling I go Legal Wise, I always know where to go for assistance (Male, 70 years).*

> *You know my family is so far away but they do phone me. I get phone calls from them, I get letters from them, I get emails from them, I have a lot of family support (Female, 66 years).*

Emotional support appears to be an intervention that takes place following a life-changing event. Engaging with social networks on this event in an attempt to seek solutions is regarded as a better way of dealing with challenging issues. Any intervention that does meet these requirements is not regarded as emotional support. Some respondents did not only interrogate the concept of emotional support but also the efficiency of the assistance provided. In addition, any unsuccessful intervention does not deserve to be labelled emotional support because it failed to provide relief to a relative or peer in need. This mixed feeling is captured in the quote below:

> *When I am sick my children come and say, oh mum I hope you get better, I do not think this type of conversation deserves to be called emotional support. Emotional support is when you are going through a difficult time, your friends or relatives come and assist in getting a solution or dealing with it (Female, 63 years).*

It is important to note that several people are involved in providing emotional support for the elderly. Firstly, almost everyone who lives in an old age residence is a potential source of support because of his or her proximity. Secondly, family members use several ways to keep in touch with their loved ones since they have a lot in common with the elderly. Some of the

ways used to provide support are via telephonic conversations and personal visits. The utilisation of electronic media such as cellphone messages and email seems to be the easiest way of keeping in contact with loved ones. Finally, church members and ministers are also part of those on whom the elderly rely on for emotional support. In the absence of a trustworthy person for support, self-talking and reading are used. Understandably, emotional support is perceived as a nursing intervention that takes place after a major or life-changing event. Thus, it should aim at exploring some possible solutions and eventually come up with satisfactory outcomes.

Although there are more women than men in the old age home, almost every older man tends to be married or live with a partner. The elderly believe that those who are not involved in one of these relationships are emotionally weak or lonely. In a sense, older men are more likely to benefit from emotional support than their female counterparts. This is because they are more likely to be living with their partners.

5.4 Gifts and instrumental support

The elderly do not regularly receive gifts from their adult children. Regardless of their place of residence, the elderly rarely receive gifts from their adult children. Table 5.3 highlights that the contribution of adult children living with the elderly is inexistent while those who do not co-reside, provide a negligible contribution (0.2%). The absence of this support could be equated with their inability to generate an income rather than their lack of generosity. On the other hand, it appears that the elderly without children are less inclined to receive gifts as they did not report receipt of any in this regard.

Table 5.3: Percentage of respondents by receipt of gifts and living arrangements

Statement	Receiving gifts %	Not receiving gifts %	N
Living with children			
Yes	0.2	99.8	1057
No	0.0	100.0	1227
Total	0.1	99.9	2284

** Using NIDS weighted data, wave 5, year 2017*
**Although 3545 respondents took part in the survey, some skipped certain questions in this section.*

The respondents who took part in the qualitative study report receiving some assistance from friends and family members in many ways. The type of support is crucial and valued by respondents whose life would be different if there was no such intervention. Sometimes the recipients feel humbled to benefit from such an act of generosity. The elderly acknowledge that their benefactors have numerous competing priorities but they still manage to take some time off their busy schedule to come to socialise with them at their old age residence. This support is perceived as a reward for having maintained good relationships during their active life. The following respondents share their experience in the quotes below:

> *My children are spoiling me now, the saddest part is my oldest son carries food and comes to give me (Female, 70 years).*

> *My niece is married and works hard, my nephew is married and works when they can, they visit me and that is always lovely. They bring me things like biscuits you know if they tell me they are coming they ask me if I need anything, I might want some cup of soup or whatever. Friends and family are important and I think that you get out of what you put into it all those years ago. If you were good to your friends and family, what goes round comes round. So be nice to people (Female, 68 years).*

However, not every respondent benefited from the support of family and friends. Some were disappointed and even disillusioned, they decide to fend for themselves and manage to live on their state pension. The interaction with other family members seems to be kept to a minimum and only if there is an event such as a funeral or other family gatherings. Sometimes the elderly believe that their brothers or sons are being manipulated for stopping supporting them. The extent of disappointment may lead the elderly to turn down any probable support from their relatives and decide to work to supplement their income. The following respondent speaks about his frustration and shares his experience in the quote below:

> *I was discouraged by my family that is why I am by myself and I do not trust anybody. I have discovered that they maintain themselves and I must maintain myself, I must stay away from them, I only visit if necessary. I was receiving support from my younger brother but since he got married everything changed, I want to show them*

that I can provide for myself, I am working at my age. I told my children I do not need anything from them because they disappointed me somehow (Male, 70 years).

Several respondents reported receiving different kinds of support from their relatives and friends, this various support has made a significant contribution to their life. The elderly could not conceal their gratitude for every gift received, some were their favourite. Besides food, they also receive items such as newspapers aimed at entertaining and informing them. The following respondent speaks about her special gift in the quote below:

The best present my nephew gives me every year is my subscription to the Mercury, which is delivered here, that is wonderful. And then I can do the crosswords puzzles, word games, the code-cracker and I pass the paper onto a couple of other people for them to read, the paper has to work and it does work, it is not only me who looks at it. Hence, that is my best gift every year (Female, 68 years).

Besides getting material support from family members and friends, the need for instrumental support is also crucial. Shopping is one of the tasks that compel the elderly to go out on a regular basis, however, because of their ill-health, assistance with errands is sometimes required. Wheelchair users, as well as those who have mobility issues, arrange to get people to assist them in this regard. The first people who avail themselves for assisting are other able-bodied old age home residents. To avoid seeking assistance frequently, some physically impaired older people manage to buy a large number of items that can be used over a long period. The following respondents shed more light on this issue as mentioned in the quotes below:

If I am not well, she comes and sees what is going on; she will try and get me what I want, medication or anything (Male, 84 years).

There is a special one, you know the lady that came to sit next to Alan? She runs a lifestyle section where she gets events together and exercising and walks in the morning. She is the one that handles all of that (Female, 63 years).

I have a big problem which is peculiar to me is, it is not easy for me to go shopping. If I need a litre of milk or something, we can work around it. I go to buy long-life milk, I

can have two litres or four litres a month and they can stay in my room in the cupboard until I need to use it. I do not need to look for somebody to buy for me. That is a bit of a problem but it is particular to me (Female, 68 years).

It appears that some of the elderly benefit from the assistance of adult children, friends, relatives and even other older people in many ways. In terms of availability, non-old age home residents provide food or other items required by the elderly, however, their interventions take place during a visit or in case of necessity since they have other commitments and may reside in another area. The fact of juggling between fulfilling family moral duties or caring for others and personal commitments seems to restrict the amount of support provided by family members and friends. On the other hand, some old age home residents provide a great deal of support to their peers in need. These residents are instrumental in providing support such as doing errands and shopping for their frail and sick peers. It appears that the support provided by old age home residents is often instrumental while family members and friends tend to provide gifts.

Although the amount of interaction among family members may be influenced by distance, some older people do not receive support at all. Yet, traditional old age support cannot be taken for granted since the fact of having family members and social networks does not necessarily translate into assistance. Some older people believe that having a supportive family comes naturally as a result of good relationships between them and other relatives. In contrast, some people are not getting social support not because there is no support but because they refuse it or have a previous bad experience.

5.5 Financial support

The fact of living with adult children seems to impact the number of contributions the elderly receive from their social networks. For instance, the respondents who do not reside with their living adult children report receiving more contributions from non-household members than their counterparts who co-reside with them, 14.0% and 9.7% respectively as shown in Table 5.4 below.

Table 5.4: Percentage of respondents by receipt of contributions and living arrangments

Statement	Not receiving contributions %	Receiving contributions %	N
Living arrangements			
Live with children	90.3	9.7	1227
Do not live with children	86.0	14.0	2025
Total	87.6	12.4	3252

** Using NIDS weighted data, wave 5, year 2017*
**Although 3545 respondents took part in the survey, some skipped certain questions in this section.*

The elderly who took part in qualitative interviews report receiving financial support from various stakeholders such as adult children, grandchildren, and other relatives. This support takes place either monthly or occasionally. To avoid being a burden to their relatives and friends, some respondents dislike receiving frequent support and prefer to be assisted on request. In addition, the amount of support received depends on the presence of adult children and the existence of mutual understanding between the elderly and other family members. The elderly with no children are less likely to benefit from support unless their relatives step in to help. This observation seems to hold true for those who may have adult children but do not get along with them. Some respondents believed they were living in an old age home because their children were not willing to take on any caring roles. The following respondents speak about their experience in the quotes below:

> *My sister gets money from her daughter who stays in London, then she can give me some. If she does not get money from her daughter, there is nothing for us. She also stays in the same lodge with me (Female, 67 years).*

> *My adult children are so far away if I need money I ask and they will send it through to me. The only support I get from them is financial now and then. But you will find here, I am talking to some people here, they get no support from anybody. They were brought here by their children to be dumped (Male, 65 years).*

My daughter and granddaughter always give me something, money, every month (Female, 70 years).

Almost all my relatives are dead and I only have one brother who is still alive, when I phone him, he does not return the call. Before his death, my elder brother said you must be strong, carry on, fight for your right and I do not know what my right is (laughing), sometimes I am helpless. You cannot always be miserable, pull yourself together and get on with your life (Female, 69 years).

Besides the reluctance of family members to support the elderly, other genuine reasons can be put forward in this regard. Some relatives are unable to support because they do not have a source of income. Instead, they even seek assistance from the elderly who are on old age pension. On the other hand, the elderly avoid getting in touch with some of their adult children since such an attempt might be interpreted as a desperate search for assistance. The following respondents provide insights into this issue in the quotes below:

I do not receive financial support, they come and borrow from me (Female, 64 years).

One of my sons used to send me money but not anymore maybe he is in difficulties. I do not even give him a phone call which might be interpreted as a reminder that I have no food, I do not want him to feel that I am worrying him (Female, 70 years)

Grandchildren, adult children, and other family members are mentioned as people who provide financial support for older people. Factors such as employment status, mutual understanding, and generosity of family members seem to impact the extent to which the elderly receive financial support. Getting along with adult children as well as other family members may result in more support. However, despite their willingness to provide financial support, some relatives are unable to afford it because of a lack of income. In contrast, they may even expect financial assistance from the elderly.

5.6 Support and family members

Factors such as marital status and living arrangements were explored to understand the dynamics of support for the elderly. It is believed that co-residence can be used as one of the

ways of taking care of the elderly. Although an estimated 64.1% of adult children do not live with their parents, co-residing with married parents appears to be their choice of living arrangements as 36.5% share the same households. Table 5.5 provides further light on this issue.

Table 5.5: Percentage of respondents by marital status and living arrangements

Statement	Not living with children %	Living with children %	N
Marital status			
Married	63.5	36.5	589
Not married	65.1	34.9	227
Total	64.1	35.9	816

** Using NIDS weighted data, wave 5, year 2017*
**Although 3545 respondents took part in the survey, some skipped certain questions in this section.*

In terms of assistance, daughters, sons and other relatives were mentioned as important sources of financial and material support. The elderly believed that their generosity is in compliance with family and moral obligation and it is also dependent on their ability to generate an income. In particular, having a child who earns a substantial income appears to result in a relatively high amount of support. The study also found that adult children with a higher income tend to be more supportive than their lower-income earner counterparts. The following respondents shed more light on this issue in the quotes below:

> *My daughter in Wentworth helps the most and she is the only one, my son cannot do anything for me, he cannot afford because he is not working (Female, 70 years).*

> *My son and my daughter-in-law help more than others out of love and concern (Female, 68 years).*

> *All my relatives help the same, no one helps more than another (Female, 76 years).*

Older people receive several types of support from their family members. Supportive relatives are concerned with the well-being of the elderly and perceive their action as a family obligation. Because of their commitment to providing better support, adult children do everything in their power to tackle their parents' challenges. However, despite their

inclination to assist financially their parents or older relatives, support is costly and cannot be afforded by the unemployed. Therefore, some children are not in a financial position to support their elderly parents because they do not have an income.

5.7 Children occupation and location

It appears that the amount and type of support received by older people depend on their place of residence and the employment status of their adult children or relatives. Working family members seem to be more inclined to support the elderly. In addition, it seems acceptable for an adult child living in the same area or in the neighbourhood of the elderly to step in and provide support than those who stay far. For instance, the elderly might require instrumental support or someone to run errands, this kind of assistance can be obtained from people who live in the area or within a reasonable distance. The following respondents speak about their relatives as shown in the quotes below:

> *They are both working, what work they are doing I do not know, I know one has something to do with a funeral cover company at Empangeni but the other one is far away, I can't remember the name but he is a manager of something, they have good jobs (Female, 69 years).*

> *At the moment he is in Durban but he used to be in Gauteng. His work takes him all over the place, actually, he has been the project coordinator for Northern Natal and is based here in KwaZulu-Natal (Female, 73 years).*

> *My daughter and her family migrated to New Zealand in 2010, after arriving she was trained as a librarian and was offered a job in a school which caters for children with special needs (Female, 68 years).*

Migration seems to be an important feature in an attempt to understand the support of the elderly. For adult children living in South Africa, they can be located in the same area or different province from their older relatives. Although living far from parents may not prevent an adult child from supporting his or her parents but it affects the amount and type of support. In terms of psychological effect, distant support may not be as warm as face-to-face interaction. Furthermore, the fact of being unemployed has a significant impact on the ability

to provide support for the elderly. Being committed to supporting can be challenging on the part of relatives and friends since it requires having a source of income. Even providing instrumental support might incur some cost, especially, when the elderly do not live in the same area with the rest of the family.

5.8 Support from NGOs and community

While talking about getting support from NGOs or other organisations, respondents provided different answers. Some revealed that they used to receive support in the past, others believed that it is still happening but they could not elaborate on its frequency. It appears that these acts of generosity take place yearly especially during major celebrations such as Easter or Christmas. The type of support received is various and aims at meeting the needs of the elderly as much as possible. The following respondents share their experiences in the quotes below:

> *We used to get something here once a year, they used to give us parcels but now they stop, they cannot afford it (Female, 75 years).*

> *During Christmas time we get hampers that come to us from different people (Female, 81 years).*

> *We received towels and slippers from some people who I believe made these donations on behalf of their NGOs and that is very nice (Female, 68 years).*

The contribution of the community and NGOs is believed to be an attempt to help the elderly meet their basic needs. Whenever the elderly are offered the opportunity of eating home-cooked food, they feel excited. These organisations seem to be active with the frequency of visits amounting to four times a month. Besides giving free meals, the community sells clothes at an affordable price for almost all old age residents. However, they fail to accommodate everyone since some older people are overweight and cannot find their size. The following respondents elaborate more on this contribution in the quotes below:

The community is very supportive now and again. You will find that during a month at least three or four times we will get home-cooked food from the community and the residents get excited (Male, 65 years).

They do sell clothing here but I can hardly find my size (Female, 75 years).

It seems clear that NGOs, as well as other charity organisations, do their best to provide some relief to the elderly but their contribution is not acknowledged by every old age resident. This attitude may be explained by their indifference towards these contributions. It is worth noting that meeting the expectations of everyone may be a difficult exercise, but it seems important to ask the elderly about the type of support they would like to receive. Their reaction can lead to the assumption that some of the items they receive are not as useful as expected. Nevertheless, the type of support varies and seems to take place towards the end of the year as well as during religious celebrations. On the other hand, although there may not be prior coordination or collaboration among these organisations, their interventions are frequent enough to help meet several needs. In addition, the elderly do not only receive free items from the community but also buy some at a discounted price, notably clothing.

5.9 Support from church

Churches provide three different kinds of support: spiritual, emotional and material. Although respondents acknowledge that they do not often practice their religion, other congregants or ministers visit them or hold services. These congregation members provide emotional and/or spiritual support as well as food handouts. However, given that this support is not structured, some older people do not benefit from it. Instead, emotional support appears to be one of the interventions that several respondents tend to benefit more from rather than handouts. Churches seem to play an important role in the emotional well-being of older people as some respondents reveal that ministers always make some time to meet with them whenever they need support. The following respondents highlight their experience in the quotes below:

I am Roman Catholic and the man who was talking with me, he is telling me when the church is going to be here. I cannot go to church at the moment so they come here (Male, 84 years).

The church is here, they support me spiritually. We have services here twice a month, they come and hold services here but they do not support me any other way just spiritually (Male, 65 years).

Once a month the church gives us a handout, handout of food, groceries (Female, 64 years).

No, not really, no I do not get any spiritual support (Female, 73 years).

The impact of churches on the emotional well-being of older people seems substantial as some report that pastors or ministers either hold services or come to meet with them whenever they seek help. Besides supporting the elderly emotionally, some churches give away handouts on a regular basis. Their contribution provides relief and can sometimes fill in the vacuum left by family members. The support of churches seems to be also crucial for people with no relatives or friends to lean on in difficult times.

5.10 Public support

This section aims at assessing the extent to which older people receive public support. Old age pension is one of the prominent features of this support. The size of older people on pension matters since it gives a good indication of the way a society caters for its senior citizens. The support of the central government is one of the most widespread and has no ambiguity. Almost all respondents who took part in the qualitative study acknowledge receiving public old age pensions. It is the main source of income for a substantial number of older people especially those who did not have formal employment during their active life. The elderly who had formal employment report receiving employment-based and public pensions. This stable source of income does not deter some older people from working, they report embarking on income-generating activities to supplement their income. The willingness to continue working highlights their commitment to live independently and avoid being regarded as a burden. The following respondents share their experience in the quotes below:

I have two pensions, the one from the state and the other is a private one, a small one. What they do is they add the two together and take 85% (Male, 65 years).

I get financial support from the government, I live by faith and do my things to live. If someone gives me something it is fine otherwise, I do not ask (Male, 68 years).

I do not get any financial support, I only get my old age pension (Female, 73 years).

Despite the inability of the extended family to provide for older people as it used to be in the past, the onset of old age pensions seems to help improve their living conditions. Although having a regular source of income has the merit of providing some financial relief for the elderly, human or instrumental support represents another important feature towards the improvement of their well-being.

5.11 Support from local government

None of the respondents remembered receiving any support from the local government. Nevertheless, for those who could recall, the support from the local government seems to be an occasional event as some respondents reported having attended their meetings. The following respondents provide their insights on this issue in the quotes below:

I do not receive anything from the local government unless once they organised a Christmas party for us and it is not a Christmas party, it is political, you do not get anything to your satisfaction (Male, 70 years).

Regarding the involvement of the local government in the support of the elderly living in old age homes, there is not a clear-cut answer. Unlike other respondents who believe that these local institutions do not provide any assistance, some argue that a given number of interventions do take place. In order to substantiate this viewpoint, reference was made to other provinces where some form of assistance did take place. The following respondent makes this point in the quote below:

I do not know how far they are involved in all these things but I am almost certain that they support in some way. I know for example when I was in the Cape a lot of old age homes were getting subsidies from the local government to look after old people. I think it is happening here in KwaZulu-Natal as well, some form of subsidies are

paid. Anyway, we do not know and we do not want to know, that is up to the management (Male, 65 years).

The local government is one of the administrative bodies that should support the elderly. According to the administrative hierarchy, local governments are autonomous and closest to the people. This should imply that some matters concerning the citizens living within their jurisdiction are well addressed, however, the type of support required should not overlap with the national government. This may allow the local government to play its role in the sphere of the government (that is close to the people) by taking care of the most vulnerable citizens. This support does not necessarily need to be individual; it can be collective and designed to benefit as many older people as possible.

5.12 Summary

This chapter has presented several critical issues that influence the health and well-being of older people such as eating habits, emotional support as well as highlighted various type of assistance. Other features such as healthy lifestyle and independent living were also investigated. The elderly did not see their age as a set-back, instead, they had accepted it and were willing to cope with aging by seeking ways of improving their well-being.

The elderly who needed emotional support were able to choose one of the available or the most accommodating sources such as family members, relatives, friends or others living in the old age home. The elderly and their social networks also used telephone calls, emails and messaging systems to provide emotional support when it was not possible to meet up. For those who were not comfortable with approaching others to seek support, reading or talking to oneself was seen as a good alternative. The influence of social support on the well-being appears to be substantial as revealed by the social support theory (Cohen and Wills, 1985). It was argued that keeping in touch with family members and social networks telephonically or receiving visits on a regular basis resulted in improved social well-being (Mirzazadeh et al., 2019). Furthermore, a study in Canada by Gilmour (2012) found that more social contacts were associated with better health and well-being. It is believed that having a face-to-face interaction or communicating over the phone has an impact on their physical, social, spiritual and mental health (Mirzazadeh et al., 2019).

Women make up the largest proportion of people aged 60 years and older. In terms of marital status, more males than females tend to live with their partners. As far as living arrangements are concerned, over 50% of adult children live away from their parents. Research suggests that the elderly are less likely to co-reside with adult children, they either live as a couple or alone (Knodel et al., 2015). It is mostly those who have less than four living adult children who live alone. Migration and fertility declines are believed to be responsible for the demise of traditional support networks (Fonchingong, 2013; Knodel et al., 2015). The fact of being married appears to decrease the likelihood of feeling lonely compared to not married. The importance of marital status on well-being is highlighted by Knodel et al. (2015) who reveal that spouses can provide crucial emotional, material and social support during times of ill-health. Similarly, living with adult children is believed to be associated with less feeling of loneliness.

The fact of having adult children who live with the elderly was associated with a decrease in the number of contributions from non-household members. It transpired that adult children living away from their parents play a significant role in these contributions. Although adult children are not the only source of support, childless elderly tend to receive less contribution compared to their counterparts with living adult children. In Senegal, it was found that wives with rivals preferred to have at least one son who would serve as old age insurance in case of widowhood (Lambert and Rossi, 2016). For inheritance sake, the fact of having a son plays a crucial role in settings with a high rate of polygamous unions. Older women appear to be the most disadvantaged since they tend to be financially dependent on their male partners, have lower earnings and spend much of their active life on activities that do not generate an income (Kritzer, 2008).

It was revealed that older people were less likely to receive gifts and contributions from family and friends. Several reasons such as misunderstanding between the elderly and the rest of the family, unemployed adult children and/or relatives, never having children during childbearing age and a lack of social networks were put forward to explain this situation. Some adult children were assisting their parents more than others. It was believed that their generosity or actions were triggered by access to an income and love for their parents. Furthermore, older people were beneficiaries of various types of valuable assistance and they could be assisted by any person who availed himself or herself. For instance, older people with impaired mobility required the assistance of their peers to run errands, this task was also

performed by family members and friends when they were available. This is consistent with a study by He et al. (2016) who revealed that the financial well-being of the elderly depends on various sources of support which can be monetary or non-monetary. In addition, the generosity of adult children towards their parents is believed to be dependent not only on filial obligation but also on their appreciation (Aboderin, 2017).

It was found that older people were willing to live independently and improve their well-being. They were conscious that some of their challenges such as mobility impairments could be circumvented by the use of a wheelchair or walking aid. This would allow them to live independently or require limited assistance. Furthermore, it was interesting to highlight that they had come to an understanding that some chronic conditions could be well managed with regular exercise rather than medication. They acknowledged the positive impact of an adequate diet and physical exercise on their health. Similarly, researchers have highlighted the positive impact of physical activity on the health of the elderly (American College of Sports Medicine et al., 2009; Dias et al., 2017), the beneficial effect can be more felt throughout aging if the elderly continue to exercise. Physical exercise improves health and the quality of life as well as slows down physical degeneration (Rodrigues et al., 2010). In addition, the processes of conditions such as dementia and Alzheimer tend to be delayed (Rovio et al., 2005).

Despite the inability of the extended family to play its role in full as it used to be in the past and the onset of new types of social support for the elderly, it was found that several stakeholders attempted to take on a distinct caring role. The contribution of the national government is essentially financial and complemented by institutions such as old age homes that endeavour to provide a home to the elderly. Older women were more likely than older men to receive an old age pension. Increased reliance on the state pension is witnessed with age. Without this support, a substantial proportion of the elderly may live in poverty since they do not have sufficient resources to live on (He et al., 2016). The fact of being old age pension recipients had a positive impact on health in old age since the elderly were able to keep their medical appointments and afford other essential items for their health. These findings were confirmed by other studies that mentioned the existence of a relationship between having a stable source of income and better health (Sigaroudi et al., 2013; Vameghi et al., 2013).

Stakeholders such as churches, NGOs and local government attempt to fill in the vacuum left by the extended family in providing several types of support in line with their different fields of expertise. It seems important to mention that the role played by the extended family or family members is no longer central for the elderly living in old age homes and even for some who still live at home. Over time, the family contribution seems to become less impactful or inexistent. These findings highlight the role of partial substitutes for filial responsibility played by assistance programmes outlined by the modernisation and aging theory (Cowgill and Holmes, 1972). A study by Alambo and Yimam (2019) revealed that the elderly do not benefit from adequate informal care from family members as it used to be in the past, poverty and migration of young adults are put forward as responsible for the erosion of the longstanding traditional support net. It is important to highlight that although these new stakeholders have not succeeded in taking on all the tasks previously performed by the extended family, their contribution has brought a great deal of improvement in the well-being of older people.

CHAPTER 6: DETERMINANTS OF HEALTH

6.1 Introduction

Respondents were asked to provide a subjective rating of their general health. Although using self-rated health may not be adequate but it remains one of the most straightforward tools of investigations. It is not only useful for assessing and monitoring disparities in health care access but it also helps identify vulnerable groups for targeted interventions (Ardington and Gasealahwe, 2014). Self-rated health appears to be a simple way of getting insights into the health problems of the elderly. It is quite common that poor health is misinterpreted and even equated with aging rather than a medical condition (Ramírez and Palacios-Espinosa, 2016).

Old age is often associated with an increase in morbidity and frequent visits to health care facilities. Non-communicable diseases have become increasingly a major cause of ill-health and deaths, an estimated 75% of deaths take place in the developing world (Lozano et al., 2012). The burden of non-communicable diseases in low-income and middle-income countries is worsened by limited access to health care and treatment. It is believed that early diagnosis and treatment can help mitigate a given number of risk factors and prevent further complications (Hogerzeil et al., 2013). A rise in the burden of chronic conditions coupled with population aging is likely to strain resources and increase the workload of health care professionals. This is mostly felt in developing countries where harsh living conditions, common risk factors, and deprivation have already made the elderly vulnerable (Akosile et al., 2018; Chen et al., 2018; Menezes and Thomas, 2018).

Accessing health care is costly; it mostly depends on the socio-economic status of the individual. People on medical aid schemes are more likely to access health care than those who are not. Studies reveal that people without medical aid were less inclined to seek preventive care and they had more unmet needs (Flores et al., 2017). Accessing health care is still a serious challenge in many countries across the globe. It is even more difficult with elderly patients since they have to deal with several barriers standing in the way of accessing comprehensive treatment such as inadequate health care, unskilful health care professionals, user-unfriendly facilities, and mobility issues (Adibelli and Kılıç, 2013; Govender and Barnes, 2014).

Providing cost-effective health care to the elderly remains a serious challenge in both more developed and less developed countries. The proportion of people on medical aid schemes in South Africa is very low, an estimated 17.4% in 2016 (Statistics South Africa, 2017). Almost all older people depend on free health care, however, public institutions are congested, offer only basic services and cannot meet their specific demands (Fox et al., 2018). An increase in the number of patients suffering from chronic conditions represents a serious challenge to the health systems that were structured to address infectious and acute conditions, child and maternal care (Jakovljevic et al., 2017).

This chapter presents the results on health challenges in old age. It highlights some suggestions made by the elderly in an attempt to help circumvent or alleviate their health burden. Challenges encountered by older people while seeking health care are highlighted as a way of helping shed light on some misconceptions about health in old age. Negative as well as positive experiences are mentioned since every visit at health facilities cannot always go wrong. Given that population aging is becoming a reality in the developing world, it is believed that the results of this study will help tackle some challenges inherent in health in old age.

6.2 Analysis of health challenges of respondents

Quantitative and qualitative data were used to explore challenges inherent in health in old age as respondents were asked about the type of support they receive from health care facilities. Features that have an impact on health seeking behaviour in old age were explored to capture the amount of effort made to access health care. The assessment was done using questions regarding the frequency of hospital visits, challenges encountered while attempting to access health care as well as other aspects such as self-reported health, health conditions and time spent on medication. Further insights from the NIDS survey were added to this section to depict a full picture of health challenges. Some suggestions aiming at improving health seeking experiences are also mentioned.

6.3 Visits to a health care facility

Health seeking behaviour is an important component of physical well-being, the frequency of visits to health care facilities is a key feature in this regard. Table 6.1 provides insights on the

utilisation of health care services by people aged 60 years and older. An estimated 50.5% of the elderly consulted someone about their health in the last 30 days while close to 3.7% have never had a health consultation.

Table 6.1: Percentage of men and women who ever visited a health facility

Statement	Men and women %
Last health consultation	
In the last 30 days	50.5
One to five months ago	16.9
Six to twelve months ago	9.5
More than a year	19.5
Never	3.7
Total	3545

** Using NIDS weighted data, wave 5, year 2017*
**Although 3545 respondents took part in the survey, some skipped certain questions in this section.*

By the same token, old age seems to be associated with an increase in utilisation of health care services as some respondents acknowledge that their visits to health care facilities have become more frequent. This also holds true for people who lived with chronic conditions before old age. Ailing health has a profound impact on lifestyle and performance. This can affect daily tasks such as the ability to perform activities of daily living. Hence, the onset of chronic conditions does not only result in restricted mobility, it may also impose a different lifestyle. The following respondents speak about their experiences in the quotes below:

> *I go much often now than before. When I was young, I was very fit and I ran Comrade Marathon for seven years, Durban to Pietermaritzburg, Pietermaritzburg to Durban. I also used to play rugby, tennis and all sort of sports but now all I can do is walking (Male, 84 years).*

> *It is more frequent now than when I was young. I was fit when I was young and I have no problems (Female, 66 years).*

> *In the last three years, I have been going to seek health care more than before. At age 28 I was only visiting the psychiatric clinic once a month but now I have to go to the main hospital too (Female, 64 years).*

Some respondents believe that their current ailing health is a result of unhealthy lifestyles. Although they may be aware of the health risks associated with tobacco consumption, smokers tend to ignore it until they are diagnosed with a chronic condition or become deeply affected. It appears that change in behaviour occurs only when the damage is already done and they are bound to stop using the product. Lifestyle in early life can have an impact on health in old age, some respondents regret their past, unhealthy behaviours. The following respondents share their experiences in the quotes below:

> *The vascular disease that I have is causing other problems. Organs such as heart, kidneys, and pancreas are all affected while five years ago it was not like that. I was bound to stop smoking, at first it was difficult but not impossible. Imagine how challenging it was for me, I have been smoking from the age of 8 and I am 65 now. Gosh, I have been smoking for 57 years, that is a long time (Male, 65 years).*

> *High cholesterol is the only health issue and it represents a major threat in me, it was caused by smoking. If I had a different lifestyle, my health would have been better (Male2, 65 years).*

A rise in the utilisation of health care services is not unanimously experienced since some respondents did not acknowledge it. They reported visiting health care facilities at the same rate as some years ago. It can be argued that some elderly do not have major health issues or their conditions do not have much impact on their current rate of utilisation of health care services. Equating old age with illness can be misleading since some respondents reported having developed chronic conditions at younger ages while others do not have any medical conditions. The following respondent provides insights into this issue in the quotes below:

> *There is no difference in the utilisation of health care services now than before, it is still the same (Female, 73 years).*

> *I go to the hospital once a month and there is no difference in the frequency of the utilisation of health service between now and before (Female, 75 years).*

In terms of health appointments, almost all respondents report going to health care facilities once a month for collecting medication and once every six months on a doctor's appointment. Furthermore, depending on the seriousness of their conditions, some respondents have more than one appointment a month. The rate of utilisation of health care services of the elderly living with multiple morbidities is higher than those who have one chronic condition. On average, people living with one condition are expected to visit health facilities at least once a month. Besides these scheduled appointments, other visits can also take place in case of necessity for instance when their condition deteriorates. The following respondents highlight their experience regarding the utilisation of health care services in the quotes below:

> *I go once a month just to collect tablets and every six months I see the doctor but if I need to see the doctor more regularly then I go (Male, 65 years).*

> *I go to the hospital once a month. Every 20th day and on the 5th we take blood and on the 6th I see the doctor to be briefed on the result (Female, 67 years).*

> *I visit the psychiatric clinic and the main hospital four times a month, notably, to collect medication and undergo routine check-ups twice a month respectively (Female, 64 years).*

Often, aging is misunderstood and equated with chronic medical conditions. Although those who support this viewpoint use features such as an increase in episodes of ill-health and demand for health care to substantiate their beliefs, it is not based on any evidence. Indeed, a rise in the rate of utilisation of health care services occurs in people who live with non-communicable diseases as well as the probability of developing these conditions increases with age. Given that older people are not a homogeneous group, the level of demand for health care is variable since some older people are more affected than others; they do not all suffer from the same condition and differ in terms of exposure to risk factors. However, it should be noted that the more people grow older, the more vulnerable they become and their health needs to be monitored closely. In addition, the demand for health care in people diagnosed with multiple morbidities is higher than average.

On average, every stable elderly person suffering from a chronic condition is expected to visit a health care facility at least once a month to collect their medication. The scheduled

appointment with the doctor takes place every six months. Past and present lifestyle has an impact on health in old age, people who live healthy tend to have fewer health problems. Similarly, the most vulnerable elderly were more likely to be part of those who were involved in poor consumption patterns and exposed to risk factors.

6.4 Accessing health care facility

Unlike able-bodied people, attending health care facilities can be challenging for people living with a physical disability. The number of challenges can be worsened by the distance to the hospital or clinic since a long distance would entail more obstacles to overcome. There were respondents with impaired mobility who found it difficult to get to health care facilities. In general, the nature of challenges varies and depends on the degree of impairment. Some respondents have managed to circumvent their physical challenges by making arrangements allowing them to keep healthcare appointments. For instance, arrangements were made with the ambulance services and friends to help them commute to health care facilities. Although the old age home was within two miles, walking was excluded for the elderly living with a disability. The following respondents express their concerns in the quotes below:

> *Moving around is quite challenging for me as I am using a walking stick (Male, 70 years).*

> *I do not have any health problems that might prevent me from going to the hospital or clinic. I do not have any worry with my mobility as I can still walk, the hospital is so close. If I fall and break a leg or I am very sick, they call an ambulance, it will come and take me to the hospital (Female, 66 years).*

> *Sometimes, it depends on my arthritis and then a friend of mine helps me to access the health care facility. They help by walking with me or holding my arm. I have difficulties bathing myself, walking around, going from point to point, I have problems doing physical things (Female, 73 years).*

> *If I need transport for a scheduled appointment, I ask the old age home transport department for assistance. There is a nominal charge and I can get there on my own and I have proved it but by the time I get there, I am finished and I do not think it is a*

good idea to do it. Furthermore, I feel a bit vulnerable since there are thieves around, an old "beige bird" (white lady) in a wheelchair is an easy picking (Female, 68 years).

Although accessing health care from the hospital or clinic located in the neighbourhood of patients imposes less burden, the elderly with restricted mobility may still find it challenging. For wheelchair users, seeking health care is not only viewed from the perspective of moving from one point to another but also the condition in which it takes place. Besides living within a short distance to the hospital or clinic, the elderly manage on their own to get to the health care facility. Wheelchair users are more cautious because their conditions render them a soft target to crime, especially, when they commute early in the morning in an attempt to avoid being caught in interminable queues. Commuting with an ambulance appears to be their better option as it addresses both issues of vulnerability and frailty. Unfortunately not all disabled elderly on a routine visit benefit from this type of privilege and their access to health care can be severely hindered.

6.5 Long queues

Besides the private and public health system divide, the provision of health care seems to be extended to other stakeholders as highlighted in Table 6.2 below. This table reveals that public health care facilities are the most utilised by the elderly with an estimated 61.3% relying on it while private health care institutions account for 38.1%. In terms of individual age groups, people aged 60-69 yearss and older recorded the highest rate of utilisation with approximately 62%, followed by those aged 70-79 with 60.4%. Less than 1% utilised the services of herbalists or traditional healers. The majority of older people utilise conventional medicine.

Table 6.2: Percentage of respondents by age group and place of consultation

Statement	Public health care **%**	Private health care facility **%**	Other (nurse, traditional healer, chemist) **%**	**N**
Age in years				
60-69	62.0	37.6	0.5	1556
70-79	60.4	38.5	1.1	845
80+	60.3	39.7	0.0	325
Total	61.3	38.1	0.6	2726

** Using NIDS weighted data, wave 5, year 2017*
**Although 3545 respondents took part in the survey, some skipped certain questions in this section.*

Public health care facilities are congested on a daily basis with numerous people seeking health care. Given that services are provided on the basis of the first come first serve principle, almost all patients make every effort to arrive early at a health facility. However, coming early and even being first in the queue does not necessarily help cut down on the amount of waiting time, patients are expected to wait for a minimum of four hours before receiving any assistance. Some respondents find this situation frustrating and unacceptable. Furthermore, regardless of the extent to which some patients are sick, there is no difference in the way they should be dealt with. It is assumed that all patients are equally vulnerable and they should follow the same procedure. The following respondents expand on this issue in the quotes below:

> *In hospitals, they do not prioritise those who are critical. It is better to treat them and give them first priority. Queueing for a long time delays treatment and causes discomfort (Male, 70 years).*

> *It is so ridiculous to go to the hospital at five in the morning and come back at about 10 or 11 o'clock. I do not know what is going on, maybe there are not enough members of staff at the hospital to take care of people timeously. Otherwise, it does not make sense, it is painful to see that people living with diabetes are standing in the queue while they are expected to eat something regularly every two or three hours. I can witness some are getting sick and are not even able to cope (Male, 65 years).*

Some respondents believe that spending much time on health care visits is not a problem, instead of complaining, patients should keep themselves busy while waiting. For instance,

they should read books or do anything that can help avoid feeling bored until their turn comes. When the provision of health care services is inadequate, patients tend to blame health workers. The approach taken by these respondents aims at highlighting that the issue of congestion at public health care facilities is a challenge for the whole health system. This challenge requires a holistic approach and should not be treated as an isolated matter or blamed on health care workers. In other words, it is better to have another approach to this problem instead of complaining because it will never change anything. The following viewpoints can be picked up in the quotes below:

> *The biggest complaint I hear is people hate waiting, I do not know why they do not take the book with them and try to do something about it. They always sit and complain, I do not know what can be done to alleviate that. For me, it runs pretty well (Female, 68 years).*

> *I do not have another problem at the hospital, I get patient. You get patient for everything, you get no patient for dying (Female2, 68 years).*

> *I do not have a problem with long queues, I can take a book to read if you do that, time goes on and you do not notice until your turn comes. So, I do not have any problem with waiting (Female, 66 years).*

The inadequacy of the health system is a serious challenge for vulnerable patients. Although every effort is made to ensure that no one is privileged or discriminated against, the well-being of the sick and vulnerable may be worsened. The elderly along with young adults are expected to utilise the same facility on an equal basis; queueing for long hours and following the same procedure which could have an impact on their health. A better way of taking care of patients should be by taking into consideration their medical conditions without overlooking the need for others to access health care.

6.6 Health care workers workload

Almost all respondents attending public health care facilities reported that the workload of health care workers was very high. They are appreciative of the commitment and effort made on every health visit to assist them. In an attempt to cope with a high demand for health care

services, health care workers tend to shorten the consultation time with every patient. This attitude is perceived by some respondents as an expression of their frustration which makes it difficult for them to communicate with patients in an efficient way. The following respondents express their view on this matter in the quotes below:

> *They are not really keen on patients now and they do not want, you talk to a nurse for something, he ignores you and walks away or the doctors get irritated if you do not understand them properly if you complain a lot the doctor will not understand and he ignores. They deal with many patients and are unable to cope with the workload (Female, 70 years).*

> *Mainly, they have to employ more health care workers and pay them properly. They overwork these poor guys. I mean we see them, some of them walk around like zombies because they have not had a decent night sleep (Male, 65 years).*

> *I asked the doctor why they changed my medication from 300 mg to 500 mg, he gave a long story and said go. Doctors do not like talking to patients, because they have a lot of others queueing outside (Female, 67 years).*

It appears that the communication between health care workers and patients is broken since the focus is placed more on quickening the pace to assist every patient. The quality of health care may be compromised as some patients feel frustrated to engage with the health care workers on their condition. Furthermore, because of the pace of work and high patient turnout, it may be difficult to brief patients on their diagnosis and type of treatment. For patients on chronic medication, a previous prescription may have resulted in side effects, doctor-patient communication remains the cornerstone of any successful intervention. Otherwise, every health care visit may be likened to a tick-box exercise, where the emphasis is placed on clearing the queue rather than addressing the health needs of patients efficiently.

6.7 Attitude of health care workers

Administrating treatment to patients is not only about the quality and type of health care facilities but also about how it takes place. There is an expectation of respect and trust between care providers and care recipients. According to some respondents, the attitude of

health care professionals is not conducive to mutual understanding and respect. The treatment that some older people receive at the hand of nurses is not good, they claim to be regarded as children and even sometimes ignored. The following respondents speak about their frustration in the quotes below:

> *Ladies have bad attitudes, screaming does not help, they should be nice to people instead of shouting (Male, 68 years).*

> *I do not go to that public hospital, we are treated like animals, especially, older people. Ten years ago it was the best hospital in Southern Africa but now it is horrible (Male, 76 years).*

> *Absolutely, sometimes we get pushed around, they do not care. They just push you around, it is not a very good facility (Female, 73 years).*

Some respondents concede that the issue of ill-treatment at health care facilities is a reality but it cannot be generalised. Furthermore, the attitude of health care workers must be understood as a result of the number of demands placed upon them rather than a deliberate action to offend others. In other words, the issue of attitude should be interpreted as the inability on the part of some health care workers to cope with the pressure. Therefore, it is not everyone who is harsh since others can handle pressure and treat patients with dignity and consideration. This viewpoint is expressed in the quotes below by some respondents.

> *Health care professionals are working under pressure and some of them are not gentle because hospitals are very congested. I do not blame them, they work in a cumbersome environment and are expected to treat many people on a daily basis (Female, 73 years).*

> *Their attitude is a little bit rough sometimes, not all of them but some are very rough (Female2, 73 years).*

> *I know some health care workers with whom we met for the first time when I was 28 years old; they are friendly, always greet and talk to me with consideration. There are also some who are reserved but most of the time we get nice ones. Wherever I go, I*

never had a problem with anyone maybe because I am friendly too (Female, 64 years).

Older people had numerous encounters with health care workers on various medical appointments. It appears that their health seeking experience was not always pleasant. Although there is no consensus on the attitude of health care workers towards patients, some older people felt welcome whenever they sought health care services. This experience contrasts with others who complained about the way their visits were handled. This contrast shows that being inconsiderate or moody towards patients is not a standard practice but can be a result of old age stereotypes or a way used by health care workers to express their frustration on patients.

6.8 Quality of health care

The quality of health care is an important component of well-being and can make a significant contribution to the life of older people. An increase in visits to health care facilities can be better managed if the type of assistance provided meet the health needs of patients or help provide some relief. Some respondents are not pleased with the quality of services offered, they blame it on a lack of adequate medications. The following respondents expand on this issue in the quotes below:

The distribution of medication is not done according to prescriptions. The treatment is not satisfactory, hospitals run short of medicines and it seems the doctor's prescriptions are changed by pharmacists. Doctors do not want to listen to you when you talk to them about your ailment, so our sicknesses are not manageable (Male, 70 years).

If I have to rate the service I receive at the health facility, I will grade it about 50% (Female, 73 years).

Trusting in health care workers can have a positive impact on patients as well as on the administration of the treatment. Some respondents are appreciative of the competence and skills of the health care workers of the health care facilities they attended. In order to substantiate their viewpoint, they put forward some good experiences of hospital admissions

and surgeries. Sometimes, they have been attended by the same persons for many years. The following respondents provide further light on their experiences in the quotes below:

> *The health care workers are skilful enough to deal with our condition and are nice to us (Female, 75 years).*

> *The doctors are good, I must admit it, I am a stroke survivor and no one will take notice of it. I was treated in bed for two months and would be sleeping for two hours a day after taking medication. Those tablets cured me, prior to that, my hand was dead and I could not use it anymore (Male, 65 years).*

> *They have enough skills to deal with me, I have a doctor that has seen me for the last four years. He knows my condition and is a very friendly doctor, I am grateful for his assistance (Female, 64 years).*

The competency of health care workers is questioned by some respondents. For instance, their reluctance to be consulted on some conditions leads these respondents to cast doubt on their competence. The proponent of this viewpoint believes that doctors hide their ignorance by refraining from being challenged. On the other hand, it is argued that resident doctors are well-equipped to deal with the health of older people but they are not committed to doing their job, most tasks are performed by student doctors. The following respondents express their opinion on this issue in the quotes below:

> *Doctors are mainly students and unskilled, it is only natural for them to be like that. Only resident doctors know precisely what is recommended of them but they are busy with cellphones (Female, 67 years).*

> *If you tell the medical practitioner that the treatment is not helping you, they will look at you as someone funny, they will force you to take the treatment because their word is final. It is unfortunate, I have experience with hospitals and it used to be my working place (Male, 70 years).*

Older people seek health care services for various reasons, some of their chronic conditions were developed before they turned 60. Medical conditions in old age tend to include non-

communicable diseases and require special skills which entail further training on the part of health care workers. The issue of communication appears to be an important component in the interaction between health care workers and patients, any unanswered questions or miscommunication can be interpreted as a result of incompetence. Administrating treatment is not an automatic procedure but it is entrenched in human relations which requires a semblance of trust on the part of both stakeholders. The issue of overcrowding and long queues resurfaces as one of the key features in the assessment of the quality of services.

6.9 Self-reported health

Self-reported health provides insights into the perceptions of the respondents' well-being as shown in Table 6.3 below (the 5-Likert scale was transformed to a binary variable with yes and no responses for the purpose of analysis as highlighted in the section below Table 6.3, The outcomes such as excellent, very good and good were recoded to good while fair and poor were labelled poor). Nearly 70.7% and 29.3% of respondents rank their health as good and poor respectively. In terms of gender, males report their health as good (79.0%) compared to their female counterparts (66.7%). There is a slight difference in reporting poor health between respondents on high blood pressure treatment (38.2%) and those who were not (35.9%). The level of income influences the perception of health since a substantial share of the elderly living in households with low income (42.3%) rate their health as poor compared to their peers in households that earn more (21.3%).

Table 6.3: Self reported health status by background characteristics

Statement	Poor %	Good %	N
Gender			
Female	33.3	66.7	2358
Male	21.0	79.0	1183
Total	29.3	70.7	3541
Elderly on blood pressure medication			
No	35.9	64.1	118
Yes	38.2	61.8	1792
Total	38.0	62.0	1910
Household income in Rands			
Less than 2001	42.3	57.7	137
Between 2001 and 10000	31.5	68.5	1059
Over 10000	21.3	78.7	447
Total	29.3	70.7	1643

** Using NIDS weighted data, wave 5, year 2017*
**Although 3545 respondents took part in the survey, some skipped certain questions in this section.*

In order to assess the significance of self-reported health, the 5-Likert scale was transformed to a binary variable for the purpose of analysis. The following outcomes excellent, very good and good were recoded to good while fair and poor were labelled poor. Three explanatory variables, notably gender, household income and taking medication for high blood pressure were included in the model. After running logistic regressions, the univariable model was highly significant at $p<.001$. The stronger predictor of self-perceived health status is high blood pressure treatment (odds ratio 2.7), gender and household income are the second predictors (odds ratio 1.8). The multivariable model is also highly significant at $p<.001$ and household income is the strongest predictor (odds ratio of 2.5). The stronger pedictor of self-perceived health in the multivariable model is household income. After controlling for high blood pressure treatment and gender, the elderly living in a household that earns more than 10000 Rands are 2.5 times more likely to report good health than their counterparts in a household with a lower income. Similarly, the likelihood of reporting good health in males is twice as highas their female counterparts. Further illustrations are provided in Table 6.4 below.

Table 6.4: Logistic regression predicting the likelihood of self-reported good health in the past week

	Odds Ratios and 95% confidence intervals	
	Model I	**Model 2**
Gender	**Unadjusted**	**Adjusted**
Female	1.00	1.00
Male	1.878(1.864-1.891)	2.016(1.997-2.036)
Elderly on blood pressure treatment		
No	1.00	1.00
Yes	2.743(2.722-2.764)	0.915(0.899-0.931)
Household income in Rands		
Less than 2001	1.00	1.00
Between 2001 and 10000	0.757(0.752-0.763)	1.498(1.474-1.522)
Over 10000	1.797(1.783-1.810)	2.543(2.500-2.587)

**P<.001*

** Using NIDS weighted data, wave 5, year 2017*

The elderly who took part in the interviews had a positive perception of their health. Although this perception seems to be in contrast with their medical history, it is worth noting that respondents were battling with some medical conditions. Their reporting seems to highlight the absence of symptoms during the moment of interaction. In a sense, the absence of symptoms leads them to perceive their health status positively. The following respondents share their insights on this issue in the quotes below:

> *I manage well, I can walk around, at the moment I feel quite ok, for about three months, I have been all right (Male, 84 years).*

> *I am healthy except for minor things like arthritis (Male, 70 years).*

> *Physically fit but I had a stroke on my right, I can still do things, go everywhere (Female, 67 years).*

> *My health is right, although I survived a stroke some years ago and I have arthritis (Female, 81 years).*

> *My health is perfect, the doctor says I have blood pressure but I do not believe in that and I trust God to get rid of that (Male, 68 years).*

Some respondents reported experiencing difficult times and compromised well-being. Their ill-health can be severe to the extent that they cannot perform activities of daily living. Their assessment seems to focus mostly on what is wrong just before or during the interaction. In addition, this assessment does not take into consideration any latent illness and it may be difficult to quantify the number of risks. The following respondents speak about their experiences in the quotes below:

> *My health is terrible, I am very restless and struggle to sleep at night with heavy breathing as a result of high blood pressure. The doctor told my breathing is not good, I like reading and keeping my room tidy but I could not perform all that because of the medication that I was on, even bathing was a challenge as I was not even able to change clothes on a regular basis (Female, 68 years).*

> *My health is bad, I am sick, look I have back problems and arthritis (Female, 73 years).*

> *I have few health issues such as high blood pressure and cholesterol, it is really a burden (Female, 66 years).*

Despite the presence of a medical condition in a person, some people may rate their health as perfect or very good, this assessment may be subjective or relative. The absence of diagnosis or evidence may lead them to question its reliability since some people may be tempted to talk from the perspective of what they believe in rather than their real health problems. In the absence of any test, the self-assessment of health may not equate the true reflection of health problems in a particular individual. Thus, self-reported health has the merit of providing insights into the health status and can be used as a basis for further investigations.

6.10 Aging and health

A multiple category set combining conditions such as high blood pressure, diabetes, stroke, heart problems, and cancer was used since the elderly are likely to be affected by more than one chronic condition. High blood pressure is one of the most prevalent conditions in old age

with around 63.6% of cases diagnosed. The age group 70-79 recorded the highest proportion with 64.4%, followed by those aged 80 years and older with around 63.6%. Diabetes appears to be the second-largest chronic condition as far as prevalence is concerned with approximately 17% being diagnosed. In terms of age groups, the highest prevalence was recorded among people aged 70-79 years with 17.5%. An estimated 10.1% of respondents were diagnosed with heart diseases and the highest proportion of heart sufferers was found among people aged 80 years and older with around 12%. Conditions such as cancer and stroke afflict 5.4% and 3.9% of people aged 60 years and older respectively. Table 6.5 below provides a further illustration of this issue.

Table 6.5: Percentage of respondents reporting chronic conditions by gender and age

Statement	High blood pressure	Diabetes	Stroke	Heart problems	Cancer	N
	%	%	%	%	%	
Gender						
Female	63.6	17.8	5.2	10.4	3.0	1579
Male	63.5	14.9	5.8	9.4	6.4	659
Total	63.6	17.0	5.4	10.1	3.9	2238
Age in years						
60-69	63.8	17.3	4.9	9.9	4.2	1253
70-79	64.4	17.5	5.3	9.9	3.0	715
80+	60.1	14.8	7.6	12.0	5.5	270
Total	63.6	17.0	5.4	10.1	3.9	2238

** Using NIDS weighted data, wave 5, year 2017*
**Although 3545 respondents took part in the survey, some skipped certain questions in this section.*

Old age comes with conditions that are less common in the general population. The ability to manage any medical condition remains an important feature as far as physical well-being is concerned. In case of infection or ill-health, some respondents avoid taking further risks by seeking alternative treatment, they stay away from any activity that can worsen their conditions and only seek conventional medicine. Praying is also put forward as one of the better ways of dealing with health issues. The following respondents shed light on their experiences in the quotes below:

> *Praying is the best weapon that helps me manage my condition. I just go with praying and rebuke it (Female, 70 years).*

I manage very well by taking the high blood pressure pills prescribed by the doctor. I just use conventional medication (Female, 69 years).

To avoid worsening my condition I take the lift to go upstairs since, otherwise I will end up having difficulty breathing but I can handle going downstairs (Female, 75 years).

It appears that aging increases the risk of developing chronic conditions and even multiple morbidities as reported by some respondents. Although some of the conditions could be referred to as minor, it was observed that almost all older people who took part in this study had at least one chronic disease. Conditions caused by lifestyle such as obesity are also found in old age. The influence of lifestyle on well-being is acknowledged as the main cause of ill-health. This viewpoint is substantiated by the improvement experienced in well-being after changing their lifestyle. It is possible to witness the re-emergence of injuries picked up at younger ages in old age. The following respondents provide a highlight on their medical conditions in the quotes below:

I suffer from blood pressure and sugar. Some years back, at age five, I had a heart attack and fractured my leg in a car accident. The accident is catching up with me now in old age (Female, 70 years).

I am diabetic, hypertensive, a wheelchair user and have a lot of other ailments but I do not let any of that deter me from proceeding with my planned tasks (Female, 73 years).

My health is fairly good, I did have a stroke last year which was all my fault. Heavy smoking led to a mild stroke on the left side of my right hand, I was put on medication for two months and they urged me to stop smoking before it becomes serious. I gave up smoking and now I feel much better (Male, 65 years).

One of the strategies used for managing medical conditions is medication. The time spent on medication for these respondents is variable and depends on the age at which the condition was diagnosed. Some respondents have been on medication for six months and others for more than 30 years. Aging affects people differently since some octogenarians did not have

any major health problems until recently while other sexagenarians reported being on medication for decades. Although the likelihood of developing a chronic condition is higher in old age, it does not mean that other population age groups are immune to it. A typical example is of some respondents who reported having developed a chronic condition at younger ages. The following respondents speak about the time spent on medication in the quotes below:

> *I have been on medication long ago, I cannot remember, maybe twenty years ago, before the passing of my husband (Female, 69 years).*

> *It has been quite long now and I cannot express it in terms of years because we have been here in town for 12 years, 27 years spent in Chatsworth and I have been on medication during all this time (Female, 81 years).*

> *I have been on medication for about six months now (Male, 84 years).*

> *I have been on medication from the age of 28 (Female, 64 years).*

In order to be efficient, the management of a medical condition requires consistent medication. This can be achieved with the commitment of patients provided they understand the health risk associated with non-strict adherence. Respondents on medication revealed that they were fully aware of the importance of medication and its impact on well-being. It is not always easy to take medication consistently since it may be associated with some side effects. Sometimes the positive contribution of medication to well-being can hinder the elderly from having a more active social life. In general, this happens when the elderly become unable to interact with others after taking medication and are forced to sleep maybe for the rest of the day. The following respondents have experienced some issues with their medication and speak about the way they attempt to cope.

> *I take my medication consistently, there are side effects, then I go to sleep after breakfast. Too much medication block your social life because of a stroke and blood pressure and epilepsy, I am on strong vitamins for energy, I just feel like going to lie down, how can I have a social life? (Female, 67 years).*

I got into the habit of taking it at night so that I can do my business and get done during the day I am free. I have not missed out on my diuretic and not paying the penalty for it because I know if I do not take this what will happen (Female, 73 years).

The extent to which people are affected by side effects depends on their medical conditions and medications. Some respondents reported having experienced no side effects in treatment. They emphasise that it is a key feature taken into consideration by health care workers before prescribing any medication. More importantly, all respondents acknowledge the contribution of medications to their well-being as well as the health benefits associated with adherence. The following respondents are more explicit on this issue as expressed in the quotes below:

I do not really see any side effects. I know the value of the prescribed medication and I do take it. For instance, I am on Diuretic, I know if I do not take that diuretic I know what is going to happen. So I take it regularly, I make sure I take it regularly (Female, 73 years).

No side effects, I never experienced that, doctors assess and prescribe what can give you less trouble (Male, 76 years).

In old age, people tend to fall sick more often than at younger ages, their conditions can be minor or serious. The response of older people to these frequent episodes of ill-health plays an important role in the successful management of a condition. Besides using conventional medicine for the treatment of diseases, experiencing a change in lifestyle seems to be a positive move towards better management of health issues. It is crucial to highlight that the extent to which side effects can hinder social life needs to be taken into consideration. Given that the elderly are expected to experience healthy aging rather than living in isolation, there is an amount of side effects that those who are on medication can handle, otherwise, their social life can be affected.

6.11 Medication dependence

Every respondent suffering from a chronic condition reported taking medication at least once a day. There was no ambiguity on what was at stake as they made it clear that their well-being and survival depend on medication. To be efficient, people on medication are required

to be consistent and follow the doctor's prescription. Every effort was made on their part to adhere to this. In order to avoid missing doses, several strategies were put in place. For instance, a member of staff was entrusted with the responsibility of reminding an older person to take his or her medication at mealtime. Another option was to display the daily dose in a way that would remind whether it was already taken or not yet. The following respondents highlight their experiences as mentioned in the quotes below:

> *Sometimes, I get confused and cannot remember whether I have taken it or not. To avoid this, I face the tablets clip on one side when I take it out of the cupboard if it is turned the other way round that means I have already taken it. So this serves as a reminder or a way of making sure that I do not take it twice (Male, 65 years).*

> *I have given it to Sister Tina downstairs; she gives it to me at breakfast, lunch and supper time. I always take medication on time but I have not been downstairs to fetch it today (Female, 64 years).*

> *Absolutely, as you can see, it is my daily routine, I take my morning medication and I take my evening one. As a reminder, if it is not on this spot I know that I have not taken it and I must take it. That particular medication is vital to me (Female, 73 years).*

> *The most important thing in my condition is taking my medication on the double, once I take my medication I am fine if I do not take my medication I will be an ambulance case (Female2, 73 years).*

The importance of medication is well acknowledged as well as its impact on well-being. It appears that older people take their health seriously as they make arrangements to overcome their weaknesses or avoid skipping doses. Every effort is made to take the daily prescribed dose consistently since it impacts their well-being.

6.12 Taxi fare and fees

People aged 60 years and older without medical aid can access health care for free. However, even if they are not required to pay user fees, their health seeking visit is not always free.

Unless they live within walking distance of a health care facility, they have to pay taxi or bus fare. In general, every older person on chronic medication is expected to visit a health care facility once a month. The number of monthly appointments is often higher for patients with multiple morbidities. For every medical appointment taking place in the nearest health care facility, almost every respondent can walk. The nearest health care facility is within a two and a half kilometres distance. When the appointment is scheduled in another health care facility, a fee of R10 is paid to cover the cost of transportation for a round trip. Some older people can manage to face this expense while others struggle to cope with it. The financial burden of health seeking behaviour may be higher for patients with multiple morbidities as they are expected to have more than one medical appointment a month. The following respondents speak about their experience in the quotes below:

> *We spend R10 on our hospital visit and I cannot say that is a lot of money. My friend is going tomorrow and she will pay R10 and next month will be my turn, it is not so much to squeal about (Female, 69 years).*

> *I do not pay fees, there is a special concession for pensioners but the problem is I must pay taxi fare every month to collect medication, R10 for the taxi to take me to the hospital. Where will all that money come from? (Female, 70 years)*

> *I used to pay R2O, it became free when Zuma came to power. Before relocating here, I used to spend more on bus fare to get to the hospital. Now it is even easier, as a free patient I just need to spend R10 on taxi fare. My challenge is there will be no money left after that (Female, 64 years).*

Although older people are regarded as free patients, their appointments are not always costless. Depending on their mobility, those who live in the neighbourhood of health care facilities are more likely to keep their appointment at no cost. This holds true for routine medical appointments as they are less likely to experience further health deterioration. The elderly are well aware of the positive impact of the routine medical appointments on their well-being. Although they are not financially better off, the proximity of a health care facility seems to be an added advantage as far as keeping medical appointments is concerned.

6.13 Suggestions to improve health care access

A given number of suggestions were made by respondents to improve the quality of services they receive at health care facilities. The type of improvements suggested ranges from the facilities used to welcome patients to the actual services. Some suggestions are individually based while others aim at addressing the provision of services in general. For instance, it is argued that older people are vulnerable and they should be treated differently. A better way of catering for them can be achieved by making collective appointments, scheduling all of them on one day. The following respondents express their opinion over this issue in the quotes below:

> *Firstly, the nearest hospital is congested, they should send other patients at the nearest clinic and fix the benches we sit on before registering. Secondly, they should see patients by age groups, it lessens the volume of people because everybody goes any day. Finally, they should computerise their data and avoid believing in anyone who claims to live in the neighbourhood (Female, 67 years).*

> *It is better to schedule one medical appointment for everyone living in this old age home to get treated, just one day. This will spare people from leaving here at 3 o'clock in the morning, they are older people and it is not good for them to leave that early to seek health care (Male, 84 years).*

> *They should provide adequate supervision to the hospital members of staff to avoid things such as file losses, people collapsing after standing for hours in the queue. It is better to prioritise older people instead of treating everybody the same. In addition, uneducated and people without any knowledge of nursing should not be senior to nurses and doctors (Female, 70 years).*

The amount of workload and congestion leads health care workers to shorten consultations to attend to other patients as soon as possible. The quality of services provided seems to be questionable as in most cases, treatment is based on explanations provided by patients rather than diagnoses. Doctors attempt to quicken the pace of work by prescribing any medication demanded by patients. It is believed that the quality of health care can be improved if skilled doctors are hired. Some respondents complain about the lack of continuity in the service

provided because doctors are changing on every visit. The fact of being consulted by different doctors does not allow the elderly to build trust, they have the impression of starting over with a new face on every appointment. The following respondents provide further light in the quotes below:

> *More doctors are needed, they must be able to know what they are talking about, they must be competent and be able to examine you instead of just asking questions and end up prescribing medication (Female, 66 years).*

> *Doctors are changing, we cannot have the same doctor for our condition (Female, 67 years).*

> *Nine out of ten times doctors are in a hurry to get rid of me and they end up prescribing what I need (Male, 65 years).*

An older person claims to have offered to work voluntarily at a health care facility in an attempt to help decongest it. The respondent did not say what kind of strategy he would have put in place to achieve his goal but he reported being successful in his attempt before being asked to stop. The issue of long queues seems to have a negative impact on health seeking behaviour. It might be difficult to assess the extent to which the management of health care facilities has attempted to relieve the burden of patients. This desperate attempt may highlight a lack of initiative on the part of those in charge to address this issue. The following respondent speaks about his experience in the quote below:

> *The manager of the hospital is a problem, I volunteered to work at the hospital, the manager got rid of me, he told me not to come back, he thought I would get his position. I was a production manager where I was working and it was easier to get rid of the unnecessary queue and people were very appreciative of me at the hospital, but the guy was not happy with me and he told me to leave. They tried to do it without me and it did not work because they did not know how to do it. I was willing to teach them (Male, 68 years).*

Improving the quality of health care for older people can help enhance their well-being. It is better to bear in mind that older people should be regarded as patients with special needs and

given preferential treatment over those who are not critically sick. Although every person coming to health care facilities may experience ill-health, some patients are more vulnerable and require to be attended as soon as possible. Older people are part of patients who visit health care facilities on a regular basis. In general, their visits revolve around issues such as the collection of medication, doctor appointments or other routine check-ups. Assimilating the elderly with other patients in terms of priority may be misleading or should be done by taking into consideration their specific condition. For instance, people suffering from diabetes, wheelchair users should have a special counter they report to or be allowed to skip queues to shorten the time they spend before receiving treatment.

6.14 Experience at a health care facility

Depending on their conditions, older people have at least one monthly visit to a health care facility. Adequate treatment and good interaction turn their health care visits into a positive experience. In a sense, a good day at a health care facility is described in terms of time spent in the queue. This means that every short visit is appreciated but also the attitude of health care workers can make a long waiting day acceptable if they show consideration for patients. The following respondents elaborate on their experience in the quotes below:

> *I was there for five hours today, nobody wanted to hit each other because the doctors were running late. We understood and I found out from the doctor who said he has been up all night, thanked him for being so pleasant to me, that was a good experience (Female, 63 years).*

> *Yesterday I was smiling, I went to the hospital after lunch, I left home at about 12.30 and I was back home at 15.45 after collecting medication and seeing the doctor, that was really fast. People normally go early in the morning and finish in the afternoon. That was my best day otherwise you must be prepared to spend half day there (Male, 65 years).*

> *When people in charge, the workers there attend to you nicely it makes a lot of difference, it cuts down your frustration just by them being nice to people. When they talk in a haughty manner, it sort of puts you off (Female, 73 years).*

Visiting a health care facility can be an annoying moment as some respondents have reported. The day of medical appointments seems to bring back frustration as it is often associated with bad experiences. One of the main problems lies with the time spent waiting for treatment or collecting medication. For many, spending the whole or half-day at a health care facility haunts them. The elderly also express concern over being ill-treated by health care workers and when they fail to collect their chronic medication. The following respondents express their view in the quotes below:

> *It is always a bad experience because it does not matter how earlier you come you will find it full, you have to sit there the whole day, you must bring your lunch along with you and be prepared to spend the whole day (Female, 75 years).*

> *I am a blood pressure patient, the only thing is when they run short of my medication as it is becoming common at the hospital (Female, 67 years).*

> *When doctors do not have extra time to spend with patients and the attitude of the staff, sometimes, after queueing for a long time, nurses end up bullying you around. They send you from one point to the other point in the hospital just wasting your time. Older people cannot walk that long, the hospital is big (Male, 65 years).*

The reception of the elderly seeking heath care receive at the hand of health care workers is likely to hinder their health seeking behaviour. They express concern over the attitudes of health care workers, shortage of key medication and long waiting time. Although spending much time in the queue is not always acceptable, the elderly would like to be treated with respect instead of being ignored or regarded as inexistent.

6.15 Eating habits and consumption

Lifestyle appears to be an important determinant of health. Although some of the behaviours may have a negative impact on health, it is not always easy to accommodate the change. Table 6.6 highlights the level of cigarette consumption among the elderly. It appears that non-smokers account for the largest share of older people with 86.9%. In terms of gender, there are more smokers among older men (22.9%) than older women (4.8%). Married people (12.7%) tend to smoke less than those unmarried those or living with partners (12.7%).

Table 6.6: Percentage of respondents who reported cigarette consumption by gender and marital status

Statement	Smoker %	Non-smoker %	N
Marital status			
Married	12.7	87.3	1406
Not married	14.0	86.0	357
Total	13.1	86.9	1763
Gender			
Male	22.9	77.1	1184
Female	4.8	95.2	2355
Total	10.7	89.3	3539

** Using NIDS weighted data, wave 5, year 2017*
**Although 3545 respondents took part in the survey, some skipped certain questions in this section*

Eating habits are an important feature of physical well-being since a healthy diet is more likely to result in better health outcomes. Eating healthy is regarded as a better way of looking after oneself and even boosting the immune system. When asked about their eating habits, some respondents reported being comfortable with it and even the most recent enjoyable experience was mentioned to express their satisfaction. However, the fact of being satisfied seemed to conceal their reluctance to engage on this issue or any attempt to avoid confrontations. The quotes below provide more insights into the issue reported by these respondents:

> *I am happy, like yesterday I enjoyed very well the meals we just had it was very lovely, it was beans, it was very nice, I do not always complain about meals. I enjoyed my meals, we have three meals a day and good meals, I cannot complain (Female, 69 years).*

> *I am satisfied with my eating habits (Female, 81 years).*

Besides having respondents who were pleased with their eating habits, others have different opinions about food. They argue that it lacks variety and is of poor quality, complaints such as the repetitiveness of the menu and unhealthy food served almost daily are made to substantiate their stance. To circumvent these challenges, some respondents use spices or buy

food elsewhere. By spicing up their food, they hope to make it healthy and even add variety. On the other hand, regardless of his or her health condition, every respondent is served the same menu whether pleasing or not. For those who are not pleased with this menu, they report getting food delivered by relatives or family members. The following respondents share their experiences as quoted below:

> *I am satisfied with my eating habits and I think people should be allowed to choose what they want. I eat properly, I go to Wimpy and make my breakfast every morning, whatever is made at Wimpy but I do not cook, instead, I just have porridge (Female, 68 years).*

> *I am not satisfied, nearly every day we are eating potatoes. Sometimes we have mashed potatoes for lunch and supper. It is not healthy and they do not allow us to cook our food (Female, 75 years).*

> *Thank God, I have jam, butter, peanut butter, and cheese, sometimes my children bring food. I do not bother them, I must think for myself, they are battling too. I got nice food from them today, I was crying while eating (Female, 68 years).*

> *I do not particularly enjoy the food but I have to spice it. You know, changing food is difficult but I do buy a disposable black pepper meal and take it down to the dining room as well as garlic. To make soup taste nice I put a teaspoon of garlic. So I try to add healthy spices like garlic and others that give taste (Female, 68 years).*

The elderly reported having three meals a day, notably breakfast, lunch, and supper. Some respondents revealed they have made an effort to accommodate themselves with the eating hours of the old age home. This may not only mean they have managed to accept anything offered to them but also succeeded to change their eating habits. The elderly come from different backgrounds and require some time to get used to the new environment. Furthermore, a given number of medical conditions impose a constraining eating schedule such as having several meals or snacks regularly. It also appears that some respondents are aware of the benefits of a healthy diet as it is believed to be one of the contributing factors in the successful management of their conditions. More light on this issue is provided by the quotes below:

I have become acclimatised since living here at this residence, we have a certain time for eating. I have adapted to that, I have my three meals, breakfast, lunch and supper. I have my three cups of Rooibos tea a day that I find very relaxing because when I heard about Rooibos here about four to five years ago and the effect of it, believe me, my hypertension is so controlled, it is unreal because I believe that Rooibos tea relaxes you. And once you are relaxed, your pressure comes down, that is where my pressure is controlled (Female, 73 years).

Like I said because I am diabetic I have to eat constantly, a little not a lot at a time. I was diagnosed when I was 30, I am now 65, so for 35 years, I have been conditioning myself on eating regularly and so on (Male, 65 years).

It appears that healthy eating is regarded as one of the priorities for some respondents since a wide range of healthy food is provided. However, what is healthy in someone may not necessarily hold true for another. The fact of offering a single healthy diet may be misleading and cannot be taken for granted when dealing with a group of people affected by diverse conditions. The following respondent expands on this matter in the quote below:

I am eating healthy in this place although some people are not happy with the type of food offered in this place. There is a variety of food, a lot of vegetables and I think it is good. Sometimes it is a bit too many carbohydrates and that might be the reason many people residing in this place are diabetic, too much of starchy food, carbohydrates like potatoes and mealie meal porridge and rice. Even though I do not take sugar at all, that is still sugar since the body converts it to sugar. This is a major health issue; people that are living with diabetes should not be given this food, it is killing them. Two weeks ago, residents made comments on the type and quality of food and I suggested having a diabetic diet but nothing happened. You know, they have already a lot of carbohydrates and then you give them tablets to bring their sugar down, it does not make sense to me and it is not logical (Male, 65 years).

Eating habits are particularly important in old age because of their impact on health. Having an adequate diet helps the elderly to benefit from improved well-being and live healthy. A healthy diet is put forward as an important feature in the successful management of numerous

chronic conditions. When the elderly are offered a single menu for breakfast, lunch, and supper, it emerges that one menu cannot accommodate all dietary restrictions for people suffering from various conditions. For instance, what is acceptable for a stroke survivor may not be applicable to a diabetes sufferer. Healthy eating is a relative concept that cannot be achieved with one menu, the elderly should be offered several options to choose from. Unfortunately, all older people do not receive support from relatives or cannot afford food whenever they are not happy with the old age home menu, instead, they are compelled to accept any available meal. Furthermore, some elderly express concern over the lack of variety of food and its impact on health. To circumvent this challenge, alternatives such as adding spices, buying fast food or getting home-cooked food are used. It appears that there is no clear cut distinction between healthy and tasty food on the part of older people since replacing meals cooked for old age home residents with fast food does seem to be the healthiest option. In addition, it is worth mentioning that some healthy food does not necessarily taste good.

6.16 Meal skipping

Despite reporting having three meals a day, meal skipping is quite widespread. Some respondents revealed it occurs on the medical appointment day for either collecting medication or meeting with the doctor. Knowing that appointments at public health facilities last between two to seven hours and given that almost all respondents approached are not on medical aid, this long waiting time is likely to compromise their well-being. Meal skipping increases the vulnerability of the elderly who cannot afford food and whose health requires regular eating. Any visit that lasts more than five hours, results in two meal skipping. The following respondent speaks about what happened to his brother in the quote below:

> *You skip your meal like my brother went yesterday at 5 o'clock, breakfast is served at 8 o'clock so he loses his meal, he is going to wait for lunch at noon (Male, 65 years).*

It appears that older people attend medical facilities regularly for either collecting medication or consulting with the doctor. These frequent visits are not only crucial for their health but also associated with some health challenges such as long waiting hours. Any person who is not in the dining room at mealtime is less likely to be served. This may represent some health hazards for those who cannot afford food. Preferential treatment to the elderly may be a better

way of circumventing this issue. A skip queue permission should be granted as this helps minimise the time spent at medical facilities and even avoid having further implications.

6.17 Lifestyle

Some respondents report participating in physical activities that enable them to be fit; walking appears to be the exercise of choice. Walking is regarded as an expression of independent living which contrasts with dependence in old age. Other entertaining activities such as playing chess or watching TV were mentioned as well. Viewed from the perspective of their proponents these entertaining activities help them to keep fit although it does not require energy expenditure. Similarly, practicing mental activities such as reading was believed to be another example of fitness exercises. The following respondents express their opinions in the quotes below:

> *I play chess, watch TV, I am a TV addicted (Male, 76 years).*
>
> *I do a lot of walking or sit and read a book (Female, 66 years).*
>
> *I take a walk to uShaka and back. I am still physically fit, I have not reached the age of using a walker or stick (Female, 63 years).*
>
> *My bones are too sore, I cannot even pick up my hand like this, it gets caught. Imagine from seven years old walking from one side of the leg, there is nothing that I did like an abnormal person (Female, 70 years).*

Some older people are conscious of the importance of physical activities and their impact on fitness. In most cases, they seem to be involved in activities of low intensity such as walking, they can cover a distance of three kilometres or more. Walking is perceived also as the embodiment of independent living, it is believed to distinguish older people from other age groups. The concept of physical activities differs, it is equated with entertaining and reading. Although some of these entertaining activities can have the merit of being enjoyable and keeping the elderly away from feeling lonely, they do not necessarily provide the same health benefits as those that require the expenditure of energy. Hence, their health benefits seem to be less significant compared to physical activities. Furthermore, the elderly suffer from a

multiplicity of medical conditions that may not allow them to exercise or restrict their mobility. For instance, a disability may serve as a deterrent to physical activities. This challenge can be well addressed by instructing the elderly on specific exercises that can accommodate their physical impairments.

Older women tend to be more affected by high blood pressure (52.9%) than older men (37.7%), BMI seems to be another factor that highlights a lack of a healthy lifestyle in old age since 54.6% of those who are overweight or obese suffer from high blood pressure compared to 29.7% of normal weight. Old age seems to be associated with a rise in prevalence of high blood pressure with 55.9% and 42% being diagnosed among those aged over 69 and 60-69 years older respectively. Table 6.7 below provides further light on this issue.

Table 6.7: Percentage of respondents who reported blood pressure status by background characteristics

Statement	No high blood pressure %	High blood pressure %	N
Gender			
Female	47.1	52.9	1929
Male	62.3	37.7	1002
Total	52.2	47.8	2931
Smoking			
No	50.5	49.5	2502
Yes	33.7	66.3	424
Total	47.2	52.8	2926
BMI			
Underweight	75.1	24.9	161
Normal weight	70.3	29.7	777
Overweight	45.4	54.6	1803
Total	53.7	46.3	2741
Marital status			
Not married	52.3	47.7	286
Married	55.1	44.9	1184
Total	54.3	45.7	1470
Age in years			
70+	44.1	55.9	1179
60-69	58.0	42.0	1752
Total	52.2	47.8	2931

** Using NIDS weighted data, wave 5, year 2017*
**Although 3545 respondents took part in the survey, some skipped certain questions in this section.*

In order to assess the influence of lifestyle on the likelihood of reporting high blood pressure, five variables such as age, BMI, gender, smoking, and marital status were used. It turns out that two explanatory variables were highly significant in the univariable model, notably gender and BMI. The univariable model was also highly significant at p<.001. BMI was the stronger predictor of reporting high blood pressure with an odds ratio of 2.9. This is to say overweight older people were 2.9 times more likely to be diagnosed with high blood pressure than their underweight peers. After running the multivariable model, using again all these five explanatory variables, they were all significant at p<.001, BMI remains the stronger predictor. After controlling for age, gender, marital status and smoking, the overweight were 7.7 times more likely to be diagnosed with high blood pressure than their underweight counterparts. The second predictor was smoking with an odds ratio of 1.5. As far as gender is concerned, older men were 0.8 times less likely to be diagnosed with this condition. In addition, the fact of being married and aged 60-69 years was less likely to be diagnosed with high blood pressure. Table 6.9 below provides further details on this illustration.

Table 6.8: Logistic regression predicting likelihood of reporting high blood pressure diagnosis by background characteristics

	Odds Ratios and 95% confidence intervals	
	Model I	**Model 2**
Gender	**Unadjusted**	**Adjusted**
Female	1.00	1.00
Male	0.540(0.536-0.543)	0.802(0.793-0.811)
Smoking		
No	1.00	1.00
Yes	0.519(0.513-0.525)	1.479(1.453-1.505)
BMI		
Underweight	1.00	1.00
Normal weight	0.384(0.381-0.388)	1.851(1.788-1.916)
Overweight	2.965(2.942-2.988)	7.726(7.465-7.995)
Marital status		
Not married	1.00	1.00
Married	0.894(0.884-0.903)	0.747(0.737-0.756)
Age in years		
70+	1.00	1.00
60-69	0.571(0.567-0.574)	0.418(0.413-0.422)

**P<.001*

** Using NIDS weighted data, wave 5, year 2017*

The elderly who were interviewed in qualitative data reveal that being in motion is seen as a way of life for them. To get relieved, respondents suffering from some medical conditions regard physical activities as a necessity. Walking is favoured, it can be done on a special occasion or as part of daily routine. The distance to cover should be long enough to provide some comfort. By the same token, a respondent using a wheelchair argues that the fact of performing household chores already stands for physical activities. Moving around with a wheelchair requires much energy that can be equated with a fitness activity. The following respondents highlight their stance in the quotes below:

> *I do a lot of walking, I try to walk as much as I can to stretch my legs. I am an arthritis sufferer and it is important to keep my legs moving so I walk from here to Pick n Pay which is quite a long walk and back here, I also go to uShaka (Female, 73 years).*

> *Actually, I used to go to the frail care unit to do it but now my individual exercise covers up (you can see). For instance, I am going up and down my bed from my wheelchair to the bed. It is enough and I wheel myself down to the dining room three times a day to me it is an exercise. This business of going from the wheelchair onto the bed and sitting on my bed, making my bed it is all part of the exercise as long as I am invigorating my body, not just sitting (Female, 73 years).*

Walking appears to be the favourite physical exercise of the elderly. Sometimes, it is perceived as a compulsory task that should be done regularly to relieve the pain for those who are suffering from a chronic condition. Walking works as a catalyst for independent living since the elderly strive to perform activities of daily living bearing in mind that their well-being depends on it. Similarly, avoiding being dependent on others for wheelchair users and performing household chores are equated with physical activities. There is a perception that the amount of energy disbursed while performing these tasks is similar to physical exercise.

6.18 Summary

The objective of this section was to explore the reported health status of the elderly and highlight their health challenges. A whole set of challenges inherent in health seeking behaviour had to be investigated as well. It was acknowledged that there is an increase in the

utilisation of health care services with age as the elderly recorded more frequent medical appointments. There were two scheduled routine visits to health care facilities for collecting medication and meeting with the doctor once a month and once every six months respectively. It is worth noting that all older people were not affected in the same way, those suffering from multiple morbidities had on average more than one medical appointment a month. Similarly, studies have found that multiple morbidities resulted in frequent hospitalisation, increases in health visits and health expenditure (Jankovic et al., 2018; Marengoni et al., 2011; S et al., 2015). Older women were more likely than their male counterparts to develop multiple morbidities (Aye et al., 2019). The elderly argued that their unhealthy lifestyle at younger ages was to blame for their current ill-health. Risk factors such as smoking and alcohol consumption, obesity and physical inactivity are responsible for a great deal of ill-health and death in old age (Heise et al., 2019; Jacob et al., 2016). They substantiated their viewpoint by revealing that a noticeable improvement in well-being was observed after adopting healthy behaviours.

In terms of physical activity, a substantial share of both male and female elderly were not exercising. For those who were worried about their fitness, walking was the exercise of choice. Physical activity was acknowledged as a necessity because of its health implications as also highlighted by other studies (Gobbo et al., 2015; McPhee et al., 2016). The relief provided by physical exercise on well-being can be extended to any condition since it was suggested that muscle function in people with impaired mobility could be improved by seated muscle strengthening exercises as well (Castrogiovanni et al., 2019). High sedentary behaviour and low physical activity are believed to be positively associated with the loss of skeletal muscle mass and mortality in old age (Chastin et al., 2015). The likelihood of developing chronic conditions such as high blood pressure was higher in women than men. Furthermore, the probability of developing a condition such as high blood pressure was high in overweight and obese people. Consistent with other studies (Campbell et al., 2015; Gobbo et al., 2015), the risk of suffering from high blood pressure in smokers was found significant. High blood pressure was one of the most prevalent chronic conditions with over 50% being diagnosed with it. Diabetes appears to represent another health challenge with close to 20% of cases, it is followed by heart diseases with nearly 8.6%. This is consistent with other studies that found a substantial share of sub-Saharan older people affected by diabetes, heart diseases, and a high prevalence of high blood pressure (Aye et al., 2019; Campbell et al., 2015; Pilleron et al., 2017).

Although the elderly report suffering from chronic conditions, more than 50% rated their health as excellent, very good or good. Consistent with other studies (Fonta et al., 2017; Wang et al., 2014; Wong et al., 2017), older men tend to rate their health as excellent or very good compared to older women. In order to manage successfully their medical conditions, the elderly were required to be on medication and adherent as long as possible, probably for the rest of their life. To meet these requirements, several ways were used to avoid skipping doses and compromising their well-being. Some of these arrangements highlighted their ingenuity and commitment to avoid worsening their fragile well-being.

Eating habits are one of the crucial features of healthy living and an important determinant of health. It was revealed that the elderly living in the old age home had three meals a day, notably breakfast, lunch, and supper. Some older people found their eating habits accommodated while others expressed concerns over the lack of variety and the repetitiveness of the menu. Furthermore, although it was acknowledged that the menu was healthy, it did not take into consideration the health risks associated with the consumption of some types of food for sufferers of a particular chronic condition. Eating patterns are thought to be one of the main components of successful aging. The meals offered to the elderly did not seem to match the Mediterranean diet which is believed to be the most adequate for achieving healthy aging (Sofi et al., 2013).

The majority of older people were reliant on public health services, which are free in the country. Living within a walking distance of a health care facility was an additional motivation for keeping medical appointments. Consistent with a study in Myanmar that found that the elderly relied more on conventional medicine and tended to visit the nearest health care facility (Aye et al., 2019). Although the elderly are free patients, commuting by taxi or bus represented a financial burden that some struggled to cope with, especially, those suffering from multiple morbidities. Furthermore, a serious challenge to health seeking behaviour was also observed in the elderly living with a disability as they required adequate transportation. Marengoni et al. (2011) highlighted the existence of a link between multiple morbidities and adverse health outcomes such as dependence and disability which increased the utilisation of health care services and poor quality of life. In other words, regardless of the challenging nature of their medical conditions, the fact of living in the neighbourhood of a health care facility had a positive impact on health seeking behaviour in the elderly.

The majority of older patients, utilising public health care facilities, cast doubt on the quality of treatment as they confronted challenges such as congestion and difficult interaction with health care workers. Banerjee (2015) argues that health care workers are not adequately trained to deal with health in old age notably non-communicable diseases, multiple morbidities and/or long term conditions. Furthermore, high patient turnout seems to challenge the quality of care. It was revealed that the amount of pressure placed on health care workers was high, they had to race against time and ensure that every patient was served before the health care facility closes. Working at a high pace was adopted as a better way of dealing with congestion, it helped shorten the time of consultation and ensured that there were more patients consulted within a short time. As a result, health care workers did not often carry out thorough diagnoses and could end up prescribing all medication suggested by patients.

On the patient side, there was less excitement to visit health care facilities on the appointment day. For instance, the negative attitudes of health care workers and long waiting time were put forward as reasons for their reluctance to visit health facilities. The minimum amount of time spent on every medical appointment was four hours, short visits seemed to be cherished or appreciated. The first come first serve principle on which health care services work is based does not seem to be fair to the elderly since it does not take into consideration their vulnerability and multiple morbidities. Treating all patients on the same basis sounds fair but the elderly were reluctant and questioned the reasoning behind this decision. Waiting for long hours was likely to compromise their well-being since some of them were afflicted by a multiplicity of health challenges. In addition, the attitude of health care workers towards older patients was described as unwelcoming. The elderly recalled being shouted at, ignored or treated in an unfriendly manner on several occasions. This is consistent with a study by Haskins et al. (2014) who revealed that health care workers were working under much pressure and end up disrespecting their patients.

CHAPTER 7: DISCUSSION AND CONCLUSION

7.1 Introduction

For years the issue of population aging was overlooked in the developing world, particularly in sub-Saharan Africa. The youthful nature of the population was one of the reasons leading policymakers and scholars to pay less attention to the elderly and focus on the younger generations (Apt, 2012; Makoni, 2008). At present, the elderly are at risk of experiencing heightened vulnerability as a result of a decline and even loss of traditional support (Aboderin, 2012; Aboderin, 2017). While with advancing age people tend to develop non-communicable diseases, the health systems seem to ignore their health needs and remain focussed on medical conditions prevailing at younger ages, notably infectious and acute illnesses (Ng et al., 2010). It is believed that an increase in the number of the elderly in unprepared countries is more likely to represent a serious challenge for their well-being.

The study attempted to understand social support and determinants of health of people aged 60 years and older living in South Africa and provide a comprehensive definition of the concept of old. The concept of old was explored as it remains one of the contentious issues of population aging. The heterogeneity of old age in different settings, notably, between developed and developing countries makes it difficult to find common ground (Maharaj, 2013; Makoni, 2008). The elderly were called on to reflect on their perception of old age since they are those whose life is most affected, they also provided insights on their health as well as on various types of support received. Engaging with the elderly was useful and thought-provoking as it resulted in an important source of first-hand information.

A review of literature on health in old age in the developing world, particularly in South Africa reveals that it has not benefited from extensive research. The dearth of empirical work in this country raises concerns over the well-being of the elderly since it is home to one of the largest share of the older population in the sub-Saharan African region (Statistics South Africa, 2018). Research on the health of the elderly has been substantially explored in the more developed world. Although most recent studies tend to focus on the economic impact of population aging, aging in place, healthy aging, the link between perception of aging and health, aging and challenges to families, in the less developed world, the research has attempted to address issues such as challenges inherent in chronic conditions in Africa,

intergenerational care, social networks and aging, challenges for elderly care, differences in composition of social networks and gender, happiness and lifespan, accommodating the needs of multiple morbidities patients, aging and health. Overall, these studies highlighted several challenges inherent in population aging, however, the concept of old used to conduct these investigations differs from one research to another. The commencement of old age differs and may depend on the perception of every society. In addition, no study seeks to understand the influence of social, economic and social support on health in old age drawing from qualitative and quantitative components. If ever interventions are to be made, it seems necessary to use empirical evidence from studies representative of the social and economic context of each country.

This study has utilised both qualitative and quantitative methods approaches. Although the largest part of the study was qualitative, it also made use of quantitative investigations. In fact, in terms of research design, descriptive and explanatory techniques were adopted. An interview guide was used for conducting in-depth interviews and secondary data from NIDS provided a great deal of relevant quantitative information. Using triangulation as a methodological approach has the benefit of circumventing weaknesses inherent in each of the methods and providing better outcomes. Triangulation offers more prospects of understanding the research problem by addressing research questions from a wide range of perceptions. This section discusses the main findings on social and economic factors that impact health in old age in South Africa.

7.2 Discussion

The findings of the study show that the elderly tend to describe old age according to others. Regardless of their age, they argue that chronological age is a number and can be used to substantiate an argument rather than the main criteria for describing the concept of old. There is on their part a perception that old age should be experienced and not imposed, many of them do not feel old. This is consistent with Jones (2006) who reveals that people are less likely to associate themselves with the category of being old. This perception is shared by people who are referred to as old on the grounds of their appearance and chronological age. Similarly, Leach et al. (2013) argue that the baby boomers do not describe themselves as old. Instead, they perceive their cohort as a bridging generation between the old ways and the younger generations. This viewpoint seems to be upheld by their youthful consumption-

oriented lifestyles. Caring about themselves, dressing smart, appearing and spending as the youth has been part of their values (Gilleard and Higgs, 2005).

The study has challenged the current concept of old, based solely on chronological age. Using chronological age to describe old age leads to the assumption that people aged 60 years and older belong to a homogeneous age group and aging is uniformly experienced. This definition does not seem to hold true since diversity is portrayed as one of the key features of old age. Some people aged 80 years can be compared to many 20-year-olds in terms of physical and mental capacities. On the other hand, some people experience a decline in mental and physical capacities by the time they turn 60 or 70 years and require assistance to perform activities of daily living (World Health Organisation, 2015). Equating an independent 60-year-old with a dependent 60-year-old based on their chronological age seems flawed and unrealistic. It is noteworthy that the elderly do not form a homogeneous group that can be distinguished by certain characteristics. Furthermore, the fact of being exposed to different environment and lifestyle impact the aging process (Steves et al., 2012; Yamasoba et al., 2013). Yet old age is a heterogeneous concept that cannot be described from a one-size-fits-all approach.

This study highlights that functional aging does not necessarily correspond with chronological age. Even using physical appearance as a measurement, being chronologically young does not necessarily translate into looking young. In other words, some chronologically young people tend to look older than they should. Smoking cigarettes could be one of the reasons leading some people to experience facial aging (Morita, 2016; Seitz et al., 2012). Yet using physical appearing as a basis for describing old age may challenge the current concept. To substantiate this finding, a study by Chen et al. (2015b) argue that discrepancy between chronological and physiological age can amount to ±6 years in people who belong to the same birth cohort. Sternäng et al. (2018) make the same argument in revealing that the pace of aging differs in one another since some people tend to age earlier than others. Understandably, having a different pace of aging is likely to result in dissimilar functional aging. This is to say it is possible to find functionally old and young people within the same birth cohort. Describing old age on the basis of one feature seems simplistic and fails to capture its full picture. According to Viana Medeiros et al. (2016), the perception of the concept of old should encompass cultural values, background, and personal history. In a sense, the definition of old age cannot be dissociated from the socio-cultural context of the

community it represents. For instance, the fact of using the same terminology does not necessarily result in similar interpretations. Given that the concept of old is a social construction, its meaning is not universally shared but depends on the culture and history of the society (Hepworth, 2000).

This study found that old age begins when people become unable to work and fulfil their family responsibilities. In other words, older people are entitled to continue to play an active role as long as their health permits. This perception differs from what is commonly used as the retirement criteria when people who reach a fixed chronological age are taken out of active life. The assumption behind the chronological age approach seems to be that upon reaching the retirement age, every person becomes unfit to continue playing an active role in society. Investigating this issue, Warburton et al. (2017) argue that the retirement age has as a basis the exclusion of the elderly from active life. It is possible to assume that using chronological age as a basis for describing old age can be sometimes puzzling. In a sense that a chronologically young person with a fast functional aging pace may be preferred to his or her peer on account of chronological age while he or she may no longer be able to perform better than a chronologically older person. The concept of old seems to perceive old age from a stereotypical viewpoint and ignore healthy and cognitively able older people (Sternäng et al., 2018).

Besides a consensus on the aging process in the human race, the study fails to tell what gender ages earlier. Some older people believe that men age earlier than their female counterparts while others believe the other way round holds true. Nevertheless, they acknowledge that women live longer than their male counterparts as highlighted by research conducted in almost every part of the world (Austad, 2006; Ginter and Simko, 2013; Glei and Horiuchi, 2007). Despite this consensus, it was found that the fact of reaching the retirement age does not mark the commencement of old age or make someone old. An older person may be regarded as someone who has lost his independence and relies on others to perform his or her activities of daily living. This is to say a fit and independent 70-year-old may not be referred to as an older person while a dependent 60-year-old can bear this label. Health is perceived as one of the main determinants of aging and its impact on the concept of old cannot be overlooked. It appears that aging is a process that affects people differently, this fact seems to be acknowledged by countries that have set two different retirement ages for males and females (Tanga, 2015).

Furthermore, having features such as wrinkles, sight impairment, grey hair, lack of fitness and changing voice have been highlighted as likely to be associated with old age. However, if taken themselves these features cannot make someone old, it must be accompanied by a loss of independence. It is worth mentioning that some of these features can be present in some younger individuals. A study by Shin et al. (2015) reveals that factors such as smoking, obesity and family history are responsible for premature hair greying before the age of 30. An investigation by Quartilho et al. (2016) maintains that age-related macular degeneration, glaucoma, and hereditary retinal disorders were the leading causes of sight impairment in England and Wales at the end of March 2013. Lifestyle also seems to play an important role in influencing appearance as some research has linked smoking cigarettes to the appearance of wrinkles. The likelihood of developing premature facial wrinkling is higher in smokers than non-smokers (Doshi et al., 2007; Seitz et al., 2012).

The study has revealed that the proportion of married men is higher than their female counterparts, this seems to highlight their ability to remarry after divorcing or experiencing the death of a partner. This observation in marriage differences is more likely to be explained by higher mortality rates in older men than older women rather than remarriage rates. This pattern is consistent with other studies conducted in the developing world (Faye and Andrade, 2018). In terms of emotional support, married people or those living with partners are believed to benefit from more comfort than those who are not in a relationship. The availability of a partner appears to be an added advantage for couples; they are likely to benefit from mutual emotional support. It was found that not married people (widowed, divorced and separated) were more likely to feel lonely than those who were married or living as unmarried couples. This is to say marriage remains an important source of emotional support and the existence of other alternatives appear to be useful as well. A study carried out by Carr and Springer (2010) has highlighted the positive impact of marriage on the emotional well-being of the couple. Similarly, Kalmijn (2017) argues that marriage is associated with a sense of belonging, it provides emotional support in difficult times and decreases or prevents the likelihood of developing depressive feelings. This argument seems to contrast with other investigations highlighting that the fact of being married does not result in the automatic provision of emotional support, the quality of the union is also paramount. Unhappily married people struggle to lead a normal life since their problematic marriages take a toll on their emotional well-being (Chen et al., 2015a). On the older hand, never-

married people manage to adjust to their situation and seek relationships outside marriage that may provide them with emotional support. Living with adult children can be one of the options as reported in South Africa (Madhavan et al., 2017). Furthermore, living with the elderly is regarded as one of the traditional obligations of family members towards them (Lloyd-Sherlock and Agrawal, 2014).

For the residents of old age homes, it may not be possible to live with kin. The elderly have several sources of emotional support that can be extended to friends and relatives. A great deal of emotional support comes from other peers who reside in the same institution as they often have frequent interactions and gatherings daily. Telephonic conversations are one of the ways through which they receive emotional support from relatives who may be unable to come for a visit. Other ways of keeping in touch with friends and relatives are via postal mails and emails. This is consistent with research conducted in England and Wales that highlights the use of telephonic conversations as a way of overcoming the distance between the elderly and their adult children living in different areas. They used Skype, Facebook, email and webcam to communicate (WRVS, 2012). Using communication tools such as these have the advantage of accommodating working people, bridging the distance barrier and being less expensive. The English and Walsh study reveals than an increase in distance between the elderly and their adult children resulted in fewer face-to-face visits. High levels of interaction and frequent contact may increase the buffer effect for negative life outcomes while a less supportive family may reduce its efficiency (Li et al., 2014).

This study also reveals that ministers such as pastors and priests as well as church members are instrumental in ensuring that the elderly are emotionally healthy. These men and women of faith visit the elderly on-demand or on appointment and also hold services in old age homes. A religion-based study by Hovey et al. (2014) perceived emotional support as the strongest predictor of social support and also the strongest predictor of health outcomes. Furthermore, regarding the elderly who could not find a reliable person for emotional support, self-talk or reading a book was used as a coping mechanism. The positive effect of social support on the well-being highlighted in these findings is in line with the social support theory (Cohen and Wills, 1985).

An important point made in qualitative data is about the efficiency of emotional support. In a sense, any intervention that fails to yield positive results should not be referred to as

emotional support. This seems to highlight the obligation of results by ensuring that every attempt leads to a positive outcome. Studies have documented the positive impact of emotional support on the well-being of the elderly. The company of friends and family members or a good social network is believed to be a strong predictor of quality of life (Chatters et al., 2015; WRVS, 2012). In contrast, loneliness appears to be associated with a negative impact on health which compromises the quality of life. It is argued that loneliness can lead to risky behaviour such as drinking, smoking cigarettes, alcohol consumption, absence or less physical activity, inadequate diet, poor sleep among others (Hawkley et al., 2010). WRVS (2012) reveals that support provided by family members can be inclusive of informing, listening to problems, advising, sharing news, and also, emotional support.

7.2.1 Financial and instrumental support

The results from the qualitative component have highlighted that some older people receive presents from their relatives and social networks while others have to rely on pensions to meet their needs. The fact of maintaining a good relationship during active life is put forward as the main reason for this differential treatment. This support has made a significant contribution to their well-being and quality of life as widely acknowledged. Consistent with a study conducted in Ghana by Aboderin (2017) who argues that the amount of support of children for their parents may no longer be dependent on filial obligation but in line with their appreciation, gratitude, and indebtedness. It appears that filial support cannot be taken for granted or may no longer be automatic. Instead, the elderly are repaid for having successfully fulfilled their parenting role during their active life.

In contrast, those who do not receive any assistance from their relatives feel frustrated and disappointed, they have to fend for themselves and do their best to survive on the state pension. According to Chatters et al. (2015), factors such as the economic crisis, the rise in female employment, migration, the gradual breakdown of the extended family are responsible for a decline in support for older people. The qualitative component of this study reveals that the amount of family support for the elderly depends on the number of people involved in income-generating activities. High-income earners tend to be more supportive than other family members and friends. On the other hand, Aboderin (2017) believes that economic hardship has led adult children to blame their parents for failing to provide them with an education that would have enabled them to better their life. Therefore, filial support is

dependent on children's judgement, it is an honour given only to some deserving parents. Furthermore, instrumental support is another important assistance especially for the elderly living with a disability, impaired mobility or poor health. In case they may be compelled to go shopping, the first option at their disposal for running errands on their behalf is other older people living in the same old age residence with them. Family members and other social networks can also step in to assist if possible. Likewise, WRVS (2012) highlights that various support was provided for the elderly such as transporting, shopping, household chores, and even personal care.

The qualitative component reveals that the elderly receive financial and material support from different social networks, such as adult children, grandchildren, and friends. Sons and daughters are reported to be the most supportive of all social networks. Besides the level of income, mutual understanding is put forward as one of the reasons leading these relatives and friends to be generous. It transpires that the likelihood of benefiting from support is diminished for childless people. Childlessness appears to be one of the causes that worsen vulnerability in old age. It is argued that the most vulnerable elderly are those who have lost all their children as a result of death (Lemtur, 2018). They are at high risk of suffering from anxiety, loneliness, isolation and they struggle to deal with activities of daily living. Studies conducted in Europe maintain that older people receive a lot of informal (unpaid) support from adult children, this sheds light on the key role played by relatives as providers of old age support (Brandt, 2013). While extended family or social networks help childless older people to stay afloat by supporting them sporadically, this help erodes when their health deteriorates and requires an intense demand for support. In most cases, childless older people struggle to find support when their health deteriorates to the extent they become unable to live independently. As a result, they end up compensating for this lack of children's support with formal welfare institutions (Deindl and Brandt, 2017).

It transpires throughout this study that the elderly were uncomfortable with receiving support on a regular basis since they would be perceived as a burden on the family or social networks. Instead, they want to be assisted occasionally or on-demand. They require assistance only in case of emergency or after failing to handle an issue. It is out of concern for their image that they behave in such a way. They make every effort to avoid being portrayed or labelled stereotypically. These findings are consistent with Canvin et al. (2018) who argue that the elderly make every effort to restrict the amount of assistance they require. They may use the

issue-by-issue approach to assess the necessity of seeking assistance. Low expectations are one of the causes leading them to adopt this attitude. For instance, they may perceive themselves as worthless or very old to require support. High expectations play its part in the decision to seek support as some older people remain active and believe they can handle any challenging issue. Their first attempt could revolve around managing or finding a way of adjusting their needs to available resources. Both low and high expectations are two crucial aspects that weigh on their decision-making whenever an issue arises (ibid). An emphasis has been put on two features believed to be responsible for causing reluctance in the elderly. Firstly, it was dependent on the way independence or being active is perceived. If receiving support is equated with loss of independence, they may fail to realise that independence could be obtained through assistance. Secondly, being a recipient of assistance is synonymous with a burden that seems to be conflicting with their perception of independence (Mackichan et al., 2013). In addition, Kasiram and Hölscher (2015) found that some older people were ready to do anything to maintain their independence, they would even perform dangerous tasks.

Qualitative data reveal that various type of support is offered to the elderly by the community, non-governmental organisations (NGOs) and non-profit organisations (NPOs). It seems that the motive behind these contributions is to offer them a home away from home. One of the exciting days is when home-cooked food is served, it is described as a real delicacy. Besides food, the wardrobe is taken care of by selling clothes at the lowest prices that would enable everyone to afford it. Unfortunately, they fail to cater for every old age home resident especially those who require larger sizes because of obesity. Although the elderly could not elaborate on how frequent these organisations support them, it seems to happen during major celebrations such as Christmas and Easter.

It appears that some of the donations made to the elderly are based on the assumption of what is believed to be essential for them. Instead, it would become more interesting if their real needs were investigated before undertaking such generous activities. Asking the preference of the elderly on the type of donations that would be more helpful appears to be a good initiative since it is representative of their aspirations. Given that some organisations offer more than one type of support, it is possible to address a substantial share of the elderly's needs. For instance, besides providing emotional support as mentioned earlier, church members and pastors support the elderly with food parcels. Keeping in touch with the elderly is believed to have an impact on their well-being, especially, visiting or involving them in outdoor or

indoor activities during the holiday season is regarded as a good initiative since it spares them from loneliness and isolation (Stevenson, 2017). This initiative has the merit of entertaining the elderly and offering them an opportunity regardless of their place of residence.

Regarding any attempt by the local government to improve the well-being of the elderly, there is no clear answer. Some older people report not being aware of the extent to which this local branch of the executive is involved in their support while others argue that it makes some contributions without providing further details. In an attempt to substantiate their argument, they mention some contributions made towards supporting the elderly in other provinces and believe the same principle should apply everywhere. Kim and Warner (2016) reveal that local governments use several alternatives to maintain service delivery to the elderly in the USA. Local governments tend to be less involved in the day to day provision of service delivery; they outsource it to the private sector to ease pressures on themselves.

The results from the quantitative component provide an estimated 71.6% of women and 28.4% of men aged 60 years and older on pension. The state-funded old pension is the largest cash transfer scheme and almost all study participants acknowledged receiving it. The old age pension is an important source of income for almost all older people and the main requirement for any older person seeking to get accommodated in some old age homes. Becoming a pension recipient is crucial since it provides the elderly with some financial independence and relief. Consistent with other studies, the introduction of the pension system is reported to be an important milestone in old age (Tanga, 2015). Pension receipt has led to a profound improvement in health and quality of life in South Africa. Pension recipients have become attractive and essential members of the households (Madhavan et al., 2017). Similarly, in Lesotho, the perception of the elderly has shifted from worthless to valuable members, those who can contribute. They feel empowered and are regarded as trustworthy community members (Tanga, 2015). Despite this stated positive impact on well-being, living on a pension alone may be challenging even for old age homes residents. Some older people struggle to make ends meet and attempt to supplement their income by working part-time (ibid).

7.2.2 Subjective well-being and self-reported health

A large share of older males tends to rate their health positively (excellent, very good and good) compared to their female counterparts. In general, this rating appears to be contrasting with their health status as some acknowledge suffering from chronic conditions. This inconsistency between self-perception of health and clinical status was also observed in subjective unhealthy and objective healthy individuals by Cho et al. (2015). These authors found that coming across some objectively healthy individuals grappling with health issues was a fact. Tkatch et al. (2017) argue that these subjectively unhealthy older people have been struggling with poor health for years and have come up with better coping mechanisms. In contrast, following a long life without major health concerns, the objectively healthy older people have witnessed the development of new medical conditions. They have not succeeded to adjust to their new reality and are still puzzled by the prospect of being afflicted for the rest of their life.

An assessment of self-reported health using logistic regression in the elderly on hypertension treatment reveals that the model is significant. The elderly living in high-income households were more likely to have a positive rating of their health than their counterparts living in low-income households. This is consistent with Gu et al. (2019) who highlight factors such as income, residence, health insurance and region as responsible for inequality. The presence of chronic disease in older people does not deter them from rating their health as excellent or very good. This is consistent with Rose (2018) who reveals that self-rating health status in the elderly does not necessarily depend on the absence or presence of a medical condition. Also, Levy and Myers (2004) found that the elderly with higher self-reported health were more likely to have a positive perception of aging and tended to be involved in healthy behaviours. The likelihood of having a positive perception of aging was significantly higher in these elderly than in those who rated their health negatively.

7.3 Health seeking experience

Old age appears to be associated with an increase in the frequency of utilisation of health care services. The qualitative component reveals that every older person has at least one medical appointment a month. In most cases, they visit a health care facility once a month to collect medication and every six months on an appointment with the doctor. Regarding the elderly

suffering from multiple morbidities, they may have more than one monthly appointment depending on the number of their conditions. Besides these scheduled visits, some are unplanned and take place in case of necessity. For instance, an emergency or sudden deterioration of health may compel the elderly to visit a health care facility. This finding is consistent with Prütz and Rommel (2017) who report an increase in the utilisation of health care services among outpatients in Germany with advancing age. The German study reveals that the rate of hospitalisation among people aged 65 years and older over the period of 12 months was found to be twice as high as those aged 45 years and older. Despite this high demand for hospital admission, no significant differences are found between men and women (Prütz and Rommel, 2017). Old age is also associated with an increase in the proportion of people on prescribed medication. Knopf et al. (2017) argue that in Germany, the proportion of people aged 65 years and older on medication is between two and a half to four times as high as in the 18-29 age group. The impact of old age on the utilisation of health care services appears to be substantial.

Although the elderly without medical aid are free patients, health seeking behaviour often comes with a cost. Unless they manage to walk to public health care facilities, the elderly are expected to spend a nominal fee of R10 for their return trip on every appointment day. This spending can represent a serious financial burden for people suffering from multiple morbidities as they are bound to book more than one monthly appointment. The elderly living with a disability or having impaired mobility may struggle to keep their medical appointments. Regardless of the distance between their residence and health care facilities, accessing health care appears to be a continuous challenge especially when there is no adequate transportation. A study by Kasiram and Hölscher (2015) acknowledges the negative impact of impaired mobility on health seeking behaviour in old age. Similarly, Hussey et al. (2017) reveal that a lack of accessible transportation for people living with a disability represents a serious hindrance in South Africa. Using transportation for abled-bodied people could be challenging as well as. For instance, although there may be sufficient space to accommodate a wheelchair, the negative attitudes on the part of public transporters remain another hurdle. Also, the public transportation systems accommodating disabled people are more likely to be found in urban than rural areas. The type of infrastructure inherent in health facilities seems to represent another barrier. A substantial number of health care facilities do not meet international accessibility standards. Even-recently built facilities failed to meet the requirements (ibid). Other features such as commuting costs can deter the elderly living at

home from keeping their medical appointments. It is revealed that South Africa has one of the highest commuting costs in the developing world and even in the developed world (Kerr, 2017).

The elderly do not experience poor health in the same way, some have severe health issues while others are still fit and healthy. In terms of the rate of utilisation of health care facilities, public institutions record the highest number of patients aged 60 years and older compared to the private sector. The high patient turnout daily represents an additional challenge for all patients, particularly the elderly. Patients are treated according to their time of arrival, early comers are more likely to be the first in the queue. The waiting time is quite long and can amount to four hours or more, no distinction is made between older and young people. It is assumed that all patients are equal and should be treated in the same way. It appears that on every visit, the prospect of spending the whole day at a health facility haunts the elderly.

Public health care facilities are congested, the elderly acknowledge that health care workers deal with a large number of patients on every visit, as a result, they are not given enough time to engage with their health concern. Health care workers focus the most on clearing the queue and ensuring that all patients receive treatment while the quality of service is neglected. Interactions between health care workers and patients have taken a toll as some older people tend to equate their consultation time with a tick-box routine. After spending much time waiting for their turn and when it comes, they are rushed to make some time for others, the elderly have the impression of failing to achieve their goal, especially when they are compelled to go home with unanswered questions or without being given time to ask any questions.

The elderly describe the attitudes of nurses towards them as appalling, they report being treated as children and sometimes ignored. A study conducted in Israel found that older patients were less consulted or bypassed by health care workers. Instead, they tend to approach younger family members to query about clinical input because it is perceived to be an easier way of getting answers. Furthermore, for health care workers using humour with younger patients is more acceptable than with older patients and also they tend to remember the names of younger patients (Ben-Harush et al., 2017). It appears that negative attitudes towards aging are responsible for the poor quality of care and poor interactions between older patients and health care workers. Chambaere et al. (2012) highlighted that the likelihood of

consulting patients or involving them in decision-making to reduce pain declines with advancing age.

Because of their perception of aging, some health care workers decide to withhold information that would shed light on the condition of their patients. For instance, by arguing that back pain is a result of aging, they do not make the elderly aware but rather make them believe nothing can help relieve their discomfort (Makris et al., 2015). According to Drury et al. (2017), many older people believe that they do not receive the right treatment, instead, they are overlooked and treated with contempt. The perceptions of health care workers towards old age can lead them to make a wrong diagnosis and, of course, prescribe a wrong treatment. For instance, two patients who displayed the same symptoms but were different in age were diagnosed with dementia and depression. The younger patient (aged 39 years) was correctly diagnosed while his counterpart aged 81 years appeared to be a victim of old age stereotypes (Royal Society for Public Health, 2018). It is argued that the elderly are vulnerable to negative attitudes towards aging as a result of both self-stereotyping and the threat of being stereotyped (ibid).

Furthermore, some older people believe that the attitude of health care workers is not a result of a deliberate action instead they may be unable to handle pressure and end up offending patients. Consistent with Haskins et al. (2014) who highlight that nurses from a rural hospital in South Africa blame their bad behaviour on several challenges they face such as high workload, staff shortages and ill-treatment at the hand of hospital managers. They even went further in emphasising that nursing was not their calling. Despite this blame-shifting game, all well-mannered health care workers remain composed despite dealing with harsh working conditions daily. They do not crush under the burden of the workload, instead, they treat every patient with dignity and consideration. A study in rural South Africa reveals that patients were exposed to rudeness, neglect and verbal abuse by those who are supposed to care for them. Nurses would openly speak about their abuse in the presence of their peers and patients without remorse and no one dared reprimand them (Haskins et al., 2014). This is consistent with Billings (2006) who stated further ill-treatment such as the exclusion of the elderly from conversations that may be sensitive or not, little attention paid to the preferred way of treatment, patronising attitude, not enough privacy while assisting the elderly with dressing, washing or toileting, ignoring the choice of the elderly regarding what and where to eat, and the elderly receive a lot of medication without often further assessment.

The issue of abuse is tempered by some older people who acknowledge it but argue that all nurses are not rude, some of them are interested in caring for patients to the best of their ability. This view is shared by Smith et al. (2009) who argue that despite the challenging nature of their tasks, some nurses are interested in the complete healing of their patients. Every effort is made to help patients to improve their health and be discharged from health care facilities. Dealing with patients can be strenuous, health care workers are required to remain as professional as possible by complying with ethical codes. Also, they should be able to help patients in dealing with the management of their conditions by providing support and any type of useful information.

The attitude of health care workers towards older patients raises some suspicions about their competence. Ill-treatment is believed to be an approach used by health care workers to hide their ignorance by avoiding further confrontation with patients. The elderly are afflicted by conditions that are uncommon among youth and young adults (Prince et al., 2015). A substantial number of health systems in the developing world tend to be less prepared for non-communicable diseases associated with old age (United Nations General Assembly, 2015). It was found that prejudice towards old age may be caused by the type of training received by health care workers. Studies list inadequate training as a probable cause of antipathy since it does not place much emphasis on the elderly's care (Kydd et al., 2014).

From a safety point of view, the elderly represent a soft target for criminals. Living within a walking distance of the nearest health care facility may not necessarily be regarded as an advantage. Some older people feel unsafe and cannot go unaccompanied early in the morning to seek health care. They either manage to get accompanied by an able-bodied peer or be ferried by an ambulance for any appointment taking place at the nearest health care facility. Germiston City News (2018) maintains that an older person is regarded as a soft target, especially, if he or she is walking alone. A quiet and safe area can turn out to be a hideout for criminals who may easily ambush and prey on unsuspicious older people.

7.4 Lifestyle and health

It is revealed that past and present lifestyle impact on the likelihood of experiencing ill-health in old age. The elderly recall being involved in drinking and smoking cigarettes at younger

ages and even in old age, they attribute their present poor health to past risky behaviours. This study found that married people tend to smoke less than the unmarried. The fact of being married may lead these elderly to adopt healthy behaviours. For instance, having partners who can tell one another what to do may play an important role and seem to be an added advantage. While a person with no partner may seek addiction to compensate for the relationship vacuum which can be perceived as a coping mechanism. A married person does not only benefit in terms of companionship but also lives with a partner who can judge her or his actions. Depending on his or her leverage, a partner can play an important role in the couple's lifestyle. This is consistent with other studies that found that married people are less likely to engage in risk-taking behaviour (Hilz and Wagner, 2018; Ross et al., 2016).

The fact of reaching old age does not deter the elderly from leading an unhealthy lifestyle, it is rather the onset of a chronic condition that tends to compel them to avoid risk-taking behaviours. Once the diagnosis is made, the elderly are likely to become remorseful and attempt to change their lifestyle. Obesity can be put forward as one of the examples of an unhealthy lifestyle in the elderly. Consistent with Wu et al. (2015) who found a high rate of obesity among people aged 60 years and older in South Africa and old women were at higher risk compared to their male counterparts. These authors revealed the existence of a relationship between income and obesity since the elderly who live in wealthy households tend to be obese. However, studies from high-income countries reveal the existence of an inverse relationship between income and obesity (McLaren, 2007). This assessment seems to provide a better description of the unhealthy lifestyle in old age with older women recording the worse outcomes.

Regarding the type of physical exercise practiced, walking appears to be the most favourite. Other activities that do not require the expenditure of energy such as playing chess, reading and watching TW were equated with physical exercise. It is worth mentioning that these entertaining activities may be emotionally beneficial but cannot offset the positive effect of physical exercise on health. In other words, equating them with physical exercise could entail a discrepancy in the definition of the concept of physical exercise between some elderly and what is commonly accepted. On the other hand, the presence of a disability in some older people can be regarded as a deterrent. Household chores were equated with physical exercise by some older people. The positive impact of physical activities on health is acknowledged as

some older people report experiencing an improvement in well-being following a change in lifestyle.

High blood pressure is the most prevalent chronic condition in old age. The likelihood of being diagnosed with high blood pressure in older women was highly significant. It is reported that its prevalence rises with age in low-income and middle-income countries. It is more prevalent in urban areas than in rural areas (Prince et al., 2012; Prince et al., 2015). Bauer et al. (2014) reveal that factors such as cigarette smoking and exposure to second-hand smoke, high blood pressure, high BMI, alcohol consumption, lack of physical activities and poor diets are responsible for much of the burden of chronic disease. An increase in exposure to these risk factors is believed to stem from the expansion to low-income and middle-income countries of tobacco companies as well as processed food and manufacturers (Stuckler et al., 2012).

7.5 Eating habits and consumption

It was found that the elderly living in old age homes have three meals a day, in the morning, at noon and in the evening. This eating schedule seems standard and acceptable but it does not make provision for people who must have snacks in between. For instance, a person living with diabetes may struggle to adjust unless he or she can afford snacks. Qualitative data show that the quality of food is questionable, complaints about the repetitiveness of the menu are expressed as well as its unhealthy aspect. To circumvent these issues and avoid starving themselves, the elderly use spices to make it healthy and add different flavours. A second alternative is to have food delivered by social networks or family members. However, regardless of their medical conditions, every older person is served the same menu. Although the menu offered is described as healthy, the elderly suffer from numerous conditions that cannot be accommodated with a single menu. For instance, a healthy diet for a hypertension sufferer may not be recommended for a person living with diabetes. In terms of diet, a one-size-fits-all approach is less likely to work out because of the amount of the health risks associated with every medical condition, especially, in old age. People suffering from diabetes are recommended to consult dietitians for nutrition therapy as soon as they are aware of the diagnosis. This helps manage their condition in an efficient way and enable follow-up. Unfortunately, a substantial number of diabetes sufferers do not benefit from such support. Evert et al. (2014) reveal that it is important for a diabetes patient to know how to quantify

his or her carbohydrate intake for better management. Sometimes, the elderly are compelled by harsh living conditions to eat anything. A study by Sixsmith et al. (2014) reveals that eating healthy was secondary among older people living in Eastern European countries, their limited financial resources compel them to focus on having shelter and food.

On the other hand, some elderly seem to grapple with the concept of healthy and tasty food. They report using fast food as an alternative in case of dissatisfaction with the old age home menu. Often fast food is designed to be tasty while healthy food does not always have a good taste. Unfortunately, using processed food is not regarded as a healthy option (Stuckler et al., 2012). The association between dietary patterns and healthy aging has benefited from a given number of investigations, particularly, the Mediterranean diet. Research has revealed that strict adherence to this diet results in a lower risk of developing cardiovascular diseases and it even reduces mortality (Mathers, 2013; Tyrovolas et al., 2014). The elderly are more likely to skip meals whenever they have medical appointments. This appears to be an additional challenge that may increase their vulnerability, especially, those who cannot afford replacement meals and eat regularly as per their dietary requirements.

7.6 Conclusion

Until recently, Africa was regarded as immune to population aging. This perception was shared by both policymakers and scholars. They were lured by the youthful nature of the African population and tempted to believe that aging did not require any intervention. This belief was also reinforced by the traditional safety net entitled to cater for the elderly and vulnerable members of the community. An increase in the proportion of the elderly as a result of a rise in life expectancy coupled with the prospect of the demise of the extended family has revived the desire to reconsider this standpoint. This flame has been ignited by a rise in the number of lobby groups and more than two decades of awareness. Scholars have come on board, with an ever-growing number of publications that highlight challenges that loom large as a result of population aging in the continent.

At present, there is a gradual increase in the proportion of older people across the continent. Although the growth rate is not uniformly experienced, population aging has become a reality. Indeed, some regions have already recorded a significant growth rate while others are still lagging far behind. Population aging is a developing issue that requires to be attended to

ease its challenges and impact. Aging is one of the inevitable processes of human development, working on providing the elderly with more accommodating conditions can result in improved well-being. In doing so, the elderly can expect to age healthy and become less dependent on family members as well as other social networks.

In the developing world, population aging leads to more concern about the fate of the elderly. Old age is equated with vulnerability, having more older people is likely to be translated into growing vulnerability, particularly, in the absence of policy development and efficient public welfare institutions. Speaking about the modernisation theory and abandonment of the aged, this study could not confirm the abandonment of the elderly as posited by the theory. Providing support is indeed costly and unaffordable for a substantial number of adult children. They face challenges such as poverty and unemployment, as a result, they are compelled to focus on their nuclear family or immediate dependent. On the other hand, those who are involved in income-generating activities tend to support the elderly more. This highlights the selective character of old age support that is solely based on individuals' purchasing power and willingness. The prospect of receiving financial support or gifts is not evenly distributed since some older people end up struggling while others are looked after in an acceptable manner. The worse outcome appears to be recorded by childless older people who have nearly no one to provide for them. It is worth mentioning that adult children tend to keep in touch with their parents although they do not live under the same roof.

The means-tested public transfer cash has provided the elderly with a stable source of income and made them less financially dependent on family members. This scheme has the merit of funding alternative facilities, such as old age homes, used to house poor older people. It plays an important role in health and well-being in old age. Vulnerable older people without supportive family members or who cannot afford decent accommodation find a place to call home; old age residence. Every effort is made to provide support for the elderly, to the extent of matching the amount of support they would have received from their family members or adult children. However, in terms of setbacks, old age homes have limited intake and cannot accommodate people without a source of income. This feature contrasts with the traditional safety that was made at the expense of family members and could absorb a significant number of the elderly.

Traditionally, intergenerational support was achieved through co-residing. The outbreak of the HIV/AIDS epidemic and its high prevalence in the southern and sub-Saharan African region has challenged the traditional support net. The death of young adults as a result of AIDS has deprived the elderly of crucial support. The vacuum created by this epidemic has turned them into caregivers of sick adult children and surrogate parents of orphaned grandchildren. In a sense, the elderly were forced to come out of retirement and become primary breadwinners. This highlights the vulnerability and volatility of this intergenerational support. From a socio-demographic point of view, the challenges experienced by the traditional support net of the elderly are twofold. Firstly, it is based on the generosity or willingness of adult children. The likelihood of receiving support cannot be predicted since it is a private matter that cannot be regulated. Secondly, a reduction in the supply of young adults, notably a decline in fertility and an increase in the proportion of the elderly represent a serious threat to its sustainability. All these factors seem to highlight the importance of more public involvement in the support of the elderly to improve their well-being.

Old age is accompanied by an increase in the frequency of utilisation of health services, the elderly tend to have more health visits than other age groups. On average, the elderly suffering from a chronic condition have one monthly visit to a health care facility for collecting medication and one every six months for consulting with the doctor. Depending on the type of medical condition, they can have more than one medical appointment a month. Compared to the 18-29 age group; the utilisation of health care services in old age can be close to three times high. This increase in the demand for health care services holds true for in-patients as well as out-patients. Furthermore, health in old age is intertwined with the present and past lifestyle. Although they were aware of this reality, a substantial proportion of the elderly is still leading an unhealthy lifestyle. They tend to change their lifestyles once diagnosed with a chronic condition. In contrast, there was only a marginal share of older people who engage in physical exercise. Mostly, they favour activities that require less energy expenditure such as walking.

Although the elderly do not disburse any money to receive treatment in public health care facilities, they still face several challenges when it comes to accessing health care services. Unless they live within walking distance, transport fare can represent a serious deterrent, especially, when they have to keep several medical appointments. Their condition can represent another puzzle, particularly for those who have mobility issues or disabilities. It is

difficult for wheelchair users to get adequate public transport especially, in rural areas. In addition, public health care facilities are not only congested but also less accommodating for the elderly. Regardless of their poor health, older patients are at risk of compromising their well-being since they are treated like any person who seeks health care. They are expected to queue for long hours and follow the protocol as every patient. The attitude of health care workers towards them is an additional hurdle, ill-treatment, and poor interaction are put forward as some of the factors that deter the elderly from seeking health care.

This study has discussed the concept of old which contrasts sharply with what is commonly used by governments in the developing world. The elderly tend to describe old age according to others, this fact highlights their attempt to dissociate themselves from the label old. They regard chronological age as a number that does not have much to do with old age if taken separately or in isolation from other features. To be more specific, using chronological age as a basis to describe old age leads to assuming that the age group 60 years and older is homogeneous. In a sense, this homogeneity results in the uniformity of the trajectory of aging or leads every person to age in the same way. Yet, it can be confidently asserted that the elderly belong to a heterogeneous age group since the process of aging affects different people in various ways. Labelling every individual who turns 60 older people is regarded as misleading and fails to provide a comprehensive description of this concept.

It is argued that a person becomes older when he or she is unable to live independently. Understandably, health is regarded as an important feature of the aging process. An independent pensioner cannot be labelled an older person. Incapacitating illnesses are put forward as the major cause of old age. This is to say as long as a person does not represent a burden for others, there is no need to label him or her old. Likewise, the study has attempted to highlight the difference between functional and chronological aging. It was found that a person can be chronologically older but functionally younger. By the same token, a chronologically old person can look younger than others who belong to a young birth cohort.

It appears clear that the concept of old needs to be rethought to comply with the challenges inherent in aging. Besides addressing the concern of the concept of old, it is crucial to highlight that old age has an intrinsic cultural dimension. A better definition is believed to be representative of every society. Without placing much emphasis on chronological age, an older person is described as an individual who has contributed to the survival of his or her

community by procreating and ensuring that the future of the community is not in jeopardy. More importantly, they should live long enough to see their grandchildren and eventually great-grandchildren. Culturally speaking, old age confers honour upon the elderly for their contribution to the survival of the community.

Suggestions and recommendations

Although aging is one of the human development stages, it is still perceived as an illness. Every effort should be made to avoid treating the elderly in a stereotypical way. Training health care workers and making them more knowledgeable about old age can help change this perception. Furthermore, the elderly are vulnerable and require to be treated differently during their medical appointments. Shortening their visits by giving them preference over less sickly patients appears to be one of the ways of alleviating their discomfort. For instance, arranging collective medical appointments, scheduling every older person who collects medication regularly can help ease their burden.

Lifestyle is an important feature of health in old age, the rate of obesity in old age seems to be alarming. A change in lifestyle is one of the best ways of tackling this problem, particularly physical exercise. Raising awareness in this regard can help improve their well-being. A lack of a facility appears to deter them from exercising especially when they have to walk for a long distance. Providing them with a gym facility or an outdoor space can motivate those who are reluctant to become active, especially, during winter months or inclement weather. Disabled older people are less likely to be knowledgeable about the type of physical exercise that can accommodate their condition, training them on a specific activity can be beneficial. Furthermore, rethinking the concept of old appears to be an important step towards addressing the challenges of the elderly. Globally, a better definition should take into consideration the heterogeneity of culture and society as well as functional aging.

This research has benefited from extensive data on old age in South Africa. It is one of the first studies that make use of mixed methods to investigate challenges inherent in health in old age. The combination of qualitative and quantitative data has provided further insights into the aging debate and sheds light on some of the issues that could not be explored using one method. This study has the merit of giving the voice to the elderly in an attempt to gain insights into their perception of the concept of old. On the other hand, it is worth mentioning

that the amount of missing data in the quantitative component did not help capture the extent to which the elderly benefit from the support of their family members. Nonetheless, the availability of data on the state pension recipients has helped circumvent this challenge since it was used as an alternative. The qualitative component has the merit of highlighting the reason for support and the type of family members who are very instrumental in this regard. Conducting further investigation can help understand the extent to which family members are still involved in providing support for the elderly.

References

Abioye, A., Isanaka, S., Liu, E., Mwiru, R., Noor, R., Spiegelman, D., . . . Fawzi, W. (2015). Gender differences in diet and nutrition among adults initiating antiretroviral therapy in Dar es Salaam, Tanzania. *AIDS care, 27*(6), 706-715.

Aboderin, I. (2000). *Social change and the decline in family support for older people in Ghana: An investigation of the nature and causes of shifts in support.* (PhD in Social Sciences Ph.D thesis), University of Bristol, Bristol.

Aboderin, I. (2004). Modernisation and ageing theory revisited: Current explanations of recent developing world and historical Western shifts in material family support for older people. *Ageing and Society, 24*, 29-50.

Aboderin, I. (2010). Understanding and advancing the health of older populations in sub-Saharan Africa: Policy perspectives and evidence needs. *Public Health Reviews, 32*(2), 357.

Aboderin, I. (2012). Ageing Africa: Opportunities for development. *Global Population Ageing: Peril or Promise?, 161*(242), 69.

Aboderin, I. (2017). *Intergenerational support and old age in Africa*. New York: Routledge.

Aboderin, I., & Kizito, P. (2010). Dimensions and determinants of health in old age in Kenya. *Nairobi: National Coordinating Agency for Population and Development*.

Adibelli, D., & Kılıç, D. (2013). Difficulties experienced by nurses in older patient care and their attitudes toward the older patients. *Nurse education today, 33*(9), 1074-1078.

Adkisson, J., Hill, J., Korber, D., & Vogel, N. (2011). *Caregiver roulette: California fails to screen those who care for the elderly at home* Sacramento, CA California Senate Office of Oversight and Outcomes

Akanbi, A. (2014). *Variations in Old Age Support in an Urbanising Society: A Study of South-Western Nigeria.* Covenant University, Ota,

Akosile, C., Mgbeojedo, U., Maruf, F., Okoye, E., Umeonwuka, I., & Ogunniyi, A. (2018). Depression, functional disability and quality of life among Nigerian older adults: Prevalences and relationships. *Archives of gerontology and geriatrics, 74*, 39-43.

Alambo, F. I., & Yimam, H. T. A. (2019). Elderly care and social support systems among the Gedeo of Southern Ethiopia: Socio-cultural contexts, forms, dynamics and challenges. *African Studies Quarterly, 18*(3), 15-28.

Alexander, J. A., Hearld, L. R., Mittler, J. N., & Harvey, J. (2012). Patient–physician role relationships and patient activation among individuals with chronic illness. *Health services research, 47*(3), 1201-1223.

American College of Sports Medicine, Chodzko-Zajko, W. J. M., & Proctor, D. N. (2009). American College of Sports Medicine position stand: Exercise and physical activity for older adults. *Medicine and Science in Sports and Exercise, 41*(7), 1510–1530.

Apt, N. (1997). *Ageing in Africa*. Geneva: World Health Organisation.

Apt, N. (2012). Aging in Africa: Past experiences and strategic directions. *Ageing International, 37*(1), 93-103.

Apt, N. (2013). Older people in rural Ghana: Health and health seeking behaviours. In P. Maharaj (Ed.), *Aging and Health in Africa* (pp. 103-119). New York: Springer.

Ardington, C., & Gasealahwe, B. (2014). Mortality in South Africa: Socio-economic profile and association with self-reported health. *Development Southern Africa, 31*(1), 127-145.

Asada, Y., Whipp, A., Kindig, D., Billard, B., & Rudolph, B. (2014). Inequalities in multiple health outcomes by education, sex, and race in 93 US counties: Why we should measure them all. *International journal for equity in health, 13*(1), 47.

Ataguba, J. E.-O., & Alaba, O. (2012). Explaining health inequalities in South Africa: A political economy perspective. *Development Southern Africa, 29*(5), 756-764.

Ataguba, J. E., & McIntyre, D. (2012). Paying for and receiving benefits from health services in South Africa: Is the health system equitable? *Health policy and planning, 27*(suppl_1), i35-i45.

Atobrah, D. (2016). Elderly women, community participation and family care in Ghana: Lessons from HIV response and AIDS orphan care in Manya Krobo. *Ghana Studies, 19*(1), 73-94.

Austad, S. (2006). Why women live longer than men: Sex differences in longevity. *Gender medicine, 3*(2), 79-92.

Awasthi, P., & Mishra, R. (2007). Role of coping strategies and social support in perceived illness consequences and controllability among diabetic women. *Psychology and Developing Societies, 19*, 179-197.

Aye, S. K. K., Hlaing, H. H., Htay, S. S., & Cumming, R. (2019). Multimorbidity and health seeking behaviours among older people in Myanmar: A community survey. *PloS one, 14*(7), e0219543.

Ayokunle, A., Oyeyemi, F., Onipede, W., Femi, T., Olagunju, A., Makinde, G., . . . Oluwatomipe, A. (2015). The Definitions and Onset of an Old Person in South-Western Nigeria. *Educational Gerontology, 41*(7), 494-503.

Bacci, M. L. (2017). *A concise history of world population*. Hoboken, NJ: John Wiley & Sons.

Banerjee, S. (2015). *Multimorbidity-older adults need health care that can count past one* (Vol. 2019). Brighton: Centre for Dementia Studies, Brighton and Sussex Medical School, University of Sussex.

Barbosa, K., Costa, K., Pontes, M., Batista, P., Oliveira, F., & Fernandes, M. (2017). Aging and individual vulnerability: A panorama of older adults attended by the family health strategy. *Texto and Contexto-Enfermagem, 26*(2), e2700015.

Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: A critical review. *BMC medical research methodology, 9*(1), 59.

Barrientos, A. (2012). Social transfers and growth: What do we know? What do we need to find out? *World development, 40*(1), 11-20.

Barrientos, A., & Lloyd-Sherlock. (2002). Older and poorer? Ageing and poverty in the South. *Journal of International Development, 14*, 1129–1131.

Baruch, Y., Sayce, S., & Gregoriou, A. (2014). Retirement in a global labour market: A call for abolishing the fixed retirement age. *Personnel Review,, 43*(3), 464-482.

Bauer, U. E., Briss, P. A., Goodman, R. A., & Bowman, B. A. (2014). Prevention of chronic disease in the 21st century: Elimination of the leading preventable causes of premature death and disability in the USA. *The lancet, 384*, 45-52.

Bauernschuster, S., Driva, A., & Hornung, E. (2018). *Bismarck's health insurance and the mortality decline*. CESifo Working Paper No. 6601. Munich Society for the Promotion of Economic Research - CESifo GmbH.

Beard, J., Biggs, S., Bloom, D., Fried, L., Hogan, P., Kalache, A., & Olshansky, J. (2012). *Global population ageing: Peril or promise?* Retrieved from PGDA Working Paper No. 89. World Economic Forum: http://www.hsph.harvard.edu/pgda/working.htm

Beard, J., Officer, A., de Carvalho, I., Sadana, R., Pot, A., Michel, J.-P., . . . Mahanani, W. (2016). The World report on ageing and health: A policy framework for healthy ageing. *The lancet, 387*, 2145-2154.

Ben-Harush, A., Shiovitz-Ezra, S., Doron, I., Alon, S., Leibovitz, A., Golander, H., . . . Ayalon, L. (2017). Ageism among physicians, nurses, and social workers: Findings from a qualitative study. *European journal of ageing, 14*(1), 39-48.

Bengtson, V. (2018). *Global aging and challenges to families*. New York: Routledge.
Billings, J. (2006). Staff perceptions of ageist practice in the clinical setting: Practice development project. *Quality in Ageing and Older Adults, 7*(2), 33–45.
Boerma, T., Hosseinpoor, A., Verdes, E., & Chatterji, S. (2016). A global assessment of the gender gap in self-reported health with survey data from 59 countries. *BMC public health, 16*(1), 675.
Bor, J., Herbst, A. J., Newell, M.-L., & Bärnighausen, T. (2013). Increases in adult life expectancy in rural South Africa: valuing the scale-up of HIV treatment. *science, 339*(6122), 961-965.
Bowling, A., Gabriel, Z., Dykes, J., Dowding, L., Evans, O., Fleissig, A., . . . Sutton, S. (2003). Let's ask them: A national survey of definitions of quality of life and its enhancement among people aged 65 and over *Internation Journal of Aging and Human Development, 56*(4), 269-306.
Brandt, M. (2013). Intergenerational help and public assistance in Europe: A case of specialization? *European Societies, 15*(1), 26-56.
Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers? *International journal of qualitative studies on health and well-being, 9*. doi:10.3402/qhw.v9.26152.
Bremner, J., Frost, A., Haub, C., Mather, M., Ringheim, K., & Zuehlke, E. (2010). World population highlights: Key findings from PRB's 2010 World Population Data Sheet. *Population Bulletin, 65*(2), 1-14.
Brophy, T., Branson, N., Daniels, R. C., Leibbrandt, M., Mlatsheni, C., & Woolard, I. (2018). National Income Dynamics Study panel user manual [Press release]
Bryman, A. (2006). Integrating quantitative and qualitative research: How is it done? *Qualitative Research, 6* (1), 97–113.
Burgess, E. (1960). *Ageing in western societies*. Chicago: University of Chicago Press.
Burgess, E. W., & Locke, H. J. (1954). *The family*. New York: American Book Company.
Bytheway, B. (2005). Age-identities and the celebration of birthdays. *Ageing and Society, 25*(4), 463-477. doi:10.1017/S0144686X05003831
Cacioppo, J. T., & Cacioppo, S. (2014). Social relationships and health: The toxic effects of perceived social isolation. *Social and Personality Psychology Compass, 8*, 58-72.
Campbell, N. R. C., Bovet, P., Schutte, A. E., Lemogoum, D., & Nkwescheu, A. S. (2015). High blood pressure in sub-Saharan Africa: Why prevention, detection, and control are urgent and important. *The Journal of Clinical Hypertension, 17*(9), 663-667. doi:10.1111/jch.12599
Canvin, K., MacLeod, C. A., Windle, G., & Sacker, A. (2018). Seeking assistance in later life: How do older people evaluate their need for assistance? *Age and ageing, 47*(3), 466-473.
Cardoso, S. W., Torres, T. S., Santini-Oliveira, M., Marins, L. M. S., Veloso, V. G., & Grinsztejn, B. (2013). Aging with HIV: A practical review. *The Brazilian Journal of Infectious Diseases, 17*(4), 464-479.
Carr, D., & Springer, K. (2010). Advances in families and health research in the 21st century. *Journal of Marriage and Family, 72*(3), 743-761.
Carstensen, L. (2011). *A long bright future: Happiness, health, and financial security in an age of increased longevity*. New York: Public affairs.
Castrogiovanni, P., Di Rosa, M., Ravalli, S., Castorina, A., Guglielmino, C., & Imbesi, R. (2019). Moderate physical activity as a prevention method for knee osteoarthritis and the role of synoviocytes as biological key. *Int J Mol Sci, 20*(3).
Central Intelligence Agency. (2018). *The world fact-book, Nigeria* Retrieved from https://www.cia.gov/library/publications/the-world-factbook/geos/ni.html

Chambaere, K., Rietjens, J. A., Smets, T., Bilsen, J., Deschepper, R., Pasman, H. R. W., & Deliens, L. (2012). Age-based disparities in end-of-life decisions in Belgium: A population-based death certificate survey. *BMC public health, 12*(1), 1.

Chastin, S., Buck, C., Freiberger, E., Murphy, M., Brug, J., & Cardon, G. (2015). Systematic literature review of determinants of sedentary behaviour in older adults: A DEDIPAC study. *Int J Behav Nutr Phys Act, 12*(1), 127.

Chatters, L., Taylor, R., Woodward, A., & Nicklett, E. (2015). Social support from church and family members and depressive symptoms among older African Americans. *The American Journal of Geriatric Psychiatry, 23*(6), 559-567.

Chen, J.-H., Waite, L., & Lauderdale, D. (2015a). Marriage, relationship quality, and sleep among US older adults. *Journal of health and social behavior, 56*(3), 356-377.

Chen, W., Qian, W., Wu, G., Chen, W., Xian, B., Chen, X., . . . Tang, K. (2015b). Three-dimensional human facial morphologies as robust aging markers. *Cell research, 25*(5), 574-587.

Chen, Y.-Y., Walker, R., & Hong, L. (2018). Subjective experiences of older adults in poverty in urban China and the role of social policy. *Asia Pacific Journal of Social Work and Development, 28*(1), 1-14.

Chepngeno-Langat, G., Falkingham, J., Madise, N. J., & Evandrou, M. (2010). Socioeconomic differentials between HIV caregivers and noncaregivers: Is there a selection effect? A case of older people living in Nairobi city slums. *Research on Aging, 32*(1), 67-96.

Cherry, K., Walker, E., Brown, J., Volaufova, J., LaMotte, L., Welsh, D., . . . Wood, R. (2013). Social engagement and health in younger, older, and oldest-old adults in the Louisiana healthy aging study. *Journal of Applied Gerontology, 32*(1), 51-75.

Cho, J., Martin, P., & Poon, L. (2015). Successful aging and subjective well-being among oldest-old adults. *Gerontologist, 55*(1), 132-143.

Clark, S. J., Gomez-Olive, F., Houle, B., Thorogood, M., Klipstein-Grobusch, K., Angotti, N., . . . Tollman, S. (2015). Cardiometabolic disease risk and HIV status in rural South Africa: Establishing a baseline. *BMC public health, 15*, 135.

Cloos, P., Allen, C. F., Alvarado, B. E., Zunzunegui, M. V., Simeon, D. T., & Eldemire-Shearer, D. (2010). 'Active ageing': A qualitative study in six Caribbean countries. *Ageing and Society, 30*(1), 79-101.

Cobb, S. (1976). Social support as a moderator of life stress. *Psychosomatic medicine, 38*(5), 300-314.

Cohen, S., & McKay, G. (1984). Social support, stress and the buffering hypothesis: A theoretical analysis. *Handbook of psychology and health, 4*, 253-267.

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin, 98*, 310-357.

Collins, M., & Lienhardt, H. B. (2014). *Research brief: Program impact and implications for policy and practice* (Vol.). University of Wisconsin-Madison: AARP Foundations.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The health and health system of South Africa: Historical roots of current public health challenges. *The lancet, 374*(9692), 817-834.

Cowgill, D. O., & Holmes, L. D. (1972). *Ageing and Modernization*. New York: Appleton-Century-Crofts.

Davey, J. (2017). *Age-friendly cities and communities: World experience and pointers for New Zealand*. Wellington: Ministry of Social Development.

Dayton, J., & Ainsworth, M. (2004). The elderly and AIDS: Coping with the impact of adult death in Tanzania. *Social Science and Medicine, 59*(10), 2161-2172.

de-Graft Aikins, A., Unwin, N., Agyemang, C., Allotey, P., Campbell, C., & Arhinful, D. (2010). Tackling Africa's chronic disease burden: From the local to the global. *Globalization and Health, 6*, 5.

Deindl, C., & Brandt, M. (2017). Support networks of childless older people: Informal and formal support in Europe. *Ageing and Society, 37*(8), 1543-1567.

Dhemba, J., & Dhemba, B. (2015). Ageing and care of older persons in Southern Africa: Lesotho and Zimbabwe compared. *Social Work and Society, 13*(2).

Di Cesare, M., Khang, Y.-H., Asaria, P., Blakely, T., Cowan, M. J., Farzadfar, F., . . . Ezzati, M. (2013). Inequalities in non-communicable diseases and effective responses. *The Lancet, 381*(9866), 585-597. doi:10.1016/s0140-6736(12)61851-0

Dias, G. N. F., Couceiro, M. S., Mendes, P., & Almeida, M. d. L. (2017). "Physical activity benefits in active ageing," in Active Ageing and Physical Activity Guidelines, Functional Exercises and Recommendations. In G. N. F. Dias & M. S. Couceiro (Eds.), *SpringerBriefs in Well-Being and Quality of Life Research* (pp. 21-34). Cham, Switzerland: Springer International Publishing.

Dilworth-Anderson, P., & Gibson, B. E. (2002). The cultural influence of values, norms, meanings, and perceptions in understanding dementia in ethnic minorities. *Alzheimer Disease and Associated Disorders, 16*, S56-S63.

Dilworth-Anderson, P., Pierre, G., & Hilliard, T. S. (2012). Social justice, health disparities, and culture in the care of the elderly. *The Journal of Law, Medicine and Ethics, 40*(1), 26-32.

Doody, O., & Noonan, M. (2013). Preparing and conducting interviews to collect data. *Nurse researcher, 20*(5), 28-32.

Doshi, D., Hanneman, K., & Cooper, K. (2007). Smoking and skin aging in identical twins. *Archives of dermatology, 143*(12), 1543-1546.

Drewes, Y., den Elzen, W., Mooijaart, S., de Craen, A., Assendelft, W., & Gussekloo, J. (2011). The effect of cognitive impairment on the predictive value of multimorbidity for the increase in disability in the oldest old: The Leiden 85-plus Study. *Age and ageing, 40*(3), 352-357.

Drucker, P. (2017). *The pension fund revolution*. New York: Routledge.

Drury, L., Abrams, D., Swift, H. J., Lamont, R. A., & Gerocova, K. (2017). Can caring create prejudice? An investigation of positive and negative intergenerational contact in care settings and the generalisation of blatant and subtle age prejudice to other older people. *Journal of Community and Applied Social Psychology, 27*(1), 65-82.

Ebbinghaus, B. (2015). The privatization and marketization of pensions in Europe: A double transformation facing the crisis. *European Policy Analysis, 1*(1), 56-73.

Engelgau, M. M., Sameh El-Saharty, P., Kudesia, V. R., Rosenhouse, S., & Okamoto, K. (2011). Rationale for action. In M. M. Engelgau, P. Sameh El-Saharty, V. R. Kudesia, S. Rosenhouse, & K. Okamoto (Eds.), *In Capitalizing on Demographic Transition:Tackling Noncommunicable Diseases in South Asia*. Washington, DC: World Bank.

Enstrom, J., & Breslow, L. (2008). Lifestyle and reduced mortality among active California Mormons, 1980–2004. *Preventive medicine, 46*(2), 133-136.

Evans, B., & Palacios, R. (2015). *An examination of elderly co-residence in the developing world*. Washington D.C: World Bank.

Evert, A. B., Boucher, J. L., Cypress, M., Dunbar, S. A., Franz, M. J., Mayer-Davis, E. J., . . . Jr, W. S. Y. (2014). Nutrition therapy recommendations for the management of adults with diabetes. *Diabetes Care, 37*, S120-S143.

Ezeh, A. C., Bongaarts, J., & Mberu, B. (2012). Global population trends and policy options. *The Lancet, 380*(9837), 142-148.

Faye, O., & Andrade, G. (2018). The Madrid international plan of action on ageing: Where do we stand fifteen years later? Experience and lessons from selected countries in West and Central Africa. *International Journal on Ageing in Developing Countries, 2*(2), 153-172.

Fejerman, L., John, E. M., Huntsman, S., Beckman, K., Choudhry, S., Perez-Stable, E., . . . Ziv, E. (2008). Genetic ancestry and risk of breast cancer among US Latinas. *Cancer research, 68*(23), 9723-9728.

Ferris, R., Blaum, C., Kiwak, E., Austin, J., Esterson, J., Harkless, G., . . . Tinetti, M. (2018). Perspectives of patients, clinicians, and health system leaders on changes needed to improve the health care and outcomes of older adults with multiple chronic conditions. *Journal of aging and health, 30*(5), 778-799.

Flores, G., Lin, H., Walker, C., Lee, M., Currie, J., Allgeyer, R., . . . Massey, K. (2017). The health and healthcare impact of providing insurance coverage to uninsured children: A prospective observational study. *BMC public health, 17*(1), 553.

Fonchingong, C. C. (2013). On the fringe of poverty: Care arrangements for older people in Rural Cameroon. In P. Maharaj (Ed.), *Aging and Health in Africa* (pp. 157-170). New York: Springer.

Fonta, C. L., Nonvignon, J., Aikins, M., Nwosu, E., & Aryeetey, G. C. (2017). Predictors of self-reported health among the elderly in Ghana: a cross sectional study. *BMC geriatrics, 17*, 171.

Fox, M. P., Pascoe, S. J., Huber, A. N., Murphy, J., Phokojoe, M., Gorgens, M., . . . Fraser-Hurt, N. (2018). Assessing the impact of the National Department of Health's National Adherence Guidelines for Chronic Diseases in South Africa using routinely collected data: a cluster-randomised evaluation. *BMJ Open, 8*(1), e019680.

French, D., Sargent-Cox, K., & Luszcz, M. (2012). Correlates of subjective health across the aging lifespan: Understanding self-rated health in the oldest old. *Journal of aging and health, 24*(8), 1449-1469.

Frenk, J. (2010). The global health system: Strengthening national health systems as the next step for global progress. *PLoS medicine, 7*(1), e1000089.

Gaskin, C., & Orellana, L. (2018). Factors associated with physical activity and sedentary behavior in older adults from six low-and middle-income countries. *International journal of environmental research and public health, 15*(908).

Germiston City News. (2018, 10 April). Elderly residents must be aware of criminals and take precautions. *Germiston City News*. Retrieved from https://germistoncitynews.co.za/176371/elderly-residents-must-aware-criminals-take-precautions/

Gilleard, C., & Higgs, P. (2005). *Contexts of ageing: Class, cohort and community*. Cambridge: Polity.

Gilmour, H. (2012). Social participation and the health and well-being of Canadian seniors. *Health Reports, 23*(4), 23-32.

Ginter, E., & Simko, V. (2013). Women live longer than men. *Bratislavske lekarske listy, 114*(2), 45-49.

Glei, D., & Horiuchi, S. (2007). The narrowing sex differential in life expectancy in high-income populations: Effects of differences in the age pattern of mortality. *Population Studies, 61*(2), 141-159.

Gobbo, L. C. D., Kalantarian, S., Imamura, F., Lemaitre, R., Siscovick, D. S., Psaty, B. M., & Mozaffarian, D. (2015). Contribution of major lifestyle risk factors for incident heart failure in older adults: The cardiovascular health study. *JACC: Heart Failure, 3*(7), 520-528.

Goldman, D. P., Chen, C., Zissimopoulos, J., & Rowe, J. W. (2018). Opinion: Measuring how countries adapt to societal aging. *Proceedings of the National Academy of Sciences of the United States of America, 115*(3), 435-437.

Gómez-Olivé, F., Angotti, N., Houle, B., Klipstein-Grobusch, K., Kabudula, C., Menken, J., . . . Clark, S. (2013). Prevalence of HIV among those 15 and older in rural South Africa. *AIDS care, 25*(9), 1122-1128.

Gomez-Olive, F. X., Thorogood, M., Clark, B., Kahn, K., & Tollman, S. (2013). Self-reported health and health care use in an ageing population in the Agincourt sub-district of rural South Africa. *Global health action, 6*(1), 19305.

Goodenough, W. H. (1981). *Culture, language, and society*. Menlo Park, CA: Benjamin Cummings.

Gore, S. (1981). Stress-buffering functions of social supports: An appraisal and clarification of research models. In S. Dohrenwend & P. Dohrenwend (Eds.), *Stressful life events and their contexts* (pp. 202-222). New York: Prodist.

Gorman, M. (2017). Development and the rights of older people. In J. Randel, T. German, & D. Ewing (Eds.), *The ageing and development report: Poverty, independence and the world's older people* (pp. 21-39). London: Routledge.

Govender, T., & Barnes, J. (2014). The health status and unmet health needs of old-age pensioners living in selected urban poor communities in Cape Town, South Africa. *Journal of community health, 39*(6), 1063-1070.

Grignon, M., & Spencer, B. (2015). On Removing "age" and especially "old age" as a criterion in social programs. *Canadian Public Policy, 41*(3), 241-251.

Griswold, M., Fullman, N., Hawley, C., Arian, N., Zimsen, S., Tymeson, H., . . . Salama, J. (2018). Alcohol use and burden for 195 countries and territories, 1990–2016: A systematic analysis for the Global Burden of Disease Study 2016. *The lancet, 392*(10152), 1015-1035.

Grundy, E., & Murphy, M. (Eds.). (2018). *Population ageing in Europe*. New York: Oxford University Press.

Gu, H., Kou, Y., You, H., Xu, X., Yang, N., Liu, J., . . . Li, X. (2019). Measurement and decomposition of income-related inequality in self-rated health among the elderly in China. *International journal for equity in health, 18*(4), 1.

Haas, S., Krueger, P., & Rohlfsen, L. (2012). Race/ethnic and nativity disparities in later life physical performance: The role of health and socioeconomic status over the life course. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 67*(2), 238-248.

Hairault, J.-O., Sopraseuth, T., & Langot, F. (2010). Distance to retirement and older workers 'employment: The case for delaying the retirement age. *Journal of the European Economic association, 8*(5), 1034-1076.

Harling, G., Morris, K., Manderson, L., Perkins, J., & Berkman, L. (2018). Age and gender differences in social network composition and social support among older rural South Africans: Findings from the HAALSI study. *The Journals of Gerontology: Series B*.

Haskins, J., Phakathi, S., Grant, M., & Horwood, C. (2014). Attitudes of nurses towards patient care at a rural district hospital in the KwaZulu-Natal province of South Africa. *Africa Journal of Nursing and Midwifery, 16*(1), 32-44.

Hawkley, L., Preacher, K., & Cacioppo, J. (2010). Loneliness impairs daytime functioning but not sleep duration. *Health Psychology, 29*(2), 124-129.

He, W., Goodkind, D., & Kowal, P. (2016). *An aging world: 2015*. U.S. Census Bureau, International Population Reports, P95/16-1, Washington, DC: U.S. Government Publishing Office,.

Heinze, J., Kruger, D., Reischl, T., Cupal, S., & Zimmerman, M. (2015). Relationships among disease, social support, and perceived health: A lifespan approach. *American journal of community psychology, 56*(3-4), 268-279.

Heise, L., Greene, M. E., Opper, N., Stavropoulou, M., Harper, C., Nascimento, M., & Zewdie, D. (2019). Gender inequality and restrictive gender norms: Framing the challenges to health. *Lancet, 393*, 2440–2454.

HelpAge International. (2010). *A study of older people's livelihoods in Ethiopia. London: HelpAge International* London: HelpAge International

HelpAge International. (2014). *Older people count: Making data fit for purpose*. London: HelpAge International.

HelpAge International UK. (2017). *Report of trustees and annual accounts 2016/17*. London: HelpAgen International.

Hepworth, M. (2000). *Stories of ageing*. Buckingham: Open University Press

Hilz, R., & Wagner, M. (2018). Marital status, partnership and health behaviour: Findings from the German Ageing Survey (DEAS). *Comparative Population Studies-Zeitschrift für Bevölkerungswissenschaft, 43*, 65-97.

Hogerzeil, H. V., Liberman, J., Wirtz, V. J., Kishore, S. P., Selvaraj, S., Kiddell-Monroe, R., . . . Group, L. N. A. (2013). Promotion of access to essential medicines for non-communicable diseases: Practical implications of the UN political declaration. *The lancet, 381*(9867), 680-689.

Holloway, I., & Wheeler, S. (2010). *Qualitative research in nursing and healthcare* (Third ed.). Oxford: Wiley-Blackwell.

HoltLunstad, J., & Uchino, B. (2015). Social support and health In k. Glanz, B. Rimer, & K. Viswanath (Eds.), *Health Behavior: Theory, Research, and Practice* (pp. 183-204). San Francisco: John Wiley and Sons.

Hosseinpoor, A., Williams, J., Amin, A., De Carvalho, I., Beard, J., Boerma, T., . . . Chatterji, S. (2012). Social determinants of self-reported health in women and men: Understanding the role of gender in population health. *PloS one, 7*(4), e34799.

House, J. S. (1981). *Work stress and social support*. Reading, MA: Addison-Wesley.

Hovey, J., Hurtado, G., Morales, L., & Seligman, L. (2014). Religion-based emotional social support mediates the relationship between intrinsic religiosity and mental health. *Archives of suicide research, 18*(4), 376-391.

Hung, W., Ross, J., Boockvar, K., & Siu, A. (2011). Recent trends in chronic disease, impairment and disability among older adults in the United States. *BMC geriatrics, 11*(1), 47.

Hunter, N., & May, J. (2013). Ageing in Post-Apartheid South Africa: An Analysis of the "Nearly Old". In P. Maharaj (Ed.), *Aging and Health in Africa* (pp. 171-196). New York: Springer.

Hupin, D., Roche, F., Gremeaux, V., Chatard, J.-C., Oriol, M., Gaspoz, J.-M., . . . Edouard, P. (2015). Even a low-dose of moderate-to-vigorous physical activity reduces mortality by 22% in adults aged ≥60 years: A systematic review and meta-analysis. *British Journal of Sports Medicine, 49*(19), 1262-1267. doi:10.1136/bjsports-2014-094306

Hurst, L., Stafford, M., Cooper, R., Hardy, R., Richards, M., & Kuh, D. (2013). Lifetime socioeconomic inequalities in physical and cognitive aging. *American Journal of Public Health, 103*(9), 1641-1648.

Hussey, M., MacLachlan, M., & Mji, G. (2017). Barriers to the implementation of the health and rehabilitation articles of the United Nations convention on the rights of persons with disabilities in South Africa. *Internation Journal of Health Policy and Management, 6*(4), 207-218.

Ibanez-Gonzalez, L., & Norris, S. (2013). Chronic non-communicable disease and healthcare access in middle-aged and older women living in Soweto, South Africa. *PloS one, 8*(10), e78800.

International Labour Office. (2016). *South Africa: Older person's grant*. Geneva: International Labour Organisation.

International Labour Organisation. (2017). *World social protection report 2017-19: Universal social protection to achieve the sustainable development goals*. Geneva: International Labour Office.

International Labour Organisation. (2018). *Employment situation in Latin America and the Caribbean: Labour market participation of older persons, needs and options*. Santiago: United Nations.

Islam, M. K., Gerdtham, U. G., Clarke, P., & Burström, K. (2010). Does income-related health inequality change as the population ages? Evidence from Swedish panel data. *Health economics, 19*(3), 334-349.

Ismail, Z., & Kollamparambil, U. (2015). Youth unemployment duration and competing exit states: What hides behind long spells of black youth unemployment in South Africa? *African Development Review, 27*(3), 301-314.

Jackson, R., Howe, N., & Nakashima, K. (2010). *The global aging preparedness index*. Washington, DC: Center for Strategic and International Studies.

Jackson, R., Howe, N., & Peter, T. (2013). *The global aging preparedness index*. Washington, DC: Rowman & Littlefield.

Jacob, M. E., Yee, L. M., Diehr, P. H., Arnold, A. M., Thielke, S. M., Chaves, P. H. M., . . . Newman, A. B. (2016). Can a healthy lifestyle compress the disabled period in older adults. *JAGS, 64*(10), 1952–1961.

Jain, Pawar, A., Ravjibhai, H., & Bansal, R. (2010). Morbidity profile of elderly people in slums of surat city. *National Journal of Community Med, 1*(1), 53-54.

Jakovljevic, M., & Laaser, U. (2015). Population aging from 1950 to 2010 in seventeen transitional countries in the wider region of South Eastern Europe. *SEEJPH*. doi:10.12908/SEEJPH-2014-423

Jakovljevic, M., Potapchik, E., Popovich, L., Barik, D., & Getzen, T. (2017). Evolving health expenditure landscape of the BRICS nations and projections to 2025. *Health economics, 26*(7), 844-852.

Jankovic, J., Mirkovic, M., Jovic-Vranes, A., Santric-Milicevic, M., & Terzic-Supic, Z. (2018). Association between non-communicable disease multimorbidity and health care utilization in a middle-income country: Population-based study. *Public Health, 155*, 35-42.

Johnson, B., Onwuegbuzie, A., & Turner, L. (2007). Toward a definition of mixed methods research. *Journal of Mixed Methods Research, 1*, 112. doi:10.1177/1558689806298224

Johnson, J. M. (Ed.) (2002). *In-depth interviewing.* California: Sage Publications, Inc.

Jones, R. L. (2006). 'Older people'talking as if they are not older people: Positioning theory as an explanation. *Journal of Aging Studies, 20*(1), 79-91.

Kahn, K., Collinson, M., Gómez-Olivé, X., Mokoena, O., Twine, R., Mee, P., . . . Khosa, A. (2012). Profile: Agincourt health and socio-demographic surveillance system. *International journal of epidemiology, 41*(4), 988-1001.

Kalmijn, M. (2017). The ambiguous link between marriage and health: A dynamic reanalysis of loss and gain effects. *Social Forces, 95*(4), 1607-1636.

Kalomo, E., & Liao, M. (2018). Burden of care among caregivers of persons living with HIV/AIDS in rural Namibia: Correlates and outcomes. *Social work in public health, 33*(1), 70-84.

Karimli, L., Ssewamala, F. M., & Ismayilova, L. (2012). Extended families and perceived caregiver support to AIDS orphans in Rakai district of Uganda. *Children and Youth Services Review, 34*, 1351-1358.

Kasedde, S., Doyle, A. M., Seeley, J. A., & Ross, D. A. (2014). They are not always a burden: Older people and child fostering in Uganda during the HIV epidemic. *Social Science and Medicine, 113*, 161–168. doi:10.1016/j.socscimed.2014.05.002.

Kasiram, M., & Hölscher, D. (2015). Understanding the challenges and opportunities encountered by the elderly in urban KwaZulu-Natal, South Africa. *South African Family Practice, 57*(6), 380-385.

Kautz, T., Bendavid, E., Bhattacharya, J., & Miller, G. (2010). AIDS and declining support for dependent elderly people in Africa: Retrospective analysis using demographic and health surveys. *BMJ, 340*, c2841.

Keehan, S., Stone, D., Poisal, J., Cuckler, G., Sisko, A., Smith, S., . . . Lizonitz, J. (2017). National health expenditure projections, 2016–25: Price increases, aging push sector to 20 percent of economy. *Health Affairs, 36*(3), 553-563.

Kelley, A. S., Deb, P., Du, Q., Aldridge Carlson, M. D., & Morrison, R. S. (2013). Hospice enrollment saves money for Medicare and improves care quality across a number of different lengths-of-stay. *Health Affairs, 32*(3), 552-561.

Kelley, S. J., Whitley, D. M., & Campos, P. E. (2010). Grandmothers raising grandchildren: Results of an intervention to improve health outcomes. *Journal of Nursing Scholarship, 42*(4), 379-386.

Kerr, A. (2017). Tax (i) ing the poor? Commuting costs in South African cities. *South African Journal of Economics, 85*(3), 321-340.

Kim, K., Cheng, Y.-P., Zarit, S. H., & Fingerman, K. L. (2015). Relationships between adults and parents in Asia. In S. Cheng, I. Chi, H. Fung, L. Li, & J. Woo (Eds.), *Successful Aging* (pp. 101-122). Dordrecht: Springer.

Kim, Y., & Warner, M. (2016). Pragmatic municipalism: Local government service delivery after the great recession. *Public Administration, 94*(3), 789-805.

Kinsella, K., & He, W. (2009). US Census Bureau, international population reports. *Washington, DC: US Census Bureau*.

Klenk, J., Keil, U., Jaensch, A., Christiansen, M., & Nagel, G. (2016). Changes in life expectancy 1950–2010: Contributions from age-and disease-specific mortality in selected countries. *Population health metrics, 14*(1), 20.

Knodel, J. (2014). Is intergenerational solidarity really on the decline? Cautionary evidence from Thailand. *Asian Population Studies, 10*(2), 176-194.

Knodel, J., & Im-Em, W. (2004). The economic consequences for parents of losing an adult child to AIDS: Evidence from Thailand. *Social Science and Medicine, 59*(5), 987-1001.

Knodel, J., Teerawchitchainan, B., Prachuabmoh, V., & Pothisiri, W. (2015). *The situation of Thailand's older population: An update based on the 2014 Survey of Older Persons in Thailan*. Paper 1948, Research Collection School of Social Sciences.

Knopf, H., Prütz, F., & Du, Y. (2017). Use of medicines by adults in Germany. *Journal of Health Monitoring, 2*(4). doi:10.17886/RKI-GBE-2017-130

Kowal, P., & Dowd, E. (2001). *Definition of an older person: Proposed working definition of an older person in Africa for the MDS Project*. Geneva: World Health Organization.

Kritzer, B. E. (2008). Chile's next generation pension reform. *Social Security Bulletin, 68*(2), 69–84.

Ku, I., & Kim, C.-O. (2018). Decomposition analyses of the trend in poverty among older adults: The case of South Korea. *J Gerontol B Psychol Sci Soc Sci, 00*(00), 1-10.

Kuate Defo, B. (2014). Demographic, epidemiological, and health transitions: Are they relevant to population health patterns in Africa? *Glob Health Action, 7*, 22443.
Kydd, A., Touhy, T., Newman, D., Fagerberg, I., & Engstrom, G. (2014). Attitudes towards caring for older people in Scotland, Sweden and the United States. *Nursing Older People, 26*(2), 33-40.
Lafortune, L., Martin, S., Kelly, S., Kuhn, I., Remes, O., Cowan, A., & Brayne, C. (2016). Behavioural risk factors in mid-life associated with successful ageing, disability, dementia and frailty in later life: A rapid systematic review. *PloS one, 11*(2), e0144405. doi:10.1371/journal.pone.0144405
Lambert, S., & Rossi, P. (2016). Sons as widowhood insurance: Evidence from Senegal. *Journal of Development Economics, 120*, 113–127.
Latham, K. (2014). Racial and educational disparities in mobility limitation among older women: What is the role of modifiable risk factors? *The Journals Of Gerontology. Series B, Psychological Sciences And Social Sciences, 69*(5), 772-783. doi:10.1093/geronb/gbu028
Lazarus, R. S., & Launier, R. (1978). Stress-related transactions between person and environment. In L. Pervin & M. Lewis (Eds.), *Perspectives in Interactional Psychology* (pp. 287-327). Boston, MA: Springer.
Leach, R., Phillipson, C., Biggs, S., & Money, A. (2013). Baby boomers, consumption and social change: The bridging generation? *International Review of Sociology, 23*(1), 104-122.
Lee, J., Yoo, M., & Jung, D. (2010). Caregiving appraisal of family caregivers for older stroke patients in Korea. *International nursing review, 57*(1), 107-112.
Lemtur, S. (2018). *Challenges for elderly care in China: A review of literature*. Working Paper, Institute of Chinese Studies.
Levy, B. R., & Myers, L. M. (2004). Preventive health behaviors influenced by self-perceptions of aging. *Preventive Medicine: An International Journal Devoted to Practice and Theory, 39*, 625–629.
Lewis, J., & Ritchie, J. (2003). *Generalisiong from qualitative research*. London: SAGE Publications
Li, H., Ji, Y., & Chen, T. (2014). The roles of different sources of social support on emotional well-being among Chinese elderly. *PloS one, 9*(3), e90051.
Liu, X., Gu, W., Li, Z., Lei, H., Li, G., & Huang, W. (2017). Hypertension prevalence, awareness, treatment, control, and associated factors in Southwest China: An update. *Journal of hypertension, 35*(3), 637-644.
Liu, Y.-e., Norman, I. J., & While, A. E. (2012). Nurses' attitudes towards older people: A systematic review. *International Journal of Nursing Studies*. doi:http://dx.doi.org/10.1016/j.ijnurstu.2012.11.021
Lloyd-Sherlock, P. (2010). *Population ageing and international development: From generalisation to evidence*. Bristol: Policy Press.
Lloyd-Sherlock, P., & Agrawal, S. (2014). Pensions and the health of older people in South Africa: Is there an effect? *The journal of development studies, 50*(11), 1570-1586.
Lloyd-Sherlock, P., Beard, J., Minicuci, N., Ebrahim, S., & Chatterji, S. (2014). Hypertension among older adults in low-and middle-income countries: Prevalence, awareness and control. *International journal of epidemiology, 43*(1), 116-128.
López-Entrambasaguas, O. M., Granero-Molina, J., & Fernández-Sola, C. (2013). An ethnographic study of HIV/AIDS among Ayoreo sex workers: Cultural factors and risk perception. *Journal of clinical nursing, 22*(23-24), 3337-3348.
Lozano, R., Naghavi, M., Foreman, K., Lim, S., Shibuya, K., Aboyans, V., . . . Ahn, S. (2012). Global and regional mortality from 235 causes of death for 20 age groups in

1990 and 2010: A systematic analysis for the Global Burden of Disease Study 2010. *The lancet, 380*(9859), 2095-2128.
Mackichan, F., Adamson, J., & Gooberman-Hill, R. (2013). 'Living within your limits': Activity restriction in older people experiencing chronic pain. *Age and ageing, 42*(6), 702-708.
MacKinnon, A. S. (2008). Africans and the myth of rural retirement in South Africa, ca 1900–1950. *Journal of Cross-Cultural Gerontology, 23*(2), 161-179.
Madhavan, S., Schatz, E., Gómes-Olivé, X., & Collinson, M. (2017). Social positioning of older Persons in rural South Africa: Change or stability? *Journal of Southern African Studies, 43*(6), 1293-1307.
Maharaj, P. (2013). *Aging and health in Africa* (Vol. 4). New York: Springer.
Maher, D., & Sekajugo, J. (2011). Research on health transition in Africa: Time for action. *Health research policy and systems, 9*(1), 5.
Makoni, S. (2008). Aging in Africa: A critical review. *Journal of Cross-Cultural Gerontology, 23*(2), 199-209.
Makris, U. E., Higashi, R. T., Marks, E. G., Fraenkel, L., Sale, J. E., Gill, T. M., & Reid, M. C. (2015). Ageism, negative attitudes, and competing co-morbidities–why older adults may not seek care for restricting back pain: A qualitative study. *BMC geriatrics, 15*(1), 1.
Marengoni, A., Angleman, S., Melis, R., Mangialasche, F., Karp, A., Garmen, A., . . . Fratiglioni, L. (2011). Aging with multimorbidity: A systematic review of the literature. *Ageing research reviews, 10*(4), 430-439.
Masie, D. (2015). How much is too much? Finance in South Africa. *New African, 49*(548), 70-72.
Mathers, J. C. (2013). Nutrition and ageing: Knowledge gaps and research priorities. *Proc. Nutr. Soc, 72*, 246–250.
Mayosi, B., Flisher, A., Lalloo, U., Sitas, F., Tollman, S., & Bradshaw, D. (2009). The burden of non-communicable diseases in South Africa. *Lancet, 374*, 934-947.
McCullough, P. R. D. (2011). Insights and opportunities. *Marketing Research, 23*, 30-31.
McKinnon, B., Harper, S., & Moore, S. (2013). The relationship of living arrangements and depressive symptoms among older adults in sub-Saharan Africa. *BMC Public Health, 13*, 682.
McLaren, L. (2007). Socioeconomic status and obesity. *Epidemiol Rev, 29*, 29–48.
McPhee, J. S., French, D. P., Jackson, D., Nazroo, J., Pendleton, N., & Degens, H. (2016). Physical activity in older age: Perspectives for healthy ageing and frailty. *Biogerontology, 17*, 567–580.
Medici, A. (2011). How age influences the demand for health care in Latin America. In *Population aging: Is Latin America ready?* (pp. 135-190). Washington, DC: World Bank.
Menezes, S., & Thomas, T. (2018). Status of the elderly and emergence of old age homes in India. *International Journal of Social Sciences and Management, 5*(1), 1-4.
Milte, C., & McNaughton, S. (2016). Dietary patterns and successful ageing: A systematic review. *European Journal of Nutrition, 55*(2), 423-450. doi:10.1007/s00394-015-1123-7
Minicuci, N., Biritwum, R., Mensah, G., Yawson, A., Naidoo, N., Chatterji, S., & Kowal, P. (2014). Sociodemographic and socioeconomic patterns of chronic non-communicable disease among the older adult population in Ghana. *Global health action, 7*(1), 21292.
Mirowsky, J. (2017). *Education, social status, and health*. London: Routledge.

Mirzazadeh, A., Sigaroudi, A. E., Moghaddamnia, M. T., Leyli, E. K., & Saeed, A. N. (2019). Social well-being and its related areas in older people living in nursing homes. *J Holist Nurs Midwifery, 29*(1), 36-42.

Moore, A., Prybutok, V., Ta, A., & Amey, F. (2018). Personal social networks and health among aging adults in Agincourt, South Africa: A multidimensional approach. *Social Networks, 55*, 142-148.

Moran, A., Forouzanfar, M., Sampson, U., Chugh, S., Feigin, V., & Mensah, G. (2013). The epidemiology of cardiovascular diseases in sub-Saharan Africa: The global burden of diseases, injuries and risk factors 2010 study. *Progress in cardiovascular diseases, 56*(3), 234-239.

Morita, A. (2016). Tobacco smoke and skin aging. In M. Farage, K. Miller, & H. Maibach (Eds.), *Textbook of Aging Skin*. Berlin: Springer.

Munthree, C., & Maharaj, P. (2013). Growing old in the era of AIDS: Perspectives and experiences of older men and women in South Africa. In P. Maharaj (Ed.), *Aging and Health in Africa* (Vol. Vol 4, pp. 121-138). New York: Springer.

Murray, C., Vos, T., Lozano, R., Naghavi, M., Flaxman, A., Michaud, C., . . . Aggarwal, R. (2013). Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990-2010: A systematic analysis for the Global Burden of Disease Study 2010. *The lancet, 380*, 2197–2223.

Musumeci, G., Castrogiovanni, P., Coleman, R., Szychlinska, M. A., Salvatorelli, L., & Parenti, R. (2015). Somitogenesis: From somite to skeletal muscle. *Acta Histochem, 117*(4–5), 313–328.

Mwanyangala, M. A., Mayombana, C., Urassa, H., Charles, J., Mahutanga, C., Abdullah, S., & Nathan, R. (2010). Health status and quality of life among older adults in rural Tanzania. *Glob Health Action, 3*(Suppl 2), 36-44.

Nakagawa, F., May, M., & Phillips, A. (2013). Life expectancy living with HIV: Recent estimates and future implications. *Current Opinion In Infectious Diseases, 26*(1), 17-25. doi:10.1097/QCO.0b013e32835ba6b1

Nankwanga, A., Neema, S., & Phillips, J. (2013). The impact of HIV/AIDS on older persons in Uganda. In P. Maharaj (Ed.), *Aging and Health in Africa*. New York: Springer.

National Institute on Aging. (2011). *Global health and aging*. NIH Publication no. 11-7737: United States Department of Health and Human Services.

Negin, J., Geddes, L., Brennan-Ing, M., Kuteesa, M., Karpiak, S., & Seeley, J. (2016). Sexual behavior of older adults living with HIV in Uganda. *Archives of sexual behavior, 45*(2), 441-449.

Ng, J., Bierman, A., Elliott, M., Wilson, R., Xia, C., & Scholle, S. (2014). Beyond black and white: Race/ethnicity and health status among older adults. *The American journal of managed care, 20*(3), 239-248.

Ng, N., Hakimi, M., Byass, P., Wilopo, S., & Wall, S. (2010). Health and quality of life among older rural people in Purworejo District, Indonesia. *Global health action, 3*(1), 21-25.

Nhongo, T. (2004). *The changing role of older people in African households and the impact of ageing on African family structures*. Ageing in Africa Conference 18 to 20 August 2004, Johannesburg.

Niño-Zarazúa, M., Barrientos, A., Hickey, S., & Hulme, D. (2012). Social protection in Sub-Saharan Africa: Getting the politics right. *World development, 40*(1), 163-176.

Nojilana, B., Bradshaw, D., Wyk, P.-v., Msemburi, W., Laubscher, R., Somdyala, N., . . . Dorrington, R. (2016). Emerging trends in non-communicable disease mortality in South Africa, 1997 - 2010. *S Afr Med J, 106*(5), 477-484. doi:10.7196/SAMJ.2016.v106i5.10674

Nyirenda, M., Chatterji, S., Falkingham, J., Mutevedzi, P., Hosegood, V., Evandrou, M., . . . Newell, M.-L. (2012). An investigation of factors associated with the health and well-being of HIV-infected or HIV-affected older people in rural South Africa. *BMC public health, 12*(1), 259.

Nyirenda, M., Chatterji, S., Rochat, T., Mutevedzi, P., & Newell, M. (2013). Prevalence and correlates of depression among HIV-infected and-affected older people in rural South Africa. *Journal of affective disorders, 151*(1), 31-38.

O'Rand, A. M. (1990). Stratification and the life course. In *Handbook of Aging and the Social Sciences* (3rd ed., pp. 130-148). California: Academic.

OECD. (2015). *"Old-age income poverty", in Pensions at a Glance 2015: OECD and G20 indicators*. Paris: OECD Publishing.

Ogura, S. (1994). The cost of aging: Public finance perspectives for Japan. In Y. Noguchi & D. A. Wise (Eds.), *Aging in the United States and Japan: Economic Trends* (pp. 139 - 174): University of Chicago Press.

Oldewage-Theron, W., & Kruger, R. (2011). Dietary diversity and adequacy of women caregivers in a peri-urban informal settlement in South Africa. *Nutrition, 27*(4), 420-427.

Opdenakker, R. (2006). Advantages and disadvantages of four interview techniques in qualitative research. *Forum: Qualitative Social Research, 7*(4), 1-13

Orimo, H., Ito, H., Suzuki, T., Araki, A., Hosoi, T., & Sawabe, M. (2006). Reviewing the definition of "elderly". *Geriatrics and Gerontology International, 6*(3), 149-158.

Paula, J., Busse, M. D., & Mathur, S. K. (2010). Age-related changes in immune function: Effect on airway inflammation. *J Allergy Clin Immunol, 126*(4), 690-699.

Payne, C., Gómez-Olivé, F., Kahn, K., & Berkman, L. (2017). Physical function in an aging population in rural South Africa: Findings from HAALSI and cross-national comparisons with HRS sister studies. *The Journals of Gerontology: Series B, 72*(4), 665-679.

Peltzer, K., & Phaswana-Mafuya, N. (2013). Hypertension and associated factors in older adults in South Africa. *Cardiovascular journal of Africa, 24*(3), 66-72.

Pigliautile, M., Ricci, M., Mioshi, E., Ercolani, S., Mangialasche, F., Monastero, R., . . . Mecocci, P. (2011). Validation study of the Italian Addenbrooke's Cognitive Examination Revised in a young-old and old-old population. *Dementia and geriatric cognitive disorders, 32*(5), 301-307.

Pilleron, S., Aboyans, V., Mbelesso, P., Ndamba-Bandzouzi, B., Desormais, I., Lacroix, P., . . . Guerchet, M. e. (2017). Prevalence, awareness, treatment, and control of hypertension in older people in Central Africa: The EPIDEMCA study. *Journal of the American Society of Hypertension, 11*(7), 449–460.

Pirani, E., & Salvini, S. (2015). Is temporary employment damaging to health? A longitudinal study on Italian workers. *Social Science and Medicine, 124*, 121-131.

Population Reference Bureau. (2018). *World population data sheet with a special focus on changing age structures*. Washington, DC: Population Reference Bureau,.

Prados-Torres, A., Calderón-Larranaga, A., Hancco-Saavedra, J., Poblador-Plou, B., & van den Akker, M. (2014). Multimorbidity patterns: A systematic review. *Journal of clinical epidemiology, 67*(3), 254-266.

Prasad, S., Sung, B., & Aggarwal, B. B. (2012). Age-associated chronic diseases require age-old medicine: Role of chronic inflammation. *Preventive medicine, 54*, S29-S37.

Prince, M., Ebrahim, S., & Acosta, D. (2012). Hypertension prevalence, awareness, treatment and control among older people in Latin America, India and China: a 10/66 cross-sectional population-based survey. *J Hypertens, 30*, 177–187.

Prince, M. J., Wu, F., Guo, Y., Robledo, L. M. G., O'Donnell, M., Sullivan, R., & Yusuf, S. (2015). The burden of disease in older people and implications for health policy and practice. *Lancet, 385*, 549-562.

Prütz, F., & Rommel, A. (2017). Utilization of inpatient medical care in Germany. *Journal of Health Monitoring, 2*(4). doi:10.17886/RKI-GBE-2017-128

Pype, K. (2018). Will families in Ghana continue to care for older people? Logic and contradition in policy. In J. Hoffman & K. Pype (Eds.), *Ageing in sub-Saharan Africa: Spaces and Practices of Care*. Bristol: Policy Press.

Quartilho, A., Simkiss, P., Zekite, A., Xing, W., Wormald, R., & Bunce, C. (2016). Leading causes of certifiable visual loss in England and Wales during the year ending 31 March 2013. *Eye, 30*, 602–607.

Ralston, M., Schatz, E., Menken, J., Gómez-Olivé, F. X., & Tollman, S. (2015). Who benefits—or does not—from South Africa's old age pension? Evidence from characteristics of rural pensioners and non-pensioners. *International journal of environmental research and public health, 13*, 85.

Ramírez, L., & Palacios-Espinosa, X. (2016). Stereotypes about old age, social support, aging anxiety and evaluations of one's own health. *Journal of Social Issues, 72*(1), 47-68.

Riley, M., Kahn, R., Foner, A., & Mack, K. (1994). *Age and structural lag: Society's failure to provide meaningful opportunities in work, family, and leisure*. Oxford: John Wiley & Sons.

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2013). *Qualitative research practice: A guide for social science students and researchers* (Second ed.). Los Angeles: SAGE.

Roberson, D. (2014). Measuring HIV knowledge among women incarcerated in jail. *Journal of Correctional Health Care, 20*(3), 213-219.

Robinson, H., & Hort, K. (2012). Non-communicable diseases and health systems reform in low-and-middle-income countries. *Pacific Health Dialog, 18*(1), 179–190.

Rodrigues, B. G. D. S., Cader, S. A., Torres, N. V. O. B., Oliveira, E. M. D., & Dantas, E. H. M. (2010). Pilates method in personal autonomy, static balance and quality of life of elderly females *Journal of Bodywork and Movement Therapie, 14*(2), 195–202.

Rönnlund, M., Nyberg, L., Bäckman, L., & Nilsson, L.-G. (2005). Stability, growth and decline in adult life span development of declarative memory: Cross-sectional and longitudinal data from a population-based study. *Psychology and Aging, 20*, 3-18. doi:10.1037/0882-7974.20.1.3

Roohafza, H., Talaei, M., Pourmoghaddas, Z., Rajabi, F., & Sadeghi, M. (2012). Association of social support and coping strategies with acute coronary syndrome: A case–control study. *Journal of Cardiology, 59*, 154-159.

Rose, L. (2018). *Healthcare for the elderly*. UC Santa Cruz, Retrieved from https://escholarship.org/uc/item/1b64m80w

Ross, C. E., Hill, T. D., & Mirowsky, J. (2016). Reconceptualizing health lifestyles: The case of marriage. In J. J. Kronenfeld (Ed.), *Special Social Groups, Social Factors and Disparities in Health and Health Care* (Vol. 34, pp. 243-260): Emerald Group Publishing Limited.

Rovio, S., Kareholt, I., & Helkala, E.-L. (2005). Leisure-time physical activity at midlife and the risk of dementia and Alzheimer's disease,. *The Lancet Neurology, 4*(11), 705–711.

Rowland, J., Akbarov, A., Maan, A., Eales, J., Dormer, J., & Tomaszewski, M. (2018). Tick-tock chimes the kidney clock–from biology of renal ageing to clinical applications. *Kidney and Blood Pressure Research, 43*(1), 55-67.

Royal Society for Public Health. (2018). *That old age question: How attitudes to ageing affect our health and wellbeing*. London: Royal Society for Public Health.

Rubinstein, A., Campero, A., Barros, R., Castillo, C., Gaviria, A., Espinosa, V., . . . López, L. (2017). *Population aging: Challenges for health systems in South America towards a healthy aging*. ISAGS-UNASUR

Ryder, N. B. (1975). Notes on stationary populations. *Population index, 41*(1), 3-28.

S, P., S, S., MA, H., S, K., & C, S. (2015). Prevalence, correlates, and outcomes of multimorbidity among patients attending primary care in Odisha, India. *Annals of Family Medicine, 13*(5), 446–450.

Saenz, J. L., & Wong, R. (2016). Educational gradients and pathways of disability onset among older Mexicans. *Research on Aging, 38*(3), 299-321. doi:10.1177/0164027515620243

Sanderson, W., & Scherbov, S. (2010). Remeasuring aging. *science, 329*(5997), 1287-1288.

Saravanan, S. (2013). An ethnomethodological approach to examine exploitation in the context of capacity, trust and experience of commercial surrogacy in India. *Philosophy, Ethics, and Humanities in Medicine, 8*(1), 10.

Schatz, E., Madhavan, S., Collinson, M., Gómez-Olivé, X., & Ralston, M. (2015). Dependent or productive? A new approach to understanding the social positioning of older South Africans through living arrangements. *Research on Aging, 37*(6), 581-605.

Schatz, E., Seeley, J., & Zalwango, F. (2018). Intergenerational care for and by children: Examining reciprocity through focus group interviews with older adults in rural Uganda. *Demographic Research, 38*, 2003-2026.

Schroeder, D., & Gefenas, E. (2009). Vulnerability: Too vague and too broad? *Cambridge Quarterly of Healthcare Ethics, 18*(2), 113-121.

Schwarzer, R., & Knoll, N. (2007). Functional roles of social support within the stress and coping process: A theoretical and empirical overview. *International journal of psychology, 42*(4), 243-252.

Seitz, C., Strack, R., & Wyrick, D. (2012). Cigarette smoking and facial wrinkles: A review of the literature. *Journal of Smoking Cessation, 7*(1), 18-24.

Sells, S. (1970). On the nature of stress. *Social and psychological factors in stress, 134*, 139.

Shetty, P. (2012). Grey matter: Ageing in developing countries. *The lancet, 379*(9823), 1285-1287.

Shin, H., Ryu, H., Yoon, J., Jo, S., Jang, S., Choi, M., . . . Jo, S. J. (2015). Association of premature hair graying with family history, smoking, and obesity: A cross-sectional study. *Journal of the American Academy of Dermatology, 72*(2), 321-327.

Shor, E., Roelfs, D. J., & Yogev, T. (2013). The strength of family ties: A meta-analysis and meta-regression of self-reported social support and mortality. *Social Networks, 35*(4), 626-638.

Siedlecki, K., Salthouse, T., Oishi, S., & Jeswani, S. (2014). The relationship between social support and subjective well-being across age. *Social indicators research, 117*(2), 561-576.

Sigaroudi, A. E., Nayeri, N. D., & Peyrovi, H. (2013). Antecedents of elderly home residency in cognitive healthy elders: A qualitative study. *Global Journal of Health Science, 5*(2), 200-207.

Simmons, L. W. (1945). *The role of the aged in primitive societies*. New Haven, Connecticut: Yale University Press.

Simmons, L. W. (1946). Attitudes toward aging and the aged: Primitive societies. *Journal of Gerontology, 1*, 72–95.

Simon, A. K., Hollander, G. A., & McMichael, A. (2015). Evolution of the immune system in humans from infancy to old age. *Proc. R. Soc. B, 282*(1821), 20143085.

Singer, M. (2012). Applying the concept of culture to reduce health disparities through health behavior research. *Preventive medicine, 55*(5), 356-361.

Sipila, S., Heikkinen, E., Cheng, S., Suominen, H., Saari, P., & Kovanen, V. (2006). Endogenous hormones, muscle strength, and risk of fall-related fractures in older women. *J Gerontol A Biol Sci Med Sci, 61*(1), 92–96.
Sipilä, S., Narici, M., Kjaer, M., Pöllänen, E., Atkinson, R., & Hansen, M. (2013). Sex hormones and skeletal muscle weakness. *Biogerontology, 14*(3), 231–245.
Sixsmith, J., Sixsmith, A., Malmgren Fänge, A., Naumann, D., Kucsera, C., Tomsone, S., . . . Woolrych, R. (2014). Healthy ageing and home: The perspectives of very old people in five European countries. *Social Science and Medicine, 106*, 1-9.
Smith, G., Banting, L., Eime, R., O'Sullivan, G., & Van Uffelen, J. (2017). The association between social support and physical activity in older adults: A systematic review. *International Journal of Behavioral Nutrition and Physical Activity, 14*(1), 56.
Smith, K. B., Profetto-McGrath, J., & Cummings, G. G. (2009). Emotional intelligence and nursing: An integrative literature review. *International Journal of Nursing Studies, 46*, 1624–1636.
Sofi, F., Macchi, C., & Abbate, R. (2013). Mediterranean diet and health status: An updated meta-analysis and a proposal for a literature-based adherence score. *Public Health Nutr*, 1-14.
Spector-Mersel, G. (2006). Never-aging stories: Western hegemonic masculinity scripts. *Journal of gender studies, 15*(1), 67-82.
Statistics South Africa. (2015). *Mid-year population estimates*. Pretoria: Statistics South Africa.
Statistics South Africa. (2017). *General Household Survey 2016*. Pretoria: Statistics South Africa.
Statistics South Africa. (2018). *Mid-year population estimates*. Pretoria: Statistics South Africa.
Stephen, S., Vos, T., Flaxman, A., Danaei, G., Shibuya, K., Adair-Rohani, H., . . . Andrews, K. (2017). A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990-2010: A systematic analysis for the Global Burden of Disease Study 2010. *The lancet, 380*, 2224–2260.
Sternäng, O., Palmer, K., Kabir, Z. N., Hasan, M. I., & Wahlin, Å. (2018). Associations between functional biological age and cognition among older adults in rural Bangladesh: Comparisons with chronological age. *Journal of Aging and Health*, 1-23.
Stessman, J., Hammerman-Rozenberg, R., Cohen, A., Ein-Mor, E., & Jacobs, J. (2009). Physical activity, function, and longevity among the very old. *Archives Of Internal Medicine, 169*(16), 1476-1483. doi:10.1001/archinternmed.2009.248
Stevenson, S. (2017). Celebrating holidays with seniors in assisted living. Retrieved from https://www.aplaceformom.com/blog/12-22-14-celebrate-holidays-in-assisted-living/
Steves, C. J., Spector, T., & Jackson, S. (2012). Ageing, genes, environment and epigenetics: What twin studies tell us now, and in the future. *Age and ageing, 41*(5), 581-586.
Stuckler, D., McKee, M., Ebrahim, S., & Basu, S. (2012). Manufacturing epidemics: The role of global producers in increased consumption of unhealthy commodities including processed foods, alcohol, and tobacco. *PLoS medicine, 9*(6), e1001235.
Swift, D., Johannsen, N., Lavie, C., Earnest, C., & Church, T. (2014). The role of exercise and physical activity in weight loss and maintenance. *Progress in cardiovascular diseases, 56*(4), 441-447.
Tanga, P. (2015). Growing old gracefully: The role of old age pension in Lesotho. *Perspectives on Global Development and Technology, 14*(5), 567-583.
Thoits, P. A. (2011). Mechanisms linking social ties and support to physical and mental health. *Journal of health and social behavior, 52*, 145-161.

Tkatch, R., Musich, S., MacLeod, S., Kraemer, S., Hawkins, K., Wicker, E. R., & Armstrong, D. G. (2017). A qualitative study to examine older adults' perceptions of health: Keys to aging successfully. *Geriatric Nursing, 38*, 485-490.

Togunu-Bickersteth, F., & Togonu-Bickersteth, F. (1988). Perception of old age among Yoruba aged. *Journal of Comparative Family Studies, 19*(1), 113-122.

Tollman, S., Kahn, K., Sartorius, B., Collinson, M., Clark, S., & Garenne, M. (2008). Implications of mortality transition for primary health care in rural South Africa: A population-based surveillance study. *The lancet, 372*(9642), 893-901.

Tong, R. (2014). Vulnerability and aging in the context of care. In C. Mackenzie, W. Rogers, & S. Dodds (Eds.), *Vulnerability: New Essays in Ethics and Feminist Philosophy* (pp. 288-308). New York: Oxford University Press.

Tyrovolas, S., Haro, J. M., Mariolis, A., Piscopo, S., Giuseppe Valacchi e, Tsakountakis, N., . . . Panagiotakos, D. (2014). Successful aging, dietary habits and health status of elderly individuals: A k-dimensional approach within the multi-national MEDIS study. *Experimental Gerontology, 60*, 57–63.

UNAIDS. (2013). *HIV and aging: A special supplement to the UNAIDS report on the global AIDS epidemic 2013*. Geneva: UNAIDS.

UNAIDS. (2014). *The gap report 2014: People aged 50 years and older*. Geneva: UNAIDS.

UNAIDS. (2016). *Social isolation and medical appointment in the elderly*. Geneva: UNAIDS.

UNAIDS. (2018). *Data 2018*. Geneva: UNAIDS.

United Nations. (2011). *Current status of the social situation, wellbeing, participation in development and rights of older persons worldwide*. New York: United Nations Department of Economic and Social Affairs.

United Nations. (2013). *World population ageing 2013*. New York: United Nations Department of Economic and Social Affairs, Population Division.

United Nations. (2015a). International Day of older persons: Secretary-General's message for 2015. http://www.un.org/en/events/olderpersonsday/2015/sgmessage.shtml. Accessed on Wednesday 11 November 2015.

United Nations. (2015b). *World population ageing*. New York: Department of Economic and Social Affairs, Population Division, ST/ESA/SER.A/390.

United Nations. (2015c). *World population ageing 2015*. New York: Department of Economic and Social Affairs Population Division.

United Nations. (2017a). *Ageing and disability*. Retrieved from New York: https://www.un.org/development/desa/disabilities/disability-and-ageing.html

United Nations. (2017b). *Population facts: Population ageing and sustainable development*. New York: United Nations, Department of Economic and Social Affairs, Population Division.

United Nations. (2017c). *World Population Ageing 2017 Highlights*. New York: United Nations.

United Nations Development Programme. (2014). *Sustaining human progress: Reducing vulnerabilities and building resilience*. New York: United Nations Development Programme.

United Nations Development Programme. (2016). *Human Development Report 2016: Human development for everyone*. New York: United Nations Development Programme.

United Nations General Assembly. (2015). *Report of the Secretary-General on follow-up to the International Year of Older Persons: Second World Assembly on Ageing*. Retrieved from

United Nations Population Division. (2009). *World population ageing 2009*. New York: United Nations Population Division.

United Nations Population Fund. (2012). *Ageing in the twenty-first century: A celebration and a challenge*. New York: United Nations Population Fund.

Vameghi, M., Sadighi, J., M, T., Jahangiri, K., Azin, A., & Omidvari, S. (2013). Social relationships and health: Findings from the Iranian Health Perception Survey (IHPS) (Persian)]. *Journal of the Iranian Institute for Health Sciences Research, 12*(2), 183-194.

Vellakkal, S., Subramanian, S. V., Millett, C., Basu, S., Stuckler, D., & Ebrahim, S. (2013). Socioeconomic Inequalities in Non-Communicable Diseases Prevalence in India: Disparities between Self-Reported Diagnoses and Standardized Measures. *Plos One, 8*(7), 1-12. doi:10.1371/journal.pone.0068219

Vellas, B., Scrase, D., Rosenberg, G., Andrieu, S., de Carvalho, A., & Middleton, L. (2018). WHO guidelines on community-level interventions to manage declines in intrinsic capacity: The road to prevention cognitive decline in older age? *The Journal of Prevention of Alzheimer's Disease, 5*(3), 165–167

Viana Medeiros, D., Santos, W. N. d., das Graças de Melo Sousa, M., de Cássia Dias da Silva, T., Silva, P., Teles, P., & de Fátima Ferreira de Castro, S. (2016). Elderly's perception on old age. *Journal of Nursing UFPE/Revista de Enfermagem UFPE, 10*(10), 3851-3859.

Walker, A., & Maltby, T. (2012). Active ageing: A strategic policy solution to demographic ageing in the European Union. *International Journal of Social Welfare, 21*, S117-S130.

Wang, B., Yu, S., Noh, J., & Kwon, Y. (2014). Factors associated with self-rated health among north Korean defectors residing in South Korea. *BMC public health, 14*, 999. doi:10.1186/1471-2458-14-999

Warburton, J., Scharf, T., & Walsh, K. (2017). Flying under the radar? Risks of social exclusion for older people in rural communities in Australia, Ireland and Northern Ireland. *Sociologia Ruralis, 57*(4), 459-480.

Ward, R. (1984). *The aging experience: An introduction to social gerontology*. New York: Harpercollins College Division.

Whittaker, A. C., Asamane, E. A., Aunger, J. A., Cabbia, D. B., Doody, P. D., Gensous, N., . . . Yeung, S. S. Y. (2019). Physical activity and nutrition influences in ageing: Current findings from the PANINI Project. *Advances in Geriatric Medicine and Research, 1:e190005*.

Wills, T. A. (1985). Supportive functions of interpersonal relationships. In S. Cohen & S. Syme (Eds.), *Social Support and Health* (pp. 61-82). San Diego, CA, US: Academic Press.

Wong, R., Michaels-Obregon, A., & Palloni, A. (2017). Cohort profile: The Mexican Health and Aging Study (MHAS). *International journal of epidemiology, 46*(2).

Workneh, M. H., Bjune, G. A., & Yimer, S. A. (2016). Prevalence and associated factors of diabetes mellitus among tuberculosis patients in South-Eastern Amhara Region, Ethiopia: A cross sectional study. *PloS one, 11*(1), e0147621.

World Bank. (2012). *Reports: Life expectancy at birth; total (years) in Nigeria, Trading Economics*. Retrieved from Geneva: www.tradingeconomics.com/Nigeria/life-expectancy-at-birth-total-years-wb-data.html

World Bank. (2015). *Data catalog*. Retrieved from http://datacatalog.worldbank.org/

World Health Organisation. (2000). *Information needs for research, policy and action on ageing and older adults in Africa*. Harare.

World Health Organisation. (2001). *Information needs for research, policy and action on ageing and older adults*. Dar-es-Salaam: WHO.

World Health Organisation. (2002). *Active ageing: A policy framework*. Second United Nations World Assembly on Ageing, Madrid: World Health Orgarnization.
World Health Organisation. (2007). *Prevention of cardiovascular disease: Guidelines for assessment and management of cardiovascular risk*. Geneva: World Health Organisation.
World Health Organisation. (2009). *Women and health: Today's evidence tomorrow's agenda*. Geneva: World Health Organisation.
World Health Organisation. (2010). *Global recommendations on physical activity for health*. Geneva: World Health Organisation.
World Health Organisation. (2011). *Estimate on the burden of disease from second hand tobacco smoke*. Geneva: World Health Organization.
World Health Organisation. (2012). *World health day: Are you ready? What you need to know about ageing*. Retrieved from Geneva: http://www.who.int/world-health-day/2012/toolkit/background/en/index3.html
World Health Organisation. (2015). *World report on ageing and health*. Geneva: World Health Organisation
World Health Organisation. (2016a). *Global health estimates: DALYs by cause and region 2000-2016* Retrieved from Geneva: https://www.who.int/healthinfo/global_burden_disease/estimates/en/index1.html
World Health Organisation. (2016b). *Health statistics and information systems*. Retrieved from Geneva: http://www.who.int/healthinfo/survey/ageingdefnolder/en/
World Health Organisation. (2017). *Dementia*. Retrieved from Geneva: http://www.who.int/news-room/fact-sheets/detail/dementia
WRVS. (2012). *Loneliness amongst older people and the impact of family connections*. Cardiff.
Wu, F., Guo, Y., Chatterji, S., Zheng, Y., Naidoo, N., Jiang, Y., . . . Kowal, P. (2015). Common risk factors for chronic non-communicable diseases among older adults in China, Ghana, Mexico, India, Russia and South Africa: The study on global AGEing and adult health (SAGE) wave 1. *BMC public health, 15*, 88. doi:10.1186/s12889-015-1407-0
Wyman, M. F., Shiovitz-Ezra, S., & Bengel, J. (2018). Ageism in the health care system: Providers, patients, and systems. In L. Ayalon & C. Tesch-Römer (Eds.), *Contemporary perspectives on ageism* (Vol. 19, pp. 193-212). New York: Springer, Cham.
Yamasoba, T., Lin, F., Someya, S., Kashio, A., Sakamoto, T., & Kondo, K. (2013). Current concepts in age-related hearing loss: Epidemiology and mechanistic pathways. *Hearing research, 303*, 30-38.
Yasuda, T., Iwai, N., Yi, C.-C., & Xie, G. (2011). Intergenerational coresidence in China, Japan, South Korea and Taiwan: comparative analyses based on the East Asian social survey 2006. *Journal of Comparative Family Studies*, 703-722.
Zarulli, V., Jones, J., Oksuzyan, A., Lindahl-Jacobsen, R., Christensen, K., & Vaupel, J. (2018). Women live longer than men even during severe famines and epidemics. *Proceedings of the National Academy of Sciences, 115*(4), E832-E840.
Zihindula, G., & Maharaj, P. (2013). Health and health seeking behaviour in the Democratic Republic of the Congo: Perspectives of the Elderly. In P. Maharaj (Ed.), *Aging and Health in Africa* (pp. 91-101). New York: Springer.
Zimmer, Z., & Dayton, J. (2003). *The living arrangements of older adults in sub-Saharan Africa in a time of HIV/AIDS*. New York: Population Council, Policy Research Division Working Paper No. 169.

APPENDICES

APPENDIX A

LETTER OF ETHICAL APPROVAL

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

09 June 2015

Mr Alpha Kosse 208522101
School of Built Environment & Development Studies
Howard College Campus

Dear Mr Kosse

Protocol reference number: HSS/1513/014D
Project title: Understanding social support and determinants of health in old age in South Africa using a mixed method approach

Full Approval – Committee Reviewed Protocol

This letter serves to notify you that your application in connection with the above has now been granted full approval.

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach/Methods must be reviewed and approved through an amendment /modification prior to its implementation. Please quote the above reference number for all queries relating to this study. Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

Best wishes for the successful completion of your research protocol.

Yours faithfully

[redacted]
Dr Shenuka Singh (Chair)

/px

cc Supervisor: Professor Pranitha Maharaj
cc Academic Leader Research: Dr Catherine Sutherland
cc School Administrator: Ms S Naicker

Humanities & Social Sciences Research Ethics Committee
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APPENDIX B

LETTER OF INFORMED CONSENT

INFORMED CONSENT FORM

My name is Alpha Kosse (student number 208522101). I am doing research on a project entitled 'Understanding social support and determinants of health in old age in South Africa using a mixed method approach'. The main aim of the research is to investigate the socio-economic, cultural and racial factors that impact on the health in old age and understand the concept of aging from the perspective of older people.

This project is supervised by Professor Pranitha Maharaj at the School of Built Environment and Development Studies, University of KwaZulu-Natal. Should you have any query and may want to enquire from my school, please contact Dr Singh in the HSSREC Research Office at: Tel 0027 31 260 3587/ 8350/4557, email: ximbap@ukzn.ac.za, mohunp@ukzn.ac.za

I am managing the project and should you have any questions my contact details are: Development Studies, School of Built Environment Development Studies, University of KwaZulu-Natal, Durban 4041. Cell: 0722403587. Email: hogradi@gmail.com or 208522101@stu.ukzn.ac.za.

Thank you for agreeing to take part in the project. Before we start I would like to emphasise that:

-our participation is entirely voluntary;
-you are free to refuse to answer any question;
-refusal not to participate will not result in any form of disadvantage;
-you are free to withdraw at any time;
-notes will be taken and the interview will be recorded;
-gathered data will be incinerated 5 years after the research has been complete;
-this meeting will take at least 30 minutes to one hour.

The interview will be kept strictly confidential and will be available only to members of the research team. Excerpts from the interview may be made part of the final research report.

DECLARATION

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

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

I consent/ I do not consent to this interview to being recorded

Sign/thumbprint/put a cross Date

....

If you if you wish to receive a copy of the research report, please provide your contacts/postal addresses where the report or summary of the research can be sent:

.....

.....

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.....

.....

APPENDIX C

INDEPTH INTERVIEW GUIDE

INTERVIEW GUIDE

1. **Background Questions**

Today's date_____

Age_____

Date of birth _____

Sex: Male_____ Female_____

Marital status: Married _____ Living Together _____ Never Married _____ Divorced _____ Widow _____

Do you have children?

How many male children do you have?

How many female children do you have?

Probe: are they working? How many are working? Male? Female? Do they live in the same area with you? Did they migrate?

2. **Old age**

How old are you?

According to your understanding, who can be or is referred to as an older person?

Probe: When can a man be described as old? When can a woman be described as old? List some signs of seniority? What does being old mean in your culture?

3. **Health status**

How would you describe your health?

Probe: Sick or healthy? Do you have any health problems? How long have you been experiencing these health problems? Do you have any chronic illness? Name the disease? How do you manage your condition? What treatment do you use for your condition? What traditional remedies do you use for your health? What home remedies do you use for your health? Tell us about some cultural practices that older people rely on for their physical well-being?

Do you happen to contract diseases such as flu, cough, diarrhoea as well as other infectious diseases? Provide some experiences and the remedy used? Provide some experiences of cultural health practices?

4. **Assessment of nutritional status**

How many meals do you have a day? How many people share a meal with you? Are you satisfied with your eating habits? What do you think older people should eat?

5. **Challenges**

How often do you go to the clinic/hospital?

Probe: are you going to health facility more or less than before? Why is this? How far is this health facility?

In your opinion, are there some illnesses that are better treated than others at the clinic or hospital you usually go to?

Probe: why? list them? What should be done to improve the health care of older people at the hospital or clinic you usually attend? What are your good experiences of the hospital/clinic? What happened? What are your bad experiences? What happened?

Are you currently on any medication?

Probe: How long have you been on medication? Do you find it hard to take your medication consistently? Are there side effects? What side effects have you experienced? Can you expand on it?

If you were to fall ill would you be able to get to a health facility?

Probe: What are some difficulties or barriers older people like you may face in accessing health services? User fees? Poor service? Medical staff attitude towards the elderly? Taxi fare? Poor health facilities? Long queues? Unskilful medical staff?

Is there any health issue that may prevent you from accessing health facilities?

Probe: Arthritis? Rheumatism? Swelling? Stiffness? Walking stick? Any mobility issue?

Is there any cultural belief that impedes from going to heath facilities? Is there any cultural belief that facilitate going to heath facilities?

Probe: beliefs? Traditions? Food? Traditional healers or inyanga more effective than modern medicine? Culture?

What is your understanding of traditional medicine?

Probe: trustworthy? Substitute modern medicine? Complement modern medicine?

What in your opinion can be done to ease your burden?
Probe: financial support from government, community/ family member
Social support from community/ church
Emotional support from community/ friends/ family
Spiritual support from religious organisation
Physical caring from community groups/ church/ friends/ family Other

What are the challenges and difficulties faced by older people on a daily basis?
Probe: financial? Physical? Health? Isolation? Caregiving? Insufficient food? Clothing? Inadequate housing?

6. Support

What kind of support do you receive from family members?
Probe: Relationship, gender, emotional support, financial support, material support? Community? Church? Local government? NGOs? Is it enough? Which relative help you the most? Why do you think he/she does so? Does he stay far from you? In the same area? Who do you think is responsible for taking care of the elderly? Why?

What kind of public support do you receive?
Probe: Pensions? Housing? Food allowances? Medical care? Food parcels?

What kind of support do you need to get to the hospital/clinic?
Probe: People to help you move around? Guide?