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International Journal on Ageing in Developing Countries

Contents

Editorial

Rosette Farrugia-Bonello[1] and Marvin Formosa[2]

Welcome to the second issue of volume three of the *International Journal on Ageing in Developing Countries* (IJADC). In this edition, we continue to explore how ageing is being addressed in different parts of the world. Those of us working in the field of global ageing are familiar with the numbers. Current trends and projections on ageing are unprecedented. The United Nations reported that the number of persons over the age of 60 will more than double by 2050, exceeding 2 billion people and surpassing the number of children for the very first time in history. This change is upon us now and population ageing is a global issue affecting all nations and people. Ageing demands a response in order to be equipped with the best possibilities for a better quality of life. This issue contains six original entries from Africa, Eastern-Europe and Asia, and two book reviews - namely, 'Active healthy ageing in Malta: Gerontological and geriatric inquiries' (Formosa, 2019) reviewed by Mario Barbagallo and 'A Common wealth of experience' (Eyers & Waddington, 2019) reviewed by Nidhi Gupta.

The first contribution, by Susanne Spittel, Elke Kraus, André Maier and Karin Wolf-Ostermann, is titled 'Healthcare challenges of older people with and without dementia in Ghana. An exploratory pilot study'. In Ghana, the proportion of older persons is growing comparatively faster than high-income countries and other parts in Africa. This article highlights the importance of identifying current healthcare challenges facing older people and people living with dementia in Ghana. This was done through a mixed-method approach by using a quantitative and qualitative approach in its explorative, descriptive design. The study revealed that though older persons above the age of 60 are more vulnerable to dementia, Ghana still lacks sufficient structures and adequate programmes to address the needs of older persons. Besides, lack of awareness of the ageing process is resulting in stigmatising older people and of those living with dementia. The authors also reveal that in Ghana, people still associate older people and persons living with dementia to witchcraft and there had been cases whereby the latter live socially excluded lives in witch-camps, are beaten and killed. The article concludes by calling for an urgent paradigm shift in Ghana's healthcare system focusing particularly on ageing and dementia. The latter need to be addressed and placed as a priority on the national agenda. The authors also emphasise the need of public awareness,

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further research in the area, increase in capacity building of health care specialists on ageing and the implementation of programmes and services which addresses the needs of older people and persons living with dementia.

The second contribution, by Friday Eboiyehi Asiazobor and Caroline Okumdi Muoghalu, is titled 'Economic recession, challenges and coping strategies among the rural aged in selected communities in Ile-Ife of south-western Nigeria'. In this article, the authors investigated the impact of the economic recession in four low-income residential rural areas in Ile-Ife namely Abiri-Ogudu and Owena in Ife East and Tokere and Akile in Ife Central Local Government Areas in Nigeria. Research was carried out by using qualitative and quantitative data. Results indicated that the economic recession affected the aged in various ways including their inability to afford food and medication due to high cost; poor living condition increased due to increased unemployment of adult children – therefore they were unable to provide financial and material support. The study revealed that coping strategies adopted by older people included subsistence farming, petty trading, dependence on remittances from offspring, financial and material assistance from religious organizations, working for other people, alms begging and pension. The paper concludes that the economic recession has impacted negatively on older persons living in rural areas. The authors suggest that there is a need for government to address the needs of older people living in rural areas and who are left behind by their adult children since the latter are in search of greener pasture in towns and cities.

The third article in this issue is another paper from Africa. This time it is a study which had been carried out in Uganda and titled 'The Kisoro Elders Project in villages of rural southwest Uganda: A model for geriatric care in developing countries?' The paper is authored by Harrison G. Bloom, Patricia A. Bloom, Moses Iraguha, Sam Musominali, Immaculate Owembabazi and Gerald Paccione. The contribution is a brief report which describes the inception of a healthcare project aimed at offering interventions which are meant to have an immediate impact on the quality of life of older adults living in rural villages in Uganda. The paper speaks about the 'The Kisoro Elders Project', a unique programme in the Sub-Sahara Africa - which aims to screen for and treat major health problems. Screening of older persons in Kisoro resulted in negative quality of life with challenges that included visual impairment, hearing deficits, mobility and pain problems, depression and dementia. What is interesting in this project is that interventions delivered in rural villages were done by trained Village Health Workers. This move eliminated significantly the usual barriers to care. Given the rapid ageing of low-income countries and countries with economies-in-transition, together with the crisis of shortages of health professionals as seen in most countries, the authors hope that this project would serve as a model for similar efforts elsewhere.

'Age-related ageism among social and health care employees' is the fourth contribution which is written by Andrei Ilnitski, Lola Kolpina and Kiryl Prashchayeu**.** This paper is an attempt to explain age in light of ageism. The authors explained this through representations of discrimination of advanced age population that took place in practices of medical and social

attendance. The study is an analysis of data gathered through an interview carried out amongst healthcare and social employees of regional society in Russia. The study revealed that the youngest group of social and healthcare employees are more aware than others in recognizes the presence of a gerontological ageism in both social and medical practices, but denies any personal participation. Findings revealed that those that fell within the age bracket of 40-49 years, strongly denied the presence of ageism in general and in their own professional activity. However, senior employees age 60 years and over recognized ageism. This paper concludes that there is a difference in identifying ageism amongst social and medical practitioners which is based on their chronological age.

This article, which is the fifth paper in this issue reviews 'A life innovation analysis framework in Asia and the Pacific from the perspective of social quality for older persons: Empowerment by the MIPAA process in the era of the SDGs'. This paper has been submitted by Tetsuo Ogawa and Osama Rajkhan. In view of the fact that the Madrid Internal Plan of Action of Ageing (MIPPA**)** is reviewed with the concept of *Social Quality (SQ)* as it links the objectives of this normative international instrument with the aims of the 2030 Sustainable Development Goals (SDGs) Agenda, in this article, the authors argue that the SQ framework is a useful policy tool to monitor the process of empowerment of older persons and raising the level of their wellbeing. The article shows how SQ was designed as a life-time vehicle which monitors human life from birth till advanced age. The authors argue that policies guided by the SQ approach should be considered more coherent and oriented toward nurturing the daily lives and welfare of older persons. The three pillars of MIPAA - that is, development, health, and enabling environments emphasise the quality of life in later life while the SQ platform showed how social systems influence individual and collective aspects of welfare. This paper reveals how the SQ platform can help policy makers to address the right questions about how to address the real needs of older people and hence implement innovative forms of programmes and services.

The last paper in this issue, written by Lochana Shrestha, Shambhu Nath Pant and Sulav Shrestha discusses the 'Nutritional and functional assessment of older people at Health Home Care Nepal'. This study sought to assess the functional activities of daily living (ADL) and nutritional status of older persons admitted to Health Home Care Nepal. With the aim of developing better care management protocol, attention was placed on identifying explanatory factors of functional status among residents and the associations between their socio-demographic variables. As much as 165 residents above the age of 60 (>60 years old) took part in the study. Socio demographic information, comprehensive geriatric assessments, including nutritional and functional assessments, in accordance to a nutritional checklist and the Barthel score index were gathered respectively. Results revealed that there was a significant association of nutrition with age, gender, education and income whilst functional status was significantly associated with education and income. Significant associations were also noticed between specific socio-demographic variables with both nutritional and functional status significantly interrelated too. The paper concludes that the collection of data is deemed important for the planning of care activities and rehabilitation for admitted older persons.

As a conclusion, all six papers making up this issue - coming from different disciplinary backgrounds - are all a welcome addition to research in the field of ageing. Without doubt, findings and conclusions presented in each respective paper show that whilst ageing is increasingly evident on policy agendas in both low-income countries and in countries with economies-in-transition, there are still significant challenges and obstacles that must be recognised and addressed in order to really have a society for all ages. There is a demographic revolution occurring and we are all pioneers on how we evolve our societies to account for this new reality. In the meantime, we do hope that you find this journal's rich and varied content instructive and inspirational.

Healthcare challenges of older people with and without dementia in Ghana: An exploratory pilot study

Susanne Spittel[1], Elke Kraus[2], André Maier[3] & Karin Wolf-Ostermann[4]

Abstract. Dementia prevalence in those aged over 60 is increasing worldwide. Relevant literature shows that, in Ghana, the proportion of the elderly is growing comparatively faster than in developed countries and other parts in Africa (Agbényiga and Huang, 2012). There is, however a dearth of controlled research addressing dementia in Ghana (Quansah and Karikari, 2016). This study aims to identify current healthcare challenges facing older people and people with dementia in Ghana. The methodology used combined a quantitative and qualitative approach in its explorative, descriptive design. One hundred and seventy-one (171) questionnaires were retrieved from Ghanaian nursing students; five expert-interviews were conducted in Ghana and one in Germany. Quantitative data have been deployed in respect of descriptive methods; transcribed interviews were examined using content analyses. Despite low life-expectancies in sub-Sahara Africa this study revealed that people in Ghana live beyond 60 and become correspondingly more vulnerable to dementia than is often supposed. To this day, sufficient structures and adequate assistance facilities for the elderly do not exist. A lack of awareness of the ageing process results in stigmatisation of the aged and people with dementia. Alarmingly, Ghanaians still accuse older people and people with dementia of witchcraft. Consequently, these people living socially excluded lives in witch-camps, are often beaten or even killed. Ghana's healthcare system remains unprepared for demographical changes. Missing specialists and aged-care facilities present a relevant deficit to sufficient health care for older persons. A shift in public awareness of understanding dementia as an illness instead of witchcraft seems imperative. Lack of knowledge of ageing and dementia need to be addressed as a priority in the national agenda. Further research is strongly recommended.

Keywords: Dementia, awareness, stigmatisation, witchcraft, Africa.

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Introduction

Between 1950 and 2000 the mean age of world populations increased from 23.9 to 26.7 (Goldstein, 2009). Recent publications predict an increase to 38.1 years of age by 2050 (ibid.). In sub-Sahara Africa (SSA) life-expectancy is growing together with the risk of developing dementia (Mavrodaris, Powell, & Thorogood, 2013; Kalaria et al., 2008). Within the population 60+ the relationship between dementia prevalence and age is consistent, with rates doubling every 5.1 years (George-Carey et al., 2012; Jorm, Korten, & Henderson, 1987). Moreover, it should be stressed that dementia can occur in people below the age of sixty (60) as well, such as the case of younger adults living with HIV-associated dementia (Habib, et al. 2013). Until now no cure has been found and dementia is among the most feared diseases of older people (George-Carey et al., 2012; Kessler, Bowen, Baer, Froelich, & Wahl, 2012). Recent estimates indicate that the number of people with dementia living worldwide will double every 20 years; this means that by 2030 there will be 65.7 million People with dementia, increasing to 115.4 million by 2050 (World Health Organization, 2012). Nearly two-thirds (60 % in 2001) live in developing countries; with the figure expecting to rise to 71 % by 2040 (Prince, Livingston, and Katona, 2007). Due to low life expectancies most SSA countries are excluded from debates about population ageing (Goldstein, 2009).

Table 1. Projected population ageing in the world, low-income countries, Africa, SSA regions and Ghana from 1950 to 2050

	Population 60+ (million)			Population 60+ (% of total population)		
	1950	**2015**	**2050**	**1950**	**2015**	**2050**
Low-income countries*	6.6	33.2	114.8	5.0	5.2	8.3
Africa	12.1	64.5	220.3	5.3	5.4	8.9
Sub-Saharan Africa**	9.4	30.6	161.1	5.2	4.8	7.6
Eastern Africa	3.3	18.9	72.4	4.9	4.8	8.3
Middle Africa	1.6	6.9	24.4	5.9	4.5	6.6
Southern Africa	0.9	4.7	11.5	6.0	7.5	14.7
Western Africa***	3.6	16.0	52.8	5.1	4.5	6.6
Ghana	0.2	1.4	4.8	4.1	5.3	9.7

Source: United Nations, (2015).

*The country classification by income level is based on 2014 GNI per capita from the World Bank.

**Sub-Saharan Africa refers to all of Africa except Northern Africa.

***This includes, Saint Helena, Ascension, and Tristan da Cunha.

However, it is established that a percentage growth in the population 60+ will increase more in African than in Asian countries (Kowal et al., 2010) Ghana, a developing country describing itself as a lower middle-income country, is witnessing a greater rapid growth in its older persons than in other parts of Africa (Agbényiga, 2012). In last decades the proportion of older persons in Ghana increased rapidly (Mba, 2010). By 2050 the population 60+ is expected to more than triple (see Table 1) (United Nations, 2015).

Current estimates point out that the percentage of the population 60+ in Ghana will also age in the future (United Nations, 2015). Moreover, the current average life expectancy is 62 years and is higher than the average life-expectancy in other SSA-countries (59.2 years) (ibid.). Noteworthy to observe is that epidemiological literature on dementia in Africa is very limited – the dementia prevalence or incidence has not been subject to either study or research in Ghana (Quansah & Karikari, 2016; George-Carey et al., 2012; World Health Organization, 2012,). Estimates can, however, be used from other West-African studies conducted in Benin (Paraiso et al., 2011; Guerchet et al., 2009), Nigeria (Gureje, Ogunniyi, Kola, & Abiona, 2011; Uwakwe et al., 2009) and Senegal (Toure et al. 2012) these yielded prevalence figures varying widely between 2.6 % (Guerchet et al., 2009) and 8.9 % among persons aged 65+ (Toure et al., 2012). The demographic patterns referred to above give an indication that in the coming decades Ghana´s People with dementia is likely to rise steeply (George-Carey et al., 2012); this fact coupled with the absence of meaningful scientific research bedevils attempts at the higher policy levels to address the healthcare challenges of People with dementia. It is the purpose of this paper to explore such healthcare challenges in an endeavour to generate hypotheses for use in future studies aimed at improving the quality of People with dementia lives.

Material and methods

Study design

Using an explorative, descriptive study design, a mixed-method approach, by combining qualitative and quantitative research methods, data were collected to generate hypotheses facing healthcare challenges of Ghana´s older persons with and without dementia. Data collection took place in two urban areas of Ghana (Greater-Accra; Central-Region) in March 2012 and in Germany in August within the same year, grounded on an expertise on ageing and cultural beliefs in Ghana. Participants were selected according to the following criteria: formal integration in the health care sector, as well as awareness and knowledge of ageing and dementia in Ghana. Older persons were defined as those aged 60+. Dementia was defined based on typical signs and symptoms of the disease, such as memory loss and loss of independence in daily tasks as described by the World Health Organization (World Health Organization, 2012). Persons with dementia and people without knowledge on ageing or dementia were excluded from the study.

Ethical considerations

Ethical considerations were addressed at the Alice-Salomon University of Applied Sciences. Participants were anonymous, participated on a voluntary basis and were free to decline or terminate participation at any time. No harm or disadvantage of any sort threatened them.

Quantitative study

Sample

A convenience sample of students of three nursing colleges in the area of Cape Coast, Central Region was selected during March 2012. The area was choosen because one of two existing nursing schools specialised in mental health. Questionnaires (n=175) were distributed to those enrolled in a degree for nursing at the three nursing colleges in this area.

Outcome measures

A standardised written questionnaire was developed to collect general descriptive data about awareness on ageing and dementia. The questionnaire, based on the issues formulated in the introduction of this paper, was divided into three areas: 1) demographic information; 2) information on aged healthcare situation; and 3) information about respondents´ awareness of old people with and without dementia. Two questions gave opportunity for further exploration: Why do you think a) older people and b) dementia diseases need more attention? The questionnaire was pre-tested using a sample of 25 nurses in Ghana, and consequently the content and wording of the questionnaire was modified.

The "Approach to Dementia Questionnaire" (ADQ) – developed by Lintern, Woods and Phair (2000) was used to measure attitudes towards People with dementia. The ADQ is a 5-point Likert-scale from (1) strongly agree to (5) strongly disagree with 19 items measuring a global score (19-95) and two sub-scores, 'hope' (8-40) and 'personhood' (11-55). A higher global score indicates more positive attitudes. The subscale 'hope' (8 Items) indicates levels of hope, greater hope with higher scores. The second subscale measures recognition of 'personhood' (11 items). Higher scores indicate greater recognition that People with dementia are sentient human beings.

Statistical analysis

Basic characteristics of participants were described using descriptive statistics, e.g. absolute numbers, simple percentages, mean and median. Correlations among ordinal variables were examined by Pearson's and Spearman's correlations. Chi-square tests, Fisher's exact test and t-tests were also used to analyse the data. Explanations to the open ended questions were coded and catagorised in relation to the content: including (a) demographical aspects, (b) the health care situation of older people and People with dementia, (c) awareness and understanding of dementia, and the issue on stigmatisation and discrimination. The categorized answers were finally quantified in numbers and percentages. Significance

(nominal p-value) was set at p<.05. All statistical analyses were carried out using SPSS® (V20.0).

Qualitative study

Sample

A convenience sample of interviewees based on expertise and knowledge of ageing and dementia aimed to obtain a fair representation of key stakeholders involved in ageing and dementia care. Experts were selected on the basis of having worked for at least four years with the Ghanaian healthcare sector involving ageing or dementia. Such experts working in the field of dementia in Ghana are limited. In this regard one German expert was selected for the interview in setting up a NGO in Ghana and the knowledge of cultural aspects and ageing. Exclusion criteria include missing awarness and knowledge of ageing and dementia.
Of eight identified experts, six agreed to participate. The guided interviews were conducted with five Ghanaian experts in March 2012 and one German expert in August 2012 (see Table 2). The first author (SS) conducted the interviews. Persons with dementia have not been interviewed.

Table 2. Characteristics of the interviewees

IP 1	Researcher and deputy director of *United Nations Regional Institute* for population studies in Ghana, senior lecturer at *University of Ghana*
IP 2	Lecturer for mental health at a nursing and midwife college (Central Region Ghana)
IP 3	Assistant director of policy planning, monitoring and evaluation at *Ministry of Employment and Social Welfare* (Accra; Ghana)
IP 4	Governing social worker at the NGO HelpAge Ghana
IP 5	Medical director *o*f a psychiatric hospital (Central Region Ghana)
IP 6	German historian, founder of an association and a vocational training school in Ghana

Expert interviews conducted in Ghana (IP 1 – IP5) in March 2012 and Germany (IP 6) in August 2012. IP: Interviewee partner; NGO: non-governmental organization.

Semi-structured expert interview

The method of semi-structured interviews was used to obtain the individual views of the interviewees on an issue. The developed interview guide was lightly structured with the expectation that the interviewee reply as freely and as extensively as they wish. A number of questions were prepared to cover the intended scope of the interview. The interview guide constructed on current research and the fomulated problem:

(1) general information on aged care and dementia in Ghana;
(2) Ghana´s healthcare situation and treatment of old persons with and without dementia;

(3) deficits in the healthcare of older people and People with dementia;
(4) experts´ views of future perspectives.

Data analysis

Transcribed interviews were examined using manifest and latent content analyses based on Mayring (Flick, 2011; Mayring, 1983). Segments of the interview data were coded on the topic including the same themes used for open ended questions of the questionnaires (a) to (c).

Results

The quantitative and qualitative results are summarised in the same three categories: a) demographic aspects, b) healthcare structures and c) awareness of ageing and dementia diseases and its linkage to witchcraft stigmatisation.

Quantitative results

In total 171 questionnaires were completed. Slightly more females participated in the study (59.6 %; n=102) with an average age of 22.9 years (n=166) (see Table 3).

Table 3. Characteristics of respondents (n=171)

Characteristics	Classification	n	%
Sex	Female	102	59,6
	Male	69	40,35
Age	> 20	17	10,2
	21-29	146	87,9
	30-45	3	1,8
Year of training	2nd	101	59,4
	3rd	58	34,1
	4th	11	6,5

Questionnaires were handed out to Ghanaian nursing students (n=175) at 3 different nursing colleges in the Central Region in March 2012. The research field represents more an urban area.

The ADQ questionnaire was fully completed by 90 % (n=154). Within these answers, significant differences between respondents' gender (Fisher Exact Test, p=1.0) or age (t-Test, p=.962) have not been found. 98.8 % of the responding nursing students were of the opinion that older people (n=168) and dementia diseases (n=163) need more attention. The majority gave further exploration why older people (86 %, n=146) and why dementia diseases (81.3 %, n=138) require more attention. Those argued along demographical aspects (e.g. older age as a risk for developing dementia), the poor healthcare situation for older persons, awareness of ageing and dementia and its linkage to witchcraft stigmatisation.

Demographical aspects:

Results of the survey revealed that people in Ghana reach ages above 60 years. Respondents indicated an average age of 80.3 (±13.9) for their grandparents. About 18 percent acknowledged that grandparents in their family suffered from dementia symptoms, such as memory loss and loss of independence in daily tasks (see Table 4). 21.9 % (n=32) argued that the risk of developing dementia is the reason as to why older people need more attention (see Table 5).

Table 4. Age of the grandparents with and without dementia symptoms of the respondents

	Mother´s side		**Father´s side**	
	Grandmother	**Grandfather**	**Grandmother**	**Grandfather**
Mean age	79.3	80.1	80.5	81.6
Median age	79.0	80.5	80.0	81.0
Valid data	n=121	n=106	n=107	n=91
With dementia valid data	13.5 % (n=23) n=124	9.9 % (n=17) n=112	11.7 % (n=20) n=101	10.5 % (n=18) n=94
Mean age	84	82	81	81
Age median	83	80	80	80
Valid data	n=23	n=15	n=14	n=11

Survey of nurses: Questionnaires were handed out to Ghanaian nursing students (n=175) at 3 different nursing colleges in the Central Region in March 2012. The research field represents more an urban area.

Table 5. Three main categories of answers quantification to the open-ended questions of the surveyed nurses (n=171)

Reasons why older people need more attention (n=146)	**Reasons why age-related diseases need more attention (n=138)**
a) Demographical aspects –prone to dementia	
21.9 %; n=32	15.9 %; n=22
Many people especially those in the rural areas [are prone to dementia]. During that age, they tend to lose concentration in their surrounding and behave childishly. Due to the condition they at times behave as children and will this they require much care and attention. They need care because they are prone to dementia.	There are a lot of people with dementia in Ghana. It is now on the increase. Everybody is predisposed to as soon as one gets to the age 60+. Most old people might have suffered the disease but they might not be aware and have no insight into the disease.

b) Healthcare structures – need of care	
52.1 %; n=76	19,6 %, n=27
Most of these aged are always needy and poor and sometimes lack proper living homes and therefore need to be given attention by other and the nation as well. Some do not have people to care for them so aged care facilities should be put up for them. No care or specific facility is being offered to them. Because most family members find it difficult to care for them.	A lot more of the aged groups are not being cared for. They need more care since they can´t undertake activities on their own. It is a disease and it must be treated and managed. Most of them are not cared for and are neglected. The government does not include mental patients (demented clients) in the drawing.
c) Awareness of ageing and dementia and the issue of witchcraft	
13.0 %; n=19	34.1 %; n=47
Old age is mostly not understood by people. They are sometimes neglected by family and people in the society. Most are being neglected by their relatives hence they need more attention and support from amateurs. Some of these people are branded as witches and wizards and are left alone by their families. We turn to neglect them and call them witches. People neglect them due to problem associated with ageing and relate it with witchcraft. The aged are sometimes considered to be witches and wizards and so they are neglected and sometimes society says they are the cause of their own predicaments.	People in Ghana does not have much knowledge about dementia. There is inadequate education about dementia. People try to neglect them due to their behaviour. There is a need for an awareness to be done on the condition since most people, who find themselves in such state do not have the insight and therefore effective care is not given. People don´t know the disease and associates it to witchcraft. Normally when dementia occurs in the aged, people often attribute it to witchcraft neglecting them. Most old people in Ghana with dementia are being classified as witches and are being maltreated at all times.

Nota bene. Questionnaires were handed out to Ghanaian nursing students (n=175) at 3 different nursing colleges in the Central Region in March 2012. The research field represents more an urban area.

Moreover, respondents had significant contact with People with dementia – 35.2 % (n=56) in their private field and 70.2 % (n=120) in their working environment. ADQ mean values (Global: 66.6; Hope: 24.5) are located in the middle third of the value range and indicate positive attitudes of nurses towards People with dementia and a moderate level of hope. The average value for recognition of personhood (∅ 42.1) is in the top third and indicates an even more positive attitude of respondents towards People with dementia in terms of they are recognised as sentient human beings.

Healthcare structures:

Respondents referred to people they met who were in need for permanent care (47.3 %, n=79), the majority (62.6 %, n=57) suffering from dementia symptoms. 9.9 % (n=16) referred to nursing homes, but named psychiatric hospitals (n=9) instead of places where older people are cared for. The majority (52.1 %, n=76) see a need for care for the aged and aged-healthcare structures that barely exist (Table 5). Moreover, assistive devices and aids are difficult to organise. 54.1 % stated being able to obtain canes or walking sticks. About 30 % felt there were opportunities to obtain walking frames, wheelchairs or incontinence materials.

Awareness of ageing and dementia and the issue of witchcraft:

Nearly all participants (95.8 %, n=159) indicated that the term dementia was part of their nursing curriculum. 34.1 % (n=47), suggested a lack of knowledge of dementia among Ghanaians and referred to resulting stigmatisation of People with dementia, e.g. through not knowing their condition and behaviour (Table 5). The obvious neglect of older people was quoted by 13.0 % (n=19) of participants to be another reason to increase the focus on older people. Accusing older people (5.5 %) and People with dementia (13 %) of witchcraft appears to be a major stigmatisation issue. Furthermore, results revealed that neglecting older people and People with dementia is not only an issue among other community members; it also occurs within the families.

Qualitative results

As with the quantitative data, the results of qualitative data collection based on six expert interviews (Table 3) are summarised in the same categories.

Demographical aspects:

Interviewees (IPs) pointed out that Ghana´s population becomes increasingly older. "Ghana is gradually ageing as the proportion of older people doubles out every ten years". (IP3) "[…] older people need more attention because of advancing age". (IP1) Reasons for rapid ageing in Ghana according to experts are the decline of fertility rates, improvements of life conditions and better viabilities of Ghanaians (IP1; IP6). Reduced infant mortality and high numbers of children with better viabilities indicate that more elderlies will live in Ghana in the future (IP6). Furthermore, all interviewees pointed out that Ghana's population show effects of urbanisation, e.g. the extended family system is breaking apart. Younger Ghanaians see chances in big cities like striving for better education and perspectives (IP1; IP5) or looking for ways going abroad for better life-standards in developed countries (IP6). Additionally, younger persons do not want to live extended-family ways anymore. Nowadays they use family planning methods. "People want their privacy […]. They want to go the nuclear family way." (IP1) Because of urbanisation older Ghanaians will stay behind in rural areas without any help to counter their problems. "Now, more older people living alone, because other family members migrated […]." (IP5)[…] if you are an older person how will you survive?

Because first you are not working, you are not having any stable source of income. So, you just become […] a pop-up on the streets. (IP3)

Healthcare structures:

All interviewees stated that aged care facilities and geriatric wards in hospitals are virtually non-existent. "They [older people] are provided with general healthcare like any other age group." (IP3)

> We don´t have a geriatric service-centre for older people. And that is a must. […] that is something we should have. (IP3)
> So, whether the family likes it or not, they have to live with them. Or they have to get people to live with them. (IP4)

Furthermore, there are few geriatric-experts, so the diagnoses for dementia is rare. Especially the population without medical training would have difficulties in identifying dementia symptoms. People define anything mentally abnormal as madness.

> I don´t think we have any procedure for diagnosing dementia in Ghana. We only look at your age and the behaviour you putting like and diagnose that as dementia. But it will be difficult for Ghanaians. (IP2)
> Nobody screens for dementia. To the Ghanaians' society those things are in code madness. Nobody screens for madness. (IP5)

Awareness of ageing and dementia and the issue of witchcraft:

The interviewees also spoke about the lack of knowledge and awareness of the ageing process. Older people and People with dementia are seen as useless with the result that these people are left alone.

> There is a mentality that when somebody gets the age of 60 the person is useless. […] The person should just go home and sit somewhere and wait for the time for them to die. (IP3)

Strong traditional beliefs are a reason why people in Ghana still accuse and condemn People with dementia with practicing witchcraft. Especially older females are regarded as witches. Medical explanations – like memory problems, confusion, and wondering during menopause – are rarely used.

> […] it is a belief concept that we have about the aged. That especial the female aged are considered to be witches. (IP2)
> People start behaving strangely […]. We believe that is witchcraft. (IP4)
> When women get to their menopause period they act funny. Sometime[s] their behaviour can be abnormal and because of that, people accuse them of witchcraft. (IP3)

Being accused as a witch has enormous consequences for older persons, and even more if family members reject them and stop to care for them.

> People will just accuse them [people with dementia] wrongly that they are witches. And then more treat them, mistreat them in a lot of ways, some people are killed and some people are banned. (IP3)
> If you go to the prayer camp, because of the signs and symptoms of dementia, some are confessing they are going out of delusion, they are saying they are witches. They will even take the family members away from them. […] if you are a witch, means you are not somebody that will get help by the family. (IP2)

Discussion

Ghanaian nursing students and healthcare experts indicate several challenges concerning the healthcare situation of older persons with and without dementia. The responses to the questionnaires had a high response rate from the nursing students who were predominantly female and, with an average age of 22, tended to reflect the views and attitudes of the younger generation. The healthcare experts, although predominantly male and demographically older, expressed views and attitudes which were very similar.

United Nations Population Estimates and Projections (2015) show Ghana´s current life expectancy is slightly over 60 years (United Nations, 2015); in contrast, responses to the questionnaire show that many of the nursing students perceived their grandparents to be aged over 80. This discrepancy is difficult to analyse not least because prior to 1965 there were no proper procedure of registering birth and death (Mehta & Assie, 1979; Ghana: Act No. 301, 1965). However, the fact remains that Ghana´s younger population is growing and younger Ghanaians discern older persons living in the country. Improved living standards and better viabilities of the older population will steadily rise and will continue to do so in the future (United Nations, 2015; Mba, 2010). Abgényiga and Huang (2012) conclude that Ghana is one of the most rapidly ageing countries in Africa (Agbényiga, 2012); the Wolrd Health Organization (2014) believes that the ageing population in Ghana is growing faster than in many developed countries. Furthermore, many of the survey respondents had contact with People with dementia within their work environment and their private field. Low life-expectancy and high fertility rates should not eliminate the fact that people in Ghana can reach to old age and are prone to dementia.

Dementia prevalence is understudied in Ghana, but studies from other West-African countries like Benin (Paraiso et al., 2011; Guerchet et al., 2009), Nigeria (van et al., 2011; Uwakwe et al., 2009) and Senegal (Toure et al., 2012) show that Ghana, with its higher life-expectancy (United Nations, 2015), is highly likely also to have a higher dementia prevalence. This hypothesis demonstrates that dementia should not, be seen only as a 'white people's disease' relevant for study only in Western or developed societies. The demographic changes referred to above require national policies designed to meet the needs of older persons with and without dementia. Yet Ghana's healthcare system fails at present to address these

challenges; as still, Ghana´s health-care infrastructure is inadequate, supply of medicine insufficient and health-care facilities and providers are in a short supply (World Health Organization, 2014). In this respect, results of this study show that aged-care facilities and geriatric wards are to this day, non-existent, and assistive devices like walking sticks or a walking frames are extremely difficult to organise.

Family assistance becomes, in this context, much more important and yet the extended family-system – an important traditional system caring for the older members of the family – is breaking apart (Apt, 2001; Apt, 2002). Younger Ghanaians look for better education in cities or trying to go abroad. Consequently, older persons are left behind in rural areas. This issue is also addressed by other studies (Mba, 2004; Van der Geest, 2002). In rural areas the healthcare situation is much more frightening and can impair the health condition more negatively. Apt (2001; 2002) described the neglect of older people because of the changing family-system. Ogwumike and Aboderin (2005) identified a higher risk of older people living in poverty and that they are much more likely to depend on family support than younger adults. It may be assumed that the number of younger people aiming to go the 'nuclear family' way and using family planning methods will increase in the future. Furthermore, Ghana´s women now have access to education, training schools and universities. Universities in Ghana have embarked on strategies to increase the enrolment of female students (Kwapong, 2007). This empowerment of women could influence their involvement in taking care of older family members, with the consequence that the number of older Ghanaians, with and without dementia left behind and living alone in the rural areas will increase and they will be left helpless (Apt, 2002). Experts in geriatric care who diagnose dementia diseases are extremely rare in Ghana, so even those families wishing to understand and deal with dementia do not have access to relevant information.

The failure of Ghana´s policy makers to provide adequate care for older persons with and without dementia (in distinction to the extant 'ageing policy') is hard to understand (Yiranbon et al., 2014). The rights of persons with disability to treatment is enshrined in Chapter 5 of Ghana´s Constitution as a 'fundamental right'; it is prescribed that persons with disabilities have the inherent right not to be subjected to differential treatment in virtue of their disabled condition as well as the right to be protected from discriminatory, abusive or degrading treatment (Art. 29 (2) & (4)). The reason why the general lack of awareness of the linkage between ageing and dementia among the Ghanaian public (as supposed to the nurses and health professionals) proves particularly problematic for People with dementia is the widespread belief in witchcraft (Ofori-Atta et al, 2010). Witches are believed to possess the power to cause sickness, blight their enemy´s crops, cause impotence and sterility and death; the secrecy of their identity creates in people paranoia and suspicion especially against older women (Bannerman-Richter, 1982). Older women with and without dementia are still often stigmatised as witches (Badoe, 2012). Higher stigmatising attitudes towards people with mental illness are related to lower educated people (Barke, Nyarko, & Klecha, 2011). This study reveals a connection between witchcraft accusations and living with dementia because people do not understand symptoms of dementia such as memory loss and loss of daily tasks. For example in the Northern part 'Gambaga' over 3,000 women are condemned as witches and excluded from society and family by being forced to live in witch-camps – gloomy tiny

huts without clear water and lacking hygiene (Badoe, 2012). Aboderin (2006) observes that the stigma was also often attached to older women lacking the support by their own children (Aboderin, 2006). Ofori-Atta et al. (2010) further conclude that those suffering symptoms of menopause are also subject to similar treatment (Ofori-Atta et al., 2010). A further example is the story of a 72-year-old woman, who was burnt alive to death for being a witch. Her son explained that his mother was never a witch but was only exhibiting signs of forgetfulness and other symptoms of old age (Smith, 2010).

A way forward is shown by the surveyed nurses who, in the light of their training, showed a more positive attitude towards People with dementia which could indicate that they will treat them in better ways. This should help to counter the inhumane effect on older people and People with dementia resulting from the prevailing cultural beliefs′, and contribute to the realisation that older persons living with and without dementia deserve to be treated with dignity and humanity. This survey has been limited to a small sample and has also suffered limitations because of the language barrier. English is the official and educational language but within families the spoken language varies strongly in terms of cultural backgrounds. Survey-participants represent one urbanised region. Nurses from other country-areas may not get lessons on dementia and beliefs or attitudes towards older people with and without dementia could be different, especially in rural areas where traditional beliefs seem to be stronger than in the Northern parts where the accused witches live (Badoe, 2012).

Conclusion

Ghana′s healthcare system remains unprepared to address the ageing population and the related increase of age-related diseases like dementia, as evidenced by the lack of specialists, and the absence of aged-care wards in hospitals. Debates about this issue should not be hampered in SSA simply by the perception of low life-expectancies and high fertility rates as this study shows that SSA is home to older persons and People with dementia than it is commonly assumed. The absence of debate and the corresponding lack of public awareness lead to stigmatisation and accusation of witchcraft. In this regard, awareness campaigns are required as a matter of urgency through which healthcare workers and geriatric experts need to raise public consciousness. In the absence of such public awareness and the input of experts on geriatric care older persons with and without dementia are unable to enjoy the right to live the kind of dignity and absence of discrimination that the Constitution of Ghana guarantees to them.

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Economic recession, challenges and coping strategies among the rural aged in Selected communities in Ile-Ife of South-Western Nigeria

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Abstract. Many studies have been carried out on the impact of economic recession on the populace, however these studies have failed to focus on impacts on rural aged. This oversight may be attributed to the fact that provision of care and support for aged parents is considered the responsibilities of the adult children and other relatives in the Nigerian context. Inspired by the challenges faced by the rural aged during the last Nigeria's economic recession, this study was conducted to investigate the impact of economic recession on the rural aged, particularly as it affects the high costs of their drugs, nutrition and adult children's inability to provide the necessary care and support due to unemployment and underemployment and mechanisms employed to mitigate these shocks. Four low-income residential rural areas in Ile-Ife namely: Abiri-Ogudu and Owena in Ife East and Tokere and Akile in Ife Central Local Government Areas were purposively selected for the study. Primary data was obtained utilizing both quantitative and qualitative data. In all, 240 questionnaires were administered to both men and women aged 70 years or older out of which 200 were retrieved from the selected communities. Altogether, 16 in-depth interviews were also conducted with men and women aged 70 years or older. The results indicate that the economic recession affected the aged in various ways including their inability to afford food and drugs due to high cost. Also, poor living condition, increased poverty combined with adult children's inability to provide financial and material support were found to have resulted to the aged inability to eat nutritious food or three times in a day. The coping strategies adopted include involvement in subsistence farming, petty trading, dependence on remittances from offspring, financial and material assistance from religious organizations, working for other people, alms begging and pension among others. The paper concludes that the economic recession has impacted negatively on the rural aged and suggests that there is need for government to address the needs of the rural aged left behind by their adult children who are in search of greener pasture in towns and cities.

Keywords**:** economic recession, rural aged, challenges, coping strategies, Nigeria.

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Introduction

The last two decades have proven extremely thorny for the Nigerian economy. The economic situation was so bad that the Central Bank of Nigeria (CBN) and the Minister of Finance (2016) announced that the Nigerian economy was in recession. The set of macroeconomic data released by the National Bureau of Statistics (2017) also proclaimed that the economy was in bad shape and has indeed slid into recession, contracting to -2.06 percent in the second quarter of 2016 after an initial negative growth of -0.36 percent in the first quarter of the same year. Since then, the term "economic recession" has become a subject of commentary by different shades of analysts, public affairs commentators and has also been a daily song on the lips of every Nigerian including the aged (Noko, 2016). It comes to no surprise that economic commentators Onyinye Nwachukwu and Chux Ohai in their article published in The Punch Newspapers (2016) entitled: 'Nigerians groan as economy bleeds' lamented the acute poverty and hunger being experienced by Nigerians as a result of the downturn of the economy.

According to Alisi (2016), economic recession is a period of general economic decline usually as a contraction in the GDP for six months (two consecutive quarters) or longer. The period is usually marked by high unemployment, stagnant wages, and fall in retail sales accompanied by high increase of inflation resulting to low purchasing power of many people**.** The National Bureau of Economic Research (NBER, 2008) defines a recession as a significant decline in economic activity spread across economy, lasting more than a few months, normally visible in a real gross domestic product (GDP), real income, employment and industrial production and wholesale-retail sales. Eneji, Mai-Lafia and Weiping (2013), observe that the current economic crisis confronting the Africa's most populous country has had a catastrophic and debilitating effect on the generality of Nigerian populace including the aged. According to them, the current Nigeria's economic situation has not only reduced the purchasing power of aged but also of those of their adult children who are supposed to obtain the goods and service needed to secure the wellbeing of their aged parents. Sadly, economic recession is a period when employers, both public and private sectors of the economy are compelled to place embargo on further employment while others adopt either retrenchment or pay cut as a survival policy (Omololu, 1990). The Nigeria Bureau of Statistics (2016), while reporting Nigeria's ailing economy indicate that 3.67 million Nigerian graduates of tertiary institutions became jobless in the fourth quarter (Q4) of 2016. The report also shows that the number of all the unemployed youths has increased to about 11 million in the third quarter of 2016, from around 9.5million recorded in the first quarter of the same year; while output contracted by 2.4 percent over the same period. This figure was expected to increase in 2017 due to continuous loss of jobs. This general economic situation cuts across every sphere of life: business, technology, industry and education and has affected all category of people in a number of ways, particularly adult children who are supposed to provide necessary care and support for their aged parents (Noko, 2016). The economic commentators have also argued that while the economic crisis has affected nearly all Nigerians, the aged and their adult children bear much of the shock as a large number of them have share of job losses in period of economic recession (Afolabi, 2017). In practical consequence, those mostly affected by the recession are the low-income households particularly households that are being resided by the aged and other households where adult children have migrated to urban areas in search

of greener pastures (Eboiyehi, 2010). The migrant children who are fortunate to get employment are so far away from their aged parents and so, are unable to discharge their filial piety (Liu, 2016). There is no doubt therefore that the present economic recession in Nigeria has placed many of the aged at the bottom of the well-being scale and at the risk of exclusion (Hurd & Rohwedder, 2010).

Traditionally, the role of children in providing economic support for their aged parents has been constantly maintained by scholars (Oyeneye, 2003; Ebigbola, 2000; Adawo & Atan, 2013; Fajemilehin, 2000; Udegbe, 1990; Fapohunda & Todaro, 1988; Orubuloye, 1987; Caldwell, 1982). For instance, Udegbe (1990) has observed that in the past, the aged among the Yoruba of south-western Nigeria were dependent on their adult children for physical, social and economic support particularly when they are too old to engage in domestic and agricultural work. With advancing age, adult children in conjunction with the extended family members cater to their needs through collective efforts (Eboiyehi & Onwuzuruigbo, 2014; Cattell, 1993). This cultural practice was feasible because adult children and their aged parents lived together in the extended family household where they managed to survive on subsistence agriculture (Eboiyehi, 2008a; Okojie, 1994). Udegbe (1990) notes that while the able-bodied men and women worked in the farm, the aged stayed at home to look after the children in reciprocal relationships. Ebigbola (2000) argues that adult children whether or not they have moved away; have married or have children of their own provide economic, medical and psychological support to their aged parents especially when they are unable to support themselves. According to Fajemilehin (2000), at that period, the aged neither experienced economic hardship nor do they suffer poverty and hunger as it was culturally imperative for adult children and members of the extended family to provide their basic necessities. Fajemilehin (2000) further explains that this practice was possible because the traditional Nigerian society was based on descent and kinship ties that enhanced group solidarity and reverence for the aged. Therefore, in the absence of formal social security, the aged relied on these people for their economic support. Support in this sense is defined in terms of space (e.g. co-residence), material (e.g. money or goods) or time (e.g. household assistance or care), and transfers (Eboiyehi & Onwuzuruigbo, 2014). The aged could also move freely among members of the extended family and be assured of best of care and support. The social relationship and structure of the extended family were such that they promoted closeness among members, thus reducing the problems of economic crisis among the aged (Oyeneye, 2003). By this, the physical, economic, social and emotional needs of the aged were met through this informal network (Fadipe, 1970).

However, the role of adult children and the extended family system described above are now being threatened by an economy that is bedevilled by recession. This has resulted in the face of high unemployment and high rate of inflation, the normative expectation of the aged that they would be catered for by their adult children/relatives in the evening of their lives could be uncertain. With high unemployment rate, adult children who are struggling to keep their immediate families may barely have enough to meet their own needs, let alone saving enough to cater for their aged parents (Ogwumike & Aboderin, 2005). Evidence from the National Bureau of Statistics (2017) indicates that youth unemployment had reached a pandemic scale to the extent that it is almost impossible for adult children to meet the needs of their aged

parents. NBS (2016), Olasnde (2016) and Ashinuneze (2011), maintain that over 40 percent of Nigerian youths are unemployed and that about 20 percent of them are so poor that they cannot afford three square meals a day meaning that they will not be able to cater for their aged parents. The Bureau also stated in the report that the number of people that were unemployed or underemployed increased from 24.4 million as at the end of the first quarter to 26.06 million persons. The resultant effect therefore is the decline in purchasing power as the rising cost of medical bills and price of food items may force many of the aged to reduce their household budgets leading to high risk of poverty, poor diet and all the associated health impacts.

Sadly, the economic recession occurs at the time the extended family system which used to sustain older family members is diminishing, placing a high-risk factor for the longer-term mental health of the aged (Fajetimehin, 2000). Coupled with the above is the defective pension and gratuity management which has led to severe delays - up to several months - of pensions, and to non-payment of terminal benefits of retirees (Ogwumike & Aboderin, 2005). Furthermore, those who managed to save have seen their reserves depleted or eroded through inflation and worsening exchange rates (CBN, 2014). This situation may further contribute to the large number of older persons destitute who were either formerly wage paid workers or those that have been abandoned by relatives who themselves are retrenched without any means of livelihood (Togonu-Bickersteth, Akinnawo, Akinyele & Ayeni, 1997). This means that the prevailing economic situation in the country has provided the impetus for the existence of older persons begging on the streets in Nigeria (ibid). There is no doubt therefore that the present economic situation has overnight spurned an army of helpless and needy aged who may need to survive the hard times.

Studies have shown that economic hardship among the aged is more felt in the areas of health (Fajemilehin, 2000). In the rural areas, which is the focus of this study, health care service is a scarce commodity and when available, it is unaffordable to the aged (Fajemilehin, 2000). Consequently, the traditional means of health care service becomes the better option to them (ibid.). It therefore becomes necessary to examine the consequences of economic recession on the aged and their survival strategies. In addition, a study of this nature would be fascinating as economic recession affects both the aged and their adult children (their presumed primary caregivers) who by reason of economic downturn do not have enough resources to cater for their needs, the needs of their immediate families and those of their aged parents. In spite of this reality, there have not been many studies in Nigeria that have examined the impact of economic recessions on the aged in rural Nigeria. It is in this respect that this study was conducted in four low-income rural communities in Ile-Ife of south-western Nigeria namely: Tokere and Akile (Ife Central Local area) and Abiri-Ogudu and Owena (Ife East Local area).

Research Questions:

The questions addressed by the study are:

i. What are the challenges confronting the aged in rural areas in period of economic recession?
ii. What strategies do the aged adopt to address the identified problems?

Research Objectives:

In order to answer these research questions, the specific objectives are to:

i. examine the challenges confronting the rural aged in period of Nigeria economic recession in the study area; and
ii. investigate the various strategies adopted by the aged to address the identified challenges.

Conceptual Clarification:

The following concepts are defined within the context of this paper.

Economic Recession. For the purpose of this study economic recession is defined as a downturn in the economy. It is an economy characterized by symptoms such as rising prices of goods and services, inability of government and individuals to meet financial obligations, exchange rate fluctuations, and poor performance of other macroeconomic variables which defines the state of the economy per time.

Aged. The term aged as used in this paper implies men and women aged 70 years or older who by reason of old age and ill health are unable to provide for themselves. In this paper the terms "older persons", "aged", "older men" and "older women" are used interchangeably.

Survival Strategies. These include various mechanisms employed by the aged to cope with challenges imposed by economic recession.

Rural areas. For the purpose of this paper rural areas refer to the countryside with sparsely populated, agricultural community with large concentration of aged with low income.

Theoretical framework

The political economy theory frames this study. Political economy originated from the work of Adam Smith. In his *Wealth of Nations*, Smith (2007) posited that real wealth is the annual produce of the land and labour of the society. He considered political economy to be a science of the state man, to supply plentiful revenue for the people and to enable them to provide such revenue sufficient for public services. In the critic of the political economy Marx (1976) maintained that conflict between social classes was the driving force of change throughout history (Marx & Engels, 1976). With the arrival of industrial era, this conflict became one between capitalists and the working class. Marx posited that there is a constant struggle between the bourgeoisie and the proletariat and that the bourgeoisie is driving down wages lower and lower making it difficult for the proletariat to live decent lives (ibid.). As such, political is concerned with the interplay between politics and economics and it is grounded on the fundamental observation that politics and economics are inherently linked (Asiimwe, 2015). It is the interconnection between political climate (government policies, peace and social order, security of life and property) and the economic situation that accompany it

(Roncaglia, 2003). The political climate influences the economy of a nation and determines the economic situation of the people and their general quality of life generally.

Political economy theory becomes relevant to this study owing to the fact that the current economic recession in Nigeria has made it difficult for most Nigerians to meet their basic necessities of daily living. This is specially so for the aged in the rural areas (Eboiyehi, 2013). This segment of the population live in abject poverty and many of them survive on stipends sent by their children that live in towns and cities (ibid.). Currently, the economic recession has brought about much hardship on the working population (Noko, 2016). As such, many people in towns no longer send money to old parents in the rural areas thereby compounding the challenges faced by the aged (Apt, 2000). In the midst of all of these, the aged are battling with a lot of health challenges which also require money for treatment (Makoge, Maat, Vaandrager & Koelen, 2017). As a result of the problem of poverty, many of them do not attend hospitals when they are sick but rather resorted to self-medication and in this way many of them die avoidable deaths (ibid.). To make matter worse, healthcare has become very expensive in Nigeria due to the current economic situation in Nigeria (Menizibeya, 2011).

Importantly, the Nigerian government has not come out with a clear welfare package/policy or social security system that would take care of the aged (Eboiyehi & Onwuzuruigbo, 2014). Unlike in the developed world, there are no old people's home and geriatrics in Nigeria for them (ibid.). It is therefore not surprising that this segment of the population is left to be catered for by their children who are themselves are facing economic hardship which prevents them from carrying out the roles expected of them such as sending money home to aged parents in the rural areas (Eboiyehi, 2008a). This situation constitutes stressors in the family which tend to weaken the strong family ties enjoyed by Nigerians in the traditional Nigerian society. Furthermore, among the aged are the childless who have nobody to cater for them and who depend on charity which has dwindled in recent times (Eboiyehi, 2009). Many of them now resort to begging and eating in scarcity which has serious implications for their health and quality of life (Togonu-Bickersteth, Akinnawo, Akinyele & Ayeni, 1997; Eboiyehi & Onwuzuruigbo, 2014).

Using Smith (2007)'s idea, political economy as the common wealth of the Nigerian nation produces plentiful wealth which has been left in the hands of the privileged few and majority are suffering due to corruption and ostentatious life style of the political class which has partly resulted in the recession in the first place (Aloko, 2018; Awojobi, 2015; Achebe, 1988). As such, public services are not readily available and there is no tangible policy on the welfare of the aged as it is generally believed that it is duty of the children and the extended family of the aged to cater to them (Eboiyehi, 2019). This privileged few as Karl Marx's bourgeoisie while the majority of Nigerians are the proletariat. This is the scenario which is faced by older persons in contemporary Nigeria and it is not clear when this scheme of things will change.

Methodology

The study involved data collection using both quantitative and qualitative methods. Data for the study was collected quantitatively through the administration of questionnaires at the

household level, while qualitative data were collected through in-depth interviews involving men and women aged 70 years and older. The study was carried out in four low-income areas with high concentration of older persons. The selection of these areas was influenced by the fact that households in these areas are more affected by the prevailing economic conditions. In this study we define low income households as those families whose annual income is not adequate enough to provide basic family need of clothing, shelters, health care and food. According to Kalu, Agbarakwe and Anowor (2014), low income group includes employees or the self-employed whose income per annum is ₦216, 000 that is ₦18,000 minimum salary per month of which 70% of Nigerians fall within this earning group.

Using questionnaires, the household survey was conducted to elicit information on the effects of the Nigeria's economic recession on the aged; specific challenges confronting them and mechanisms employed to mitigate the identified challenges. Four low-income residential areas of Ile-Ife namely: Abiri-Ogudu and Owena in Ife East and Tokere and Akile in Ife Central Local Government Areas were sampled. The questions posed to the participants centred on their socio-economic characteristics, such as their ages, highest level of education attained, number of surviving children, number of co-residing and non co-residing children, number of working and non working children and whether they receive remittances from the working children among others. Furthermore, 16 in-depth interviews among men and women aged 70 years and older was conducted. The in-depth interviews focused on the specific challenges confronting the aged while the third part dwelled on various mechanisms, they adopt to mitigate the identified challenges. The in-depth interviews were mainly conducted in the Yoruba language because the aged of the selected communities are largely Yoruba-speaking and are not verse in English language. Quantitative data obtained were collated and tabulated. The Statistical Package for the Social Science (SPSS) software was used for the basic statistical analysis including simple percentages. The qualitative data obtained from the in-depth interviews were translated, transcribed and content-analyzed along with the main theme of the study.

Contextualising rural household in Ile-Ife

Ile-Ife is located in Osun State in South-western Nigeria. It is comprised of over half a million inhabitants and its people speak Yoruba language. Majority of the population of Ile-Ife reside in the rural areas. Before having established contact with the Europeans, the habitants were mainly farmers who lived in extended family household (Facts.NG, 2018). Each man had the assistance of the dependent male members of his family in tilling the field, planting crops, as well as reaping while the women were expected to harvest crops (Fadipe, 1970). The sexual division of labour between the husband and the wife is carried over to the disposal of the farm produce (ibid.). The wife is responsible for selling either an elaborately processed form or practically as harvested, some of the products of the farm that are in excess of the normal requirement of the farmer and his family. While the unmarried girls assist their mothers at whatever may be their occupation, sons from age six up to marriage assist the father in productive operation on the farm (Okojie,1994). Therefore, a Yoruba man in the olden days had to rely on his own labour, supplemented by that of his wife or wives, unmarried sons and daughters, the labour of the extended family members and on the labour of slaves and peons

(Fadipe, 1970). The only source of commercial labour which could be obtained in the pre-colonial days was that of slaves and pawns otherwise, it was not the practice to sell labour of free-born was freely given when required but on the basis of mutual reciprocity (ibid.).

Support was provided through extended family networks for the vulnerable members. Of the two kinds of collective help of a productive nature which the farmer may rely on in certain circumstances, one has to be specially commissioned by the party desiring, it is known among the Yoruba as 'owe' (Oyerinde, 2006; Arinola, 2005; Fadipe, 1970). It is used in building a house or to rebuilding or re-roofing of one's house and the clearing of land or bush or forest growth (ibid). In this kind of cooperative help, a man son in-law and other relatives together with friends and neighbours will take part (Eboiyehi, 2008a; Oyerinde, 2006).

Besides 'owe', there is a form of standing association for mutual help known as 'aro'. A number of 'aro' associations are entitled to call upon the entire group to come and help him on the farm, either to clear the land of the weeds preparatory to planting or to plant seeds. All the obligations that fall upon the host is, as in the case 'owe', to feed his associates and second to reciprocate in kind (Oyerinde, 2006)

The people of Ile-Ife's contact with the Europeans began with the 'Missionary Society' which introduced Christianity that has remained the dominant religion in Ile-Ife ever since. The church was also involved with promoting education, translating and printing the Bible in English and establishing schools. The first schools were "pastor's schools" in which children were taught reading, writing, and arithmetic (Babalola, 1976). The majority of changes had been material items adopted from European culture, but the acceptance of Christianity and the introduction of formal education had been the most significant elements of change through the mid-1950s (Mbachirin, 2006). Since then, there had been general improvement of the standard of living in Ile-Ife as there are increased opportunities for wage employment, agricultural improvements, and consolidation of schools, among others (Effoduh, 2015). In short, the modern era began in Ile-Ife shortly after Nigeria gained political independence in 1960 (Facts.NG, 2018). The first priority project of the government of western region included the establishment of the University of Ife (now Obafemi Awolowo University) located in Ile-Ife (ibid). Other projects included the construction of modern roads and modern markets. Health and sanitation standards were also important aspects of the rehabilitation campaign, with major efforts directed toward eradication of diseases (Facts.NG, 2018). Another health measure introduced was a family planning programme, which was embraced by the inhabitants. This has consequently led to the reduction of childbirth in the area, especially in the urban area (Esike et al., 2017).

The most dramatic changes, however, was in the economic sphere. The establishment of banks, hospitals, schools and industries provided employment for young school leavers (Akintoye, 2010). By the time this study was conducted, these changes were evident. A large number of Ife people, mostly young school leavers, were working primarily in the wage-labour market (Adepoju, 1976). Others migrated to other urban centres in search of employment (Ajaero & Okafor, 2011). With the increased availability of wage employment opportunities, fewer people engage in agricultural activities or are available to assist their

parents on the farm (Torimiro, 2013). Imports of food had become increasingly important as they had demands for other products such as automobiles, television sets, and clothing, among others. It is not surprising that a few specialty shops selling ready-made clothing, shoes, or sports equipment have been established in recent years especially in the urban Ile-Ife towns. There are also a variety of recreational activities on which the habitants spend their money (for example, movie theatres, night clubs and tennis courts (Akinjogbin, 1992)

The educational system in the area ranges from early childhood education for preschoolers, through primary schools, secondary schools to tertiary institutions. Like every other Nigerian cities, housing has also become increasingly western. Telephone and television service is available in virtually all the towns and villages. Improvement in communication and transportation has made life more interesting as many people are now more aware of happenings within and outside their own locale and no doubt encourage some of the changes within it (Alhaji and Lawal, 2017). These kinds of changes, along with urbanization and rural-urban migration, have been suggested as those most likely to negatively affect living arrangements of the aged and their economic support in the study area (Eboiyehi & Onwuzuruigbo, 2014).

Results

Socio-Economic and Demographic Characteristics of Respondents

The respondents for this study were drawn from four rural areas namely, Abiri-Ogudu, Owena, Tokere and Akile within Ife East and Ife Central Local Government Areas of Osun State, Nigeria. The age structure of the respondents in the sample indicated that 31.0% were aged 70-75 years, 27.5% were in the age group 76-80 years, 26.5% were within the age cohort 81-85, 12.5% in the age bracket 86-90 years while only 2.5% were above 90 years (Table1). This revealed that over 40% of the respondents (i.e. 41.5%) fell within old-old age group (i.e. above 80 years). The implication for this is that majority of the respondents within this age group might be too old to engage in economic activities that would enable them fend for themselves.

Table 1 also showed that the sexes of the respondents were equally represented (50% males and 50% females). Half of the respondents (50%) subscribed to African Traditional Religion (ATR) compared to 35% Muslims and 15% Christians. With regard to marital status, an overwhelming majority of the respondents (78.0%) were widowed while only 22% were married. A vast majority 60% had no education, 29% attended only primary school, 10% had secondary education while only 1% were graduates from tertiary institutions. This is a pointer to the educational backwardness of rural areas in Nigeria in which the aged did not see the relevance of education to succeed earlier in life. More than half of the respondents (60%) were farmers. This result was expected since the major occupation among rural dwellers in Nigeria is farming. This was followed by 25% of petty traders (all of whom were women). However, 15% of them had no occupation. This group of the respondents were within the 86+ age bracket who admitted they were too old to engage in any occupation. This finding was in tandem with an in-depth interview with a male interviewee aged 90 years old who said:

> I was a well-known farmer in Ile-Ife. In the whole of this community and beyond, there is nobody who did not know me or hear about me. But now I cannot farm because I am too old to do so, there is no strength to engage in any strenuous work.

Table 1 also showed that the respondents' level of income is extremely low. The level of income is a determinant of wellbeing in old age without which the aged would be susceptible to poverty. Table revealed that 10% of the respondents had no steady income. About one-quarter (25.5%) earned between ₦40,000 –₦60,000 while 16%, 5% and 2.5% of them received between ₦61,000-₦80,000; ₦81,000 - ₦100,000 and above ₦100, 000 per annum respectively. The low-income level of the respondents is traced to the educational background and occupation.

With regards to the number of surviving children, Table 1 also showed that 4% of the respondents had no surviving children. In African communities, children served as old age social security and inability to have them implies suffering at the twilight of their lives (Eboiyehi, 2008a). About 6% of them had between 1 and 2, 16% had between 3 and 4 while 18% had between 5 and 6 surviving children. The majority of the respondents (30%) had between 7 and 8 surviving children while 26% had more 8 surviving children. According to male interviewee aged 93 years:

> In those days we prayed for many children because we needed many hands to help us in the farm. It was believed that the more children a man has, the larger the size of his farm and the larger farm, the more he is respected in the community.

More than half of the respondents (51%) stated that they were not co–residing with their adult children. This suggests that this group of the aged were living alone without physical support of their adult children. This result is contrarily to the traditional African society, whereby co-residence in multi-generational household was a key mechanism through which the aged were supported and catered for. Co-residence is a situation whereby the aged live with their adult children, grandchildren and members of the extended families within the same households or in nearby households (Eboiyehi, 2008b). In such household, the aged were actively involved in caring and nurturing of their grandchildren and in return, the children and grandchildren assisted in daily household activities such as cleaning, washing, laundry, running of errands and providing both financial and material support (Udegbe, 1990). This is in line with filial piety, a belief that necessitates children to cater to their ageing parents in traditional African society (Udegbe, 1990). However, the result shows that 34% of the respondents had only 1 of their adult children co-residing with them. This could be attributed to rural-urban migration of children in search of wage employment and other opportunities in towns and cities. About 12.5% were co-residing with 2 of their adult children while 2% and 0.5% were co-residing with 3 and 4 of their adult children respectively. With regard to the number of non co-residing adult children, 65% of the respondents indicated that they had more than 4 of their adult children not living with them, 21.5% had 4 of the adult children not living with them, 10% had 3 of non co-residing adult children while only 1% had 1 of their adult children living elsewhere. This situation was found to have left many of the aged to be living alone without physical care from their non co-residing children.

The respondents were asked to state whether their adult children were employed or not. This was to ascertain the financial ability of adult children in supporting them in times of economic recession. Only 9% of the respondents stated that their adult children were employed and highly paid (Table 2). A quarter (25%) affirmed that their adult children were underemployed and poorly paid while the majority (35% and 31%) of them stated that their adult children were either unemployed or retrenched respectively. This situation was found to have adversely affected children's financial wherewithal to support their aged parents.
As indicated in Table 3, respondents were further asked to indicate how regular the monthly salary of their adult children. According to the Table, 26% of the respondents said their adult children were not receiving monthly salary. Only 11% affirmed that their children were receiving full and regular salary while 19% stated that their adult children's salary was full but that the payment was irregular. About 20% avowed that their adult children were paid regularly but with half salary while 24% admitted that their adult children were being paid half salary but was not regular.

Table 4 shows the frequency of remittances from non co-residing adult children. From the result, only 9% of the respondents said that their adult children send remittances frequently while the majority (91%) alleged that remittances from non co-resident adult children were intermittent and infrequent. This position was also found to have negatively affected the aged in the study area.

The respondents were again asked to mention the effect of economic recession on them. As shown in Table 5 below, 18% of them stated that high cost of drugs was having negative effect on their health. This was followed by reduction and intermittent of remittances from adult children (17.5%), falling standard of living/poor living condition ((16.5%), increased in ill-health/mortality (15%) and high cost of food (14.5%). Other effects included increased poverty (9%), inability to eat three times in a day (7%) and increased of depression (2.5%). These findings could be linked to the shift from agro-based to industrial society, migration of young people to cities and unemployment of adult children which were found to have left the aged unsupported or eroded the economic independence of the respondents. It was therefore not surprising that majority of the respondents suffer from different kinds of challenges ranging from "constant illness", "poor access to basic healthcare, "poor nutrition" to "poverty". These problems were found to be more prevalent among the rural aged women. Feeding on carbohydrates without nutritional values was found to be common among the respondents in the study area. These problems were also linked to children's absence which has left many of respondents without emotional, financial and physical support thus making them vulnerable to economic crisis.

Table 1: Socio-demographic characteristics of aged women heads of households (N=200)

Variables	N	Percentage (100 %)
Age		
70-75	62	31.0
76-80	55	27.5
81-85	53	26.5
86-90	25	12.5
90 and older	5	2.5
Sex		
Male	100	50.0
Female	100	50.0
Religious Affiliation		
Christianity	30	15.0
Islam	70	35.0
African Traditional Religion	100	50.0
Marital status		
Married	44	22.0
Widowed	156	78.0
Level of education		
No education	120	60.0
Primary school	58	29.0
Secondary school	20	10.0
Tertiary Institution	2	1.0
Occupation		
Farming	120	60.0
Petty trading	50	25.0
No occupation	30	15.0
Level of Income		
No steady income	20	10.0
₦1 – ₦20,000	7	3.5
₦21,000 – ₦40,000	75	37.5
₦41,000 – ₦60,000	51	25.5
₦61,000 -₦80,000	32	16.0
N81,000 –N100,000	10	5.0
Above ₦100,000	5	2.5
No of Survival Children		
None	8	4.0
1-2	12	6.0
3-4	32	16.0
5-6	36	18.0
7-8	60	30.0
Above 8	52	26.0
No of co-residing adult children		
None	102	51.0
1	68	34.0
2	25	12.5
3	4	2.0
4	1	0.5

No of non co-residing adult children		
1	2	1.0
2	5	2.5
3	20	10.0
4	43	21.5
More than 4	130	65.0

Table 2: Employment Status of Adult Children

Employment Status of Adult Children	**N**	**%**
Employed with high salary	18	9.0
Underemployment/Employed but with poor/low salary	50	25.0
Unemployed	70	35.0
Retrenched adult children	62	31.0
Total	**200**	**100.0**

Table 3: Regularity of Monthly Salary of Adult Children

Regularity of Monthly Salary of Adult Children	**N**	**%**
No salary	52	26.0
Regular/full salary	22	11.0
Irregular salary but full salary	38	19.0
Regular but half salary	40	20.0
irregular but half salary	48	24.0
Total	**200**	**100.0**

Table 4: Frequency of Remittances from Non-Co residing Adult Children

Frequency of Remittances	**N**	**%**
Very frequently	18	9.0
Infrequent/ intermittent	182	91.0
Total	**200**	**100.0**

Table 5: Effects of Economic Recession on the Aged (N=200)

Variables	N	%
Inflation (high cost of food)	29	14.5
Falling standard of living/ Poor living condition	33	16.5
High cost of drugs	36	18
Increased of poverty	18	9
Inability of children to provide support/reduction of remittances from children	35	17.5
Inability to eat three times in a day	14	7
Increased in ill-health/mortality	30	15
Increased of depression	5	2.5
Total	**200**	**100**

Results from in-depth interviews

The Challenges

Investigation into the specific challenges facing the aged in the study area revealed that of all the problems, perhaps the most serious in terms of its consequences is the high cost of drugs in managing age related ill-health problems. Majority of the aged interviewed said they were suffering from arthritis, rheumatism, visual impairments, immobility, cardio vascular condition and malaria. Health problems generally, are products of the chronic disability conditions, which affect the ability to perform routine daily tasks of the aged (Fajemilehin, 2000). Papa Adedeji (pseudo name) aged 82 years in Abiri in Ife East Local Government Area stated:

> For many years now, I have been suffering from arthritis and rheumatism. I have found it very difficult to move my legs. The doctors prescribed some drugs for me but I cannot afford any of them because the price at which I used to buy them has tripled. Since I cannot afford any of them, I have resorted to herbal treatment which is also costly. Lack of regular income is a major problem. This is affecting my inability to attend to my ill health as I do not have money for regular medical check up or to eat properly. Many of us have been sent to early graves because they could not afford the prescribed drugs for their ailment.

Mama Adediwura (pseudo name) aged 78 years from Owena in Ife East Local Government Area also affirmed:

> The cost of drugs in managing my health condition is very high. The drug I used to buy for ₦5, 500 is now ₦ 18,500 per packet of three drugs and I need 6 packets a month.

Since some of the aged do not engage in economic activities, scarcity of food and malnutrition were found to be the major challenge confronting them. In this regard, a man popularly called Baba Kolapo (pseudo name) aged 81 years in Ogudu in Ife East Local Government area stated:

> The major problem we face is the cost of food items. As you can see, I cannot go to farm. My wife is equally old and does not have the strength to go to farm. We only depend on some good neighbours who have been kind to us. The money my son sends is not only too small but intermittent. We have dropped the habit of eating in-between meals. Sometimes we eat twice or once a day as the case may be . Many of us in this community are suffering from poverty. We cannot afford anything be it food or drugs. Things are just too costly. This is not the country of our dreams. We are not happy with this situation we found ourselves. Government should please come to our aid.

Another important revelation in the study was the problem relating to inability of adult children to support their aged parents particularly those with low income and the unemployed. In this respect a male interviewee Mr. Awoyorin (pseudo name) in Tokere in Ife central Local Government Area aged 70 years blamed his present predicament on his children's inability to support him. He stated:

> If these children tell you how much they receive as monthly salary, you will pity them. Don't forget that they have family too. They have to eat, buy clothes for them and send them to school in this hard time. It is not easy for them too! When you look at all these, it is we, their aged parents that suffer especially in this hard time.

Coping Strategies

The various coping strategies employed by the aged men in mitigating the challenges posed by economic crisis are different from their female counterparts. These include involvement of subsistence farming and night guard (30%) while 20% mainly women were engaged in petty trading. They trade in different articles such as salt, pepper, kola nuts and other articles. Most of these articles were displayed for sale in front of their doorstep. Remittances from non co-resident offspring was another major coping strategies identified by 17.5% the respondents. Remittances from offspring were found to be the most important coping strategy of the respondents even though they were said to be intermittent. Two types of material support were identified by the respondents which included the provision of food and/or clothes and provision of money. The respondents received support in form of food and/or clothes from co-resident and non co-resident adult children while others received financial and other material support such as drugs. Also observed was a cluster of related dwelling units in which married children who reside within or nearby villages share food and other resources with aged parents. About 10% of the respondents worked for other people for money and for food as their coping strategies. Among this group are the aged widows (10%) whose services range from assisting farmers in carrying their farm produce from their farms to their houses, who themselves are too old to engage in agricultural work and others who were performing the

functions of baby sitters and informal teachers for their grandchildren. Receipt of financial and material assistance from members of religious organizations also served as coping strategies for 6% of the respondents. While 7.5% depended on their pensions, 5% relied on support from friends and neighbours, 3% on alms begging and only 1% depended on government support. However, our findings differ from the impression that extended family members still provide for their aged as it was done in the traditional Nigerian society. In this respect, it was found that the traditional care and support by extended family which used to mitigate the economic hardship of the aged in the traditional Nigerian society was diminishing among the study population. It was therefore not surprising that 3% of the respondent begged for alms. This practice was seen in the past as disgraceful to the entire extended family.

Table 5: Coping Strategies of the Aged (N=200)

Variables	**N**	**%**
Engaging in subsistence farming/night guard	60	30.0
Petty trading	40	20.0
Remittances from non co-resident offspring	35	17.5
Financial and material assistance from religious organizations	12	6.0
Working for other people for money and for food	20	10.0
Alms begging	6	3.0
Pension	15	7.5
Support from friends and neighbours	10	5.0
Support from government	2	1.0
Total	**200**	**100.0**

Coping Strategies: Evidences from In-depth Interviews

The perceived coping strategies employed by the aged did not differ significantly with respect to ones obtained by the questionnaires. It is therefore not unexpected that the interviewees in the study identified involvement in subsistence farming, petty trading, material and financial support from non co-residing children, working for other people and alms begging as survival strategies. According to Mr. Olanipekun (pseudo name) aged 75 years old in Akile village in Ife Central Local Government Area:

> I am a farmer. In my farm, I plant yams and cassava though on small scale. My wife and I feed on these and sell the surplus in the market. The money we realize from the sales is expended on other things we need to take care of ourselves even if it is not enough.

Mrs. Alice Olaoye (pseudo name) aged 72 years old in Owena village also stated as follows:

> I engage in petty trading. I sell garri at Oduogbe market here in Ife. I have a lot of customers coming to buy from me especially customers from Ijebu extraction of Ogun State. The money I get from the sales is used to buy the necessary things I need for myself and my aged husband.

Material support from co-resident and non-co resident offspring was found to be the most important coping strategy among the aged. In this respect, Mr. Akintude Babalola (pseudo name) aged 86 years old from Akile in Ife Central Local Government area stated as follows:

> My children are of great assistance. Those residing within Ile-Ife and its environ visit us regularly to assist us financially and materially. The ones in the cities send us money regularly although the money is being overwhelmed by high cost of things. They also engaged a medical doctor for my wife and I and they come regularly attend to our medical needs in the family. I must confess they are trying for us. It is only that the cost of health care is very high these days. We spend almost all the money they send on drugs.

Although care and support by extended family is diminishing, the evidence from the in-depth interviews showed that it still provided assistance for its aged relatives in the study area. Mrs. Adeola Awoyorin (pseudo name) aged 81 years old from Tokere in Ife Central Local Government area affirmed:

> I lost my husband about 9 years ago. I had six children but all of them are no more. It has been my brothers, sisters and their children that have been supporting me. Even at this hard time, they do not allow me to suffer. They supply me food, clothes and drugs on regular basis. Most importantly, they visit me regularly.

The in-depth interview also confirmed the findings from questionnaire that some of the aged particularly the women work for other people for money and for food. Madam Funke Aderimbigbe (pseudo name) aged 70 years old from Abiri in Ife East Local Government area stated:

> In order to survive this hard time, I help farmers on their farms. The services I provide include assisting in carrying their farm produce. I also help people to wash their clothes and plates. I do assist the young working couples in looking after their babies while they are away to work.

This position corroborates Udegbe (1990) who found that among the Yoruba that when women are too old, the aged may perform the functions of baby sitters or informal teachers for their grandchildren. As Fatiregun Oni (Baba Tokere) (pseudo name) aged 72 years old stated:

> I have a small farm and depend on my pension although government is not paying as at when due.

Baba Fatiregun spoke the minds of so many aged Nigerians who are queuing to receive their pensions. This is an indication that even the people that worked as civil servants suffer the same fate as others showing the enormousness of the problem.

Discussion of Findings

This paper explored the challenges faced by the aged in this era of economic recession in Nigeria. It was revealed that the aged face several challenges including poor health, fallen standard of living, high cost of drugs and foods. The high cost of living was especially felt in the area drugs and funding their health. These findings corroborate that economic hardship among the aged is more felt in the areas of health (Fajemilehin, 2000). Health issues of the aged continues to come up due to the fact that many age-related diseases afflict people when they are old and as such, it is at that time of their lives that the aged need more money for their health. Apart from several health problems faced by the aged, the high cost of drugs compounds the problem by making it difficult for them to procure the necessary drugs for the ailments. This is also accompanied by hunger and fallen living standards (Food and Agriculture Organization, 2015). Importantly, all these are happening at a time when the children of the aged are finding it difficult to feed themselves well, as they no longer send money to aged parents in the villages corroborating (Eneji, Mai-Lafia and Weiping, 2013). The sufferings of the aged in this study was not surprising because a situation where the children of 91 percent of them were either under employed, unemployed or retrenched had incapacitated them and made it impossible take care of their aged parents.

The study further indicated that the aged cope by begging for alms, subsistence farming, petty trading, working for other people, support from religious bodies and neighbours. The current economic recession in Nigeria has brought to the fore the issue of the aged resorting to alms begging. Culturally, begging for alms by the aged was considered disgraceful especially for the aged, their children who should take care of them and members of their extended family (Togonu-Bickersteth et.al., 1997). Also, engaging in subsistence farming at a time when someone is already tired, old and having health challenges is akin to killing oneself gradually but the aged were doing this as a measure of last resort. Others resorted to working for other people in order to earn a living at a time when they should be resting and dependent on their children. Furthermore, others were getting support from religious bodies and neighbours. It is important to point out that this kind of support does not come all the time because it is when religious bodies and neighbours have extra resources that they are able to assist and are not under any obligation to provide since Africans believe that it is the duty of children to take care of their aged parents (Eboiyehi, 2013; 2008a). Even the aged who were classified as pensioners, disclosed that the Government was not providing their pension in due time, as was indicated by an interviewee. This corroborates with Eboiyehi's findings that Nigerian pensioners are passing through psychological trauma due to non–payment of their pensions and gratuities which has subsequently result to hunger, depression, preventable diseases and untimely death (Eboiyehi, 2006).

All these issues point to the seriousness of the problem and exposed the political economy of Nigeria in which there is no formal provision for the aged in any aspect of life. There is no provision for the health of the aged, feeding and their general wellbeing. The aged are left to be catered for by their children which was not a serious problem until the economic recession came and exposed the problem. Importantly, in the current situation in which the aged that have children were no longer getting enough support from their children, one might ask, what about the aged who never had children? What are the plans of the relevant authorities concerning this category of the aged? In present day Nigeria, the answer is "nothing". This means that the situation of this category of the aged was worse off than the other group. These are loop holes in the political economy of Nigeria. Essentially, in this political economy, the economic recession had resulted in loss of jobs, unemployment and shrinking of businesses which has resulted in general poverty for the aged and their children (Potts, 2013).

The implication of this study was that the socio-cultural safety net which shielded the aged from hardship had collapsed without any institution to replace it. The aged in the study area were now living their lives in penury and they were not enjoying their old age which was capable of instilling fear in people looking forward to old age. The implication for government and policy makers was that they should begin to draw up effective intervention programmes to ameliorate the problems encountered by the aged in Nigeria particularly those in the rural areas. The implication for further studies was that the impact of the economic recession on the aged without children in Nigeria should be explored which would enhance it being brought to the limelight. Also, the effect of economic recession on aged men and women may differ and further studies should examine this.

Conclusion and recommendations

This paper concluded that the economic recession has impacted negatively on the aged: the challenges they faced were enormous and their coping strategies were not effective and sustainable. The paper therefore recommends that:

- State and Local Governments should establish old people's homes in their localities. Although this is un-African, it is necessary since most of the caregivers are not available to attend to their needs. In this regard, there should be legislation to cover the running of voluntary and commercial "old peoples' homes" to protect those in need of such services.
- Communities should re-establish community care for the aged;
- Concessions should be provided for all the aged persons, especially those who cannot afford to obtain the basic aids such spectacles, dentures and hearing aids as well as other implements where necessary for them to continue to interact and participate fully in their local communities.
- Medical care and services with appropriate medical staff and expertise to cater for the needs of the rural aged should be set up in the rural areas to provide geriatric care, as such specialties are not yet available in Nigeria.

- As health costs tend to escalate beyond the reach of rural aged, some form of health insurance, possibly from the young should be encouraged and implemented. For those in the disadvantaged groups, both the public and private sectors should provide some form of concessions so that the aged in these groups can have access to good quality medical care.

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The 'Kisoro Elders Project' in villages of rural southwest Uganda: A model for geriatric care in developing countries?

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Abstract. This brief report describes the inception of a healthcare project aimed at offering interventions meant to have an immediate impact on the quality of life of older adults living in rural villages in Uganda. Given the rapid ageing of the developing world and the crisis of shortages of health professionals seen in most countries, it may serve as a model for similar efforts elsewhere.

Keywords: rural health care, older adults, Village Health Worker, quality of life.

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The Kisoro Elders Project aims to screen for and treat major health problems which are prevalent among older persons world-wide. The target problems, which significantly negatively impact quality of life, are visual impairment, hearing deficits, mobility and pain problems, depression and dementia. Interventions are delivered in rural villages by trained Village Health Workers, thereby overcoming significant usual barriers to care. To our knowledge, this program is unique in sub-Saharan Africa, and offers the potential to be a model to fulfil dual goals of better addressing health care needs of older adults in Africa while grappling with a critical shortage of health care personnel.

Kisoro District is a small district in the far southwest corner of Uganda, near borders with Rwanda to the south and the Congo (DRC) to the west. Just a few miles from both borders is Kisoro, the district capital, a bustling town centre of around 13,000 persons, which includes the government-funded Kisoro District Hospital and Clinics. There are 400 rural villages in the surrounding district, comprised of widely spaced family compounds (2-10 small houses/compound) set among agricultural fields. A very beautiful area dominated by three large inactive volcanoes and dotted with breath-taking lakes, its terraced fields rise steeply up hillsides. Located near the equator, its 2000-meter elevation means the weather is cool, high teens C° by day and low teens C° at night, with rainy seasons during significant blocks of the year, and three growing cycles per year. Older adults (age 60+) comprise five per cent of the population of the villages, as they do elsewhere in Africa (Wandera, Kwagala and Ntozi, 2015). Historically they have been an integral part of the family unit; however, loss of significant segments of the middle generation due to out-migration to the cities in search of jobs, and the devastation of the HIV/AIDS epidemic, has left many older persons without adequate social supports (authors observations).

Training for this project added a skill set to the previously trained Village Health Workers of the Doctors for Global Health Uganda Project, based at Kisoro District Hospital (KDH). The Ugandan health professional staff of KDH has been supported and enhanced for the past 13 years by faculty level and resident physicians and medical students of Doctors for Global Health (DGH) and two New York medical schools, Albert Einstein and Hofstra University, under the direction of one of the authors (GP). DGH has trained Village Health Workers (VHWs) in 52 villages in the sub-counties closest to Kisoro. Rigorous training of 1-2 years has equipped VHWs to address routine acute care problems (fever, diarrhoea, cough), hypertension and diabetes detection and control, prenatal care, common issues of maternal and child health, and follow-up after hospitalization. Although there are older adults followed by the CDCom program (Chronic Disease in the Community), until the inception of this project, there had been no training for specific problems affecting older adults; in fact, VHWs reported that older persons in the villages complained that they were being ignored. VHWs live in and are recruited from their own villages. They are farmers with largely a primary school education. Exploratory visits to conduct needs assessments and ascertain interest were made by one author (HGB) to villages in April and October of 2017, and training modules for 6 VHWs each time were held in February and September 2018, conducted by two authors (HGB, PAB) and a Ugandan project director (MI).

During the initial two-day training module, VHWs learned about the focus areas of the project: Vision, Hearing, Mobility and Pain, Depression, Dementia, and Function. They learned to screen for problems in these areas using E-charts for far vision, reading or figure clarity screening for near vision, the Whisper Test for hearing impairment, Timed Up and Go for mobility, a pain intensity rating scale, the Patient Health Questionnaire – 9 (PHQ-9) for depression, (Gelaye et al., 2013), the Six Item Dementia Scale for Africa (SIDSA) (Paddick et al., 2015), and an adapted Activities of Daily Living and Contributive Functions scale. In addition, they learned simple interventions: identification of significant myopia for referral to the optometrist, dispensing of reading glasses, inspection of ear canals and removal of cerumen impaction, dispensing of low cost hearing aid devices, assessment of suitability of canes (to replace traditional walking sticks), measurement for cane height, referral of older persons for follow-up mental health care in the villages for mild-moderate depression or the hospital for severe depression/suicidality, and education of family members and caregivers concerning dementia. Current developments include the formation of support groups for mild to moderate depression, modelled on the Interpersonal Therapy intervention tested elsewhere in Uganda in younger persons (Bolton et al., 2003), in conjunction with the project director (MI), who has a Masters of Social Work education, and a nurse mental health specialist (IO). In-home instruction for caregivers of dementia patients has been added to the home talk curriculum.

After the two-day training module, follow-up visits in the villages gathered older persons identified by the VHW as having vision, hearing, and mobility and pain problems. Many of the older persons had to walk several kilometres over difficult terrain to the gatherings, which proved to be happy reunions of friends for many who are socially isolated. The beneficial impact of reading glasses for many was evident: wide smiles when they realized they could once again read their Bible and participate in church, or thread a needle for sewing, or help sort beans from stones during the harvest. Listening devices for hearing impairment also had immediate and highly appreciated impact. Almost all the older persons, having worked in the fields their whole lives, have musculoskeletal pain but have never taken analgesics due to cost barriers. Acetaminophen (paracetamol), which is quite inexpensive, was dispensed by the VHW with excellent results for many of the older persons. Despite fears that canes may not be culturally acceptable compared with traditional walking sticks, frail older persons with mobility problems felt much more stable using them. A local carpenter has been given a contract for their low-cost production (with rubber cane tips obtained in the US). In-home visits for depression and dementia screening were conducted by the VHW, accompanied by the project director. Both the project director and the mental health nurse give ongoing support for VHWs' acquisition of skills in these more nuanced areas, and provide individual follow-up, as well as supervision and training in the establishment of support groups. Depression is common in rural older persons and suicidality not rare, in many if not most cases intimately related to abject poverty, hunger, loss of family or the all-important role of being able to dig in the fields, loneliness, and neglect. While the prevalence of dementia is not known, it is seen, but frequently attributed to spirits or curses.

A new aspect of the project, which began in September 2018, is the dispensing of solar lights for older persons. A serendipitous meeting of a New Yorker engaged with a solar light charity

lead to an introduction of HGB and PAB to the NGO Let There Be Light International (LTBLI), based in Buffalo, NY, and working in Uganda in partnership with Solar Health Uganda. The mission of LTBLI is to solarize community health centres and provide individual lights to vulnerable people (MODES= mothers, orphans, disabled, elderly, and students) in Uganda and Malawi. LTBLI donated 100 lights, which were dispensed to selected older persons, and promised 250 more for summer 2019. Lights offer the possibility of reducing social isolation, especially if they attract members of the family into the home of the older person at night to converse and study, and improving health and safety, as the usual kerosene candles often cause house fires, burns, respiratory diseases due to exposure to smoke and soot, and prevent the use of mosquito nets for fear of fire.

In 2018, 24 VHWs were trained, using a training manual developed by HGB and PAB and translated into 'Rufumbira', the local language, by MI. 12 VHWs were trained by HGB, PAB, and MI, and 12 subsequently by a training team lead by MI and comprised of 6 selected VHW "co-supervisors". 970 screenings were performed: 391 for vision impairment, 110 for hearing impairment, 34 for depression, 30 for dementia, and 405 for mobility and pain problems. 221 pairs of reading glasses were dispensed, and on follow-up, 182 older persons reported benefit from using the glasses for reading, sewing, peeling, and separating beans from chaff. 24 older persons have received and reported benefits in conversation from use of hearing aid devices. 45 older persons had major mobility issues that would potentially be benefited by using a cane more than the traditional walking stick; 26 have received canes and a town carpenter is proceeding with producing the others. 380 older persons were given paracetamol for musculoskeletal pain. Detailed flow sheets being used by the VHWs will capture all visits, test results, interventions made, and follow-ups (i.e. is the older person using the reading glasses, what function are they helping?) Screening gatherings and individual home visits have become a part of VHWs' calendars. The extent to which they embrace the delivery of geriatric care will be reflected in their stipend sheets, as each task they perform is rewarded by a small stipend. VHW stipend income adds significantly to family agricultural revenues; a project goal is to increase VHW stipend income by 30%. The Activities of Daily Living and Contributive Functions Scale has been incorporated into the biannual census conducted by VHWs and hospital Supervisors.

In early 2019 the project was rolled out to all 52 villages. Two authors (HGB, PAB) will continue to visit twice yearly to assist in monitoring, continuing education, and data collection. The budget for equipment, support of the project director, and VHW stipends is modest and sustainable. The project has received support from the International Institute on Aging, United Nations, Malta (INIA), the Stroud Center for the Study of Quality of Life in Older Adults of Columbia University, New York, NY, and from individual contributions by family, friends, and colleagues to Doctors for Global Health, Uganda. Two authors (HGB, PAB) continue to seek philanthropic and foundation support. With adequate support there is the possibility of extending the project to other districts in Uganda and more broadly.

"We thank you from the bottom of our hearts" is a sentiment commonly expressed by Kisoro older persons who have benefited from the project. Health care for older persons is not only morally correct, but also economically indicated in the light of the significant contributions

they make to their families and communities: support of food security, child care, and social guidance (Aboderin & Beard, 2015). In the face of the phenomenon of global ageing, particularly in the developing world, this low cost, practical project, when appropriately modified for local culture, demographics, and existing health care infrastructure, could serve as a sustainable model, with an immediate impact on quality of life, for geriatric care in rural areas currently lacking access to health care. Since most of the VHWs are women, it also addresses multiple international calls for the education and empowerment of women.

The authors warrant that this work is original, non-defamatory, and that all statements contained herein as facts are true. None of the authors have any conflicts of interest.

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Age-related ageism among social and health care employees

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Abstract. This paper makes the attempt to explain age determination in light of ageism, representing the discrimination of the advanced age population which takes place in practices of medical and social attendance is made in the article. The attempt is made on the analysis of data gathered by means of administering a sociological survey among healthcare and social employees of regional society (Russia). It is revealed that the youngest group of social and healthcare employees are more aware than others in recognizing the presence of ageism in society, in both practices of social and medical attendance, but categorically denies the personal participation in it. 40-49-year-old medical and social employees strongly deny the presence of ageism in general, even within their own professional activity. Older employees aged 60 and over, are more aware in recognizing ageism. A difference in relation to the age group, together with a degree of gerontological competence and it's identification with advanced age is among the various reasons social and healthcare employees, hold in understanding and acknowledging the various degrees of ageism.

Keywords: healthcare and social employees, ageism, age determination, gerontophobia, gerontological competence, elderly people, age identification.

Introduction

Statistics show that with age quality of life declines. The incidence and quantity of diseases succumb by a person increases with age, especially those associated with functionality. This results in loss of autonomy as observed at advanced and senile age. Owing to this fact, quality of life to a great extent depends on the quality of service provided by healthcare institutions and social service. Research outlines the various causes and serious negative consequences of ageism especially impacting older citizens. Such manifestations are documented within medical and social work practices, and therefore highlights the need for further research in need of developing preventative measures.

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Ageism represents the form of age discrimination against age advanced citizens which is shown in the practices of humiliation; lack of dignity; violation of basic human rights and also in the exhibit of negative stereotypes and installations concerning older persons (Smirnova, 2008; Butler, 1969). It should be noted that ageism exists not only in relation to older persons, but also other age groups, most often - youth. But it is greater pronounced towards older persons (Garstka & Schmitt, 2004), this is primarily due to having a higher degree of vulnerability. The level of ageism is promoted by a utilitarian approach to the person accepted in modern society owing to the attitudes towards him. This depends upon the persons economic potential, and capacity in interacting with goods and services. As Traxler (1980) notes, the youngest, as well as the most older age groups are considered as unproductive by society and therefore – perceived as a burden. However children posses the capacity of future economic potential, and older persons, on the contrary, hold some kind of "financial liability" that also causes a greater concern for ageism (ibid.).

Although age discrimination "on prevalence can compete to a sexism and racism" (Mikljaeva, 2009), this problem became acknowledged in the western scientific discourse only in the last quarter of the 20th century, while in Russian only recent years with varying interpretations. Miklyaeva (2009) considers that lack of interest in such researches acts towards further existence of ageism. The reason of such deficit, in her opinion, is the population's perception of discriminatory practices concerning older persons as the social norm owing to what "the problem of ageism isn't realized by either subjects, or subjects to discrimination" (Mikljaeva, 2009: 149). Puchkov (2009) explained that scientific research on ageism is scarce, with difficulties being that of reliable information due to the unavailability of a population to open discuss the issue (ibid.). In particular, he specified that physical, economic and psychological violence against old-aged people is one of the most latent forms of violence that results in difficulties in assessment of its scales (Puchkov, 2006).

Such situation is the result of the sensitivity towards this issue, which is caused by people's awareness of social unacceptability of ageism, and, owing to this fact, unwillingness of open representation of its reasons and manifestations even within the sociological polls. The specified "sensitivity" interferes not only to scoring of this subject in a public discourse, but also to its updating at the level of consciousness, "starting" various protective psychological mechanisms ("rationalization", "replacement", "transfer"). These mechanisms preserve the person against "deeply concealed alarm …, personal disgust and feeling of hostility to aging people, to diseases, disability; fear of helplessness, uselessness and death" (Butler, 1969) (the psychological reasons of ageism), they mask a contradiction between socially approved (standard) requirements to feelings and behavior in relation to elderly people and real.

The negative opinion on aged patients are peculiar to social and healthcare employees, as well as considerable part of the population: they are considered depressive, decrepit, not a subject to treatment. The manipulation of older persons, the aggressive, hostile relation is commonly witnessed throughout the working service years of specialists (Mikljaeva, 2009; Krasnova, 2003; Wilkinson and Ferraro, 2002). In the report of the UN General Secretary (2007) it was emphasized, that even in cases of discrimination on the basis of age, the negative attitude to aged and protection of their health remains, and quite often has an effect on their treatment

(Commission of social development. 45th session, 2007). Further, during the UN II World Assembly, the following priorities were also determined: eradication of all forms of negligence to older citizens; abuses and violence; providing older citizens with general and equal access to medical care and medical services, including services in protection of their physical and mental health; recognition that all persons, irrespective of age, shall have an opportunity to conduct full-fledged, healthy life (United Nations, 2002).

Research objective

To reveal and explain ageism among healthcare and social employees.

Research methods

The research was conducted by means of a questionnaire using a stratified selection (2013, N = 207 people). The sample was composed of: healthcare - 65,7% (28,5% - doctors, 37,2% - nurses) and social employees - 34,3% of Belgorod region (Russia). The following age categories were distinguished: 18-29 years (15,9%), 30-39 (22,7%), 40-49 (28,0%), 50-59 (26,6%), 60 years and older (6,8%).

Research results and discussion

The data in this poll has showed that ageism, from the point of view of healthcare and social employees, is a frequent phenomenon both in public life, and in practices of medical and social care. In particular response to the question: "Have you faced negligence to older persons in everyday life, during your profession?", 62,3% of healthcare and social employees have reported that they have experienced such negligence at some level (17,4% - often, 44,9% - sometimes). Unambiguously negative answers were given by 32,5% of respondents. At the same time respondents of various age groups have had an essential difference in answers to the question.

For the purpose of age specifics detection relating to the questions and responses to this study, an "abstract" (not connected with personal practices) on ageism for each age group was calculated. The following formula was used: n "yes, frequent" + ½ n "sometimes" - n "never", where n – is a share of the respondents who have chosen this possible answer. The highest values of the "abstract" ageism index have appeared in group of respondents of 18-29 years (28,8), then - (with a big discrepancy) - in groups of 60 years and older (14,3) and 50-59 years (9,1). Negative answers about situations of collision with ageism prevail among 30-39-year-old and 40-49-year-old: the values of the corresponding index are -3,2 and-6,1 respectively (see Table 1).

The wide spacing in values of answers to the question among different age groups, while respondents are at approximately in the similar situation, reflects the existence of age determination, in at least, the ageism perception. The recognition of the existence of discrimination is one of factors of its prevention. Negative attitude, bias, violence, injustice, restriction in rights of people due to belonging to a certain social group (in this case – created

on an age sign) can be perceived by the subject as discrimination only on condition of perception of these phenomena as unfair and unacceptable. This, in turn, serves as a prerequisite of "personal" ageism reflection – own gerontostereotypes, negative installations concerning old age and older persons and practices realized on its basis, however it is not the key.

Table 1: Have you faced negligence to older persons in everyday life, during your profession?

	18 - 29 -year-old	30 – 39 -year-old	40-49 -year-old	50–59 -year-old	60 years and older
Yes, frequent	21,2%	17,0%	8,6%	23,6%	21,4%
Sometimes	57,6%	40,4%	50,0%	36,4%	42,9%
Never	21,2%	40,4%	39,7%	32,7%	28,6%
I find it difficult to answer	0%	0%	0%	1,8%	0%
There is no answer	0%	2,1%	1,7%	5,5%	7,1%
An "abstract" ageism Index	28,8	-3,2	-6,1	9,1	14,25

Recognizing an "abstract" ageism in everyday life and profession in general, respondents generally deny their own participation in ageistic practices (in "personal" ageism). The absolute majority (78,6%) of negative answers in a varying degree to a question of prevalence of situations when respondents had to make decisions, to make the actions violating the rights or interests of older persons in their profession testifies to it. The main share of respondents came up against such situations seldom (35,6%) or never faced (43,0%), whereas constantly and from time to time – less than every tenth (2,9% and 6,3% respectively). (Tab. 2)

The "personal" ageism index, was calculated on the basis of the data, presented in table 2 with a formula: n (constantly) + ½ n (from time to time) - ½ n (seldom) – n (never), where n – is a share of the respondents who have chosen this possible answer. The "personal" ageism index has sharply negative values (-52,02), unlike the index of an abstract ageism (8,5). The specified data can confirm both of lower ageism prevalence among social and healthcare employees, in comparison with the population in general, and of concealment of this problem or its replacement for understanding borders.

The highest and lowest values of personal ageism have appeared on age poles, respectively, at respondents of 60 years and older (-35,7) and 18-29-year-old (-71,2). Besides the youngest, respondents of 40-49 years are stronger than others deny the participation in ageistic practices: the index of "personal" ageism makes -59,6, and also respondents of 30-39 and 50-59 years recognize ageism, besides the most old. Values of this index at them make -46,8 and - 47,3 respectively (see Table 2).

Table 2: If within your profession you had to make decisions, in taking actions to violating the rights or interests of older persons, how often would you be faced with such situations? (%)

	18-29 year-old	30–39 year-old	40-49 year-old	50–59 year-old	60 years and more senior
Constantly	0	2,1%	0	5,5%	14,3%
From time to time	3,0%	10,6%	8,6%	3,6%	0
Seldom	36,4%	31,9%	27,6%	32,7%	57,1%
Never faced	54,5%	38,3%	50,0%	38,2%	21,4%
I find it difficult to answer	6,1%	12,8%	6,9%	16,4%	0
Haven't answered	0	4,3%	6,9%	3,6%	7,1%
A "personal " ageism Index	-71,2	- 46,8	-59,6	-47,4	-35,7

It is remarkable that those age groups which are stronger than others deny ageism in their own professional practices (18-29 and 40-49 years-old), are rarer than others report about special attention and goodwill towards older persons from of their colleagues. So, with the question "If during the professional duties the attitude of your colleagues towards older clients/patients differs from the attitude towards other groups of the population, then where is this more prominent?", the share of 18-29-year-old social and healthcare employees who have answered so has made 24,2%, 40-49-year-old - 56,9%, in other age groups it varies within 60-66%. Thus, the proportion of 18-29-year-old social and health care workers who answered the question "If in the process of fulfilling your professional duties, the attitude of your colleagues towards older clients, patients differs from the attitude towards other groups of population, then how does that manifest itself?" was 24.2%, 40-49-year-olds – 56.9%, in the rest of the age groups it varies in the range of 60-66%. The fact that practically every fifth of social and healthcare employees within the 18-29 years-old bracket, and every fourth of 40-49 years-old bracket has pointed out psychological pressure (intimidation, threats, indignity gerontological abuse) in interaction with older persons which is experienced by colleagues during their professional duties, attracts attention. In other age groups, every tenth, on average (30-39 years of 8,5%, 40-49 years of 19,0%, 50-59 years of 10,9%, of 60 years and older – 0) has reported the same remarks concerning their colleagues (Table. 3). Specified data explains low values of "personal" ageism among representatives of 18-29 and 40-49 years-old groups with low a degree of their reflection caused by the operation of psychological protection mechanisms - namely "projections", as shown in transfer of negative concerning own feelings, thoughts, acts, on others.

This mechanism operation was noted not only in the analysis of age determination of ageism, but also when comparing the responses with social workers and medical staff. The questionnaire has shown that social employees are inclined to speak more often about the existence of ageism in physicians' activity, but not in social employees' activity, and physicians – social employees. The manifestation of protective mechanisms in discussion confirms its high psychological state of charge. Mutual "charges" of social and healthcare employees of ageism at simultaneous aspiration to concealing of such facts in the sphere of professional activity, forces to assume the existence of specific corporationism in spheres of medical and social care. This notion owes to the recognition of ageism in colleagues activity

to be considered as violation of the professional solidarity conflicting to professional ethics. It is possible therefore, that the youngest employees - less than others incorporated in labor collective, and therefore are weaker exposed to pressure of group norms, almost twice more often than others (9,1% against, on average, 5,3% on other age groups) point to some neglect in which the attitude of their colleagues towards older clients and patients differs (table. 3). Also, along with 29-39-year-old respondents, more often than others point to the prevalence in their profession, of the position that older persons are considered as a burden or "economically not expedient" category. On average 18,5% of representatives of two younger groups and 4,5% - of three older (40-49 years-old, 50 - 59 years-old and 60 years and older) have reported of meeting such position “often”, “sometimes” - respectively 45,0% against 35,0%.

Table 3: If during the professional duties the attitude of your colleagues towards older clients/ patients differs from the attitude towards other groups of the population, is shown in?

	18-29 year-old	30–39 year-old	40-49 year-old	50–59 year-old	60 years and more senior
In special attention, goodwill	24,2%	66,0%	56,9%	60,0%	64,3%
In some neglect	9,1%	0	5,2%	3,6%	7,1%
In bigger emotional pressure	24,2%	8,5%	19,0%	10,9%	0
Doesn't differ	24,2%	14,9%	13,8%	21,8%	21,4%
Other (write)	0	0	1,7%	0	0
I find it difficult to answer	15,2%	6,4%	0	1,8%	7,1%
There is no answer	3,0%	4,3%	3,4%	1,8%	0

By comparison of different age respondents’ answers to questions of "abstract" and "personal" ageism, it is necessary to draw a conclusion on lack of obvious regularities that confirms multidimensionality of an age discrimination problem. However, attention is drawn in the understanding of age determination of ageism. Where, healthcare and social employees of 40-49 years deny both an "abstract" and "personal" ageism more often than others. Respondents aged 60 and over, were more sensitive than others to recognize its presence in either form. The youngest group of social and healthcare employees (18-29 years) was characterized by the most polar answers of abstract and personal ageism. It inclined more than others in recognizing the lack of connectedness within their own professional activity and the denial of its manifestations within personal professional practice.

Data from across the Russian poll has help to make an explanatory hypothesis concerning why 40-49-year-old social and healthcare employees more than others deny the ageism existence concerning older persons. According to this, the majority of Russians are inclined to associate the best period of their lives with the age of 20-40 and the first significant response to the issues of ageing was given by the 40-year-old respondents. (Levinson, 2005). However,

the readiness to accept this fact is still absent, so it is made to force out everything that is connected to old age on the periphery of consciousness. This explanation is coordinated with a position of a number of authors, that of gerontophobia - generally unconscious fear of old age and death - among the most important ageism psychological factors. In one of the developed definitions given by R. N. Butler ageism is described as reflecting the deeply concealed alarm of some young and middle-aged people, their personal disgust and feeling of hostility towards older persons, for diseases, disability, fear of helplessness, uselessness and death (Krasnova & Liders, 2003). Thus, ageism is a way of psychological distancing older persons (we are not them, and we will never be like them) and the alarm associated with it concerning old age and death. In this regard it is remarkable that this age group gives a significant share of the answers which are negatively characterizing the citizens of advanced ages surrounding them. 13.8% of its representatives (against, on average, 5% on other age groups), have reported that more than a third of this group consider that among the older people the majority look after themselves and live in dignity consciously aware of their daily conduct. And in the same group the "positive" answers shared is among the lowest - that the majority of older people try to stay afloat, not to be extremely active, simply striking a balance in order to prevent decline in activity (see Table. 4).

Table 4: Among the elderly people surrounding you it is more of those who:

	18-29 year-old	30–39 year-old	40-49 year-old	50–59 year-old	60 years and more senior
Looks after himself, conducts estimable life	21,2%	36,2%	36,2%	50,9%	50,0%
Tries to stay “afloat”, "acts" not very strongly, but also doesn't dare to fall	69,7%	51,1%	41,4%	32,7%	35,7%
Has lowered hands, has stopped looking after himself, just lives life	3,0%	8,5%	13,8%	1,8%	7,1%
Lives at the expense of relatives or social services and wants to do nothing, considers that all have to him	3,0%	2,1%	3,4%	3,6%	0
I find it difficult to answer	0	2,1%	3,4%	0	0
There is no answer	3,0%	0%	1,7%	10,9%	7,1%

Therefore, the group of 40-49-year-old social and healthcare employees, is more often than others giving negative characteristics to the older persons surrounding them, more categorical than others insists on lack of ageism in general and in own professional activity. This means that the negativity felt by representatives of this group concerning older persons, and their behavior which is in consequence perceived by them, not as ageism itself, but as a proper response to older persons and their interaction with them. In process of retirement age and the acceptance of the inevitable ageing process, that of once above the age of 60 to be identified with group of older persons. This can explain why in groups of respondents of 50-59-year-old and 60 years and older, brought about the greatest share of responses that among the surrounding idea of older persons most of all those who looks after themselves, conduct an

estimable life. With 50% agreeing with this statement, against 21–36% of the respondents of other ages (see Table. 4).

It can be explained with the emergence of positive identification with the advanced ages population changing gerontophobia and rejection of aging. Owing to this fact this group of employees sensitivity to ageism and readiness for discussions surrounding such challenges amplifies high shares of their answers about the existence of ageism as abstract, and in personal professional practices. As for specifics of 18-29-year-old social and healthcare employees, it was observed that the "abstract" ageism was more than others recognized by them in the manifestation of maximalism and critical perception of the world peculiar to this age which influence a little their ability to their own ageism reflection. The low estimates of "personal" ageism characterizing this group should be explained, firstly, by a weak reflection of it by representatives of this problem, owing to a smaller work experience, including, with older persons, and, finally, by insufficient gerontological competence, secondly, by a weak identification with advanced ages groups causing their low sensitivity to this problem.

The connection between ageism and low level of personnel training to the professions rendering services to older persons is specified in various researches and official documents (Puchkov, 2009; U.N. Economic and Social Council. , 2012; National Council on Ageing and Older People 2005). Roughness and an inattention from healthcare and social employees to older clients and patients, causes irritation and difficulties of interaction because of insufficient competence in the field of gerontology and geriatrics. The understanding of advanced age its specifications and reasons of age discrimination, which manifest in professional activity of healthcare and social employees, is an important condition of ageism prevention. Young respondents are rarer than others who specified that they have enough knowledge in the field of aging to cater for full implementation of their professional obligations. This fact demonstrates the insufficiency of gerontological competence among young social and healthcare employees. There are 15,5% among 18-29-year-old who correspond to this conclusion, among 30-39-year-old – already 36,2%. Among respondents of 40 years and over, senior such answers were recorded by 52-57%. The stated weak identification of young social and healthcare employees with advanced age and its representatives is natural and doesn't need the proof. However, this should explain their substantial indifference towards older persons and therefore low sensitivity towards the perception of the facts of ageism. So, answering the question "What, in general, feelings and emotions are caused in you by older clients/patients?", they though not essentially, but more often than others pointed that they don’t have any special feelings (12,1% against 8% on average on other groups), rarely felt sympathy and pity (63,6% against 69,5%).

Conclusion

Age specifics of ageism determination are shown that the youngest social and healthcare employees are inclined to recognize "abstract", not connected with own professional practices ageism, both in society, and in the sphere of professional activity. However, at the same time, do not recognize personal participation in it; 40-49-year-old employees prefer to deny ageism manifestations both in daily vital practices, and in own professional activity. Social and

healthcare employees of advanced ages recognize ageism more than others. Findings show that the most problem group is a group of 40-49-year-old social and healthcare employees with the distinctive feature in the highest response threshold to ageism, perceiving ageistic practices rather as proper response to features of advanced and senile age patients and clients. The "marginal" position of this age category caused by the end of the "optimum" age period, extrusion on the periphery of consciousness negative experiences connected to it. This is also reflected in problems with old age and aging as being the psychological reason of ageism, specific to this age.

The factors causing age determination of ageism are: at 40-49-year-old social and healthcare employees - gerontophobia, at the youngest – low extent of identification with advanced age and the insufficient level of gerontological competence, in older age groups – high identification with advanced age. Specific corporativism in the form of destructive professional solidarity (when ageism recognition within the activity can be considered as violation of professional solidarity) can be an ageism factor in the middle age groups of social and healthcare employees (30-59 years).

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A life innovation analysis framework in Asia and the Pacific from the perspective of social quality for older persons: Empowerment by the MIPAA process in the era of the SDGs

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Abstract. MIPPA is reviewed with the concept of Social Quality (SQ) as it links the objectives of this normative international instrument with the aims of the 2030 Sustainable Development Goals (SDGs) Agenda. We argue that the SQ framework is a useful policy tool to monitor the process of empowerment of older persons and raising the level of their well-being, which are encompassed in the SDGs, and show how SQ was designed as a vehicle for building up the human conditions and quality of life all the way to old age. Consequently, policies that are guided by the SQ approach can be considered more coherent and oriented toward nurturing the daily lives and welfare of older persons. The three pillars of MIPAA; i.e., development, health, and enabling environments emphasize the quality of life in old age as well, and the SQ platform shows how social systems influence individual and collective aspects of welfare. We also show how the SQ platform can help policy makers ask the right questions about how to introduce new and improved forms of social services, like better health to increase satisfaction with life, infrastructure to improve mobility, and connectivity to increase interaction with and participation in society.

Key Words: social quality, wellbeing in old age, life innovation, local social governance, social realities, Asia and the Pacific.

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What is MIPAA and how it relates to the SQ concept and the SDGs?

The Madrid International Plan of Action on Ageing (MIPPA) is an internationally agreed plan guided by bioethics and human rights treaties to help empower older persons and integrate their concerns in development policies that can lead to improvements in their quality of life and well-being so that they are not left behind, which is what the SDGs are committed to. This means older persons need to be empowered in relation to other groups in society where they interact with as social agents (United Nations, 2002) Social Quality by definition also focuses on social interaction and is defined as the "extent to which people are able to participate in the social and economic life of their communities under conditions which enhance their well-being and individual potential" (Beck, van der Maesen, Thomese, & Walker , 1997).

The Plan was adopted at the Second World Assembly on Ageing in Madrid, Spain in 2002 (ibid.). Governments have taken the responsibility to implement its numerous provisions and the United Nations reviews their response every five years to ensure that they stay on track. The first five-year review in Asia and the Pacific was carried out the by United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) in Macao, P.R. China, in 2007. It was followed by a The Second Review in Bangkok, Thailand in 2012, and more recently followed by the Third Review which took place also in Bangkok in 2017 (United Nations ESCAP, 2017).

The MIPAA offered the global community a good starting point to illuminate and share insights about the difficulties and risks associated with dependency and helplessness in old age that some older persons may face in their daily lives. Three areas of life are covered by MIPAA, which are considered detrimental to older persons' empowerment in their communities:

i. Older persons and development
ii. Advancing health and well-being into old age
iii. Ensuring enabling and supportive environments

Older persons and development

Of concern under this pillar from the SDGs perspective, in particular SDG 8, is ensuring access to income-support systems in old age. Access is considered necessary to alleviate poverty and help improve well-being. SDG 8 is focused on inclusive economic growth measured with annual per capita economic growth. The SDG calls on governments to achieve at least 7 per cent gross domestic product growth per year to lift the bottom 40 per cent of the population above the national average of income. Low pension coverage in old age tend to be norm in most countries in the Asian region. As such, this pillar is aligned with what the SQ concept is concerned with, which are increasing pay, longer vacations, and more satisfaction with work conditions and, also extends its approach to better relationships and living well and long. Therefore, the SQ approach is grounded on a similar vision of quality of life in old age and offers specific definitions at the individual and collective levels related to measuring the objective aspects of quality of life, including income and longevity. It also defines more

subjective aspects, like happiness and emotional satisfaction with work and relationships, and offers indicators to measure them as well (Zaidi, 2018).

Advancing health and well-being into old age

The second pillar of MIPAA places emphasis on active ageing as a foundation of staying healthy in old age. Its definition of health mixes objective indicators, like the absence of disease with subjective ones as wellness and pleasure in life. Therefore, MIPAA guides governments' response to meeting old-age needs in place as well as encouraging them to promote higher levels of happiness and satisfaction. Achieving both can be fraught with challenges and the SQ approach attempts to provide measurable definitions for both by balancing quality and quantity of life. It also considers the impact of time (which is wider than the definition used by WHO). To be sustainable, the long-term consequences of a person's life style need to be addressed by social policy and the SQ approach takes this dimension into consideration in practical terms. This includes the prevention of non-communicable disease and obesity, for example (United Nations, 2018a).

A measurable difference between any two societies is whose citizens live longer and healthier. The SQ approach understands that a determinant of longevity is individual income level and social empowerment. Sustainability, as stated in the Kyoto Protocol, is also a determinant of longevity – which is perhaps why Japan's citizens boast the longest lives. An essential SQ health factor, equity, is also important for sustainability, which is the concern of SDGs 3 (inclusive health) and 10 (reducing income inequality) (Holman & Walker, 2018).

Many countries today provide free health care to older persons and subsidize long-term care but the coverage remain problematic (Suter & Mallison, 2015). Access and quality are two issues commonly cited by experts. Inactivity in old age, can risk diseases in impairment leading to poor overall health. However, this may not always be the case as the incidence of acute conditions, like infections, tend to decrease with age. However, when they do occur, acute conditions can be more severe in older age and would require intensive clinical interventions, especially for older women, as in the case of pneumonia and the flu. These conditions can pose social restrictions that can limit interaction and result in poverty and destitution, even death (ibid.).

SDG 3, concentrates on inclusive health, promotes access to universal, safe, and effective health coverage, including financial risk protection (United Nations, 2018b). The SQ approach also considers inclusive health and attributes health to social empowerment and participation in decision making, in addition to community-based care and behaviour pathways, like those that enhance or damage health, including psycho-social and physiological pathways to enhance or reduce cognitive and immunological function. Such provisions are seen as lacking, or difficult to access, in many communities in the region, an example is mental health counselling care. Naturally, communities that have limited exposure to the wider citizenry and insularity, as research has shown, tend to possess limited relationships and civic participation which predispose its members to various health problems. This means social

status and roles in society combine with access to material health provisions to determine health outcomes.

Therefore, the SQ approach can provide insights on why two communities with similar income levels have different health outcomes. Again, the Japanese health experience, as well as the Northern Italian and former Soviet Union countries', is instructive as the SQ approach draws insights from all three regions (Morris & Zelmer, 2005).

Geriatric care is also problematic in many parts of the region and MIPAA has pointed this out, especially for persons living with disabilities and restricted daily activities. For example, middle- and high-level income countries have experienced the epidemiological transition with industrialization and today obesity levels are unprecedented, which different health outcomes, some are similar or even worse than low-income countries (Rajkhan & Blumberg, 2004). In this connection, the SQ approach can supplement SDG 3 with insights to explain these differences.

Ensuring enabling and supportive environments

Older adults tend to prefer ageing at home (ESCAP, 2018). This is perhaps why governments in the region have put in place various supporting measures to facilitate the realization of this preference, like ensuring transportation systems are accessible. However, these measures tend to be limited in their reach and leave many behind. Public spaces need to be upgraded to meet the need to older persons, especially when disability and frailty are addressed.

What is the Social Quality approach?

SQ is a model of social relations that emerge from individual activities and social interactions with people, considered as social agents; that is people who tend to be thoughtful but not brilliant. These interactions form relationships that happen every day between people and are critical features of the wellbeing of both individuals and their communities in any society. Activities and interactions are experienced at the individual level and, therefore, must be measured (Walker, 2002).

Thus, Walker (2002), encoded these daily activities and encounters in the social quality theory and presented it as a comprehensive conception of their dynamics, which are considered as the foundation of Societal Quality of Life. Social and economic researchers, as well as environmentalists, have incorporated the same attributes, that is activities and interactions, in most social research as both have been identified as the basis of population growth and economic growth. The SQ model focuses on disadvantaged groups in society; considered by age, gender, disabilities, ethnicity and belief (Ferge, 1997); and as such, its aim is to overcome the obstacles that restrict their daily activities and interactions in society to improve their lot. This is important because with ageing, longevity, migration, and urban population growth, the obstacles continue to rise. Trends in activities of daily living (ADL) in many modern settings support this claim. In epidemiology research, this is very well documented with data (BMJ, 2017). For example, a study entitled "1 In 4 women and 1 in 6 men aged 65+ will be

physically disabled in Europe by 2047," confirms the analysis of other studies in Asia and cites rising restrictions to daily activities in old age as a source of concern and would require policy action.

Based on questions and interviews with government officials from a wide range of sectors that represent women, men, children, minorities, and migrants, taking account of cultural differences and the different levels of welfare systems, the theory is built on four themes of 'Conditional Factors' for human behavior: (1) Socio-Economic Security; (2) Social Inclusion; (3) Social Cohesion; and (4) Social Empowerment. This thematic approach reflects the primary sources and causes for most forms of discrimination, inequality, insecurity, injustice and social divisions (Walker, 2002). What the theory observed is that in every society, regardless of its claimed ethical values, there is a constant tension (acting as behavioural constraints) between the individual aspiration to self-realisation (as in Maslow's hierarchy of needs) and participation in the various collective social domains that constitute everyday life and the collective identify of the community. The two forces are in constant tension. The *SQ* concept is imbedded in this understanding.

The tension arises, more specifically, from, on the one hand, the biographical and societal development (agency and social structure) and, on the other hand, the world of organisations and the one comprising informal relationships (system and lifeworld) (Yee & Chang, 2009). Therefore, SQ can be defined as an adaptive struggle between two opposing forces that permeants not only social policy but also economic, environmental and other relevant policies. It is theorized that this struggle leads to an unequal relationship between social and economic policy, which prompted Allen Walker and colleagues, like Laurant van der Maesen, to find innovative approaches aimed at establishing a balance between economic and social development (Walker, 1998).

According to Walker (2011), there are four main factors that, in combination, can open the possibility for SQ, and therefore the SDGs, in policy: Social Recognition (or respect of human dignity); the Rule of Law, Human Rights and Social Justice; Social Responsiveness of institutions (the openness of society - flexibility); and the individual's own capacity to engage (skills and learning). These are considered Constitutional Factors that are theoretically and intuitively derived from the above-mentioned local tensions that have system-wide global implications (see Table 1).

Table 1: The Social Quality and related social development Factors: Conditional, Constitutional and Normative Factors of MIPAA and SDGs

CONDITIONAL FACTORS DIMENSION OF RESOURCES	**CONSTITUTIONAL FACTORS** DIMENSION OF HUMAN ACTIONS	**NORMATIVE MIPAA and SDGs Objectives** DIMENSION OF ETHIC/IDEOLOGY
Socio-economic security Social cohesion Social inclusion Social empowerment	Personal(human) Security Social recognition Institutional responsiveness Personal(human) capacity	Development, Health, Enabling environments Social empowerment Human dignity Inclusion Participation

Source: Social Quality: A Vision for Europe, The Hague, Kluwer Law International (Beck, 1997).

The above model captures the social reality of urban and rural communities as best as can be measured with the use of available statistical data and qualitative information. Once the constitutional factors, which encompass most of the SDGs,[3] are constituted, the four conditional factors determine the opportunities for the achievement of SQ, what Allen Walker (1998) called societal QOL components and well-being. Social systems may be enabling and supportive (social empowerment); institutions and groups may be accessible (social inclusion); people will have variable access to the material, environmental and other resources necessary for participation (socio-economic security); and their society and communities will be characterised by different forms and levels of cohesion (social cohesion) (Yee & Chang, 2009). This is how the constitutional factors intersect with the conditional factors in every society studied by Walker and colleagues who put this theory to the test. Noteworthy is the *SQ* research by Yee & Chang (2009). It showed that the four conditional factors can drive inequality in old age, especially gender inequality. This is because self-realisation may imply individual autonomy while collective identities may be open and liberating or closed and authoritarian. The tension between the two can lead to acceptable or unacceptable social outcomes. According to Walker & Sidorenko (2004), 'development' must be ethical to be sustainable (not only technological), this means that it needs to be humanistic (not just utilitarian) and respecting of dignity. In line with this ethic, the SQ approach has been proposed as a set of standard tools for improving social and economic policies; the above factors in Table 1 can help policy decision makers measure the extent to which people's daily lives in old age have attained an acceptable level of old-age empowerment.

With the rising challenges of education, healthcare, social housing, transportation and pollution, which are commonly faced by urban and mega city coupled with the background of ageing and migration, the four conditional factors of SQ can provide the right questions and insights for further exploration (Yee & Chang, 2009; 2011). This approach allows the researcher to explore the social realities in a new way that reconstructs social life with more coherence, combining both the natural environment and biophysical environment. Recent

[3] In particular, SDGs 4 (inclusive education), SDG 8 (full employment), SDG 10 (reduction of income inequality), SDG 16 (peace, justice and responsive institutions), and SDG 17 (partnerships for development).

years have seen a considerable expansion in the statistical data available to policy makers in Asia, including statistical digests from the WHO's ICF (the International Classification of Functioning, Disability and Health), ESCAP, World Bank and OECD. While this expansion of information is a positive step, some paradoxical dimensions are found (van der Maesen & Walker, 2014).

The shortcoming of statistics

As vital as statistical data is to policy making, and political participation, and empowerment, it tends to reinforce policy fragmentation, which makes it hard for policy makers and NGO practitioners to tackle the problems the SDGs are trying to solve in a holistic way (Philips, 2006). Because the whole of society is bigger than the sum of the parts, for older persons to comprehend what is happening to their communities, a more comprehensive understanding of the patterns of society is needed, not just the components. This is where the SQ concept comes in; the above factors enable researcher to ask older persons and those that represent their communities and the sectors that provide services to them questions about how to improve policy.

By addressing the four conditional factors of SQ, policy makers and NGO practitioners then can start developing a better understanding of the emergent big picture of the near future and which can improve their budgeting practices, like planning and encumbrance, related to education, health and social care, and social pensions (a non-contributory universal old-age cash benefit scheme) as claimed by the HelpAge International (2017). It is stated that the learning that resulted from the outcome of the third Review of MIPAA did not only concern the right amount of cooperation, between the public and private sectors, or between individuals and society, the model has to assume a change in the way health and care support provisions are functioning in the community (Van der Maesen & Walker, 2014).

The Progress of MIPAA in the ESCAP region from the lens of SQ

The three sets of factors in Table 1 can be fitted to MIPAA and the SDGs in conducting interviews. For example, when interviewing government officials and NGO representatives who attended the 'Asia-Pacific Intergovernmental Meeting on the Third Review and Appraisal of the Madrid International Plan of Action on Ageing', in Bangkok (ESCAP, 2017) with questions based on the factors listed in the Table, the following insights emerged about the ageing reality in their countries:

(1) Development and older persons:

a. Sustainability must be localised first, taking into consideration social and cultural values and norms.
b. Learning and financing need to go hand in hand. Learning means continuously harnessing the emergent picture of ageing. Financing means to support the learning that needs to happen with better monitoring and measurement of the

three sets of factors of the *SQ's* framework to better implement MIPAA at the local level.

c. Ethical development in practice also means ensuring income security in old age or disability by giving access to opportunities for re-employment, and this needs the support of the private sector.
d. Social empowerment in enabling older persons to enhance their wellbeing in their community.

(2) Personal health:

a. Personal health today is a serious challenge, so severe it should be treated as if affected by an epidemic, mostly affecting older persons and causing health inequality, but increasingly young adults too, as young as 40 years old.
b. A considerable gap exists in the literature on medical diseases, that usually start in youth, as disease is primarily a result of the transformations that occur to social processes because of development, like building a road that connect two cities or villages with modern transportation, for instance, that lead to the emergence of obesity, mental health problems, and social conflict, as it affects the four SQ*'s* conditional factors, and manifest themselves in old age.
c. Prevention can work if the above social override that leads to disease is addressed. Financial easing to pay for health care can also help address this problem.
d. Capacity assessment of patients is very important when it comes to making decisions about health treatment.
e. Culture is important in the delivery of health care and patient consent usually leads to higher levels of satisfaction.
f. Only five per cent or less of older population can rely on formal long-term care and financial assistance.
g. Preventive personal health needs to be promoted with alternative medicines and approaches.
h. There is a health gradient within societies due to income inequality and which affects the poor more acutely.
i. Social protection improves the welfare infrastructure in society and favours better health.
j. Community-based health care is underutilized. The demand is higher for in-patient hospitalization.

(3) Enabling environments:

a. The new emerging picture of ageing in most Asian cities also means adequate housing – it follows from this that the views of older persons determine living

conditions, such as the location of preference, size, proximity to working-age family members, networks, charities, facilities, and other attributes considered adequate today.

b. The interaction with the environment is dynamic (not static).
c. As stated by the respondents, every city, should be concerned with the rising problems of inadequate housing arrangements and chronic diseases faced most older persons – particularly women, and those living alone.
d. Accessibility is an issue for the poor, especially in rural areas.
e. Data was also important.
f. Stress can have a deleterious effect on health, for example, it can raise blood pressure, weaken the immune system, harms the cardiovascular systems and induce inflammation.

Clearly, the policy implications of the above account indicate the interaction between income security, social protection and health. If health is a determinant of income security and social protection, it means resources need to be concentrated on the poor if no one is to be left behind.

Form the SQ perspective (Holman & Walker: 2018), 'old-age empowerment' is understood as a process of adaptation that enables an older person to overcome obstacles in their social system that lead to losses in their income and well-being, offset with better access to resources, increased work opportunities, and control over one's life. Therefore, empowerment at the individual level can help mediate the cost of care today and in the coming future. The SQ approach is also concerned with the structural or institutional level, which also plays a role in empowering older persons. The institutional environment can impose limitation and constraints on older persons that can disempower them.

The living standard of the poor becomes a function of their health; health risks can shape their attitudes and expectations. The concern here was that the growing demand for long-term care due to physical de-functioning with ageing required higher spending on older persons keeping; to become financially secure and physically active and dignified in society (ESCAP, 2018). The Third Review of MIPAA concluded that this was a dilemma and the SQ approach would then recommend focusing resources in the communities that need it the most. Ethnic communities tend to be the most disadvantaged and excluded and typically suffer from multiple illnesses and low levels of personal security, in particular women and children; the Rohingya is a case in point. As most social welfare structures are rigid in the region, to become empowered, older persons would need to be enabled with learning, skills and placements in jobs with state and market support, which the MIPAA called for, and which the report of the Third Review stressed in Paragraph 18 (f) under the heading "Older Persons and Development":

(a) "To focus support on older persons in rural and urban areas without kin, older women who face a more extended old age, often with fewer

> resources, thus giving priority to the empowerment of older women in rural and urban areas through access to financial and infrastructure services" (ESCAP, 2018: 19).

Developing regions such as Asia has witnessed much positive social and economic changes that has led to the transfer of more resources to older persons and those who care for them or are cared by them since the adoption of the MIPAA (ibid.). However, disparities remain high regarding the overall phenomena of population ageing; perhaps the most striking feature in most societies today is the change in the old-age dependency ratio. On average, this ratio has doubled in the last 20 years as the pace of the magnitude of population ageing picked up speed, it is most pronounced in East and North-East Asia, North and Central-Asia and the Pacific (ESCAP, 2018). This is happening while contributory pensions are creating substantial old-age income inequality, with many unable to offset the cost of care and subsequently, increase the burden of maintenance for their families, especially the women as they are the primary caregivers, often unpaid. Perhaps a shift in the current direction of ageing politics towards securing income in old age with personal empowerment with a contextual focus is necessary.

Conclusion: A need for *A Life Innovation Analysis Framework* from the Asia and the Pacific

Allen Walker's SQ theory (2018), posits that combination of constitutional factors, like the objectives of MIPPA and SDGs, and individual conditional factors, like social empowerment and capabilities determines the challenges and opportunities for improving social quality of life. It was discussed how the SQ's conditiona**l** and constitutional factors connect MIPAA to the SDGs framework to enrich understanding of the human conditions and quality of life in old age today. It was also highlighted how the SQ framework enables the capacity to ask the right questions, it is appropriate for exploring the difficult social realities of disadvantaged groups, in particular older persons, and issues pertaining to their quality of life as constructed by MIPAA's three pillars; i.e., development and older persons, health, and enabling environments. The three sets of factors as demonstrated in Table 1 are interrelated, and can help policy makers formulate better questions to understand the extent to which social support, or the lack of, is acceptable and ethical.

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Nutritional and functional assessment of older people at health home care Nepal

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Abstract. This study sought to assess the functional activities of daily living (ADL) and nutritional status of older persons admitted to Health Home Care Nepal. In aim of developing better care management protocol, attention was placed on identifying explanatory factors of functional status among residents and the associations between their socio-demographic variables.165 residents above the age of 60 (>60 years old) were included. Socio demographic information was gathered from family members and comprehensive geriatric assessments, including nutritional and functional assessments, in accordance to a nutritional checklist and the Barthel score index, respectively. According to the nutritional screening initiative, 48.5% of residents were at high risk and 20.0% had good nutrition. There was a high nutritional risk in urban residents (56%) in comparison with rural residents (30%); 70.0% of illiterate residents and 39.1% of educated residents were at high nutritional risk.62.0% of illiterate residents were dependent whereas only 58.2 % of educated residents were dependent. The Barthel score index score was significantly lower in those at high risk of malnutrition compared to those at moderate risk and those with good nutrition. There was a significant association of nutrition with age, gender, education and income. However functional status was significantly associated with education and income. Significant associations were noticed between specific socio-demographic variables with both nutritional and functional status which are significantly interrelated too. The Collection of data is deemed important for the planning of care activities and rehabilitation for admitted older persons.

***Keywords*:** Older People, Functional, Nepal, Nutrition.

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Introduction

In recent years, there has been a sharp increase in the number of older persons worldwide. According to the 2011 census, conducted by the Government of Nepal, National Planning Commission, Central Bureau of Statistics of Nepal, the population of people aged 60 years and over, referred to as senior citizens was 2.15 million, accounting for 8.1 percent of Nepal's total population of 26.5 million (Government of Nepal, National Planning Commission, Central Bureau of Statistics, 2012). (Table 1).

Table 1: Demographic situation of ageing Nepal, 1961 – 2011

Census Year	Population (60+)	Population growth rate		Percent of elderly(+60)			Percent of elderly(+60)	
		Total (%)	Elderly (%)	Rural	Urban	Total	Male	female
1961	489346	1.65	1.79	5.22	5.23	5.2	4.8	5.6
1971	621529	2.07	2.42	5.63	5.12	5.4	5.3	5.9
1981	857061	2.66	3.26	5.74	5.11	5.7	5.9	5.5
1991	1071234	2.10	2.26	5.95	4.99	5.8	5.9	5.7
2001	1504311	2.24	3.40	6.60	5.70	6.5	6.4	6.3
2011	2154410	1.36	3.65	8.4	6.8	8.1	8.3	8.0

Health Home Care Nepal (HHCN) is the residential care home for older persons which was established to provide comprehensive holistic package of services addressing human ailments (social, psychological & medical needs), while ensuring comfort for its residents and their family care providers. Functional independence and the ability to manage daily routines are of major concern for older persons. The prevalence of both chronic conditions and activity limitation increases with age, with health-related limitation in mobility or self-care increasing fourfold between ages 65-74 and 85 or older (Eberhardt, Ingram, & Makuc, 2001).

Assessment of functional capacity is a key element in geriatric health, as it can help in identifying what services or programs are needed (Stuck, et al. 1999). Malnutrition is the major geriatric problem associated with poor health status and high mortality, marking this challenge as well recognized in clinical outcomes (Ahmed & Haboubi, 2010). Nutrition changes the functional activity of people through changes in body composition (Kuczmarski, Weddle, & Jones, 2010). The prevalence of malnutrition is increasing among the Nepali population and is associated with a decline in functional status (Fang et al., 2013). It is argued that the functional ability of older persons could be enhanced by improving their nutritional status by means of proper diet management. In order to administer optimal and adequate care in HHCN, it is deemed better to disclose information about the functional and nutritional status of patients during admission followed by several intervals throughout his or her stay at the care home. The ideal goal of services for older persons should be better quality care. The objectives of the study was to assess the functional (ADL) and nutritional status of older persons at admission and to identify explanatory factors of functional status so that better care management protocol would be developed for the better care of the residents. The explanatory

factors are to clarify the impact of socio-demographic factors on nutritional status of the older persons in addition to the interrelationship between both.

Method

This study has been carried out on 165 residents admitted at this HHCN during the period between January 2013 to January 2016. The cross-sectional descriptive study was conducted with older persons admitted to this 20bed HHCN and who have been residing for the last three years. Socio-demographic information was collected, from both residents who could answer for themselves, and those requiring the assistance from their family members with consent. The Barthel Score Index (BSI), was used, which is a validated and reliable generic instrument used to measure daily functioning, specifically the activities of daily living (ADL) and mobility (Mahoney & Barthel, 1965).This Index measures the capacity to perform 10 basic ADL and gives a quantitative estimation of the patient's level of dependency, with scoring from 0 (totally dependent) to 20 (totally independent) (ibid.). All assessments were carried out by the nurses together with an experienced physiotherapist. Patient characteristics and outcome measures were analyzed with descriptive statistics. Residents were classified according to age, as follows: young old (60–74.9 years), old old (75–84.9 years), and oldest old (≥85 years). All participants or family members gave informed consent and the study was given approval from local ethical committee.

The nutritional screening initiatives (NSI) are the most frequently used nutritional screening tool for older adults (Bassem & Kim, 2011). It is intended to prevent impairment by identifying and treating nutritional problems before they become a detriment to the lives (Sennett et al., 2010). For this study the NSI was used as a nutritional screening tool, which included 10 items with a total score of 21 points. A score from 0to 2 was considered as good nutrition, 3 to 5 as moderate nutritional risk, and 6 or more as high nutritional risk (The Nutrition Screening Initiative, 2007).Nutritional screening indicators include illness and tooth or mouth problems affecting feeding; number of meals per day; types of foods and drinks, the level of independence for meal preparation, feeding oneself, and weight management.

Data were checked, entered, and analyzed using SPSS version 21.0 for data processing and statistics. Categorical variables were compared with the chi-square test(X^2). For all analyses, *P*value <0.05 was considered statistically significant.

Results

Socio-demographic data of the studied residents are presented in Table2. A total of 165older persons were included in the study. The majority of residents (47.9%) were oldest old and female (53.9%) of primary education level (38.8%), with friends (66.1%) and children (81.2%), even though most are no longer in close contact with their friends and children. It was further noted that the majority of residents came from moderate income (58.2%) and were paying to reside in this HHCN.

Table 2: Socio-Demographic data of studied patients:

Age Group		**Frequency**	**%**
	Young old ((64 - 74.9)	45	27.3
	Old old (75 - 84.9)	41	24.8
	Oldest old (85 and above)	79	47.9
Gender			
	Male	76	46.1
	Female	89	53.9
Residence			
	Urban	118	71.5
	Rural	47	28.5
Education Level			
	No formal education	51	30.9
	Primary education	64	38.8
	Secondary education	31	18.8
	Tertiary education	19	11.5
Presence of close friends			
	Yes	109	66.1
	No	56	33.9
Income			
	Low	**0**	**0**
	Moderate	96	58.2
	High	69	41.8
Children			
	Yes	134	81.2
	No	31	18.8

Table 3: Nutritional Assessment (NCL Category) and Functional Assessment (BSI-category)

Nutritional Assessment (NCL Category)		Frequency	Percent
	Good nutrition (0 - 2)	33	20.0
	Moderate risk of malnutrition (3 - 5)	52	31.5
	High risk of malnutrition (6 and above)	80	48.5
Functional Assessment (BSI-category)			
	Dependent (1)	98	59.4
	Needs some help (1-10)	42	25.5
	Independent (11 - 20)	25	15.2

Table 4: Variables associated with - Functional Assessment (BSI) & Nutritional Assessment (NCL)

		Functional Assessment (BSI)						Nutritional Assessment (NCL)						
		Dependent		Needs some help		Independent		Good nutrition		Moderate risk of malnutrition		High risk of malnutrition		Total
		N	%	N	%	N	%	N	%	N	%	N	%	
Age Group	Young old ((60-74)	13	29	17	38	15	33.3	19	42	19	42	7	16	45
	Old old (75 - 84)	28	68	9	22	4	9.8	11	27	21	51	9	22	41
	Oldest old (85 and above)	57	72	16	20	6	7.6	3	4	12	15	64	81	79
	X^2	69.06						27.06						
	P value	0.00						0.00						
		Dependent		Needs some help		Independent		Good nutrition		Moderate risk of malnutrition		High risk of malnutrition		
		N	%	N	%	N	%	N	%	N	%	N	%	
Edu. Level	No formal education	31	62	15	30	4	8	5	10	10	20	35	70	50
	Primary education	32	50	20	31	12	19	7	11	25	50	32	50	64
	Secondary education	20	63	7	22	5	16	10	31	15	30	7	22	32
	Tertiary education	15	79	0	0	4	21	11	58	2	4	6	32	19
	X^2	11						39.7						
	P value	0.08						0.00						
		Functional Assessment (BSI)						Nutritional Assessment (NCL)						
		Dependent		Needs some help		Independent		Good nutrition		Moderate risk of malnutrition		High risk of malnutrition		Total
		N	%	N	%	N	%	N	%	N	%	N	%	
Income	Moderate	53	55	20	21	23	24	32	33	26	27	38	33	96
	High	45	65	22	29	2	3	1	1	26	38	42	61	69
	X^2	14.35						25.58						
	P value	0.001						0.00						
		Functional Assessment (BSI)						Nutritional Assessment (BSI)						
		Dependent		Needs some help		Independent		Good nutrition		Moderate risk of malnutrition		High risk of malnutrition		Total
Residence		N	%	N	%	N	%	N	%	N	%	N	%	
	Urban	70	59	23	19	25	21	23	19	29	25	66	56	118
	Rural	28	60	19	40	0	0	10	21	23	49	14	30	47
	X^2	15.70						11.12						
	P value	0.00						0.00						

		Functional Assessment (BSI)						Nutritional Assessment (NCL)						Total
		Dependent		Needs some help		Independent		Good nutrition		Moderate risk of malnutrition		High risk of malnutrition		
		N	%	N	%	N	%	N	%	N	%	N	%	
Gender	Male	45	59	23	30	8	11	7	9	27	36	42	55	76
	Female	53	60	19	21	17	19	26	29	25	28	38	43	89
	X^2	3.27						10.2						
	P value	0.19						0.006						
		Functional Assessment (BSI)						Nutritional Assessment (NCL)						
		Dependent (1)		Needs some help (1-10)		Independent (11 - 20)		Good nutrition		Moderate risk of malnutrition		High risk of malnutrition		Total
		N	%	N	%	N	%	N	%	N	%	N	%	
Marital Status	Married	40	53	21	28	14	19	13	17	37	49	25	33	75
	Widowed	39	59	16	24	11	17	9	14	10	15	47	71	66
	Divorced	5	100	0	0	0	0	4	80	1	20	0	0	5
	not married	14	74	5	26	0	0	7	37	4	21	8	42	19
	X^2	8.30						40.49						
	P value	0.21						0.00						

According to NSI, 48.5% of the residents were at high risk, 31.5% at moderate risk and 20.0 % had good nutrition. 59.4% of the study residents were found to be dependent and only 15.2 % were independent (Table 3).

This study found an association between age group with NSI as well as BSI. It found that 81.0% of oldest old were at high nutritional risk and 22.0 % of old old had high nutritional risk but the percent in young old was 16.0%. In terms of BSI, 29.0% of young old residents were dependents, which increased to 68% among old old and to 72% among oldest old.70.0% of illiterate residents were at high nutritional risk and 39.1% of educated residents were at high nutritional risk. 62.0% of illiterate residents were dependent where as 58.2% of educated residents were dependent. There was significant association between education with BSI (*P*= 0.08) and with nutrition *(P*=0.00). A significant association between income with NSI as well as with BSI was discovered. There was a high nutritional risk in urban residents 56%, in comparison with rural residents 30%; it was found that almost same percent of urban as well as rural residents were dependent with significant difference. No significant association was found between BSI and gender (*P*=0.19), but significant association found between NSI and gender (*P*= 0.006). A significant association of demographic variables with respect to NSI and BSI indicate that both nutrition and functional ability are interrelated. Also, it was found that a significant interrelationship between the nutritional status of the elderly and functional capacity (Table 4).

Discussion

According to NSI, the results showed that about 48.5 %of patients had high nutritional risk. A study conducted in Canada indicated that 37–62% of older persons were at risk of poor nutrition (MacLellan & vantTil, 1998), while a similar study in India indicated 50.3% (Baweja, Agarwal, Mathur, & Haldiya, 2008). A recent study in China which was carried out using the NSI found that the overall prevalence of under nutrition and nutritional risk was 17.8% and 41.5%, respectively (Fang et al., 2013). Result of this study is close to India study but different result in different studies may be due to differences in the selection criteria of older persons as well as in socio-demographic variables. The results in relation to NSI and age group correspond with that obtained by study carried out in China (Fang et al., 2013) with findings showing that the prevalence of nutritional risk was significantly higher in patients more than 70 years.

In this study finding of higher nutritional risk was found in illiterate patients as opposed to educated patients. This is similar to the findings of a study carried out in Nigeria (Olasunbo & Olubode, 2006*).* However, study (Yap & Ng, 2007) carried out in Singapore found no significant correlation between NSI and education. In this study high nutritional risk was found among high income people rather than in moderate income as was found in a study carried out in Egypt (Esmayel &Hassan, 2013). Regarding functional assessment, this study found a significant direct association between functional activities and advancing age, where functional activity decreased with advancing age. The same notion was found in study carried out in rural Malaysia (Hairi, Bulgiba, Cumming, Naganathan, & Mudla, 2010). Similarly, significant association was found between functional activity and income, education level and residence. This resulted in functional activity to decrease with increasing level of income, education and among urban dwellings. Such association was not found in the study carried out in Egypt (Esmayel & Hassan, 2013) where no significant association was found between disability and income. This study found that both older male and female showed similar prevalence of functional limitation, with 59% and 60% respectively. This finding is similar to study (Bergamini et al., 2007) done in Italy but in contrast to the study carried out in Egypt (Esmayel & Hassan, 2013) and Malaysia (Hairi et al., 2010) which suggested that such challenges resulted from limited education contributing to further functional limitation among older persons. Findings from this study further delineates that increased incidence of functional limitation was found to be associated with risk of malnutrition. This is in agreement with the study carried out in Brazil (Oliveira, Fogac, & Leandro-Merhi, 2009) which assessed the relationship between nutritional status and functional capacity. In a study carried out by (Cereda, Valzolgher & Pedrolli, 2008) and a study carried out in Montreal, Quebec (Chevalier, Saoud, Gray-Donald & Morais, 2008) showed that the poorer functional status was associated with low nutrition.

Nutritional risk increased significantly in urban residents in compare to rural residents and in males compare to female. High nutritional risk found to be among widowed people 71.0 % in relation to marital status.

Conclusion

Significant associations were noticed between specific socio-demographic variables with both nutritional and functional status. Hence socio demographic and nutritional factors can be taken as explanatory factors for the functional status of older persons. Special attention to these factors can better assist in the planning and the overall better outcome of care activities and rehabilitation for older persons who are admitted to this care home. Knowing the level of risk of malnutrition after admission could better aid in the planning of a proper diet plan, which may include an additional quantity or increase frequency of feeding enriched with the correct amount of protein and carbohydrates. Oral liquid high energy supplements or enteral feeding would be considered for high risk residents. Planning of different level of care activities depend on the Barthel score of every resident. Care activities include: bladder exercise for incontinence, assisted walking, and assisted feeding for those who can't eat by themselves. This implies that prior functional and nutritional assessment is needed before administration to a care home for older person sin order to establish proper management and outcome. Also, it is necessary to pay special attention to functional capacity when planning nutritional care for older persons, especially when they are debilitated.

Limitation of study

The patients included in study are residents at one care home only. Larger number of people should be included from different care homes. Further advanced research analysis is required for future research in this field.

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Reviewed by Mario Barbagallo[1]

Extraordinary demographic changes are occurring in the 21st century with increasing ageing of the populations around the world. Mediterranean countries are among the longest living of the world. This extraordinary success of humanity brings with it many challenges to build a future with healthy seniors. The present remarkable increased life expectancy is most probably the result of better living conditions, medical progress, and better health care organization. The World Report on Ageing and Health, one of the most important WHO documents in recent years, confirms the crucial importance of the maintenance of functional ability throughout life. Malta is one of the fastest ageing countries in the European Union. In the next 30 years the United Nations foresee an increase of 6.4 and 6.3 years for males and females, to reach 85.1 and 89 years of life expectancy, respectively.

The excellent book of Prof. Marvin Formosa - Active and Healthy Ageing in Malta - explores the actual situation in Malta, and testifies the impressive number of social and health care services that have been introduced in the last few years in Malta, but it is also a thoughtful analysis of the possible interventions to be implemented in order to promote functionally independent ageing, as well as of the strategies to help delay, prevent, or reverse the frailty process. This book documents the progress in living conditions, in social and health care but also shows the future directions to challenge the problems and the opportunities of the demographic challenge, and is also an important tool for policy makers, to help the routing of resources and political interventions.

Active and healthy ageing is a societal "duty", but it is also a personal responsibility. Everyone eventually has the old age that deserves. This makes us think on the opportunity, at any age, to care for the own ageing. Lifestyle and behaviour across the life course (e.g., physical exercise, adequate nutrition, non-smoking) are fundamental. It is for this purpose that we all need to build and disseminate a culture of "Active and Healthy Ageing". In parallel, preventing

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diseases that increase disability, and delaying or preventing frailty and dependency, needs to become a core focus of public health actions, in all the nations. The duty of the societies and of the national health systems is to create the conditions and the services that allow people to age successfully, fight frailty, and avoid social exclusion in case of disabilities.

The book shows that Malta is trying to address all these points. A pension system has been recently reformed resulting in significant innovations with a strategy that allows old citizens an adequate but sustainable pension income, and reduces the gender discrimination. Social changes have been implemented to consent provision of support, security, and care, in order to improve social network for older gay men, with positive results in overall wellbeing, with the ambition to make Malta become an old gay friendly nation. Malta has also recently revised and modernised the legislation on elder abuse. This is a very important achievement since this is an increasing diffuse and underreported problem in all continents. In this regard, the creation of an office where older abused person may report any form of abuse deserves recognition.

The policy on long term care (LCT) for older adults has evolved and reoriented in the last few years, moving from a protective one based largely on the medical model to community-based services aimed to encourage and support ageing in place. Over the years also the role of the state has changed moving from being the main provider of LTC to include contracting and purchasing of services. However, the role of residential care in Malta is still greater than in many other European countries. Quality of life in residential care has received increasing attention, and assistance has been reoriented from the hospital model to one that privileges autonomy, privacy, dignity, and psychological health of the residents, trying to minimise isolation, encouraging socialisation, and limiting the use of physical restraint. An interesting initiative that has been implemented in Malta is a residential respite care programme for caregivers with the provision of residential beds in four different sites (3 facilities in Malta and 1 facility in Gozo) that may be offered for a maximum of three weeks, up to three times a year. In these facilities older persons are engaged and empowered in a number of activities, trying to maximize the functional independence of the recipient of care.

Particular attention deserves the Malta national strategy for dementia and the dementia intervention team: persons diagnosed with dementia that enter the programme will have a care plan developed by a multidisciplinary team specialized in dementia care management that includes a dementia care coordinator, a practice nurse, and an occupational therapist. A psychologist may also be part of the core team. The team discusses with the clinician and assesses short- and long-term goals, and facilitates access to the appropriate services for the person under care. The programme had a tremendous success and the demand for the programme is growing, probably requiring future increase in resources. Communication training programmes have been started for informal caregivers of persons with dementia in rehabilitation hospital, to help reducing caregiver stress and burden.

Among other interesting programmes that have been implemented aiming to guarantee healthy ageing in Malta, the book reports the important results of an oral health programme in older persons, of a nutritional assessment as an important component of health among older adults, the approaches to implement nutritional interventions, and a programme aiming to

guarantee assistance to persons with heart failure and undergoing a coronary artery bypass graft. Other specific programmes have been developed for the end of life and palliative care that guarantee artificial nutrition and hydration, although some bioethical aspects need further elaboration.

Malta has started a process to elaborate a Vulnerable Person Act that would increase the concern for the important issue of vulnerability in its social, psychological and medical aspects. This act should include procedures to report mistreatment, safety plans at home, education of the public to the concept of vulnerability in the older persons, and a support network for the person and the carers. It is also noteworthy that the University of Malta is implementing undergraduate and postgraduate programmes in gerontology, geriatrics and dementia studies.

Altogether, this remarkable book by Prof. Formosa shows the notable number of initiative and programmes put forward in Malta to protect vulnerable persons and their caregivers. It also highlights how these policy initiatives and these University research and studies are going in the right direction to improve the capacity of building an active ageing society in Malta.

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Reviewed by Nidhi Gupta[1]

The book *A Common Wealth of Experience: Freedom fighters, child brides and other untold real life stories*, edited by Ingrid Eyers and Annie Waddington-Feather, is a unique addition to the body of knowledge in the field of ageing and captures older person's life stories and experiences of growing old in varied socio-cultural, political, environmental and economic contexts. This book provides a detailed perspective about the phenomenon of ageing in African, Asian, Australian, European as well as Canadian contexts.

The stories in the book illustrate older people's life struggles and resilience coupled with the changing socio-political and economic scenario due to the development of the Commonwealth as its member's transit from being a colony into gaining and maintaining independence. Every story has two sections, the primary section is the story of the older persons and their life experiences due to the choices and circumstances and the second section of each story is about the author's learnings from the life stories of older person. It is interesting that the authors are young persons and they have reflected on what they learnt from experiences of older persons and what they would imbibe from the experiences of the older persons to improve their life experiences and perspectives, after arduous engagement with the older persons to understand their life stories. Hence, the methodology adopted by the editors in this book has a dual benefit, one presenting and disseminating life stories of seniors and the events that impact lives of people in general and at the other end engaging youngsters to pen these stories of seniors, who are the future. This methodology not just strengthens the intergenerational solidarity and bonding but also provides readership to a wide age group, who shall identify with some or the other aspect of each story. The editors and authors have been able to present the complex stories of older persons in a very simplistic manner highlighting the positive aspects of their lives and ways seniors adapted to the challenges in their lives.

The common beads in most of the stories are the essential elements to longevity like optimism, smiling in every situation, belief in self, being the change-maker to change the situation and spirituality, that have been unveiled explicitly in some stories while is implicit in others. Some

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of the common themes that emerged from these stories are the phase of pain and sorrow, resilience, their role models and inspirations, change in social roles with age, challenges due to functional decline and health with age, while some distinct stories illustrate the cultural connotation associated with infertility, implications of being stylish, being a non-conformist, polygamy, havoc of HIV/AIDs and its implications on families, among others. The stories also highlight the role of education in Improving the perspectives of people and dealing with situations, the negotiations people make in their lives with respect to needs, wants, and desires in the trajectory of life.

The wide array of contexts, the socio-cultural, political, economic as well as environmental scenarios that shaped the lives of people and the message, they have for the next generations are an intangible resource for the mankind. In conclusion, the book provides a message that 'knowing about the past helps in future' and each story illustrates that the challenging phase of life is an opportunity for a person to be a better being, if there is optimism and zeal to remain happy in any situation. This book is an excellent read for diverse age groups, gender, people from any caste, class and nationality. Moreover, the simple linguistic tone adopted in documenting the life stories enables readers from across the globe to comprehend the meanings implicit in the writings and relate to emerging themes based on their own cultural contexts.

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