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*Special Issue*

# Population Ageing in Africa

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# International Journal on Ageing in Developing Countries



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# Editorial

**Emem Omokaro**[1]

This special issue of the International Journal of Ageing in Developing Countries (IJADC) focuses on 'Ageing in Africa'. As guest editor for this issue, I know that this publication is going to be very welcomed and applauded by researchers in Africa. The call for papers for this first publication coincided with the momentum building up to the 6th UN ECA/African Regional Forum on Sustainable Development scheduled for February 24-28 2020; preparations for 2nd Elders' Forum planned on the side lines of the Commonwealth Heads of Government Meeting in Kigali Rwanda, June 22-27 2020; the on-going review and revision of the African Union Policy Framework and Plan of Action on Ageing (2002), as well as preparations for the 11th Session of the United Nations Open- ended Working Group on Ageing (OEWGA), April 6-9 2020. However, all preparations and already planned activities were disrupted by the challenges and changes accompanying the sudden occurrence of infections from the Corona virus. Programs like the UN OEWGA which were not out rightly cancelled were transformed from physical meetings to the digital space with minimized agenda.

With COVID-19's intense activity and increasing mortality rates across the globe, WHO declared the disease a global Pandemic on March 11, 2020 (World Health Organization, 2020). and, Africa registered its first case in Egypt in April 2020 (Africa News, 2020). The unprecedented impact on older persons in the African continent was the subject of the survey conducted by the Stakeholder Group on Ageing in Africa. The findings of the study of the impact of COVID-19 containment and mitigation strategies on the rights of older persons in Africa, is one of the 6 articles published in this edition. It affirms the distressed health and socio-economic landscape across 18 African Countries, highlights fragile infrastructure of health care for pre-existing conditions during the pandemic and, in most cases, the lack of social protection for older persons as well as, actions to uphold their voices and human rights. The paper on the SGA Africa Report, 2020 discusses the inadequate mechanisms for coordinated inclusion and participation of older persons in COVID -19 policy response.
COVID-19 provides a lens to view the deepening ageism and discrimination against older persons, and pointers for stakeholders to seek mechanisms for promoting stakeholder's

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collaboration and partnerships for effective actions to address inequality, vulnerability, abuse and neglects of older persons in Africa.

The UN Census Bureau 2020 Report on Ageing Africa provides new comprehensive and up to date statistics on current and projected future population ageing and patterns in Africa and sub-Saharan Africa. It reports that between 2020 and 2050, the older African population is projected to triple from 74.4 million to 235.1 million; Africa's growth will outpace that of any region of the world even though, majority of African countries have less than 7% older population in 2020 (He, Aboderin, & Adjaye-Gbewonyo, 2020). The low proportions still translate to increasingly growing absolute numbers. Such a demographic transition has profound impact on every aspect of individual, community and national life. Population ageing is therefore poised to become a major issue in Africa. It is therefore important to integrate the mega –trend within the larger process of development in the region.

In Africa, diverse stakeholders including researchers in the field of ageing are taking the responsibility of mobilizing support towards comprehensive responses across the African continent on older persons. The process of strengthening the protection of rights of older people in Africa is being accelerated, including the nature of the support needed by countries to accelerate the ratification of the Protocol to the African Charter on Human and People's Rights on Rights of Older Persons in Africa, as well as the African Member States' participation in the United Nations Open –ended Working Group on Ageing (OEWGA) sessions. INIA's on-line journal 'Focus on Africa' definitely provides a window for researchers, to share both the challenges and the progress made.

The African Union Agenda 2063 as well as the 2030 Agenda for Sustainable Development and, its Sustainable Development Goals, provide blueprints of action for people of all ages, and are both explicitly grounded in human rights standards. In recent years, more African countries have adopted national policies on ageing and have set-up social protection schemes to tackle vulnerability including social pensions, agricultural subsidies and emergency relief (Omokaro, 2019). Despite such progress, older people face and continue to face severe challenges in their everyday lives. Research findings provide concrete evidence of the systemic inequality and discrimination of older women and men in the African context and the significant impact of ageism on the realization of envisioned continental prosperity for all (Stakeholder Group on Ageing, Africa (SGA Africa), 2019).

The UN Census Bureau 2020 reports that health systems for Africa's older persons, in particular, rural residents, suffer insufficient financial resources and understaffing of health workers, inadequate health insurance coverage and high out of pocket payments. It also suggests that this is happening with increasing dominance of non-communicable diseases in older persons in Africa (He, Aboderin, & Adjaye-Gbewonyo, 2020).

Many older persons face challenges in accessing social security, justice, loans, housing, nutrition, health care and support systems, education and lifelong learning opportunities and are often denied the rights in participating in development activities (SGA Africa, 2019). The

same declaration also acknowledged, that older persons in Africa are experiencing ageism and age discrimination making the stakes for regional and international normative framework, strong institutions policy and, disaggregated data high. Combating discrimination based on age and promoting the dignity of older persons is fundamental to ensure that all Africans enjoy a life of fulfillment (ibid.).

Five research papers are featured in the section on Focus on Africa. '*Socio-economic Factors Influencing Ageism among Undergraduates of the University of Lagos, Nigeria*' by Bola Amaike & Tunrayo Seidun interrogates ageist attitudes and perceptions which jeopardize older adults' life chances, providing evidence that negative perceptions of older people are influenced by level of knowledge (study) with grave implications for their quality of life and life satisfaction in old age; the article '*Doing qualitative research on dementia with carers in Kenya: A reflection on fieldwork experiences*' by Purity Mwendwa, shares practical reflections on fieldwork experiences in the context of challenges of rising incidence of none communicable and chronic diseases and rising caring needs in families and communities with focus on dementia in sub-Saharan Africa. The paper explicitly details the researchers' motivation to focus on dementia and the challenges faced as a researcher in an emerging knowledge domain, providing very vivid insight on factors influencing dearth of much needed international research, knowledge and evidence base about conditions of sufferers and care givers in Africa.

In the empirical article titled, *Forsaking Treatment and Enduring the Status: Ageing into Disability*, Namaganda Rehem presents findings from research conducted in Uganda on older persons and the process of disablement. The research highlights social factors including, the decisions made by older persons; whether or not to seek treatment during events of injuries and, when to stop the treatment seeking journey, as determinant of the disablement process beyond disease. The paper addresses financial and infrastructure challenges also, as factors in understanding the process that leads to disability among older persons

Kabelenga Isaac shares his report on *Political Abuse of Older Persons in Zambia.* This paper raises awareness about political abuse of older persons during parliamentary elections and the role played by politicians, political cadres, older people's family members and election polling officers in determining and perpetuating abuse of vulnerable older people, particularly those with poor eye sight, the illiterates and those living in monetary poverty.

The paper on *Perception, Attitude of Women on Ageing, Old Age and Geriatric Care in River State, Nigeria* by Bellgam & Enebe, presents findings from a cross sectional study of women in River State, Nigeria. It brings to the fore, cultural perceptions and definition of old age and the preferred long-term care system as well as traditional family aversion of institutionalized homes. These documented perceptions and attitude, should add to the on-going discourse of cultural orientation and current reality of weakening family support and long-term care options in Africa. The findings on insurance or retirement/pension plans and preparations for an inevitable phase of life in old age are informative. All the articles suggest ways of designing appropriate interventions.

This special issue also features two book reviews. The first book selected is titled, *What Retirees Want: A Holistic View of Life's Third Age* by Ken Dychtwald & Robert Morison. The reviewer, Dr. Dorian Mintzer, a board-certified retirement coach and author, succinctly brings out the overriding message and the 'call-to-action' for the reader on transforming or retiring "retirement" and focusing on 'Life's Third Age as Life's New Frontier with more learning, more intergenerational contributions, and more activism'. The second book reviewed is titled, *Men, Masculinities, and Aging: The Gendered Lives of Older Men* by Edward H. Thompson Jr. The reviewer, Roberta Sultana, gives an excellent analysis of the book section by section. The author provides the reader with a new standpoint on men's experiences with corporeal ageing, growing older in an ageist society and the last but not the least on how old men steer the non-existent cultural instructions for being an ageing man.

The publication of this special edition of INIA Journal of Ageing in Developing Countries with a 'Focus on Africa', keys into Africa's stakeholders' call for coordinated advocacy for the protection of the rights of older persons in Africa via the regional multi-stakeholder participatory platform on ageing. It would have been easier to send the call to members of the Stakeholder Group on Ageing in Africa (SGA Africa), a regional multi-stakeholder coalition of CSOs, professional bodies, academia, research and human rights institutes, inviting submission of papers for this special edition. However, responses from Uganda, Zambia, Nigeria, Kenya and the SGA Africa report on the impact of COVID-19 on older people across 18 African countries, demonstrate that by working together, we can share and advance knowledge of ageing in Africa and influence policy action. The 'Focus on Ageing in Africa' initiative by INIA is commendable and Africa's researchers and practitioners in the field of ageing, look forward to contributing papers for publications in subsequent editions.

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# Perceptions and attitudes of women on ageing: Old age and geriatric care in Rivers state, Southern Nigeria

**Hope Ilanye Bell-Gam [1], Enebe Francis Ikechukwu[2], and Ekechi Amadi[3]**

***Abstract.*** Old age though desired by many can be the period of anxiety, despondency and economic challenges (Berkowitz, 1969). Some persons also view old age with regrets, apprehension and view ageing into older ages negatively as morbidity and mortality become more common (Torges, Stewart, & Nolen-Hoeksema, 2008; Stumpers, Cohen, & Mander, 2015). Due to an increase in the ageing population worldwide and even more so in Africa, care of the health of the elderly (Geriatric Medicine) is becoming of greater importance as awareness increases (Tanyi, Andre, & Mbah, 2018). This paper is set to examine the perception and attitude of women to old age, ageing and Geriatric care in Rivers state, Nigeria. This involved a cross-sectional study of 410 consenting women. Data was obtained via a questionnaire administered to various women groups in Rivers State. Ethical approval was obtained from the Research and Ethics committee of the University of Port Harcourt Teaching Hospital. Data obtained was analyzed using Statistical Product and Service Solution (SPSS) Version 23.0. The Majority of the women who participated in this study were between 38-47years. It was found that the modal age perceived to define "old age" was 70 years while 91% of women perceived old age as a negative phenomenon. Also, most women preferred to be cared for by their families rather than in institutionalized homes at old age with a significant percentage of women having no existing insurance or retirement/pension plans. Women's perception and attitude towards old age is mostly negative with poor or non-existent preparations for an inevitable phase of life - old age.

***Keywords:*** women, old age, perception, ageing, attitude.

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## Introduction

Ageing has become a Worldwide phenomenon, as more people are reaching older age (World Health Organization (WHO), 2015). Globally the greatest increase in the number of older people is occurring in developing and middle-income countries like Nigeria (Pew Research Centre, 2014). There are rapid shifts in all these countries from high fertility and high mortality to a much-reduced fertility and greater longevity (ibid.). It is estimated that in 2025 the population of Nigerians aged 60 and above will constitute about 6% of the country's population, a double rise from the estimated 2.7% (ibid.). The importance of this projection in the older population structure is that this figure aids in the planning of geriatric care. How this care is given and accepted greatly depends on attitudes and perceptions towards ageing and geriatric care (Besidine et al., 2005). The ratio of women to men is higher in old age with a constant rise in this ratio noticed from the middle ages in favour of women (Ajomale, 2007). Societal attitudes have also generally been viewed as being less than sympathetic to old age (Olson & Kendrick, 2008).

Age and gender have been found to consistently influence beliefs about aging of oneself in terms of age-related morale, personal development, physical and social loss and ageing in general. Since women outnumber men at this time of life, their perception matters and is to be inquired (WHO, 2015; Centre for Health Workforce Studies, 2006). Based on the observations of older people, people may either positively or negatively evaluate their own ageing process (Chan & Hubbard, 2014). The health of people and the functioning of their bodies have been suggested to be linked to attitudes to ageing. A positive outlook towards aging can help curtail the huge decline in physical well-being (ibid.).

Most studies do not put into cognizance the experiences of women as regards to how they feel about old age and care of older persons (Bernard et al, 2000; Hurd, 2000). Women experience losses in various aspects of their life including their physical outlook and perception of beauty in old age, especially with societal norms portraying the normal female habitus to be that of a slim and youthful body stature as the standards for healthy women (Queniart & Charpentier, 2012) even though the true definition of beauty varies as people age (Vieria &Turato, 2010).

Women generally live longer than men on the average in terms of life expectancy (WHO, 2014). Thus, they experience a great deal of the ageing process and suffer from the physical, biological, psychological and social challenges that are attributable to their unproductive state in later life with no ability to fight for themselves in any way even more so if coupled with a decline in their cognitive abilities (Renata et al., 2014). Also, earlier studies have shown that ability to carry out physical activity without aid, outlook and mental alertness will decline and play a major role in women's self-assessment as they grow older (Musaiger, D'Souza & Al-Roomi, 2013).

In Nigeria, co-morbidities in physical or psychological health may affect the ability of older persons to perform activities of daily living independently (Animasahun & Chapman 2017). Care for older women in Nigeria is majorly informal with family members providing 80-90% of their long-term care needs with a few also being institutionalized (Oladeji, 2011). This care

could also include getting helpers (paid or unpaid) which may or may not be satisfying. How this affects the female perception of old age or their attitude towards growing old for themselves is a major unaddressed concern. Their opinions are also formed as they watch the outcomes for much older women in the developing world. It is quite notable that receiving poor geriatric care may promote feelings of anger, abandonment, loneliness and a vacuum created by absence of children and family support mechanisms in older women. This is seen as potentially impinging on their overall quality of life, where such frustrations are displaced on caregivers at home or in institutionalized homes (Renata, et al, 2014). These care givers are mostly young women whose ideas about old age is in its formative stage.

The authors found difficulty in locating studies regarding women's perception of ageing and geriatric care especially considering the peculiar feelings and opinion of women as they grow older. This study was performed to evaluate the perception and attitude of women to Old age, Ageing and Geriatric care in Rivers State, Southern Nigeria.

## Method

This was a cross-sectional study in which a simple random sampling technique was employed to recruit four hundred and ten (410) consenting patients and relatives attending the Geriatric Clinic of the University of Port-Harcourt Teaching Hospital, Rivers State and various. The participants were all women ranging across different spheres of life. Ethical clearance for the study was obtained from the Research and Ethics committee of the University of Port-Harcourt Teaching Hospital, Rivers State. Data Obtained was analyzed using International Business machines Statistical Product and Service Solutions (IBM-SPSS) version 23.0. Data obtained was presented as frequencies and percentages.

## Results

*Sociodemographic characteristics*

*Age*: As can be seen in Table 1, the mean (SD) age of the study was 45.89 years (11.90%), with the majority of the respondents aged between 38 and 47 years of age (22.9%) with most of the women (>60%) sampled being less than 60 years.

**Table 1: Age distribution of respondents**

| Age class (years) | Frequency (n) | Percentage (%) |
|---|---|---|
| 18 -27 years | 59 | 14.4 |
| 28 – 37 years | 74 | 18.0 |
| 38 – 47 years | 94 | 22.9 |
| 48 – 57 years | 86 | 21.0 |
| 58 – 67 years | 69 | 16.8 |
| 68 – 77 years | 11 | 2.7 |
| 78 – 87 years | 6 | 1.5 |
| 88 years | 11 | 2.7 |

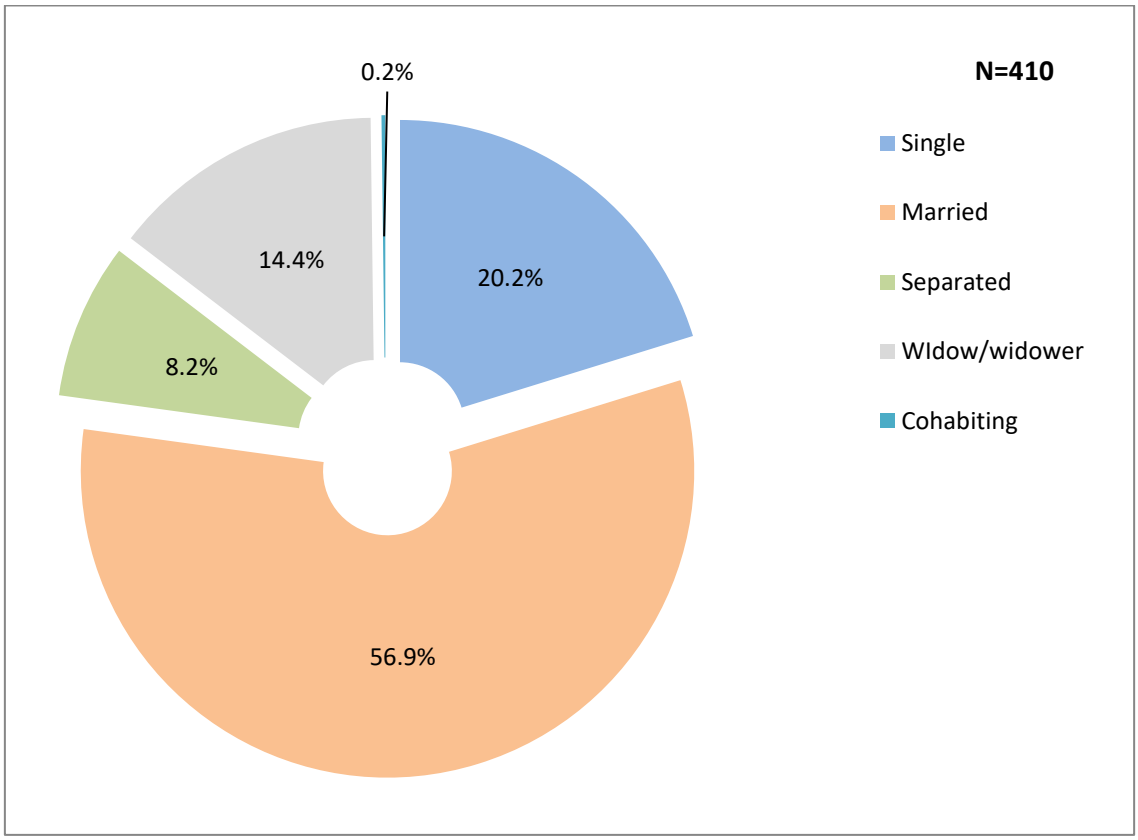
**Table 2: Tribe of respondents**

| Tribe | N | % |
|---|---|---|
| Ijaws | 100 | 24.4 |
| Igbo | 85 | 20.7 |
| Ikwerre | 185 | 45.1 |
| Opobo | 40 | 9.8 |

*State of origin and tribe:* The study sampled 70.1% of women from Rivers state. Table 2 shows how Ijaws, Igbos, Ikwerre and Opobo women accounted for 24.4%, 20.8%, 10% and 9.7% of individuals studied.

*Marital status:* Figure 1 shows that 56.9% (233) of respondents were married at the time of sampling with 22.6% (117) living alone either as a result of bereavement or separation. 20.2% (83) of women sampled were single (never married). Only one respondent was cohabiting with a partner.

**Figure 1: Marital status of respondents**




*Level of education:* Over 90% of the women sampled were educated with 52.2% (214) having a tertiary education. Secondary and primary level of education was attained by 26.6% (109) and 13% (53) of women respectively.

*Employment/religion:* Most women had some form of employment. 41.5% (170) of them were self –employed, 37.2%( 153) were staff of various organizations and 17.5% (72) of individuals were unemployed. About 92.1% (378) of respondents were Christians.

*Menopause:* Table 3 shows the modal age of menopause was 46years and 33.7% of the subjects had attained menopause.

**Table 3: No. of respondents who had attained menopause**

| | | Frequency N=410 n | Percentage (%) |
|---|---|---|---|
| Women who have attained Menopause | Yes | 138 | 33.7 |
| | No | 272 | 66.3 |

*Past medical history*

As can be seen in Table 4, a history of hypertension was present in 70.6% of respondents with 15.3% of respondents having a history of Diabetes Mellitus. Other illnesses suffered by respondents were urinary incontinence (21.5%), ophthalmologic problems (33.0%), lower back pain (12.3%), Arthralgia (25.0%) and dental illnesses (21.8%).

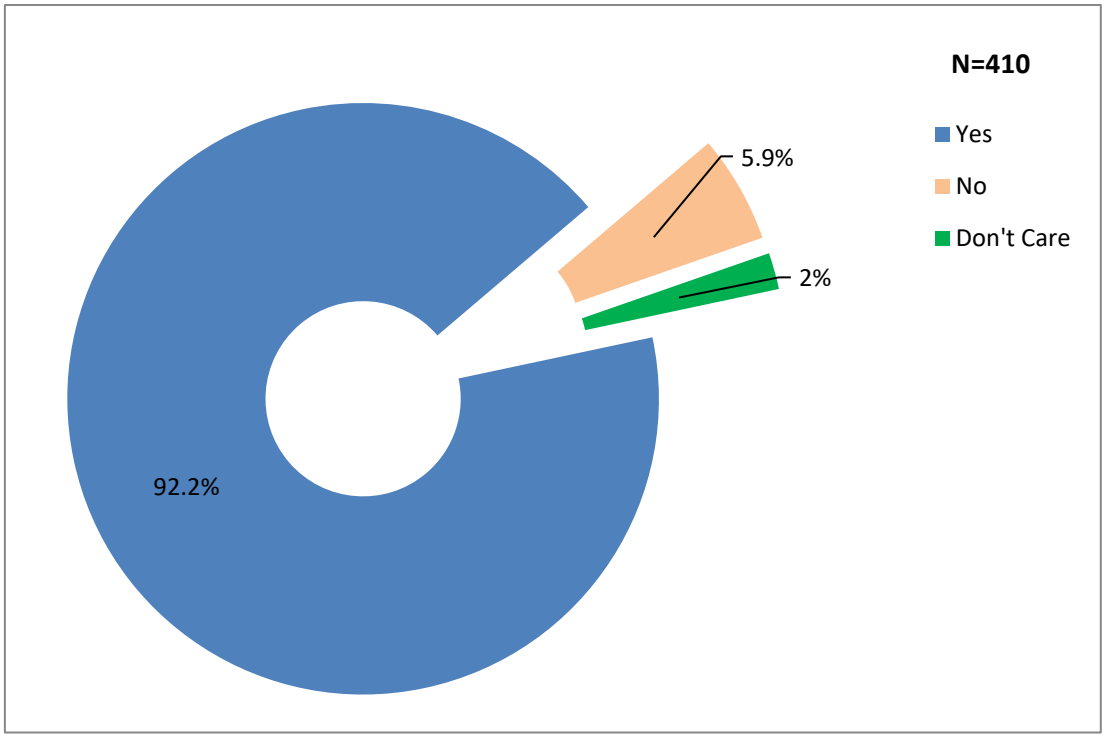
**Table 4: Past medical history of respondents**

| Past Medical History | Frequency N=410 n | Percentage (%) |
|---|---|---|
| Hypertension | 289 | 70.5 |
| Diabetes Mellitus | 63 | 15.4 |
| Urinary Incontinence | 88 | 21.5 |
| Low back pain | 50 | 12.2 |
| Ophthalmologic Conditions | 135 | 33.0 |
| Athralgia | 103 | 25.1 |
| Dental illnesses | 89 | 21.7 |

*Perception and attitude towards ageing*

Respondents were asked if ageing was a perceived as a good thing or a bad thing. Table 5 outlines that most respondents (91.0%) answered that ageing was a bad thing. Respondents were further asked if they would like to grow old (Figure 2), 92.2% answered "Yes".

**Figure 2: Distribution of respondents: Who would like to be old?**




*Age considered to be of old age*

The women were asked to state the age a woman can be considered old (Table 5). The mean age according to respondents was 69 years of age. The most mentioned age was 70 years (28.1%). Closely following was 60 years, accounting for (27%.)

**Table 5: Perception and attitude towards ageing**

| | | Frequency N=410 n | Percentage (%) |
|---|---|---|---|
| **Perception of ageing** | As a bad thing | 373 | 91.0 |
| | As a good thing | 37 | 9.0 |
| | | | |
| **Would you like to grow old** | Yes, I would | 378 | 92.2 |
| | No, I wouldn't | 32 | 7.8 |
| | | | |
| **Who do you prefer to care for you in old age** | Self | 17 | 4.1 |
| | Family | 281 | 68.5 |
| | Government | 23 | 5.6 |
| | Pension Agency | 20 | 4.9 |
| | Both | 30 | 7.3 |
| | Others | 39 | 9.5 |
| | | | |
| **Who should pay for your care** | Federal government | 69 | 16.8 |
| | State government | 40 | 9.8 |
| | NHIS* | 20 | 4.9 |
| | Private Insurance | 12 | 2.9 |
| | Family | 226 | 55.1 |
| | Yourself | 35 | 8.5 |
| | Your family | 2 | 0.5 |
| | Others | 6 | 1.5 |
| | | | |
| **Where would you like to be cared for in old age** | My Home | 362 | 88.3 |
| | Nursing Home | 24 | 5.8 |
| | Government Home | 13 | 3.2 |
| | Commercial Care Home | 3 | 0.7 |
| | Others | 8 | 2.0 |
| | | | |
| **Present aging plans of respondents** | Existing Pension Plan | 153 | 37.3 |
| | Existing Insurance Plan | 85 | 20.7 |
| | Written Will | 79 | 19.3 |

**National Health Insurance Scheme(NHIS)*

*Perception and attitude towards geriatric care*

In assessing responses from respondents (Table 5), 68.5% prefer to be cared for by their families in old age and 88.3% in their homes with 5.8%, 3% and 0.7% of respondents preferring Nursing Home, Government Care home, and Commercial Care Homes respectively. Notably, 55% of respondents believe that their family should bear the cost of their care in old age.

It was further established that, only 37.4% of respondents had an existing pension plan (Table 5) while 20.7% of women studied had laid down insurance policies with only 19.3% of women studied having a will.

*Next of kin of respondents*

Respondents were asked who their next of kin's were. Their responses are found in Table 6 with most women choosing their progeny as next of kin. 35.4% of women chose their sons, with 13.4% choosing their daughters. 19.8% of respondents did not specify the sex of their next of kin though they agreed that it was their child. Only 17.4% of women had their husbands as their next of kin.

**Table 6: Next of kin of respondents**

| Next of kin as self-reported by women | N | % |
|---|---|---|
| Son | 145 | 35.4 |
| Daughter | 55 | 13.4 |
| Children | 81 | 19.8 |
| Husband | 71 | 17.4 |
| None | 58 | 14.1 |

## Discussion

Eight in ten women born in Northern America and Europe in 2000-2005 are projected to survive to age 80, with up to 43% of women born in Africa during the same period expecting to similarly survive as against an expected survival till 80 years of only 19% of African women born in 1950- 1955 (United Nations, 2015). The over 80 years age bracket is regarded as being the fastest growing segment of the older population today (Mirkin & Weinberger, 2000). The world health organization acknowledges the issues of sexism in relation to an existing knowledge gap on the schematics and biology of women in older ages (WHO, 2006).

This study considered the perceptions of young and older women on the subject of ageing. A study like this may be expected to consider the perceptions of just the older female population but it is quite important to point out that the health challenges of women in old age begin from deprivation to quality education, gender discrimination at a younger age, care-giving responsibility to older persons, domestic violence and the role of societal and cultural influences on the life of the girl child (Bartley, Blane & Montgomery, 1997). Socio-cultural factors affect healthcare seeking behaviour and overall health in the long run (Latunji & Akinyemi 2018).

The mean age of attaining old age in this study as stated by respondents was that of 69 years. This is a higher figure than the 60-year age as defined WHO (2006). This shows that a lot of women would like to grow older but at the same time hold negative perceptions about old age as shown in this study. With the effects of varying influences, such as: socio-cultural; personality traits; education; and overall quality of life, women may be at increased risk of developing negative perceptions towards ageing (Freeman et al., 2016). Women at advancing ages have been stated to be the group likely to have negative feelings towards old age (Pinkas et al., 2016). However, this study shows that the negative self-perception may cut across all ages in women. A particular finding which falls true to this is the concept of ageism. Ageism is a belief in a stereotypical pattern on the life of a group of individuals based on their age (Quadagno, 2008; Palmore, 1999). If younger women sense the neglect and loneliness experienced by older women especially when in direct contact such as when offering care-giver services to much older grand-mothers or great grand-mothers, the negative aspects of ageism are bound to set in. The concept of ageism is further cemented in women by the principle of internalization where women embed cultural and societal mis-norms as norms, these mis-norms when repeatedly re-emphasized and taught through experiences become a way of life for women and a belief system that is difficult to change (Gupta & Schork, 1993). Also, physical outlook may account for why most women also do not want to grow old. An earlier study showed that physical beauty and weight gain may create developments of negative perceptions about old age (Fin, Portella & Scortegagna, 2017; Marshall, Lengyel & Utioh, 2012).

The presence of disease or physical disability is seen in this study where over 70% of women had at least one chronic medical condition. Morbidity can create a feeling of loss of autonomy over one's health and reduce the quality of life. Feelings of loss of control and the thought of physical dependence could also account for negative self-perception towards ageing (Sherman, 2001), while feelings of powerlessness and poor sleep have also been noted to accompany negative self-perceptions in both sexes (Jong-ni, 2016). In Africa, the majority still view old age as a disease (Okoye & Obikeze, 2005). A good number of old people live alone at home with a few living in institutionalized homes (Tanyi, Andre & Mbah, 2018). Cultural beliefs also encourage individuals to preferably die at home than in an institutionalized setting. They hold sentimental values to the houses they have lived in and died. It is also not uncommon for old people to request to be buried in their rooms when they die (Ogbuagu 1989).

Although cultural values play a role in how geriatric care is perceived (for example an average African mother finds it disrespectful to be sent to a nursing home), cultures in which older persons are valued and highly respected bring about positive perceptions as regards geriatric care. In contrast to African cultures, Eastern Turkish cultures see old people as epitomes and reservoirs of wisdom meant to be protected and cared for (Guler, Tugce, Ebru & Imatullah, 2017). The negative perceptions in African settings allow for skepticism and suspicious/ discriminatory treatment of the elderly (Okoye & Obikeze, 2005).

Various factors may have encouraged the development of negative perceptions on aging and geriatric care but the role of socio-cultural values seem to be greatest in addition to the effects of ageism and education.

**Conclusion**

The findings of this study clearly call for action at various points of the social and educational development of the girl child. This is to be carried out in addition to empowerment efforts through capacity building and human capital development to ensure that any negative self-perception towards growing old is eradicated. Attitudes can be understood to be stable, integrative judgements that summarize the thoughts and experiences people have towards objects or situations. As has been discussed, attitudes can be formed by events which took place earlier on in life, holding the possibility of influencing and determining how people perceive old age and ageing. Ageism will therefore, need to be tackled at all levels of the society. Most women in this study showed a negative perception towards ageing and therefore seem not to have overcome the negative stereotype associated with aging.

Following the results of this study, it is important that the government seriously looks at firming up National policies and to provide adequate funding to ensure improvements in Geriatric care services in Nigeria.

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# Political abuse of older people in rural and urban Zambia: A focus on perpetrators and suggested solution

**Isaac Kabelenga**[1]

***Abstract.*** This paper is aimed at raising awareness at a global level about political abuse of older people, in rural and urban Zambia, through the experiences of community leaders. On the basis of qualitative research undertaken in rural and urban Zambia on elder abuse, this paper argues that from the experiences of the participants, political abuse of some older people is a common problem which takes place during local government, parliamentary and presidential elections. It is determined by four categories - politicians, political cadres, older people's family members and election polling officers. The older people who are usually abused are those with poor eye sight, the illiterates and those living in monetary poverty. Because political abuse of some older people is very sophisticated and has huge negative consequences on the governance of Zambia, the participants recommend exemption of some older people from voting as the viable solution that could end political abuse of some older people in Zambia. The paper concludes that findings of this study have significant implications on scientific knowledge on elder abuse in both the global South and North. The findings further suggest new ways of thinking about elder abuse as well as directions for future research.

***Keywords:*** *political abuse; older people; rural and urban Zambia; qualitative study*

## Introduction

Research gaps exist in scientific knowledge on the typologies of elder abuse in both the global North and South. International scientific knowledge identifies five categories of elder abuse namely physical abuse, sexual abuse, verbal abuse, material abuse and neglect (Wolf, 2000); World Health Organization (WHO), 2002; HelpAge International, 2012; WHO, 2015). In the study undertaken in Zambia between 2014 and 2018, it is evident that one typology of elder abuse should be added to the above list. This is 'political abuse' of older people. Thus, this paper shall focus on perpetrators of political abuse in rural and urban Zambia and the suggested solution on how to address the vice.

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> Elder abuse is commonly defined in world reports as a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or stress to an older person (WHO, 2012:1).

This is a challenge faced across the globe (WHO, 2008; Kabelenga, 2014). For example, the United Nations (2013) has reported that globally, the number of cases of elder maltreatment is projected to increase as many countries face rapidly increasing ageing populations. Phelan (2013) estimate that of the total 868 000 000 older people [that is, people aged 60 years and above] globally, between 2 percent and 10 percent suffer abuse. In absolute numbers, this means that between 17, 360, 000 to 86, 868, 000 older people suffer abuse globally. This global statistical information shows how widespread elder abuse is globally. In international literature, political abuse of older people is rarely talked about when talking about abuse of older people. Dominant literature leaves out this type of elder abuse, which is reported in this study undertaken with community leaders in Zambia between 2014 and 2018. Thus, if this typology is added to the above five categories which constitutes elder abuse, it is estimated that global statistics on elder abuse would be higher. Because political abuse of older people is rarely talked about in global literature, scientific literature on political abuse of older people is also scanty.

Notwithstanding the above, when talking about violation of elderly people's rights in Zambia, Kamwengo (2004) briefly talked about the phenomenon of political abuse. For instance, Kamwengo reports that between 1994 and 1997, the first republican president, Kenneth Kaunda, was stripped-off his Zambian nationality by the high court which made Kaunda stateless. This was politically instigated. However, the Supreme Court reversed the decision. Between 1994 and 1996, some politicians in the Movement for Multi Party Democracy (MMD) and United National Independence Party (UNIP), called on former president Kaunda to retire from politics because, as they argued he was too old to continue participating in politics. Although this enlightened literature, two limitations were noted in Kamwengo's account. First, Kamwengo focused only on former president Kaunda. Thus, it is difficult to understand how widespread the problem of political abuse of older people in Zambia is. Given the fact that Kaunda was a political figure as he was at the helm of Zambian politics as republican president for 27 years (Chiluba, 1999; Lewanika, 2003; Phiri, 2006), it is difficult to generalize Kaunda's experiences to other older people in Zambia. Second, it is also difficult to tell whether Kaunda's political life suffered due to political abuse of older people or whether it was due to political persecution by his political opponents who wanted to prevent him from re- contesting presidential elections in 1996 (Human Rights Watch, 1996; Rakner, 2006; Phiri, 2006).

Scientific papers written by Kabelenga (2014; 2015b & 2018) seem to bring out detailed information about political abuse of older people in Zambia. Focusing on one rural district of Zambia, local community leaders who included former election officials described political abuse of older people in Zambia as a widespread problem which was common during local government, parliamentary and presidential elections. By community leaders, it meant influential people who on everyday basis managed affairs of their geographical localities. As such they knew all major happenings in their geographical localities. The community leaders

highlight the following as being the main causes of political abuse of older people in their district:

*Old age.* Community leaders reported that old age itself was one of the main causes of the political abuse of some older people. It was reported that as the person grew older, they reached a certain stage where their mental faculties became weak and for some their eye sights became frail. These changes created fertile ground for political abuse as they were not able, for example, to distinguish between different political parties and also to notice names of political candidates on ballot papers when voting (Kabelenga, 2015b; 2018).

*Illiteracy*. Given that some older people are not able to read and write in Zambia, community leaders disclosed that during elections some election presiding officers deliberately made some older people to vote for the candidates who were not of their own choice (Kabelenga, 2015b; 2018).

*Income/material poverty.* Community leaders saw income/material poverty as another factor that made some older people to be vulnerable to political abuse. That is, because many older people in their district were living in income/material poverty, they were easily manipulated by politicians by giving them trivial things like little food, beer, clothes and small amounts of money in turn for their votes (Kabelenga, 2015b; 2018).

*Perceived benefits of political abuse*. Community leaders also disclosed that the perceived benefits of winning an election on the side of the abusers were causing political abuse of some older people. The perceived benefits included the monetary gains and the social status that accrue from being in political power (Kabelenga, 2015b; 2018).

*Multiparty democracy*. Community leaders also saw the emergence of many political parties in Zambia in the name of democracy as another factor that was fueling political abuse. Their views were that multiparty democracy had brought about stiff political competition on how to win an election as political parties always competed for votes from the electorates. As a result, some politicians had resorted to using socially unaccepted ways of winning elections which included manipulation of vulnerable people such as some older people to cast their votes on political candidates who were not of older people's choice (Kabelenga, 2015b; 2018).

*Flaws in the Zambian electoral system*. Weaknesses in the Zambian electoral system was also brought out to be another cause of political abuse. Examples of the weaknesses included allowing only the presiding officer or any family member to assist some old people with special needs when voting in the election's booth. Community leaders reported that presiding officers and/or family members always had their own preferred political candidates during elections and when helping some old people to vote in election booth, some presiding officers or family members guided some older people to vote for the presiding officer's or that respective family member's preferred candidate (Kabelenga, 2015b; 2018).

Although Kabelenga's publication seems to shed more light on political abuse of some older people in Zambia, a critical look at Kabelenga's work brings out two limitations. First,

Kabelenga has not provided any detailed information about the perpetrators of political abuse. Second, because the publication was just on one rural district of Zambia, it is not clear whether the political abuse of older people was more of a rural Zambia than urban Zambia. This article addresses both of these of gaps with focus on the following two specific objectives: (1) to establish the perpetrators of political abuse of some older people in rural and urban Zambia (2) to establish the views of the informants on what needs to be done to address political abuse of older people in rural and urban Zambia.

## Methodology

### Data and methods

To achieve the above objectives, qualitative data was collected. This included three (3) focus group discussions (FGDs) and eleven (11) one-on-one interviews with 16 participants (10 from one rural district of Zambia and 6 from one urban district of Zambia). In total fourteen (14) in-depth interviews were conducted. From a qualitative research point of view, this sample size (participants composed of community leaders was considered reasonable to enable new insights and better understanding about perpetrators of political abuse of older people, and the way forward in addressing the vice. Creswell (2009) and Yin (2003) advice that even if there is no agreed upon sample size in qualitative research, it is recommended to have a small sample size preferably not exceeding 30 informants. This is to allow the researcher to go in-depth of a phenomenon being studied. Thus, the sample size would allow for in-depth information to be collected by allowing probing and re-probing of every aspect of political abuse of older people.

The main research questions asked during the study was: *how widespread is the problem of political abuse of older people in this community and the whole district?; Who are the perpetrators of political abuse of older people in this community and the whole district?; What are effects of this form of abuse on the abused older people and the whole Zambian society?; What recommendations can you make to the Zambian government and other stakeholders on what should be done to address political abuse of older people?* The interviews were recorded using two audio tapes. This was meant to act as back-up in case one recorder developed a fault and did not record the interviews. Before recording the interviews, the purpose for the study was explained to all the participants. Participants were also assured that their names would not be mentioned when reporting the findings of the study. Only those who were willing to participate in the study participated in the study. All participants signed a consent form and encouraged to contact the researcher after the interview if needed (Erlingsson, Saveman & Berg, 2005).

### The participants

The participants for this study were community leaders who had participated in addressing elder abuse. All the participants had the first-hand encounters with political abuse of older people in their districts. Participants were identified through previous generic research which was carried out on elder abuse recorded in one rural district and one urban district of Zambia, where some participants reported political abuse as one of the types of elder abuse recorded. Interestingly to note, was that some of the participants had actively participated in Zambian

elections either as presiding or polling officers. Some also openly reported that they had either suffered political abuse before or they had witnessed it first-hand taking place during elections in both urban and rural Zambia.

In this paper, the term 'community leaders' also called 'local leaders' refers to influential members of the two districts of Zambia. These are the people who have institutional powers to influence the affairs of their communities on daily basis. They included traditional leaders such as the chiefs, village headmen, village court judges, community crime prevention units, leaders of various social groupings such as leaders for the churches, youth groups, women's groups, elderly people, area development committees, political parties, senior government workers such as ward councillors, head teachers, doctors, nurses, social workers, conventional court judges, community development workers and leaders of civil society organizations. Because of the powers which they had, they always intervened in social problems that affected their districts as well as problems faced by individual community members such as elder abuse. A number of these participants especially civil servants and leaders of civil society organizations worked in different parts of Zambia. Thus, they had experiential knowledge about political abuse of older people not only in the two districts of Zambia where this study took place but in different parts of Zambia where they had worked before as election officials (Kabelenga, 2018).

Since data was collected from different categories of participants, this approach allowed for triangulation of data from different categories of the community leaders in the two districts. In doing so, the common grounds and divergences about perpetrators of political abuse and suggested ways of addressing the vice were established.

The participants were aged between 27 and 72 years. Of the 16 participants, 10 were from rural district and 6 were from urban district and the majority were males (12 males) and 4 females. In terms of educational attainments, 1 participant had primary school education, 10 had college [vocational] education and 5 were university graduates with maximum qualification of a masters degree. The disparity in the number of participants was due to the fact that there were more participants who were willing to participate in the study from the rural district than the urban. Disparities in gender of participants could be explained by the cultural constructions of the Zambian society where there are more males than females who are community leaders in both rural and urban Zambia (Zambia National Gender Policy, 2002).

## Data analysis

The analysis of data was content oriented. Analysis involved several steps. First, through listening to the audio interviews and reading the transcribed transcripts several times. This enabled the researcher to get a sense of the issues raised by the participants. Second, by means of coding the accounts in the transcribed interview material. This involved marking different perpetrators and suggesting ways on how to address political abuse of older people. Third, was to categorize the codes under four themes about perpetrators from the data. These were: politicians, political cadres, presiding officers and family members. Fourth, search the data for

suggested ways by the participants on how to address political abuse of older people. The main theme was the exemption of some older people from voting during elections. Fifth, in order to enhance credibility of this paper, the researcher searched for representative statements from the interviews to support the above themes. Erlingsson, Saveman & Berg, 2005) advise that the foundation for credibility of qualitative data lies also within the examples of statements from the original texts offered in the findings section. Sixth, the examining of the interplay of themes reflectively (Nikupeteri & Laitinen, 2015). The researcher's reflections upon the data in relation to available literature on elder abuse, politics and political violence served as background that helped to elicit more detailed accounts of the data. Seventh, was the search for concepts from the data and literature to use to interpret the data. The concepts of relationships, power and ageism were established as analytical tools to interpret the data. These concepts were chosen after attentive reflections upon the data. That is, all the issues that the participants disclosed seem to revolve around the above three scientific concepts. Furthermore, in the quotations, the participants' names have been anonymized to protect their identity.

## Results and discussion

### Widespread of political abuse of older people in rural and urban Zambia

Political abuse of older people was described by all the participants to be widespread in their districts during times of local government, parliamentary and presidential elections. Political abuse is defined by the participants as any intentional act that hurts the political life of the older person with or without their knowledge. Examples mentioned by the participants included forcing, threatening or to trick the older person to vote for a certain political candidate which was not of the particular older person's choice. For example, during the first FGD, one participant who participated in an election as a presiding officer disclosed the following:

> Political abuse is common here. They use the grandchildren to direct the grandfathers on who they should vote for. It is even worse when the grandfather doesn't know how to write because he will be escorted just as a procedure to say - put your finger here for example on the MMD[2] name, the grandchild may just make him hold the palm there and tick and we have seen this [laughs participants] and that is the worst abuse you can see which I saw when I was the presiding officer - someone holding the pen for the older man and going direct on the…[laughs participants] and asks him to tick there. At some point I tend to think that senior citizens should be exempted from voting. (FGD.1, Rural Zambia)

In urban Zambia, similar position to that held by participants in rural Zambia was provided. The following dialogue held with Executive Director for a Non-Governmental Organization (NGO), serving in promoting the well-being of all older people throughout Zambia, disclosed the following:

[2] Movement for Multiparty Democracy (MMD) is the former ruling political party in Zambia. It was in power from 1991 – 2011.

> **Researcher:** Now mum we talked briefly about political abuse in the first interview. I would like us in this second interview to go into details about political abuse of older people in Zambia where some people are taking advantage of older people to support certain political party or certain candidates to win elections. So, when is this type of abuse common?
> **Participant:** At election time they abuse and so on. And as soon as they [politicians] have their positions that's it until the next election time. So, the people who abuse older people are the politicians...
> **Researcher**: But what types of older people are abused?
> **Participant:** It's the ones who are not educated mainly. And again, it is vulnerability.
> **Researcher:** But let me ask the question mum. I would like to find out mum if someone is vulnerable and they are 60 years of age and above, why is it that they can easily be prone to political abuse?
> **Participant:** there is no social security. They have no social protection and they suffer political abuse. Sometimes even the older people who are educated they suffer political abuse. They suffer political abuse. You will be surprised because even them want to survive - maybe we are going to get some grants or we are going to get some loans if this politician wins the election. So, let me do all I can [politically abuse an older person] to put him in power. (Thirteenth One-on-one in-depth interview, Urban Zambia)

Similar revelations were made by the retired civil servant who once participated in elections as an election supervisor and at the time of this study worked for one Civil Society Organization that fought for the rights of the older people in Zambia:

> To me, that is just one dimension of the abuse where the very old, unable to write are abused. I remember when I was very young, I got involved in these polling elections especially when it came to supervision and if you are not careful you would find yourself being abused by politicians. Definitely polling assistant or a polling officer is given the mandate to help a blind person, a person who cannot read and write, a person who is too old to go in the booth and say; who is the candidate of your choice? Now, depending on the calibre or the values, the principles of this polling officer, there is a tendency that, that's where [political] abuse takes place where the voter would whisper to you to say my preferred candidate is this one but you having an interest as a polling officer will now use that to mark on somebody else and so to me, it is not being sincere, it's being dishonest. And so, that's one form of abuse. (Fourteenth One-on-one in-depth interview, Urban Zambia)

From the above self-confessed episodes, it is clear that participants hold experiential knowledge that political abuse of some older people took place in both rural and urban Zambia. The episodes imply that political abuse of some older people in rural and urban Zambia is seasonal. This is because from the above data, a straight forward analysis means that some older people suffer political abuse during times of local government, parliamentary and presidential elections. After that, it is put to a halt. The overall-data can be interpreted using the concept of political power. That is, the data imply that, it is the struggle for political power that leads to political abuse of some older people. Because it is difficult to win an election, political contestants try to manipulate other members of society so that they can get political support from the voters with or without their consent.

*Perpetrators of political abuse of older people.* In light of the above revelations, the next question asked was: *who are the perpetrators of political abuse of older people in this district?* Four categories of perpetrators emerged from the data collected from both rural and urban districts. These are: politicians, political cadres, older people's family members and polling officers. From the data collected, it was clear that politicians, political cadres and older people's family members always work hand in hand when abusing some older persons. Thus, these categories of perpetrators are presented together.

**Politicians, political cadres and older people's family members**

Participants disclosed that the people who perpetrated political abuse of older persons in their districts were the politicians and political cadres. Interestingly, the data revealed that, it was evident that politicians found it easier to manipulate older persons using their own family members. Family members had a strong influential control due to having daily contacts with their older family member, from election campaign up to the actual date of elections. For example, during the first FGD, the participants exposed the perpetrators in this way:

> The same young people who take care of them are the ones who demand on them to support a particular candidate because these young people are the ones who are able to discuss, hold conversations with these political party leaders and they are the ones who are persuaded by the political parties leaders to support them and hence they are the ones the political parties leaders use to go and entice their grandparents to vote for them so that things would be better for them while in actual sense things may not be. (FGD.1, Rural Zambia)

Similar disclosures were made by court judges during the second focus group discussion which were held in the court room:

> You find that these politicians, you only see them going to rural setups when it is time to vote but in town they don't normally go there because they know the people are up to date. And in most cases it is the youths that go to these old people to tell them something that is wrong for example maybe if they have a candidate of their choice so they go to them and feed them that wrong information just because this candidate has bought them beer and they can go and interact with these old people because they are conversant with the language that is spoken there. (FGD.2, Rural Zambia)

Interestingly, even the chairperson for one of the older people's organizations that fights for the rights of the older people throughout Zambia and globally agreed with the other participants:

> The people who abuse older people are the politicians because they can put a stop to it. They use youngsters. They intimidate the neighbourhoods. And these kids are given some pocket money and some food stuffs and alcohol and you know to them they are employed during the duration of the campaigns. (Thirteenth One-on-one in-depth interview, Urban Zambia)

From the above finding, it can be deduced that the perpetrators of political abuse are a heterogeneous group. However, politicians seem to be at the center stage of every form of political abuse. This is because politicians are the ones who mobilize the youths and family members of older persons to manipulate older people. Thus, this result challenges literature that always associate abuse of older people with the youth (see WHO, 2002; WHO, 2008; WHO, 2015). From the data, it is evident that besides the youths, adults and fellow older people also participate in political abuse of older people. This is because since the national independence of 1964 to date, the majority of political party leaders in Zambia were adults with some classified under the category of older people (Human Rights Watch, 1996; Constitutional of Zambia, 2016). This means that this paper has broadened the equation on perpetrators of elder abuse. Taken together, the data can be interpreted using the concept of political power. That is, the data connote that participants hold experiential knowledge in desire to acquire political power that in is leading to the political abuse of some older people in rural and urban Zambia.

**Presiding officers**

Presiding officers were also exposed by the participants to be another category of perpetrators. Participants reported that because of the weaknesses of the Zambian electoral system which allows the presiding officer to assist certain voters with special needs such as the illiterates and the blind among others, some presiding officers took advantage of some older people with special needs by deliberately making them to vote for candidates who were not of the older people's choice. Participants gave testimonies of what they had seen for themselves during elections as follows:

> …I remember an incident somewhere where this candidate is fond of putting on a jacket so they even nicknamed him, jacket man. So, an old woman comes and says, who is your preferred candidate? This woman just says the jacket man but when you look at the ballot paper, so many candidates there have jackets so that woman since she has mentioned of the jacket, even when I point at my preferred candidate as a youth [election presiding officer] who is very interested in that candidate, she will go for it. So, you find that in the rural setup it is very common. (Court judge during FGD. 3, Rural Zambia)

The head teacher who served on several occasions as election observer shared the followings experiential knowledge:

> Political abuse of older people is common in the sense that you know these ballot papers are written in English and the majority of the voters in most cases they can be old people who don't know how to read and so these electoral officers during that time they take advantage of misleading them. Instead of telling them the right candidate of their choice they can probably take advantage over that and give them one which they favour most and when they are writing in booth, the old person may say that I want this person with this picture and because she/he can't see properly and interpret that picture she/he will be made to tick on a wrong candidate and so those are some of the things and it means that those old people haven't chosen their own candidate of their choice. (Tenth One-on-one in-depth interview, Rural Zambia)

One retired civil servant who served during his civil service work as an election supervisor and now worked as Executive Director for one Civil Society Organization that fought for the rights of the older people in Zambia also agreed with his counterparts from rural Zambia:

> …Definitely polling assistant or a polling officer is given the mandate to help a blind person, a person who cannot read and write, a person who is too old to go in the booth and say; who is the candidate of your choice? Now, depending on the calibre or the values, the principles of this polling officer, there is a tendency that, that's where an abuse takes place where the voter would whisper to you to say my preferred candidate is this one but you having an interest as a polling officer will now use that to mark on somebody else….. (Fourteenth One-on-one in-depth interview, Urban Zambia)

The above episodes suggest that participants hold experiential knowledge that political abuse of some older people in rural and urban Zambia takes place in very sophisticated manner. This is because at times it takes place without the knowledge of the abused older people. The data further implies that participants hold experiential knowledge that political abuse of some elder people in Zambia is directly linked to the weak political relationships that exist between some older people and some election officers.

Some of the fertile grounds that bleed political abuse of some older people which was stated by the participants is also clearly stipulated in the Zambia Electoral Act. For example, the Zambia Electoral Act (2006: 43) on Assistance to Certain Voters states that:

> the presiding officer or another election officer, at the request of a voter who is unable to read or due to physical disability, shall assist that voter in voting in the presence of – (a) a person appointed by or as an accredited observer or monitor, if available or (b) two election agents of different candidates, if available or (2) A person may assist a voter in voting if – (a) the voter requires assistance due to a physical disability (b) the voter has requested to be assisted by that person and that person has attained 18 years; (3) The secrecy of voting as stipulated in the constitution shall be preserved in the application of this section.

However, the pertinent questions that arise are: (1) if other election officers or observers are not available, can't the presiding officer abuse the voter who wants assistance? (2) Given all the electoral powers vested in the presiding officer, can't presiding officer connive with the family member of the assisted older person to guide the voter in the booth so that he/she can vote for presiding officer and family members preferred candidate? And (3) can't the presiding officer deliberately prevent other election officers from observing how the assisted voter is casting a vote in the booth under the pretext that the family member will assist such a voter and yet the presiding officer wants the family member to manipulate the voter in the booth? Unfortunately, these questions were not asked during the study. This is because they were not on the list of interview guide used. Thus, it is recommended that future studies to address them.

When linked to available literature, the data is in agreement with other global studies done on democratic elections. For example, in the global studies on democracy and voting, Butler and Ranney (1994), Lijphart (1997) and Lever (2009) have established that insincere voting is

possible in democracy. They have argued that strategic or insincere voting is not uncommon when a group knows the redistribution of potential votes in advance. They have established that many political actors ask for preference schedule of everything. This is to arrive at the final group rank ordering of all the contestants that best express the desires of the electorates. Because of this, voters can be made to vote insincerely by changing the order of the preference schedule (Lever, 2009). This means that what the participants disclosed have also been established in other parts of world.

**How to address political abuse in rural and urban Zambia**

A much unexpected recommendation on how to address political abuse of some older people in rural and urban Zambia came out from all the participants, and that was in exemption of some older people from voting. Below are the details:

*Exemption of elder people from voting.* Given the sophisticated nature of political abuse of older people and its grave consequences on the governance of Zambia, all the participants suggested exemption of some elder people from voting as the main solution that could be used to address the problem of political abuse of older people in their districts and Zambia in general. Participants justified this proposal using different perspectives. For instance, some used the experiential perspective and argued that some older people such as those who are too old or with dementia could be stopped from voting because it was not possible to sensitize them on political abuse, arguing that even if they were sensitized, most of them did not remember the sensitization messages given to them. Using the human rights perspective, some argued that some older people's political rights were being stolen from them and the only way that could be stopped is to exempt them from voting. Others used the pragmatic approach and argued that in human life there was always time for retirement and that should be considered in Zambian politics with regard to the right to vote among the older people. Participants felt that if some older people were stopped from voting, automatically their political abuse would be stopped as politicians and other perpetrators of political abuse will have nothing to do with the older people. This is further highlighted in the below dialogue with the participants:

> **Researcher:** So, what do you think should be done to address this form of elder abuse?
> **Participant.1:** If we are to fight this type of abuse, we need to exempt certain old people from voting. Like those with mental disorders, who are too old who cannot even think, those older people are not supposed to be allowed to vote. Because even if you go and sensitize those people, they do not have the mental capacity really to follow what you are telling them to say that maybe there is some corruption taking place or maybe some electoral malpractices.
> **Researcher:** But won't that be an infringement on their rights if we say we exclude them? I don't know, what do you think? Is not disfranchising them if we say that maybe because he cannot see, he's tired and then we say that maybe they don't vote. What do you think could be the likely implications with regard to their political rights - the right to vote, the right to choose their own political candidate?

> **Respondent.1:** I think that would not be a problem. I think that would be better because for sure some of these [older] people cause even wrong people [politicians] to go in office. They do not know the repercussions
> **Respondent.2:** totally, there is time for everything. There is time for retirement. Even in churches you find that this was a church elder and the like and he will reach a point to say that I am tired and I can no longer lead this ministry and so for now let us give it to younger ones.
> **Respondent.1:** In fact, most older people just vote for the ruling party
> **Researcher:** Always ruling party?
> **Respondent.2:** The ruling party. The one usually on top
> **Respondent.2:** and when you explain for example to say this is MMD and they say that same one and that cuts your continuation and for the rest she will just be agreeing through and you wonder to say is it yes everywhere but where exactly? It's a dilemma, you see and if you have actually very much gone into these things you will see the flaws which can cause abuse. (FGD.1, Rural Zambia)

Surprising even court judges who served as election officials on several occasions made similar recommendation during FGD.2: *They should be exempted because their right [political rights] is stolen. It is being abused by someone else. So, it is better for those people with mental disorders to just stay away from voting.* (FGD.2, Rural Zambia).

The Executive Director for one of the older people's organizations also provided similar thoughts:

> Let them [human rights formulators] go and be debated at the UN [United Nations] to say this [political right to vote for some older people] is not workable. Let it be amended in this manner so that it corresponds with what is happening on the ground. The arguments between you and me are that when somebody is very old, definitely there are disadvantages, they are disadvantaged. After all I don't think there is participation, they wouldn't even be able to walk to the [election voting] booth. (Fourteenth One-on-one in-depth interview, Urban Zambia)

Similar phraseology is received from the Board chairperson for the NGO that promotes the rights of the older people in Zambia and globally: *I think it could be a good idea just to put an age limit to voting. Like what they do at the Vatican. Nobody who is 80 years and above can vote at the Vatican. Anyone who is 80 and above can't vote for the Pope.* (Sixteenth One-on-one in-depth interview, Urban Zambia)

The above data can be interpreted using the concepts of political ageism and political relationships. That is, the data imply that participants are suggesting that solutions for addressing political abuse of some older people lies in addressing political ageism against older people and improving political relationships among political actors, and between political actors and older people. From the above episodes, it is evident that all the participants in Rural and Urban Districts of Zambia share the view that if political ageism against older people is addressed, political influence of the politicians and their cadres on the older people will be reduced. This in turn may result into bringing about positive political relationships among politicians, political cadres and older people which are essential preconditions in the fight against political abuse of older people (Kamwengo, 2004).

Reflections upon the above data seem to be in line with the proposals made by some scholars globally on the right to vote. For instance, Mubiana (2015) has recommended that the right to vote in Zambia should be given to persons who have the requisite mental state to make right decisions for Zambia. He also proposes the need to have certain restrictions to the right to vote, among them people who are not able to read and write. This is because they are usually tricked by those who assist them when voting and end up voting for political candidates who are not of their voice. For example, Mubiana argues that most of the voters in this category are literally instructed on how to vote. They are told that if they vote a particular way, they will be provided with alcohol and cigarettes. Some are given as little as K20 (USD 1.33) for them to vote a certain way. In Italy, where political gerontocracy has been going on for about 68 years now, public demands have been made calling on political change to take course in shifting power from the old to the young generation (Albertini, 2008). In the Vatican, the Cardinals who are aged 80 and above are not allowed to vote because of their old age (Glatz, 2015). Thus, it can be argued that what participants proposed are part of the on-going global debates about participation of certain categories of older people in elections. This suggests that the recommendations made by the participants should be taken seriously by all human rights activities. They should be intensively and extensively debated at a national level such as at the Human Rights Commission, Electoral Commission and National Assembly of Zambia, regional bodies such as African Union and global bodies and the UN, so that a common ground is established about the political right to vote among some categories of older people. Experiences of community leaders that participated in this study further highlighted that the political right to vote is not enjoyed by some older people. In re-emphasizing on the need for various human rights activists to take seriously the revelations made during the study, one of the community development workers who was instrumental in addressing elder abuse in rural Zambia stated the following:

> It is just an emphasis to the government that some of these things they are coming from deep down here in the community. It is important that they take keen interest as to see what is supposed to be done to improve the lives of the elderly people. The elderly people they need protection, they need some support here and there. Sure. (Eighth One-on-one In-depth Interview, Rural Zambia)

When everything talked about is brought together, it means that all the participants hold the view that there is political violence against older people in some parts of Zambia. In political science, violence is commonly defined as the illegitimate and unauthorized use of force to effect decisions against the will or desires of other people in the society (Wolf, 1969; Mahajan, 2003). The end-product of political violence is thuggery. That is, violence is the means through which thugs achieve their aims (Aondowase et al., 2013). This is exactly what this study established. However, globally, political violence is well known to have negative effects on societal well-being. In a society which is so explicitly divided by political violence, it is hardly surprising that tension and inter communal conflict arises. This is evident in Northern Ireland. Such conflicts often occur at working class interface areas where attacks on homes and property take place. Sectarianism functions at many levels in Northern Irish society and its insidious effects are often reflected in everyday thoughts and action which, in turn, creates distrust and fear among members of the same society (Campbell, 2007). Sectarianism is

maintained and reproduced, not just through the explicit use of violence and physical and social separation, but also by negative and discriminatory representations of the other. This leads to repetitive and circular expressions of fear and mistrust and reluctance to cross boundaries, whether these are geographical, social or psychological (Campbell, 2007).

Focusing on Nigeria, Aondowase et al., (2013) report that politicians employ local secret sect to compel innocent people to vote against their wishes. The party agents at the polling booths are openly threatened to compromise, and election officials are forced to do what they would not have done ordinarily. Thus, political violence is servicing as an organized criminal enterprise used for seeking, gaining and retaining power in order to rob public treasury. Because of this, political violence negates peaceful coexistence, law and order. In addition to security concerns, it militates against the consolidation of democracy and social coexistence. This in turn impact negatively on the social and economic wellbeing of the nation and creates imbalances in social relations (Howell, 2004). Political violence brings complex set of events such as poverty, ethnic or religious grievances which affect the social relationship of the people in the society. Aondowase et al., (2013) posit that violence, particularly political violence, represents a disturbance movement to the political equilibrium and peaceful co-existence of the system.

The findings of this research also correspond with Afrobarometer Study (2002-2009). In its study of 46 nationally-representative surveys from 2002-2009 in Sub-Saharan Africa, Afrobarometer reports that despite the marked decrease in the incidence of civil war in Africa, political violence remains pervasive. Much of this political violence is directed (or tacitly allowed) by ruling regimes and their allies, by opposition political parties, and by loosely organized groups of ordinary individuals – both at times of electoral competition but also in patterns of puzzlingly 'routine' everyday violence (Garcia-Ponce & Pasquale, 2013). By using Zimbabwe as a case study, Garcia-Ponce & Pasquale (2015), report that in Zimbabwe the effects of repression increase when approaching elections, bolstering the idea that autocrats employ violence in order to win elections. However, this makes civilians to lose confidence in world order which is retardation to socio-economic development.

In light of the revelations made by the participants, this paper has raised a crucial issue which needs special attention not only from the people of Zambia, but throughout the whole world especially at the African Union and UN levels. This is because it is within Zambian, African Union and the UN levels where solutions to the political abuse of some older people can be found. The issue should also be paid urgent attention to at these levels because it is a serious violation of older people's political rights which ultimately impact negatively on the socio-economic and political development of Zambia and a direct assault on democracy for which many people globally are fighting for (Kabelenga, 2015b).

## Conclusion

Based on the findings of this study, the following are the conclusions: To begin, it is clear that participants confidently talked about the phenomenon of which they knew to have taken place in their districts and other parts of Zambia where they worked before. It is evident that participants hold experiential knowledge that political abuse of some older people is taking place in both rural and urban Zambia. It seems that the problem is common during local government, parliamentary and presidential elections. The older people who are vulnerable to political abuse are those with poor eye sights, illiterate and those living in monetary poverty.

Participants in both districts brought out four (4) categories of perpetrators of political abuse of older people. These are the politicians, political cadres, older people's family members and polling officers. From the findings, politicians, political cadres and older people's family members always work in tandem in abusing some older people. This is motivated by the desire to win the elections. However, the politicians are at the center stage of catalyzing political abuse of some older people.

It is also clear that participants hold experiential knowledge that even if the right to vote is a human right for Zambians aged 18 years and above (Constitution of Zambia, 2015), it is just on paper for some older people in Zambia. Some older people do not enjoy this right when voting. It is within this framework that the participants recommend exemption of some older people from voting.

This study has raised an important issue affecting some older people in some rural and urban Districts of Zambia, and could be happening in other parts of the world. Given the fact that ageing is a normal process of human life which every human being expects to go through and that the world is moving towards population ageing (Kamwengo, 2004; WHO, 2008; Kabelenga, 2015a; 2018), evidence of political abuse of some older people in Zambia should be taken seriously. This reality can happen to any older person provided they have risk factors that participants brought out in this paper. These raise the following implications for frontline workers like social gerontologists and human rights activists who deal with issues of abuse of older people:

To begin with, political abuse of older people should be brought into the mainstream literature on elder abuse especially those published by the Zambian Government, Regional bodies like the African Union, and global bodies like the UN if it is to be addressed. Documents produced by these institutions are 'Buzz Documents'. That is, they speak high volumes which are usually heard and paid particular attention to by influential society members at local, national, regional and global levels, and who can in turn play vital roles in re-construction of human society where no human being is abused by another human being (Rawl, 1999; Conwall & Brock, 2005).

The current categorization of elder abuse into five forms – physical, verbal, sexual, material and neglect that has dominated literature should be broadened to include political abuse

(WHO, 2002; 2008; 2015; United Nations, 2013). This is essential in making political abuse of older people to receive global attention.

In addition, there is need to improve the mechanisms for monitoring of voting among the older people [in Zambia]. Particular attention should be paid to older people who are too old, illiterate, with poor eye-sights and those with mental lapses. This calls for making serious amendments to the current Zambia Electoral Act. For transparency in the way voters [older people] who want assistance when voting to be guaranteed, two amendments should be made to the Zambian Electoral Act and the Zambian constitution in general. One measure could be that it should be made mandatory that when assisting voters such as older people with special needs, the presiding officer should always be accompanied by election agents from all the political parties, and accredited election monitors or observers and a family representative. However, the family representative should not be allowed to guide the particular older person when voting. This means that the aspect of secrecy of voting as stipulated in the Zambian constitution would not be applicable to such voters. The presiding officer and all the election attendees who assisted the voter should write their full names, national registration cards and the organizations they represent against the name of the assisted voter. If the particular older person does not remember the name of the political candidate or party in the election booth, they should not be allowed to vote, and the ballot paper should be classified as spoiled.

There is also need to debate the recommendation made by the participants of exemption of some old people like those with dementia, poor eye sights and who are illiterate from voting. This is because the recommendation may be seen by other segments of society as disfranchising and in itself another form of abuse of some old people. Targeting international and regional organizations like the Office of the United Nations High Commissioner for Human Rights, African Union, Southern Africa Development Community (SADC), the Government of Zambia, international and local Civil Society Organizations involved in human rights, and electoral issues where political rights of the older people originated from should be prioritized. This is because if the Zambian government decides alone to exempt older people in Zambia from voting, there is danger that Zambia would receive global and regional condemnations and sanctions for violation of international and regional conventions and agreements on the political rights of older people for which Zambia is signatory to.

Notwithstanding all the aforesaid, this paper was written on the basis of qualitative data collected from 16 participants. Although this is not a small sample size from qualitative research point of view (Creswell, 2009; Yin, 2003) and the participants were community leaders, the revelations made in this study should be cautiously applied to other parts of Zambia and the whole world. This is because elder abuse is socially constructed and what may be true in one setting may not be true in other settings (Phelan, 2013; Kabelenga, 2014; 2018).

In light of the aforementioned limitation, future research should investigate further how widespread political abuse of the older people in Zambia is. Because elder abuse is a global problem, such studies should be undertaken also in various regions across the world. Future studies should also assess the extent to which people across the world agree with the

recommendation made by participants in Zambia to exempt some older people from voting or simply say, to establish the retirement age from voting. Notwithstanding the limitation of this paper, this study has broadened scientific knowledge on elder abuse by bringing in the global debates political abuse of older people. Thus, it is my hope that this study has put into place one more piece of the puzzle in scientific knowledge that will one day result into showing the global picture of political abuse of older people and result into intense debates in both global North and global South on how to address the vice.

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# Doing qualitative research on dementia with family caregivers in Kenya: A reflection on fieldwork experiences

**Purity Mwendwa**[1]

***Abstact.*** In this paper, I present reflections on a self-funded study that explored the experiences of caring for people with dementia (PWD) in Kenya. I use an autoethnographic approach to examine and discuss some key issues that emerged during the planning and fieldwork phases of the study. This approach entails auto-reflection and the analysis of each part of the research experience. This paper does not report on the study's findings but provides an understanding of the difficulties encountered while researching in Kenya on a topic which is little understood. The paper begins with a background to the study, followed by the motivation of conducting the research. I then discuss the critical issues encountered during the various phases of the project. These included i) difficulties securing funding for the project, ii) challenges recruiting participants and iii) the lack of emotional support for the researcher during this process. The paper also offers suggestions on strategies that could benefit researchers seeking to study a similar problem in this context.

**Keywords**: *dementia, caregiver, qualitative fieldwork, autoethnography, sub-Saharan Africa, Kenya*

## Background

Family caregivers play an essential role in caring for people with chronic conditions, such as dementia, who often have complex care needs (Brodaty & Donkin, 2009). In sub-Saharan Africa (SSA) caregivers are most of the time the only support available to older family members. This is based on the cultural configuration of society, as well as a result of limited government support for older people (Aboderin & Hoffman, 2015). Dementia includes a group of symptoms that affect the memory and the ability to carry out basic daily tasks such as bathing, dressing or even feeding (World Health Organisation, 2019). Dementia results from different diseases that affect the brain with Alzheimer's disease considered the most common cause (The Alzheimer's Association, 2020). Current global estimates suggest that

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there are 50 million people with dementia (PWD) (World Health Organisation, 2019), and in 2015, 2.13 million people were living with dementia in SSA. With the numbers of PWD expected to rise to 3.48 million by 2030 (Guerchet et al., 2017), the care needs of this population are expected to increase (O'Shea, 2007).

Dementia is not well known or recognised in most SSA countries (Mushi et al., 2014). In this context, dementia is often believed to be a normal part of ageing, and most families support the PWD at home (ibid.). A lack of diagnosis or misdiagnosis (Bradford et al., 2009), stigma (Faure-Delage et al., 2012), social isolation for PWD and their caregivers (Schoenmakers, Buntinx, & Delepeleire, 2010), and lack of national dementia policies (Heslop & Gorman, 2002) are some of the factors that make dementia care challenging. And while research on family caregivers is growing in the region, little is known about the impact of caring for a PWD (Mwendwa & Kroll, 2019). Available research has focused on the experiences of those caring for younger populations, for example, children with a (physical) disability (Geere et al., 2013), caregivers for children and people with HIV/AIDS (Abasiubong et al., 2011). Such a gap in evidence limits the ability to highlight the critical role played by caregivers for PWD and has implications for their consideration in national and local health policies and budgets.

Research, mainly qualitative, is suited to exploring the impact that dementia places on PWD, caregivers and families (Prorok, Horgan, & Seitz, 2013). However, designing and implementing such research presents several obstacles including: inadequate funding for research projects; difficulties recruiting participants for studies; ethical dilemmas (Carmody, Traynor, & Marchetti, 2014), researchers' lack of understanding and knowledge of the socio-cultural context (Hinton et al., 2000) and little or no emotional support for researchers while in the field (Mitchell & Irvine, 2008). In a context where little research on caregivers for PWD is available, it becomes imperative to understand potential difficulties associated with conducting such research and strategies that may serve to overcome them. Such information can benefit researchers seeking to include caregivers for PWD in their research projects.

This paper shall proceed as a first-hand account of the fieldwork as experienced by the author. This narration is purposely done in the first person, to enable the reader to join the researcher (author) and the routes taken in completing this research study.

The rest of this article describes my personal experiences in planning and implementing a research project that explored the experiences of caring for a PWD in Kenya. The purpose of this article is to (a) highlight the challenges to planning and implementing the project, (b) identify the strategies that were employed to overcome the difficulties and (c) provide recommendations to future researchers. I use autoethnography, an approach to research and writing, that aims to describe and systematically analyse (*graphy*) personal experience (*auto*) and provide an understanding of cultural experience (*ethno*) (Ellis, Adams, & Bochner, 2010). Anderson (2006), distinguishes two types of autoethnography; evocative and analytic autoethnography (AA). I employed the former, as it required mainly the description of the researcher's own experiences and feelings as opposed to the AA whose main aim is the analysis of data and comparison of the outcomes with other empirical data (Anderson, 2006).

## Motivations for undertaking the project

This project was driven by my personal experience with dementia (having a parent with dementia) and experiences of caring for PWD (being a professional caregiver). These personal factors, coupled with being a seasoned researcher in social sciences, were hugely beneficial in informing the design and implementation of this project. Before embarking on the project, I felt that, being relatively new to researching the topic, my understanding of the topic and potential impact of the project would be limited without grasping the foundational concepts related to dementia. With this in mind I took to self-directed learning (Knowles, 1975) and completed various e-learning modules including 'Understanding dementia' and 'Preventing dementia,' both offered by the Wicking Dementia and Research Centre at the University of Tasmania, Australia.

To enrich my knowledge on dementia, I continue to attend conferences, seminars and workshops on the topic and read books written by PWD and by caregivers of PWD. I have recently completed an online *family carer training* that is offered by the Alzheimer's society in Ireland. This experience has expanded my knowledge and understanding of dementia care and strengthened my competence and confidence about speaking on the topic. I have also, held several outreach events in Kenya to raise awareness about dementia.

## Funding the project

I will borrow from Zoe Muller's blog post (Muller, 2017) in which she writes about the pros and cons of self-funding for academic research and says "If you want something badly enough, you make arrangements. If you don't want it badly enough, you make excuses." I made no excuses, and that is why, after several unsuccessful funding applications, I decided to self-fund the project. At this stage in my career, I have become accustomed to writing proposals for funding, been successful at a few, and disappointed at most. Recent evidence suggests that the success rate for proposals in Europe is quite low, around 12.6 % in 2019 (Nature, 2019). While I am still honing my grant writing skills with every proposal that I draft, I would argue that my biggest hurdle to success at securing funding was being a "newbie" on the topic. Albeit armed with a ton of transferable skills, having little knowledge and experience on this topic was probably one reason funders did not see the potential for the work I was proposing to do. In hindsight, I realised that I was not applying to the right funders, but that equally, I may have failed to effectively communicate to funders and convince them that while being a "newbie" I was worth funding (Nature, 2019). One of the ways I could have increased my chances of securing funding was to collaborate with colleagues who have particular expertise on the topic (Sternberg, 2014).Yet, this experience enhanced a whole range of skills, not least, honing my grant-writing and communication skills, time and financial management, and I should mention patience! (as I waited for that crucial decision email from funders).

## Pre-fieldwork phase

*Ethical approval and research permit*

In Kenya, ethical approval is provided by accredited ethics review committees listed on the National Commission for Science, Technology and Innovation (NACOSTI) website (NACOSTI, 2020). For this study, I obtained ethical approval from two ethics review committees: Kenya Methodist University (KEMU) and from my institution, University College Dublin in Ireland. Subsequently, I obtained a research permit from NACOSTI. Prior to the study appropriate authorities in the counties where the study was to be conducted were informed of the study and provided approval. Care was taken in explaining what the study entailed and any potential risks and information sheets for participants, including consent forms, were translated into the local languages (Ramsay et al., 2014). Informed consent was obtained from each participant. However, ethics in this context is more than just explaining what the study is about and signing forms; it mandates being tuned into the cultural environment and understanding the cultural expectations (Gokah, 2006). Familiarity with the context and experience researching in this context meant that I was well aware of the expectations of me as a researcher.

*Sampling techniques*

I used convenience sampling (Etikan, Musa, & Alkassim, 2016) to select the study sites and used my existing relationships with organisations in these sites to identify families with a PWD. Before the study, I invested considerable time (at least six months) liaising with caregiver support groups and organisations working with older people to promote the project and identify potential participants. I also gave talks in churches and met with community groups within the selected study sites to talk about the proposed project and gauge the feasibility of conducting the study.

Overall, my familiarity with the context worked to my advantage. For example, apart from being familiar with the social-cultural aspects of the context, I was also well versed with the processes of acquiring ethical approval and research permits, based on my past experience with previous submissions. Others may argue that familiarity can sometimes jeopardise the research process, particularly when the researcher, who by all counts believes that he or she 'belongs', is suddenly treated with suspicion, deemed an 'outsider' and 'intruder' in his or her own native country (Gokah, 2006). When I showed up late to one of the interviews, one of the participant's said: ''... when I was told you now live in Europe, I said I better not keep to the African time. When I arrived and you were not here, I thought to myself, what? I am here before the mzungu[2]?'' In my experience having lived or studied abroad makes locals at times treat researchers differently, viewing native-born researchers as foreign, an experience shared by others (ibid.).

[2] of European descent

## Participant recruitment

Recruitment is often a challenging aspect of research but one which is not adequately addressed in the current literature (Riedel-Heller, Busse, & Angermeyer, 2000). Identifying and recruiting caregivers for PWD, particularly in rural locations where dementia is not well understood, was a challenge for this study. Previous research has cited logistical and practical difficulties such as distance to travel sites (Morgan et al., 2019), opportunity costs, and language (Shanley et al., 2013) as barriers to participation in dementia-related research. Social and cultural differences related to dementia between populations may influence the success rates of recruitment (Kwon & Kim, 2011). Having a family member with dementia symptoms carries a social stigma in this context, which may have led families to shun participation.

The importance of building trust with gatekeepers to help identify potential participants cannot be overstated. I identified gatekeepers through personal contacts and people working closely with communities, particularly with older adults. One of the key lessons from this was the need to establish a good and close working relationship with the gatekeepers, over a considerable time, at least 6 months to one year, before the study (although current funding structures don't always allow for this). This helps to build their trust and support for the project. The gatekeepers were instrumental in advising me about the most effective strategies to help recruit participants.

Personalised communication with potential participants, including face-to-face contact, has been noted as a successful recruitment approach in other studies (Riedel-Heller et al., 2000). Discussions with potential participants need to demonstrate why the study is important and potentially beneficial to the individuals. It is notable, that participants in this context may have difficulties understanding academic research and its potential to help address the problems they face on a day to day basis. Equally, time emerges from the literature as a key aspect of the recruitment strategy that requires incorporation into research costs (Bartlett, Milne, & Croucher, 2018). Arranging visits at a time that is convenient for the potential participant (Mody et al., 2008), and providing enough time to enable discussion about the study (Norton et al., 1994) are important to encourage and enable participation.

## The interview

Despite the difficulties encountered, we managed to recruit and interview 10 family caregivers from three counties in the country. The interviews took place in the home environment with the PWD present or at a location that was convenient for the caregiver. Interviews were conducted, at the request of the caregiver, in either English, Swahili or Kimeru.

As alluded to prior, most caregivers did not quite understand the purpose of interviews, and the potential benefits of the information they were to provide. Previous research with ethnically diverse communities shows that research may be new and confusing to participants (Shanley et al., 2013). For most, this was the first research interview and hence every effort was made to provide a detailed explanation of the study and the potential impact in the local

language (tailored to the caregiver's needs). I believe having first-hand understanding and knowledge of the socio-cultural context, being conversant in two local languages (Swahili and Kimeru) and having conducted various interviews with communities in this context made this process much easier.

In five of the ten interviews conducted, the PWD was present at the interview as these were conducted in the home environment. I observed that time and again as the interview with the caregiver progressed the person with dementia would make gestures, smile, laugh or utter something that was evidently in response to the interview. As the interviewer, it felt odd, sitting there and talking about the PWD as though they were not present. As I listened to the interview recordings and reflected on the experience of doing this work, I was reminded of a quote from Kate Swaffer's book: "What the hell happened to my brain ?" in which she writes "…people with dementia are still not included in the really important conversations about them, and we are still such a long way from being dementia-friendly"(Swaffer, 2016, p.66). There is no straightforward and easy way of interviewing caregivers at home and excluding the PWD; in all instances where the PWD was present the caregiver was the only person in the home at the time.

Another important issue I observed during the interviews was how most caregivers seemed at ease and spoke openly, providing vivid descriptions about their journey. I was struck by how some recalled details for example relating to dates (year) when the PWD began developing symptoms, the number of times they had been to see a health care professional seeking help or a diagnosis, the type of tests performed, including the names of medications prescribed at the initial stages to manage the condition. I believe having shared my own experience at the beginning of the interview may have served to "..... minimise the distance and separateness of researcher-participant relationships'' (Karnieli-Miller, Strier, & Pessach, 2009, p.279). Closely linked to this, I would argue, is how the interviews were conducted. Indeed, on listening to the recordings, I now realise how much time I allowed the participants to speak at a comfortable pace without interruption, paraphrasing and reflecting on their emotional story (Guion, Diehl, & McDonald, 2011). Having conducted several research interviews over the years no doubt has improved my ability to be an active listener. Potentially useful advice for new researchers in this context, is to allow adequate time on the interview date for introductions and sometimes prayers. In some cases, the host will offer tea to the guest before or after the interview. It would be regarded disrespectful to disregard such hospitality.

Caregivers were compensated for their time and reimbursed for their travel expenses, where applicable. In accordance with sound ethical practice in Africa (Njue et al., 2015) participants received cash as opposed to non-cash benefits as this would allow them to prioritise their own needs. The actual amount paid to participants is important and affects whether it is considered undue influence or whether this is justifiable (Alzheimer Europe, 2011). In my experience reimbursement should be based on the number of hours they commit to the study and their travel costs and respite care allowance factored in.

## After the interview

I now acknowledge that this research experience was emotionally draining and at times distressing. Often, I was overcome by what I saw in the homes I visited to conduct interviews, particularly how the caregiver was struggling to manage the care for the PWD and on other occasions, by the stories they shared with me. In several interviews, caregivers got very emotional and fortunately, there was support available to them. However, for me, there was no specific local emotional support system built into the study and other studies have reported this (Mitchell & Irvine, 2008). I truly had not anticipated the emotional effect this process would have on me. What I found helpful, at times, was discussing my field experiences over the phone with a colleague who was also part of the study, but not based in the field, to provide an update about how the fieldwork was progressing. Future work on this topic must consider the potential emotional impact for researchers and ensure that local support is built into the study.

## Conclusion

My personal experiences with dementia provided a motivation for this study. Using autoethnography, this paper offers a reflexive account of my fieldwork experiences as a seasoned researcher, researching a new and what is regarded as a stigmatised topic in this context. This article has discussed a range of challenges related to designing and conducting research with caregivers for PWD in Kenya. A key challenge for the research process was recruitment. I argue that the labels people use to describe dementia and the attributions they make to its causes made recruitment much harder. Based on my experiences with this project, I maintain that successful recruitment and retention of participants is contingent on identifying key stakeholders in the communities and holding face-to-face meetings prior to the study. Coupled with the fact that dementia is not well understood in this context, it is essential for future research to explore the meanings attached to dementia among the different ethnic groups (Cipriani & Borin, 2014). This information has the potential to inform the design of support and services for PWD and their caregivers and can also contribute to public health messaging.

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# Socio-economic factors influencing ageism among undergraduates of the University of Lagos, Nigeria

**Bola Amaike[1] and Tunrayo Seidun[2]**

***Abstract.*** Ageism is a complex social problem that affects older people negatively in terms of care, support, employment opportunities and social integration, among others. It is a complex phenomenon because most young adults hold ageist perceptions that they are not aware of, even when such negative perceptions harm older people (Raina & Balodi, 2014). This study examined the socio-economic factors influencing negative perceptions of older people among undergraduates of the University of Lagos, Nigeria. Modernization and social exchange theories of ageing are adopted as theoretical tools. In order to achieve the study objectives, a non-experimental research design was adopted while cross-sectional survey and descriptive method were adopted as research methods. A total of 240 respondents was selected for the survey using purposive sampling technique and snowball sampling technique. The dependent variable which is negative perceptions of older people was measured by poor knowledge of Palmore 'Facts on Ageing Quiz' (Palmore, 1977). Hypotheses were formulated and tested using binary logistic regression and Pearson's chi-square and the significant level was set at less than 0.05. The findings reveal that male students were 1.252 times more likely to have poor knowledge of 'Facts on Ageing Quiz' than female students of the University of Lagos. The level of study was a predictor of poor knowledge of 'Facts on Ageing Quiz' among undergraduates of the institution. The study concludes with the need to have evidence-based advocacy and effective policies which will promote public awareness about ageing process and influence positive perceptions of older people, among undergraduates of the University of Lagos, Nigeria.

***Keywords*:** *ageism, older people, socio-economic factors, undergraduates, ageing quiz.*

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## Introduction

Ageism is an ideology that justifies stereotypes or discrimination based on age (Butler, 1969). It involves the maltreatment of people usually older people because of their age, and the use of physical traits such as wrinkled skin/face, grey hair as signs of personal deficiency or incompetence (Amaike, 2017; Okoye & Obikeze, 2005). Ageism is ubiquitous; it is in our perception of older people, and in our actions towards them. Elements of ageism can be found in individual behaviours, cultural values and organizational regulations (Ayalon & Tesch Romers, 2018; Palmore, 1977). In individual behaviours, ageism can be subtle, for example, when a young girl prefers to sit far away from an older woman in a bus (because of fear of witchcraft attack). In cultural values, ageism can be overt, for example, a young man without being asked, rushes to carry groceries bag for an older woman; this means that he has assumed that she is fragile and weak. However, in organizational regulations, ageism is institutionalized, for example, formal organizations like the Zenith Bank insist that, the maximum age of entry for new employees is 26 years, a major reason for this is that, older adults are assumed to be slower and less productive than young adults. Such stereotypes are simply misconceptions. Thus, Wilkinson and Ferraro (2002) defined ageism as prejudicial attitudes towards older people, old age and the ageing process, discriminatory practices against older people and institutional practices and policies that perpetuate stereotypes about older people.

There are different forms of stereotypes against older people, which include defining old age as being synonymous with disease, decline and deterioration. Ageing is therefore despised in modern society which places high premium on vitality and youthfulness, with concomitant negative effects on the quality of care and support available to older people (Ayalon & Tesch Romers, 2018; Morgan & Kunkel, 2015; Moody, 2002; Butler, 1969). Similarly, older persons are described as being of little value; a burden to the family and society; old-fashioned; difficult or impossible and slow to accept change. Thus, older people are seen as senile, sterile, eccentric, childish and irrational (Amaike, 2017; North & Fiske, 2015; Morgan & Kunkel, 2015).

Ageist stereotypes often lead to discrimination and mistreatment of older people. A recent Health Service Executive (HSE) (2009), "*Open your eyes*" highlighted how people's attitudes and perceptions can have a significantly negative impact on the lives of older people. The report states *inter alia*: "Ageism and ageist attitudes are not the sole factors contributing to elder abuse but can give rise to a culture which creates a fertile environment in which elder abuse can develop, leading to age discrimination, and devaluing and disempowering older people" (HSE 2009, p. 21). In addition, ageist stereotypes towards older adults may lead older people to act as he or she is expected to behave, making ageism 'a self-fulfilling prophecy' (Ayalon & Tesch Romers, 2018). Therefore, in a bid to avoid negative stereotypes, older adults (people aged 60 years and older) strive to look younger than their age (Schoemann & Branscombe, 2011). For example, in Nigeria, they dye their hair, buy expensive cosmetics products and treat themselves to luxurious spas. However, as they grow extremely older, it becomes difficult to conceal signs of ageing. Then, they are faced with ageism which they have tried so hard to avoid.

Growing old is a natural biological phenomenon; that is, everyone will grow old in the absence of death (Amaike, 2017). Therefore, stereotyping ageist belief may label or define older adults, but it also tells us how our own future will look like or how we will be perceived by others (Raina & Balodi, 2014; Butler, 1969). It is in view of such, that this study was set to investigate the influence of socio-economic factors on ageist perceptions of older persons among undergraduates in the University of Lagos.

**Theoretical underpinnings**

Modernization theory of ageing argues that as societies modernize (transit from agrarian to industrial societies), the roles and status of older people decrease, they become vulnerable and more likely to experience neglect, maltreatment and ageism in the society (Amaike, 2009; Cowgill & Holmes, 1972; Butler, 1969 ). In agricultural or traditional society, older people had well defined roles through which they contributed their own quota to the development of society and improved their status and quality of life. The modernization of production changed everything including how society functioned (Morgan & Kunkel, 2015). Youthful generations are preferred and celebrated in the automated production process thereby relegating older persons whose skills are considered obsolete and no longer required for the smooth running of the society (Cowgill & Holmes, 1972). Modernization theory has been criticized as being Eurocentric in nature and it also fails to recognize the peculiarities of different societies (Homans, 1961; Morgan & Kunkel, 2015). For example, despite modernization, older people are still respected in Africa. Social exchange theory of ageing is the second theoretical tool. It asserts that the role and status of individuals in social relationships depend on the exchange of social resources such as time, money, power and support (Homans, 1961). This is premised on the cost-benefit analysis where individuals calculate the costs and benefits, they stand to receive from social interactions. Since older people are less likely to bring valuable resources to social interactions, their roles and status will diminish because they have little or no benefits for others to exchange with them (Dowd, 1975) which invariably exposes them to negative perception (ageism). Social exchange theory has been criticized for focusing on only material exchanges and failing to consider altruism in social exchange.

## Research methods

The research method of this study entailed the independent variable such as "socio-economic factors" explained through the lenses of gender, ethnicity, religious affiliation, level of study and parents' income while the dependent variable "ageism" was measured by the indicator 'poor knowledge of Facts on Ageing Quiz'. A non-experimental research design which consisted of cross-sectional survey and descriptive method was used to generate quantitative data for this study. A total of two hundred and forty undergraduate students of the University of Lagos was covered through questionnaire. In order to have gender balance, equal copies of questionnaire were allocated to both male and female undergraduates. After the quota system, the researcher analyzed 240 copies of the questionnaire. Respondents were selected for the survey using purposive sampling technique and snowball sampling

technique. Each respondent was duly informed about the study objectives before their consent was obtained.

In addition, in order to ensure confidentiality, the respondents were assured that their responses will be used for the study only. Descriptive statistical tools such as frequencies, percentages, tables, cross-tabulation, binary logistic regression and chi-square were used to analyze the findings from the quantitative data and the statistical significance level was set at less than 0.05.

## Results

*Socio-economic and demographic background of respondents*

Table 1 shows the percentage distribution of the respondents according to their socio-economic and demographic background. The table clearly shows that the study analyzed equal number of male and female respondents. Clearly, the majority of the respondents (57.1%) were between the ages of 20 to 24 years, single, 236 (98.3%) and from Yoruba ethnic group 175 (72.9%). Similarly, most respondents, 188 (78.3%) were Christians, followed by Muslims, 43 (17.9%). On levels of study, the majority of the sampled undergraduate students, 61(25.4%) were in 300 level and the majority of the respondents' fathers, 108 (45.0%) earned N150, 000 and above ($417 and above) per month, while majority of their mothers, 76 (31.7%) earned between N50, 000-N149, 999 ($139 - $417) per month. Most respondents' parents' monthly income was average, 117(48.8%).

**Table 1: Percentage distribution of respondents by their socio-economic and demographic background**

| Socio-economic and Demographic Variables | Frequency | Percentage (%) |
|---|---|---|
| **SEX** | | |
| Male | 120 | 50.0 |
| Female | 120 | 50.0 |
| **Total** | **240** | **100.0** |
| | | |
| **AGE GROUPS** | | |
| 15-19 years | 81 | 33.8 |
| 20-24 years | 137 | 57.1 |
| 25-29 years | 20 | 8.3 |
| 30 years and above **mean age = 21years.** | 2 | 0.8 |
| **Total** | **240** | **100.0** |
| | | |
| **MARITAL STATUS** | | |
| Single | 236 | 98.3 |
| Married | 3 | 1.2 |
| Separated | 1 | 0.4 |
| **Total** | **240** | **100.0** |
| | | |

| | | |
|---|---|---|
| **Ethnicity** | | |
| Yoruba | 175 | 72.9 |
| Igbo | 36 | 15.0 |
| Hausa | 2 | 0.8 |
| Others | 27 | 11.2 |
| **Total** | **240** | **100.0** |
| | | |
| **Religious affiliation** | | |
| Christianity | 188 | 78.3 |
| Islam | 43 | 17.9 |
| Traditional Religion | 3 | 1.2 |
| None | 6 | 2.5 |
| **Total** | **240** | **100.0** |
| | | |
| **Level of study** | | |
| 100 level | 45 | 18.8 |
| 200 level | 50 | 20.8 |
| 300 level | 61 | 25.4 |
| 400 level | 56 | 23.3 |
| 500 level | 22 | 9.2 |
| 600level | 2 | 0.8 |
| Extra year | 4 | 1.7 |
| **Total** | **240** | **100.0** |
| | | |
| **Range of fathers' monthly income** | | |
| Below N18,000 (($50) | 14 | 5.8 |
| N18,000 –N49,999 ($50 - $139) | 32 | 13.3 |
| N50,000-N149,999 ($139 - $417) | 69 | 28.8 |
| N150,000 and above ($417 and above) | 108 | 45.0 |
| No response | 17 | 7.1 |
| **Total** | **240** | **100.0** |
| | | |
| **Range of mothers' monthly income** | | |
| Below N18,000 ($50) | 24 | 10.0 |
| N18,000-N49,999 ($50 - $139) | 55 | 22.9 |
| N50,000-N149,999 ($139 - $417) | 76 | 31.7 |
| N150,000 and above ($417 and above) | 73 | 30.4 |
| No response | 12 | 5.0 |
| **Total** | **240** | **100.0** |
| | | |
| **Range of both parents' monthly income** | | |
| Below N100,000 ($278) | 40 | 16.7 |
| N100,000-N299,999 ($278 - $833) | 117 | 48.8 |
| N300,000 and above ($833 and above) | 64 | 26.7 |
| No response | 19 | 7.9 |
| **Total** | **240** | **100.0** |

*Gender and poor knowledge of 'Facts on Ageing Quiz'*

This section examines the influence of gender on poor knowledge of 'Facts on Ageing Quiz'. The findings are presented in Table 2.

**Table 2: Percentage distribution of respondents by their sex and poor knowledge of 'Facts on Ageing Quiz'**

| **All five senses tend to decline in old age** | **Male** | **Female** | **Total** |
|---|---|---|---|
| True | 86 (71.7%) | 80(66.7%) | 166(69.2%) |
| False | 34(28.3%) | 40 (33.3%) | 74 (30.8%) |
| **Most older people are set in their ways and unable to change** | | | |
| True | 95(79.2%) | 88(73.3%) | 183(76.2%) |
| False | 25(20.8%) | 29(24.2%) | 54(22.5%) |
| No response | 0(0.0%) | 3(2.5%) | 3(1.2%) |

The above table presents the percentage distribution of respondents by sex and responses on poor knowledge of 'Facts on Ageing Quiz', among undergraduates of the University of Lagos. According to the table, 86 (71.7%) among male respondents it was reported true that all five senses tend to decline in old age, while the remaining 34 (28.3%) reported this as false, while 80 (66.7%) of the female respondents reported that it was true that all five senses tend to decline in old age, while the remaining 40 (33.3%) of them reported false. Furthermore, when the respondents were asked whether most older people were set in their ways and unable to change, 95 (79.2%) of the male respondents believed that most older people were set in their ways and unable to change, while 25(20.8%) of them believed that most older people could change. On the other hand, 88 (73.3%) of the female respondents believed that most older people were set in their ways and unable to change, 29 (24.2%) of them believed that most older people could change, while the remaining 3 (1.2%) of them did not answer the question. The conclusion one can draw from this finding, is that, the majority of the respondents 183 (76.2%) believed that most older people were old fashioned and set in their way.

*Religious affiliation and poor knowledge of 'Facts on Ageing Quiz'*

This section examines the influence of religious affiliation on poor knowledge of 'Facts on Ageing Quiz'. The findings of the study are presented below.

**Table 3: Percentage distribution of respondents by their religious affiliation and poor knowledge of 'Facts on Ageing Quiz'**

| About 80% of the elderly are healthy enough to carry out their normal activities | Christianity | Islam | Traditional | None | Total |
|---|---|---|---|---|---|
| True | 91 (48.4%) | 21 (48.8%) | 0 (0.0%) | 4 (66.7%) | 116 (48.3%) |
| False | 97 (51.6%) | 22 (51.2%) | 3 (100.0%) | 2 (33.3%) | 124 (51.7%) |
| **Majority of older people (past age 65years) are senile (i.e. defective memory, disoriented or demented)** | | | | | |
| True | 100 (53.2%) | 25 (58.1%) | 0 (0.0%) | 4(66.7%) | 129 (53.8%) |
| False | 86 (45.7%) | 18 (41.9%) | 3 (100.0%) | 2 (33.3%) | 109 (45.4%) |
| No response | 2 (1.1%) | 0 (0.0%) | 0 (0.0%) | 0 (0.0%) | 2 (0.8%) |

Table 3 presents the percentage distribution of the respondents' religious affiliation and their responses on poor knowledge of 'Facts on Ageing Quiz'. According to the table, 91 (48.4%) of the Christian respondents believed that 80% of older persons were healthy enough to carry out their normal activities, while the remaining 97 (51.6%) of them disagreed, 21 (48.8%) of the Muslim respondents believed that 80% of older persons were healthy enough to carry out their normal activities, while the remaining 22 (51.2%) of them disagreed, 3 (100.0%) of the respondents who practiced African traditional religions believed that 80% of older persons were not healthy enough to carry out their normal activities, 4 (66.7%) of the respondents that did not affiliate with any of the religions believed that 80% of older persons were healthy enough to carry out their normal activities, while the remaining 2 (33.3%) of them disagreed. Furthermore, when the respondents were asked to give their responses on whether majority of older people were senile (defective memory, disoriented or had other symptoms of dementia), 100 (53.2%) of the Christian respondents believed that majority of older people were senile, 86 (45.7%) of them dissented, while the remaining 2(1.1%) did not answer the question, 25 (58.1%) of the Muslim respondents believed that majority of older people were senile, while the remaining 18 (41.9%) of them dissented, 3 (100.0%) of the respondents that practiced African traditional religions disagreed that majority of older people were senile, 4 (66.7%) of the respondents that did not affiliate with any of the religions believed that older people were senile, while the remaining 2(33.3%) of them dissented. It can therefore be established from this study that majority of the respondents, 129 (53.8%) believed that most older people were senile.

*Ethnicity and poor knowledge of 'Facts on Ageing Quiz'*

This section shows the distribution of respondents by ethnic origin and poor knowledge of 'Facts on Ageing Quiz'. The findings of the study are presented in Table 4.

**Table 4: Percentage distribution of respondents by their ethnic origin and poor knowledge of 'Facts on Ageing Quiz'**

| **Physical strength tends to decline in old age** | **Yoruba** | **Igbo** | **Hausa** | **Others** | **Total** |
|---|---|---|---|---|---|
| True | 159 (90.9%) | 32 (88.9%) | 2 (100.0%) | 24 (88.9%) | 217 (90.4%) |
| False | 1 3(7.4%) | 3 (8.3%) | 0 (0.0%) | 3 (11.1%) | 19 (7.9%) |
| No response | 3 (1.7%) | 1 (2.8%) | 0 (0.0%) | 0 (0.0%) | 4 (1.7%) |
| **Majority of older people have incomes below the poverty level (as defined by international standard, $1.90 a day)** | | | | | |
| True | 105 (60.0%) | 23 (63.9%) | 2 (100.0%) | 11 (40.7%) | 141 (58.8%) |
| False | 66 (37.7%) | 12 (33.3%) | 0 (0.0%) | 15 (55.6%) | 93 (38.8%) |
| No response | 4 (2.3%) | 1 (2.8%) | 0 (0.0%) | 1 (3.7%) | 6 (2.5%) |
| **Majority of older people would like to have some work to do including housework and volunteer work** | | | | | |
| True | 118 (67.4%) | 24 (66.7%) | 2 (100.0%) | 16 (59.3%) | 160 (66.7%) |
| False | 54 (30.9%) | 11 (30.6%) | 0 (0.0%) | 11 (40.7%) | 76 (31.7%) |
| No response | 3 (1.7%) | 1 (2.8%) | 0 (0.0%) | 0 (0.0%) | 4 (1.7%) |

The above table presents the percentage distribution of respondents' ethnic origin and their responses on poor knowledge of 'Facts on Ageing Quiz'. From the table, it can be observed that 159 (90.9%) of the Yoruba respondents believed that physical strength tends to decline in old age, 13 (7.4%) of them disagreed, while the remaining 3 (1.7%) did not respond to the question. 32 (88.9%) of the Igbo respondents believed that physical strength tends to decline in old age, 3 (8.3%) of them disagreed, while the remaining of them 1 (2.8%) did not respond to the question. 2 (100.0%) Hausa respondents believed that physical strength tends to decline in old age, 24 (88.9%) of respondents that belonged to other ethnic groups believed that physical strength tends to decline in old age, while the remaining 3 (11.1%) of them dissented. Table 4 also reveals that 105 (60.0%) of the Yoruba respondents believed that majority of older people had incomes below the poverty level as defined by international standard, $1.90 a day, 66 (37.7%) of them dissented, while the remaining 4 (2.3%) of them did not answer the question, 23 (63.9%) of Igbo respondents believed that majority of the older people had incomes below the poverty level as defined by international standard, 12 (33.3%) of them dissented, while the remaining 1 (2.8%) of them did not answer the question. 2(100.0%) Hausa respondents believed that majority of the older people had incomes below the poverty level as defined by international standard, 11 (40.7%) of respondents who belonged to other ethnic groups believed that majority of the older people had incomes below the poverty level as defined by international standard, 15 (55.6%) of them dissented, while the remaining 1 (3.7%) of them did not answer the question. Furthermore, when respondents were asked whether majority of older people would like to have some work to do, including housework and volunteer work, 118 (67.4%) of the Yoruba respondents believed that majority of older people would like to have some work to do, 54 (30.9%) of them said it was not true that older people didn't want to do any kind of work, while the remaining 3 (1.7%) of them did not respond to

the question. 24(66.7%) of the Igbo respondents believed that majority of older people would like to have some work to do, 11(30.6%) of them said it was not true that older people didn't want to do any kind of work, while the remaining 1(2.8%) of them did not respond to the question. 2 (100.0%) Hausa respondents believed that majority of older people would like to have some work to do, 16 (59.3%) of the respondents who belonged to other ethnic groups believed that majority of older people would like to have some work to do, while the remaining 11 (40.7%) of them dissented. Therefore, it can be established from the study that a lesser percentage of the respondents 76(31.7%) believed that older adults were sources of burden to their families and the society.

*Levels of study and poor knowledge of 'Facts on Ageing Quiz'*

This section sought to examine the relationship between levels of study and poor knowledge of 'Facts on Ageing Quiz'. Some questions were asked in this regard and the responses of the respondents are presented in table 5.

Table 5 presents the percentage distribution of respondents by their levels of study and responses on poor knowledge of 'Facts on Ageing Quiz'. From the table, it can be observed that 37 (82.2%) of the respondents in their 100 level believed that the reaction time of most older people tends to be slower than the reaction time of younger people, 7(15.6%) of them dissented, while the remaining 1 (2.2%) of them did not respond to the question. 41 (82.0%) of respondents in 200 level believed that the reaction time of most older people tends to be slower than reaction time of younger people, while the remaining 9 (18.0%) of them dissented. 48 (78.7%) of respondents in 300 level believed that the reaction time of most older people tends to be slower than reaction time of younger people, while the remaining 13 (21.3%) of them disagreed. 46 (82.1%) of respondents in 400 level believed that the reaction time of most older people tends to be slower than the reaction time of younger people, while the remaining 10 (17.9%) of them dissented. 17 (77.3%) of respondents in 500 level believed that the reaction time of most older people tends to be slower than the reaction time of younger people, 4 (18.2%) of them dissented, while the remaining 1 (4.5%) of them did not answer the question. 2 (100.0%) of respondents in 600 level believed that the reaction time of most older people tends to be slower than the reaction time of younger people, 4(100.0%) of respondents that had extra year believed that the reaction time of most older people tends to be slower than the reaction time of younger people.

Table 5 also reveals that 27 (60.0%) of the respondents in 100 level, agreed that most older people were pretty much alike, 16 (35.6%) of them said false; older people were not pretty much alike, while the remaining 2 (4.4%) of them did not answer the question. 33(66.0%) of 200 level respondents believed that most older people were pretty much alike while the remaining 17 (34.0%) of them dissented. 38 (62.3%) of 300 level respondents believed that most older people were pretty much alike, 21 (34.4%) of them disagreed, while the remaining 2 (3.3%) of them did not respond to the question. 36 (64.3%) of 400 level respondents believed that most older people were pretty much alike, 17 (30.4%) of them dissented, while the remaining 3 (5.4%) of them did not answer the question. 12 (54.5%) of 500 level respondents believed that most older people were pretty much alike, 9 (40.9%) of them dissented, while

the remaining 1 (4.5%) of them did not answer the question. 2 (100.0%) of 600 level respondents believed that most older people were not pretty much alike while 4 (100.0%) of respondents that had extra year believed most older people were pretty much alike.

**Table 5: Percentage distribution of respondents by their level of study and poor knowledge of 'Facts on Ageing Quiz'**

| **The reaction time of most older people tends to be slower than reaction time of younger people** | **100** | **200** | **300** | **400** | **500** | **600** | **Extra year** | **Total** |
|---|---|---|---|---|---|---|---|---|
| True | 37 (82.2%) | 41 (82.0%) | 48 (78.7%) | 46 (82.1%) | 17 (77.3%) | 2 (100.0%) | 4 (100.0%) | 195 (81.2%) |
| False | 7 (15.6%) | 9 (18.0%) | 13 (21.3%) | 10 (17.9% | 4 (18.2%) | 0 (0.0%) | 0 (0.0%) | 43 (17.9%) |
| No response | 1 (2.2%) | 0 (0.0%) | 0 (0.0%) | 0 (0.0%) | 1 (4.5%) | 0 (0.0%) | 0 (0.0%) | 2 (0.8%) |
| **In general, most older people are pretty much alike.** | | | | | | | | |
| True | 27 (60.0%) | 33 (66.0%) | 38 (62.3%) | 36 (64.3%) | 12 (54.5%) | 0 (0.0%) | 4 (100.0%) | 150 (62.5%) |
| False | 16 (35.6%) | 17 (34.0%) | 21 (34.4%) | 17 (30.4%) | 9 (40.9%) | 2 (100%) | 0 (0.0%) | 82 (34.2%) |
| No response | 2 (4.4%) | 0 (0.0%) | 2 (3.3%) | 3 (5.4%) | 1 (4.5%) | 0 0.0%) | 0 (0.0%) | 8 (3.3%) |
| **It is almost impossible for most older people to learn something new.** | | | | | | | | |
| True | 22 (48.9%) | 26 (52.0%) | 22 (36.1%) | 35 (62.5%) | 5 (22.7%) | 1 (50.0%) | 1 (25.0%) | 112 (46.7%) |
| False | 23 (51.1%) | 24 (48.0%) | 39 (63.9%) | 21 (37.5%) | 17 (77.3%) | 1 (50.0%) | 3 (75.0%) | 128 (53.3%) |

Furthermore, when respondents were asked if it was almost impossible for most older people to learn something new, 22 (48.9%) of the respondents in 100 level believed that it was almost impossible for most older people to learn something new, while the remaining 23 (51.1%) of them did not agree. Most older people could learn something new, regularly, 26 (52.0%) of the respondents in 200 level believed that it was almost impossible for most older people to learn something new, while the remaining 24 (48.0%) of them did not agree. Most older people could learn something new, regularly, 22 (36.1%) of the respondents in 300 level believed that it was almost impossible for most older people to learn something new, while the remaining 39(63.9%) of them did not agree. Most older people could learn something new, regularly, 35

(62.5%) of the respondents in 400 level believed that it was almost impossible for most older people to learn something new, while the remaining 21(37.5%) of them did not agree. Most older people could learn something new, regularly, 5(22.7%) of the respondents in 500 level believed that it was almost impossible for most older people to learn something new, while the remaining 17 (77.3%) of them did not agree. Most older people could learn something new, regularly, 1 (50.0%) respondent in 600 level believed that it was almost impossible for most older people to learn something new, while the remaining 1 (50.0%) did not agree. Most older people could learn something new, regularly, 1 (25.0%) of the respondents that had extra year believed that it was almost impossible for most older people to learn something new, while the remaining 3 (75.0%) of them did not agree. The conclusion one can draw from these findings is that a lesser percentage of the respondents 112 (46.7%) believed that older adults were slow to accept change.

*Parents' income and poor knowledge of 'Facts on Ageing Quiz'*

This section interrogates the nexus between range of respondents' parents' monthly income and poor knowledge of 'Facts on Ageing Quiz'. The findings of the study are presented in Table 6.

**Table 6: Percentage distribution of respondents by the range of their parents' monthly income and poor knowledge of 'Facts on Ageing Quiz'**

| Majority of older people are seldom bored | Below N100,000 ($278) | N100,000 - N299,999 ($278 -$833) | N300,000 and above ($833 & above) | No response | Total |
|---|---|---|---|---|---|
| True | 25 (62.5%) | 68 (58.1%) | 33 (51.6%) | 13 (68.4%) | 139 (57.9%) |
| False | 15 (37.5%) | 47 (40.2%) | 31 (48.4%) | 6 (31.6%) | 99 (41.2%) |
| No response | 0 (0.0%) | 2 (1.7%) | 0 (0.0%) | 0 (0.0%) | 2 (0.8%) |
| **Older workers cannot work effectively as younger workers.** | | | | | |
| True | 34 (85.0%) | 103 (88.0%) | 58 (90.6%) | 17 (89.5%) | 212 (88.3%) |
| False | 6 (15.0%) | 13 (11.1%) | 6 (9.4%) | 2 (10.5%) | 27 (11.2%) |
| No response | 0 (0.0%) | 1 (0.9%) | 0 (0.0%) | 0 (0.0%) | 1 (0.4%) |

Table 6 presents the percentage distribution of range of respondents' parents' monthly income and their responses on poor knowledge of 'Facts on Ageing Quiz'. The table reveals that 25 (62.5%) of the respondents whose parents earned below N100,000 ($278) per month believed that majority of older people were seldom bored, while the remaining 15 (37.5%) of them responded that it was not true (false) that older people were always bored, 68 (58.1%) of the respondents whose parents earned between N100,000 –N299,999 ($278-$833) per month believed that majority of older people were seldom bored, 47 (40.2%) of them reported that it

was not true (false); older people were always bored while the remaining 2 (1.7%) of them did not answer the question, 33 (51.6%) of the respondents whose parents earned N300,000 and above ($833 and above) per month believed that majority of older people were seldom bored, while the remaining 31 (48.4%) of them reported that it was not true (false), 13 (68.4%) of respondents who did not indicate their parents' monthly income believed that majority of older people were seldom bored, while the remaining 6 (31.6%) of them said it was false; older people were always bored. Furthermore, when respondents were asked to give their responses on whether older workers couldn't work effectively like younger workers, 34 (85.0%) of the respondents whose parents earned below N100,000 ($278) per month believed that older workers couldn't work effectively like younger workers, while the remaining 6 (15.0%) of them believed that they could, 103 (88.0%) of the respondents whose parents earned between N100,000 - N299,999 ($278 - $833) per month believed that older workers couldn't work effectively like younger workers, 13 (11.1%) of them believed that they could, while 1(0.9%) did not respond to the question, 58 (90.6%) of the respondents whose parents earned N300,000 ($833) and above per month believed that older workers couldn't work effectively like younger workers, while the remaining 6 (9.4%) of them believed that they could, 17(89.5%) of respondents who didn't indicate their parents' monthly income believed that older workers couldn't work effectively like younger workers, while the remaining 2 (10.5%) of them believed that they could. The conclusion one can draw from these findings is that majority of the respondents 212 (88.3%) believed that older people were frail and weak.

**Test of hypotheses**

This section seeks to address the specific objectives of this study. The hypotheses formulated in this study were also tested. To achieve this, Binary Logistic Regression and Pearson Chi-square ($X^2$) statistical methods were adopted.

*Hypothesis one*

**$H_1$:** Male students are less likely to have poor knowledge of 'Facts on Ageing Quiz' than female students of the University of Lagos.

**Table 7: Classification table**

| | | | Predicted | | |
|---|---|---|---|---|---|
| | | | Most older people are set in their ways and unable to change. | | |
| | Observed | | True | False | Percentage Correct |
| Step 1 | Most older people are set in their ways and unable to change. | True | 183 | 0 | 100.0 |
| | | False | 54 | 0 | .0 |
| | Overall Percentage | | | | 77.2 |

a. The cut value is .500

The binomial logistic regression was used because the dependent variable of this study was dichotomous or binary in nature. That is, the responses of the dependent variable were coded as either true or false. Also, the test was used because the independent variable was a nominal variable which was gender, of which the males were the target group. In essence, the data analysis technique was used because hypothesis one met all the assumptions needed to use a binary logistic regression test and it was also deemed the most appropriate, since it shows whether male students were more likely to agree that older people were set in their ways and unable to change than the female students of the University of Lagos, which other tests such as Pearson chi-square would have not been able to show in a relationship.

**Table 8: Variables in the equation**

| | | B | S.E. | Wald | Df | Sig. | Exp(B) | 95.0% C.I.for EXP(B) | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Lower | Upper |
| Step 1[a] | Gender | .225 | .310 | .525 | 1 | .469 | 1.252 | .681 | 2.301 |
| | Constant | -1.335 | .225 | 35.273 | 1 | .000 | .263 | | |

a. Variable(s) entered on step 1: Gender.

Table 7 explains the variation in the dependent variable. The majority of the respondents agreed that most older people were set in their ways and unable to change, while a lesser number of respondents stated this was not true (false). Furthermore, the overall percentage row reveals that this prediction is correct 77.2% of the time. On the other hand, table 8 reveals that gender was not a statistically significant predictor of negative perceptions of older persons ($p>0.05$), and it is accurate 77.2% of the time.

A logistic regression test was performed to ascertain the influence of gender on poor knowledge of 'Facts on ageing Quiz'. The association was not statistically significant, $X^2 = 0.525$, and $p=0.469$. That is, $p > 0.05$. The model explained 3.0% (Nagelkerke $R^2$) of the variance in poor knowledge of 'Facts on Ageing Quiz' and correctly classified 77.2% of cases. The null hypothesis is accepted. Male students were 1.252 times more likely to have poor knowledge of 'Facts on Ageing Quiz' than female students of the University of Lagos.

*Hypothesis two*

**$H_2$:** There is a relationship between religious affiliation and poor knowledge of 'Facts on Ageing Quiz' among undergraduates of the University of Lagos.

**Table 9: Religious affiliation and poor knowledge of 'Facts on Ageing Quiz'**

| Religious affiliation | Majority of older people (past age 65years) are senile (i.e defective memory, disoriented, or demented) | | | Total |
|---|---|---|---|---|
| | True | False | No response | |
| Christianity | 100(53.2%) | 86(45.7%) | 2(1.1%) | 188(100.0%) |
| Islam | 25(58.1%) | 18(41.9%) | 0(0.0%) | 43(100.0%) |
| Traditional | 0(0.0%) | 3(100.0%) | 0(0.0%) | 3(100.0%) |
| None | 4(66.7%) | 2(33.3%) | 0(0.0%) | 6(100.0%) |
| **Total** | **129(53.8%)** | **109(45.4%)** | **2(0.8%)** | **240 (100.0%)** |
| **$X^2 = 4.802$, df=6, p=0.569** | | | | |

Table 9 presents the results of cross-tabulation with chi-square that shows the relationship between religious affiliation and poor knowledge of 'Facts on Ageing Quiz', among undergraduates of the University of Lagos. The data indicates that 100 (53.2%) among Christian respondents believed that majority of older people were senile, 86 (45.7%) opined that this was not true (false), while the remaining 2 (1.1%) of them did not respond to the question. This was followed by 25 (58.1%) of Muslim respondents that believed that majority of older people were senile, while the remaining 18 (41.9%) of them opined it was not true (false).

A chi-square test was conducted to determine the relationship between religious affiliation and poor knowledge of 'Facts on Ageing Quiz', among undergraduates of the University of Lagos. The test indicates that the relationship was not statistically significant, $X^2 = 4.802$, and p=0.569. That is, (p>0.05). The null hypothesis is accepted. There is no relationship between religious affiliation and poor knowledge of 'Facts on Ageing Quiz', among undergraduates of the University of Lagos.

*Hypothesis three*

**$H_3$:** There is a relationship between ethnicity and poor knowledge of 'Facts on Ageing Quiz' among undergraduates of the University of Lagos.

**Table 10: Ethnicity and poor knowledge of 'Facts on Ageing Quiz'**

| Ethnic Origin | Majority of older people would like to have some work to do (including housework and volunteer work) | | | Total |
|---|---|---|---|---|
| | True | False | No response | |
| Yoruba | 118(67.4%) | 54(30.9%) | 3(1.7%) | 175(100.0%) |
| Igbo | 24(66.7%) | 11(30.6%) | 1(2.8%) | 36(100.0%) |
| Hausa | 2(100.0%) | 0(0.0%) | 0(0.0%) | 2(100.0%) |
| Others | 16(59.3%) | 11(40.7%) | 0(0.0%) | 27(100.0%) |
| **Total** | **160(67.8%)** | **76(32.2%)** | **4(1.7%)** | **240(100.0%)** |
| **$X^2$ =2.709, df=6, p=0.844** | | | | |

Table 10 presents the results of cross-tabulation with chi-square that shows the relationship between ethnicity and poor knowledge of 'Facts on Ageing Quiz', among undergraduates of the University of Lagos. The results indicate that significant number of Yoruba respondents 118 (67.4%) believed that majority of older people would like to have some kind of work to do, including housework and volunteer work, 54 (30.9%) stated that this was not true (false); older people wouldn't want to do any kind of work, while the remaining 3 (1.7%) of them did not answer the question. This was followed by 24 (66.7%) of Igbo respondents that believed that majority of older people would like to have some work to do, 11 (30.6%) of them dissented, while the remaining 1(2.8%) of them did not respond to the question.

A chi-square test was conducted to ascertain the relationship between ethnicity and poor knowledge of 'Facts on Ageing Quiz', among undergraduates of the University of Lagos. The test indicates that the relationship was not statistically significant. This is because the chi-square value was $X^2$ =2.709, and p=0.844. That is, (p>0.05). The null hypothesis is accepted. There is no relationship between ethnicity and poor knowledge of Facts on Ageing Quiz, among undergraduates of the University of Lagos.

*Hypothesis four*

**$H_4$**: There is a relationship between level of study and poor knowledge of 'Facts on Ageing Quiz' among undergraduates of the University of Lagos.

**Table 11: Level of study and poor knowledge of 'Facts on Ageing Quiz'**

| Level of study | It is almost impossible for most older people to learn something new | | Total |
|---|---|---|---|
| | True | False | |
| 100level | 22(48.9%) | 23(51.1%) | 45(100.0%) |
| 200level | 26(52.0%) | 24(48.0%) | 50(100.0%) |
| 300level | 22(36.1%) | 39(63.9%) | 61(100.0%) |
| 400level | 35(62.5%) | 21(37.5%) | 56(100.0%) |
| 500level | 5(22.7%) | 17(77.3%) | 22(100.0%) |
| 600level | 1(50.0%) | 1(50.0%) | 2(100.0%) |
| Extra year | 1(25.0%) | 3(75.0%) | 4(100.0%) |
| **Total** | **112(46.7%)** | **128(53.3%)** | **240(100.0%)** |
| **$X^2$=14.885, df=6, p=0.021** | | | |

Table 11 presents the results of cross-tabulation with chi-square that shows the relationship between level of study and poor knowledge of 'Facts on Ageing Quiz', among undergraduates of the University of Lagos. The table indicates that 22 (48.9%) of undergraduate students in 100 level believed that it was almost impossible for most older people to learn something new, while the remaining 23 (51.1%) of them disagreed; older people could learn something new, regularly. This was followed by 26 (52.0%) of undergraduate students in 200 level, who believed that it was almost impossible for most older people to learn something new, while the remaining 24 (48.0%) disagreed.

A chi-square test that was performed to ascertain the relationship between level of study and poor knowledge of 'Facts on Ageing Quiz' indicates a statistically significant relationship. This is because the chi-square value was $X^2 = 14.885$, and $p=0.021$. That is, ($p<0.05$). The alternate hypothesis is accepted. There is a relationship between level of study and poor knowledge of 'Facts on Ageing Quiz', among undergraduates of the University of Lagos.

*Hypothesis five*

**$H_5$:** There is a relationship between parents' income and poor knowledge of 'Facts on Ageing Quiz' among undergraduates of the University of Lagos.

**Table 12: Parents' income and poor knowledge of 'Facts on Ageing Quiz'**

| Range of both Parents' monthly income | Older workers cannot work effectively as younger workers | | | Total |
|---|---|---|---|---|
| | True | False | No response | |
| Below N100,000 ($278) | 34 (85.0%) | 6 (15.0%) | 0 (0.0%) | 40 (100.0%) |
| N100, 000-N299, 999 ($278 - $833) | 103 (88.0%) | 13 (11.1%) | 1 (0.9%) | 117 (100%) |
| N300, 000 and above ($833 and above) | 58 (90.6%) | 6(9.4%) | 0 (0.0%) | 64 (100.0%) |
| No response | 17 (89.5%) | 2 (10.5%) | 0 (0.0%) | 19 (100.0%) |
| **Total** | **212 (88.3%)** | **27 (11.2%)** | **1 (0.4%)** | **240 (100.0%)** |
| **$X^2$= 1.854, df=6, p=0.933** | | | | |

Table 12 presents the results of cross-tabulation that shows the relationship between parents' income and poor knowledge of 'Facts on Ageing Quiz', among undergraduates of the University of Lagos. The table indicates that 34 (85.0%) of respondents, whose parents earned below N100, 000 ($278) per month, believed that older workers could not work effectively like younger workers, while the remaining 6 (15.0%) of them believed that they could. This was followed by 103 (88.8%) of respondents, whose parents earned between N200, 000-N399, 999 ($278 - $ 833) per month, who believed that older workers could not work effectively like younger workers, 13 (11.1%) of them believed that they could, while the remaining 1 (0.9%) of them did not answer the question.

A chi-square test that examined if any relationship existed between parents' income and poor knowledge of 'Facts on Ageing Quiz', among undergraduates of the University of Lagos indicated that the relationship was not statistically significant at $X^2 = 1.854$ and p=.0.933, that is, (p>0.05). Therefore, the null hypothesis is accepted. There is no relationship between parents' income and poor knowledge of 'Facts on Ageing Quiz', among undergraduates of the University of Lagos.

## Discussion of findings

The main objective of this study was to examine the socio-economic factors influencing negative perceptions of older persons, among undergraduates of the University of Lagos. Five hypotheses were tested, after which four null hypotheses were accepted and one alternate hypothesis was accepted. From the results, it was discovered that male students were more likely to have poor knowledge of 'Facts on Ageing Quiz' than female students of the University of Lagos. This is because the p-value produced in this regard was greater than the alpha of 0.05. This finding corroborates the findings of Bernardini Zambrini *et al,* (2008); Allan & Johnson (2009); Kalavar (2001) that on the average, males exhibit more negative perceptions towards older people and fewer positive ageist behaviours than females. The finding also aligns with the assumption of the modernization theory of ageing that as societies transit from

agrarian to industrial societies, the status of older persons decreases, and they are increasingly more likely to experience neglect, stereotypes and ageism (Morgan & Kunkel, 2015; Moody, 2002). This finding is also supported by the findings of Amaike (2009); Akeredolu-Ale & Aribiah (2001); Song & Bian (2014); Bookman & Kimbrel (2011) and Okoye & Obikeze, (2005) who discovered that in Nigerian societies, the norms of filial piety were practiced and extended to older relatives and neighbours in the communities. Therefore, types or forms of old age care and support were strongly linked to relationship types (relationship status) that existed between the older persons and their caregivers. Since daughters were socialized to be caregivers, they often provided both material and non-material supports. Expectedly, females were more likely than males to be primary care givers and exhibit less ageist behaviours (Bookman & Kimbrel, 2011; Moody, 2002).

This study also revealed that there was no relationship between religious affiliation and poor knowledge of 'Facts on Ageing Quiz', among undergraduates of the University of Lagos. This is because the chi-square test produced a p-value of 0.569 which is greater than the alpha of 0.05. This analysis depicts that whether the respondents were Christians or Muslims or Traditionalists, their religious affiliation did not influence them to have negative perceptions of older persons. This was also established by North & Fiske (2015) who affirmed that religions such as Confucianism of China, Hinduism of India and Christianity promote value and respect of older persons. Similar observation was also made by Sagner (2001), who found that negative perceptions of older persons do not exist among the Xhosa people of Southern Africa, because of the influence of Xhosa traditional religious worldview. This phenomenon is probably due to the fact that most religions such as Christianity, Islam and African traditional religions teach and enforce moral codes of conduct, such as greeting, respect, and value of older people. For example, in the Bible, 1 Timothy 5:1 says "Do not sharply rebuke an older man, but rather appeal to him as a father, to the younger men as brothers". However, the finding was inconsistent with the postulation of the age stratification theory of ageing that posited that older adults were discriminated against by younger adults, because of their chronological age and norms within that particular society (Morgan & Kunkel, 2015; Moody, 2002; Palmore, 1977; Cowgill & Holmes, 1972). This is because the norms or doctrines of religious affiliation such as Christianity, Islam and African traditional religions were not biased or prejudiced, if they were, majority of the respondents, who affiliate with these religions, would hold negative perceptions of older persons.

The study also revealed that there was no relationship between ethnicity and poor knowledge of 'Facts on Ageing Quiz', among undergraduates of the University of Lagos. The chi-square test in this regard produced a p-value of 0.844 which is greater than the alpha of 0.05 which led to the conclusion that there was no relationship between ethnicity and negative perceptions of older persons, among undergraduates in the institution. The analysis depicts that regardless of the ethnic group, the sampled respondents belonged to, it didn't influence them to have negative perceptions of older persons. This finding is supported by Sung (2001) who in his study discovered that non-western cultures in sub-Saharan Africa were influenced by the values of filial piety and the practice of ancestor worship, which are thought to promote positive views of ageing and high esteem for older persons. However, the finding was contrary to the finding of Ajala (2006) who in his study claimed that negative perceptions of

older persons exist among the Yorubas of Southwestern Nigeria and that there was the conceptualization of a stage of old age as "over-age" or senescence, and death in the Yoruba culture, where older persons were regarded as hopeless and pathetic, and were seen as a burden to the society in the Yoruba culture and among other cultures in contemporary Nigerian society. This is because majority of the sampled respondents of this study were Yorubas, yet their ethnicity did not predispose them to see older adults as a burden to the society. This is probably because our cultural values and norms promote respect and value of older people. For example, a young Yoruba boy is expected to prostrate completely, when greeting an older person. Expectedly, these values promote positive perceptions of older persons.

The study also revealed that the level of study influenced poor knowledge of 'Facts on Ageing Quiz', among undergraduates of the University of Lagos. The chi-square test conducted in this regard produced a p-value of 0.021 which is less than the alpha of 0.05 which led to the conclusion that respondents' level of study is a significant factor to explain negative perceptions of older people. This finding corroborates the finding of an earlier study conducted by Okoye and Obikezie (2005) where respondents with higher levels of education possessed fewer ageing stereotypes than the less educated respondents. A possible reason why levels of study influenced negative perceptions of older persons, is because most undergraduate students in 100 and 200 levels were still quite young, majority of them were in their teens, therefore they were more likely to be under the tutorship of their parents or guardians (older persons), who had enforced discipline on them, which must have influenced them to hold negative perceptions of older persons compared to undergraduate students in 300, 400, 500 and 600 levels.

It was further revealed that there was no relationship between parents' income and poor knowledge of 'Facts on Ageing Quiz', among undergraduates of the University of Lagos. This is based on the result of the chi-square test that was conducted to ascertain if any relationship existed between the two variables. The test produced a p-value of 0.933, which is greater than the alpha level of 0.05. This analysis depicts that whether the respondents' parents were high, average or low monthly income earners, it did not influence the respondents to have negative perceptions of older persons. This is contrary to the postulation of the social exchange theory of ageing that in as much as relationships are based on mutual exchanges, as older persons become less able to exchange resources, they see their social status diminishes, because there are less benefits for others to exchange with them (Moody, 2002; Homans, 1961; Dowd, 1975). In essence, the study revealed that negative perceptions of older persons were not economically determined.

## Conclusion

The study was conducted to interrogate the fact that negative perceptions of older people are inevitable which have grave implications for their quality of life and life satisfaction in old age. Specifically, ageist attitudes and perceptions jeopardize older adults' life chances, employment opportunities, social integration, quality of health care services and living conditions among others. The predictors (factors) influencing negative perceptions of older

persons among undergraduates from this study are gender of the perceiver and level of study. In the light of this, it is imperative to focus more on young male adults rather than young female adults and on undergraduates' lower levels of study, in order to prevent the prevalence of ageist perceptions of older people in Nigerian society.

*Recommendations*

The recommendations of the study are:

- The socialization of children especially the University undergraduates should emphasize the importance of sustainable informal old age care and intergenerational relations/transfers. Parents and extended families should educate both boys and girls to discharge the age-long traditional old age care and support which will reduce ageist attitudes and perceptions among young adults.
- United Nations (UN) and World Health Organization (WHO), among others should establish programmes that promote the idea of care giving roles among young male adults in Nigeria. If the programmes are properly designed and implemented, boys will accept care giving roles, which in turn will influence positive perceptions of older people among young male adults in Nigeria.
- More Youth should be encouraged to enroll for courses or programmes in Gerontology at the University which will improve their knowledge of ageing process and perceptions of older people.
- Introduction to Gerontology should be included in the General Studies (GST) for all fresh entry undergraduate students of the University of Lagos. For example, 100 level and Direct Entry students should take the introductory course in Gerontology which will improve their understanding and appreciation of the contributions of older people in traditional and modern African societies. This will improve their knowledge of the contributions of older adults to the society and invariably influences positive perceptions of older people.
- Governments should embark on continuous public awareness and education about ageing process and the relevance of older people in Nigeria.
- Non-Governmental Organizations (NGOs) should adopt evidence-based advocacy and rights approach to promote positive attitudes and perceptions of older people in Nigeria.

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# Forsaking treatment and enduring the status: Ageing into a disability

**Rehema Namaganda[1], Isaac Kajja[2], Steven Kiwuwa[3] and David Kyaddondo[4]**

***Abstract.*** This article explores the process(es) through which people age into and experience disabilities. It focuses on acquired disabilities among older persons in rural areas of Wakiso district in Uganda. The cases presented reveal the complexities involved in seeking and accessing health care for older persons, and ultimately how it all contributes to the disablement process. It further highlights the fact that what characterizes the disablement process of older persons goes beyond diseases, and includes the decision-making process which affects the treatment seeking journey, especially on whether to seek treatment or not, and when this is to be ceased. The article draws from a qualitative study on ageing and disability in Uganda, in which 30 older persons were interviewed in their homes. The paper's original contribution and emphasis is that of what characterizes the disablement process of older persons, which goes beyond diseases and other environmental factors to include perceptions and decisions of older persons as well as their significant other(s) especially in seeking treatment.

***Keywords****:* ageing, older persons, disability, treatment, Uganda

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## Introduction

Disability debates have pointed to the contribution of both the impairment and the social environment to the disablement of individuals (Oliver, 2013; Regler, 2018; Whyte & Ingstad, 1995). The treatment seeking process is part of the social environment that significantly contributes to the disablement of the older person. The two cases shown in this paper, seeks to delineate how the decision on whether and when to seek treatment for the older person is commonly a function of many actors within and outside the family. These decision-making processes are influenced by several factors including infrastructural challenges, available care arrangements, as well as availability or absence of financial resources (Ssengoba, 2010). It is evident that bio-medical causes account for old age disabilities, because of the general belief that old age brings about decline in health and functional ability (Kowal et al., 2010). However, this paper will go beyond the attribution of bio-medical causes to disabilities in old age, and analyze other social factors related to the decision to take or ignore treatment of bio-medical conditions, that underline this process and journey into a disability. It is argued that what characterizes the disablement process of older persons goes beyond diseases, but factor in the decisions made during events of injuries and the treatment seeking journey, especially on whether to seek treatment or not, and when to stop. Understanding the process that leads to disability among older persons is important in designing appropriate interventions. However, there is inadequate information on the profile of disability among the older persons.

In order to answer the key question of how older people age into and experience disability, this paper, presents two (2) cases: The first case is about how Nabanja was hit by a banana plant, from which she acquired a mobility impairment and how she maneuvered her treatment seeking process. The second story illustrates some of the participants whose journey was followed when seeking treatment. Besides the above two accounts, other statements and examples are explored revealing similar experiences from other respondents, to support the main arguments of this paper. The paper attempts to break down the journey that led to disability in the lives of the participants, older persons, between the age of 60 to 95 who formed part of this study. This shows how older persons maneuver the treatment seeking journey and how that shapes, their experiences of ageing into disability. Subsequently, this paper highlights the importance of understanding the events that characterize the transition from health to disability among older persons.

### Case one: Nabanja and her treatment seeking journey

When you meet Nabanja for the first time, you cannot miss her sparkling grey hair and her dark glaring and humorless face. Nabanja has little recollection of the year she was born, but she estimates her age to be somewhere past 80. She lives in a well-built iron roofed 2-bedroom house in Sumbwe, a rural village in Wakiso. She claims to have built the house from her own income she got from the sale of part of her land where the house is now located. Nabanja lives alone at night in the house but during day, one of her great granddaughters aged 25 years old, comes around to help her with house chores such as washing clothes, cleaning the house and sometimes cooking.

Nabanja narrates that in the year 2015 while in her garden behind the house a banana stem that she was cutting hit her back, causing her to fall and broke her leg. *This is when my life started changing*," explains Nabanja. She was taken to Mulago, a National referral hospital in Kampala for treatment. She was told by the doctors, that she needed surgery that would cost her a minimum of 2.5 million Uganda Shillings (approximately 800 dollars). Unfortunately, Nabanja did not have that amount of money and decided to leave the hospital and went to her son`s home to be taken care of temporarily. Nabanja narrates that the pain increased, and her son contacted a traditional herbalist in that area who started treating Nabanja with herbs, rubbing them on her back, the broken leg and wherever she felt the pain. Although the treatment from the herbalist gave her some relief, Nabanja says she did not heal and could not walk. On realizing that she was not likely to get better soon, Nabanja asked her son to return her to her house in Sumbwe. In her home, Nabanja continued to use both the herbal medicine and painkillers bought from a nearby drug shop. By the time we met again in August 2017, Nabanja had stopped using the drugs from hospital because she felt her children were spending a lot of money and she did not realize much improvement in her health, but acknowledged that the pain had reduced to a great extent.

> I didn't see any reason why my children should spend that much! They have young children to take care of! Me I am aged now! I decided to come back to my house and die from here.

Desirous to walk again, Nabanja sent her granddaughter to ask a nearby carpenter to make for her a pair of walking sticks, but she was unfortunately unable to use the walking sticks. The sticks did not provide enough support that she needed. She then asked the carpenter to instead make under arm crutches. Sadly, Nabanja realized that she might not be able to use the crutches either, as she could hardly support herself to stand and walk with them. This is when she resorted to crawling as the best option. Ever since the accident, Nabanja never regained her full functioning and performance of everyday chores and she narrates:

> When I realized that I might not be able to do my work the way I used to, I called my granddaughter with her husband, and I asked the husband if he could allow my granddaughter to come and help me at home sometimes. Her husband agreed. Now my granddaughter comes here almost daily and helps me with house chores. She helps me particularly to wash clothes, clean the house and other chores. Most times I cook for myself if she can bring the food near here. The good thing, as soon as I built this house, I planted gasiya, (a type of tree) from which I get firewood to cook. After buying for me food, it would be too much asking my children to buy firewood as well. So, I had to find an alternative source (conversation with Nabanja, November 2016).

Ten months later, Nabanja was visited again by the research team and found her in a frailer state. She could not do any work by herself anymore. She could not even see clearly. In her own words, the only thing she did was to, *sit and eat*.

Looking at this story, Nabanja acquired her impairment from an accident of a falling banana plant during her everyday work. When the attempts to seek treatment turned out to be futile, coupled with her perception about her ageing body, the views of the significant others, the

impairment became a permanent state of her body, and ultimately qualifies her to a state of disability.

**Case two: Mutumba, Mariam and Namusoke; Manoeuvring the treatment seeking journey**

As a moral ethic, the research team made some efforts to support some of the participants to access health care during the study period. Overwhelmed by the appalling health situation, the pain, unpleasant odour in some of the houses, (as the majority of older people with disabilities could not take themselves to the latrine anymore), left the research team distraught and sometimes saddened. This aspect of the research process many at times proved challenging to continue the fieldwork. One of the study team members, an orthopaedic surgeon, offered to give treatment at no cost to some of the old people that we thought were in dire need of urgent health care. With gratitude, the research team reflected through our participants and approached three of them: Mutumba, Mariam (Mutumba's wife), and Namusoke, whom we thought most needed urgent health care.

Mutumba`s two lower limbs were both broken when a cyclist knocked him down. In our first interaction, Mutumba informed us that he was taken to hospital and the doctor recommended a surgery whose financial cost was unaffordable for them as a family. Mutumba's wife, Mariam disclosed how the doctors had also advised that he was too old for such a major surgery. Mariam had a stroke that paralyzed her right-hand side. Namusoke had suffered from a swollen leg that was quite painful and to what cause she had not established yet, but was suspicious that her neighbours were not happy with her progress as she had one of her children working in UK, so this could have caused this problem to her by bewitching her.

Thinking of how to bring them to the health facility was quite a challenge. All of them ideally needed a caretaker to come along with and could not easily use public transport, given the pain and their immobility. So, the research team had to organize private means of transport. Mutumba needed to be lifted in and out of the car. The physical distances between the two homes was also quite long. Namusoke lived completely in a different sub-county from Mutumba and his wife. Moreover, it was preferred to take the three of them at once, at least for the first visit, to the orthopedic surgeon.

Namusoke lived close to the road and was agreed, that Namusoke`s caretaker should bring her to the hospital. Mutumba and his wife were to be picked up by the research team from their home, this was done with support from their grandson and our research assistants who lifted him into the car.

To the research team surprise, Namusoke did not show up, although money for transportation was provided to her caretaker. When Namusoke's neighbor was called to find out what had happened, she explained that they failed to walk up to the taxi stage (about 300 meters from the home). On the other hand, Mutumba and his wife was so pleased to visit a doctor. Mariam was recommended for physiotherapy, which ideally is supposed to be a free service provided at this government referral hospital. However, such services could hardly be reached free of charge. The research team often had to part with some small amount of money every week

for her to get the physiotherapy treatment. After about two months, Mariam registered a tremendous improvement in her mobility. She was able to move slightly faster and a few times without a walking stick, which was an exciting moment for her and the research team.

After living with a lot of pain and on pain killers for a long time (when he got them), Mutumba too was so pleased to meet the Orthopedic Surgeon. Mutumba is generally a very happy man, and he was over delighted when he entered the doctor`s room. We were touched by his expressions; *Who am I to see a big doctor, a real doctor, one so kind to touch a person like me*. He asked the doctor to close his eyes for a prayer that he himself made. In his prayer, Mutumba thanked God for such a kind doctor who even remembered and cared for old people. Based on the results of the x-rays which Mutumba did that same day, the doctor recommended surgery for both Mutumba's limbs, one at a time. Although the doctor was willing to offer the surgery for free there were other medical supplies requirements that needed to be bought, which was agreed to be provided by the research team. When this news was communicated with Mutumba's daughter (who lives in a distant district), she was hesitant to the surgery. Her concern was that no one would be available to take care of him while in hospital (In Uganda, normally when one is hospitalized, they will need a caretaker to stay with them in hospital to attend to them). She explained that she lived far from them, had a big family to take care of at home and there would be no one to care for Mutumba if he was to receive surgery. Mutumba seemed disappointed but accepted her decision.

## Context and methods

This paper is part of a bigger study on disability and technology by a group of researchers who focused on the complex interaction of people experiencing disability and assistive technologies in Uganda and Switzerland. This component of the study was conducted in Wakiso District in the Central region of Uganda. The field work was done for a period of 10 months, in two phases; the first phase was in August 2016 to January 2017 and the second in August 2017 to December 2017.

Wakiso is a predominantly rural area. We worked with Village Health Teams as entry points, to identify old people who had mobility impairments in the villages in Wakiso district. VHTs are locally trained health volunteers in Uganda, that were introduced in Uganda's healthcare system by the Ministry of Health through the National Health Policy and Health Sector Strategic Plan in the year 2003 and are managed at the village level, to help increase the uptake of health services in communities (Nakigudde, 2011a). Since then, VHTs are being used to support several community-based health initiatives in the country and are thus familiar with residents in their areas. The paper may not give a comprehensive picture of the life of all older people in Uganda, neither does it portray a full picture of life with a disability in Uganda, but it describes the local situation lived by some older persons who have acquired impairments especially along their life journey or during old age.

There is an upward trend of older persons with disabilities in Uganda, in 2006, the Uganda National Household Survey estimated that, over 40% of people above 60 years have had at least some difficulty in functional areas such as hearing, seeing and other physical

disabilities(Uganda Bureau of Statistics (UBOS), 2006). In 2012, the Demographic and Health Survey estimated the number to have increased to 66.8% (Uganda Bureau of Statistics (UBOS), 2012). More people are living longer due to reduction in mortality rates, advancement in technology and health care (World Health Organization (WHO), 2015)

Wakiso district population was estimated to be over 2 million people during the 2012 population census, accounting for about 6% of the total national population (Uganda Bureau of Statistics (UBOS), 2013). Of the district population, 2.3% are older persons (60 years and above), while 53% of these have disabilities (Uganda Bureau of Statistics (UBOS), 2017). In terms of administrative structures, Wakiso has 17 sub counties, 153 parishes and 188 villages. The study was specifically conducted in 2 sub counties of Makindye Ssabagabo and Wakiso sub counties. While the biggest part of the district is semi-urban, with characteristics of urban, densely populated areas, suburbs, and with petty trading, it also has rural areas with small and scattered settlements that are predominantly agricultural with less or absence of developed infrastructure such as public means of transport and other social services.

In this paper, materials have been obtained from the qualitative part of the study, which involved 30 older people, comprising of 11 males and 19 females. We conducted at least two visits to each of the 30 respondents in their homes and some were visited more than 3 times within a period of 10 months. In-depth interviews, observations and informal conversations were held during these visits. All respondents were in the age range of 60 to 95 years and data was collected in their home settings. It is important to note that older people in Uganda predominantly age at home.

Ethical clearance was obtained from the Makerere University School of Medicine Institutional Review Board (IRB), and approval was secured from the Uganda National Council of Science and Technology (UNCST). Prior to interviews and observations, consent was obtained from participants. For purpose of protecting the identity of participants, pseudo names were assigned.

All interviews were audio recorded, and later transcribed and analyzed using the thematic content analysis (Graneheim & Lundman, 2004). Themes from each section are highlighted to form some of the arguments and then used to describe the meaning and significance of experiences in ageing and the use of assistive technologies.

## Discussion

### A step by step in the disablement process

*Deciding to seek treatment and manoeuvring the treatment seeking journey*

The accounts presented reveal the common difficulties older people find in accessing treatment. Manoeuvring the public transport system, getting attention when they visit health facilities, and meeting the financial needs that come with seeking treatment are almost impossible for many older persons especially in rural areas of Uganda.

Observations reveal that older people acquired the impairment either due to sickness or accidents. In many cases, episodes of sickness and accidents followed by seeking treatment over a series of steps over a given period. The treatment seeking process that many participants went through and continue to go through, is a nonlinear process, but one characterized by alternations in treatment options and making decisions time and time again. The decision by the older person to seek treatment often involves significant others such as children, grandchildren, neighbours and other community members. What Janzen refers to as therapy management group, a common practice in many African societies (Janzen, 1987). When and where to go and how long to stay on treatment or when to stop, are always the issues at stake, with multiple challenges including the difficulties of manoeuvring the infrastructure at the health centres, long queues and having to wait at the health centre as well as the uncertainty of one's ability to afford health care.

As shown in the case of treatment seeking for Mutumba, Miriam and Namusoke, treatment seeking decisions are made complex by general infrastructure challenges including poor roads and unreliable mode of transport. In rural areas of Uganda in particular, accessing health care is a challenge for everyone but is much more difficult for older persons. The Uganda National Household Survey of 2012/13 indicates an average distance to a government hospital in rural areas as being 7.6 km and 3.4 km for lower government health facilities (Uganda Bureau of Statistics (UBOS), 2014). Older people with impairments and mobility difficulties, and without private means of transport can hardly manoeuvre to find their way to these distant health facilities. Moreover, as in the case for Mutumba, most older persons either live alone or with a spouse who is most often also of old age and frail or have grandchildren that are often young. They often need support from an adult, for instance a son or daughter who would be living in another area or district, especially when requiring assistance in visiting a health facility. During this study alone, different people had to be mobilized for support, where the research team had to make use of a private vehicle to take Mutumba and his wife for medical treatment. It thus must be a responsibility of either their son or daughter to arrange and take their old parent to a health facility. Given the mobility problems faced by older persons, seeking care sometimes also entails hiring or borrowing a private car, making the process rather expensive.

It is not only challenging for older persons to reach the health care facilities, but it is also an intricate process to receive services. Most health facilities in Uganda are characterized by congestion and a long waiting process. Standing in long queues for hours completely disadvantages older persons. Moreover, at some facilities the infrastructure is inadequate, such as absence of ramps or rails, a matter which reportedly renders accessing the facility difficult for the older person (Ssengooba, 2010). On the other hand, inadequacy in staffing usually means that people literally must struggle to get enough attention from a health worker in public health centres. According to Africa Health, there was a very low doctor to patient ratio: for every 24,725 patients, there was 1 doctor, and for every 11,000 patients there was 1 nurse (AfricaHealth, 2017). Moreover, the World Health Organization recommends one physician per 1,000 people (World Health Organisation (WHO), n.d). With this situation, the quality of care, particularly in terms of time spent regarding health personnel-patient interaction is often poor. It is perhaps for this reason and his experience that Mutumba was

surprised when he received close and warm attention from the orthopaedic surgeon when we took him to the hospital.

Affordability of treatment is another issue at stake. Old age has been reported to be one of the leading causes of individual poverty in Uganda and chronic poverty among older persons in Uganda has been attributed to unemployment, and persistent ill health. 88% of Uganda's population live in rural areas (UBOS, 2014) with older persons and other vulnerable groups constituting a significant fraction of this figure (Wandera, Ddumba, Akinyemi, Adedini, & Odimegwu, 2017). This means that their access to services, including quality medical services even with the capacity to pay, is technically limited (Ssengoba, 2010). The health budgets do not specifically spell out health-related needs for older persons and there is no health insurance schemes for such vulnerable categories of people (ibid.). Mutumba, his wife and Namusoke could evidently not afford to pay for the costly healthcare services if private transport to the health center was a challenge itself. There were instances when the children of older persons could raise the required amount of money, but some older people themselves did not want their children to incur such a cost for the surgery. They instead opt out as was the case of Nabanja who opted out of the surgery plans that was to cost her 2.5 million Uganda shillings.

From our interaction with older persons in this study, several of them would get fatigued with having to look for money to pay for medicines at drug stores, while others, their children often living far would take very long to come to pay for the drug debts. When the debts accumulate it makes the older person uncomfortable and they tend to give up, and they instead opt to endure the pain and discomfort of their illness or disability. Other older people just get frustrated when symptoms do not seem to reduce despite taking lots of medicines for a long time. While for others it is the difficulties involved in their mobility for the regular refill when the medicines run-out. Mutumba`s grandchildren for example, would pick drugs from the drug seller near their home who was supplying the cream painkiller that Mutumba used. Later, his daughter who lives about 120km away would come after some months and pay for the medicine. However, when the debt accumulated, he stopped. Mutumba however, often requested the research team to buy pain killer cream for him, which he said gave him great relief whenever he had it. Considering all the above challenges, often, giving up was almost the easiest option for many of the older people.

After going through a series of treatment seeking options together with their related challenges, it was noticed that many older people often abandoned or stopped using any kind of treatment for their illness, sickness or impairment. Sometimes it is the older person and other times, like the case of Mutumba, it is the members of the treatment group who take the decision. For example, Mutumba did not undergo the recommended surgery because of the decision made by his daughter. From our observation, older people are often kept on painkillers or antibiotics or sometimes both. And to sustain these, those responsible for the treatment also opt for local sources of these medicines in the treatment circle. Drug sellers also try and make sure that they stock such drugs for clients. Most importantly, many a times they also provide on credit when the family has no money but need the drugs. Therefore, befriending this new partner in treatment was often important for these families.

Among our participants, abandoning was especially common for medicines and treatment from hospitals due to costs and distance. This is followed by medicine from drug shops due to financial costs and sometimes-traditional herbal medicines would be resorted to. Often older persons combined the use of both traditional and western medicine and would retain the former after abandoning western medicine.

*Perception of self and by others: Too old to treat?*

For many of the participants, if one had fallen and broken their limb(s), they were sometimes informed that they needed surgery, but were too old for the procedure, and would take a very long time to heal. 16 of the 30 participants had been informed that they had fractures and needed surgery. Only 2 of them had been operated whilst the other 14 could not, either because the financial cost that was too high, or they were advised that due to their age recovery would take a long course. The common medication given to this category was painkillers and antibiotics. Apart from being told by health workers that they were too old to be operated on, the story of Mutumba also reveals that this perception of being too old for a surgery was equally a result of a negotiation process that both the older person and their caretakers went through.

The *othering* of people with disabilities (Reid-Cunningham, 2009) seems to apply to older people too, specifically older people with disabilities, this is experienced especially when it comes to treatment decisions. In the case of older people in this study however, they do not seem to only be *othered* by other people, but by themselves as well. During this study, it was not uncommon for an older person to decide to quit treatment because they thought it was too expensive for their caretakers compared to what they considered to be their own value given their age! This kind of stigma and *othering* of the older person on themselves and by their significant others greatly influenced the treatment decisions and their life thereafter.

Another part of the negotiation process was the question of whether to treat the condition as either old age, sickness or disability. The answer to this question is seen to have informed or influenced the treatment decision. During the interaction with the participants, it became apparent that there was a negotiation on whether one perceived or should perceive their condition as old age or disability. Whereas the World Health Organisation argues that old age is the leading cause of disabilities(World Health Organization (WHO), 2011), participants seemed to have differing opinions. Some thought that disabilities made them seem older than they actually were, while others argued that the two were quite distinct. One of our respondents, Nsereko said: *Old age does not bring disabilities. However, by having this disability, you cannot do anything for yourself, you just sit, day after day, and year after year, so you become elderly* (Interview with Nsereko, September 2017).

Another participant Ms. Kiwanuka, narrated the following:

> My daughter now let me teach you this; old age is old age, and disability is disability. People who are like me in age, what they have is not a disability, but they are simply old.

> People who got accidents when they are young, or people who are born crippled or with a serious impairment are the disabled, and these two are different (Interview with Kiwanuka's wife, October 2017)

Self-perception as either disabled, old or sick greatly influenced the responses of the participants, on whether one continued treatment or tried to use mobility aids to support their movement or did nothing about their situation. Self-perception and the perceptions by significant others involved in the treatment seeking process greatly influenced the decisions to seek treatment and adhere to it or not. It further influenced the nature of treatment sought for and provided, for example, whether one went for and received surgery, or had to survive on painkillers or even completely give up treatment, all of which shaping the day to day realities and experiences of older persons. Certainly, other practicalities such as the availability of caretakers also mattered. Many older persons also expected their energy levels to reduce as they age, and therefore their ambitions to restore their mobility and become active again greatly diminished. This means that disability was kind of expected in the *ageing culture*! Cultural relativity of disability has had a profound influence on the treatment of people with disabilities over time (Reid-Cunningham, 2009), but it's now important to note how this cultural relativity also has a profound influence on how older persons themselves deal with their condition and outcomes.

*Consulting, asking and seeking for spiritual explanations*

From our observations, older persons do not simply resign and accept their conditions, but try to make sense of their situations, the new mobility and health status and bodily changes. Many of the participants sought explanations for their situation and resorted to spiritual issues like God's plan for their lives or witchcraft. Receiving explanations from the health workers on the condition or illness were not always enough. Many continued to seek explanations for their conditions from other sources including diviners. This does not mean that they were seeking for a cure to these conditions but simply seeking for an explanation of what and why it happened - what Susan Whyte refers to it as "*asking*", while writing about the Nyole in Eastern Uganda in their response to adversity when they doubted why (Whyte, 1997). While several of our participants at this stage of their disablement process doubted if they will ever get a cure, they kept trying to understand their condition.

Older people like Nabanja would consult traditional herbalists or healers from whom they often got explanations like a neighbor or someone in the family might have caused their condition, because they were jealousy of something in the older person's life. Common grounds for jealousy reported were for example, if the older person had a child or children abroad, then one of the family members or a neighbor would feel jealousy and had done something to harm and cause unceasing pain to the older person.

God's will. This was often resorted to by some of our participants when there seemed to be no cure coming forth. Therefore, the individual referred to it as God`s will upon their lives and that God destined that this would happen and he (God) knows what is to come next. Although some of participants looked at it as simply God`s will that they would be in such a

situation, others still held on to the hopes that God would one day do something to rectify the situation. While others simply said they waited upon God to do whatever he deemed best for them. Nsereko, one of the participants, saw nothing outside God. This is depicted in his perception and belief in father Ngobya, a Catholic priest who died. Nsereko believes that father Ngobya protected him every day. Jaaja Mulokole *(*her nick name given by members of her community, literally meaning old grandmother*)* 60 years, who could neither walk nor stand but instead crawls in her house, still holds on to the hope that one-day God will decide that she should walk again and she believes that once this day comes, she will surely walk. Cherishing that hope, she always endeavors to tell her neighbors and everyone about God and asks them to believe in God. Because she cannot walk to go and talk to the people, she writes a scripture on her door every morning to tell her neighbors and by-passers about her God. The lack of knowledge on what old age will or might bring, leaves a lot of unanswered questions and a quest for answers on the changing bodies as well as health status of older persons.

*Transiting from sickness, to old age and to disability*

The social model of disability looks at disability as an interaction between the individual having the impairment and their environment, not the impairment itself. The model tries to explain that beyond disease and impairment, there are other environmental factors that do influence and cause disability (Oliver, 2013). Although this is also evident from this study, findings further reveal that individuals negotiated the environment and made significant decisions that ultimately contributed to their disablement.

After the point of seeking for treatment, often discussions among them or their neighbors and friends turned from asking them about how they are "feeling with the illness" (*oli otya obulwadde?* as often asked in Luganda) to how they are "with the weakness-that results from illness" (*oli otya obugonvu?*). *Obulwadde* is illness, sickness or disease in Luganda (language spoken in central Uganda), and *obugonvu* can be described as the body weakness that results from sickness. In this state, an individual is not yet perfectly healthy, but recovering from the sickness. The term is commonly used for and by older people in reference to their ill health. It was common for instance to greet an older person and in response he or she would say "*gyetuli tuli bagonvu*" literary meaning, *we are there, and we are weak (bagonvu)* and this could continue until the point when no more treatment is sought and "disability" as a category is claimed and taken on by the individual.

It is important to note that the above process does not reflect a linear model through which disability is acquired by the older person as presented by the disablement model by the International Classification of Impairments, Disabilities and Handicaps ICIDH (World Health Organization (WHO), 1980). The disabling conditions do not take place in a sequential manner neither do the people`s responses to it. Older persons went on treating one symptom after another, from one treatment method to another, until a cure could not be found or perceived as difficult or impossible, and then at this point, individuals resorted to God`s will, which in their view could not be changed by a human being but only God.

Various studies carried out in African settings suggest that traditional medical treatment is common especially at the onset of the disability, and moreover disabilities are treated as illness (Shuttleworth & Kasnitz, 2006). Helander (1995) argued that there is lack of clarity on the bio-medical view where a disability is presented as a disease, but this is understandable as many of the disabling conditions start as disease. However, as seen earlier, even when treatment is sought, sometimes it not received or received but abandoned along the way.

The decision not to give the deserving treatment such as surgery to an older person was a complex one, and presented difficult ethical dilemmas, not only for the family, older person themselves but for health workers as well. Health workers often had to make difficult decisions on whether and how to treat the older person within a context of stiff competition for the inadequate medical resources as well as contemplating the health complications associated with the patients' age. Such decisions were almost a compromise unconsciously reached by the various parties involved in these scenarios, including: the state that has not provided sufficient access to health care for the older person; the health worker who is weighing the available resources on one hand and the likelihood of the healing process taking longer for the older patient on the other hand. Sometimes it is the relatives and children of the older person who could not afford to pay for health care or provide the physical care. As noted by Eeuwijk (2014) growing old and old age are significantly shaped by the provision or lack of care. In some countries in Africa such as Ghana, existing practices of adolescent fosterage, in which more extended and poverty-stricken relatives whose children would otherwise not continue their schooling, are called up to help provide care for older persons in exchange of school fees, or promise an apprenticeship after some years of service (Coe, 2018). Such arrangements although do exist in several homes of elderly people in Uganda, are still unreliable for several reasons primarily that many older people reside in rural areas where there are no schools nearby, and informal care providers might not stay long and these keep changing since the relationships are not based on any formal arrangements making it slippery.

The older person, considering all the above, weighs between what they consider a huge cost for their health care on one hand, and how many more years they anticipate living as well as the inconveniences of the healing process on the other. Studies in palliative care in various parts of Africa have revealed that often times the expectations, perception and attitudes of people towards death and dying do have multiple implications for care (Buhl, 2019). Behind every abandonment of treatment therefore, there was an aspect of frustration with the treatment seemingly not being effective, or treatment seeking being of inconvenience either due to cost, distance of absence of caretakers. Such treatment seeking process further complicates the experience and can propel the older person's disabling condition.

Because the perception of several older persons was that neighbours and other people's jealousy accounted for these accidents, falls, diseases and ultimately the impairments that they experienced, *consulting* and *asking* was a common phenomenon. As noted earlier, consulting and going to ask was not so much of seeking cure for the impairment or disability but rather helping them to understand the cause of the impairment. Scholars have written about the cultural understanding of disability in an African society, and highlight that African societies were more concerned with explaining what caused these disabilities (Shuttleworth & Kasnitz,

2006). Although a lot of efforts too are invested in seeking for a cure where possible, the desire to seek for a cause could subsequently justify such moves as consulting.

There came a point therefore when one 'accepted' their bodily situation, especially when one stopped the search for a cure and abandoned treatment. This is when the person started to think of their situation as either a disability, old age or both. Ultimately, if one stopped seeking for treatment, he or she would make several conscious and unconscious adjustments in his or her day-to-day life. This would enable him or her to accommodate the new identity and level of strength. When the impairment was significant and could not allow the older person to physically move from one place to another, often this would be accepted as disability. Whereas, when minor mobility impairments were sustained, often they would not be regarded as disability but simply old age. It was practically difficult to tell the difference or to precisely categorize the condition.

Some scholars have described disability in these similar situations. For instance, Helander (1995), noted that disability is what lies at the end of the line when all attempts to get back the normal body have failed. Some scholars have also shown the indistinctness that exists between the process of ageing and the acquisition of disability in later stages of the life course (Painter, 2010; Weeks, 2005). This is probably because older persons expect their bodies to function less and less as they age. In fact, a study of older adults' definitions of successful ageing in Bangladesh revealed that Bangladeshis see disease and disability as a normal part of ageing and do not emphasize freedom from disease or longevity as much as North Americans and the US-focused successful ageing discourses do (Amin, 2017).

Chaskes (2010) highlighted using his personal experience that one's identity as a person with a disability is always in a state of evolution and not a stable and fixed state. Additionally, some scholars have emphasized disability as an umbrella term that denotes different things in different places at different times and that is partially negotiated (Livingston, 2005)

Disability is also a fluid concept and is contextual. Currently, disability is seen as a constructed category and not a static state of the body. Social scientists generally believe that individuals are impaired if they experience, or are perceived by others to experience physiological or behavioural statuses or processes which are socially identified as problems, illnesses and other negatively valued differences (Shuttleworth & Kasnitz, 2006). Disability therefore exists when people experience discrimination on the basis of perceived functional limitations (Reid-Cunningham, 2009). This means, that in a society, culture, or place, certain impairments may not result into disabling conditions if they are not perceived as so. If this is the case, it probably explains why some of the older people in this study specifically did not perceive themselves as having a disability, while others would at some point mention that they have a disability and deny the same at another time. This is in agreement with Deegan's argument that ''Feeling normal or disabled,'' then, is a fluid condition, one that can change quickly and at any time (Jo Deegan, 2010). Many of the older people in this study expected their energy levels to reduce, they did not expect themselves to run up and down in household chores especially those that involve moving some distances such as fetching water, firewood, or even running

errands at home by themselves. This perception greatly influenced their morale to seek health care, once they did not have any more pain, there was a tendency to accept the status quo.

Further still, disability is seen as a limitation inability to perform parts or the whole of a desired social role, such as working, being a parent, attending church among others (Altman & Barnartt, 2001). In this view of disability, then the category of "disabled" is socially, rather than medically constructed, in part by the demands and limitations of the social and physical environments in which an individual lives, and in part by cultural values, expectations and definitions. Kohrman (1995) in the book Disability & Culture argues that many persons with disability do not accept the liminal identity ascribed to them by society and may create their own 'culture of disability' to support and inform their experiences. Older people often argued on whether or what they have should be a disability or simply old age. They therefore created their own culture of old age that is independent of disability! The debate about the definition of a 'disabled culture' or 'culture of people with disabilities' continues to rage, among researchers. Some researchers assert that the community of people with disabilities may be considered a culture or subculture, or that certain groups of disabled people may have their own culture (such as Deaf Culture) (Reid-Cunningham, 2009).

There was no standard definition of what it means to be an older person among the people that took part in this study. There was equally no standard definition of disability. Both these terms were used depending on what the person felt and experienced from one time to another. In Uganda, an older person is defined as anyone above the age of 60 (Government of Uganda (GOU), 1995). This definition, however, did not seem to be part of the lives of the people who took part in this study, partly because they probably were not in the formal sector where they need to retire from work. The markers of old age among our respondents were things like reduced strength, stopping to have sex, having grandchildren among others.

The International Classification of Functioning, Disability and Health (ICF) further defines disability as a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives (World Health Organization (WHO), 2007). Based on the ICF definition of disability, 19% of the Ugandan population is estimated to have some form of disability (Uganda Bureau of Statistics (UBOS), 2016; World Health Organization (WHO), 2011) and globally, the prevalence of disability is likely to increase due to ageing populations and an increase in chronic health conditions (World Health Organization (WHO), 2015). Uganda has a somewhat vibrant disability movement, as well as a promising disability legal and policy framework. Furthermore, the country has been praised to be a champion in sub-Saharan Africa for advocating for the rights of persons with disabilities (Abimanyi-Ochom & Mannan, 2014). Despite such positive stance, older persons are often not included in disability initiatives in the country and rarely targeted by NGOs and other actors.

## Conclusion

This paper brought to light the challenges that older persons must go through when accessing health care. These include: maneuvering the public transport system; the infrastructure at the health centers; the congestion; having to wait in long queues; and having to pay for treatment at the health center. Both the impairment and the physical environment do contribute to disability among older persons. The social environment too plays a significant role and most especially the treatment decisions that are made either by the older person themselves or their caretakers. This is further shaped by their perception of who an older person should be, and their expectations on the functionality of their age. Individual decisions play an important role in this process and are not only acted upon by the impairment and the environment.

Self-perception as either disabled, old or sick greatly influenced the responses of participants on whether one continued treatment or tried to use mobility aids to support their movement or did nothing about their situation. Although self-perception and the perceptions by significant others involved in the treatment of the older person, (including health workers, children care takers and relatives), might not have had anything to do with the reality of the bodily state, it greatly influenced the decisions of the older person and those around them, whether to seek treatment and adhere to it or not. It was observed that, disease would translate into disability, not only when there was a gap created between an individual having the impairment and their environment, but rather when treatment seeking options could not avail much and when the condition is perceived as incurable by either the individual or the significant others and finally a decision is reached to quit treatment.

It could be concluded that older person's perception and response during the process of seeking for treatment has a significant influence on their disability experiences. It is therefore important to understand the events that characterize the transition from health to disability among older persons if effective measures are to be sought.

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# Stakeholder Group on Ageing (SGA): Africa survey on the impact of COVID-19 containment and mitigation strategies on the rights of older persons in Africa

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***Abstract***. COVID–19 was declared a global pandemic on March 11, 2020 by the World Health Organization (WHO). Africa recorded her first case in Egypt on February 14, 2020, since then, a total of fifty-four (54) African countries have been severely and progressively affected, with older persons bearing the higher rates in mortality across all 18 countries surveyed. In response to the COVID-19 global health emergency, African governments adopted extraordinary measures to contain and mitigate the pandemic, in order to save lives. This Report is a synopsis of the findings of Stakeholder Group on Ageing Africa (SGA Africa) survey of the impact of COVID-19 containment and mitigation strategies on the rights of older persons in Africa. In addition to the findings from the 18 African countries, the unique context of two countries; Cameroon and South Africa are detailed in the Report. Among various critical objectives, the survey also sought to identify and assess community level support and volunteerism and to ascertain, if these mechanisms provided the needed support to older persons. Results show that although, these strategies are put in place to prevent the spread of Coronavirus, they have implications (both positive and negative) for the rights of older persons in Africa. The absence as reported in most countries, of government social protection infrastructure for older persons, leads to income challenges especially, with the exclusion of most of the older persons as recipients of palliatives. In most countries, older persons were not consulted during containment preparatory stages and, their concerns were not considered. Other noticeable effects included increased incidences of elder abuse.

***Keywords:*** Africa**,** older persons, COVID-19, human rights, Stakeholder Group on Ageing.

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## Background

Older persons are the fastest growing demographics in Africa. The population of older persons estimated at 4.9% of the total population in 2015 is projected to reach 7.6% by 2050, which is more than triple in absolute numbers from 69 million in 2017 to 226 million in 2050 and may account for 10.9% of people over age 60 years old globally (UNDESA, 2019; UNFPA, 2019; Goodkind & Kowal, 2016). Regional variation in the rate of population ageing shows that age 60+ is projected to increase. For instance, ECOWAS region which was 4.8% in 2005 is projected to be 5.4% in 2025 and 8.8% in 2050 (UNDESA, 2019; Kamiya, 2016). With varied intrinsic capacities, older persons continue to contribute to families, communities and the larger society in economic, social, political and cultural spheres. However, more and more numbers of older persons in sub-Saharan Africa are entering retirement age when they continue to make significant contributions to economic and social support systems. At the same time, due to increased likelihood of illnesses in old age, some older people require long-term care and other support services such as rehabilitation, protection against neglect, abuse and violence, but these services are seldom in place (United Nations, 2017; Kihumba, n.d.). The projected rapid population of older persons despite the relatively young population in Africa is posing simultaneous and significant policy challenges. These include sustaining strong economic growth and establishing effective intergenerational investments in education, job creation and health for younger generation towards reaping the demographic dividends while also establishing support and health care for older persons (UNFPA, 2020; UNDESA Population Division, 2019).

Experiences of older persons and the particular context of old age are still not sufficiently addressed from a human rights perspective (Global Alliance, 2020). The United Nations Human Rights Office of the High Commissioner reports that when it comes to older persons, the current legal frameworks at both the national and international levels remain grossly inadequate and inconsistent, with only a limited number of countries providing explicit guarantees of equality and non-discrimination based on age (Adebowale, Atte & Ayeni, 2012; HelpAge International, 2015).

In Africa, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons was adopted in 2016. The Articles built on the 2002 African Union Policy Framework and Plan of Action on Ageing as well as the United Nations Principles on Older Persons, which address independence, participation, care and self-fulfillment. While some progress has been recorded by a few member states across the region including in ageing policy formulation and social protection initiatives, ageing and issues of older persons have not received much political support and guaranteed investment. Older persons are disproportionately voiceless, marginalized and vulnerable (Doron, Spanier & Lazer, 2016; HelpAge International, 2015)

Legal foundations for policy and programmatic actions in ageing are critical to reinforcing governments' commitment to age specific social innovations including devising policies, data disaggregation, innovative partnerships and new forms of business actions which are needed

to support the inclusion of older persons in SDGs and AU Agenda 2063 (Packer & Rukare, 2002).

The Stakeholder Group on Ageing (SGA) Africa is an African regional coalition of Civil Society Organizations, Non-Governmental and Professional organizations in ageing, Human Right Institutes and Institutes on Ageing, working on multi-levels as members of the UN ECA African Regional Mechanism for Major Groups and Other Stakeholders Group to achieve SDGs Agenda 2030 and AU Agenda 2063. SGA Africa has strong commitment to addressing ageism, and pervasive practice of leaving older people behind by ensuring the recognition and the integration of the life course approach, ageing and older persons' rights in the achievement of sustainable development.

The surge in COVID-19 cases is straining the health systems and the rights of older persons, with older women and children bearing the burden of this additional health care needs in the families. As part of SGA, Africa's contributions to the development and enhancement of older persons' human rights and overall wellbeing in Africa during COVID-19 pandemic, it embarked on a survey on the impact of COVID-19 containment and mitigation strategies and the State and Local responses to the global health pandemic. SGA Africa also interrogated the impact of the burden of illness and death on the economic, social and mental health of older persons, their families and communities.

This survey is to signal to policy makers across the continent the vulnerability of older persons in this crisis and to identify ways in which attention to human rights of older persons can enhance the recovery efforts towards achieving equitable and inclusive development. In keeping with SGA Africa's core values, evidence from the study will be utilized in the promotion of human rights, inclusion, and innovative engagement of stakeholders and the participation of older persons in policy responses to contain and mitigate COVID-19 to improve the quality of life and general wellbeing of older persons in Africa.

**Global population projections by region between 2017 and 2050**

Global population of older persons aged 60+ is projected to grow by 40% from 1 billion to 1.4 billion between 2019 and 2030, globally outnumbering youth (UNDESA, 2019). In Africa, the number of older persons is expected to increase from 71 million in 2019 to 216 million in 2050 (an increase of 202 per cent). The fastest increase is projected for sub-Saharan Africa, where the population aged 60 or over could grow from 50 million in 2019 to 157 million in 2050 (212 per cent). The increase in the number of older persons in Northern Africa, is expected to rise from 21 million in 2019 to 58 million in 2050 (an increase of 180 per cent). Although the number of persons aged 60 or over in sub-Saharan Africa will triple over the next 30 years, it will remain relatively small as a share of the total population; sub-Saharan Africa is still relatively young, with close to half of its population under age 20 (ibid.). Rapid declines in fertility and mortality rates along with substantial improvements in health care systems have resulted in the growth of older populations around the world. Ageing is therefore becoming a feature of human populations worldwide because of the general improvement in sanitation and the elimination of life-threatening diseases (Adebowale, Atte & Ayeni, 2012; Ajiboye, 2016).

In the last few decades, the attention of both national and international Communities has been drawn to this relatively recent but increasingly important demographic phenomenon. Thus, the World Assembly on Ageing in Vienna, in 1982, made recommendations on the various needs of older persons such as their health care, environment and consumer protection among other issues (Sanderson & Scherbov, 2007; De Jong, Blommesteijn, & de Valk, 2003). Also, the United Nations General Assembly, 1991; the 1994 Cairo International Conference on Population and Development; and the Second World Assembly on Ageing Madrid Declaration, 2002 further affirm the importance of the integration of older persons in development and their advancement into old age in healthy and supportive enabling environments as fundamental pillars of development. The Universal Declaration of Human Rights (UNDHR) (United Nations, 1948); the International Covenant on Civil and Political Rights (ICCRP) (United Nations Human Rights Office of the High Commissioner (OHCHR), 2020a); the International Convention on Economic, Social and Cultural Rights (ICESCR) (United Nations Human Rights Office of the High Commissioner (OHCHR), 2020b); existing Human Rights Treaties; and national constitutions, affirm the rights to self- determination, enjoyment of freedom, and happiness on the basis of social justice, equality of status and opportunity. However, there is no universal legally binding instrument with clarity and specificity to older persons' rights as we have for children, women and persons with disabilities (Global Alliance, 2020; HelpAge International, 2015). In the recent past, there had been re-echoed concerns for older persons worldwide, and suggested measures for improving their human rights and overall socio-economic well-being within the framework of Sustainable Development Goals Agenda 2030 and AU Agenda 2063 (UNFPA, 2020; United Nations (UN), 2017; Ajiboye, 2012).

In spite of the rapid growth, most African countries still consider the rights of older persons as low priority. Hence, the growth in population ageing has not been accompanied with corresponding social security packages which is responsible for the various forms of abuses of older persons in general and more so during COVID-19 pandemic, with its attendant effects on the human rights of older persons in Africa (UN, 2020; Kihumba, 2020). Evidence has shown that millions of older persons in Africa still suffer human rights violations each year, such as age discrimination of individuals, socio-political exclusions, physical, financial, emotional, and sexual abuse (Omokaro, 2019). Others include abuses in care homes/facilities, neglect in humanitarian settings during emergencies and denial and rationing of health care as currently being experienced since the outbreak of COVID-19 Pandemic (ibid.).

**Figure 1: Actual global older persons' population growth by regions 2019**

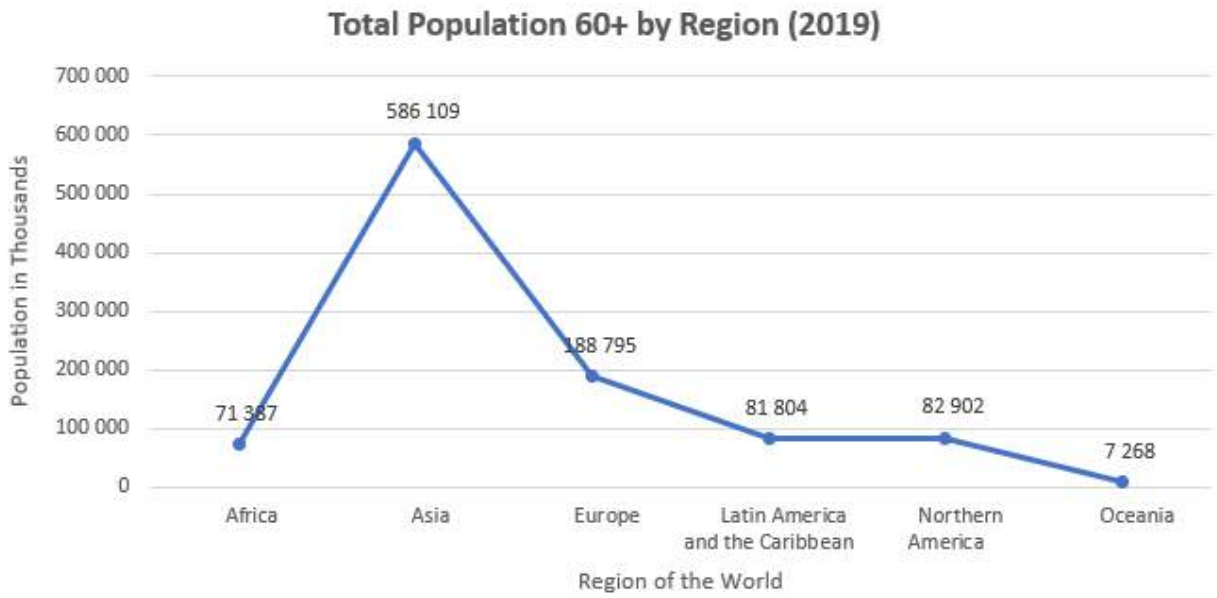



**Figure 2: Global projection of older persons' population growth by regions in 2050**

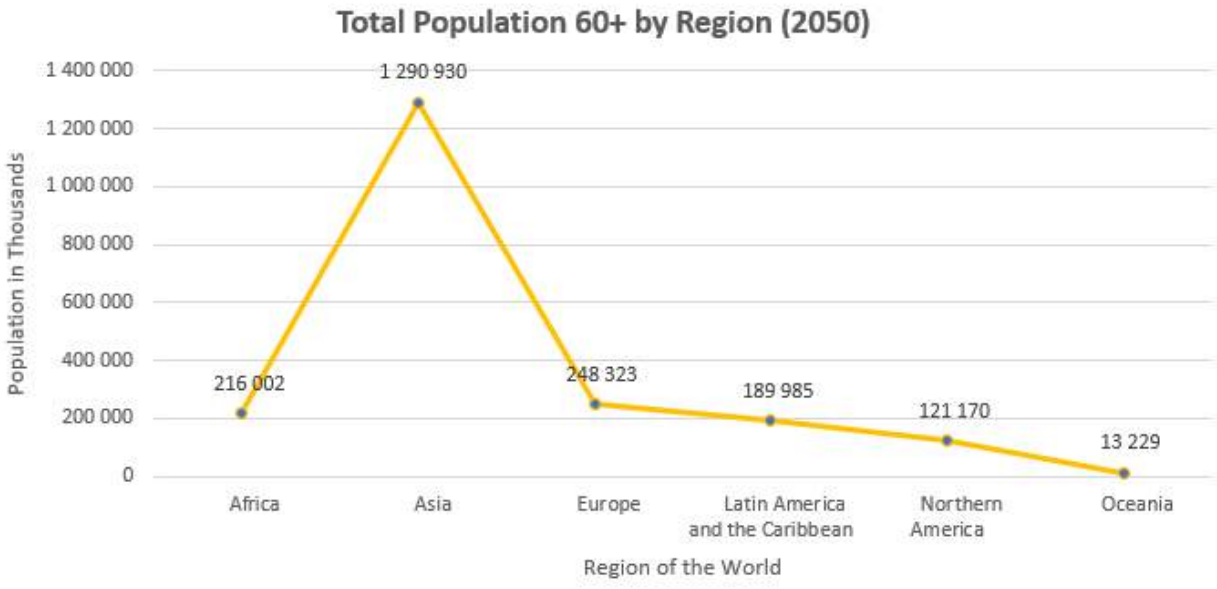
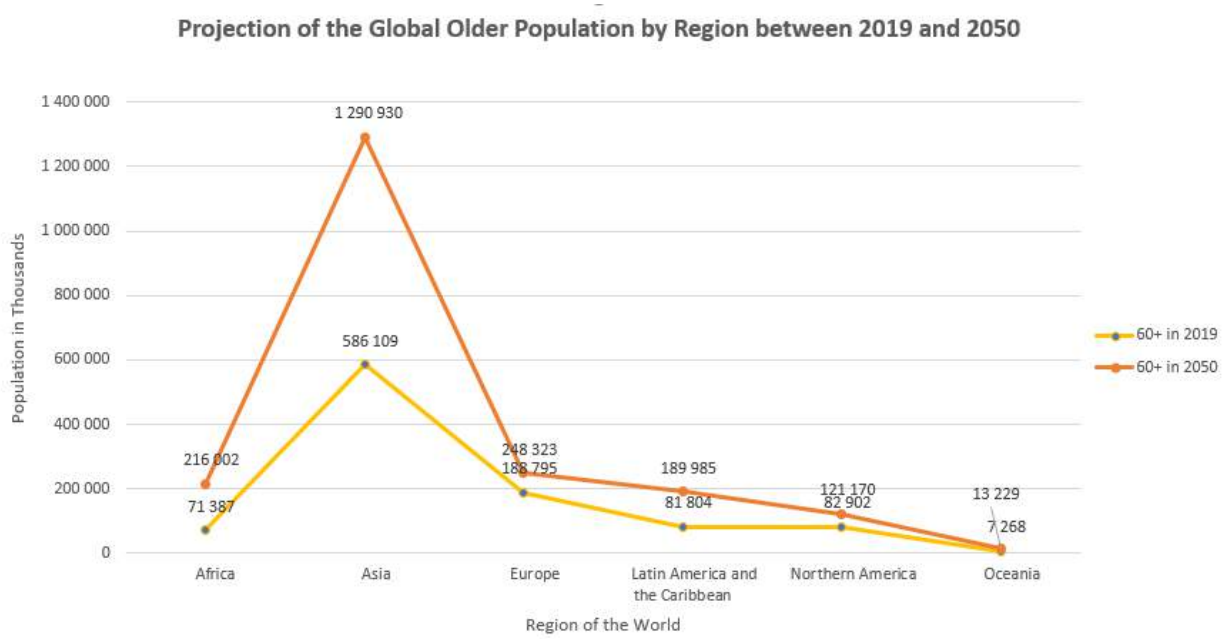


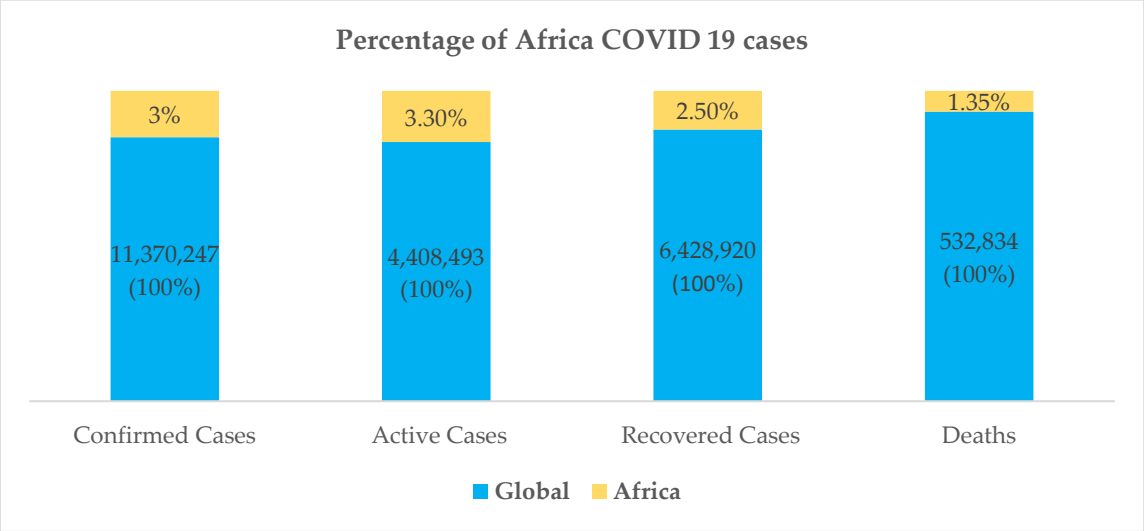
**Figure 3: Projection of the global older population by region between 2019 and 2050**




## Confirmed cases of COVID-19 in Africa as at July 5, 2020

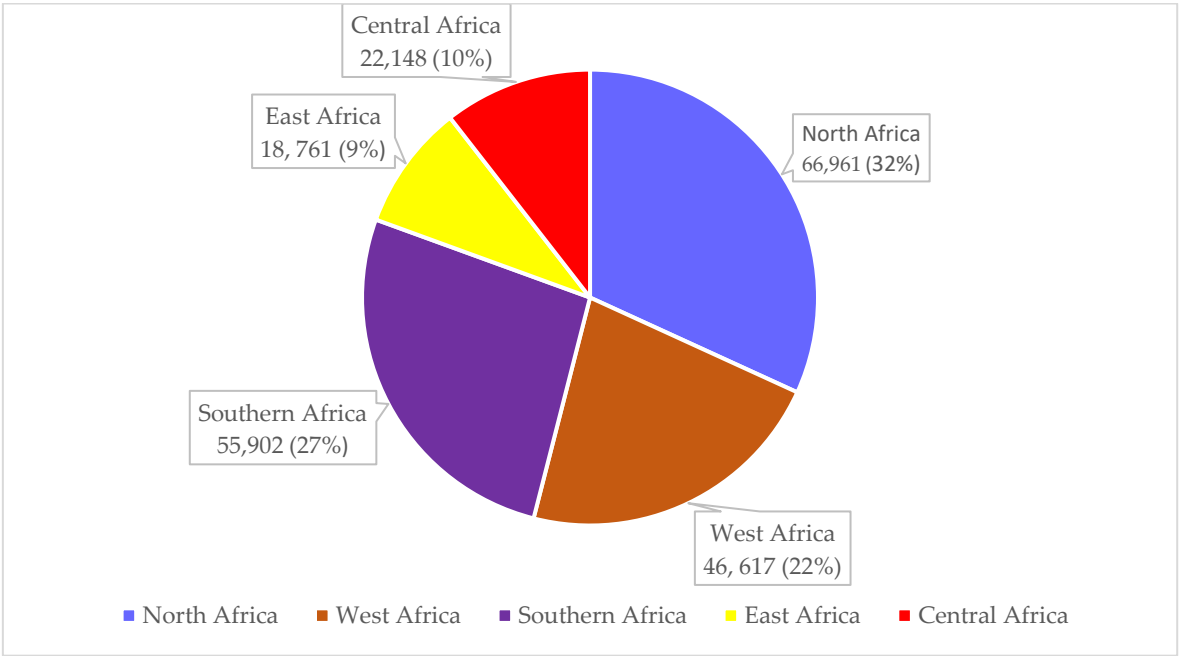
The whole world is passing through a trying period in her history with the current COVID-19 pandemic which has infected about 11, 370, 247 people globally with about 4,408,493 active cases, 532,834 deaths and 6,428,920 recoveries across 218 countries of the world (WHO Regional Office for Africa, 2020). The African continent has a total confirmed case of 448,512 with about 221,414 active cases, 216,195 recoveries and 10,903 confirmed deaths as at 5th July, 2020, and these figures have continued to increase (spike) on a daily basis (WHO Regional office for Africa, 2020). When the African figures are further disaggregated by countries the results are as presented in Figure 4 below.

**Figure 4: Percentage of the African COVID-19 cases to the global cases**




Effort was made to compare the rate of infections in Africa with the global figures of the pandemic. Figure 4 reveals that Africa recorded 3% of the global total infection, 3.30% of the current active cases, while the recoveries rate was 2.50% and death cases stood at 1.35% of the total global records as at 11 June.

**Figure 5: African countries by region as affected by COVID-19**



**Survey objectives**

To achieve the goals of the survey, the study sought to:

- Identify pre-existing public health emergencies and assess their influence on response to COVID-19 in Africa.
- Identify government containment and mitigation measures.
- Assess the impact of the response to COVID-19 on older persons.
- Find out if there was consideration for older person-specific concerns.
- Identify older person-specific areas and issues that were not addressed.
- Assess how the gaps affected older persons and breached their rights.
- Identify progress made in the implementation of COVID 19 mitigation strategies.
- Identify disruptions in cultural values and its effect on older persons.
- Assess community level support and volunteerism and ascertain if they provided support to older persons.

## Method

This is a longitudinal survey design. Data were collected using survey monkey tool. Both Primary and Secondary data were utilized. Data collected were analyzed using descriptive tools such as frequency distributions, percentages, and charts which allow for comparative analysis. Ethics of social research was duly observed, with due consideration for anonymity and confidentiality of the respondents.

**List of participating countries**

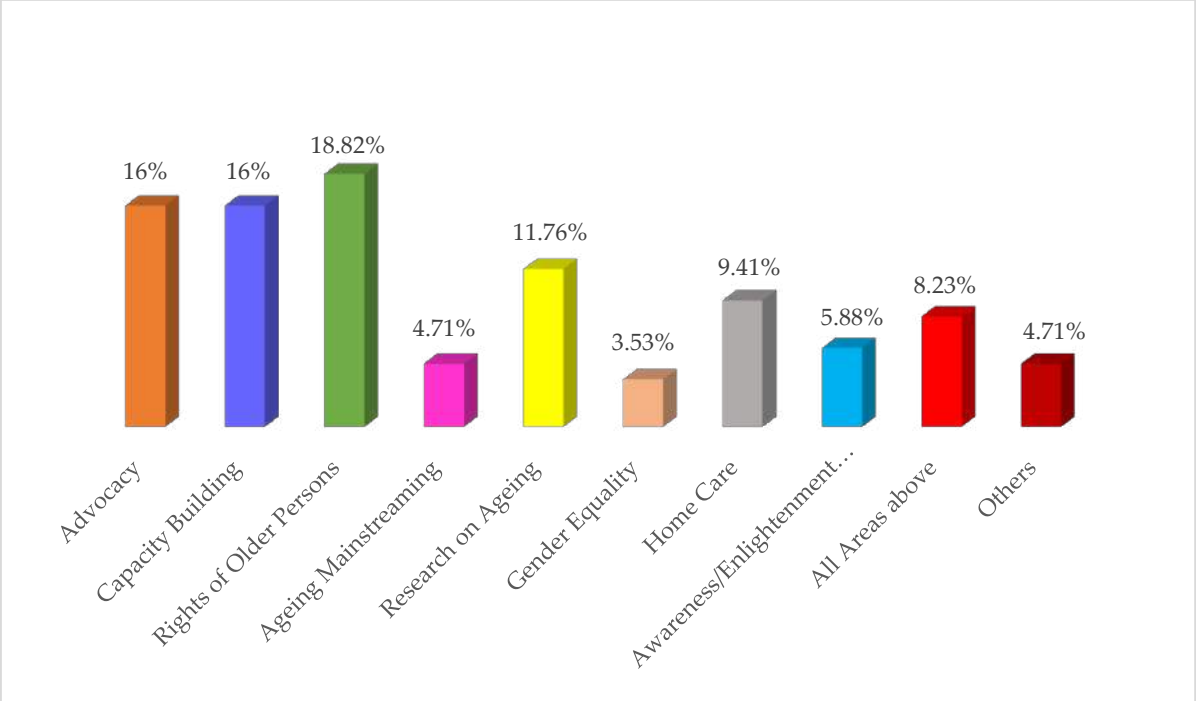
| | | |
|---|---|---|
| 1. Burundi | 2. Cameroon | 3. Democratic Republic of Congo |
| 4. Ghana | 4. Kenya | 6. Liberia |
| 7. Malawi | 8. Madagascar | 9. Mauritius |
| 10. Nigeria | 11. Rwanda | 12. Somalia |
| 13. South Africa | 14. Tanzania | 15. Togo |
| 16. Uganda | 17.Zambia | 18. Zimbabwe |

**Participants' areas of work with older persons**

Participants in the SGA, Africa survey were engaged in a wide range of body of work with the majority focusing on advocacy, capacity building, human rights of older persons, ageing mainstreaming, research collaborations and gender equity. Other areas include home care, awareness creation and enlightenment campaign. Eighteen (18) countries participated in the survey as listed above with a total of 43 respondents. When the participating countries were further disaggregated into regions, the study reveals the following figures - East African countries, 33%; Southern Africa, 28%; Western Africa, 22%; Central Africa, 11%; and Northern

Africa, 6%. The chart below is the frequency distributions of the areas of work with older persons as revealed by the survey respondents.

**Figure 6: Frequency distributions of areas of work with older persons by respondents**

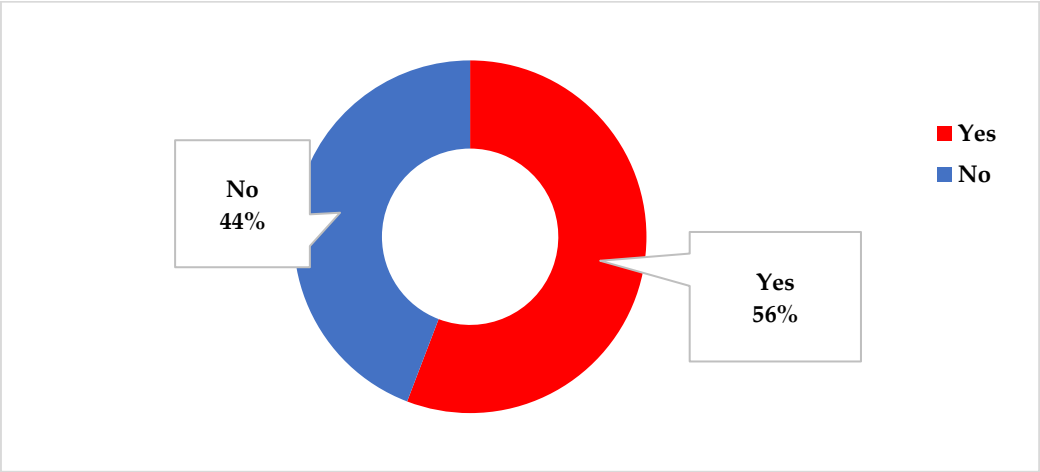



## Data overview and findings

### Contending public health emergency issues

One of the objectives of the survey was to identify pre-existing public health emergencies in various African countries before COVID-19 and assess their influence on response to the new pandemic in Africa. The findings from the survey reveal that 56% of the participating countries confirmed there were some contending public health emergency issues in their countries before the outbreak of COVID-19 Pandemic, while the remaining 44% said there was no contending public health emergency prior to COVID-19 Pandemic. This is represented in Figure 7.

**Figure 7: Older person's pre-existing public health emergency issues before COVID-19**




On further interrogation of the pre-existing contending public health emergency issues before the outbreak of COVID-19, the following were mentioned: Lassa fever; Malaria; HIV/AIDS; Tuberculosis; and Ebola. These pre-existing public health challenges have been described as underlining health problems which may affect and even worsen the health conditions of COVID-19 infected persons, particularly older individuals in those African countries.

### Specific containment and mitigation strategies

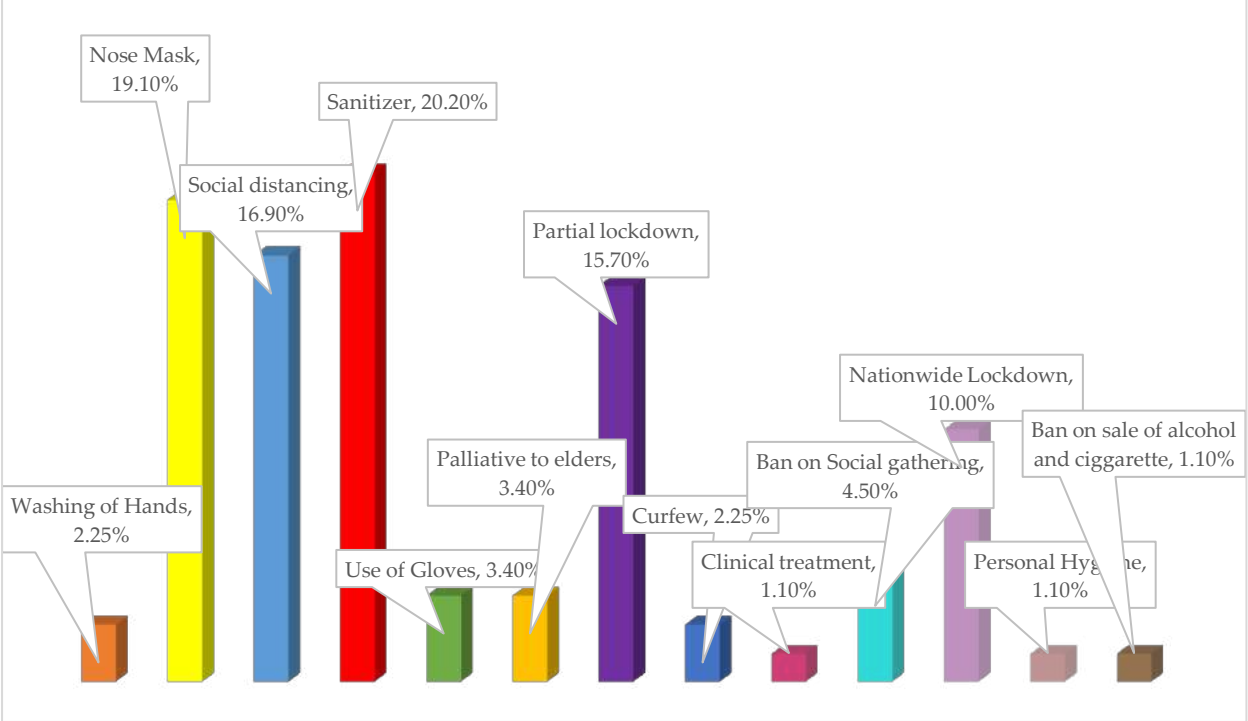
COVID-19 has been described as a highly transmittable and pathogenic viral infection caused by Severe Acute Respiratory Syndrome (SARS) (WHO, March 21, 2020a). The World Health Organization (WHO) earlier in the year 2020 declared Corona Virus a Pandemic without any clinically approved antiviral drugs or vaccine. Since then, rapid human to human transmission has been widely confirmed. In order to prevent the spread of the virus, the WHO recommended certain measures to prevent infection which include frequent hand washing, maintaining physical distancing from others (especially from those with symptoms), quarantine (especially for those with symptoms), covering coughs, and keeping unwashed hands away from the face. In addition, the use of a face covering (face mask) is recommended for those who suspect they have the virus and their caregivers (ibid.).

In its efforts to find out the level of compliance by the various African governments, and their recommended strategies to contain and mitigate against the spread of the Pandemic, SGA Africa dedicated one of the survey objectives to identifying participating countries' specific containment and mitigation processes and directives which were implemented to prevent the spread of the virus.

Among all the participating countries mentioned, various containment and mitigation directives were implemented which include: regular hand washing; use of alcohol-based Sanitizer; use of face mask; maintaining social distancing; clinical treatment; ban on social gathering; partial or total nationwide lockdown and the use of hands gloves, among others.

Responses from various participating countries indicated that there was high level of compliance with the WHO recommendations to contain and mitigate the spread of the Pandemic.

**Figure 8: Various containment and mitigation strategies mentioned by respondents**

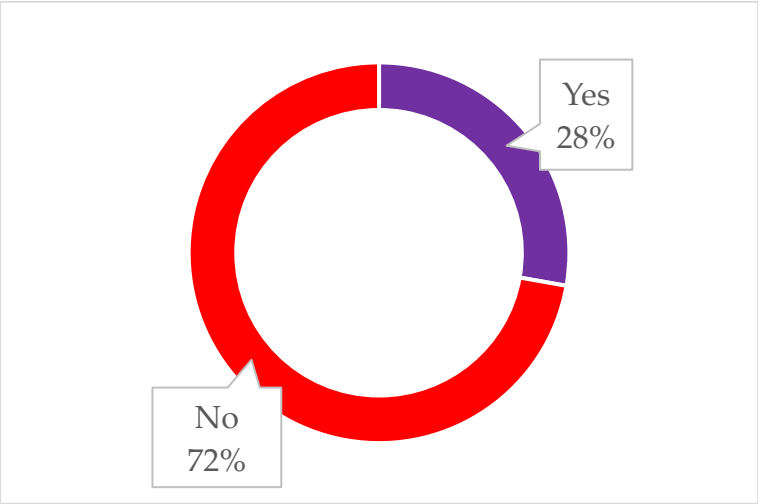



## Older person-specific protocols to manage COVID-19

In spite of several containment and mitigation strategies implemented by the various African governments, it is interesting to note that very few countries claimed to have older person-specific protocols to manage COVID-19 cases of older persons, with 28% of the total respondents indicating this option. Majority of respondents, 72% claimed that their countries did not have older person-specific protocols for managing COVID-19 cases of older persons in hospitals and care homes. Countries with older person-specific protocols to manage COVID-19 cases among older persons implemented the following programmes:

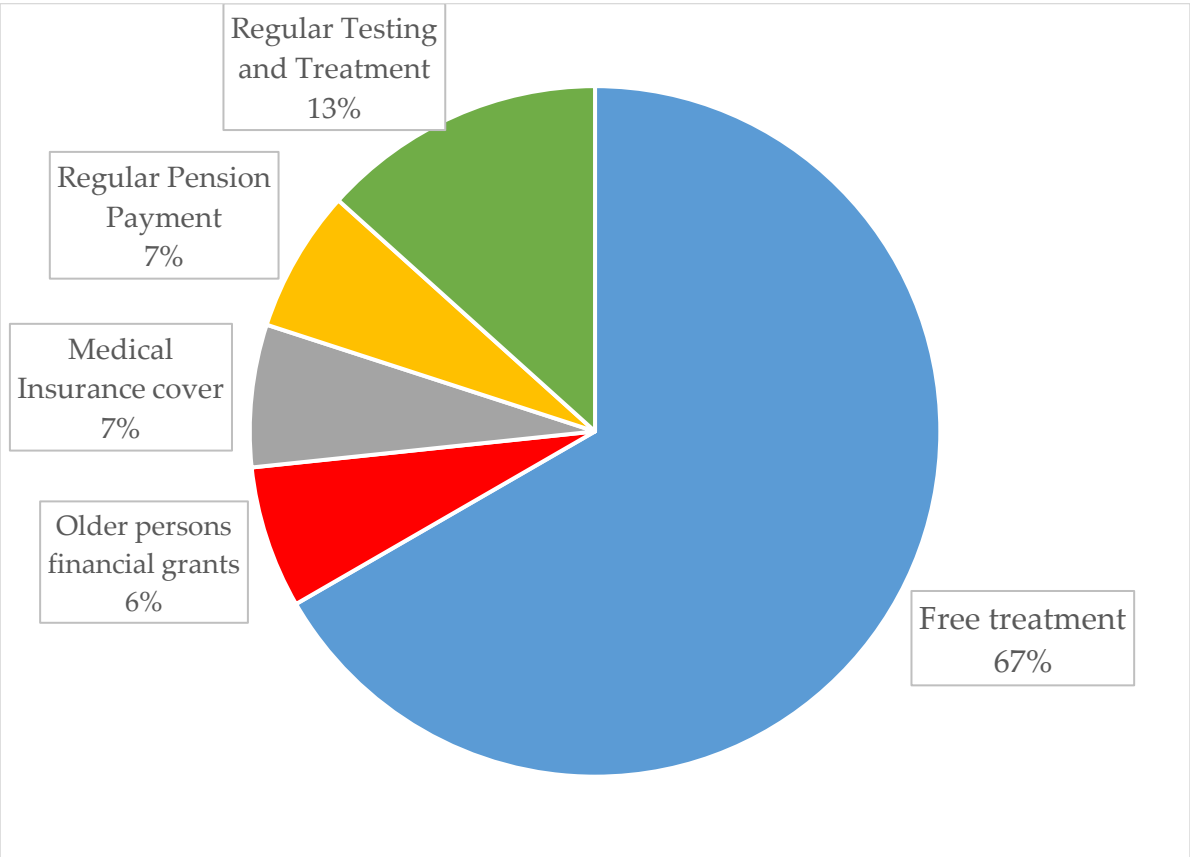
i. Nigeria – free testing and treatment;
ii. Kenya – financial grants to older persons, regular payments of pension, older person's medical insurance cover;
iii. South Africa – regular testing and treatments, provisions of home cares, subsidized facilities and services (public and private), distributions of palliative to older persons, social protections intervention, and directive on residential facilities for older persons.

**Figure 9: Older person-specific protocols to manage COVID-19**




When further asked to specify the types of older person-specific protocols available for managing COVID-19 cases of older persons in those countries, Figure 10 shows the specific protocols in these respective countries.

**Figure 10: Types of older person-specific protocols to manage COVID-19**

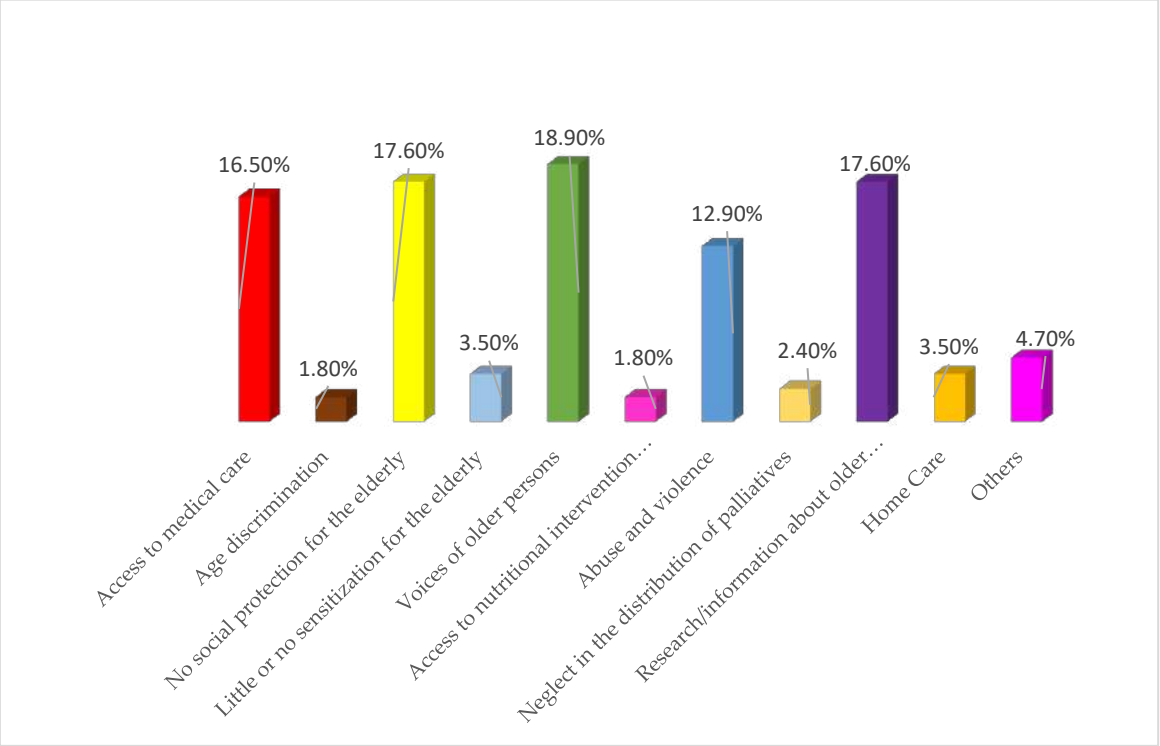


**Older person-specific issues not covered by containment and mitigation strategies**

In May, 2020, the WHO released survey reports, which charts the impact of COVID-19 on prevention and treatment services for non-communicable diseases (NCDs), since the Pandemic began (WHO, 2020). The findings of the survey indicated that more than half (53%) of the countries surveyed had partially or completely disrupted services for hypertension treatment; 49% for treatment of diabetes and diabetes-related complications; 42% for cancer treatment, and 31% for cardiovascular emergencies. The findings further revealed that, rehabilitation services had been disrupted in almost two-thirds (63%) of countries, even though rehabilitation is key to a healthy recovery following severe illness from COVID-19. The findings of the study also revealed that in majority (94%) of countries covered, ministry of health staff working in the area of NCDs were partially or fully reassigned to support COVID-19. Among the countries reporting service disruptions globally, 58% of countries used telemedicine (advice by telephone or online means) to replace in-person consultations; while in low-income countries, this figure was 42%.

As parts of its contributions, effort was made by SGA Africa to find out if the containment and mitigation strategies put in place by the various African governments fully addressed older person-specific issues. When the question was asked, responses from the various participating countries showed clearly that, there were certain older person-specific issues that the strategies did not fully cover. Some of the issues mentioned include: access to medical care; abuse and violence; lack of social protection for older persons; lack of research/information about older persons; voices of older persons not being heard; lack of access to nutritional intervention services; age discrimination; neglect in the distribution of palliatives, and inadequate sensitization for older persons.

**Figure 11: Older person-specific issues not covered by containment and mitigation strategies**



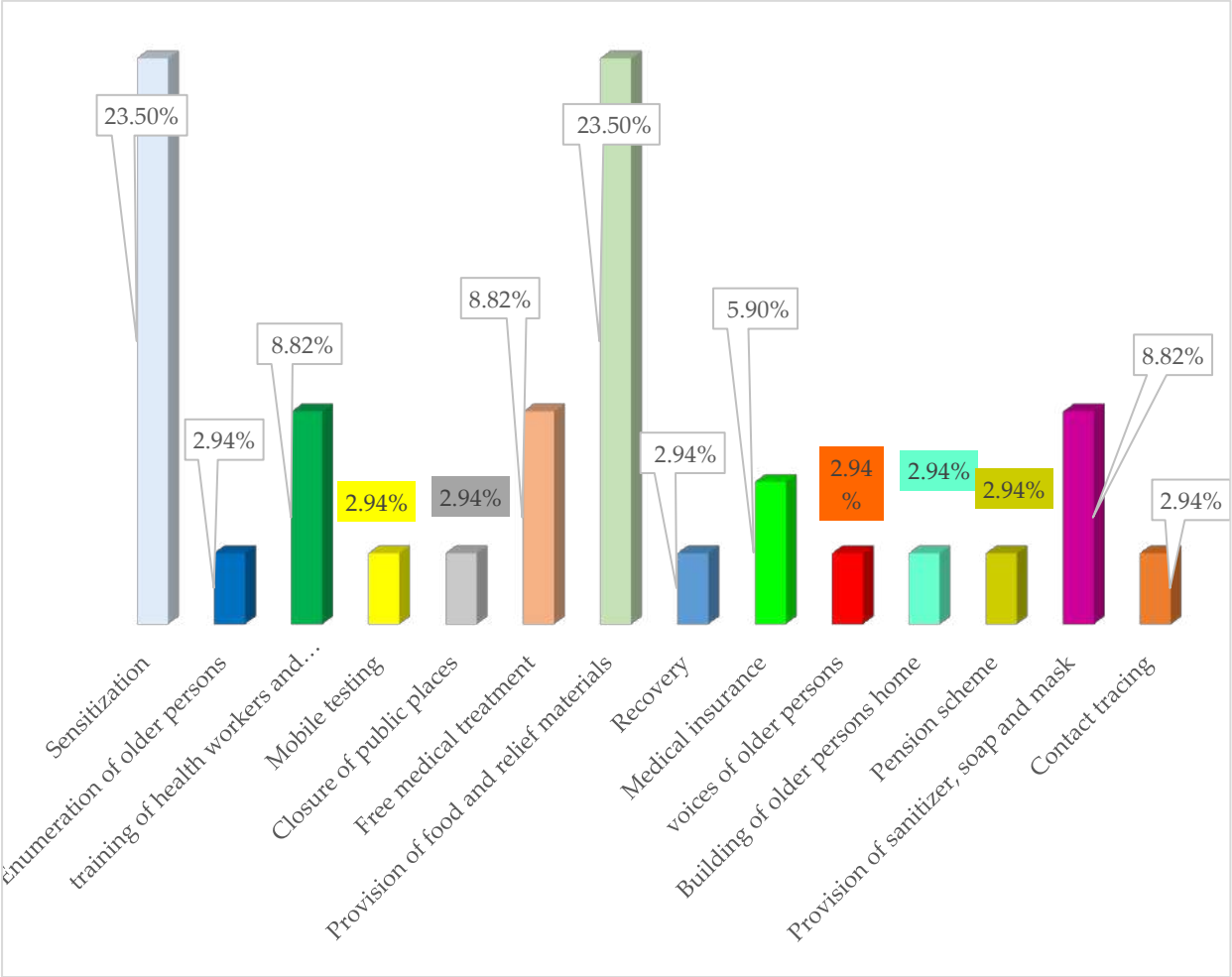

**Progress in the implementation of COVID-19 containment and mitigation services to older persons**

On the progress made by the participating countries in the implementation of COVID-19 containment and mitigation services to older persons, interesting responses were received. Some African countries including Togo, DR Congo, Mauritius and Madagascar indicated that their countries had not made much progress in terms of older person-specific programmes. Expectedly, the majority of African countries made tremendous progress in the implementation of containment and mitigation services for older persons. Of significant mention are cases from few African countries which made outstanding progress in older person-specific containment and mitigation services. For instance, the Nigerian governments at various levels implemented many intervention strategies to contain and mitigate against the impacts of COVID-19 on older persons in the country. These include: the enumeration of older persons in Kaduna state; monumental sensitizations by Faith-based organizations; sensitizations by family members; decentralized sensitization; training of health workers; distribution of food items; mobile testing; distribution of money to older persons; sensitizations on social distancing, encouragement of whistle blowers to report suspected cases of COVID-19 at the community level; and ensuring older persons in some states directly collect palliatives.

Rwanda also achieved so much for older persons. Responses from Rwanda, Kenya and South Africa indicated that the following had been achieved: sensitization on social distancing; provision of food to older persons; food distributions to older persons; advocacy for older

persons' voices to be heard; building of older persons care homes; and access to medical insurance.

**Figure 12: Progress in the implementation of COVID-19 strategies**

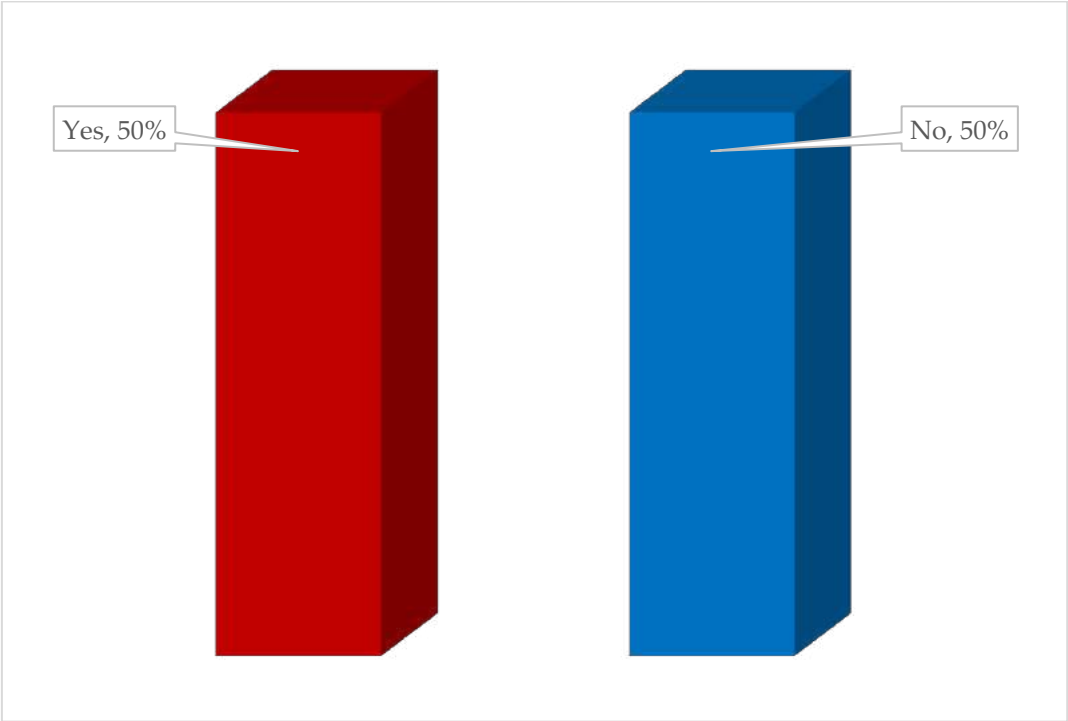



## Cultural values and practices disruptive to COVID-19 strategies

Opinions were divided among respondents on whether there were cultural values and practices disruptive to COVID-19 containment and mitigation strategies for older persons in the participating countries. Responses received indicate that half (50%) of the total respondents claimed that there were no cultural values and practices disruptive to containment and mitigation strategies for older persons in their countries, while the remaining half (50%) agreed that there were disruptive cultural values and practices militating against containment and mitigation strategies in their countries. Some of the cultural values and practices mentioned include: communal living; extended family network; social ties; belief system; emphasis on miracle healing; unproven traditional cures or claims; family visits; poor enforcement of restriction of movement; befitting burials to loved ones; extended family care; shut down of public places; and social bonding. Such cultural values and practices among others, are disruptive to the mitigation strategies. For instance, isolation

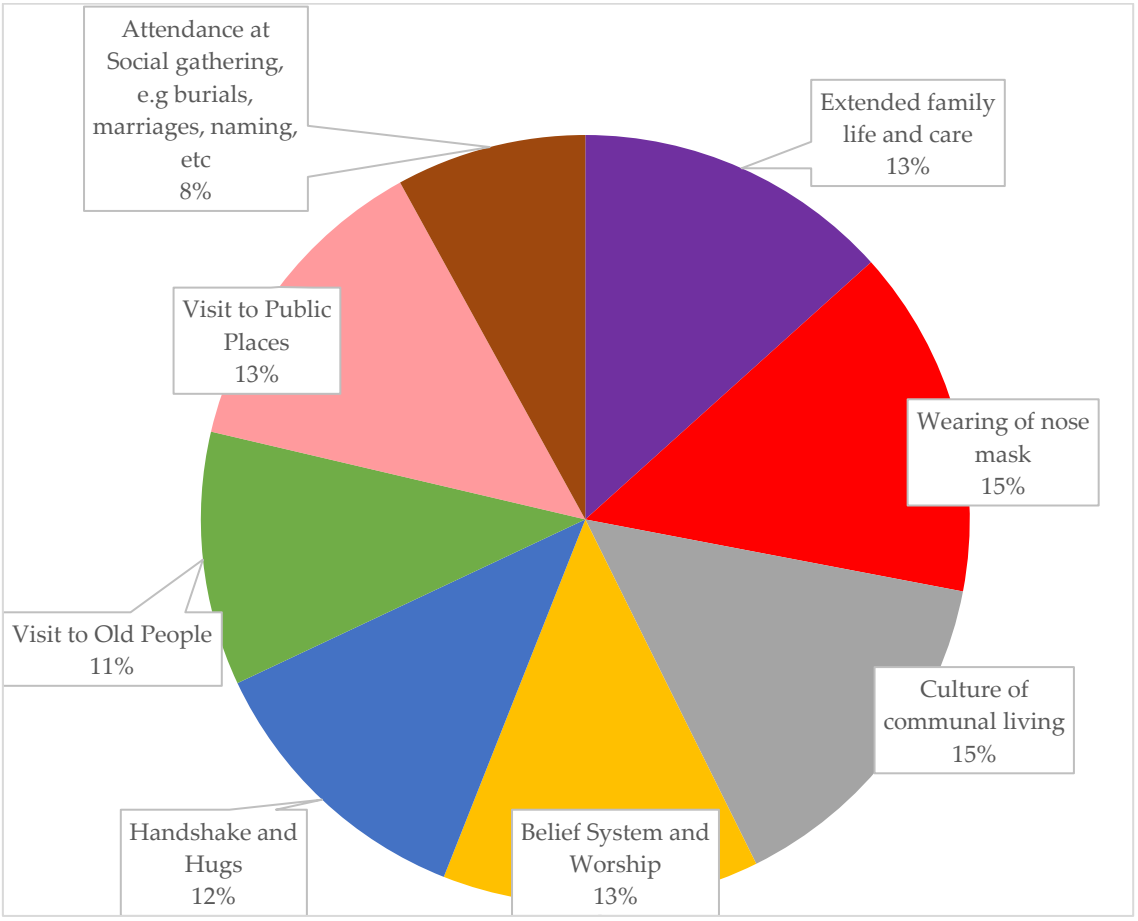
and social distancing are culturally unacceptable and pose a mental and social challenge to older persons. The wearing of face mask is also alien to people's culture.

**Figure 13: Cultural values and practices disruptive to COVID-19 strategies**




When respondents were asked to mention the various cultural values and practices disruptive to COVID-19 containment and mitigation processes and strategies, the following cultural values and practices were mentioned namely: attendance at family social gatherings; extended family life and care; visiting public places; visiting older members of the family; wearing of nose mask is regarded as not a part of peoples' culture; restrictions of hand shake and hugs are considered aberration to people's social life; culture of communal living; and the closure of religious centres was viewed as a policy against people's belief among others.

**Figure 14: Types of cultural values and practices disruptive to containment of COVID-19**




## Community level support/volunteerism

Several community support for both physical and mental wellbeing of older persons were mentioned by respondents from the participating countries. These include but not limited to: mass media jingle to sensitize older persons on the dreaded COVID-19 pandemic; visits to traditional rulers and community leaders to sensitize and educate people at various community levels; support provided to older persons by individuals and philanthropists; provision and distributions of food items to communities and ensuring older people were reached; training of advocacy groups; regular calls by relatives; sensitizations; distribution of palliative items by Non-Governmental Organizations; commercial banks and private bodies; and donations of different items by faith-based organizations among others.

**Figure 15: Percentage of countries with community supports**

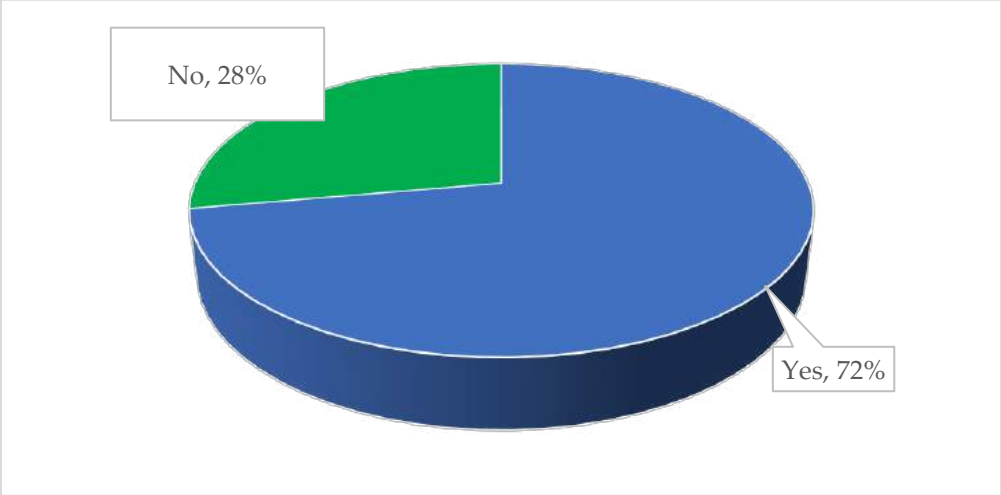
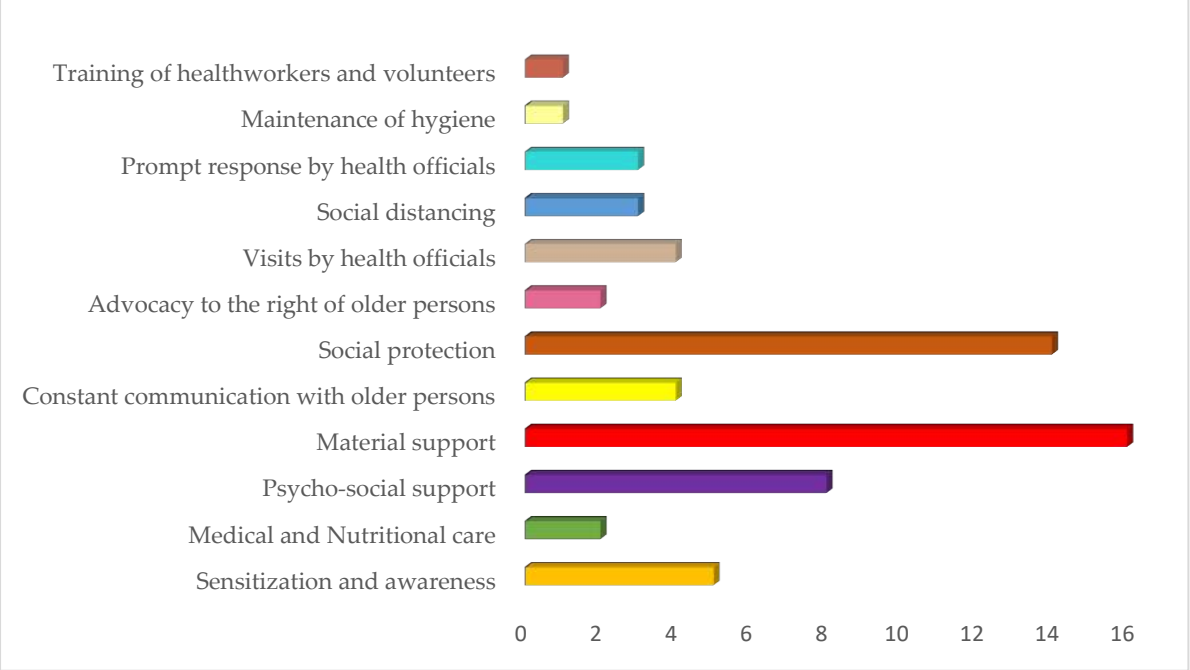



**Figure 16: Types of community support**




## Impacts of COVID-19 on older persons in Africa

Older men and women can be perfectly healthy even though their metabolic rates may slow down and their strength declines. Some mental activities also slow down or change completely. These changes and declines occur at different levels and at different rates. In favourable environments, the changes will hardly be apparent, and the benefits of old age may often mean that life improves and older persons are happier, and unsure of its veracity and essence (Cox & Pandasani, 2017; Udhayakmar & Ilango, 2013).

COVID-19 is more than a health crisis, but a human, economic and social crisis; attacking the core of the human society–as it heightens inequality, exclusion, discrimination, xenophobia, vulnerabilities and global unemployment in the medium and long terms. It affects all segments of the population and it is particularly detrimental to those in the most vulnerable situations, including people living in poverty situations (especially women), older persons, and persons with disabilities, youth migrants, and refugees among others (Aina, 2020).

The health and economic impacts of the virus are borne disproportionately by poor people. For example, homeless people, because of lack of safe shelters, become vulnerable and exposed to the danger of contacting the virus. People without access to running water, refugees, migrants, or displaced persons also stand to suffer disproportionately both from the pandemic and its aftermath (Aina, 2020).

Specifically, the impacts of COVID-19 on older persons include the following:

- Increased mortality rate among older persons due to COVID-19 Pandemic.
- Older Persons with pre-existing health challenges lack access to health care.
- Neglect and maltreatment of older persons in care homes and other institutions.
- Disruption of older persons' social networks and support systems.
- Increased incidences of abuses of older persons.
- Isolation, neglect and loneliness due to social distancing.
- Social protection for older persons has been grossly affected.
- Erosion of the means of livelihood of older persons due to the lockdown (Stakeholder Group on Ageing, Africa, 2020).

## Case Studies: country specific unique experiences (Cameroon and South Africa)

### Cameroon

Cameroon is located in Central and West Africa, known as the hinge of Africa, on the Bight of Bonny, part of the Gulf of Guinea and the Atlantic Ocean. Although, politically, Cameroon is not an ECOWAS member state, however, the North West and South West Regions are geographically and historically situated in West Africa (Nnoko, 2020).

Since 2017, some groups in Cameroon have been involved in serious armed conflict with the government defense forces for freedom of the internationally unrecognized state called Ambazonia. This situation in Cameroon has negative impacts on the containment and mitigation processes and strategies put in place by the government. The consequences of the armed conflict for older persons are so grave that it has led to increased cases of dementia (mental illness) among older persons (Nnoko, 2020).

It was reported during SGA, Africa Webinar session held on the 5 of June, 2020 by the Cameroon country representative that, the situation in Cameroon has further exacerbated the health challenges of older persons during this COVID-19 Pandemic. This is coupled with a weak healthcare system, shortages of health workers, and lack of trust in the government. Older persons are most affected by the situation because there is no special containment and

mitigation measures implemented for older persons by the government, not to mention the serious health challenges (dementia) faced by this category of older persons. In addition to the health challenges, older persons equally experienced food insecurity, lack of care, and inadequate sensitization about COVID-19. Due to the serious insecurity in the country, older persons are often abandoned.

Other challenges older persons faced in Cameroon include: increased rural-urban migration of family members who were care providers; the absence of healthcare facilities in the rural communities; lack of direct government social protection; and absence of basic social amenities that are essential for healthy ageing. All these challenges have led to further erosions of older persons' human rights.

**South Africa**

South Africa is located in the southern part of Africa with a total population of about 58.78 million. Older persons make up 9% of the total population of South Africa. South Africa is one of the countries in Africa that has the highest population of older persons in the continent (Shamam, 2020). In contrast to the experiences of older persons in Cameroon, it was reported during the SGA Africa Webinar by the country representative (ibid.), that, the rights of older persons in South Africa are secured under both the national and international declarations as well as the legal frameworks such as the UN Declaration of the Rights of older persons, the Constitution of South Africa and the Older persons Act 13 of 2006. Generally, it is known that South Africa has a well-established structure for older persons before and during COVID-19. For instance, the followings are the unique experiences of older persons in South Africa:

- 418 state subsidized facilities (Taking care of 32, 000 older persons).
- 3,000 private facilities.
- A large proportion of the 5.3 million older persons live in the community.
- State subsidized community-based services, about 1,713 supporting 107, 519 older persons.
- Total number of older persons supported through state subsidized services are 139, 282 (Shamam, 2020).

In response to the government's efforts to contain and mitigate the impact of COVID-19 on older persons in South Africa, the government of South Africa put in place some elder-specific protocols to manage COVID-19 in the homes as additional measures and directives to protect older persons in the homes which include:

- No clients may be released from the facilities during the pandemic.
- No visitation is allowed during Lockdown period.
- The family Reunification and interaction programme are suspended.
- No new admissions are allowed, except in the case of older persons in distress.
- Social protection initiatives increased in the OAG segregated payout system favouring older persons and people with disabilities.
- 80% of older persons are dependent on the public Healthcare system.

In terms of older person-specific areas and issues that were not addressed by the containment and mitigation processes and directives in South Africa, the following areas were identified as the experiences of older persons in South Africa.

- Poverty- about 13.8 million older persons are living below the poverty line.
- Many older persons live in informal housing settlements.
- Older persons in urban areas are concentrated in overcrowded slums.
- There is negative burden of HIV/AIDS.
- About 1.5 million older people over 50 years are living with HIV/AIDS and not on Anti-retroviral drugs.

In a swift response to the identified older person-specific issues listed above, the South African government embarked on the following:

- Directive regarding residential facilities.
- Social protection interventions.
- Increased screening of older persons daily for COVID-19 infections.
- Palliative items were made available and distributed to older persons.

## Conclusion and recommendations

COVID-19 Pandemic has threatened the lives of older persons and deepened ageism, discrimination and inequality. COVID-19 response and recovery interventions, humanitarian and development public policy must make deliberate efforts to include older persons like other population groups. The following are some of the key recommendations to progressively improve the dignity, wellbeing and quality of life of older persons:

- Increased consultation with older persons and their supporting organizations to ensure their voices are heard, issues and rights included in various public discourses.
- Human rights of older persons must be given due considerations and respect.
- Continued provisions of adequate health care services for older persons including mental health and long care services.
- Increased coverage of pensions and social protection for older persons and their inclusion as dignified recipients of palliatives during lockdown.
- Government should establish structure for monitoring and reporting cases of maltreatment and elder abuses in family, care homes and other institutions.
- Government should ensure continuous testing of vulnerable older persons for COVID-19 and protect older persons from infection.
- Governments and family members should find innovative ways of maintaining social support networks while observing social distancing.
- Efforts must be made to include older persons in livelihood recovery.
- Development of capacities of policy and decision makers, health care and social workers in ageing and care of older persons.
- Investment in national multi-indicator survey on ageing which should be disaggregated for policy responses.

- Development of normative frameworks to guarantee rights of older persons.
- Governments and family should support older persons to build their immunity through adequate nutrition.
- Nation states should accelerate the ratification and implementation of African Union Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa and ensure adequate resources for older persons across all levels.
- Governments should mainstream older persons into SDGs implementation, national and sectoral planning interventions and ensure equity and inclusion.
- In-depth research on the effects of COVID-19 on older persons in the rural communities should be encouraged as well as the promotion of data disaggregation by age.
- There is need for special programmes for older people in the rural communities and for non-pensioners.
- Governments and major stakeholders should ensure the provision of social amenities in communities negatively impacted by rural-urban migration.
- Governments and care providers should develop hotline service for information sharing and gathering in rural areas.

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# Dychtwald, K., & Morison, R. (2020). *What retirees want: A holistic view of life's third age*. New Jersey: Wiley & Sons, 303 pp. ISBN-978-1-119-64808-6

**Reviewed by Dorian Mintzer**[1]

## The third age

In their new book, Dychtwald and Morison present a compelling and provocative overview of the changing history and landscape of retirement and acknowledge that the current concept of retirement is becoming obsolete. With a longer life span people now have 20, 30 or more years of life past the traditional retirement age of 65, and they stress the importance of viewing this stage of life as a time for opportunity and reinvention—the third age, a term coined in Europe focusing on adult education and lifelong learning.

With the framework of the third age, they posit three ages of man: the first age, from birth to around 30 focuses on development, learning and survival. The second age, from ages 30 to around 60, focuses on productive work, formation of the family and parenting. In earlier generations people often did not live much beyond the second age. Now, with the increased life span, people have a new stage of life which allows time for self-reflection, self-discovery, reinvention, and ways to give back. They propose that the term "third age" replaces the term retirement.

This book is written for two audiences: industry thought leaders interested in understanding the holistic needs of retirees to help them anticipate their needs and to provide the products and services they need now and as they age; and for the pre-retirees and retirees themselves. Although primarily focused on the United States, some of the research highlights important global implications.

Dychtwald, a visionary and entrepreneur in the field of aging, began his Age Wave company in the 1980's when he was in his 20's. Morison, a business researcher, is an authority on the intersection of business, technology and people management. Both boomers themselves, they have been collaborating on and off since 2000.

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## The "age wave"

Beginning In the 1980's, Dychtwald anticipated the "age wave" and now, as illustrated in the book, the "age wave" is here and is the future. The Boomers, a cohort of 77 million people, once coined the phrase to never trust anyone over 30, and now they are ages 56 – 74 and are a powerful force in terms of education and buying power. There are currently 66 million people retired in the US. By 2050, there will be more than two billion people over the age of 60 worldwide.

The book begins with a discussion about the "Age Wave" and ways that Boomers are transforming retirement. Within the holistic framework there are chapters that cover the areas of work, leisure, health, family, home, finances, and purpose. Retirees are not a homogeneous group and there is no "one size fits all" approach. With the backdrop of forty years of research and input from other experts in the field, the authors have identified themes, patterns, aspirations, priorities, goals, and dreams of retirees.

## Who are the boomers?

They identify four groups: Ageless Explorers, who planned ahead and see retirement as a time of opportunity, adventure, exploration, and personal reinvention; Comfortably Contents, who are similar to Ageless Explorers in terms of their career accomplishments, but they approach retirement with a more traditional, less driven view-- their focus is on fun, recreation and relaxation; Live for Todays, who seek continued personal growth and want to reinvent themselves, but feel they have less flexibility because they haven't saved as much and are more worried about expenses, health costs and outliving their money; and the Worried Strugglers, who, compared to the other groups, are less ready and able to enjoy retirement due to fewer financial resources and fewer hopes and dreams of what they can do. It is interesting to think about how to market to and serve each group and to see if people can "course correct" and shift from one group to another.

## Stages of retirement

As pointed out in the book, people begin their retirement journey at different ages and with different circumstances, although the authors have discovered there are common factors. Influenced by the stages of grief developed by Elizabeth Kubler Ross, and supported by their research over the years, the authors have developed 5 stages of retirement that are important as one considers the mental state of pre-retirees and retirees and suggests to industries and marketeers how to reach out to the boomer population. Awareness of these stages also helps pre-retirees and retirees understand some of the changes in their own feelings and responses over time. Stage 1: Imagination (15 years or more ahead,) Stage 2: Anticipation (5 years before,) Stage 3: Liberation: Retirement Day, Stage 4: Reorientation (2 years into Retirement,) and Stage 5: Reconciliation: (15 or more years into Retirement.)

## Ageism and reframing aging

In Chapters 2 and 3, much of the emphases is on how societal and internalized ageism impacts industries and retirees, and the importance of a paradigm shift to reframe aging so that people feel aspiration and not desperation as they age. In Chapter 4 the authors focus on the role of work during this third age, recognizing new roles, different timing, and the purpose of post-retirement work. Although some people want to work in retirement, they want a better balance of work and play.

## Working retirees and the role of employers

The authors describe four different types of working retirees: Builders, who keep working and achieving in retirement since it provides opportunities to use their expertise; Contributors who find ways to give back, often working for non-profits. Balancers who work in retirement primarily for the activity and social connection and do not let work dominate their lives; and Earners who must keep working to pay their bills. They are the lest satisfied of the four groups.

Another important aspect of this book is its focus on the role of employers. They mention some corporations as models that offer programs such as phased retirement, retiree return, retiree networks, career reinvention and knowledge exchange. Older workers are often the holders of history within an organization and it is important to find ways to both honor the wisdom and experience of older workers and provide opportunities for knowledge transfer which also enables intergenerational learning, in both directions.

## The time affluence explosion

Chapter 5 focuses on what they call the time affluence explosion. With increased life span, there are fifty trillion hours to fill. The richness of the book is recognizing how important it is to focus on the use of time over the years during the retirement journey. This is helpful for different industries to consider when they offer programs and services. What people want 15 years before retirement is different from what people want during the 5 years before retirement as well as the first two years and then after 10 or 15 years into retirement.

## Other parts of the holistic landscape

Chapters 6 -10 focus on the varieties of health and wellness issues with a focus on health span and not just life span, caregiving, the importance of family relationships and the demographic shifts with multiple marriages, partnerships, blended families, no children, solo agers, grey divorce, and widowhood. From their research they identified four Boomer Health Styles: Healthy on Purpose, Course Correctors, Health Challenged and Lax but Lucky. Other chapters focus on home and community, finances, “the giving revolution,” living with purpose and leaving a legacy.

## A call for action

The final chapter of the book is a call for action. The authors conclude with the notion of retiring "retirement" and focus on Life's Third Age as Life's New Frontier with more learning, more intergenerational contributions, and more activism. They challenge the Boomers: Will it be a great age? Will the Boomers use their experiences and assets to help shape a future based on mindfulness and generosity of purpose? Or will they act only to promote their own interests? The jury is out. Can we uproot ageism and "gerontophobia", both terms coined by Robert Butler, and allow for more positive images of aging? Will we create products and services, housing and programs that treat older men and women with respect and provide comfort? There is an opportunity to foster cooperation and interdependence among people of all ages. It is a compelling and provocative book which is a call to action, for industry thought leaders and the Boomers themselves.

As the authors mention in their introduction, they submitted their manuscript before the onslaught of Covid-19. Clearly some of the hopes and dreams are shifting at least in the short run. Covid-19 has exposed the deficiencies in the financial, healthcare, and safety net systems in the United States. How and what emerges as a "new normal" remains to be seen.

# Thompson, E. H. (2019). *Men, masculinities, and aging: The gendered lives of older men*. Maryland: Rowman & Littlefield, 272 pp. ISBN: 1442278544

**Reviewed by Roberta Sultana**[1]

Penned by Edward H. Thompson Jr., a well-renowned United States professor and a pioneer in the realm of men and ageing scholarship, the book '*Men, masculinities and aging: The gendered lives of older men*' is set to acquaint readers with the gendered nature of older men's lives. Before delving further into this book review, it is noteworthy that although the title of the book refers to 'older men', in the book, Thompson refers to 'aging men', 'aged men', 'old men' and 'very old men' as he elucidates that that the term 'older' blends the extensive variances amid mature men and hazes the idiosyncratic life experiences of middle-aged and old men (p.9). Owing to his notable expertise in the field, Thompson manages to generate a vast collection of information on ageing masculinities. Throughout the book, the author makes constant reference to findings derived both from his own research and from the work of other scholars in the field.

Most importantly, the author gives prominence to the fact that ageing does not stop old men from being men despite that with increasing age they may decelerate, bow out from the warfare of youth, and narrow their social links. Thompson's book grounded on the critical studies of men and masculinities in conjunction with critical gerontology and intersectionality presents a theoretical framework on how men experience later and late life. Intersections of class, generations, geographies, ethnicities and masculinities are thoroughly examined and discussed. This book is divided into three sections namely; (i) Masculinities and Ageing, (ii) Health as men age and (iii) Social worlds of old men. These three sections are further sub-divided into twelve chapters.

The first section introduces and revolves around the examination of the notion of ageing masculinities in other words how old men's performance of never ageing masculinities are modified and substituted by their performance of ageing masculinities. As well, Thompson delves deeply in discussing the ways men traverse ageist relations and chip in the new arenas of the third age culture and by what method old men's daily lives disclose their adjustments to their transforming bodies. Moreover, Thompson talks about how nowadays more individuals have the opportunity to lead enriching and fulfilling lives at post-employment age and beyond. He also elaborates on how old men perform and represent a range of culturally and socially supported ageing masculinities.

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While the author recognises Connell's constructs of gender order and hegemonic masculinity as an important route of reasoning apropos gender practices, in relation to men and power, and as an impetus to the extensively acknowledged account on plural masculinities, he goes on to critique the pertinence of hegemonic masculinity to old men and ageing. He asserts that the hegemonic masculinity account falls short from facilitating comprehension of how old men intentionally and unintentionally situate themselves, when personifying ageing masculinities and while resisting the cultural accounts of never-ageing masculinities.

Thompson goes on to explain that the notion of hegemonic masculinity generally disregards, maybe even condescends, old men, flinging them as "complicate and subordinate and more likely as marginalized others" (p.26). As an alternative, the scholar suggests a re-examination of "Pierre Bourdieu's sociological theories of practice and of the body as symbolic and physical capital, and his concepts of - habitus, field and capital -" to facilitate novel understandings into the denotations of ageing masculinities and to permit enhanced comprehension of ageing men's social performances (p.26).

The second section centres mainly on; the disparities amid old men's corporeal and emotive well-being comprising depression and suicide, on how later life health contests turn into masculinity contests and in what manner the most prevailing discussions on old men and their sexual health are labelled and treated as medical issues. Thereby, in light of such discourse, the author accentuates on the importance of re-examining these topics. Besides, Thompson asserts that "health, like age and gender is performative" and the health performances and inequalities that we perceive echo the men's social location together with their habitus (p.112). In this section, the author goes on to maintain that the withstanding outcomes of men's social location and the way men deal with ageing-related morbidities provides hints of understanding into how much old men's health status mirrors and shapes their masculinities. However, scant research on old men's experiences with late life limits our comprehension of old men's health, health performances and their experiences with additional morbidity in later and late life.

In the third and final section of this book, Thompson concentrates on the social worlds of old men, commencing with an appraisal of their social rapports. He underlines men's resilience and the importance of agency in late life. Thompson goes on to discuss later life intimacies and old men's sexual practices and yearnings, the likenesses and dissimilarities regarding how old heterosexual and gay men consider their sexual ageing, the escalating predominance of old men turning into primary carers to their spouse/partners, old men's experiences as grandfathers and the experiences of old men confronting later life as widowers. Thompson, ends the section on old men's social worlds by claiming that the nascent fourth age culture has started to fit in with late life predilections and old men's adaptability. In the closing stages of the book, Thompson goes back to appraise and argues why ageing masculinities are the recommended alternate route of examining old men's masculinity practices.

In conclusion, it must be said that this book is a huge contribution as Thompson manages to assemble considerable pragmatic material on old men's lived experiences. He provides a new

standpoint on men's experiences with corporeal aging, growing older in an ageist society, and on how old men steer the non-existent cultural instructions for being an ageing man. This book is definitely an informative read for all those who in one way or another are inquisitive about the topic particularly students, researchers, academics and practitioners. As this book is presented in a flowing manner it makes it less complicated for the reader to follow through especially those students who are still novice to the field of men, masculinities and ageing. Throughout the book, Thompson provides a way to inquire about customary postulations vis-à-vis ageing men and reviews what lies beneath later and late life masculinities. Ultimately, this book surely serves as an impetus for further and much merited research on men and ageing masculinities.

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