CHAPTER ONE
INTRODUCTION

1.1. PROBLEM STATEMENT

The complexity of the meaning of the concept of ageing, the nature of age-related health problems, the current trend of population ageing, the social impact of HIV and AIDS, and the prevailing socio-economic situation of the country pose new challenges in the care and well being of the older persons. These factors might have negative or positive impact on the quality of life of the older people and influence their perceptions about the ageing phenomenon. Governments and health professionals are challenged to develop programs and interventions that would enable the older persons to enhance or maintain their quality of life. However, such programs and interventions should be based on the lived experiences and views of the older persons.

Population ageing has become an important developmental issue that requires urgent action. The World Health Organisation (WHO) states that "*Investing in health and promoting it throughout the life span is the only way to ensure that more people will reach old age in good health and capable of contributing to society, intellectually, spiritually and physically*" (WHO 1998a: 6). The researcher assumed that understanding ageing as viewed and lived by the older persons of Zambia is critical in planning interventions that would ensure healthy ageing.

The literature suggested that the meaning of the concept of ageing or being older has not only changed over the years but it is also complex. Authors (Eliopoulos, 2004; Irvine, Bagnall, Smith & Bishop, 1986) attributed the above variation and complexity to the facts that in the past people have had shorter lives, societies

treated and viewed their older persons differently, and in most cases people of the same age would show different parameters. Roach (2001) added that there is no typical older person, as each older adult is as different as the experiences that person has encountered over a lifetime. It is therefore relevant to go back to the older people themselves and uncover their lived experiences and views on ageing or being old.

Ageing is associated with age-related, chronic and non-communicable diseases that are often disabling and costly. These will undoubtedly strain the health and social care systems, which are already burdened with challenges of communicable diseases. With the increasing rate of the HIV and AIDS victims in Sub-Saharan Africa, Zambia inclusive, the older persons are expected to take up new responsibilities and roles, which they are not prepared for. Furthermore, HIV and AIDS cost money and strain household budgets due to its prolonged and chronic nature. Households responsible for one or more persons with AIDS expend extraordinary amounts of resources on care, treatment and funerals. These greatly worsen the poverty situation among the older persons. The impact of looking after the sick and the orphans also drains the older persons emotionally, economically and physically and require a lot of economic and psychosocial adjustments. It is assumed that specific interventions based on the understanding of the lived experiences of the older persons and their views on ageing are required to assist the older people to cope with the above changes and new roles.

The prevailing socio-economic situations in many African countries including Zambia, bring great challenges in the delivery of health and social services. With the prevailing economic and social situations of limited resources and increased demand for public and social services, maintaining or enhancing the quality

of life of the older persons might not be seen as a priority. However, the literature (Apt, 1997; Aziza, 2000; Hall, MacLennan & Lye, 1993; Help Age International (HAI), 2000) argued that enhancing or maintaining the quality of life of the older persons is a social and moral obligation of governments and society as a whole. Fulfilling these responsibilities depend on the extent to which countries have prepared both economically and socially to care for this segment of the population. The researcher assumed that the Zambian government and society are not adequately prepared both economically and socially to care for this segment of the population.

It is also assumed that health professionals in the country are not interested or well informed about the ageing issues or /and geriatric care. From the preliminary literature review related to ageing in Zambia and the researcher's own experience, it appeared that ageing issues are not given attention. There is almost no published documentation on ageing issues and there is no geriatric training available for nurses or other health professionals in country. Can this be attributed to the various social changes taking place in the country, or to the attitude of society or government toward the older persons, or to lack of guidelines or understanding of the ageing phenomenon?

In view of the complexity of the meaning of the concept of ageing, the nature of age-related health problems, the social impact of HIV and AIDS, the prevailing socio-economic situation in the country and lack of documentation on ageing that the current study was undertaken. It was anticipated that the findings of this study could be used by policy-makers and health professionals to formulate guidelines and interventions that are based on the understanding of ageing as lived and viewed by the older persons of Zambia.

1.2. BACKGROUND

The percentage of the older persons has increased over the years both in developed and developing countries. The number of this category (aged 60 years and above) was estimated at 600 million in the year 2000 or thirty percent (30%) of the world population. It is projected that the number of the older persons will reach 1.2 billion in the year 2025 and 2 billion in the year 2050 (Apt, 1997; Aziza, 2000; Eliopoulos, 2001; Hall *et al,* 1993; HAI, 2000; Irvine *et al*, 1986; Roach, 2001; UNFPA, 2002; WHO, 2002). The trend of increased number of the older persons is referred to as 'population ageing' or 'greying population' (Apt, 1997; Aziza, 2000; UNFPA, 2002; WHO, 1998a; WHO, 1999).

The growth rate of the older population is projected to sharply increase world wide shortly after the year 2005 (Aziza, 2000; HAI, 2000), when the baby boomers or the post war babies reach 60 years. Baby boomers comprise of the people born during the period of prosperity, which corresponds to the period after the Second World War. Unlike the period of recession, which saw a decline in births, the period of prosperity saw a boom in births. The effects of baby boomers on any society have been tremendous and have been likened to a 'python moving through a pig' (Eliopoulos, 2001; Roach, 2001).

Being a better-educated, healthier, and more active group than most of the previous generations, the baby boomers are expected to pose several challenges on both the social and medical resources. Baby boomers posses high educational backgrounds, they will be knowledgeable about health care, and likely to be in secure financial situations. This will make them demanding health care consumers, as they would expect high standards of healthcare (Roach, 2001). The baby boomers believe in small and nuclear families. Suggesting that there would

be lack of traditional support from the family. This would further put pressure on the already over stretched social services, as there will be no extended family to provide care and support.

Another phenomenon among the older persons in the high economy countries is a rise in the life expectancy of the older people with the numbers of those over 80 and 85 years continuing to grow (Hall *et al*, 1993; Irvine *et al*, 1986). Life expectancy at birth has increased by 20-77 years in the last few decades in the high-income countries. Life expectancy is expected to rise further (Irvine *et al*, 1986; WHO, 2001a). Fertility rates have reached replacement levels in most of the developed countries while mortality has declined to very low levels. Consequently, population growth rate of these countries is low. This means that there are fewer younger people in the population and the older populations are growing older (Kalunde, 1998). The increase in life expectancy has been slightly greater for men aged 65 and 70 years than for women. This has created changes in the female: male ratio from its present level of 1:3, to 1:2 (Hall *et al,* 1993).

Evidence (Apt, 1997) suggests that approximately two-thirds of all the older persons in the year 2025 will be living in the developing world. In Africa, the older population has been estimated to be slightly over 38 million, and it has been estimated to be the fastest of any age group during the next two decades. It is projected to reach 212 million by 2050 (HAI, 2000;Hall *et al*, 1993; WHO, 1998). It is argued that despite the destructive effects of the HIV and AIDS pandemic in Africa, which has been projected to reduce life expectancy, the number of the older persons is expected to continue to grow (HAI, 2000).

According to O'connor (1991), population growth can only be slowed down with an increased number of deaths of people who have recently entered their reproductive years. Their deaths

can boost the death rate while suppressing the birth rate almost simultaneously. However, it is assumed that the rising mortality from HIV and AIDS in that segment of the population is also likely to encourage many parents to try to guarantee their security in old age by having even more children than before.

The number of children born will probably continue to remain high enough to outstrip the higher death rate. The increasing deaths among the young adults will undoubtedly increase the dependency ratio. The dependency ratio refers to the proportion of children and the older persons to the proportion of potential income earners in the population (GRZ, 1996). In the final analysis, the accuracy of these projections will depend mainly on how accurately the demographers predict mortality among the maturing individuals (Kart, Metress & Metress, 1988).

In Zambia, the population is relatively young and the structure is typical of a developing world population pyramid. The available data indicate that forty five percent (45%) of Zambia's population are children aged 0-14 years. Of this number, 15% are children under the age of five. Twenty four percent (24%) of Zambia's population are youths aged between 15-24 years of age. The most productive age group (25–59 years) constitutes 29 percent (29%) of the population. The older persons (60 years and above) constitute four percent (4%) of Zambia's population (Central Statistics Office (CSO) 1990; Kamwengo 2001).

However, it is also indicated that the number of the older persons in Zambia has increased from 337, 236 in 1990 to 402, 368 in 2000. It is estimated that the above number, will further increase to 452, 925 in the year 2005 and 594,255 in the year 2015 (CSO 1990). This projection indicates that by the year 2015, Zambians who will be 60 years and above will constitute a significant percentage of the population. The implication of this projected

population growth is that Zambia will have to contend with the burden of chronic diseases and disabilities, which predispose the older people to depend on others for activities of daily living (AoDL).

It is recognised that the older age groups in any society pose the greatest challenge to both medical and social services. Although ageing is a normal human developmental process, it is often accompanied with the risk of developing certain chronic and debilitating conditions (Hall *et al,* 1993; Haslett, Chivers, Boon, Colledge & Hunter; Irvine *et al,* 1986 WHO 1,998a; WHO, 1999). The management and treatment of such conditions may be very costly and beyond reach of most of the older persons and economies of many developing countries. The older persons may also be expected to adjust themselves to various changes. These changes may range from financial (such as reduced income due to retirement or death of a breadwinner), or psychosocial (due to possible housing changes, loss of social support through deaths of significant others) and declining abilities to carry out ADL that occur during this developmental stage.

People in these age categories change from being contributors, to recipients and principal users of most social services (Eliopoulos, 2001; Hall *et al*, 1993; Irvine *et al*, 1986; Roach, 2001). This is because the prevalence of ill health, disease and disability do increase with age (Hall *et al,* 1993; Kennie, 1993;). The expectations to adjust to these changes and the views of the older persons towards these changes may be stressful for them. Authors (Eliopoulos, 2001; Keith, 1982) argued that stressful life events might influence the older persons' behaviour and attitudes towards meaningful life, psychosocial integrity and consequently their quality of life. It is further argued that the older persons, their caregivers and some health professionals may perceive these

changes as being inevitable and irreversible accompaniments of the ageing process. These perceptions may also influence health-seeking behaviour of the older persons and consequently their quality of life (Hall *et al,* 1993; Irvine *et a,* 1986).

In most developed countries, the social welfare systems are well established to care for the older persons. Developing countries are largely ill prepared both economically and socially to care for this segment of the population outside the traditional family setting (Apt, 1997; Aziza, 2002; Hall *et al*, 1993). In many African countries including Zambia, the social security systems are non-existent or under-developed making the older persons vulnerable and unable to cope with stressful life events (Eliopoulos, 2001).

Traditionally, care of the older persons was the responsibility of the family members, through the extended family system. Children were expected to provide support and look after the well being of their parents especially in old age. However, social changes such as urbanisation and migration of young adults to other countries or other towns in search of jobs have contributed to the destabilisation of the African values that supported the older people in their traditional environments (Apt, 1997; HAI, 2000; Kamwengo, 1999a; WHO, 1999).

Similarly, the HIV and AIDS pandemic have altered the traditional roles of the older persons. Upon the death of their children, who in most cases are primary breadwinners, the older persons are left with the burden of having to look after the (HIV and AIDS) orphans and themselves as well. This creates tremendous strain, burden and additional stresses on the older persons (MOH/CBOH, 1999; Tlou, 1996; Williams & Hunt, 1997).

In Zambia, the government has engaged several health care and reforms aimed at improving the quality of life of all the citizens. Soon after independence in 1964, the new government formulated a 5-year National Development Plan (NDP) aimed at reducing the inherited disparities between the urban and rural areas, resulting in the expansion of housing, health and social services throughout the country. This plan was followed five years later with a second NDP, which focused mainly on the health sector. It brought about a marked increase in the health facilities in the rural and urban areas.

In 1992, the National Health System was restructured as a result of the Primary Health Care (PHC) approach adopted by the government in early eighties. It resulted in the decentralisation of the health services and the ushering in of the new National Health Reforms. These reforms set out to provide a basic healthcare package based on cost-effectiveness, quality assurance, equal distribution, and geographic accessibility. The 1992, National Health Reforms also introduced the concept of cost sharing in the health care. Cost sharing meant that consumers of health care had to pay user fees for services received in the health care. However, persons below the age of five (5) and those above the age of sixty-five (65) years and those with chronic illnesses were exempted from paying the user fees (Civil Society for Poverty Reduction (CSPR): 2002).

According to the CSPR (2002) report, the 1992 Health Reforms were a significant step forward in the direction of making the health of the people a central concern. The effective implementation of these reforms was supposed to be adequate for most of the health needs of all Zambians, including the older persons. These reforms were the first ever-national target based health strategies for the older persons in Zambia. However, the

CSRP (2002) report suggested that these reforms were not effective in meeting the health needs of the older persons of Zambia. The report attributed the ineffectiveness of these reforms to various factors, including the lack of understanding and interpretation of the reforms, limited resources, poor service delivery, and socio-economic situation of the country.

For example, the Health Reforms document is quiet on how the medical prescriptions should be disposed off in case of lack of the prescribed medicines at the health facility. The inclusion criteria for 'free services' are not clearly defined, as most of the people do not know about the exemptions. Even when they are known, they have not been fully implemented. Sensitisation of health workers regarding the policy document and awareness of the need for care of the older persons has not filtered down to the delivery points. The majority of the older people are still denied free health services.

The health services are characterised by shortage of specialised manpower and lack a multi-disciplinary approach to treatment. The older people have multiple medical and social problems that cannot be singly addressed by one profession. A multi-disciplinary approach to management and treatment is required to address the health and social problems presented by the older persons in time of crisis (Hall *et al,* 1993; Irvine *et al,* 1986).

Access to essential facilities as defined in the Health Reforms document means that the people should be able to access essential facilities geographically, economically and culturally. However, some of the health care delivery points are situated very far from where the older persons reside, as such in the absence of reliable transport they cannot access the health facilities.

Access to essential services is of great concern among the older people as they suffer a lot of chronic ill health, and their treatments tend to be costly due to the chronic nature of the conditions. Healing process too tends to take long for various reasons. Failure to access care creates problems and might in most cases lead to non-compliance of treatment or even to opt for poor quality of care to cut down on costs. The older persons with money do opt to go to private medical practitioners, traditional healers or just buy medicines off the counter (CSRP 2002).

Good health depends on adequate income. The links between health and wealth cannot, therefore be ignored. Zambia's economy has changed over the years, with the GNP continuing to show a downward decline. The national savings too, which are so strategic to the overall growth of the nation, have also fallen over the years to levels that are inadequate to fund desirable investment (Poverty Reduction Strategic Paper (PRSP) 2002). The prevailing socio - economic changes have not only had serious consequences on the health and quality of life of most Zambians, but they have had an impact on the social, political and cultural situation. The social, political and cultural factors are very important, as they are strong determinants of health and the quality of life of any nation.

The living standards have continued to show a downward trend in the past years as a result of the declining economy. According to GRZ (1996) the manifestations of poverty have grown to such an extent that Zambia can be said to be experiencing a social crisis. It has been estimated that about two thirds of the Zambian population are living below the poverty line and that more than 30% of Zambians spend 85% or more of their income on food. This makes them vulnerable to shocks. Under the

influence of such high poverty levels and decayed social services, survival, especially for the older persons, becomes very difficult (GRZ 1996). The poor performance of the social services in Zambia, have been identified as the causes for the deterioration in the social indicators (GRZ 1996). The CSPR (2002) has defined human poverty as ' low life expectancy, lack of decent education, and poor access to basic needs including secure food supply, health care, education, water sanitation and housing. While HAI refers to poverty as '*The older people's trap*.'

In Zambia, the main avenue through which social safety net activities are undertaken is the Public Welfare Assistance Scheme (PWAS). While the PWAS does cover a wide range of activities, the financial allocations made are meagre. As a result of the meagre resources, the PWAS is failing to cope with the growing numbers of applicants that have been growing over the years. This has made the PWAS inadequate. For example, of the two hundred and twenty eighty thousand, five hundred and fifty eight (228,558) applicants who sought assistance in 1999, only 29% received assistance (see Table 1). Social safety nets are necessary to ensure dignity, independence and self-fulfilment among the older people. The provision of social safety nets has been relatively limited due to the declining expenditures in real terms over the years (PRSP 2002).

Table 1: Applicants, beneficiaries, and disbursements under the Public Welfare assistance scheme (1997-1999).

Years	Applicants	Beneficiaries	Amount released in (K' Billion)
1997	139,238	38506	0.68
1998	128,077	15088	1.13
1999	228,558	66,210	1.52

Source: Republic of Zambia: Poverty Reduction Strategy paper (2002:30)

The increasing trend in the population ageing, inadequate geriatric care and social welfare services, the prevailing social and economic decline in the country as described above pose great challenges to the older people and the country. The older persons are challenged to take up new roles and adjust to the emerging demands for which they were not prepared for. This situation might be stressful for the older people, consequently affect their living experiences and the meaning they attached to being old or ageing. The government is challenged to formulate new strategies aimed at improving or maintaining the quality of life of the older people. However, such strategies should be based on the understanding of ageing phenomenon from the perspective of the older persons themselves.

Within the above background, the researcher felt that it was relevant to describe the lived experiences of the older persons and the meaning of being old or ageing from the older people perspective, in order to provide frameworks that might be used to design interventions that would improve or maintain the quality of life of the older persons of Zambia.

1.3. PURPOSE AND OBJECTIVES OF THE STUDY

The study was undertaken with the purpose of: (1). gaining an understanding of the ageing phenomenon within the Zambian context (2) To provide framework that could be used by policy-makers and health professionals to formulate guidelines or interventions relevant to the lived experiences of older persons and consequently maintain or improve the quality of life of older persons of Zambia. (3) To understand the meaning attached to ageing or being old.

The objectives of the study were to describe the:

- Lived experiences of the older persons of Zambia, and
- Meaning attached to ageing or being old in Zambia from the perspective of older persons themselves.

Authors (Parse, Coyne & Smith 1985) suggest that the purpose of a phenomenological study is to seek to uncover the meanings of humanly experienced phenomena through the analysis of subjects' descriptions. It is argued that events or some types of behaviour can have different meanings depending on the culture or the historical era. The assumption is that the world is socially constructed and human beings are continuously thinking, and making sense of, or interpreting, their social world.

The lived experiences of the older persons and the meaning they attach to ageing or being older are vital in understanding the ageing phenomenon within the Zambian context. It is suggested that the world is socially constructed by human beings who are continuously thinking and making sense of, or interpreting, their social world and that events or some types of behaviour can have different meaning depending on the culture or the historical era. These personal experiences will have no

meaning unless they are shared or communicated with others (Holloway *& Wheeler,* 1996; Neuman, 1997; Parahoo, 1999).

1.4. SIGNIFICANCE OF THE STUDY

The literature (LoBiondo & Haber, 1993) argued that the direct relevance of phenomenology to health is to help understand the multi-dimensional aspects of health and illness. The literature reviewed suggested that a study of this nature has not been undertaken in Zambia. It is therefore anticipated that the findings of this study might contribute to the body of knowledge related to ageing as experienced by the older persons in Zambia. Nurses and health educators can use the findings of this study to formulate interventions relevant to the needs of the older people and also as baseline information for further research.

It is hoped that some frameworks will be deduced from the informants' descriptions of their lived experiences and the meaning attached to being older or ageing. These frameworks will contribute to the enhancement of the understanding of the phenomenon by health professionals, families, communities and policy-makers. These frameworks will not only enhance their understanding of the phenomenon but also increase their sensitivity to the older persons. Policy-makers can also use these frameworks as guidelines to develop policies and programs aimed at improving or maintaining the quality of life of the older persons in Zambia. Health professionals and stakeholders might also use the above frameworks to formulate holistic interventions that are relevant to the meanings and experiences of the older persons of Zambia.

1.5. DEFINITION OF CONCEPT

This section of the literature looked at the concept of perception as related to the phenomenon under investigation. In phenomenology, perception is regarded as the primary source of knowledge, the source that cannot be doubted. It is made up of intentions, united with sensations. It is further, suggested that perceptions are the inner world-views or emic views. It is these inner or emic views that give meaning to the phenomenon that is being experienced or lived by those individuals living or experiencing the phenomenon. It is also argued that by virtue of '*being in the world',* the subject and object forms a unit that cannot be separated. As such, one cannot describe either the subjective or objective world but only the world as experienced and lived by the subject (Fitzpatrick, 1999; Moustakas, 1994).

Beck in Fitzpatrick (1999:38) referred to perceptions as *'one's original awareness of the appearance of a phenomenon in experience'*. King in George (1995:217) defines perception as *'each person's representation of reality'***.** Colaizzi (1973) states that experience is intentional, suggesting that what we perceive or experience, are as a result of the relationship between the subject and the object. As such, perceptions cannot be investigated by a method of experimentation. Perceptions need to be investigated by a method that is in recognition of its intention.

CHAPTER TWO

LITERATURE REVIEW

2.1. INTRODUCTION

Living longer is not a new phenomenon. History tells us that there are some individuals who have lived to a great age before. However, life in later years remains a season in search of its meaning; and the survival of so many people, to the end of their life span, has several economic, social, cultural, psychological challenges. These old and emerging (HIV and AIDS) challenges are more pronounced in developing countries than in developed countries. The impacts of these challenges and age-related changes might influence the older persons' perceptions of self, the life experiences and meanings of life at this latter stage of life.

It was against the above understanding that the literature review focused on the concept health as related to ageing, the normal ageing process, the theories explaining ageing, contextual and individual factors such as the socio-cultural, socio-economic, socio-environmental, and psychological, and the empirical phenomenological evidence to ageing. This review is divided and presented into three main sections: theoretical understanding of ageing, the contextual determinant of ageing, and the empirical understanding of ageing. A summary of the literature reviewed and the conceptual framework guiding the research process are provided at the end of the chapter.

2.2. THEORETICAL PERSPECTIVE ON AGEING

This section of the literature reviewed the concept of health as related to ageing, the normal ageing process, and the theories explaining ageing. Theories explaining ageing were grouped into fundamental biodynamic or natural law, biological theories, and psychosocial theories.

2.2.1. Concept health as related to ageing

Health is a concept that is not easily defined as it has several meanings depending on how one perceives it. The definition of health becomes even more complex when referring to the older people). For example, an older person suffering from diabetes or even hypertension when asked how he/she feels would say he/she is fine. Even in appearance, that individual may look fine, yet in actual fact this particular individual has a medical problem. The variety of definitions of what is ageing that emerged from the literature might also explain the complexity of defining health as related to ageing.

Thompson (1996:15) defines ageing as '*growing old, giving the appearance of advancing age*'. Keith (1982) defined old age as '*a basis for sorting individuals into categories'*, and he places the concept of old age or older person, in a social context. However, Davies (1998: 21) defines ageing as '*a progressive loss of adaptability with time so that the individual is less and less able to react adaptively to challenges from the external or internal environment'.* This suggests that with time, the individual becomes progressively more frail and in need of increasing support to maintain his or her autonomy. Several countries (Apt, 1997; Irvine *et al,* 1986; Kennie, 1993; Roach, 2001) defined ageing in terms of the official retirement age and have used it as a measure to indicate the beginning of old age. However, this official

retirement age varied from country to country. For example, people retire at 55 years in Zambia, 65 in South Africa and 60 in the Democratic Republic of the Congo. Previously, all the people over the age of 60 years were grouped under the category of being old. However, it has been recognized that much diversity exists among different age groups, especially in late life (Eliopoulos, 2001; Irvine *et al,* 1986).

From a health perspective, old age begins around 75 years and above, and this is referred to as functional age, fourth age or biological age. Functional or fourth age is considered as the operational definition of old age as there is an increase in medical disorders and resultant physical and mental disabilities among this age group (Kennie, 1993). In terms of health measurement, ageing is mostly defined in terms of functional age (Haslett *et al*, 2002). Functional age is seen as being reliable as it evaluates age in terms of functional performance (Kennie, 1993; Roach, 2001). It is most commonly used world wide for decision-making in terms of investigations and interventions (Haslett *et al* 2002).

However, it is argued that functionality has different meanings and is measured differently in different cultural contexts (Keith,1982). Measurement and meaning of functionality depends on what is required for full social participation in various settings. This raises difficulties in establishing markers that can identify the functional age (Kennie, 1993). In high economy countries or affluent communities of the low economy countries, the level of functionality could easily be assessed or measured by the ability to climb stairs, taking a bath or clipping toe nails (Keith 1982). The chores of the poor people in Africa, Zambia, inclusive are numerous and tedious, and range from walking long distances to draw water or fetching firewood. This creates difficulty in using

standardised and acceptable measures and indicators of functionality.

In statistical terms, ageing is defined in terms of the number of years one has lived (chronological age). Chronological age rarely occurs alone, and according to the literature, reliance on chronological age could be misleading. It is acknowledged that chronological age usually occurs along with other definitions, such as retirement, physical decline, or change in mental attitude (Keith 1982). Keith (1982) observed that, when functional age rather than chronological age is used as an indicator of old age, the transition to old age is gradual. As it is thought that people who regard older people as a useful resource rarely define age in chronological terms. As compared to those who feel that people over 65 years are a burden. Several authors (Eliopoulos, 2001; Kennie, 1993; Roach, 2001) have defined the older persons in terms of both chronological and functional age.

The WHO defines health as 'a state of complete physical, mental and social well being and not just the absence of disease'. Whitehead (1995) suggests that the above definition of health is based on the understanding that the individuals' health is influenced by several factors that are often categorised into biological, physical and social environment, personal life styles and health services. The author refers to these factors as 'layers of influence', as they can have a health promoting or health damaging potential depending on the personal behaviour and the way of life that individual adopts.

Authors (Fuller, 2000; Whitehead, 1995) agree on the fact that individuals do not live or exist in isolation. By *'being in the world',* they interact with other people. These interactions expose people to different types of social and community influences, which may have a potential to damage, or promote health.

Mutual support is one of such positive factors that result from the interaction in the community. Mutual support is capable of sustaining the health of the older people in what could have been unfavourable conditions. Lack of support, may lead to social isolation of the individuals that may adversely affect their health.

Leininger (1985) agrees that the WHO definition suggests that the immediate environment is very influential in the maintenance of health. The author further agrees that the inseparable relationship between the subject and the lived world, make health and illness socially and culturally constructed. It means that the socio-economic and cultural conditions prevalent in the society have an effect on the general health outcome and standard of living pertaining to the members of that society. Socio-economic factors for example may influence the individual's choice of accommodation, employment, feeding and other social interactions.

Some authors (Irvine *et al*, 1986; Kamwengo, 2001; Kennie, 1993) argue that the WHO definition lacks an operational precision upon which specific preventive and health promotional strategies for the older persons can be based. It is believed that the emphasis on social well being and *'a complete absence of disease'* as suggested by the definition, could mean provision of goods or services that should keep the older persons more content. It should however be noted that achievement of this level of health is accompanied with a variety of costs to many of the individuals concerned.

It is believed that the social and economic environments in many African countries (high level of poverty, the effects of HIV/AIDS, limited infrastructure) do not allow access to the necessary resources to achieve anything approaching *'a state of complete physical, mental, and social well-being'*. Therefore, they support that a framework for considering the various possibilities for action and how they may contribute to the attainment of health and active ageing is required.

Fuller (2000) suggested that the concept of health maintenance as a way of contributing to achieving health and active ageing. The author argued that it is vital to maintain good health as it helps to maintain well-being and quality of life. Maintenance of good health enables the older people to maintain autonomy in order to continue making active contributions to society even in this later stage of life. However, the author argues that health maintenance is based on the concept of health and the ability of an individual to maintain desired health status. Maintenance of health is complex, as it requires a balanced state of the internal and external environment. By being in the world, people are always interacting with the changing environment.

2.2.2. Normal ageing process

The degree, at which ageing occurs, varies from individual to individual. Even different organs within the same individual may show marked decline while another demonstrates no significant change (Eliopoulos, 2001; Irvine *et al,* 1986). Varying degrees of physiologic changes, capacities and limitations have also been documented among peers of a given age group. Some people of the same age may show normal physiological parameters within their organs while others may show disability-associated pathological changes (Hall *et al,* 1993). According to Haslett *et al* (2002), a good proportion of 90-year-olds has been known to live and manage with little support. While some 70-year-olds are severely disabled as a result of ravages of disease.

Ageing as a normal development process has some common characteristics and problems. While some of the changes that take place in the body with advancing years have no clinical significance, some changes do have some clinical significance. Some changes cause loss of organ function with time. This leads to some decline in physical, mental and social capacities (Hall *et al,* 1993; Irvine *et al,* 1986). Most of the organs do not only show signs of decline in function but they also become smaller in size and show signs of decline in function. It is assumed that the reduction in function is a result of loss of the cells from which they are composed. Though not all cells behave in the same way.

Despite the marked variations in organ function with advancing age, Haslett *et al* (2002) suggests that this would not under normal conditions interfere with organ function. The only significance it has is reduction in reserve capacity of the body. The normal age-related changes that take place in the body are

referred to as *'senescence'* (Hall *et al,* 1993; Redfern & Ross, 1999; Roach, 2001).

Ageing starts from conception, and every cell in the body grows and ages. Functional capacity increases in all organs in childhood and peaks in early adulthood. The capacity begins to decline with age (Eliopoulos, 2001; Roach, 2001). Irvine *et al,* (1986) acknowledges that, ageing or growing up, has to take place in order for the cells to attain the cellular growth. Life tasks by various organs can only be fulfilled if the organs and body systems attain a certain growth.

Disability and frailty have often been associated with the ageing process. These concepts have often been mistaken as being one and the same. Admittedly the two can co-exist. There is need to understand the normal ageing process in order to be able to differentiate the differences between disability and frailty. Disability is the loss of function whereas frailty is the increased vulnerability to loss of function. The later occurs due to reduction in body reserves (Haslett *et al*, 2002). Whereas disability could either be due to an injury or an illness. Illnesses like stroke, rheumatoid arthritis are common causes of disability among the older persons. The understanding of the normal ageing process would therefore increase our ability to prevent the age-related disorders and promote healthy ageing.

Ageing is not easily recognised as changes take place silently throughout one's life. But time comes when superficial changes of ageing can no longer be concealed. Some of the notable changes are in the skin and hair. The changes that occur with age are either age-determined or age-related. Age-determined features are the changes that are inevitable. These are changes like greying of hairs and wrinkling of the skin. These changes are referred to as inevitable changes that come with

age, and have no major clinical significance. The age-related changes are as a result of accumulation of several intrinsic and extrinsic factors that have accumulated over a period of time (Irvine *et al,* 1986).

The dry and wrinkled skin is as a result of reduced secretion of elastin, collagen and sebum. This makes the skin vulnerable to breaking. This is worsened by loss with age of subcutaneous tissue that cushions the bony prominences. This puts the older people at high risk of pressure sores. This is compromised further by the changes that take place in the immune system, and nutritional disorders which have a negative impact on wound healing process. When nursing the older people, therefore, the rationale should be to prevent damage to the skin as much as possible. Though these changes may have no major health significance, nurses should be mindful that, the older people suffer from impaired skin integrity (Carpenito-Moyet, 2004; Irvine *et al,* 1986).

Stoyle (1994) offered a physiological description of the ageing process. The human body is made up of tiny units called cells. Each cell is controlled by the deoxyribonucleic acid (DNA) to perform a specific function and replaces itself when it is damaged or worn out. All cells need oxygen and nutrients to live and function. The body uses the circulatory system to transport the oxygen and other nutrients throughout the body. During this process of metabolism, the body produces waste products, which are gotten rid of by the excretory system. This process is referred to as homeostasis. However, there are some instances when the body fails to respond and maintain adequate homeostasis. It has been suggested that, the failure by the body to respond and maintain adequate homeostasis is responsible for the increased incidence of frailty and death in senescence.

Death might result even from minor illness or injury that would not have been fatal in a younger person. This is referred to as the '*survivorship analysis or behaviour'*. It advocates that the percentage of the survivors' decrease with time, while the chance of death increases with age (Redfern & Ross, 1999:4; Robert *& Hofecker* 1990:27). However for the survival analysis to be meaningful, Robert *& Hofecker (*1990: 27) suggests that, it should be looked at in relation to the biological basis of the ageing rate, and the statistical distribution of the physiological capacity in the population understudy.

2.2.3. Theories explaining ageing

The complexity of the ageing process has led theorists in exploring several factors, both internally and externally to try and explain ageing. No single theory to date can fully explain ageing or the causes of ageing (Roach, 2001). In the continued efforts to try and explain the causes of ageing and the ageing process, several laws and theories have been suggested. Eliopoulos (2001) pointed to the fact that most of the proposed ageing theories only offer varying degrees of universality, validity and reliability.

Despite, this variety of theories trying to explain ageing, there is a common understanding amongst most of the theorists (Eliopoulos, 2001; Hall *et al*, 1993; Roach, 2001; Robert & Hofecker, 1990) that:

- ageing is a universal process;
- it is a progressive and irreversible process, both in structure and function;
- all living beings age;
- beings under the point of reference emerge from the same type of organism;

- ageing is influenced by several intrinsic and extrinsic factors and;
- ageing is debilitating and resulting not only in losses but also in gains.

In this section, three categories of ageing theories (the fundamental biodynamic or natural law, biological theories and psychosocial theories) were reviewed. These theories are summarized in Table 2. Most of these theories arise from the understanding that people grow and develop physically, emotionally and socially during their human life in order to realise their full health potential (Stoyle, 1994).

2.2.3.1. Fundamental biodynamic or natural law of ageing

The fundamental biodynamic or natural law explains the ageing process as a '*linear fashion'* of 'emerging, changing and vanishing. It views ageing of man as destiny, as he has to return home into *'being'* and acknowledges that ageing starts with conception (Robert & Hofecker 1990:7). The natural law argues that the individuals are born, grow and attain optimum vitality. But with advancing age, vitality begins to fade and eventually death takes place. Kennie (1993:7) recognises that, there is a decline in physiological functioning in almost every organ and system, particularly after the eighth decade of life. This leads to decrease in the homeostatic reserve. The decrease in the homeostatic reserve leads to the body's failure to respond to iatrogenic diseases, and maintenance of adequate homeostasis.

The fundamental biodynamic law is associated with the preservation and the deprivation principles or laws. The preservation principle is also referred to as the law of preservation and applies to the period between birth and the optimum of vitality (Robert & Hofecker 1990). It is reinforced by the disposable

stroma theory that suggests that ageing is as a result of failure of body cells to repair random environmental damage (Hall *et al,* 1993; Robert & Hofecker, 1990). The deprivation principle or the law of deprivation extends from the phase of optimum vitality to death (Robert & Hofecker 1990: 3). It is more associated with biological ageing, as the processes of ageing are more conspicuous in this stage. People begin to show attributes that society associates with old age. Functional deficits and death take place mainly in this phase of life (Robert & Hofecker, 1990).

However, effects of the law of preservation are present in all stages of life, including the deprivation phase of life, as life has to continue throughout the senescence. But as one grows older, the influence of the law of preservation decreases and the effects of the law of deprivation increases. This causes an increase in the age-specific death rate seen with advancing age (Robert & Hofecker, 1990). The theory supports the Gompetz's law, which advocates that the percentage of surviving decreases with time and the chance of death increases with age (Redfern & Ross, 1999). In the final analysis, this fulfils the law of negation.

2.2.3.2. Biological theories of ageing

Biological theories suggest that, ageing is a natural process that is thought to be as a result of cell changes over a period of time. As a natural process, biological ageing proceeds irreversibly in structure and function from earlier, to the later stages of life (Irvine *et al,* 1986; Stoyle, 1994). The most commonly used theories are discussed in this section and include the genetic factor's theory, the cross-linking theory, the free radicals theory, the auto-immune reactions theory, and the wear and tear theory.

Genetic factors theory

The genetic factors theory suggests that life is programmed in the genes before birth and that people are born with biological clocks that determine the specific life span. It supports that genes control ageing, and that control occurs at the cell level. It is believed that the longer the life span, the greater the cell divisions. Some theorists believe that there is a growth substance that fails to be produced causing cessation of cell growth and reproduction. Others hypothesize that there is an excessive production of the ageing factor, which accelerates the ageing process (Eliopoulos, 2001; Roach, 2001; Stoyle, 1994).

Cross-linking theory

The cross-linking theory proposes that cellular division is threatened as a result of a chemical reaction. It maintains that a cross-linking agent attaches itself to a deoxyribonucleic acid (DNA) strand preventing normal parting of the strands during mitosis. According to this theory, cross-linking agents accumulate over a period of time, and they form dense aggregates that interrupt with intracellular mechanism. Interruption of the intracellular mechanism leads to the impairment and failure of the body's organs and systems due to poor homeostasis (Eliopoulos, 2001; Roach, 2001). The failure of the intracellular mechanism is thought to be responsible for ageing.

Free radical theory

The free radical theory suggests that ageing, is as a result of the accumulation of free radicals and faulty molecules over a period of time. It maintains that the reactions with other free radicals in the environment and the waste products in the body threaten and disrupt cellular function. It further suggests that free

radicals do damage the proteins, enzymes, and DNA by replacing molecules that contain useful biological information with faulty molecules thereby creating cellular dysfunction. As a safety mechanism, the body does produce some antioxidants to counteract the production of free radicals. Nutritional experts also advise taking of some antioxidants to slow down the ageing process. From the above theories, one would conclude that ageing begins at the cellular level and that we age every day of our lives (Eliopoulos, 2001; Roach, 2001).

Autoimmune system theory

The autoimmune system theory suggests that the changes that take place in the immune system as people grow are responsible for ageing. There is substantial evidence that several physiological changes take place in the immune system. Some of these changes cause several deficiencies in the immune system (Eliopoulos, 2001; Stoyle, 1994). The thymus and the bone marrow are the primary organs of the immune system. The ageing process affects these organs. The size of the thymus decreases with age affecting the production of the T-cell differentiation. The level of the thymus hormone also decreases to an extent that it becomes undetectable in the blood of persons older than 60 years and above (Eliopoulos, 2001).

The body is protected by the humoral immunity from cancer and viral infections. Humoral or acquired immunity is what is referred to as the cell-mediated immunity. Lymphocytes (T-lymphocytes and B-lymphocytes) are the active agents of acquired or humoral immunity. Both lymphocytes come from the stem cells, and are manufactured in the bone marrow. T cells are responsible for the cell-mediated immunity as they protect the body from diseases by destroying foreign cells directly. The T cells

stimulate other cells to assist in the immunity. It is the T cells that are responsible for initiating a rapid immune response when repeated invasion occurs. The reduction in the thymus hormone leads to bone marrow stem cells inefficiency, and reduction in the production of T cells (Eliopoulos, 2001; Roach, 2001).

These changes render the body incapable of fighting disease or infection. It is these changes in the immune system that are thought to be responsible for the older peoples' predisposition to certain infections and perhaps to the high incidence of cancers suffered in old age (Irvine *et al,* 1986).

This theory suggests that failure of the immune mechanism, leads to the accumulation of disease in the body, and this in itself is a cause of ageing. The theory also maintains that, the body misidentifies aged, irregular cells as foreign agents and attacks them. The changes that take place in the immune system are thought to be responsible for the correlation of disease and ageing. It is difficult in most cases to separate the effects of ageing from the effects of disease. As disease and ageing compound each other. Survival becomes impossible without a well-functioning immune system.

Tear and wear theory

The wear and tear theory attributes ageing to the wear and tear of the body cells with time, and failure of the body to replace the worn out cells. This theory seems to be associated with a pigment called Lipofuscin, which has been found to be higher in the ageing organs (Eliopoulos, 2001; Stoyle, 1991; Roach, 2001).

The biological theories seem to be in agreement with the fundamental biodynamic law in their approach. Biological theories have, however, been described by different authors as being unreliable due to their variability (Eliopoulos, 2001:22; Hall *et*

al, 1993: 38; Irvine *et al* 1996:11). Despite the recognised variability, biological theories are still widely used in several ways to explain the ageing process.

2.2.3.3. Psychosocial theories of ageing

The psychosocial theories of ageing explore the mental processes, behaviour and feelings of persons throughout the lifetime (Eliopoulos, 2001; Stoyle, 1994). Ajila & Adegoke (2001) refer to psychosocial theories as theories of adjustment to ageing. Ageing is associated with chronic ill health, disabilities, retirement, and, in most cases reduced income. Retirement also leads to increased free time from formal employment but increased caring responsibilities of looking after the grand children. The psychosocial theories therefore, do explore how the older persons adapt to those pressures. The psychosocial theories include the disengagement theory, the activity theory, the continuity theory, and the stress adaptation theory.

Disengagement theory

The disengagement theory holds that, as people grow older, they withdraw from active involvement in society. And that society responds by withdrawing from the older persons as well (Eliopoulos, 2001; Roach, 2001). Redfern & Ross (1999) suggest that society encourages disengagement as they see it as the time to transfer roles from the older persons to the much younger age groups. It is seen as being healthy as it minimizes problems of disruption of activities in the event of sudden illness or death of the older person.

According to Ajila & Adegoke (2001) disengagement is a gradual process rather than an imposed one. The theory views disengagement as a mutually satisfying process in which the older

person and society prepares in advance for the ultimate death of the older person. However, the theory disadvantages the older persons, as it promotes isolation of older people. Healthy and active ageing demands that the older people participate in growth stimulating interventions.

Activity theory

The activity theory as the name implies, is the opposite of the disengagement theory. It advocates that people should remain involved and be active members of society, taking on roles and responsibilities (Eliopoulos, 2001; Redfern & Ross, 1999; Roach, 2001). This theory is positive as it promotes healthy and active ageing. It maintains that people should maintain their middle life age activities. Evidence shows that those who maintain their middle life age activities leave a more satisfying life.

Continuity theory

The continuity theory is concerned with personality and culture. It suggests that as people age they become more predictable in their behaviour and would like to continue with their roles. However, personality and culture plays a major role in determining the relationship between the levels of activity and life satisfaction. The theory suggests that, the older people have certain beliefs, norms, attitudes, expectations and behaviours that differentiate them from the younger age groups (Eliopoulos, 2001; Roach, 2001).

Like the disengagement theory, this theory disadvantages the older persons as it promotes isolation and discrimination of the older people.

Stress adaptation theory

The stress adaptation theory argues that life cycle has not only a predetermined genetic programme that determines one's life span, but the non-genetic factors (stressful life events, life style, behaviour, culture, and gender) also have a role in the ageing process. It suggests that stress does accelerate ageing due to the negative effects it has on people's health. Long-term stress causes chronic fatigue, sleeping difficulties and high blood pressure (Kozier, *Erb, Berman & Snyder,* 2004). Life styles and behaviour play a major role in peoples' lives as they determine one's health status and the rate of ageing. Life styles and behaviour have a health promoting or health damaging potential depending on the life style or behaviour one adopts.

Table 2. Summary of theories explaining ageing

Theories	Short description
Fundamental biodynamic or natural law	***The fundamental biodynamic or natural law explains the ageing process as a 'linear fashion' of 'emerging, changing and vanishing. It views ageing of man as destiny, as he has to return home into 'being' and acknowledges that ageing starts with conception (Robert & Hofecker 1990:7).***
Biological theories: (1)Genetic factors theory (2)Cross-linking theory (3) Free radical theory (4) Autoimmune theory (5)Tear and wear theory	***Biological theories suggest that, ageing is a natural process that is thought to be as a result of cell changes over a period of time. As a natural process, biological ageing proceeds irreversibly in structure and function from earlier, to the later stages of life (Irvine et al 1986; Stoyle 1994;).*** (1) The genetic factors theory suggests that life is programmed in the genes before birth and that people are born with biological clocks that determine the specific life span. It supports that genes control ageing, and that control occurs at the cell level. (2)The cross-linking theory proposes that cellular division is threatened as a result of a chemical reaction. (3) The free radical theory suggests that ageing, is as a result of the accumulation of free radicals and faulty molecules over a period of time. (4) The autoimmune system theory suggests that the changes that take place in the immune system as people grow are responsible for ageing. (5) The wear and tear theory attributes ageing to the wear and tear of the body cells with time, and failure of the body to replace the worn out cells.
Psychosocial theories: (1).Disengagement theory (2) Activity theory (3). Continuity theory (4). Stress adaptation theory	***The psychosocial theories of ageing explore the mental processes, behaviour and feelings of persons throughout the lifetime (Eliopoulos 2001; Stoyle 1994).*** (1) The disengagement theory holds that, as people grow older, they withdraw from active involvement in society. And that society responds by withdrawing from the older persons as well. (2) The activity theory as the name implies, is the opposite of the disengagement theory. It advocates that people should remain involved and be active members of society, taking on roles and responsibilities. (3) The continuity theory is concerned with personality and culture. It suggests that as people age they become more predictable in their behaviour and would like to continue with their roles. However, personality and culture plays a major role in determining the relationship between the levels of activity and life satisfaction. (4) The stress adaptation theory argues that life cycle has not only a predetermined genetic programme that determines one's life span, but the non-genetic factors (stressful life events, life style, behaviour, culture, and gender) also have a role in the ageing process.

2.3. CONTEXTUAL DETERMINANTS OF AGEING

The contextual determinants refer to internal and external factors or situations to the older persons that might influence the older persons' perceptions about themselves and their lived experiences. These factors or situations were classified as biophysical determinant; socio-economic determinant; and psychosocial determinants (see Table 3).

The inclusion of these factors in the literature review is in line with the transcendental philosophical approach that emphasised that unity exists between ourselves as knowers and the things or objects that we come to know and depend upon, because all knowledge and experience are connected to phenomena, things in consciousness that appear in the surrounding world (Levinas 1998).

In addition, there is substantial amount of evidence indicating that as people grow older, they become more vulnerable and unable to effectively cope with the impacts of these factors or situations (Kennie 1993; Hall *et al* 1993; Haslett *et al* 2002; Irvine *et al* 1986). This coping inability might also influence the older persons' perception about themselves and their lived experiences.

Table 3. Summary of contextual determinants of ageing

Group	Sub-group
Biophysical determinant	- Individual health status - Physical autonomy and independence
Socio-economic determinant	- Household size and characteristics - Source of income - Social welfare
Psychosocial determinant	- Stress and coping - Social values and change - Cultural values and norms

2.3.1. Biophysical determinants

The biophysical determinants groups included the individual health status, and physical autonomy and independence. As people grow older, they are likely to develop one or more health conditions that might worsen the already fragile health status of the older persons; and consequently affect the way they view themselves and their quality of life. Similarly, the reduced physical energy and strength associated with ageing might result to loss of autonomy and independence that could also influence the way they view themselves and their quality of life.

Individual health status

It is documented that arthritis, hearing impairments, heart conditions, hypertension, endocrine conditions, pain, nutritional deficits, falls (which may result in fractures), acute confusion, urinary incontinence, sleep disturbance and dehydration, are some of the prevalent chronic conditions that affect the older

persons. Heart diseases used to be the major killers among the older persons but now there is a major shift from heart diseases to degenerative diseases (Eliopoulos 2001; Roach 2001).

The pain suffered by the majority of the older persons is attributed to the common chronic illnesses. Garret (1993) advises that pain should not only be viewed as negative. Pain is a positive early warning sign that something is wrong. The older people tend to suffer from reduced sense of pain, which causes a delayed response should there be an illness. There might, for example, be some differences of reporting of pain between the older persons depending on the availability of support (whether they are independent economically, have a family support), social responsibilities (like looking after orphaned grand children), and living conditions (living in institutions or with family members). The older people without adequate support and more social responsibilities report pain more frequently than those with adequate support and less responsibilities (Williams & Hunt 1997).

Falls and unsteadiness are common features among the older persons. According to Redfern & Ross (1999), the incidence of falls among the older people is though to be due to a combination of factors. Some of these factor include increased postural; poor balance, postural hypotension, poor eyesight, reduced muscle strength, and side effects to some of the medications. Falls have also been documented as major causes of fractures; especially fracture of the head of the femur (a condition documented as a common cause of disability among the older people). Haslett *et al* (2002) estimates that, about 30% of those aged 65 years and above, and 40% in those aged 80 years and over, fall each year. But only 10-15 % of these falls do account for serious injuries.

Authors warn that common as they might be, falls should not be ignored, they must be treated with suspect especially if they do suddenly occur, and over a period of time. Falling has been identified as one of the classic atypical presentations of illness especially among the frail. Falling also has in most cases been associated with reduced body reserves, a condition that occurs with age. The reduced reserves render the older persons incapable to maintain their balance when challenged by an acute illness (Haslett *et al,* 2002).

Sleep and rest are a basic human need that is essential for health. Sleep is a good indicator of the state of health and well-being in that one may be restless and unable to obtain sufficient sleep in the presence of pain, stress or impaired body functions. It is argued that the normal ageing process has little effect on the number of sleeping hours as compared to the quality of sleep. The majority of the older persons however do complain of sleeping disturbances (Eliopoulos, 2001; Taylor, 2001).

Transient and chronic insomnia are the most common types of sleeping disturbances described amongst the older people. Transient insomnia tends to last for a few days and does not require medical attention. It is often associated with stressful situations. Chronic insomnia however tends to last for longer periods of time and requires medical attention (Fuller, 2000; Roach, 2001).

Authors (Carpnito-Moyet, 2004; Eliopoulos, 2001; Kozier et al, 2004) associated several factors to sleeping disruption or disturbance patterns among the older people. Some of these factors include:

- Pain – causes sleeplessness due to restlessness,
- Emotional stress- fear, anxiety, and depression have been identified, as major cause of insomnia among the older persons,
- Environment – noisy and sleeping in a strange place,
- Losses that occur with ageing,
- Fatigue – normal work activities are known to contribute to restful sleep. But on the contrary, excessive exercise or exhaustion can affect one's sleep,
- Stimulants and alcohol- caffeine has some stimulation effect on the central nervous system.

Under nutrition is the most common nutritional disturbances described amongst the older persons. Several factors have been associated to the above conditions. Ageing is associated with some impairment in the senses of taste and smell that might affect eating habits. The decrease saliva and gastric juice may also affect a person's nutrition. Loneliness can lead an older person to adopt bad eating habits, as they may be unwilling to cook or sit and eat alone. Under nutrition can be life threatening as it puts older persons at risk if they develop an acute illness or suffer a major trauma such as a fracture. Under nutrition is often accompanied by anorexia and inadequate reserves to cope with the severe stress that usually accompanies such disorders or subsequent surgery (Hall *et al*, 1993).

Management and treatment of the above age-related conditions are not only costly but beyond reach of the older persons and the Zambian economy. These conditions are chronic in nature and require long-term care, which might not be on the reach of the majority of the older persons. Similarly, the management and treatment of these diseases would undoubtedly strain the health and social care systems, which are already burdened with challenges of communicable diseases (Haslett *et al,* 2002).

Physical autonomy and independence

It is documented that, as people grow older, they increasingly experience difficulty with self-care activities and become dependent on others. The dependence on others for self-care activities is said to be one of the features that often distinguish the older persons from others (Eliopoulos 2001). Limitations on self-care activities would put pressure on the already social over-stretched family system (Irvine et al 1986).

In a review of literature looking at promoting autonomy and independence for the older people within the nursing practice, authors (Davies, Laker & Ellis, 1997) identified a number of factors associated with attempts to promote the older people's autonomy and independence. They grouped these factors into the following categories:

- Systems of care delivery which promote comprehensive individualized assessment and multidisciplinary care planning;
- Attempts to encourage clients to participate in decisions about their care;
- Patterns of communication which avoid exerting power and control over clients; and

- Attempts to modify the environment to promote independence and minimize risk.

The attitude of the older people toward the above biophysical changes is also critical in understanding the meanings of ageing amongst the older people. The literature (Redfern & Ross 1999) suggests that the older persons might not be willing to accept physiological and physical changes accompanied with ageing as they might view themselves as functionally fit. This is more so among those individuals who might not consider themselves as being older, despite their chronological age being such. The physical signs of ageing would be denied by such people.

In addition, the perceptions of the older persons and others towards these health-related problems may influence the health seeking behaviour and the quality of life of the older persons. The older persons, their caregivers and even some health professionals might perceive these problems as being inevitable and irreversible accompaniments of the ageing process. It is common even among the health professionals to hear statements like *'It is only old age' or 'nothing can be done'*. The older people do not therefore see the need to seek medical help and when they do seek medical help, they usually delay in doing so.

2.3.2. Socio-economic determinants

The socio-economic determinants referred to external factors that are likely to influence the lived experiences and meanings of ageing amongst the older people. These factors included household size and characteristics, source of income, and social welfare system.

Household size and characteristics

The older people usually live in multigenerational set-ups. This type of living exposes the older people to more socio-economic difficulties. O'connor (1991: 30), says, '*though often less visible to the visitor from the outside, the older persons are more vulnerable to absolute poverty. Even when the older persons stay with or close to their relatives, the older persons must still be recognized as being among the very poorest, in terms of their own material possessions and spending power*'.

The size of the household also has a direct effect on the incidence of poverty. The incidence of poverty varies directly with the size of the household. According to the 1996 LCMS, the incidence of poverty in one-person households was 60 %. It rose to 71% in 2-3 person households, 77% in 4-5-person household, 80% in 6-9-person household and 84% in households with 10 or more people. The older people are very vulnerable and exposed to poverty more than other segments of the populations (Apt, 1997; O'connor; WHO, 1997; WHO, 1998).

People perceive poverty differently. For some, poverty is associated with having no car, for others, poverty is perceived as having no expensive clothes. For some older people, poverty might mean going to bed hungry, night after night, and having to walk a 10-km round trip to fetch water, for others, poverty might

mean living in low cost areas, or living as a family in one small room (O'connor 1991).

The vulnerability of the older people to poverty is associated with various factors, including:

- Negative attitudes of the family and society, which might lead to exclusion of the older persons from developmental programmes,
- The collapse of the incomes and loss of employment are some of the major causes of poverty among the older people,
- Inadequate pension scheme or lack of social welfare system,
- Exclusion from, or disadvantages suffered early in life in terms of low levels of education, poor health, poor employment status, and gender issues (Parker et al, 2000:75-78).

In general terms poverty means lack of human development. Human development signifies the process of enlarging people's choices and opportunities that are most basic to human development. Poverty negates this process. Instead, poverty promotes material deprivation in terms of food, and nutrition, health, education and literacy, safe water and sanitation, clothing, income, living conditions, access to medical and social services. Irrespective of the meaning given to poverty, material poverty is multidimensional and is characterised by physical deprivation, malnutrition, under nutrition and its related issues of ill health (O'connor, 1991).

Water supply, sanitation and water disposal contributes strongly to overall health and productivity in society. Adequate water supply is a prerequisite for hygienic environment. Linkage between health and water supply, sanitation and waste disposal is well-documented (Lankinen *et al,* 1994). Water, essential as it may be, has become a precious commodity among the majority of the older people in developing countries including Zambia.

The majority of the older people in Zambia reside in the rural or unplanned settlements or on the peripheral of urban centres where there is no piped water supply. For those in rural areas, long distances have to be covered to the water source. Water is heavy to carry; yet it has to be carried, often on the heads and over long distances. Water so fetched is precious, and to use it for bathing may seem to be a luxury. This predisposes the older people to water-washed diseases.

According to Lankinen *et al* (1994), lack of adequate water is a serious health hazard. When people use very little water, either because, there is little available or because it is too far away to be carried home in sufficient quantities, it is extremely difficult to maintain a reasonable personal as well as household and environmental hygiene.

Source of income

Zambia is still very much a rural society with 80 % of its population residing in the rural areas. Modern social amenities are almost non-existent in most of the rural areas. Since most of the older persons were excluded from salaried employment, on the basis of being illiterate, they do not enjoy any formal retirement benefit in their old age. This suggests that the older persons live on minimal subsistence, depending primarily on remittances from the well wishers.

The absence of secure source of income means that the older persons, their families and the community are unable to meet their basic needs. Reduction in income usually would entail relocation to a cheaper housing, skipping meals, viewing health care as luxury over other priorities such as food and rent (Togonu-Bickersteth & Akinnawo 2001). It also means the erosion of the sense of security that comes from sufficient food, warmth and shelter gets eroded (Irvine et al 1986). Material poverty affects the older persons more as they have no other options for what they would like to make their lives (Apt, 1997; WHO, 1997; WHO, 1998).

Social welfare system

Older people are part of the vulnerable segments of the society. As such the majority of them depend on the public welfare system for survival. In many developing countries, population ageing has added urgency to the problem of poverty among the older people (WHO, 1999). Society can no longer manage to support the pension and health care needs of the older people, when only few people are working to generate taxes, and to provide family care. In a survey of young adults aged 25 years and above, 68 % of the respondents reported that financial assistance to their parents created financial burdens for themselves.

Inadequate pension scheme or social welfare system is of great concern in Zambia. The Zambian public-pension-schemes favour only those in formal sector employment and even, when an individual retires, pension payments tend to be meagre, irregular and in most cases delayed. The pension payments also tend to be so meagre and eroded by inflation, which does not ensure economic well being of the older persons. Last but not least, most of the retirement packages exclude the retiree and his

dependants from most of the employment benefits including heath care.

This means that, health care and other needs must be met from the already reduced income, as there are no formalised social welfare services. Commercial insurance schemes are available in the country, but there are very few workers who can afford to take out such insurance policies during the working years to augment their reduced income on retirement.

2.3.3. Psychosocial determinants

Life is a developmental process divided into stages or phases and each of these phases or stages is associated with various changes including psychological and social changes. Individuals are expected to adapt to or accept these changes (Kozier et al, 2004; Redfern & Ross, 1999; Taylor et al, 2001). However, some individuals or society might hold negative perceptions about these changes leading to various psychosocial responses. Similarly, failure to adjust to or accept these changes might also be stressful to the individual and lead to some psychosocial problems. These problems might influence the way the older people experience ageing and the meaning they attached to it.

Stress, coping, social values and change, cultural values and norms were some of the psychosocial factors described in this section. The inclusion of these factors was based on the assumption that they might influence the way the older persons view themselves and the meanings they attached to the ageing phenomenon.

Stress and coping

Authors (Kozier et al. 2004; Nettina 2001) refer to stress as '*a change in the environment that is perceived as a threat, a challenge, or harm to the person's balanced state.'* Taylor *et al* (2001) refers to stress as '*a response or a condition in which the human body responds to the changes in its normal balanced state.'* Life is a series of stress and recovery episodes that produce no harmful effects. However, chronic stress without recovery can produce serious consequences, including life-threatening diseases, social and emotional problems. Stress is a universal human experience, which affects all age groups. Though effects of stress would be felt more among the older people due to the age related changes and the socio-economic changes that take place during this developmental stage (Eliopoulos, 2001).

The older people are exposed to various sources of stress that range from adjusting to retirement and reduced income, deaths of spouses or friends, loss of status or living standards as a result of retirement, illness and hormonal changes, failing faculties and ageism. The losses and grieving suffered during the late adulthood, predisposes the older people to stress. The ageing process is such that it reduces the body reserves and body immunity. The effects of stress on the older people will undoubtedly compromise their quality of life further (George 1995; Haralambos 1986; Kozier et 2004).

A study (Stokes & Gordon, 2003) of common stressors experienced by healthy older people using Stokes/Gordon Scale from a convenience sample of 200 healthy older adults, aged 65 years living in the community. The study identified the following ten most commonly experienced stressors: slowing down, concern for world conditions, constant or recurring pain or discomfort, time

too short with children or grandchildren, and wishing parts of one's life had been different.

The common age-related health problems that affect the older persons might pose limitations in their ability to engage in self-care activities or worsen the already reduced level of energy. The limitation in self-care activities and reduced level of energy might lead to dependency on others. While it is acknowledged that dependence can occur at any stage of development, the type of dependence seen among the older people is of great concern as it tends to be long term and in most cases overwhelming. It is seen often as a source of stress as it denies them autonomy and affects their quality of life (Irvine *et al,* 1986:4).

Balogun (2001) defines coping as things that people do on their own behalf in confronting stressful situations or as an attempt to overcome difficulties in everyday life. Fuller (2000:588) defines coping as 'a distress – relieving process which may lead to problem resolution or tension reduction.' Archley (1991:259) sees coping as '*an attempt to overcome difficulties*.' From the three definitions of coping, one can deduce that coping is an action or behaviour involving efforts that are designed in transforming or easing difficult situations. Successful coping should in the long run alter and reduce perceived threats of the situation while managing strain-provoking symptoms arising out of that situation.

Fuller (2000) classified the coping strategies into three categories, namely: -problem-focussed, emotional-focussed, and dualistic strategy. Problem focussed coping means dealing directly with the problem in an active way. It can be in form of planning or action taking. Actions taken might be in form of changing the effects of the stressor. This can either be by finding a way to eliminate it. Re-evaluating its effects and significance to

confront the stressor or find positive features in the situation. The main aim of a problem – focussed coping is to solve the problem. Emotion-focussed coping is characterised by tendency to avoid or ignore the stressor. Dualistic coping strategy refers to the use of both problem-focussed and emotion-focussed coping strategies.

The older persons might use various coping strategies and defence mechanism such as consulting health professionals or traditional healers, social network for support, and avoidance. Some of the older persons find going to church as an effective coping strategy. It is believed that God will take care of their situations. Others seek support from family and significant others. The older persons who are unable to directly face or accept their situations commonly use avoidance (Balogun, 2001; Fuller, 2000).

Cavanaugh (1990) argues that adapting to stress weakens the immune system and therefore unsuitable for the older persons. Considering the fact that the immune system declines with age, the author concludes that adapting to stress as a coping mechanism would predispose the older people further to infections and stress-related diseases. The author believes that since the body cannot resist pressure for longer periods of time, time comes when the body can no longer cope with the stressor, as adapting is only used to manage and not to overcome or control the problems at hand.

The personality of the individual is a strong factor in regulating the impact, and/or the responsibility for the acceptance or practical application of coping strategies. A person, who is positive about coping, is likely to be more successful than a person who is pessimistic. Positive, confident individuals are known to deal directly with the problem in an active way whereas those who are pessimistic tend to avoid or ignore the stressor. The availability of resources (financial and

social support) influences the individual' coping ability. A person with better resources (financial and/or social support systems) is likely to cope better with stressful life events than the one with inadequate resources (Fuller 2000).

The coping abilities are also known to change with time in response to the person's perceptions and culture. For example, in some culture, people are discouraged from complaining about pain. As such the older people put up with pain without having to complain. In some cases the older people might just avoid to show they are feeling pain because they do not want to bother their caregivers. While the majority of the older persons do adapt to their new situations, others find it difficult to cope and adjust. Those who look at life positively have been known to adapt and adjust to life circumstances positively, better than those who are pessimistic in their approach (Archley 1991).

In a study of the support needs and coping strategies of family carers conducted in Northern Ireland using focus interviews, it was revealed that for the majority of family carers their experience was one of constant searching for support and information. The anxiety and frustration associated with inconsistent and irregular support and lack of information was a major source of concern for the carers in the study. The carers employed a number of positive and negative coping strategies to deal with the stress associated with their care-giving role (Chambers; Ryan; and O'connor 2001).

The coping strategies are used to maintain or enhance the quality of life of individuals. WHO (2002) refers to quality of life as 'subjective well being of an individual' that needs to be seen in relation to culture, physical health, psychosocial state, and level of independence and social relations. Authors (Donaldson & Donaldson 1993) suggested that the individual's quality of life

depends on the extent to which the individual copes with the activities of daily living (ADL) (self-care, social activities) and stressful life events or disabilities.

In a study of self-perceived quality of life of Chinese older persons in Hong Kong using focus group interviews with six Chinese communities, it was revealed that the older people viewed the following domains and components as being important to their quality of life: physical and functional well-being (good health, leisure); psychological well-being (life satisfaction, happiness); social well-being (social interaction, social network/support) and economic well-being (money, housing). Participants' culturally related philosophical beliefs were found to influence their quality of life (Lau, Chi-l, and Mckenna 1998).

It is generally accepted that maintaining or enhancing the quality of life in later years is vital for the older persons, the family, the health care delivery system, and the country as a whole (Roach 2001). People should be kept healthy and active for longer periods of time, than unhealthy for longer periods of time. Managing stress or effective coping would enable the older persons to overcome or control the emerging challenges and remain healthier for longer periods of time. It also helps to ease family burden and cut down on health costs. Therefore, it seems relevant to understand the ageing phenomenon as experienced and lived by the older persons in order to formulate strategies that will assist them in maintaining a fulfilling and independent life.

Social values and changes

Old age is known to be a woman's world, as women tend to live longer than men do. For example in England and Wales, the number of women over 75 years is twice the number of men of the same age. While and the number of women over 85 years, is four times than the number of men of the same age (Eliopoulos, 2001; Irvine et al 1986). In Zambia the situation is different from the one described above. The 1980 and 1990 census showed that the older males were more than the older females, though the 1969 census counted more older females than males. The 1980 pattern is likely to continue to the year 2010 when the older females would start out numbering the males.

It is documented (WHO, 1990 & 1999) that in most society, women are likely to get married to men that are older than they are. This practice predisposes most of the women to widowhood, as they are likely to live longer than men. Widowhood means loss of a spouse and in most cases, loss of income, loneliness and isolation among the older persons. This in itself is a challenge as women suffer more financial constraints than men do. In Zambia, like most of the African countries, burden of care usually falls on women. However, women form a small proportion in the formal work force due to denial or social restriction to access formal education imposed on them by social norms. Education, especially female education is paramount in promoting good health (Parker, 2000).

Widowhood implies new roles for women in the family system. In addition to their traditional role of care giving, they are expected to head the family and provide for the needs of the orphans within the background of limited access to formal workforce. This situation exposes the family to poverty. A survey conducted in Zambia showed that female-headed households were poorer than male-headed households (GRZ, 2002).

The prevailing socio-economic situation in most African countries, including Zambia has not only led to increasing poverty at the household level but have also affected the structure and function of the extended family system. While in the past, family members were willing and able to care for their older relatives, family members now find themselves in a changing world that severely limits their ability to assume these traditional roles (Gladwin, 1991; GRZ 1996).

In addition, the emergence of the HIV and AIDS pandemic poses new challenges. The premature deaths of the young and potential carers for the older person from HIV and AIDS and other diseases have created a lot of adjustments among the affected households. Upon the death of their children, who in most cases are the primary breadwinners, the older persons are not only depressed due to grief, but they also remain with the burden of having to look after the AIDS orphans and themselves as well.

The increase in the numbers of the orphans comes at a time when the traditional roles of the extended family have already been breaking down due to urbanisation and prolonged economic pressure; and also at the time when they should be receiving support from their families. The premature deaths of younger people have also increased the dependency ratio, and has increased care burden among the families concerned. Family members, who undertake the care of relatives for longer periods

at home, have themselves been known to suffer from long-term stress (Kozier *et al*, 2004).

The older persons' perceptions of themselves might also be influenced by the attitude of the society toward them. The literature suggested that often, the older people are victims of negative attitudes or stereotypes because of their age (Eliopoulos, 2001; Roach, 2001). This age related prejudice is referred to as ageism. Ageism promotes discrimination against the older people, and denies them access to social services. For example, an older person might not receive appropriate care because the attending professional might associate the condition to the physical decline of the body. For example in Zambia, it is not rare to here or read in the papers of the older people who have been killed on suspect of which craft. Ageism does little to help or assist the older people as it reinforces isolation, and might influence the meanings the older people attach to life at this later stage.

Cultural values and norms

The literature suggests that ageing is socially constructed and deep rooted in the society's cultural values and norms. In a study of six traditional societies, ageing was defined as a shift in social roles such as change in work responsibility or the adult status of children (Keith, 1982). For example in Zambia, one qualifies to enter the formal labour market at 16 years and should retire at 55 years of age. In some communities people are called older when they become grand mothers/fathers.

Cultural factors are also very important in one's life. Each ethnic group has its own customs and beliefs. These beliefs and customs may have a bearing on health outcomes and the quality of life. Ethnic norms does influence diet, health practices and may

even hold distinct beliefs about ageing. Some of which could be injurious to the lives of the older persons. Traditional roles assigned to the older persons may also depend on the norms of each ethnic group. As such, real meaning and quality of life, health and care can only be known from a holistic and social structure of reference (Leininger, 1985).

2.4. EMPIRICAL UNDERSTANDING OF THE AGEING PHENOMENON

The section of the literature review focussed on recent empirical studies looking at the ageing phenomenon from a phenomenological perspective. Other recent non-phenomenological studies on ageing conducted in Africa were also included in this section (see table 4). A phenomenon is a Greek word, defined as, *'to bring to light, to place in brightness, to show itself in itself, the totality of what lies before us in the light of day'* (Heidegger, 1977:75). It is regarded as the starting point in phenomenological studies and the building blocks of human science and the basis for all knowledge (Moustakas, 1994).

The literature search showed very limited evidence of recent studies looking at ageing from the phenomenological perspective in Africa. Most of the studies using the phenomenological approach were conducted in other continent and focused on specific experience of the older persons.

Kellet (1999a) explored the family carers' experience of nursing homes placements, using hermeneutic phenomenological approach. The results showed five shared meanings including loss of control, disempowerment, feeling of guilt, sadness and relief simultaneously, possessing a sense of failure, and having to make a forced and negative choice.

Kellet (1999b) explored the families' experience of searching for new possibilities to continue caring, using hermeneutic phenomenological approach among 14 family carers. Eight shared meanings derived from the family carers experiences including feeling duty-bound, setting up possibilities for human connection, possessing special knowledge and skills, proving the personal approach, acting as an advocate, living with hope of improvement and recovery, feeling satisfied when care experienced was deemed to be quality care, and possessing a sense of worth through making a useful and positive contribution.

Lister (1999) studied early experiences of three elderly people on discharge from hospital in relation of the loss of ability to drive following a stroke in South Australia, using a phenomenological approach. Six following main themes emerged from the data: expectation of the loss, acceptance of the loss, lack of acceptable transport alternatives, lack of control over the loss, an altered lifestyle, and loss of independence.

A phenomenological study of South Asian patients' lived experiences of acute care in English hospital identified five main themes: feelings of satisfaction with care, unhappy about the service, fitting-in strategies and post-discharge coping mechanisms. It was also revealed that the informants did not want to cause disruption to the ward environment and tried to fit in to what they referred to as an 'English place' (Vydelingum 2000).

Authors (Nilsson, Ekman, and Sarvimaki 1998) studied the meaning that the older people give to their experiences of being old in relation to their quality of life. Data was collected from 30 older people, aged 82-92 years old, using a phenomenological hermeneutic approach. The results showed that six dimensions

were important to the informants' experiences of ageing and quality of life. These dimensions included: relationships, activities, health, philosophy of life, the person's past and present lives, and future perspectives. The study also revealed five patterns relating to the meaning ascribed to the experiences of quality of life and included successful ageing, a good old age, a comparatively good life in old age, bad ageing, and a miserable life in old age.

Authors (Koch & Webb 1996) studied the biomedical construction of ageing using an existential phenomenological approach amongst 14 older persons admitted in 1000-bed hospital in the United Kingdom and described two negative experiences related to feelings of powerless. These themes included routine geriatric style and segregation that showed to result in care deprivation and depersonalisation. They stated that the older people' individual needs were ignored as they became the objects of inflexible routines within the health care practice.

A study of older men's experiences of living with severe visual impairment using a phenomenological approach was undertaken with the purpose of understanding the experience of visual impairment from the perspective of the older men with macular degeneration. Data was collected from eight informants through in-depth interviews and analysed using Giorgi method. The derived general structural description revealed six main themes: older men's lives were circumscribed by what they could and could not see and could and could not do; cherishing of independence; creation of strategies; acknowledgement of the progression of visual impairment; confrontation of uncertainties; scepticism, and fears about their diagnosis and treatment; and persistence with hope and optimism (Moore & Miller, 2003).

Deeny (2001) used a phenomenological approach to study the psychological experiences of the older people who had major surgery involving intensive care. The study identified four major themes associated with the psychological experiences of older people, namely body self-evaluation, the body-mind-soul nexus, control-independence-powerlessness in the health care context, and stress-anxiety-communication in the social context of being old. Narayanasamy (2002) used a descriptive phenomenological approach to study the spiritual coping mechanisms of patients suffering from chronic illness. It was revealed that chronic illness led informants to use the following spiritual coping mechanisms: faith, prayer, and related source of support. Patients coping with chronic illness were engaged in personal and private struggle.

Fajemilehin (2000) looked at the older persons' experiences of care- giving against the background of socio-cultural and economic change in Ife/Ijesa zone, in Nigeria, using a descriptive and cross-sectional approach. A total of 150 older people aged 70 years and above participated in the study. The findings revealed various perceived meanings of care giving and their values within that cultural environment. The researcher also reported various effects including westernisation, collapsed state of the traditional extended family systems, poor finances, political and economic instability and the burden of care giving on the older people's well being.

Authors (du-Rand & Engelbrecht 2001) looked at the needs of frail older people in informal settlements in South Africa, using a survey method with the objectives of exploring and describing the world in which the older people live. The results of the study suggested that the older people were happy in the environment in which they received care in spite of their unfavourable physical

environment and limited resources. It was also showed that the communities were largely unaware of the valuable inputs they can make regarding the care of the aged.

Perold & Muller (2000) studied the composition of the old age homes in South Africa in relation to the residents and nursing personnel, using an exploratory and descriptive survey. A total of 145 older people responded to the survey and the findings showed that the residents were largely female white aged above 85 years, the old age homes were mainly managed by welfare organizations, and lay health care workers were utilized to render nursing care.

Table 4. Descriptive summary of the empirical understanding of ageing

Authors	Focus of the study	Methodological approach
Kellet (1999a)	Explored the family carers' experience of nursing home placement.	Hermeneutic phenomenological approach
Kellet (1999b)	Explored the families' experience of searching for new possibilities to continue caring.	Hermeneutic phenomenological approach
Lister (1999)	Early experiences of three older people on discharge from hospital in relation of the loss of ability to drive following a stroke in South Australia,	Phenomenological approach.
Vydelingum (2000).	South Asian patients' lived experience of acute care in English hospital	Phenomenological approach
Nilsson, Ekman, & Sarvimaki (1998)	The meaning that older people give to their experiences of being old related to their quality of life. Data was collected from 30 older people, aged 82-92 years old,	Phenomenological hermeneutic approach.
Koch & Webb (1996)	Studied the biomedical construction of ageing amongst 14 older persons admitted in 1000-bed hospital in the United Kingdom	Existential phenomenological approach
Moore & Miller (2003)	Older men's experiences of living with severe visual impairment undertaken with the purpose of understanding the experience of visual impairment from the perspective of older men with macular degeneration.	Phenomenological approach
Deeny (2001)	Psychological experiences of the older people who had major surgery involving intensive care.	Phenomenological approach
Narayanasamy (2002)	Spiritual coping mechanisms of patients suffering from chronic illness.	Descriptive phenomenological approach
Fajemilehin (2000)	The older persons experiences of care giving against the background of socio-cultural and economic change in Ife/Ijesa zone, in Nigeria.	Descriptive and cross-sectional approach.
du-Rand & Engelbrecht (2001)	The needs of frail older people in informal settlements in South Africa	Descriptive survey
Perold and Muller (2000)	The composition of the old age homes in South Africa in relation to the residents and nursing personnel.	Exploratory and descriptive survey.

2.6. SUMMARY OF THE LITERATURE REVIEWED

The literature reviewed was divided and presented into three main components including theoretical understanding of ageing, contextual determinant of ageing, and empirical understanding of ageing. It was found that ageing was a complex phenomenon that cannot be fully explained with one theory. The literature also showed that the lived experiences of the older persons and the meanings attached to ageing should be understood within internal and external determinant such as health status, the prevailing socio-economic and psychosocial environments.

Form the empirical perspective, ageing in Zambia and Africa in general is under researched and documented during the past five years. Most of the studies available in the literature were conducted outside of Africa (see table 4). These studies also focused on specific aspects of the older people and were mainly conducted in institutional environment. Quantitative approach guided most the studies conducted in Africa. Different phenomenological approaches were used in studies conducted outside Africa. These studies focussed on specific aspects of lived experiences of the older persons (see table 4). However, the transcendental phenomenological approach and the wide-open attempt in understanding the lived experiences of the older persons followed in this study were not documented in the literature reviewed.

This study would not only bring new knowledge in this particular area of study in Africa, but would also bring new perspective on the existing knowledge on ageing phenomenon generated from other phenomenological perspectives. The naturalistic qualitative paradigm to be followed in this study adds another value to this study. As stated earlier, most of the recent

empirical studies on ageing focussed on institutionalised older people. In this study, the sample will be drawn from the older people living in their communities.

2.7. CONCEPTUAL FRAMEWORK

This section of the research described the philosophical approach underlying the study. The literature (Holloway & Wheeler, 1996) suggests that qualitative enquiries are based on 'emic' perspective. The researchers attempt to examine the experiences, feelings and perceptions of the participants rather than imposing a framework on their own which might distort the ideas of the informants. Qualitative researchers uncover the meanings people give to their experiences and the way in which they interpret them, based on the premise that individuals are best placed to describe situations and feelings in their own words.

It was within the above context that the philosophical approach rather than a specific theory or model was followed to guide the study. In this study, a transcendental philosophical approach was used to guide the research method. The transcendental philosophical approach was seen relevant to the aim of the study. As stated earlier, this study was undertaken with the purpose of enhancing the understanding of the ageing phenomenon within the Zambian context, by describing the lived experiences of the older persons and the meaning attached to ageing or being old. This approach also guided the selection of the research design as well as the selection of the informants, data collection methods, data analysis process, presentation and discussion of the research findings.

Moustakas (1994) argued that transcendental approach to science emerged from a growing discontent with a philosophy of science based exclusively on studies of material things, a science that did not consider the experiencing person and the connections between human consciousness and the objects that exist in the material world. Transcendental philosophy believed that knowledge derived not only from studies of objects or the reality of external perceptions, but also from self-evidence. Therefore, what exists in consciousness, whether through intuition or reason, could be depended on unequivocally.

From the perspective of transcendental philosophy or science, all objects of knowledge must conform to experience. Knowledge of objects resides in the subjective sources of self, which include sense (phenomenon empirically given in perception), imagination (necessary to arrive at a synthesis of knowledge), and apperception (consciousness of the identity of things). It is emphasised that unity exists between ourselves as knower and the things or objects that we come to know and depend upon, because all knowledge and experience are connected to phenomena, things in consciousness that appear in the surrounding world (Levinas 1998). Intentionality, Intuition, and essence are key concepts to the transcendental philosophy.

Intentionality

The concept Intentionality in Aristotelian philosophy indicated the orientation of the mind to its object; the object exists in the mind in an intentional way (Kocklelmans, in Moustakas 1994). For Husserl, Intentionality referred to consciousness, to the internal experience of being conscious of something; thus the act of consciousness and the object of consciousness are intentionally related. Background factors such as, stirring of pleasure, early

shaping of judgement, or incipient wishes are important in understanding of consciousness (Levinas, 1998).

According to Moustakas (1994), knowledge of intentionality requires that we be present to ourselves and to things in the world that we recognise that self and world are inseparable components of meaning. The meaning is at the centre of perceiving, remembering, judging, feeling, and thinking. In perceiving, remembering, judging, and feeling; one is perceiving something (whether actually existing or not), remembering something, judging something, feeling something, thinking something, whether the something is real or not. Intentionality directs consciousness toward something (real or imaginary, actual or nonexistent). Intentionality is embodied in the concepts of '*Noema' and 'Noesis*'.

Moustakas (1994) stated that the concepts of noema and noesis were introduced by Husserl in 1932 in Ideas, stating that the noeses constitute the mind and spirit, and awaken us to the meaning or sense of whatever is in perception, memory, judgement, thinking, and feeling. The noesis refers to the act of perceiving, feeling, thinking, remembering, or judging, all of which are embedded with meanings that are concealed and hidden from consciousness. These meanings must be recognised and drawn out. The noema corresponds at all points to the noesis. In other word, wherever a noesis exists it is always directly related to a noema. The noema, in perception, is its perceptual meaning or the perceived as such; in recollection, the remembered as such; in judging, the judged as such. Author (Ihde, 1977) refers to noema as '*that which is experienced, the what of experience, the object-correlate' and to noesis as the way in which the what is experienced, the experiencing or act of experiencing, the subject-correlate'*.

Intuition

Descartes in Moustakas (1994) regarded intuition as an inborn talent directed "*towards producing solid and true judgements concerning everything that presents itself*" (Moustakas 1994: 32). The "*present itself*" was the starting point for Descartes and for Husserl in the return to things themselves. Intuition is the beginning place in deriving knowledge of human experience, free of everyday sense impressions and the natural attitude. The self is seen as an intuitive-thinking being, a being who doubts, understands, affirms, denies, wishes for or against, senses, imagines. It is believed that all things become clear and evident through an intuitive-reflective process, through transformation of what is seen; first intuitively in the common appearance, in the manner in which something is presented and then in the fullness and clarity of an intuitive-reflective process (Mustakas 1994).

An understanding of meanings that have concealed derived from reflecting on what one has seen and described. The process of looking and reflecting, looking and reflecting again and again aims at obtaining true, accurate, and complete descriptions, both in the preliminary phases of viewing something, of letting it linger before one, and in the noetic phases of reflecting on the experience, to discover its hidden meanings (Moustakas 1994).

Essence

Essence refers to what is common or universal, the condition or quality without which a thing would not be what it is. It is also referred to, as the principle of the series, the concatenation of appearances. It is radically severed from the individual appearance, which manifests it, since on principle it is, that which must be able to be manifested by infinite series of individual manifestations (Levinas, 1998). Moustakas (1994) suggested that the synthesis of meanings and essences is an important step linked to knowledge generation within the transcendental philosophical approach. It involves an intuitive integration of the fundamental descriptions into a unified statement of the essences of the experience of the phenomenon as a whole.

It is argued that the noesis and noema constitute the meaning. It means that when we look at something, what we see intuitively constitutes its meaning. When we reflect upon something and arrive at its essence, we have discovered another major component of meaning. To the extent that the perceptual meaning of an object refers to a reality, we are describing a real thing. In other words, the description of a thing incorporates its meaning and the concept of "back to things themselves or the present itself" is a way of emphasising knowledge that is rooted in meanings rather in an analysis of physical objects (Levinas 1998).

In summary, the transcendental philosophy believed that knowledge derived not only from studies of objects or the reality of external perceptions, but also from self-evidence and that what exists in consciousness, whether through intuition or reason, could be depended on unequivocally. Therefore, looking at the ageing phenomenon as perceived by the older persons themselves is in line with the transcendental philosophical

approach. Figure 1 gives an illustration of the summary of the conceptual framework.

The researcher assumed that studying the ageing phenomenon within the transcendental philosophical approach would generate knowledge that reflect the true meaning of the phenomenon within the Zambian context and that knowledge could be depended on unequivocally.

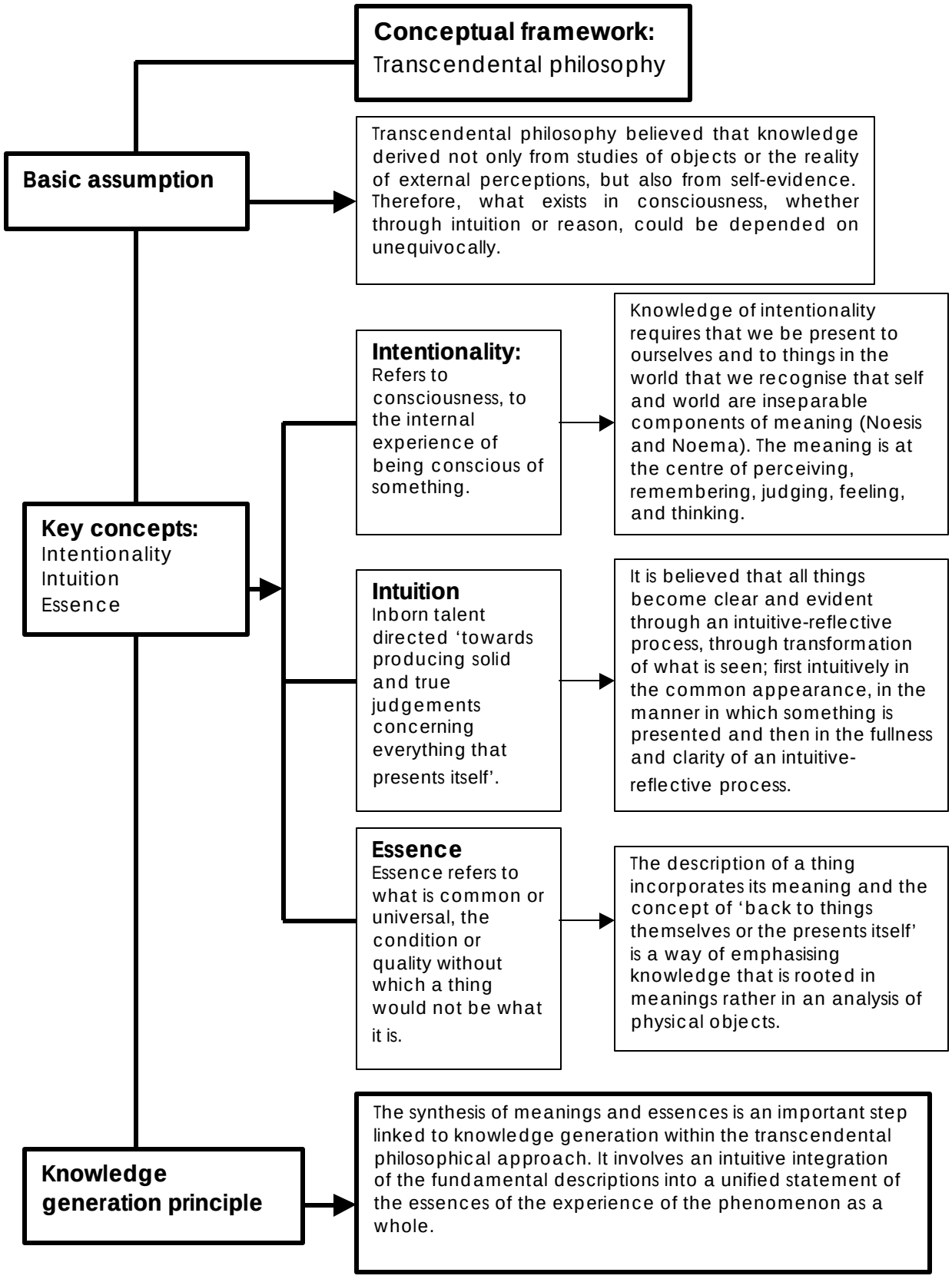

Figure 1. Summary of the conceptual framework

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. INTRODUCTION

A qualitative naturalistic research method was used to understand the lived or experienced experiences of the older people and the meaning attached to the ageing or being old in the Zambian context. Naturalistic is defined as relating to, characteristic of, or in accordance with the tenets of perceived reality in a very exact and faithful way (Encarta® World English Dictionary, 2004). Unlike the contrasting positivist notion, no causal relationships between predetermined variables are measured. The informants' ability to independently provide explanations from their own experiences is the core value in qualitative naturalistic approach.

It is suggested that qualitative research stresses the socially constructed nature of reality; the intimate relationship between the informants and what is studied; and the situational constrain that shape enquiry. It emphasises the value-laden nature of enquiry and seeks answers to questions about how social experiences are created and given meaning. In contrast, quantitative studies emphasise the measurement and analysis of causal relationships between variables, not processes (Norman & Yvonnas 2003).

The third chapter of this study described the research design, the sample and sampling technique, data collection and data analysis techniques, and the ethical considerations. The transcendental philosophy guided the research process and it application was discussed under each research step.

3.2. RESEARCH DESIGN

A transcendental phenomenological design within the qualitative naturalistic approach was used to guide the research process and to assist the researcher to reach the main objectives of the study. Transcendental Phenomenological design is rooted in transcendental philosophy described in the second chapter under the conceptual framework. Kocklelmans in Moustakas (1994) stated that the term phenomenology was used as early as 1765 in philosophy and occasionally in Kan'ts writings, but it was only Hegel who constructed a well-defined technical meaning. For Hegel, phenomenology referred to knowledge as it appears to consciousness, the science of describing what one perceives, senses, and knows in one's immediate awareness and experience. He suggested that this process leads to an unfolding of phenomenal consciousness through science and philosophy '*towards the absolute knowledge of the Absolute*' (Moustakas, 1994).

Phenomenology is the rich description of a phenomenon, as it appears to be cognitively constructed by those involved (Cirgin-Ellet & Beausang 2002). Giorgi (1985: 8, 9) views phenomenology as '*going back to the basics, to the every day world, where people are living, through various circumstances, and in actual situations'*. He recognises the value of returning to the self to discover the nature and meaning of things as they appear and in their essence. He further argues that as people live and find themselves in different life circumstances that contain within themselves essential and complex meanings, these complex meanings need to be discovered and understood.

Parse, Coyne & Smith (1986) suggested that phenomenology explicitly takes into account the human beings' participation with a situation by using written or orally descriptions presented by subjects as raw data. It is through the analysis of the descriptions that the nature of a phenomenon is revealed and the meaning of the experience for the subject understood. It is the major task of phenomenology to uncover the phenomenon under study. This includes not only the phenomenon itself but also the context of the situation in which the phenomenon manifests itself.

The literature (Holloway & Wheeler, 1996; Leininger, 1983; Parahoo, 1997) suggests that the essence of phenomenology is to describe and discover meanings of human experiences as lived in everyday life. It also helps to discover reality in circumstances where little is known about a phenomenon. Furthermore, the literature (Lo Biondo-Wood *et al,* 1993) suggests that phenomenology provides a broader understanding and deeper insight into complex human experience and meanings ascribed by individuals living the experience. It is believed that only those who have experienced the phenomena are capable of communicating them to the outside world.

Redfern & Ross (1999:15) suggested that phenomenology tries to answer the question, of '*What is it like'?* In this case, what is it like to grow older in the Zambian context? They argue that phenomenology associates reality with what one thinks, feels and perceives (the subjective or the emic) as being the truth. For what we perceive through our consciousness is the phenomenon. It is believed that one cannot understand the meaning of a phenomenon without first locating it within the context in which it exists. Holloway & Wheeler (1996) explained that '*a person has a world which is inclusive, has a being in which things have value*

and significance, and a person is self-interpreting'. This suggests that people can only be understood by use of a research method that can examine, discover and construct meaning of the individual's socio-cultural context.

According to Moustakas (1994), knowledge in transcendental phenomenology derived through the processes of *Epoche, Transcendental – Phenomenological Reduction, and Imaginative Variation.* Epoche is a Greek word meaning to refrain from judgement, to abstain from or stay away from everyday, ordinary way of perceiving things. Through Epoche process, the everyday understandings, judgements, and knowings are set aside, and phenomena are revisited, freshly, naively, in a wide-open sense, from the point of a pure or transcendental ego.

The second process means to lead back to the source of the meaning and existence of the experienced world. In this process, each experience is considered and described in its totality including its essential constituents, variations of the perceptions, thoughts, and feelings, in a fresh and open way. The process ends up with a textural description of the meanings and essences of the phenomenon, the constituents that comprise the experience in consciousness, on the ground of an open self. The third process aims at providing the structural essences of experience. The structural description of the essences of the experience presents a picture of the conditions that precipitated an experience and connect with it (Moustakas 1994).

The transcendental phenomenological design within the qualitative naturalistic approach was followed with the purpose of enhancing the understanding of the ageing phenomenon within the Zambian context, by describing the emerging circumstances of the phenomenon (demographic, socio-economic), the lived experiences of the older persons and the

meaning ascribed to the ageing phenomenon. The above design and approach guided the sampling technique, the data collection method, and data analysis method.

3.3. SAMPLING TECHNIQUE

Purposive sampling was carried out to select twenty-seven (27) informants aged 60 year old and above. Authors (Babbie & Mouton 2001) argued that sampling in qualitative research is often purposeful and directed at certain inclusive criteria, rather than random. The literature (Polit, Beck & Hungler, 2001:239; Uys & Basson, 1985:93) argues that purposive sampling is based on the judgment of the researcher regarding the characteristics of a representative sample. The researcher selects those subjects who know the most about the phenomenon and who are able to articulate and explain nuances to the researcher.

The community leaders, the medical and the Old Peoples' Homes records were used to identify older persons (male and female) aged 60 years old and above. The researcher approached the identified older persons either individually or through invitation letters with self-addressed envelopes. They were informed about the study and the possibility to select them as informants. More than 100 older persons aged 60 years were identified and approached by the researcher and sixty were prepared and willing to participate in study.

The informants' abilities to give a good account of themselves, and the potential to describe the phenomenon understudy were also used in addition to the age requirement (60 year old and above) and the willingness to participate in the study. The potential informants' abilities to give a good account of themselves were assessed using a Mini Mental State Examination (MMSE) looking at the cognitive function and though process. Nurse clinicians and researchers support the use of MMSE for identifying cognitive impairment among the older people (Dellasega & Morris, 1993). The informants' potential to describe the phenomenon under investigation was ensured by including

only participants with a minimum of 60 year old of Zambian nationality and who have lived in country from the age of 50 year old. This later inclusion criteria (have lived in country from the age of 50 year old) was based on the retirement age in the country, which is fixed at 55 year old. The researcher assumed that the period of five years offers the potential informants reasonable time to experience the phenomenon under study.

The researcher believed that the use of the above inclusion criteria offered her the opportunity to select those informants who lived and experienced the phenomenon and were able to articulate and explain nuances to the researcher.

3.4. INTERVIEW SCHEDULE

An interview schedule designed by the researcher was used to guide the interviews (see Appendix 2). The aim of the interview schedule was to facilitate the researcher to elicit a comprehensive account of the older persons' experiences of the phenomenon and not to direct the interview process. Informants were allowed to express their experiences freely and share their stories fully.

Two main open-ended questions were included in the interview schedule. The first question looked at the lived experiences of the older persons. Informants were asked to describe the most significant events or experiences in their life as older persons living in Zambia. The second question focussed on the description of the meaning of ageing or being old in Zambia. Informants were asked to describe their thoughts and feelings about being in Zambia. The design of the above open-ended questions was done in such a way that they did not influence the formation of answers. Probing was used to support the above questions when required. Basically, probing was used to clarify and validate the informants' statements as well as to facilitate the cognitive and emotional description of the meaning attached to the phenomenon.

The focus on the older persons to describe their experiences and meanings regarding the phenomenon was in line with the processes of Epoche and Reduction as described under the research design. Stanage (1987), argues that phenomenology in all its different forms has four main characteristics (it is descriptive and inductive in nature, it believes in reduction, it believes in intentionality, and it is a study of essence) and aims at finding the truth in the lived experience. It recognises the value of returning to the self to discover the nature and meaning of things as they

appear, and in their essence. The investigation starts with both the subject, the "I", and the objective world of the thinking subject and what is thought by this thinking subject.

The two main open-ended questions were introduced by a section eliciting general information pertaining to name of the informants, date, time and place of the interview, demographic information (age, gender and marital status), socio-economic information (household size, household characteristic and main source of income), and personal health history (history of any chronic disease and treatment, and health seeking behaviour). The name of the informant, date, time and place of the interview were included for the researcher's own reference and record. The inclusion of demographic, socio-economic, and personal health history was done to facilitate the structural description of the phenomenon as described in the third process of the transcendental phenomenological design and to understand the emerging context of the phenomenon.

Fitzpatrick (1999) maintained that experience is intentional. It is the person that gives meaning to experiences and the lived world. Any deviation from the social context in which the social world appears leads to loss of social meaning and its significance. It is also suggested that older people are a heterogeneous group who exhibit several differences in terms of health status, living and socio-economic conditions. These factors do have a great influence on the ageing process (Lo Biondo-Wood & Haber, 1994). Within the above context, the demographic and socio-economic data became useful in providing a profile of the informants as well as the context in which the phenomenon occurs.

3.5. DATA COLLECTION

Individual in-depth interviews and focus group interviews were used as a means of collecting data in this study. These interviews were guided by an interview schedule designed by the researcher and described in point 3.4. Authors (Moustakas, 1994; Munhau & Oiler, 1986) suggest that interviews are the primary tools of data collection in phenomenological studies. Through the interview process, the informants are given the opportunity to reflect back on their experiences and highlight on the importance of that reflection. This reflection is important as it helps the researcher to understand the meaning of what one is living through. The raw data in this study were the personal experiences of the older persons. What was collected and shared in this study were the meanings attached to the lived experiences of ageing among the older persons. According to Munhau & Oiler (1986:71) '*data are in the person,' a*s it is the person who gives meaning to the experiences of the day-to-day world.

The focus group interviews were conducted in a venue selected by the informants themselves. While, in-depth individual interviews took place at the informants' own homes unless where the informant preferred to have an interview conducted elsewhere. The conducting of interviews in the informants' own home and their decision to select a venue more convenient to them fulfilled the naturalistic property of the transcendental phenomenological approach. The literature (Beck in Fitzpatrick, 1999:38; Parahoo, 1997) argues that phenomenological studies are conducted in the natural environment of the informants. It is believed that human existence is meaningful in the sense that persons are always conscious of their environments. As such the lived experiences can only be known by attending to the perceptions and meanings that awaken consciousness.

Phenomenology helps to interpret the nature of this consciousness and of the subject's involvement in the environment. It is for this reason that phenomenological studies are conducted in the natural environment of the informants.

Focus group interviews have an advantage of obtaining viewpoints of many individuals in a short time and give opportunity to people who feel more confident when in a group than alone to speak freely. The disadvantage is that some people might be uncomfortable to express their views in front of a group (Babbie & Mouton, 2001:288-292). In depth interviews have the disadvantage of provoking one's emotions due to the recollection of the past memories, which may cause psychological pain. The above problem was overcome by taking into account the informant's choice in the allocation to focus group or in-depth individual interviews.

3.6. INTERVIEW PROCESS

Kvale (1996) argued that a complete interviewing process in qualitative research should include the following seven stages: (1) thematizing (where the purpose of the interviews and the concept to be explored are clarified); (2) designing (this refers to the laying out of the process through which the interviewer will accomplish his/her purpose including a consideration of the ethical dimension); (3) interviewing (which refers to the actual interviews); (4) transcribing (which consists of writing a text of the interviews); (5) verifying (which entails checking of the reliability and validity of the data collected); (6) analysing (which is the fact of determining the meaning of gathered data in relation to the purpose of the study); and (7) reporting or telling others what you have learned.

The seven steps of the interviewing process described above were used to guide the interview process in this study. The application of the fifth and sixth steps of the above process is described under measures to ensure the quality of data and the data analysis methods. The application of the first four steps is described below.

Thematizing

A pre-interview meeting was arranged with all the twenty-seven (27) informants. The nature and the purpose of study, the methods of data collection and the ethical considerations were addressed in detail at this meeting. All twenty-seven agreed to the terms of the study and were invited to sign the consent form (see Appendix 3). The informants were given the choice to participate either in the focus group or in-depth individual interviews.

Designing

The interview schedule was sent to each of the informants who signed the consent before the actual interview in order to give them enough time to adequately reflect on the topics prior to the interview.

The informants were informed about the full interviewing process in the pre-interview meeting.

Interviewing

The interviews started more like a social conversation but became highly interactive thereafter. The informants were reminded about the purpose of the interview and their rights as informants. Despite the use of an interview schedule, the information was solicited without controlling or manipulating the informants. They were allowed to talk freely about their experiences and their answers were used to enlarge upon the topic and to ask additional questions. The non-verbal forms of communication such as nodding, eye contact were also used throughout the interviews.

The starting of the interviews as a social conversation aimed at creating a relaxed and trusting atmosphere. The intense interaction between the researcher and the informants allowed the researcher to understand the phenomenon as perceived by the informants. The literature (Leininger 1985) suggests that the intense interaction between the researcher and informant in the course of the interview awakens the consciousness of the informants and allows them to recall and reveal events and feelings from the past from their viewpoint or frame of reference. It further helps the researcher to collect first hand / primary data.

While, Holloway and Wheeler (1996) view the interview process as a conversation with a purpose, bracketing was used in

order to avoid influencing the informants' responses and obtained original unbiased responses. According to Beech (1999), the use of bracketing enhance credibility and dependability of the data generated. Through bracketing, the interviewer personal reflections about the issue, her/his own assumptions and preconceptions are identified and set aside. He/she must be aware of his/her own subjectivity, objective and preconceptions regarding the phenomenon and not allow them to influence the informants ' views regarding the phenomenon. The bracketing strategy is also in line with the Epoche process linked to the transcendental phenomenological approach followed in this study.

During the interviews (focus and individuals), the researcher remained neutral and listened carefully to what the informants were saying. This allowed the researcher an opportunity to develop appropriate follow-up questions, to transcribe the interviews verbatim and to record them on tape. Caution was however taken throughout the interviews not to offend the informants. Ordinary language of every day speech was used and displeasing language was avoided. In some instances, the questions were translated in local languages by the researcher. This was due to language difficulties and illiteracy of some informants. It also facilitated the communication and understanding between the informants and the researcher. It further enhanced the accuracy and credibility of data as informants understood the questions better and described the phenomenon in a language familiar to them. It also accorded the researcher an opportunity to seek more clarification and even probe for further responses in language best understood by the informants.

An audit trail was kept whenever the questions were translated in local language and translated into English. The literature (Cormack, 2000) suggests that the use of a simple language and the avoidance of jargons enhance participants understanding. The researcher also watched out for data saturation throughout the interviews and the interviews were brought to an end once the informantsstarted to repeat themselves.

Transcribing

The interviews were tape-recorded and the researcher was taking relevant notes throughout the interview. The researcher's notes and the tapes were converted into write-ups and entered into the computer soon after the interview. Process memos were written after each interview to elaborate on the context in which the interview took place. In cases where questions were translated in local languages, the researcher's field notes, the tapes, the process memos and the interview schedule were given to two independent language experts at the University of Zambia to ensure the accuracy of the translation. Relevant changes were made in those notes to incorporate the comments and observations of the above experts.

3.7. MEASURES TAKEN TO ENSURE THE QUALITY OF DATA COLLECTED

The evaluation of the quality of data collected is one of the most important methodological challenges for qualitative research. In quantitative research, terms like reliability and validity are used to describe the quality of data collected. Reliability and validity also refers to the consistency with which the instrument produces the results if administered in the same circumstances and to the degree to which an instrument measures what it is intended to be measuring (Burns & Groove, 2001; Parahoo, 1997). In qualitative research, the quality of data collected is assessed in terms of confirmability, dependability, credibility, and transferability (Stommel & Willis, 2004). The description and application of the above principles are given in this section.

Confirmability

Confirmability is similar to inter-ratter reliability assessment that is used in quantitative research studies. The goal of confirmability assessment is to determine whether two or more researchers can agree on the decision taken during the study on the type of data to be collected and how to interpret the collected data. This includes the implications or relevance of the study findings for a particular field (Stommel & Willis, 2004). In this study, confirmability was achieved through the submission of the full research proposal to the Department of Health Studies of the University of South Africa and the Ethical Committee of the University of Zambia. The submission took place after the approval of the two promoters of the study. The two bodies were satisfied with the proposed study.

Dependability

Dependability refers the stability or instability of the data patterns over time or occasions. It is similar to test-retest and internal consistency reliability in quantitative studies. In qualitative research, stepwise replication technique is sometime used to assess the dependability of data. It is can be achieved by involving another researcher or consultant to collect and analyse the data independently. The data and results are then checked for comparability ((Stommel & Willis, 2004). To ensure the dependability of data collected in this study, the interview schedule and the proposal of the study was given to an independent researcher at the University of Zambia to collect and analyse data from five older persons who met the inclusion criteria for this study but were not included in the main study. The researcher also collected and analysed the data from five other older persons. The results were submitted to the promoter for comparability. The promoter was satisfied with the quality of the data collected.

Transferability

Transferability refers to the extent to which findings can be generalised to other situations and target populations. Thick description is one of the techniques used to ensure transferability in qualitative studies. It involves a detailed description of the nature of the participants, their reported experiences, and the researcher's observations during the study (Stommel & Willis, 2004). Transferability was ensured in this study by providing detailed descriptions of the informants' characteristics, the informants' description of the phenomenon as well as the researcher's observations in the reporting of the findings.

Credibility

According to Stommel and Willis (2004), credibility involves performing specific activities that increase the trustworthiness of the reported findings. These activities include prolonged engagement, peer briefing, member checking and triangulation. Credibility in this study was ensured through multiple review of the field notes and audiotapes, the neutrality of the researcher during the interview, the combination of focus group and in-depth individual interviews, member checking, careful handling of the emotional expressions, and the examination of the findings by the two promoters.

3.8. DATA ANALYSIS METHODS

Data generated from the demographic and socio-economic information were quantitatively analysed using descriptive statistics. The information derived from this analysis was used in the presentation and discussions of the findings in order to enhance the understanding of the circumstances surrounding the experiences and meanings of the phenomenon. Moustakas (1994) stated that the understanding of the meaningful, concrete relations implicit in the original description of the experience in the context of particular situation is the primary target of the phenomenological knowledge.

Qualitative method was used to analyse qualitative data generated from the open-ended questions. Authors (Holloway & Wheeler, 1996) suggest that data analysis in a phenomenological enquiry aims to understand the phenomena understudy. Basically, the process entails mapping out meaning from thematic analysis of the transcribed interviews. Colaizzi (1978) proposed a seven-steps framework for analysing qualitative data that includes (1) reading all protocols to acquire a feeling of data; (2) reviewing each protocol and extract significant statements; (3) spelling out meaning of each significant statement; (4) organising the formulated meanings into clusters (refer these clusters back to the original protocols to validate them, note discrepancies among or between various clusters, and avoiding temptation of ignoring data or themes that do not fit); (5) integrating results into an exhaustive description of the phenomenon under study; (6) formulating an exhaustive description of the phenomenon as an unequivocal statement of identification as possible; and (7) asking participants about the findings thus as a final validating step.

Giorgi (1985) proposed a five-step process for analysing empirical phenomenological data. This process includes: (1) reading the entire description to get a sense of the whole; (2) reading the same description slowly and delineating each time that a transition in meaning is perceived with respect to the intention of discovering the meaning; (3) eliminating redundancies and clarifying or elaborating the meaning of the units by relating them to each other and to the sense of the whole; (4) reflecting on the given units, still expressed essentially in the concrete language of the subject, and coming up with the essence of that situation for the subject; (5) synthesizing and integrating the insight achieved into a consistent description of the structure of the experience.

The two processes of qualitative data analysis (Colaizzi, 1978; Giorgi, 1985) described above seem to complement each other and are relevant to the philosophical approach and the research method used in this study. Moustakas (1994) suggested that Giorgi (1985) framework is more descriptive and offers two descriptive levels of the empirical phenomenological approach: (1) the first level is made of naïve descriptions of original data obtained from open-ended questions and interviews; (2) the second level, comprised of the researcher's description of the structures of experience based on reflective analysis and interpretation of the informants' accounts or stories.

According to Polit & Beck (2004), seven-steps framework for qualitative data analysis offers the researcher the opportunity to return to the informants for validation of the results and has been highly validated as conformable to phenomenological enquiry. It is believed to generate credible meanings form data collected. Giorgi (1985) shortened Colaizzi's (1978) seven-steps data analysis process into five steps. The principles outlined in the two

frameworks were used to analyse and organise qualitative data generated from open-ended questions and were applied as described below.

Reading all protocols to acquire a feeling of data

This step corresponds to Giorgi first step described above. The computer printout of the write-ups that derived from the researcher's notes, the tapes, the process memos of each interview was carefully read through while the corresponding tape was replayed in order to get a general sense of the overall data. The same process was followed for the write-ups of the interviews conducted in local language after validation by two independent language experts at the University of Zambia. According to Bogdan & Biklen (1992:166) reading constantly through the data helps to identify common or regularly appearing phrases, patterns of behaviour and the informants' ways of thinking as events are repeated and stand out.

Reviewing each protocol and extract significant statement

The write-ups were photocopied and copies given colour codes. The copies were then reread, this time reading line-by-line, paragraph-by-paragraph. These readings helped the researcher to understand the data further and to identify key statements and phrases. The identified key statements or phrases were marked off using a pencil. The common or more regularly appearing phrases or statements were identified and given codes. The coding was done to facilitate the organisation, identification, retrieval and analysis of meaningful information inherent in the data. This process is similar to the second step in Giorgi' s framework.

Spelling out meaning of each significant statement

The researcher examined each key statement to identify the underlying theme. This is in line with the intuitive-reflective process of the transcendental philosophical approach described in chapter one, under the concept framework. These statements or descriptions were then cut from the photocopied transcripts and put in marked envelopes, labelled according to the themes. This process is similar to the third step of Giorgi' s framework and the first level description as suggested by Moustakas (1994).

Organising the formulated meaning into clusters

The contents of the envelopes were poured out on the table so as to identify the patterns and themes that occurred. The contents of the envelopes were analysed and arranged into clusters of themes or categories. Where a great deal of data was identified, some subcategories were developed. To ensure connections among the pieces of information contained in the envelopes, formal writing was postponed until all the envelopes were reviewed and understood. Thereafter, the researcher formulated the meaning of each cluster through intuitive-reflective process. This process is similar to Giorgi's fourth step of phenomenological data analysis and the second level description of data as stated by Moustakas (1994).

Bogdan (1992) suggested that in a phenomenological study, data is usually analysed, interpreted and reported from the researcher's perspective and some meaning could be lost in the process of interpretation as people see and interpret things differently. This limitation was overcome by constantly consulting the original transcripts throughout the analysis process and by taking the preliminary results of the findings to the informants for validation.

Integrating results into an exhaustive description of the phenomenon

Using the same process of intuitive-reflection, the researcher examined the meanings of clustered themes or categories to formulate an exhaustive description of the lived experiences of the older persons and the description of the meaning attached to the ageing phenomenon. The process described above corresponds to the last steps of Giorgi's (1985) framework. The aim of this process was to attempt to disclose and elucidate the phenomena as they manifest themselves in their perceived immediacy.

Formulate an exhaustive description of the phenomenon as an unequivocal statement of identification as possible

The same process of intuitive-reflection was used to develop the common meaning of the ageing phenomenon within the Zambian context. The researcher examined the descriptions of the meaning of the lived experiences of the older persons and the description the meaning attached to ageing to formulate a statement describing the essence of the phenomenon ageing amongst the older persons in Zambia. This step is in line with the concept 'Essence' within the transcendental philosophical approach and also in line with the literature (Moustakas, 1994) that suggests that the synthesis of meanings and essences is an important step linked to knowledge generation within the transcendental philosophical approach. It involves an intuitive integration of the fundamental descriptions into a unified statement of the essences of the experience of the phenomenon as a whole.

Asking participants about the findings thus as a final validating step

Several measures of validating the qualities of data collected were used. These measures were described under data collection method and included measures to ensure confirmability, transferability, credibility and dependability.

3.9. ETHICAL CONSIDERATIONS

Permission to gain access to the informants was granted by the National Research Ethics Committee of Zambia (see appendix 1) after the review of the full research proposal. Measures to ensure that the rights of the informants are protected were taken by the researcher throughout the research process. Authors (Parse, Coyne & Smith, 1985) agree on the fact that the right of human subjects in phenomenological studies must be protected. The researcher must provide the prospective informants with information that would allow them to make informed decisions regarding their participation or non-participation to the study. The nature and purpose of the study, the level of involvement, the time commitment must be fully explained to the prospective informants.

Written or verbal consent for participation in the study and permission to tape record the interviews were obtained from the informants before the actual interviews (see appendix 3). Each informant received a consent form, which spelled out the nature and purpose of the study, the means of data collection, his/her rights to privacy and confidentiality (See appendix 3). Only those who signed the consent form participated in the interviews.

The informants were assured that participation in the study was voluntary and they could therefore withdraw from the study anytime without any repercussions, and that their participation would remain anonymous. The informants were also informed about the approximate duration of the interviews.

Interviews were conducted in a place and time most suitable and convenient to the informants. Other than emotional and psychological pain that may result from the interviews, there were no other anticipated potential risks in this study. However, the informants were reminded of their right to privacy throughout

the interview process. They were asked to only share what they wanted to share, and not to feel compelled to talk about things that they were not comfortable with.

The moral, ethical and cultural norms of the informants were also respected throughout the interview process. This included avoiding asking questions that could produce and encourage emotional pain. If the informant indicated that he/she was not in a position to discuss a particular question, the view of the informant was respected, and that particular question was not pursued any further.

Furthermore, the researcher handled all information collected with the utmost confidentiality and no name appeared in the final report and measures were taken to avoid the data being traced back to any one of the informants.

CHAPTER 4

PRESENTATION AND DISCUSSION OF MAIN FINDINGS OF THE STUDY

4.1. INTRODUCTION

A phenomenological study of ageing amongst the older persons in Zambia was undertaken with the purpose of: gaining an understanding of the ageing phenomenon within the Zambian context; to provide frameworks that could be used by policy-makers and health professionals to formulate guidelines or interventions relevant to the lived experiences of the older persons; to understand the meaning attached to ageing or being old; and consequently maintain or improve the quality of life of the older persons of Zambia.

The objectives of the study were to describe: (1) the lived experiences of the older persons of Zambia, and (2) the meaning they attached to ageing or being old within the Zambian context.

Focus group and in-depth individual interviews were used to generate data from twenty-seven (27) informants. Fifteen (15) informants opted for the focus group interview and twelve (12) for in-depth individual interview. The in-depth individual interviews started two weeks after the focus group interview. The focus group interview lasted for two hours with thirty minutes break between. Most of the in-depth individual interviews lasted for an hour and none of the informants were interviewed more than twice. In total 24 in-depth individual interviews were conducted in term of two interviews per informant, and two focus group interviews. Data collection covered a period of three months.

The main results of the findings are presented and discussed according to the main objectives of the study. Verbatim excerpts form the transcribed interviews were used to support the themes that emerged from data and to provide a richer picture of the situation.

4.2. DEMOGRAPHIC DESCRIPTION OF THE INFORMANTS

The informants were described in terms of age, gender, and marital status. Fifteen (15) out of 27 informants were females and 12 were males. The informants' age ranged from 60 to 87 years old. More than half (55,5% n=15) were aged between 60 and 74 year-old, nine (9) between 75 and 84, and three (3) over 84. The age of the informants was further looked at in terms of gender. Out of fifteen (15) females, nine (9) were aged between 60 and 74 year-old, five (5) between 75 and 84, and one (1) above 84. Out of twelve (12) male informants, six (6) were age between 60 and 74 year-old, four (4) between 75 and 84, two (2) over 84 (see Table 5).

In terms of marital status, it was shown that the majority (16) of the informants did not have spouses (divorced or widowed), and eleven (11) were married. The marital status was further described in terms of gender. Out of fifteen (15) female informants, ten (10) were widows, four (4) were divorced and one (1) was married. The fourteen female informants who were either widowed (10) or divorced (4) did not want to remarry despite the fact that they lost or divorced their spouses at the age where they could have still gotten married. Out of twelve (12) male informants, ten (10) were married, one (1) was divorced, and one (1) was widowed (see Table 5). It was also revealed that all twelve male informants were married to women younger than them and

more than half of them were remarried after the death of their first spouses.

Table 5. Demographic characteristics of the informants (n=27)

Gender	Total	Age			Marital status		
		60-74	75-84	Over 84	Married	Widow	Divorced
Female	15	9	5	1	1	10	4
Male	12	6	4	2	10	1	1
Total	**27**	**15**	**9**	**3**	**11**	**11**	**5**

The above findings are in agreement with most of the literature reviewed which suggest that the percentage of widowhood among women is higher in comparison with that of males of the same age. It is also suggested that men remain married even in their later years of life. The reason attributed to this is that men tend to marry women who are much younger than themselves and they tend to get married even after the death of their spouses in later stages of life (Eliopoulos, 2001; Roach, 2001).

4.3. LIVED EXPERIENCES OF THE OLDER PERSONS OF ZAMBIA

This section dealt with the first objective of the study, which focuses on describing the lived experiences of the older persons and how they viewed these experiences. They were asked to describe the most significant events or experiences in their life as older persons. The question was supported with relevant probing aimed at uncovering the older people's feelings and interpretations of these experiences.

Contextual information related to the informants' medical history, health-seeking behaviour, main source of income, household size and characteristics were quantitatively analysed and integrated with the presentation and discussion of the relevant lived experiences.

Qualitative analysis of the informants' descriptions revealed three dimensions of lived experiences: (1) health dimension, (1) socio-economic dimension, and (3) psychosocial dimension. Each dimension consisted of a number of themes and concepts. The nature of the feelings and meanings attached to these lived experiences was similar amongst all the informants and were generally negative in nature although expressed differently.

From the analysis of the descriptions of the lived experiences of the informants, it was deduced ***that the lived experiences of the older persons of Zambia comprise of three dimensions: health, socio-economic, and psychosocial, emerging from the deteriorating health status, inappropriate health care services, insecure source of income, lack of/ or poor social welfare services, lack of social support, and psychological distress; associated with a variety of negative feelings and meanings.***

Table 6 gives a descriptive summary of the lived experiences of the informants. An exhaustive framework of the lived experiences of the older persons is represented in Figure 2.

Table 6. Descriptive summary of the lived experiences of the informants

Dimension and main themes	Concepts
Health dimension	
• Deteriorating health status	-Physical dependence -Frustration -Concerns
• Inappropriate health care services	-Unfriendly -Unaffordable -Inaccessible
Socio-economic dimension	
• Insecure source of income	-Loss of social status -Risk of being neglected
• Lack of or poor social welfare services	-Unavailable -Anxiety -Despair
Psychosocial dimension	
• Lack of social support	-Social burden -Loss of companionship and isolation -Selective social prejudice
• Psychological distress	-Hopelessness -Helplessness -Search for love and affection

4.3.1. Health dimension of the lived experiences of the older persons

The health dimension of the lived experiences of the informants emerged within the context of the medical history and health seeking behaviour.

The quantitative analysis of the individual health status of the informants revealed that the majority (74% n=20) acknowledged suffering from one type of chronic health disease for which they were taking regular medication. Six (6) informants did not suffer from any chronic health disease but they indicated experiencing sleeping disturbances and back pain from time to time. One informant had a dual diagnosis (see Table 6). Female informants were more affected than male informants. Out of six (6) informants who did not have any chronic disease, four (4) were males and two were females. About 84% (n=13) of female informants were suffering from at least one chronic disease as compare to 66% (n=8) of male informants. The duration of the above health conditions varied between 5 to 10 years.

Hypertension, tuberculosis, chronic pain, diabetes, arthritis, asthma, poor eyesight and gastritis were the common chronic health diseases mentioned by informants for which they were taking regular medication. Seven (7) informants (six females and one male) were suffering from hypertension, four (two females and two males) from tuberculosis, three (two males and one female) from chronic pain, two (both males) from diabetes, one (female) from asthma, one (male) from poor eye sight, and one (female) from gastritis and stroke (see Table 6). Back pain was the prevalent type of chronic pain mentioned by the informants. Sleeping disturbances were also a source of concern among most of the informants. However, no formal diagnosis was made and none of them was taking any form of medication.

It was also shown that all the informants have used or visited public health services for most of their health problems. The informants with chronic health conditions admitted attending public health services in a regular basis for follow-up and management of their conditions. Those who did not have any chronic health conditions have indicated attending public health services for minor illnesses. On average, each informant visited the health care facilities once a month. Most of them wished to visit private health facilities for better care but were unable to do so for financial reasons.

Table 7. Health status of the informants (N=27)

Chronic health conditions	Frequency	Frequency per gender	
		Female	Male
Hypertension	7	6	1
No chronic condition	6	2	4
Tuberculosis	4	2	2
Chronic pain	3	2	2
Diabetes	2	0	2
Arthritis	4	2	0
Asthma	1	1	1
Eye sight	1	0	0
Dual diagnosis	1	1	0
Total	**27**	**15**	**12**

The chronic health conditions and other age-related conditions described by the informants in this study are not exclusive to the older persons in Zambia. The literature (Eliopoulos, 2001; Irvine et al, 1986; Roach, 2001) suggested that as people grow older, they become incapable of fighting disease or infection and vulnerable to develop some chronic health conditions such as arthritis; heart conditions, hypertension, endocrine conditions, pain, and sleep disturbances. However, the frequency (4) of tuberculosis amongst the informants in this study raised some concern. Can this be attributed to the epidemiological trend in the general population or to the poor living conditions and lack of a secure source of income experienced by the informants in this study?

The study also suggested that some informants do not suffer from any chronic conditions, except for some episodic sleeping disturbance and back pain. These findings can be seen within the context of the literature suggesting that ageing is a normal development process and that some older people can lead a healthy life despite the age related changes (Haslet et al, 1993). The episodic sleeping and back pain are supported by the literature (Eliopoulos, 2001; Taylor, 2001; Williams & Hunt, 1997) that acknowledged that the older persons might complain of pain and sleeping disturbances and such complain should be investigated to discard any underlying pathology.

Two main themes emerged form the qualitative analysis of the informants' descriptions within the health dimension of their experiences and classified as: (1) deteriorating health status, and (2) inappropriate health care services. Each of the above themes included a number of concepts reflecting the emotional and cognitive meanings attached to them by the informants.

From the perspective of the health dimension of the lived experiences of the informants, it was deduced that the ***older persons of Zambia are frustrated and concerned with the deteriorating status of their health that restrict their physical mobility and autonomy; and they are interacting with health care services that are unfriendly, unaffordable, and inaccessible to them.***

(1) Deteriorating health status

The deteriorating health status was associated with the medical history of the informants. Most of the informants viewed the chronic health conditions described above (hypertension, chronic pain, diabetes, arthritis, tuberculosis, asthma, eye sight) and other health conditions (sleeping disturbance, back pain) as the deterioration of their individual health status.

The deterioration of the health status was seen as restricting their physical mobility and autonomy, causes the feelings of frustration and concern. Three concepts derived from the informants' descriptions include: physical dependence, frustration and concern.

Physical dependence

Physical dependence was associated with physical strength and energy in addition to the chronic health conditions. Some informants stated that there was nothing wrong with ageing but were concerned with the lack of strength associated to it. They wished to see one keeps his/her strength during that time in order to move freely without an aid. They also felt that the reduced level of energy and the chronic health conditions made them unable to carry the activities they used to do and made them dependent on others.

These concepts were best illustrated by the following statements:

> '…I have almost no strength to move freely. *I would have wished that one's strengths were retained. But now you need a stick to move around.'* Said a 73-year old man.

> **'***You lose your independence, and you become totally dependent on others. Yes, people can do things for you, but in most cases you do not have energy to do things you used to do yourself. You have to depend on others to do them for you.' a* 75-year-old man lamented.

> As a 73-year-old woman observed, *'…you do not have energy to continue to maintain yourself and you have to relay on others for assistance or help. That's why you see some older people living under conditions that are not conducive to human beings.*

Frustration and concern

Frustration and concern were associated with the onset of the chronic health conditions, sleeping disturbances and pain as illustrated by some of the descriptions below:

> From a 73 year-old man, *'…I would say my health was good until 6-10 years ago when I developed some problems with my blood pressure. Now I have been diagnosed with diabetes and being investigated for possible heart disease.'*

> *A 75-year-old-woman raised concern about sleeping disturbance and said, 'Sleeping is a problem with older*

persons. You do not sleep silently like a young person. You have a lot of disturbances in the night. Sometimes you wake up in the night with heart palpitations. You sleep on another side, you find there is pain on this side.'

From the descriptions of the informants, it was deduced that the ***older persons of Zambia are experiencing chronic and other age-related health conditions that restrict their physical mobility and autonomy to perform activity of daily living; and cause frustration and concern.***

Physical dependence described by the informants might be viewed in line with the literature that suggested that as people grow older, they increasingly experience difficulty with self-care activities and become dependent on others for self-care activities (Eliopoulos, 2001). Loss of independence amongst the older persons is also described in another study conducted in a different setting with a different sample characteristics. Lister (1999) studied early experiences of three older people on discharge from hospital in relation to the loss of ability to drive following a stroke in South Australia, using a phenomenological approach. Six following main themes emerged from the data: expectation of the loss, acceptance of the loss, lack of acceptable transport alternatives, lack of control over the loss, an altered lifestyle, and loss of independence.

The older persons autonomy and independence in nursing practice can be promoted through various factors including a health care system which promotes comprehensive individualized assessment and multidisciplinary care planning; and patterns of communication which avoid exerting power and control over clients (Davies, Laker & Ellis, 1997).

However, these factors seemed to be lacking in the current health care delivery system of Zambia as suggested by the Civil Society for Poverty Reduction (CSPR) report of 1992 on Health Reforms. The report suggested that the Health Reforms initiated in the country since it independence were ineffective in meeting the health needs of the older persons. The informants in this study expressed the same views when describing their experiences with health services.

Furthermore, the literature (Davies, Laker & Ellis, 1997; Eliopoulos, 2001; Redfern & Ross, 1999; Roach, 2001) suggested that the older people who maintain their middle age activities leave a more satisfying life than those who are unable to do so. It was further suggested that a health care system that focuses on promoting comprehensive individualized approach to care for the older persons, also promote their autonomy and independence.

The frustration and concerns expressed by the older persons might therefore be seen as a psychological response to their inability to engage in activities or maintain a life style they used to do or once enjoyed. It could also be due to the inability of health care system of the country to meet the health needs of the older people within a comprehensive individualized approach.

The frustration expressed by the older persons in this study might also be attributed to their inability to access quality health care due to lack of financial resources. Access to quality care depends on adequate income. As suggested by GRZ (1996), about two third of the Zambian population are living below the poverty line and that more than 30% spend 85% or more of their income on food. The discrepancy between the desire or wish of the older persons to access quality care and the resources to their disposal might result into the feelings of frustration and concerns as expressed by the informants in this study.

(2) Inappropriate health care services

The above theme emerged from the informants' interaction with the public health services. The results of this study as presented earlier, showed that all the informants visited the public health services for their health conditions or problems. There was a general understanding amongst the informants' that the health services provided to them were inappropriate to their needs. Three main concepts were embedded in the above theme: unfriendly, inaccessible, and unaffordable.

Unfriendly health care services

The unfriendliness referred to the attitude of the service providers towards the older people when they do visit those services. They felt that the health care professionals were not kind or dispose to care of the older people.

A 73-year-old woman summarises the perceptions of other informants in the statement:

> 'R*eception is not usually good for the older people. Attitudes are very bad in these institutions. Nurses don't just care about the older people. They think the older people should just die.'*

Inaccessible and unaffordable health care services

Inaccessibility to and unaffordability of health services were related to factors such as long distances, shortage of medication, the delivery policies, availability, and ability to meet the needs of the older people. They felt that health professionals don't pay attention to the health problems and needs of the older people in the country and they were financially unable to afford or access the services.

These are some of the descriptions reflecting the informants' experiences:

> From a 73-year-old man, '...*On paper, yes, free health services exist, in reality they are not there, as I still have to pay for my x-ray and the medicines.'*
>
> A 65-year-old woman stated, '...*Yes, treatment is free but I will still need transport to get me to the hospital.'*
>
> A 75 –year-old woman stated, '...w*e need the medicines to ease the pain and not a piece of paper.'*

A 73-year-old-woman said, *'...If they do, then very few people are benefiting from the scheme... and it is in most cases those in urban areas. A well-serviced social service should take care of all issues.'*

A 71-year-old woman observed, 'A*ll we get are pieces of paper... they give you this prescription when you have no money to buy the medicine. Where do you go to borrow or ask for money from?'*

A 73-year-old woman stated, '...*We should get all the medicines there and not a prescription to go and buy medicine from the chemist,'*

A 78-year-old woman related, '...*If you have no relatives, there is no one to give you food. You will starve to death. Even if God wanted to save you from that illness, you can still die from hunger and other complications.'*

From the above descriptions of informants, it was deduced that ***health care services are unfriendly, unaffordable, and inaccessible to the older persons of Zambia.***

The health conditions accompanied with ageing pose a great challenge to health services in any society. The medical problems presented by older the persons required specialised manpower and a multi-disciplinary approach to management and treatment (Hall *et al,* 1993; Irvine *et al,* 1986; WHO, 1999). Negative experiences of the older people during their visits to health facilities are documented in the literature.

In a study of the biomedical construction of ageing using an existential phenomenological approach amongst 14 older persons admitted in 1000-bed hospital in the United Kingdom, the informants described two negative experiences related to feelings of powerlessness. These themes included routine geriatric style and segregation that showed to result in care deprivation and depersonalisation. It was stated that the older people's individual needs were ignored as they became the objects of inflexible routines within the health care practice (Koch & Webb, 1996). Although, this study was conducted in different settings, using different approach, the feelings of unfriendliness described by the informants in this study is similar to the depersonalisation described in the above study.

The attitude of the health professionals or nurses toward the older people as described by the informants in this study might be attributed to their lack of knowledge and skills regarding geriatric care or a lack of a multi-disciplinary approach to treatment. The researcher own experience revealed that geriatric nursing training is not available in Zambia. It is assumed that this lack of training on geriatric care might explain the unfriendly attitude of nurses towards the older persons as expressed by the informants in this study.

The inaccessibility and unaffordability of health services as emerged from the informants' descriptions suggest that health reforms undertaken in Zambia thus far, failed to address the needs of the older persons as revealed in the CSRPR (2002) Report. According to that report, the last Health Reforms undertaken in 1992 were a significant step forward in the direction of making the health of the people a central concern. The effective implementation of these reforms was supposed to be adequate for most of the health needs of all Zambians, including the older

persons. However, the CSRP (2002) report suggested that these reforms were not effective in meeting the health needs of the older persons of Zambia.

The above failure was attributed to various factors, including the lack of understanding and interpretation of the reforms, limited resources, poor service delivery, and socio-economic situation of the country. Most of the issues described by the older persons in this study were documented in this report. The negative views expressed by the informants in this study mean that sensitisation of health workers regarding the policy document and awareness of the need for care of the older persons has not filtered down to the delivery points. It can also be said on the basis on the inaccessibility and unaffordability rose by the informants that the older people of Zambia are being denied access to essential facilities. Access to essential facilities as defined in the Health Reforms (CSRP 2002) document means that people should be able to access essential facilities geographically, economically and culturally. However, some of the health care delivery points are situated very far from where the older persons reside, as such in the absence of reliable transport they cannot access the health facilities.

4.3.2. Socio-economic dimension of the lived experiences

The socio-economic dimension of the lived experiences of the informants emerged within the context of main sources of income and the living conditions (household size and characteristics). These factors are also indicators of the socio-economic standard of the country. The quantitative analysis of the information collected revealed that the majority of the informants did not have a secure source of income.

The majority (55,4% n=15; 8 females and 7 males) were depending on their children or relatives (44,4% n=12; 6 females and 6 males) and 'well wishers' (11% n=3; 2 females and 1 male). These three (3) informants were relying on donation from the community or "*well wishers"* to use their own expression. The children and relatives, who were providing financial assistance to the older persons, were mostly from well-educated informants and most of them were in well paying jobs or involved in some kind of income generating activities.

About 37,2% (n=10; 5 females and 5 males) were involved in some kind of income generating activities, namely informal trading (22,2% n= 6; 3 females and 3 males) and peasant farming (15% N=4; 2 females and 2 males). The four informants involved in peasant farming were all from the rural areas. Only 7,4% (n=2, both females) informants were receiving pension grant. The two were females who were still getting the pension of their deceased husbands (see Table 8).

The lack of a stable source of income as described in this study means that the older persons are exposed to additional stress, which may negatively affect their quality of life. Lack of income or low income also increases the health hazards suffered by the older people and predisposes them to poor housing, overcrowding, unsafe water and environment. Most of these

characteristics were described in the living conditions of the informants in this study. According to Eliopoulos (2001), lack of stable income leads to a lot of adjustment to one's environment. Low or no income causes significant adjustments as it triggers role, social support and psychological adjustments. The adjustments may range from relocation to a cheaper housing (which may cause under accommodation), diet restrictions (which might even lead to skipping meals) and viewing health as a luxury over other priorities.

Most informants indicated relying on others (children, relatives and well wishers) for their financial needs. This reliance might result into feelings of anxiety and hopelessness and might also expose them to abuse from the providers of income. These feelings of anxiety and hopelessness as well as the potential for abuse might be avoided or minimised if there were some safety nets in place that would cushion and assure the older people's continued support and care. If the older people were assisted to be economically independent, they would lead independent and fulfilling lives.

In terms of the living conditions of the informants, it was shown that the majority (74% n=20, 11 females and 9 males) were living in large sized households (3 to 10 people) and the minority (26% n=7, 4 females and 3 males) in small sized households (1 to 2 people). Most of the informants indicated looking after more than five people despite the fact that they did not have a secure source of income and were largely dependent on others. Some informants, mainly females reported looking after eight (8) orphans. The informants living in large sized households were mainly those in low standing status in the community as compared to those living in small sized households. It was further

noted that the informants with high standing in the community had fewer dependants than those in low standing status.

The informants were living in different types of housing units including traditional huts, high shacks and high cost houses. Informants from rural areas were mainly living in the traditional huts or thatched roof houses made of modern blocks. Informants from the urbanised areas were staying in a variety of dwelling units, ranging from high cost houses to low cost houses. The later were mainly shacks and dilapidated houses built from discarded asbestos pipes with no windows, no toilet facilities, no source of energy and clean water, with the entrance being secured with a curtain only and not a door.

Most of the informants residing in the low cost or unplanned settlements and traditional huts did not have access to clean water and proper sanitation. They reported having pit latrines, others reported having no toilets at all. The majority had dug some shallow wells, where water was being drawn from. However, they revealed that the water from the shallow wells was used for cleaning purposes and not for drinking. Drinking water was available at a cost of Zk500-00, and they had to travel about two kilometres to fetch this water. There was no source of energy in these settlements. The main source of energy for cooking was either wood or charcoal. These too, cost money.

Table 8. Socio-economic characteristics of the informants (N=27)

Characteristics	Frequency	Frequency/gender	
		Female	Male
Main source of income:			
Children and relatives	12 (44,4%)	6	6
Informal trading	6 (22,2%)	3	3
Peasant farming	4 (15%)	2	2
Well wishers	3 (11%)	2	1
Pension grant	2 (7,4%)	2	0
Household size;			
Small size household (1 to 2)	7 (26%)	4	3
Large size household (3 to 10)	20 (74%)	11	9

As shown in this study, the majority (n=20) of informants were living in large size households. It means that the older persons in Zambia are living in high poverty level and consequently in poor health status. The literature suggested the link between the size of the household and the incidence of poverty. According to the Zambia's Living Conditions and Monitoring Survey (ZLCMS) conducted in 1996, the incidence of poverty was estimated at 60% in households comprising of one person. It rose to 71% in households of 2 to 3 persons, 77% in households of 4 to 5 persons, 80% in households of 6 to 9 persons and 84% in households with 10 or more people.

It is acknowledged that the older people in Africa usually live in multigenerational set-ups. However, this type of living exposes the older people to a lot of difficulties as they are forced to share one room with many other people. This leads to over crowding which predisposes the older people to respiratory ailments and malnutrition. In addition, the orphans under the care of their grand parents living in high poverty level will be more

susceptible to malnutrition, other childhood preventable diseases, and may not receive adequate healthcare. This is likely to increase child mortality from non-AIDS causes.

The lack of access to clean water and proper sanitation described by the informants means that the older persons of Zambia are exposed to many other health threatening conditions. The literature (Lankinen *et al,* 19940) suggests that lack of adequate water is a serious health hazard. When people use very little water, either because, there is little available or because it is too far away to be carried home in sufficient quantities, it is extremely difficult to maintain a reasonable personal as well as household and environmental hygiene.

Unlike, the older people in Western countries who have secure source of income and good living conditions, the findings of this study showed that most of the informants did not have a stable source of income and the majority were living in poor conditions. Two main themes emerged within the above context and categorized as: (1) insecure source of income, and (2) lack of or poor social welfare services. Each of the above themes included a number of concepts and emotional and cognitive meanings attached to them by the informants.

From the socio-economic dimension of the lived experiences of the informants, it was deduced that the ***older people of Zambia are living in socio-economic conditions of insecure income and lack of/or poor social welfare services associated with the feelings of loss of social status, fear of being neglected, anxiety and despair.***

(1) Insecure source of income

This theme was linked to the availability and sufficient income. The availability referred to access to income while sufficiency referred to the ability of the available income to meet the needs of the older people. Limited or insufficient income was described by most of the informants and some informants were using a variety of strategies to try to readjust or meet their financial needs.

> In the words of a 61-year- old man, '*...my pension is very small. I let the annuity to accrue for the whole year, then I get a lump sum at the end of the year.'*
>
> Asked as to how he manages financially as he lets the annuity accrue for the whole year, the 61-year-old man had this to say,
>
> '*My wife runs a company. So between what she does and what I do we manage.* This confirms the importance of spouse support.

Some informants who owned big houses have indicated that they decided to put these houses on rent and they relocate to small houses. The money generated from the rent of their houses was used to pay rent for the small houses being occupied and to sustain them. Others were engaged in small informal trading.

> A 78-year-old man said, '*...my wife and I decided to rent our four bedrooms house in town, and we moved to a one bedroom flat, so that we use the rent from our house to pay the rent here and use the rest for our basic needs'.*

In the words of a 73-year old woman, *'...I make some cakes to supplement my budget. But this adds to my electricity bill,'*

It emerged from the informants' descriptions that most of them were relying on others for income. This reliance on others for financial needs meant a loss of social status, and risk of being neglected. These two sub-themes: loss of social status and risk of being neglected are illustrated below.

Loss of social status

The informants argued that the limited or insufficient income leads to dependence on others and consequently, to a loss of their social status. Although, most of them appreciated the financial support received from their children and relatives, they argued that this support should be a supplement and not a sole source of income.

A 76 –year old man said, *'If I had to change things, I would have loved to move from subsistence ... not to expect money from children. I would like to be independent, and be respected in the community.'*

'... My salary is too small to meet my life style. I have to depend on my children to meet my needs, this is not dignifying for me, especially when I go out there..' said a 73-year- old man.

In the words of a 71year old man, '... *this is not to forget that three of our four sons, are trained to professional level and are working ... they have even taken over the*

responsibility of paying fees for our younger son who is still at the university,' it makes me feel small in the community'.

Fear of being neglected

Some informants in this study argued that having a stable source of income might increase their chances of getting support from others. They though that people would be more willing to take care of older people if they knew that he/she has some income to supplement the family budget. But if an older person were seen to be a burden, they would be at risk of being neglected.

'--*You need money to maintain yourself. If you live with relatives or children, if you are able to support yourself, they are more willing to look after you. . Your chances of being neglected are higher if you are not bringing in something ..',* said a 73-year-old woman.

'... Our life is only for today. Tomorrow, you never know what you'll get. We have nothing to look forward to, without money, no one would look at you as a person out there...' Said, a 75-year-old woman.

From the informants' descriptions, it was deduced that the ***older people of Zambia are experiencing the feelings of loss of social status and fear of being neglected emerging from insecure source of income that makes them depend on others.***

The loss of social status and fear of being neglected might be seen as normal responses to the lack of financial autonomy. A secure source of income is often associated of social status and respect, and freedom of choice. These feelings can be explained by the literature that suggested that the absence of secure source of income means that the older persons are unable to meet their basic needs. The inability to meet basic needs would usually entail relocating to a cheaper housing, skipping meals, viewing health care as luxury over other priorities such as food and rent (Togonu-Bickersteth & Akinnawo, 2001). It also means that the sense of security that comes from sufficient food, warmth and shelter gets eroded (Irvine *et al,* 1986).

(2) Lack of or poor social welfare services

This theme was associated with the expectations of the older people to see their basic needs including financial need being taken care of by the public authorities. There was a general consensus amongst the informants suggesting that the government did not meet these expectations. This unmet expectation was expressed with anxiety and despair.

Anxiety

The feeling of anxiety derived from the lack of support outside the family network. The informants felt that there was nothing to expect from the government in term of social welfare services. As illustrated with the description below:

> *'It is only the family. If you have no family then you are in trouble,'* said a 76-year- old man.

Despair

In view of their insecure financial status, and poor living conditions, the informants' descriptions revealed a strong feeling of despair, which was expressed in the form of wishes. They wished that some specific health and social welfare actions could be taken to restore their hope, and to meet their basic needs. The informants wished to see the government involved in assisting the older people in meeting their basic needs and accommodation, as illustrated below:

> A 66-year old woman said, '...t*o help our older people, what should be done is to address their pension, or supply them with something such as food coupons at a certain time of a month. This will make the older persons have something to look forward to.*
>
> From a 77-year old man*, '...we need clothes and food, if the government would help us'.*
>
> A 68 year-old woman said, *'...It would be helpful if we are given clothes and beds to sleep on.'*
>
> A 78 –year old woman related, '...*It makes you feel good that there are people who care about the older people. There should be a consideration of monthly supplies. The older people usually lack affection and attention they require. It motivates one to know that there is someone out there willing to help.'*
>
> In the words of a 72-year-older woman*, 'I am looking for a place where I can stay and call home. With all my*

grandchildren around me, we can grow food… I'm pleading please help me. I want my grandchildren to stay together so that they can know each other. I would like to leave my grandchildren together, united as a family'. 'I shed tears each time I think of my grand children's plight. I do not even eat'.

A 75-year-older woman stated, *'…there should be a monthly maintenance, either in monetary form or in kind… even a bag of mealie meal will be of a great help.'*

From the informants' descriptions, it was deduced that the ***older persons of Zambia are living in an environment characterised by lack of/or poor social welfare services associated with the feelings of anxiety and despair.***

In many developed and some developing countries, social welfare services provide a safety net for the vulnerable people including the older people. The lack of or poor social services might result in various psychological responses as those expressed by the informants in this study. The literature suggested that the majority of the older people depend on the public welfare system for survival (WHO, 1999). The absence of such system, means that the informants depend largely on others as discussed previously. However, this dependence also creates problems not only for the older persons but also for the caregivers. In a survey of young adults aged 25 years and above, 68 % of the respondents reported that financial assistance to their parents created financial burdens for themselves.

4.2. 3. Psychosocial dimension of the lived experiences

Psychosocial dimension of the lived experiences of the informants emerged from the demographic, socio-economic, and health status contexts. The deaths of the breadwinners (spouses and adult children or relatives), the limited resources, the deteriorating health status, and the lack of social welfare services dominated the informants' descriptions of their psychosocial experiences. Two main themes emerged from their descriptions: (1) lack of social support, and (2) psychological distress. Each of the above themes included a number of sub-themes reflecting the emotional and cognitive meanings attached to them by the informants.

From the perspective of the psychosocial dimension of the lived experiences of the informants, it was deduced that the ***older persons of Zambia are living in a psychosocial environment of: lack of social support and psychological distress associated with the negative meanings and feelings such as social burden, loss of companionship and isolation, selective social prejudice, hopelessness, helplessness, and search for love and affection.***

(1) Lack of social support

Widowhood, divorce, deaths of young adult children, and some cultural practices were the most significant events that link lack of social support to this theme. It emerged that though the loss of significant others (through divorce or deaths), the informants found themselves in position to take up new roles and often without the resources to do so and sometimes, mostly female informants were also subjected to discriminatory cultural practices. Social burden, loss of companionship and isolation, and selective social prejudice were the concepts that emerged from the lack of social support.

Social burden

The informants acknowledged that it was not easy to look after orphans. They stated that old age was the time when the older people expect to reap what they invested in educating their children. But their hopes were washed away by the high death toll in the youthful age groups that has been worsened by the HIV/AIDS pandemic.

This is what some of the informants had to say:

> *'The problem of orphans is a very big issue. We sent our children to school. Our children are supposed to educate their children. But now we have the responsibility of educating their children as well,'* lamented a 76-year- old man.

> A 61-year-old man said, **'***... I would have been much happier if I had had better means of livelihood. It is very hard to be an old person, with all these grand children to look after'.*

> A 75 year old woman summarizes and says, *'I feel we old people are suffering. Old people need somewhere or someone to depend upon. We can't be proud of old age with grand children, because we are not working, no bread to give them, we don't even know where a bag of mealie-meal is going to come from... as we have no where to turn too.'*

Loss of companionship and isolation

Female informants viewed the deaths of their spouses, mostly male spouses as loss of support and companionship as illustrated with the statements below.

> A 78-year-old woman said*: There is no one to look after me. I do not have relatives to look after me. They are all dead. This is one of those things I have to face as an older person.'*
>
> A 71-year- old widow lamented, *'…we are only ladies. My daughter does not give me any assistance because she too lost her husband. There is no pillar from a man's side'.*
>
> *A 75-year old woman said, '…my husband died along time ago. I had five children, four girls and one son. The son is my firstborn. All the four girls are dead. My firstborn child disowned me even when the other children were still alive. I remained alone in the house without any support'.*
>
> A 71-year-old woman said, '…y*ou have a family while your husband is alive and you are strong. One relative or the other is coming; friends are visiting and so forth. So far, since he died, nobody comes. I am alone with my grand children.'*

Selective social prejudice

Selective social prejudice referred to social prejudice experienced by a specific group of older persons. In the case of this study, female informants only described it. Few female informants, the death of their spouses exposed to mistreatment and discrimination from the family members.

> This sub-theme was best illustrated by a 73-year-old woman, '*Once a husband is dead, there is the issue of property grabbing. The older you are, the more people think you don't need the property. This is the time you need the money to maintain yourself.'*

From the above descriptions of the informants, it was deduced that the older persons of Zambia are living in a ***psychosocial environment characterizes by a lack of social support embedded in the concepts of social burden, loss of companionship and isolation, and selective social prejudice.***

The social burden experienced by the informants in this study might be attributed to changes in traditional structure of the African families, the declining socio-economic situation, and challenges posed by HIV and AIDS. Traditionally, care of the older persons was the responsibility of the family members, through the extended family system. Children were expected to provide support and to look after the well being of their parents especially in old age (Apt, 1997; HAI, 2000; Kamwengo, 1999a; WHO, 1999). However, the premature deaths of the young and potential carers for the older person from HIV and AIDS and other diseases have created a lot of adjustments among the affected households. Upon the death of their children, who in most cases are the primary breadwinners, the older persons are not only depressed due to grief, but they also remain with the burden of

having to look after the AIDS orphans and themselves as well (Kozier *et al,* 2004; MOH/CBOH, 1999; Williams *&* Hunt, 1997; Tlou, 1996). It is within the above context that the social burden expressed by the informants should be understood.

The above social burden might also be understood within the socio-economic situation of the country. The decline in socio-economic situation of the country makes it difficult if not impossible for the relatives to play their traditional role even if they are willing to do so. The literature suggested that the prevailing socio-economic situation in most African countries, including Zambia has not only led to increasing poverty at the household level but have also affected the structure and function of the extended family system. While in the past, family members were willing and able to care for their older relatives, family members now find themselves in a changing world that severely limits their ability to assume these traditional roles (Gladwin 1991; GRZ 1996).

Fajemilehin (2000) looked at the older persons' experiences of care giving against the background of socio-cultural and economic change in Ife/Ijesa zone, in Nigeria, using a descriptive and cross-sectional approach. A total of 150 older people aged 70 years and above participated in the study. The findings revealed various perceived meanings of care giving and their values within that cultural environment. The researcher also reported various effects including westernisation, collapsed state of the traditional extended family system, poor finances, political and economic instability and burden of care giving itself on older people's well being.

The loss of support and companionship expressed mainly by female informants might be understood within the socio-cultural context described in the literature. The literature (WHO, 1990 & 1999) suggested that in most societies, women are likely to get married to men that are older than themselves. This practice predisposes most of the women to widowhood, as they are likely to live longer than men. Widowhood means loss of a spouse and in most cases, loss of income, loneliness and isolation among the older persons. This in itself is a challenge as women suffer more financial constraints than men do.

The selective social prejudice termed by the informant, as property grabbing should be understood within the socio-cultural context within which the older persons are living in Zambia. Property grabbing as it sounds is very common. Some relatives like taking the property of the dead relative. In most cases this type of relatives are not interested in the children left by the deceased but only in the property. In the process the grand parents only inherit grand children without any resources. With the resultant financial stress faced by the older people, it makes it very difficult, if not impossible to adequately provide for the orphans left under their care. This further exposes the older persons to more challenges. The financial constraints facing individual households and community affect coping strategies.

The above experiences can also be viewed within the context of ageism described in the literature. The literature suggested that the older people are often victims of negative attitudes or stereotypes because of their age (Eliopoulos 2001; Roach 2001). This age related prejudice is referred to as ageism. Ageism promotes discrimination against the older people, and denies them access to social services. For example, an older person might not receive appropriate care because the

attending professional might associate the condition to the physical decline of the body. For example in Zambia, it is not rare to here or read in the papers of older people who have been killed on suspect of which craft. Ageism does little to help or assist the older people as it reinforces isolation, and might influence the meanings the older people attach to life at this later stage.

The lack of social support experienced by the informants might also be seen within the context of disengagement theory. The disengagement theory holds that, as people grow older, they withdraw from active involvement in society. And that society responds by withdrawing from the older persons as well (Eliopoulos, 2001; Roach, 2001). Redfern & Ross (1999) suggest that society encourages disengagement as they see it as the time to transfer roles from the older persons to the much younger age groups. It is seen as being healthy as it minimizes problems of disruption of activities in the event of sudden illness or death of the older person.

According to Ajila & Adegoke (2001) disengagement is a gradual process rather than an imposed one. The theory views disengagement as a mutually satisfying process in which the older person and society prepares in advance for the ultimate death of the older person. However, the theory disadvantages older persons, as it promotes isolation of the older persons. Healthy and active ageing demands that the older people participate in growth stimulating interventions.

(2) Psychological distress

The psychological experiences described by the informants included the feelings of hopelessness, helplessness, and the search for love and affection. These feelings emerged mostly from the informants who lost their breadwinners, were living in very poor conditions with insecure source of income and deprivation.

Hopelessness and helplessness

The feelings of helplessness and hopelessness were associated with the deprivation experienced by the above informants. It was noted that the informants expected a different type of life than the one they were actually experiencing. They anticipated a better quality of life as older persons but they found themselves living a type of life they did not anticipate or expected. These unmet expectations gave place to the feelings of hopelessness and helplessness.

> A 75-year-old woman says, '*this is a time when I would like to have sufficient food in the house. She quickly snaps and says, there is nothing really to think about because the situation won't change.*

> A 75-year old woman, pleaded, '*…I have nothing to look forward to. When my children were alive, I was proud of being old because I had all the assistance from my children. But now, it has changed, I do not see anything good about growing old. I am only wondering why I am not dying. All my children are gone. I am left alone. That's what hurts me'.*

A 68-year old woman related, *'... I used to be well placed. I even bought a vehicle, a Peugeot. I used to be happy. With grown up children, I had no worry as I had seen the benefits of being a mother. My wish these days is to die...only to die because I have nothing to look forward to'* [she breaks down].

From a 76-year old woman, '... *It is a very difficult time for me. I don't know what to do. I have no hope and I wish I could just die.'*

Search for love and affection

The search for love and affection also emerged from the socio-cultural expectations of the informants. They expected at least as older persons to experience some form of love, care and affection from the community. But these expectations were not met. As illustrated with the statement below:

*'Older people need care, care, nothing else. Love and affection are what we need...' P*leaded a 75-year-old woman.

From the above descriptions of the informants, it was deduced that the ***older persons are living in psychosocial environment characterizes by psychological distress embedded in the feelings of hopelessness, helplessness, and search for love and affection.***

The psychological distress expressed by the informants reflects the socio-economic and socio-cultural contexts of which the older persons of Zambia are living in. As shown in this study, the older persons of Zambia are living in conditions where most of their needs are not met while they are expected to take up new roles created by the economic decline, the impact of HIV and

AIDS, social changes coupled with inappropriate health care services, lack of social welfare services, and insecure sources of income. These living conditions can lead any human being to the similar feelings described by the informants.

It is acknowledged that the older people are exposed to various sources of stress that range from adjusting to retirement and reduced income, deaths of spouses or friends, loss of status or living standards as a result of retirement, failing faculties, and ageism. The losses and grieving suffered during the late adulthood, predisposes the older people to stress. The ageing process is such that it reduces the body reserves and body immunity (George, 1995; Haralambos, 1986). The effects of stress on the older people will undoubtedly compromise their psychological well being and lead to the feelings such as those described by the informants in this study.

The chronic health conditions and other age-related changes experienced by the older persons might also be stressful for the older persons (Kozier *et al,* 2004). As indicated in this study, the informants viewed the above problems with concerns and frustration. These stressful situations without any form of support might also lead to the same feelings of helplessness, hopelessness and the search for love, affection and care described by the informants. The death of a spouse or significant others as noted in this study might also create some form of stress to the older persons and lead to the same feelings if adequate support is not provided.

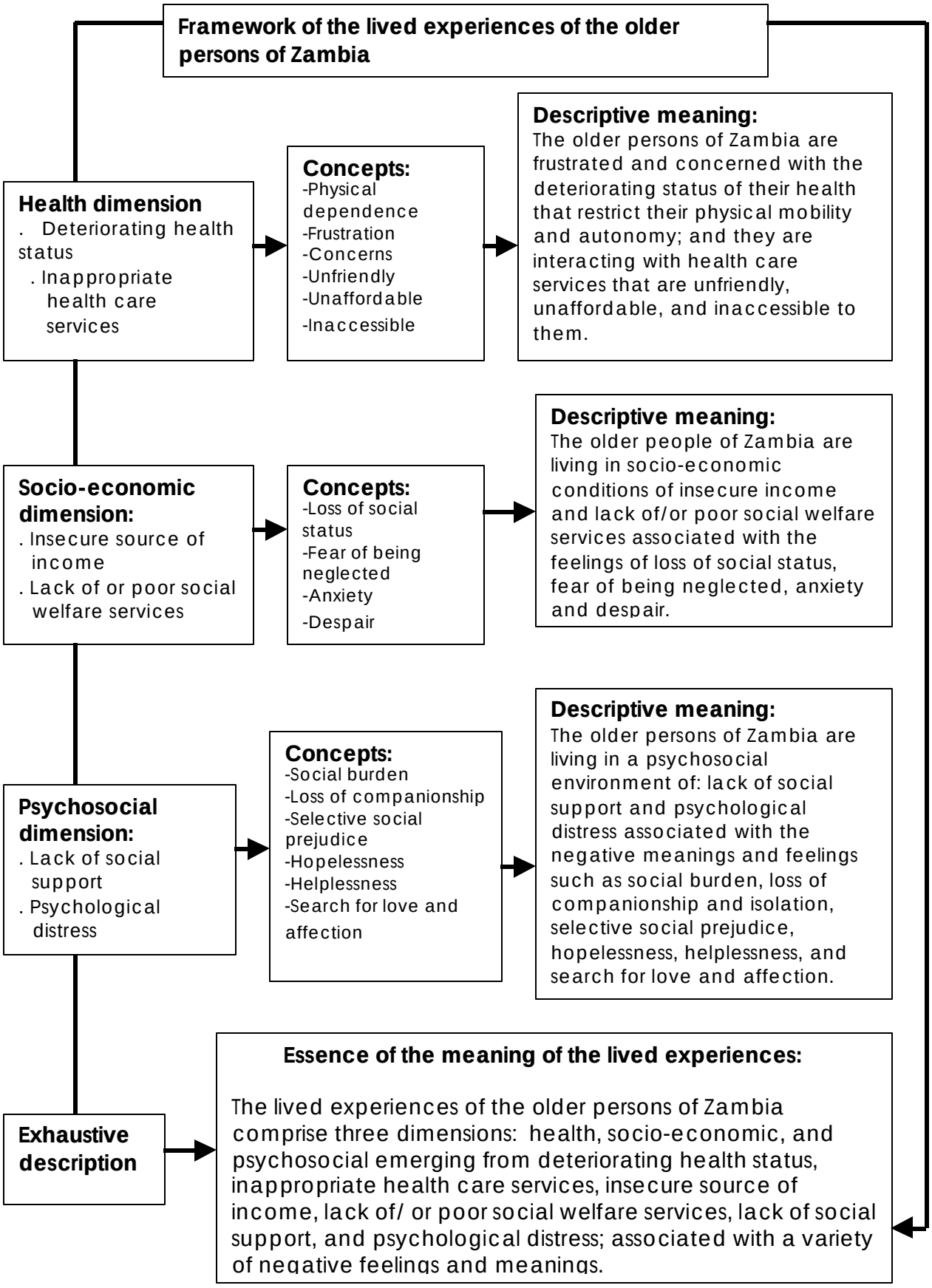

Figure 2. Framework of the lived experiences of the older persons of Zambia

The results of the findings of this study as presented and discussed in this section, provide a deep understanding of the lived experiences of the older persons of Zambia within the Zambian context. The study suggested that the lived experiences of the older persons of Zambia should be understood within the health, socio-economic and psychosocial dimensions and various negative feelings and meanings. The negative feelings and meanings expressed by the informants' should be understood within the context of: deteriorating health status, inappropriate health care services, insecure source of income, lack of/or poor social welfare, lack of social support, and psychological distress.

The literature suggested that some of these factors are important in the meanings the older persons attached to their experiences. In a study (Nilsson, Ekman & Sarvimaki, 1998) of the meaning that the older people give to their experiences of being old related to their quality of life, using a phenomenological hermeneutic approach, it was shown that six dimensions were important to the informants' experiences of ageing and quality of life. These dimensions included: relationships, activities, health, philosophy of life, the person's past and present lives, and future perspectives. The study also revealed five patterns relating to the meaning ascribed to the experiences of quality of life and included successful ageing, a good old age, a comparatively good life in old age, bad ageing, and a miserable life in old age.

On the basis of the results of the findings of this study, it is assumed that improving or maintaining the quality of life of older persons of Zambia would require interventions or measures aiming at improving their health status, access to quality health care and services, access to secure source of income, access to quality social welfare services, social support, and psychological well being.

4.4. MEANING OF AGEING OR BEING OLD AS DESCRIBED BY INFORMANTS

This section dealt with the second objective of this study, which focuses on describing the meaning attached to ageing or being old and eliciting the cognitive and emotional expressions associated to the above meaning. Each informant was asked to describe what he/she thinks and how he/she feels about being an older person in Zambia. These questions were supported with relevant probing aimed at uncovering the deep though and feelings of the informants on the phenomenon.

It was noted that the informants' ascribed positive meaning about being old, despite their negative living experiences discussed in the previous section. The analysis of the descriptions of the informants regarding the meaning given to being old revealed the following three dimensions: (1) spiritual dimension, (2) emotional dimension, and (3) socio-cultural dimension. These dimensions were embedded in a number of concepts such as divine favour, destiny, acceptance, happiness, fear, social reward, and social expectations. Figure 3 represents the deduced framework of the meaning of being within the Zambian context.

From the informants' descriptions, it was deduced that **the *older persons of Zambia define ageing within the spiritual, emotional, and socio-cultural contexts. For the older persons of Zambia, ageing is the last stage of life that demonstrates God's grace and blessings for the individual, a rewarding stage of life that is lived with mixed feelings of happiness, acceptance and fear.***

4.4.1. Spiritual dimension of ageing

God was central to the informants' descriptions of ageing as a spiritual phenomenon. For these informants, ageing was a spiritual phenomenon controlled by God. It is a blessing from God, a rewarding stage in one's life, a time for rest. Informants were grateful to God who gave them the opportunity to reach that stage of life. Two main concepts were identified under this theme: divine favour and destiny.

Divine favour and destiny

Ageing was viewed as an avoidable process that one must go through. It was compared with the natural development process. Informants felt that the same way one was born, she/he must grow and get old. However, progressing through this process is a divine favour or a blessing from God. These views were well illustrated by the following statements from the informants:

> A 71-year-old woman explained, *'…growing old is like a seed. God said, 'a seed must be planted, germinate and give fruit. Fruits are the children. So these also grow and continue with life. It is the same process God has prepared for us. You are born, you will grow up and get old, like it or not.'*
>
> A 75 year old man said, '…g*rowing old is a good feeling …it is God's blessing and I thank God for having allowed me to reach the age of 75'.*
>
> *A* 73-year-old man said, *'…I feel very happy. And I thank God for having preserved me to reach this mature age.'*

A 75-year-old female informant stated, '…*growing old is near time for you to go home… to go home and rest forever.'*

From the informants' descriptions, it was deduced that as a spiritual phenomenon, ***ageing is defined by the older persons of Zambia, as a destiny or an inevitable stage of life, a time to go home to rest and a period of life demonstrating God's grace or favour.***

The description of being old or ageing as a destiny might be understood within the fundamental biodynamic or natural law of ageing. The fundamental biodynamic or natural law describes ageing as a '*linear fashion'* of 'emerging, changing and vanishing. It views ageing as destiny, a time to return home into '*being'* which *st*arts with conception (Robert & Hofecker, 1990:7).

This description of ageing as a destiny, a time to go home to rest can also be viewed within the cultural beliefs of the African people. According to the traditional African beliefs, a person consists of a body and a spirit that are joined in a living person. This spirit becomes part of body during conception and leaves the body during death. The spirit does not lose its identity but is believed to linger around the body after death. People still have life after death and can still communicate with the living members of the family. This belief was reflected in the description of the informant who stated '…*growing old is near time for you to go home… to go home and rest forever.'*

The spiritual dimension of ageing as a divine favour or grace or blessings might be also attributed to cultural belief or religious background of the informants, which was not documented in the study. The majority of the Zambian population belongs to Christian faith. From the Christian perspective, life is a

gift, a blessing from God. Individuals should be grateful to God for being alive regardless of the material possession or living circumstances.

4.4.2. Emotional dimension of ageing

As an emotional phenomenon, ageing emerged from the functional ability and social standing of the informants. It was noted that the informants who perceived themselves as able of caring out some kind of social activities and those with high social standing in community expressed positive feelings than those with low social standing, and unable to engage in some social activities or without support.

Acceptance, happiness, and fear were the concepts embedded in the informants' views of ageing as an emotional phenomenon. The feeling of fear coexisted with the feeling of happiness in some cases. Although, being old was seen as a time of happiness but some informants were afraid to get to a certain age where they would not be able to engage in some activities.

Acceptance

Acceptance was equated to ageing as a normal period of life, mostly emerging from the ability of the informants to independently carry or attend to some social and self-care activities. These informants saw nothing wrong about growing old as illustrated by some of the descriptions below:

> A 75-year-old man said, '...t*here is nothing bad about growing old because it is inevitable. You know, I still do some of the things I used to do like visiting relatives and friends, go shopping…I just have to adjust myself and accept that they are other things I cannot do at this age.*

In the words of a 73-year-old informant, *'I did not think of my age but what I could offer to society.'*

From a 61-year old man, *'I feel I am still strong as anybody else.'*

A 68 –year old woman said, *' I am very proud that I can still go to church with my two legs, and that I can still do something for myself. So, I am really proud of being old.*'

Happiness and fear

Ageing as a period of happiness was associated with the informants' functional and social abilities, while fear was based on the loss of the above abilities. These feelings were best illustrated by the following descriptions:

In the words of a 76-year-old man, '*...I am very happy to be old but I should mention here that I am referring to the stage when one is still active and independent. But there is a stage in the ageing process that I don't want to reach. It is the stage where one is dependent on others. That stage is not good, and I would not like to reach that far.*

A 71-year-old woman related. *'...Growing old is very nice because I had a very nice life. A young life and a good marriage... now I am a widow and I am getting old, and enjoying my life with my grand children'.*

'*...I am very satisfied with my life as an older person. I get up in the morning with full strength. I have energy to work. I have energy to sing around the house, be happy with my*

grandchild and whoever comes here; I give them a good face,' bragged a 71-year-old woman. '

'As happy as I am, I do also fear to see myself like some of those older people who are totally dependent on others. I wished I could remain active so that I don't die like a cabbage', said a 67 year-old informant.

From the informants' descriptions, it was deduced that as an emotional phenomenon, ***ageing is defined by the older persons of Zambia, as a normal process of life, a period of happiness and fear depending on the functional ability and social standing of the older person.***

The descriptions of ageing or being old as a normal process of life, a period of happiness might be explained within the fundamental biodynamic or natural law and the cultural belief context described above. Viewing ageing as a man's destiny or an inevitable developmental process might lead to the feeling of acceptance as expressed by the informants. On the other hand, believing in life after death and in God might explain the informants' views on ageing as a period of happiness.

The fear attached to the ageing phenomenon might be understood within the context of their lived experiences as described in previous section 4.3. It can be assumed that the fear expressed by the informants' derived from their lived experiences or the move to an unknown situation. They were afraid to see this period of happiness be affected by negative life experiences or by unforeseen situations.

4.4.3. Cultural dimension of ageing

Ageing as a cultural phenomenon emerged from the cultural values and beliefs of the informants. Expectation was the main concept embedded in the cultural meaning of ageing. For most of the informants, ageing was seen as a time to be rewarded by the society for being old and for their past contribution as members of the society. Although being old was rewarding on its-own for the informants, they also expected some recognition and support from the community.

Expectations

For most informants being old and seeing their grand children was rewarding for them. Informants acknowledged the support given by their children and closed relatives but they expected the community to be involved in providing additional support. These views were best illustrated by the descriptions below:

> A 73-year-old man said, '*...ageing is a time for me to be rewarded by the society. Because, you are born as a member of a society and you served that society. Even in old age you are still a member of that society. Therefore, ageing is a time when society must take its responsibility and reward the older persons.'*

> A 76-year-old man said, '*...it is a time to be acknowledged by the wider society including the church and the non-governmental organisations (NGOs). This is the time of your life that you need to be acknowledged and rewarded for your contribution small might it be.'*

'…it is the time one expects the community support. In the olden days, It was a time in one's life when one used to enjoy the support from the families. Family used to look after the older people because the older people were few and the extended family system was also strong.' Said a 73-year- older woman.

Another 73-year-old woman narrated, *'…ageing for me means a time to be supported by the community. The community cannot leave everything to our children. These children also have their problems. You can't expect my grandson to look after me. He is working to prepare for his future in order to care for himself. When he has a bit of money, he has to keep a little bit here and there and buy a pair of shoes. You can't depend on grandchildren to look after you. They can help if they want, and not that you can make it a must, no. It is a time when the community should provide for the needs of their senior citizens'.*

From the informants' descriptions, it was deduced that as a cultural phenomenon, ***ageing is defined by the older persons of Zambia, as a period of life that one expects to be rewarded by the community and the society at large.***

This definition of ageing suggests that ageing is socially constructed and deep rooted in the society's cultural values and norms. Cultural factors are said to influence one's life. Each ethnic group has its own customs and beliefs that might have a bearing not only on health outcomes and the quality of life, but also on the meanings people ascribe to events or self-perceptions (Keith 1982; Leininger, 1985).

Traditionally, care of the older persons was the responsibility of the family members, through the extended family system. Children were expected to provide support and look after the well being of their parents especially in old age. However, social changes such as urbanisation and migration of the young adults to other countries or other towns in search of jobs have contributed to the destabilisation of the African values that supported the older people in their traditional environments (Apt, 1997; HAI, 2000; Kamwengo, 1999a; WHO, 1999).

The HIV and AIDS pandemic can also explain these expectations expressed by the informants. The HIV and AIDS have altered the traditional roles of the older persons. Upon the death of their children, who in most cases are primary breadwinners, the older persons are left with the burden of having to look after the orphans and themselves as well. This creates a tremendous strain, burden and additional stress on the older persons (MOH/CBOH, 1999; Tlou, 1996; Williams & Hunt, 1997).

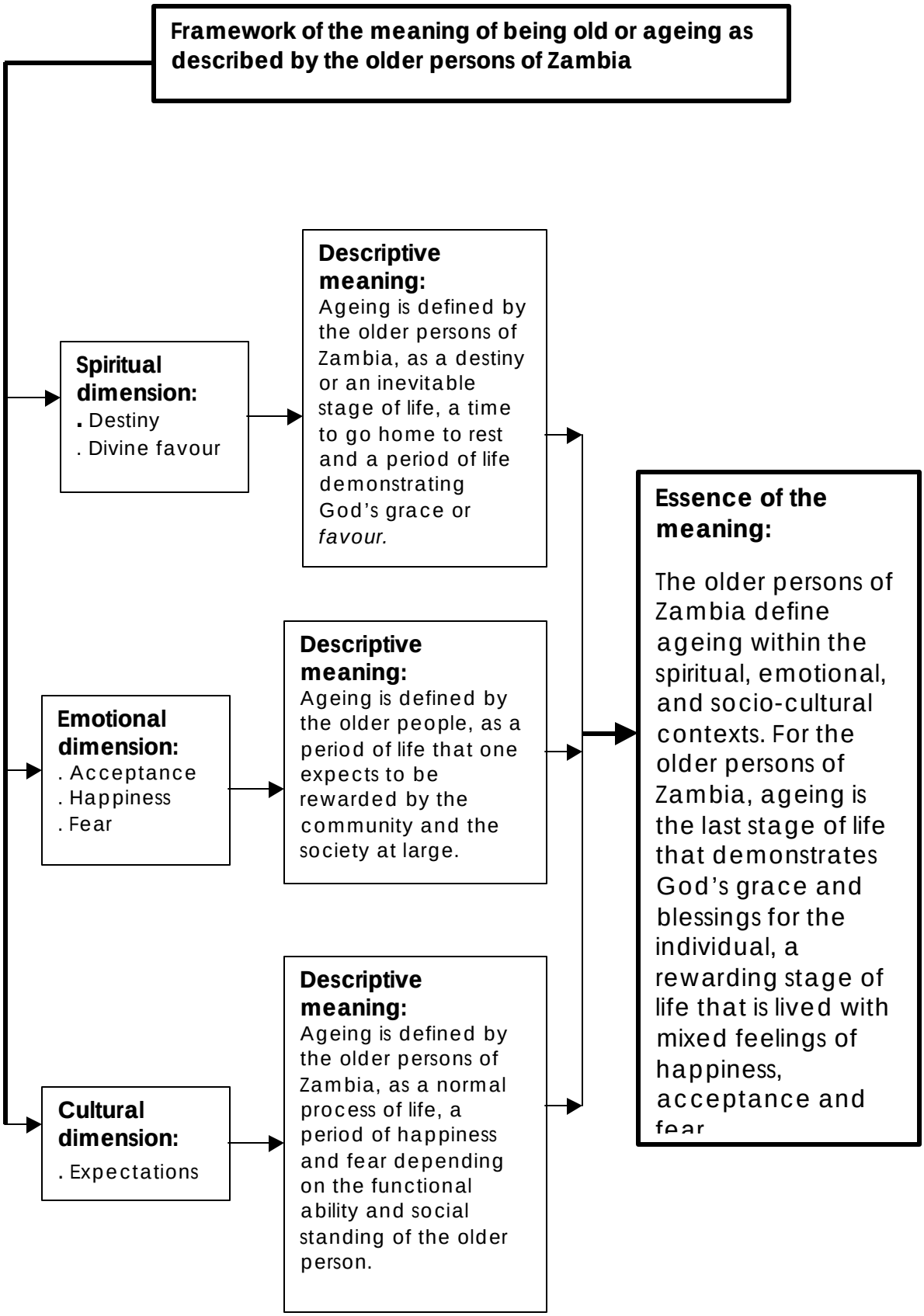

Figure 3. Framework of the meaning of ageing or being old

The meaning ascribed to ageing or being old by older persons of Zambia reflects the philosophy of life of the African people and the transcendental philosophy. Unlike, the Western world, which attached meaning of life to the material possessions, the African people attaches the meaning of life to the will of supernatural forces (Ancestors or god) and just the fact of being alive is the fulfilment of the will of these supernatural forces. This way of viewing life might explain the positive views and meanings attached to ageing by the informants despite their negative living experiences.

Similar feelings were found in a study conducted amongst the older persons in informal settlements in South Africa although the aim and the methodology were different from this study. The study (du-Rand & Engelbrecht 2001), looked at the needs of frail older people in informal settlements in South Africa. The study used a survey method with the objectives of exploring and describing the world in which the older people live. The results of the study suggested that the older people were happy in the environment in which they received care in spite of their unfavourable physical environment and limited resources.

It can be assumed from the above results that being old in Zambia do not depend on the lived experiences of the older persons but on the individual belief of the older persons, such as spiritual or cultural values or norms. These results justify the use of transcendental philosophical approach to science described in chapter two. From the perspective of transcendental philosophy of science, knowledge does not emerge exclusively from studies of material things, which does not consider the experiencing person and the connections between human consciousness and the objects that exist in the material world. Transcendental philosophy believed that knowledge derived not only from studies

of objects or the reality of external perceptions, but also from self-evidence. Therefore, what exists in consciousness, whether through intuition or reason, could be depended on unequivocally.

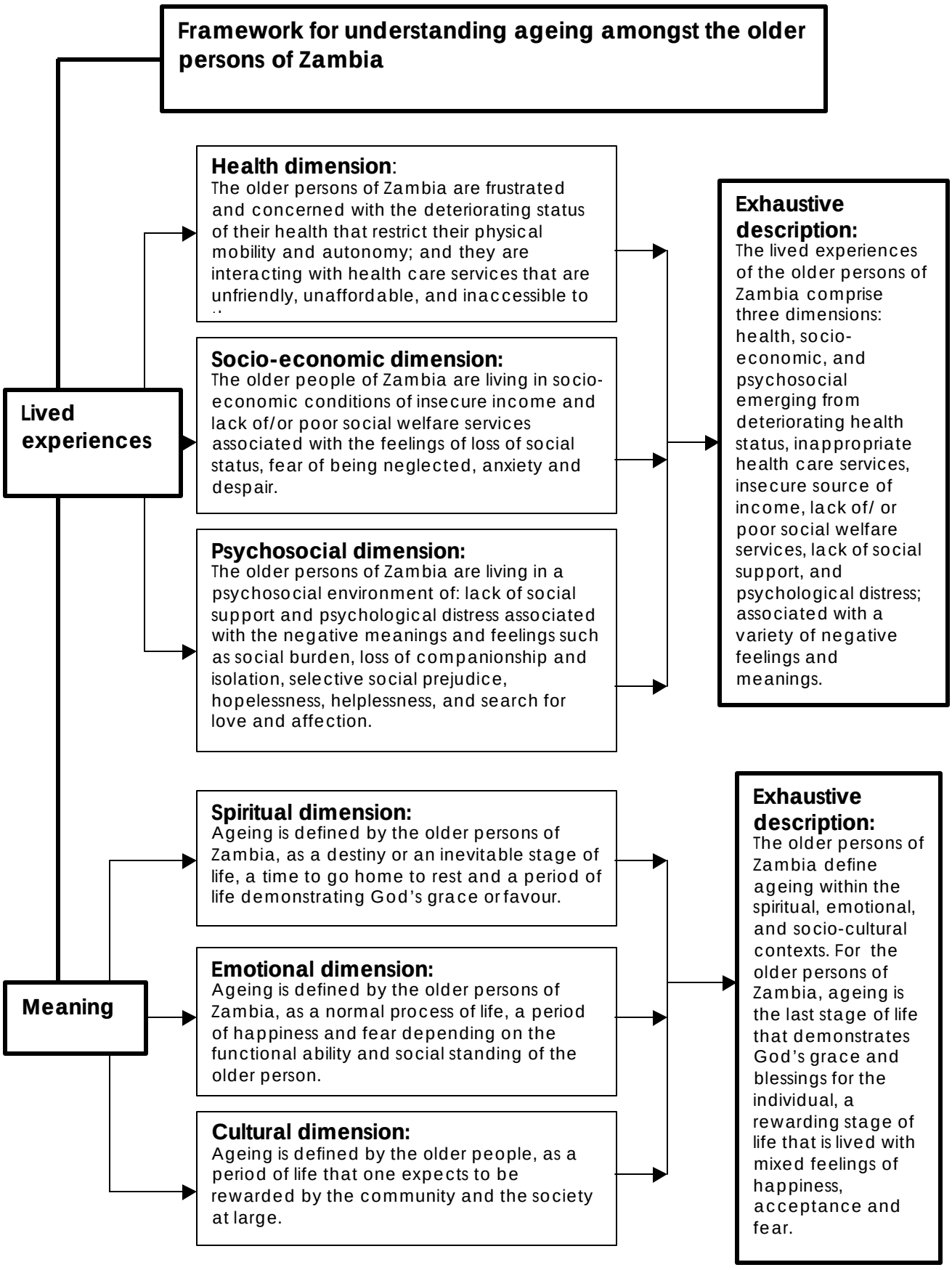

Figure 4. Framework for understanding ageing amongst the older persons of Zambia

The results of the main findings of this study as presented and discussed in this chapter suggested that there was a need to understand the ageing phenomenon from the perspective of the older persons of Zambia. The study showed that the older persons of Zambia are experiencing health related problems related to their individual health status and inadequate health care services. They are also experiencing socio-economic and psychosocial problems related to insecure source of income, poor social welfare services, lack of social support and psychological distress.

However, the meaning of being old in Zambia as described by the informants is not related to their lived experiences as older persons. There was a general understanding that the older persons were satisfied and happy of being old. This meaning was expressed in three dimensions of spiritual, emotional and cultural. Unlike the older persons in developed countries or western societies who defined ageing in terms of the material possessions, the older persons of Zambia as shown in this study, expressed positive feelings and views about being old despite their negative lived experiences. The main questions deriving from the findings of this study is to understand how do the older persons of Zambia cope in their day-to-day life or how is the quality of life of the older persons in Zambia?

This issue and many others rising from the results of this study will be dealt with in the next chapter.

CHAPTER 5

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1. SUMMARY AND CONCLUSION

A phenomenological study of ageing amongst the older persons in Zambia was undertaken with a purpose of: (1) gaining an understanding of the ageing phenomenon within the Zambian context (2). To provide frameworks that could be used by policy-makers and health professionals to formulate guidelines or interventions relevant to the lived experiences of the older persons and consequently maintain or improve the quality of life of the older persons of Zambia (3). To understand the meaning attached to ageing or being old.

The objectives of the study were to describe (1) the lived experiences of the older persons of Zambia, and (2) the meaning they attached to ageing or being old within the Zambian context.

The need to undertake this study derived from the challenges posed by the complexity of the meaning of the concept ageing, the nature of age-related health problems, the current trend of population ageing, the social impact of HIV and AIDS, and the prevailing socio-economic situation of the country. The literature reviewed suggested these factors might have negative or positive impact on the quality of life of the older people and influence their perceptions about the ageing phenomenon. The literature reviewed also suggested that enhancing or maintaining the quality of life of the older people is a social and moral obligation of governments and society as a whole. However, the available evidence suggested that Zambian government and society was not adequately prepared to care for the older people. It was in view of the above challenges and problems that the study was undertaken.

A transcendental phenomenological design within the qualitative naturalistic approach was used to guide the research process and to assist the researcher to reach the purpose and objectives of the study. Focus group and in-depth individual interviews were conducted to generate data from twenty-seven (27) informants. Fifteen (15) informants participated in the focus group interviews and twelve (12) in in-depth individual interviews. In total, 24 in-depth individual interviews were conducted in term of two interviews per informants, and two focus group interviews. Data collection covered a period of three months. Colaizzi (1978) and Giorgi (1985) techniques for qualitative data analysis were used. Verbatim excerpts from the transcribed interviews were used to support the themes that emerged from data and to provide a richer picture of the situation.

Looking at the lived experiences of the older persons of Zambia, the main results of the findings showed that three dimensions (health, socio-economic, and psychosocial) should be considered in the understanding of the lived experiences of the older persons of Zambia. The study suggests that the lived experiences of the older persons of Zambia comprises of three dimensions: health, socio-economic, and psychosocial emerging from deteriorating health status, inappropriate health care services, insecure source of income, lack of/ or poor social welfare services, lack of social support, and psychological distress; associated with a variety of negative feelings and meanings.

The health dimension of the lived experiences of the older persons is characterizes by deteriorating health status and inappropriate health care services. The deteriorating health status emerged from the chronic health conditions and other age-related problems. These conditions were viewed as restricting physical mobility and autonomy of the older persons to perform

activities of daily living and other activities they used to do. They also expressed frustration and concern toward the above changes. Inappropriate health care services emerged from their interactions with the public health services, which were viewed as unfriendly, unaffordable and inaccessible.

The socio-economic dimension of the lived experiences emerged from a context of financial dependence, inability to meet their basic needs, and poor living conditions. It was characterized by insecure source of income and lack of/or poor social welfare services; and viewed as loss of social status associated with fear of being neglected, anxiety and despair. The psychosocial dimension of the lived experiences of the informants emerged from the deaths of breadwinners (spouses and adult children or relatives), the limited resources, the deteriorating health status, and the lack of social welfare services. This dimension was characterized by lack of social support, and psychological distress. It was deduced that the older persons of Zambia are living in a psychosocial environment which lacks social support and characterised by psychological distress associated with the negative meanings and feelings such as social burden, loss of companionship and isolation, selective social prejudice, hopelessness, helplessness, and search for love and affection.

With regard to the meaning attached to ageing or being old, the study showed that the informants' ascribed positive meaning about being old, despite their negative living experiences. Three dimensions were attached to the above meaning: (1) spiritual dimension, (2) emotional dimension, and (3) socio-cultural dimension. The study suggests that the older persons of Zambia define ageing within the spiritual, emotional, and socio-cultural contexts. For the older persons of Zambia, ageing is the

last stage of life that demonstrates God's grace and blessings for the individual, a rewarding stage of life that is lived with mixed feelings of happiness, acceptance and fear.

Three frameworks derived from the findings of this study include: (1) framework of the lived experiences of the older persons of Zambia (see Figure 2), (2) framework of the meaning of ageing or being older (see Figure 3), and (3) framework for understanding ageing within the Zambian context (see Figure 4). The researcher believed that these frameworks would make a meaningful contribution towards the understanding and the development of policies and interventions that would assist in enhancing or maintaining the quality of life of the older people of Zambia.

In conclusion, the main findings of this study indicated three most significant dimensions of the lived experiences of the older persons: health; socio-economic and psychosocial. These dimensions need to be taken into account when planning for any programs or interventions aimed at maintaining or improving the quality of life of the older persons of Zambia. These interventions and programs should also address the negative feelings or meanings attached to the above experiences. The main findings of this study also show that; the meaning of being older or ageing in Zambia does not only depend on the health, socio-economic and psychosocial living experiences of the older person but largely depends on the inner values of the older persons. Which include spiritual, emotional and cultural beliefs. This means that maintaining or improving the quality of life of the older persons in Zambia would require comprehensive programs or interventions that should take into account the health, socio-economic, psychosocial, spiritual, emotional and cultural needs of the older people.

5.2. RECOMMENDATIONS

In view of the main results of the findings of this study, it appears that there is an urgent need to implement specific measures in order to improve the quality of life of the older people in Zambia. Such measures should target the health status of the older persons, the health care providers, the health care services, the social welfare services, the psychosocial well being of the older persons, spiritual and cultural beliefs of the older persons.

It is therefore recommended that:

(1) Older people should be regarded as vulnerable group and treated accordingly. This can be achieved by raising community awareness regarding problems affecting the older persons, setting up of geriatric clinics within the existing health facilities and mobile clinics to attend to the health problems of the older people. Raising awareness of the community regarding problems affecting the older persons in the country might lead to a change of attitude and the provision of support. The provision related to the older people in the current health policies need to be adhered to and reinforced by relevant authorities. The older people need to be educated about the age-related problems, self-care practices and their rights to access quality care and services.

(2) Formal geriatric training should be developed and made available to health professionals in the country. In –service training, seminars on geriatric nursing should be offered to nurses, and other health professionals attending to the older persons. Formal training or in-service training of nurses and other health professionals would increase their understanding of the ageing and age-related problems and equip them with knowledge and skills to provide quality care to the older people. This would also change their attitudes towards the older people.

(3) Specific social welfare measures need to be taken to assist the older persons with their financial and basic needs. As shown in this study, the social burden experienced by the older persons due to the social changes and the impact of HIV and AIDS is of great concern. Such assistance would require not only the involvement of the government, but the community, the non-governmental organizations, and the society at large. It means that structures should be put in place to register and evaluate the needs of the older persons.

(4) New ways of extending the social network of the older people should be investigated. The traditional reliance on family members as primary source of support is no longer relevant due to social economic changes. Given the changes in the family structure, and loss of the cohesiveness of the extended family, care of the older people should now be considered a public issue. The prevailing economic powerlessness of the older people need not be seen as a familial burden but a shared responsibility with the state and other stakeholders. The family should only operate as a safety net device, which should provide basic necessities of life and death. Support groups for the older people should be established within the different communities. These support groups will offer the older persons the opportunities to share their problems, give mutual support and instil hope amongst them.

(5) The current social welfare policies need to be extended and adapted to the living experiences of the older people. The revised policies should include provision of legislation, governance, and financial, material resources and possibly care services that ensure full participation of the older persons. The existing Pension scheme, which favours only those in the formal sector employment, should be reviewed. Though being on

pension is no guarantee for financial security. The process of accessing the pension is very long and tedious. In most cases the pension payments are meagre, erratic and over devalued to an extent that they cannot sustain subsistence.

(6) Further research should be taken to establish the coping strategies used by the older people in dealing with their living experiences. Research should also be taken to establish the impact of the socio-economic experiences of the older persons on their well being, to validate the meaning ascribed to being old or ageing by the informants of this study in a big sample.

LIST OF REFERENCES

Ajila C.O. & Adegoke A. A. 2001. Psychological adjustment to the ageing process. *Nigerian Journal of Ageing and Social Development,* vol. 1, number 1.

Apt N. 1997. *Ageing in Africa*. Geneva: WHO.

Apt N. 2002. ''The Rights and Protection of Older Persons in Africa''. Paper presented at the OAU/HAJ experts meeting in Kampala, Uganda. Unpublished.

Archley R. 1991. *Social forces and ageing. An introduction to social gerontology*. Sixth edition. Wadsworth Inc, Belmont, California.

Aziza S. A. 2000. ''Health and Nutrition''. Paper presented at experts' meeting to draw up an OAU policy framework and plan of action on ageing. Kampala, Uganda.

Babbie E. & Mouton J. 2001. *The Practice of Social Research*. South African edition. Oxford University Press Southern Africa, Cape Town.

Beech I. 1999. Bracketing in Phenomenological research. Nurse Researcher, 6(3), 5-65.

Balogun S. K. 2001. Work-family conflict, social support and coping mechanism as determinants of adjustment among working widows. *Nigerian Journal of Ageing and Social Development. Vol. 1, no. 1. 2001.*

Bogdan R.C & Biklen S. K. 1992. *Qualitative Research for Education*. Second edition. Allyn and Bacon.

Burns N and Groove SK (2001). Understanding nursing research. Philadelphia, WB Sanders. Cambridge University Press. (2004). Notes on intensive care units. UK

Cavanaugh J. C. 1990. *Adult Development and Ageing*. Wadsworth Inc, Belmont, California.

Central Statistics Office. 1990. Census Report. Central Statistics Office, Lusaka.

Central Statistics Office. Ministry of Health and Macro International Inc. 1996. *Demographic and health survey.* Lusaka: Central Statistics Office.

Chambers M; Ryan AA; Connor SL 2001. Exploring the emotional support needs and coping strategies of family carers. *Journal of Psychiatric and Mental Health Nursing, 8(2), 99-106*

Cirgin-Ellet M and Beausang C. 2002. *Introduction to qualitative research.* Gastroenterology Nursing, 25 (1), 10-14. Lippincott Williams and Wilkins.

Civil Society for Poverty Reduction. The path away from poverty. An easy look at Zambia's Poverty Reduction Strategy Paper 2004. Lusaka.

Colaizzi P. F. 1993. *Reflection and Research in Psychology. A Phenomenological Study of Learning.* Meredith publishing company. United States of America.

Creswell J. W. 1998. *Qualitative Inquiry and Research Design. Choosing among five traditions*. Thousand Oaks. London: SAGE Publications.

Dellasega C and Morris D 1993. The Mini Mental State Examination to assess the cognitive state of elders. Journal of Neuroscience Nursing, 25(3), 147-152

Deeny P 2001. The psychological experiences of older people who have major surgery involving intensive care: a phenomenological study. Nursing in Critical Care, 6(1), 14-22

Donaldson R. J. and Donaldson L. J. 1993. *Essential Public Health Medicine*. London: Kluwer Academic Publishers. Pp 357-387.

du-Rand P and Engelbrecht K 2001. Needs of frail elderly people in informal settlements. Curationis 24(4), 10-16

Eliopoulos C. 2001. *Gerontological Nursing*. Fifth edition. Philadelphia: Lippincott Williams and Wilkins.

Fajemilehin BR (2000). Old age in changing society: elderly experiences of caregiving in Osun State, Nigeria. Africa Journal of Nursing and Midwifery, 2(1) 23-27.

Fitzpatrick J. J. (ed.) 1999. *Nursing Research Digest* . Springer publishing company. New York.

Fuller J. & Schaller- Ayers J. 2000. *Health Assessment. A Nursing Approach.* Third edition. Lippincott Williams.

George J. B. 1995. *Nursing Theories: The Base for Professional Nursing Practice.* Fourth edition. Prentice Hall International.

Giorgi A. *et al.* 1983. *Duquesne Studies in Phenomenological Psychology.* Vol. IV. Pittsburgh: Duquesne University Press.

Government of the Republic of Zambia. 1996a. *National Strategic Health Plan (Investment Plan) 1995-1999. From vision to reality.* Lusaka: MoH.

Government of the Republic of Zambia and United Nations Systems in Zambia. 1996b. *Prospects for Sustainable Human development in Zambia. More choices for people.* Lusaka: GRZ.

Government of the Republic of Zambia. 1998. *Living Conditions Survey in Zambia.* Lusaka: CSO.

Government of the Republic of Zambia. April 2001. *Preliminary Report for the 2000 census of population and housing.* Lusaka: CSO.

Government of the Republic of Zambia. May 2002. *Poverty Reduction Strategy paper*. Lusaka: Ministry of Finance and National Planning, Planning and Economic Management Department.

Hall M.R. P. *et al*. 1993. *Medical Care of the Elderly*. Third edition. Chichester: John Wiley and Sons Ltd.

Haslett C. *et al*. 2002. *Davidson's Principles and Practice of Medicine*. Nineteenth edition. Churchill Livingstone.

Heidegger. M 1997. Basic writings. D. Krell (ed). New York: Happer and Row

HelpAge International. 2000. *Ageing issues in Africa. A summary.* HAI.

Holloway I. & Wheeler, S. 1996. *Qualitative Research for Nurses*. Blackwell Science Ltd.

Irvine I. E., *et al.* 1986. *The Older Patient. An introduction to Geriatric Nursing.* Fourth edition. Hodder and Stoughton.

Kamwengo M. M. 2001. *Ageing and the elderly in Zambia. Perspectives and issues.* New Delhi: Sterling International.

Keith J. 1982. *Old People as People: Social and Cultural Influences on Ageing and Old Age.* Little Brown and Company. Pp. 1-20.

Kellet UM 1999a. Transition in care: family carers' experience of nursing home placement. Journal of Advanced Nursing, 29 (6), 1474-1481.

Kellet UM 1999b. Searching for possibilities to care: a qualitative analysis of family caring involvement in nursing homes. Nursing Inquiry 6(1), 9-16.

Kennie D. C. 1993. *Preventive Care for the Elderly People*. Cambridge University Press. United Kingdom.

Koch T and Webb C 1996. The biomedical construction of ageing: impairment for nursing care of older people. Journal of Advanced Nursing, 23(5), 954-959

Kvale, S. (1996). Interviews: An Introduction to qualitative research interviewing. Thousand Oaks, CA: Sage.

Lau A; Chi I and Mckenna K 1998. Self-perceived quality of life of Chinese elderly people in Hong Kong. Occupational Therapy International, 5(2), 118-139

Leininger M. M. 1985. *Qualitative Research Methods in Nursing*. W.B. Saunders Company.

Lister R 1999. Loss of ability to drive following a stroke: the early experiences of three elderly people on discharge from hospital. British Journal of Occupational Therapy, 62(11), 514-520

LoBiondo – Wood G. & Haber, J. 1994. *Nursing Research: Methods, Critical Appraisal, and Utilisation*. Third edition. United States, Missouri: Alison Miller. Pp. 258-263.

McCormack B. 2003. A conceptual framework for person-centred practice with older person*. International Journal of Nursing Practice, 9 (3), 202-209.*
Miles B. M. & Huberman A. M. 1994. *An Expanded Sourcebook. Qualitative Data Analysis*. Second edition. Sage Publications, Inc.

Moore SL 1997. A phenomenological study of meaning in life in suicide older adults. Archives of Psychiatric Nursing, 11(1), 29-36

Moustakas C. E. 1994. *Phenomenological Research Methods*. Oaks, CA: Sage Publications.

Mullaney S. & Thompson S. (ed.) 1997. ''The Lived Experience of Phenomenology'', in *Nurse Teachers as Researchers. A Reflective Approach.* Arnold Publishers.

Munhau P. C. & Oiler C. J. 1986. *Nursing Research: A Qualitative Perspective.* Connecticut: Appleton Century. Crofts.

Narayanasamy A 2003. Spiritual coping mechanisms in chronically ill patients. British Journal of Nursing, 11(12), 1461-1464

National HIV/AIDS/STD/TB Council. 2000. *HIV/AIDS/STD/TB Strategic Framework 2001-2003*. Republic of Zambia.

NCDP (Sa) *Reducing Poverty in Zambia: Getting from ideas to action.* World Bank Public Information Centre.

Neuman W.L. 1997. *Social Research Methods.* Third edition. Allyn and Bacon.

Nilsson M; Ekman S and Sarvimaki A 1998. Ageing within joy or resigning to old age: older people's experiences of the quality of life in old age. Health care in Later Life, 3(2), 94-110

O'connor A. 1991. *Poverty in Africa. A Geographical Approach*. London, Belhaven Press.

Parahoo K. 1997. *Nursing Research. Principles, Process and Issues*, Macmillan Press Ltd.

Parker M. & Wilson, G. 2000. ‘‘Diseases of Poverty’’, in Tim Allen and Thomas Allan*: Poverty Development into the 21st Century*. Oxford University Press. Pp 75-98.

Parse R. R. *et al* 1985. *Nursing Research. Qualitative Methods*. Maryland. Brady Communications Company.

Perold A and Muller M 2000. The composition of old age homes in South Africa in relation to residents and nursing personnel. Curationis. 23(1), 87-94

Polit DF and Beck C.T. 2004. Nursing Research: Principles and Methods. 7th Edition. Library of Congress Catalogue-in-publication, USA.

Polit D.L & Hunger P. B. 1999. *Nursing Research. Principles and Methods. Sixth edition*. Lippincott Williams and Wilkims.

Polit F. D. *et al.* 2001. *Essentials of Nursing Research: Methods, Appraisal and Utilisation*. Fifth edition. Philadelphia: Lippincott, Williams and Wilkins.

Redfern S. J. & Ross F. M. 1999. *Nursing Older People*. Third edition. Harcourt Brace and Company Limited.
Roach S. 2001. *Introductory to Gerontological Nursing.* Philadelphia, Lippincott Williams and Wilkins.

Robert, L. (ed.) & Hofecker G. 1990. *The Theoretical Basis of Ageing Research*. Facultas, Universitatsverlag, Austria.

Stanage S. M. 1987. *Adult Education and Phenomenological Research. New Directions for Theory, Practice, and Research.* Florida: Robert E Krieger Publishing Company, INC. Malabar.

Stokes SA and Gordon SE 2003. Common stressors experienced by the well elderly: clinical implications. Journal of Gerontological Nursing, 29 (5), 38-46

Stommel M and Wills E.C 2004. Clinical Research: Concepts and principles for Advanced Practice Nurses. Lippincott Williams & Wilkins, London

Stoyle J. 1994. *Caring for Older People. A Multi-cultural Approach*. England: Stanley Thornes, Cheltenham.

Thompson D. (ed.) 1996. The pocket oxford dictionary of current English. Clarendon Press. Oxford.

Tlou S. D. 1996. *Epidemics. HIV/AIDS and the elderly in Africa.* Unpublished.

Togonu-Bickersteth. 2001. Growing old in Nigeria in the 21st century. *Nigerian Journal of Ageing and Social Development,* vol. 1, number 1.

Uys H.H.M. & Basson A. A. 1985. *Research Methodology in Nursing*. Creda Communications.

Vydelingum V 2000. South Asian patients' lived experience of acute care in an English hospital: a phenomenological study. Journal of Advanced Nursing, 32(1), 100-107
Whitehead M. 1995. *Tackling Inequalities in Health. An Agenda for Action*. M. Benzeval. Judge, K. and M. Whitehead Edition.

Williams R. & Hunt K. 1997. ''Psychological Distress among British South Asians. The Contribution of Stressful Situations and Sub-cultural Differences in the West of Scotland''. *Psycho Med*. Pp 27, 1173-1181.

WHO. September 1998a. *Population Ageing: A public Health Challenge*. Fact sheet no. 135. WHO. Geneva.

WHO. /HPR/AHE/98.1. 1998b. *The Role of Physical Activity in Healthy Ageing*. Geneva: WHO.

WHO HPR/AHE/98.1. 1998c. *Growing Older-staying Well: Ageing and Physical Activity in Everyday life*. Ageing and Health. Programme, Geneva: WHO.

WHO 1999. *Ageing: Exploding the Myths.* Geneva: WHO.

WHO. 2000. *The Implications for Training of Embracing. A Life Course Approach to Health.* International Longevity Centre. United Kingdom.

WHO 2001. *Research into Ageing*. Fact Sheet. Geneva: WHO.

APPENDIX 1

APPENDIX 2

INTERVIEW SCHEDULE

I. GENERAL INFORMATION

1. Age in years

2. Gender

Male	
Female	

3. Marital Status

Widow	
Divorce	
Married	
Single	
Other	

4. Main source of income……

5. Living condition (type of housing, ownership, number f people living with you)

6. Any chronic disease? If yes, when was it first diagnosed?

7. Where do you go for treatment? And how often do you go there?

II. Would you tell me about the most significant experiences in your life as an older person/older persons living in Zambia?

III. Being old, what does it mean to you as a Zambian?

Duration of the interview:

……

Name of the informant/s:

……

APPENDIX 3

CONSENT FORM

I am a student studying with the University of South Africa (UNISA). I am carrying out a research study entitled **"A PHENOMENOLOGICAL STUDY OF AGEING AMONGST THE OLDER PERSONS IN ZAMBIA".** The study is undertaken towards the fulfilment of the requirements for the degree of Doctor of Literature ET Philosophy.

Data for the study will be collected through individual interviews that may last approximately 60 minutes. The interview will be conducted in a place and time most convenient to you. Your participation to the study is voluntary. The interview will be transcribed verbatim; as well as tape recorded. The researcher will handle all information collected with utmost confidentiality and your participation will remain anonymous and no names will appear on the final report. You have a right to withdraw from the study at any given time without having to give an explanation. Your withdraw from the study will have no repercussions.

Your consent to participate in the study will be highly appreciated as the results of the study will assist in understanding ageing as lived by older persons in Zambia and also in formulating specific recommendations towards improving the quality of life of this important segment of our population.

Thank you.

I accept participation.

Signed: ---------- Date: ---------- Signed: ---------- Date: ----------

Or

Thumb print ----------

(Participant) (Researcher)