
# AN EXPLORATION OF THE CARE NEEDS OF FRAIL OLDER PERSONS IN NAMIBIA: PERSPECTIVES AND EXPERIENCES OF FORMAL AND INFORMAL CAREGIVERS

by

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# Abstract

The adequate care of older persons is a major global concern and countries are examining ways to respond to these needs, especially the needs of frail older persons in the care environment. Important strides have been made in developed countries but progress has been slow in less developed countries in the Global South and limited information exists on the care needs of frail older persons and lived experiences of formal and informal caregivers.

This thesis examines the care needs of frail older persons in Namibia. Namibia has only recently been liberated from colonial rule by Germany and apartheid South Africa. During this time black communities were disenfranchised, resource-scarce and living under poor conditions. For older persons, this meant unequal treatment, social exclusion and denial of access to decent care. The aim of this study was to provide an in-depth understanding of the needs of frail older persons in the care environment in Namibia by examining the lived experiences of caregivers and analysing policy. Using a qualitative methodology, the study collected primary data from formal and informal caregivers based on semi-structured interviews and focus groups. The data analysis relied mainly on coding strategies under Atlas-ti and qualitative content analysis. The secondary data were collected from legislation, government policy documents, journals and other public reports.

The finding revealed that Namibia's history has entrenched the current situation of unmet needs of frail older persons, exacerbated by inadequate policy protection. These limitations were highlighted by the Covid-19 pandemic. The study also found that the effective care of frail older persons is only possible through stakeholder engagement and cross-sectoral collaboration. The study therefore recommends that government should undertake a process of social reforms to ensure that the needs of this group are prioritised, that a performance framework should be implemented to ensure delivery and that all stakeholders should be mobilised.

The study has contributed to these outcomes by suggesting a model for needs assessment of frail older persons, especially during the Covid-19 pandemic. This model could be used to improve care practices, serve government in evidence-based policy making and provide a useful analytical tool for scholarship.

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# List of Abbreviations

| | |
|---|---|
| ADL | Activities of Daily Living |
| AIDS | Acquired Immunodeficiency Syndrome |
| AU | Africa Union |
| BIG | Basic Income Grant |
| CBO | Community-Based Outreach |
| CBR | Community-Based Rehabilitation |
| EST | Ecological Systems Theory |
| EU | European Union |
| GDP | Gross Domestic Product |
| HIV | Human Immunodeficiency Virus |
| IAF | International Federation of Ageing |
| IMF | International Monetary Fund |
| MVAF | Motor Vehicle Accident Fund |
| MOGECW | Ministry of Gender, Equality and Child Welfare |
| MOHSS | Ministry of Health and Social Services |
| MOPESW | Ministry of Poverty Eradication and Social Welfare |
| MLIREC | Ministry of Labour, Industrial Relations and Employment Creation |
| NHIES | Namibia Household Income and Expenditure Survey |
| NAMPHIA | Namibia Population-Based HIV Impact Assessment |
| NGO | Non-Governmental Organisation |
| NPHC 2011 | National Population and Housing Census 2011 |
| NPO | Non Profit Organisation |
| NSA | Namibian Statistics Agency |
| OAP | Old Age Pension |
| OAU | Organisation of African Unity |
| OECD | Organisation for Economic Co-Operation and Development |
| SADC | Southern African Development Community |
| SMW | Self-Management Theory of Well-Being |
| SSC | Social Security Commission |
| UN | United Nations |
| ILO | International Labour Organization |
| SSC | Social Security Commission |
| UNAIDS | United Nations Programme on HIV and AIDS |
| UNDP | United Nations Development Programme |
| UNECE | United Nations Economic Commission for Europe |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |

# Statement of Original Authorship

The work contained in this thesis has not been previously submitted to meet requirements for an award at this or any other higher education institution. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made.

Signature: _____

Date: _____

# Dedication

The completion of this undertaking could not have been possible without the support, encouragement, love, dedication and guidance from the love of my life, my husband Dr. Manfred Ririama Zamuee, who I'm dedicating this thesis to. Thank you babes for always having my back and believing in me. I love you lots.

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# Chapter 1: INTRODUCTION AND BACKGROUND

## 1.1 INTRODUCTION

In Namibia underlying needs of frail older persons remain largely unknown. This situation leads to inadequate responses in meeting the needs of this group of people. As a result, there is a significant gap in knowledge about the circumstances of this cohort. For example, it is not clear what needs are important to them to ensure quality care and well-being. Also, no knowledge exists about the nature of Namibia's care and health system and how it impacts on the needs of frail older persons. The knowledge gap is exacerbated by limited policy and legislative protection of frail older persons. Without this knowledge, interventions will not be targeted and hence prove ineffective. Given this background, frail older persons are living on the periphery of the social welfare system resulting in marginalization and increased vulnerability. As a result, in understanding the reality of frail older persons, this thesis explores their needs from the perspectives of formal and informal caregivers who are the first responders in providing them with care. The primary aim is to provide evidence-based information that will guide Namibia's policy and legislative reforms and contribute to an overall improvement in the care of frail older persons in Namibia. Using a qualitative methodology, the study provides an in-depth understanding of the needs of frail older persons in the formal and informal care environment. Data were collected from focus groups and through semi-structured interviews with caregivers of frail older persons and then triangulated using various secondary documentary data sources. The study found that historical circumstances in Namibia have had a significant influence on the inability of the current care environment to investigate and meet the needs of frail older persons. A lack of awareness of the multi-faceted needs of frail older persons has led to inappropriate policy responses and interventions in the care environment. This means that policies and legislations are developed without a specific focus on the need of this group of people. For example, if the abuse of frail older persons is addressed under a general domestic violence situation, the law will be inadequate in dealing with the unique challenges of this cohort in the care environment. Chapter 1 outlines the structure of the study and covers the background, problem statement, study rationale, research objectives and assumptions.

## 1.2: BACKGROUND

In 1990 Namibia gained independence after a combined 110 years of German and South African colonial rule, which have had significant socio-economic and political repercussions for the local population and especially for frail older persons, given their special needs (Nwauwa, 2000). In terms of population demographics, Namibia has a steadily growing elderly population consisting of people above the age of 60 years who make up approximately 7.1% of the total population of just over 2.4 million people (Namibia Population and Housing Census (NPHC), 2011). However, the number of older persons is forecasted to increase to 13% by 2050. This means that, in less than 30 years from now, the Namibian population of older persons will double, creating consequential demands on the care environment (UN, 2019a). Based on this projection, the elderly population as a proportion of the total population is growing relatively faster than any other age group, making studies into the needs of this cohort a matter of urgency. Rapid demographic population aging in a country presents serious political and socio-economic challenges, thereby necessitating an understanding of the unique needs of frail older persons as a special group of people in need of more care (Galiana et al., 2016). This has been Namibia's experience as well. Following the liberation of the country, the Namibian government had to deal with a broken social and economic architecture premised on apartheid legacies, which negatively impacted the care of older persons (Wallace & Kinahan, 2011). To address the wrongs of the past, a new democratic constitution was adopted which entrenched fundamental human rights and freedoms for all, including frail older persons. Within this constitutional framework, the provision of adequate care for older persons was prioritised (Mubangizi, 2006). In practice, this requires government to formulate social policies and welfare legislation that give effect to this constitutional aspiration. Therefore, when no provision is made for appropriate policies, the needs of frail older persons are not being prioritized by government.

According to Chiwara and Lombard (2017), a government's response to the needs of older persons depends on the availability of resources to develop and implement appropriate policies. With limited resources at its disposal, since independence the government has only been able to adjust old age pensions, leaving the broader needs of frail older persons largely unmet (Chiripanhura & Niño-Zarazúa, 2013). According to Lombard and Kruger (2009), frail older persons have multiple needs for which inclusive policy and legislation are needed. For example, while poverty eradication is the over-arching constitutional objective, frail older persons have a fundamental right to decent living arrangements, encompassing access to the basic necessities of life (Mubangizi, 2006). However, the reality is that many frail older persons in Namibia still live under unfavourable conditions, with most of their needs

unmet (Perold, 2000). Lack of access to an affordable and quality healthcare system has also compromised the ability of frail older persons to live a decent life, especially those with multiple morbidities (Van Rooy et al., 2015). Although one of the primary goals of a social welfare system is to ensure that older persons are adequately protected, there is a clear disconnect in Namibia between constitutional provisions, social policy and the actual needs of frail older persons (Amukugo & Nangombe, 2017). Although various broader social policy and legislative interventions have been instituted in Namibia, they have fallen short of examining or addressing the specific needs of frail older persons.

Furthermore, in seeking to compare experiences and perspectives relating to the needs of frail older persons, it was imperative to review global and regional literature. Indeed, these comparative perspectives have highlighted important gaps in the literature on the topic and provided interesting insights into how the Namibian situation could be improved.

## 1.3 PROBLEM STATEMENT

According to Issahaku and Neysmith (2013), frailty associated with aging is increasingly becoming a global phenomenon and one that brings with it unique needs for this cohort. In Namibia, the population of older persons is growing fast and approximately 3% of that cohort are frail (NPHC, 2011). This situation has policy and practical implications for Namibia, especially in terms of the distribution of national resources to ensure that the needs of frail older persons are understood and effectively addressed. To ensure equitable access to a country's resources, the needs of frail older persons must be examined as a basis for adequate budgetary and fiscal provision. In this regard, demands for quality care for frail older persons can put an added strain on the social welfare system (Issahaku & Neysmith, 2013). This is a problem because many African governments not only fail to understand the needs of frail older persons, but also lack the resources to effectively address them.

According to Galiana et al. (2016), the situation of older persons in Africa is worsened by the fact that there are too many social issues competing for resources. Therefore, frailty associated with aging presents unique challenges to governments in developing countries. In this regard, the United Nations (2020) states that the primary determinant of the socio-economic, cultural and psychological well-being of older persons is the quality of their living arrangements. This broadly refers to access to basic necessities of life like electricity, water, decent housing, sanitation and primary healthcare. Durán-Valverde et al. (2020) emphasise that while decent living conditions are important, there is also a compelling need to examine the

broader needs of frail older persons, and as Feng et al. (2017) indicate as well, a comprehensive needs assessment would improve overall planning and target appropriate areas of geriatric care.

While research has been done on the conditions under which older persons in Namibia live (Indongo & Sakaria, 2016), in general there is a paucity of scholarly work focusing on the needs of frail older persons in Namibia, especially from the perspectives of formal and informal caregivers. In fact, a combined study of this nature has not yet been conducted in the country and this creates a research gap on this subject. According to Woodhouse et al. (1988), the identification of the needs of frail older persons aims to reduce marginalisation, vulnerability, abuse, inequality and functional incapacity. Thus, without relevant research, the underlying needs of frail older persons in Namibia will not be adequately understood (Van Rooy et al., 2015). In other words, the failure to address this research vacuum will create barriers to evidence-based interventions for improvement of the care of frail older persons. Chiwara and Lombard (2017) support this view and argue that policy and legislative interventions must be informed by scientific understanding of the needs of frail older persons. This means that social welfare law and policy reforms must be knowledge-based and involve systematic understanding of the specific needs of frail older persons (Riege & Lindsay, 2006). According to Ananias (2014), this type of research is even more important in a developing country like Namibia, which does not have an effective legal framework in respect of frail older persons.

In addition to its national context, there is also a continental multilateral imperative for undertaking research of this nature. This is based on the fact that under the AU's Social Policy Framework for Africa, governments are required to adopt a bottom-up developmental approach, which requires a deeper understanding of the underlying needs of older persons (AU, 2008). This approach highlights the need for scientific insight into the needs of frail older persons. Rodrigo (2005) argues that failure to undertake relevant research in this area results not only in poor policy development, but also in misguided implementation of welfare programmes.

Furthermore, Browne et al. (2016) stipulate that the missing link between availability and efficient distribution of social welfare resources is the lack of knowledge and understanding of the needs of beneficiaries. In addition to the shortage of social workers in Namibia, there is no efficient inter-government coordination of social welfare and geriatric health services, which indicates a limited understanding of where the greatest needs reside (Chiwara & Lombard, 2017). Accordingly, information asymmetry has negative implications for the efficient and effective distribution of social services. Against this background, the research seeks to address the problem

of lack of understanding of the underlying needs of frail older persons in Namibia. This is important in ensuring that the care environment of frail older persons is improved and interventions are evidence-based.

## 1.4 RATIONALE FOR THE STUDY

The rationale for this study is articulated on the basis of the different dimensions relevant to the lives of frail older persons in Namibia. These are 1) caregivers and care interventions, 2) the older persons themselves and their needs, 3) policy formulation to support the needs of frail older persons, and academic and societal knowledge generation.

### 1.4.1 Rationale in relation to caregivers

Caregivers play a critical role in the care of frail older persons and their insights could inform necessary reforms relating to the needs of frail older persons. Although caregivers are crucial for the wellbeing of frail older persons, they are often neglected themselves and are not at the epicentre of debates on reform (Pot et al., 2001). Caregivers who are caring for frail older persons face many challenges and sometimes perform their roles at a personal cost, given the emotional and financial impacts (Chow & Ho, 2015). According to Hoffman (2014), by sharing perspectives and experiences, caregivers may actually raise awareness of their burdens. In some cases, because of their physical, physiological and mental impairments, frail older persons are unable to fully describe their needs and hence the perspectives of caregivers become a representative medium through which to ensure improved quality of care for frail older persons (Holroyd-Leduc et al., 2016). The inclusion of caregivers is a core aspect of achieving the research objectives in relation to the needs of frail older persons. As some of the formal caregivers are social workers themselves, the study findings contributes to knowledge and social work practice and social developmental since old age is in itself a social problem (MacIntyre, 2018). According to Kumari and Dua (2020) older persons are faced with many social problems including abuse, which is an area extensively covered in the study.

### 1.4.2 Rationale in relation to frail older persons

This study is relevant to frail older persons because it provides an opportunity to explore their underlying needs in order to better understand their challenges in the care environment.

### 1.4.3 Rationale for academia

Lombard (2008) argues that in addressing the needs of frail older persons, a sound legal framework must be guided by evidence-based information about social phenomena. This study holds a clear benefit for government as they can derive data from scientific insights, which is necessary for social welfare law reforms. Although policy makers are sometimes slow or reluctant to respond to empirical data (Feldman et al., 2001), the study offers a foundation for understanding the circumstances and needs of frail older persons. This is even more important in a country like Namibia, where the legislative and policy framework relating to older persons is weak and inadequate as regards providing care and protection to frail older persons (Holden, 2005).

The study rationale for academia is embedded in its contribution to knowledge through the use of a qualitative methodology and design to understand the nature and complexity of the needs of frail older persons in Namibia. The initial literature review highlighted the gaps in knowledge about the needs of frail older persons, based on the experiences and perspectives of formal and informal caregivers in Namibia. Therefore, the empirical findings reveal a new conceptual model that adds to our understanding of the specific needs of frail older persons. This model aims to fill the vacuum in the literature by enriching existing knowledge of geriatric needs assessment tools, not only in Namibia, but also in developing countries in general.

## 1.5 RESEARCH QUESTIONS

The aim of this study was to explore the needs of frail older persons in order to gain a deeper understanding of their circumstances and on this basis devise strategies to improve their overall care. Consequently, the main research question was: What are the needs of frail older persons in Namibia? The following sub-questions were devised to address the research problem:

- What are the needs of frail older persons in Namibia from the perspectives of formal and informal caregivers?
- What are the experiences of formal and informal caregivers in providing care to frail older persons?
- To what extent does the Namibian constitutional, legal and policy (regulatory) environment support the needs of frail older persons?
- Which social welfare models would be useful in addressing the needs of frail older persons in Namibia?

## 1.6 RESEARCH OBJECTIVES

Research objectives define the purpose of the study or the specific milestones the researcher seeks to achieve with the study project (Williams, 2007). The objectives are embedded in the aim of the study, which was to explore the needs of frail older persons from the perspectives of caregivers. Therefore, the following objectives were pursued:

- To explore and describe the perspectives of formal and informal caregivers of older persons in Namibia in relation to the needs of frail older persons;
- To explore and describe the experiences of formal and informal caregivers in providing care to frail older persons;
- To determine the extent to which the Namibian constitutional, legal and policy (regulatory) environment provides for the needs of older persons; and
- To recommend useful social welfare models towards understanding and addressing the needs of frail older persons in Namibia.

## 1.7 MAIN RESEARCH ASSUMPTIONS

Research assumptions are a critical component of research and create synthesis by explaining what is already known to support the theoretical discourse (Oyserman et al., 2002). Research assumptions are the background ideas that inform the chosen theoretical path. This study made the following methodological assumptions:

The first assumption was that responses from study participants would be honest and open during the interviews and focus group discussions (Petros, 2011). Study participants were not under duress and hence were free at all times to express their independent views without intimidation or fear. Based on the responses, it appears that some of the study participants were at times very open to engaging on the topic of interest. Therefore, the assumption was that the research instrument provided a reliable and credible means of eliciting adequate information, through semi-structured interviews, to answer the research questions. The second assumption was that study participants were able to engage in the interviews and provide important information and were in no way incapacitated from participating in the interviews and focus groups (Cesari et al., 2017). While some of the questions were sensitive, e.g. questions on abuse of older persons, the study participants were comfortable in answering these questions without much emotional difficulty.

The researcher made the further assumption that caregivers are sincere in looking after the interests of older persons and use available resources exclusively for the benefit and welfare of older persons without seeking gain. This assumes the

relationship between caregivers and care beneficiaries to be fiduciary, based on good will and emotive considerations (Piercy, 2000). This is an important assumption in gaining a deeper understanding of the needs of frail older persons, as it suggests that caregivers act on the basis of altruism rather than commercial gain when providing for the needs of frail older persons. Most of the frail older persons are mentally or physically impaired and therefore unable to independently carry out the activities of daily living unassisted and are dependent on caregivers. According to Cesari et al. (2017), frailty from aging usually manifests in the form of mental and physical incapacity, which impairs functional independence. This is a vital assumption as caregivers can be perceived as representing the voice of frail older persons relating to their needs in the care environment.

## 1.8 OVERVIEW OF RESEARCH METHODOLOGY

Although discussed fully in Chapter 4, this provides a brief overview to introduce the methodology used in the study. Because the aim of the research was to elicit the perspectives and experiences of caregivers relating to the needs of frail older persons, a qualitative methodology was identified as the most suitable for this research, as qualitative research explains the subjective views of participants in a real-life setting (Phoenix, 2018). Based on this paradigm, a constructivist approach, which attempts to understand human experiences was used in the interpretation of the research data (Mills et al., 2009).

According to Creswell and Poth (2018), the constructivist paradigm asserts that the truth is not universal and hence knowledge is acquired through a process of producing meaning. In this way, knowledge is constructed through interpretation of human experiences to gain better understanding.

Since the study sought to explore perspectives and experiences of caregivers in their natural setting, both an inductive and a deductive approach were implemented to ensure a sound process of empirical and theoretical data analysis. According to Soiferman (2010), an inductive approach develops theory from the data whereas deductive reasoning is about theory testing. The use of both deductive and inductive reasoning is appropriate to give meaning to complex social phenomena in an interpretive study (Baxter & Jack, 2008). This means that the research project starts with theory development, followed by deductive reasoning for validation of findings (Soiferman, 2010).

Under this qualitative methodology, various approaches were implemented with regard to population sampling, data collection and data analysis. Specifically, the

study relied on a non-probability sampling design, based on purposive sampling and snowball sampling (Babbie & Mouton, 2010). This approach was used to select study participants, who consisted of formal and informal caregivers and were selected for their ability to provide insights into the care needs of frail older persons. Key informants were an additional sample set consisting of a directorate from a non-governmental organisation (NGO) and all the officials dealing with social welfare issues in the four Namibian government departments, namely the Ministry of Health and Social Services (MOHSS); the Ministry of Justice; the Ministry of Labour, Industrial Relations and Employment Creation (MLIREC) and the Ministry of Poverty Eradication and Social Welfare (MPESW). The data collection for formal caregivers was through focus discussion, while semi-structured interviews were used for the informal caregivers and key informants. In addition, secondary data were collected from various policy reports, academic articles and other high-impact publications relevant to the study objectives.

The data analysis in this study applied a computer-assisted qualitative data analysis (CAQDAS) design. ATLAS-ti version 8.0 was used to perform the analytical process, which is considered ideal for large volumes of textual data. According to Saldaña (2016), the use of ATLAS-ti for data analysis is appropriate for data reductions through various coding techniques, which lead to the development of themes in answering the research questions. Therefore, using qualitative content analytical tools, parts of the emerging data from interviews and focus groups were automatically transferred to the coding frame components under ATLAS-ti (Schreier, 2012). In addition to the computer-assisted data analysis, content analysis, which is a qualitative interpretive technique that helps with thematic deductions from the data (Bowen, 2009), was included to analyse the textual data. As suggested by Bowen (2009), the interview data from key informants were summarized and then classified using content analysis. Content analysis was central in the analysis of the secondary data from documents, reports and other archived materials which provided information about the research phenomenon. According to Yin (2017), the use of multiple methods of data collection enhances triangulation of qualitative research and this method was integrated into this research.

## 1.9 CLARIFICATION OF TERMS

### 1.9.1 Frail older person

The World Health Organization (WHO) defines a frail older person as someone whose chronological age exceeds 60 years, and who is also burdened with physical, physiological and/or mental incapacity that compromises the person's

functional ability for self-care (WHO, 2009b). Therefore, frailty in older persons is largely seen in terms of functional incapacity to undertake the activities of daily living and dependence on caregivers to provide assistance with such activities (Lally & Crome, 2007). However, the extent of frailty also plays a role in determining levels of dependence on others for self-care (Cramm et al., 2013). Thus, the concept of frailty in old age is not absolute and hence you may find situations of frail older persons who have limited functional abilities for self-care and hence reduced dependence restorative (Steverink et al., 2005). This is an important distinction because while aging and frailty may happen simultaneously, this is not always the case since a person may be aged but still lead a productive and independent life without frailty (Bond & Corner, 2004).

### 1.9.2 Caregiver

According to Joubert (2005), "caregiver" as a gerontological concept refers to any person looking after a frail older person to assist the older person to carry out the activities of daily living. Despite the different experiences of formal and informal caregivers, conceptually the term "caregiver" is used interchangeably in the study where there are common and shared experiences (Penhale, 2010).

### 1.9.3 Formal caregivers

For the purposes of this study, any person who is employed and is in receipt of a salary, emolument or other reward to provide care to frail older persons in an institutional setting is referred to as a formal caregiver (Joubert, 2005). Reference to formal caregivers in the study includes various categories of persons involved in the care of frail older persons. For example, the one category of formal caregivers are social workers registered under the Namibian Social Work and Psychology Act 6 of 2004 and the other professional nurses registered under the Namibian Nursing Act 8 of 2004 (as amended by Act 10 of 2018). The other category of formal caregivers is represented by persons without formal professional qualifications who are employed with remuneration to provide care to frail older persons and also includes all other remunerated care workers in an institutional setting as opposed to home-based or family care. Accordingly, formal caregivers include nursing staff, social workers, paraprofessionals and auxiliary worker (assistant social workers) in both the public and private sectors, incorporating non-governmental organizations and other community-based organizations, as identified in the policy. In describing their role, Carelse (2018) indicates that formal caregivers are endowed with first-hand knowledge about the care environment and can contribute informed, relevant and holistic perspectives on the needs of frail older people under their care.

### 1.9.4 Informal caregiver

An informal caregiver is any person, usually a family member or neighbour, who undertakes to look after older persons, usually without pay (Hooyman & Kiyak, 2011). Informal caregivers include persons providing both physical and emotional care to frail older persons (Stoltz et al., 2004). Usually, informal care is home-based and is provided by a spouse, children, grandchildren, relatives or community members. In Namibia, informal care is primarily a practice found in intergenerational households (Ananias et al., 2016). Most informal caregivers of older persons in Namibia are family members who are culturally obligated to look after their elders. This makes informal care an intergenerational practice where the role is passed on from generation to generation across the life cycle (Lowenstein, 2010). The informal care arrangement is more prevalent in rural settings where the heads of households are predominantly female (Njororai & Njororai, 2013). For the purposes of this study, an informal caregiver was taken to be any person looking after a frail older person without monetary reward or compensation.

### 1.9.5 Successful aging

Successful aging of older persons relates not only to their health but also to broader issues of social participation and functional mobility (Lowry et al., 2012). According to Frieswijk et al. (2004), successful aging refers to the ability of frail older persons to enjoy self-enhancing life satisfaction despite their condition of frailty as they progress through the process of aging. Therefore, various factors enhance successful aging. These include life satisfaction, self-management, human dignity, self-confidence, psychosocial support and access to quality healthcare (Ferri et al., 2009). Successful aging consists of the design and implementation of strategies to enhance mental and physical vitality in order to avoid incapacity and suffering in late age (Lamb et al., 2017). According to Dahany et al. (2014), physical and psychological factors, together with adequate nutritional content and physical activity, influence successful aging. However, Litwin (2005) argues that the correlates of successful aging are not universal and depend on the circumstances of each country. For example, factors determining successful aging in the developed countries will not necessarily be the same for developing countries like Namibia, making it imperative to conduct studies that reflect the local character of particular countries (Gureje et al., 2014).

### 1.9.6 Quality of life

Quality of life is used in this study as a distinct concept referring to overall subjective well-being of frail older persons in the aging process and implies access to life's basic necessities, such as healthcare, housing and basic utilities (Ralston, 2018).

According to Jivraj et al. (2014), quality of life implies that the broader physical, environmental, psychological, social and spiritual needs of older persons are met in the care environment. However, quality of life and subjective wellbeing can only be achieved within the context of relevant "culture and value systems in which they live and in relation to their goals, expectations, standards and concerns" (World Health Organization Quality of Life (WHOQOL) Group, 1998, p. 1570). This suggests a subjective appreciation of quality of life based on the unique circumstances of frail older persons. For example, in Africa issues of loneliness, poor housing, and financial challenges have been found to be important determinants of quality of life that have to be considered in choosing interventions for older persons (Maniragaba et al., 2018).

## 1.10 THESIS OUTLINE

This thesis has been divided into seven chapters, an outline of which is given below:

Chapter 1: This chapter provides the introductory background together with the problem statement, rationale, study objectives and basic summary of the research methodology. It outlines the scope of the study and provides the context of the inquiry. Overall, the chapter highlights how frail older persons face multiple challenges that require collaborative stakeholder engagement and sound policies and legislation to ensure that the needs of this group are met.

Chapter 2: Chapter 2 provides a historical perspective on aging in Namibia and describes the country's old age policy. It deals with the early conceptualisation of care and protection of older persons as a part of the cultural practice of *Ubuntu*, the African concept of mutuality among people based on their common humanity. The impact of colonialism and apartheid on the family system in Namibia is critically discussed in relation to the care of frail older persons. This chapter provides a historical context for the current situation regarding the care of frail older persons and the various challenges attendant on this situation as a result of the past. It is important to understand the trajectory of historical events as it provides a means to inform social policy development, and to improve the care of frail older persons based on the lived experiences of frail older persons in Namibia in the context of historical disadvantage and oppression.

Chapter 3: Chapter 3 presents the literature review and theoretical framework for the study, highlighting the position of frail older persons, the various issues affecting them and the theoretical principles required to understand them. It reviews comparative scholarly debates on the subject matter, which identify the knowledge gaps in this area of study. As such, the chapter covers studies done on the topic

relating to formal and informal caregivers and exploring their perspectives and actual experiences of caring for frail older persons. Given limited information on the care of frail older persons in Namibia, the literature review is structured to provide first a global, then a regional and thereafter a local Namibian situational perspective on the subject. Various intersecting issues related to the research objectives are also discussed in order to provide deeper insights into the topic on the basis of the literature. Through the study's focus on social policy related to older persons, the literature review also looks at gaps in the literature around constitutional, legislative and policy frameworks in addressing the needs of frail older persons through social welfare reforms.

Chapter 4: Chapter 4 outlines the research methodology and the use of the qualitative research paradigm based on an interpretive constructivist design. The methodology includes sampling, data collection and data analysis. It outlines the qualitative content analysis that was used as an iterative data analytical process. The study logic is both inductive and deductive, based on the theoretical literature and empirical domains. With the aid of this analytical roadmap, the data that were analytically summarized into themes, using the ATLAS.ti software program, are outlined. This chapter concludes with a discussion of ethical issues in relation to the study, trustworthiness and triangulation of the data and methods.

Chapter 5: This chapter outlines the findings of the study. The findings are presented as four themes that highlight the needs of frail older persons through the perspectives and experience of caregivers. The chapter provides the basis for the analytical discussion in chapter 6.

Chapter 6: The discussion chapter synthesises the research findings, the literature and the theoretical observations. The interplay of theory and practice produced to some deeper insights into the research phenomena. As a result, new knowledge was created around a conceptual model for assessment of the needs of frail older persons in Namibia. Recommendations for practice provide advice to guide policy and law reforms.

Chapter 7: This chapter concludes the study. It links the discussions and outcomes of the various chapters and discusses them in relation to the research objectives. The chapter integrates the research holistically and serves as a summary of the overall findings. Practical recommendations to improve policy and practice in the care of frail older persons in Namibia are presented.

## 1.11 CONCLUSION

This chapter provides an introductory background to the study and provides a brief description of the knowledge gap arising from the Namibian situation of frail older persons. For example, the chapter provides the historical context for events that have impacted on the nature and functioning of the current care environment of frail older persons in Namibia. In terms of the problem statement, the chapter discusses the literature gaps relating to understanding the needs of frail older persons in Namibia and also highlights the slow progress towards creating a legal and policy framework for the protection of frail older persons. Equally, the study rationale is captured in terms of the importance of the study to caregivers, frail older persons, government and academia. The problem statement was aligned to the research objective, which seeks to explore the needs of frail older persons in Namibia from the perspectives and experiences of formal and informal caregivers. In terms of research assumptions, the chapter describes the background knowledge that informed the chosen theoretical path, based on the initial literature survey. The study followed a qualitative methodology, based on a constructivist paradigm. This chapter concludes with a clarification of key terms used in the study through the definition of concepts like formal and informal caregivers, quality of life, successful aging and frail older person. Finally, this chapter also presents a brief overview of the various chapters in the study.

# Chapter 2: A HISTORY OF NAMIBIA'S OLD AGE POLICY AND LEGISLATIVE DEVELOPMENTS

## 2.1 INTRODUCTION

This chapter describes the history underlying Namibia's policy development as it relates to frail older persons with the aim of providing a context for their current care needs. According to Kandjimbi (2014), Namibia's old age policy has been greatly influenced by historical events and these should be examined to provide a relevant context, since what happened in the past has led to current circumstances. A description of the historical events that have had a bearing on old age policy is important as it provides better insights into the factors that have influenced the current conditions of frail older persons, thereby serving as an explanatory basis for understanding their needs. For effective protection and safety of older persons, governments need to develop social policies that recognise various socio-economic, political and cultural circumstances that are the product of significant historical events (Issahaku & Neysmith, 2013). It is therefore important to understand the roots of Namibia's current inadequate old age policy framework, the roots of which can be found in the country's precolonial, colonial and postcolonial periods as they relate to old age policy developments. This chapter overviews this history and contemporary challenges.

Namibia is a developing African country that has experienced two waves of colonisation, one during the 19th century by Germany and the other by apartheid South Africa in the early 20th century, extending until independence in 1990. German rule was met with fierce local resistance by the indigenous Herero and Nama people which, according to Dierks (2002), led to the first genocidal war of the 20th century in which hundreds of thousands of black Namibians were killed, socially displaced and materially dispossessed. This genocidal war was waged mainly against the Ovaherero and Nama populations of Namibia, who are both part of what was referred to as the Bantu groups of Africa and the original inhabitants of Namibia. Demographically, the Ovahereros and Namas now make up 7% and 5% of the total population of Namibia respectively (Worldatlas, 2021). Before colonisation, the Ovahereros were the most populous ethnic group in Namibia (Cooper, 2007). Both the Nama and Ovaherero ethnic groups were nomadic pastoralists and their social protection system was based largely on livestock, mainly cattle. In military terms, the Ovaherero and Nama peoples were the most organised and socio-economically

self-sufficient ethnic groups in Namibia (Gewald, 1999). The genocidal war against the Ovahereros and Namas had implications for the care and protection of frail older persons, the reason being that many were left destitute as their primary means of survival during the precolonial era, namely cattle and land, were expropriated without compensation under German colonial rule (Du Vivier, 2007). This means that during the colonial period, the local ethnic groups in Namibia had to fend for themselves without any government-funded social protection programmes. As a result, the care of frail older persons during these times was dependent on members of the extended family, most of whom were employed as cheap labourers on agricultural farms and mines under the migratory contract labour system (Adamchak, 1995). Under this migratory labour system, dispossessed blacks were employed as cheap labourers, mainly on German-owned commercial farms, where remuneration often took the form of labour in exchange for food parcels (Stichter, 1985). Thus, even the contract labour system during this period did not include any provision for social security safety nets for blacks that could provide adequate support during old age (Hishongwa, 1992).

The second phase of colonisation began when South Africa took over the administration of Namibia under the supervisory mandate of the League of Nations (Idowu, 2000). This came about as a result of the defeat of Germany during the Second World War by the Allied powers (Great Britain, France, the Soviet Union, the United States and China), which led to Germany's having to surrender. This period had additional dire consequences for the care of older persons, considering that most of the local ethnic groups were emerging from the yoke of German colonialism and its devastating effects on their livelihoods (Tötemeyer, 2001). Nevertheless, the period of South African rule heralded the introduction of a limited social welfare system for black older persons, albeit a racially segregated system (Devereux, 2001). For example, black older persons received a modest old age pension. Therefore, by the time Namibia gained independence in 1990, the social welfare policies had been crafted to support racial divisions and the unequal distribution of resources under the South African apartheid government.

During the post-colonial period, the newly formed Namibian government was confronted with the arduous task of social reintegration of historically disadvantaged Namibians into the fabric of an equal and democratic society (Pelham, 2007). In terms of social service delivery, the social welfare system had to be revamped to provide income security and enhance the overall protection of older persons who had witnessed the brutality of colonialism and its catalytic effect on poverty (Devereux, 2001). Since most black, frail older persons had no access to decent housing, affordable healthcare or basic necessities for quality living, the government

introduced various legislative and policy interventions to equalise social grants without ethnic, racial and gender bias (Chiripanhura & Niño-Zarazúa, 2010). However, radical social and welfare reforms were hampered by constitutional provisions which required post-apartheid laws and policies to remain valid and enforceable until declared unconstitutional by a court of law (Mubangizi, 2006). According to Geingob (2004), this constitutional compromise was necessary to ensure orderly succession and balancing of interests. The implication of this was that the government's social reform programmes were restricted to working within the past policy frameworks and modifying them progressively instead of implementing change through radical transformation (Nakuta, 2008). In practice it meant that the pace of reform was slow and that this disadvantaged frail older persons whose multiple needs remained unmet. This constitutional conundrum resulted in slow delivery of social welfare services to frail older persons (Jauch, 2019a).

At the moment, the situation around the status of policy and legislative reforms relating to frail care needs of older persons has not improved much. While in 2016, the Ministry of Health and Social Services advertised a consulting tender to conduct a situational analysis and development of a comprehensive national policy on older persons (New Era, 2016) to date nothing came of it. As of recent, the Deputy-Minister of Health and Social Services introduced a motion in Parliament about the plight of older persons in Namibia and more specifically around their financial abuse and exploitation by family members (Republic of Namibia, 2022). In this Parliamentary motion, the Government described the need for focus group based research towards the development of a national policy and legislative interventions on the care of older persons (New Era, 2022). This means that currently no clear policy and legislative interventions have been commissioned to understand and improve the care needs of frail older persons in Namibia.

Against this background, this chapter describes the historical evolution of Namibia's old age policy and its overall implications for the care of frail older persons, including constraints on reforms.

## 2.2 THE PRECOLONIAL ERA AND THE CARE OF OLDER PERSONS

During the precolonial era in Namibia, the concept of government social protection frameworks for the care of older persons did not exist. Instead, communities relied on a highly functional informal community welfare system which was based on African cultural and value systems of self-reliance and subsistence and in which the care of older persons was central (Nwauwa, 2000). In this system, looking after older persons was an integral part of the normative moral obligation of care, which

depended on the extended family system. Hence, the care of older persons was based on much more than immediate biological affinity and involved an extended family genealogy based on broader ancestral linkages grounded in the concept of *ubuntu* (Folbre, 2014). At a basic level, this means that the duty of care for frail older persons was broader than kinship and was based on broader tribal relationships, which promoted values of humanity or *ubuntu*. The etymology of the word *ubuntu* is derived from the Nguni ethnic groups of Southern Africa and means "a person is a person through other persons" (Gade, 2011, p. 302). As it relates to care, this means that caring for older persons is a moral and ethical responsibility embedded in humanity as a basic condition for identity and preservation of cultures and traditions (Bujo, 2009).

Early ethnographic studies indicate that indigenous Namibian communities, like the Ovahereros, also practised *ubuntu* under what is known as *Omajanda* and *Oruzo* (Hangara, 2017). Broadly, these concepts refer to non-biological relationships formed outside the formal family kinship system and used as a means to enforce an extended social care system for the community at large and older persons in particular (Luttig, 1933). According to Hangara (2017), the concept of family in precolonial periods was based on a reciprocal intergenerational duty of support, which promoted broader intertribal social affiliation and descent systems rather than the narrow nuclear family system.

On this point, Folbre (2014) argues that based on the African conceptualisation of extended family relationships, matrilineal and patrilineal descent determined mutual obligations to support and care for older persons. This highlights the importance of ancestry as a basis of care and the important role older persons played in maintaining traditions and cultures (Hangara, 2017). According to Rampke (2016), through *ubuntu* or *Omajanda* and *Oruzo*, as practised in precolonial Namibia, older persons were seen as peacemakers, a source of infinite wisdom and deserving of special care by their relatives and the community at large. Under these circumstances, abuse and neglect of frail older persons was taboo and could lead to social reprimand and ostracization in terms of traditional social norms (Becker, 2007). In fact, reverence for older persons continued beyond their death as older persons became revered ancestors, a belief which many Namibian communities still subscribe to even today, based on ancestral intermediation with God. This practice is based on the belief that the connection to the deity is through the spirit of the departed, based on the institution of the so-called holy fire ritual where the spirits of older persons as ancestors are invoked for protection (Westerlund, 1991). This practice implies that deceased older persons occupy a special seat close to the deity and hence effective messages for the living can be mediated via them. Caring for older persons then becomes an

expected intergenerational religious and traditional obligation in addition to being a family and societal responsibility. In this regard, the obligation to provide for the needs of frail older persons was shared by the broader community under *ubuntu*, having regard for available resources (Folbre, 2014). Equally, the standard of care for frail older persons was based on the intrinsic values that promoted human dignity and respect for them in general (Hangara, 2017). In other words, during the precolonial era, care for frail older persons was fundamental to the preservation of family and societal values.

Thus, as Beckman and Sachikonye (2001) observed, while formal social welfare organizations did not exist during precolonial times in Namibia, the needs of frail older persons were provided through family and societal relationships that were based on the subsistence economy. Overall, the care of older persons in the precolonial era can be seen as an enduring informal cultural model of care that continues in Namibian society to the present day.

## 2.3 THE COLONIAL ERA AND THE CARE OF OLDER PERSONS

This discussion covers the period of German and South African colonisation of Namibia, with specific focus on historical perspectives on the policy and legal developments relating to older persons.

### 2.3.1 German colonialism

The arrival of German settlers in Namibia in 1884 heralded the first form of colonialism, which denigrated the established African welfare system for older persons in particular and the communities at large (Dierks, 2002). Under German occupation, Namibia witnessed the most brutal form of colonial occupation, one that saw many blacks killed, others displaced and left destitute. This was perpetrated through a genocidal war waged against local ethnic groups, especially the Ovahereros and Namas, who resisted German occupation and annexation of their land (Tötemeyer, 2001). The fierce war of resistance led to the extermination order issued by the German government against these local inhabitants who had taken up arms against them. The war of resistance in Namibia provided the basis for the first 20th century genocide, which not only destroyed the lives of the local black communities, but dispossessed them of their cattle and land, which had served as their sole means of survival and social protection (Berat, 1993). During this period of German colonialism black people in general and older persons in particular were reduced to begging and left without the economic means to survive or sustain themselves. The subsistence economy was completely destroyed and poverty was rampant amongst

the ethnic groups (Werner, 1993). According to Dierks (2002), the local ethnic groups lost everything on which they depended for social security, including their intergenerational support networks, as many of them were displaced and others died while fleeing into neighbouring Botswana and South Africa for refuge.

In describing the situation during the period of German rule, Melber (2010) argues that despite the genocide in Namibia, the affected communities were able to re-organise themselves socially and culturally through a strong sense of solidarity. However, they did not have the resources to provide adequate social protection and care to meet the multiple needs of frail older persons who were negatively affected by the German colonial war and consequent dire socio-economic conditions (Dierks, 2002).

The social protection environment was different for the Germans in the country since the colonial German government introduced programmes to look after frail older persons of German descent. According to Werner (1993), the first social policy for older persons in former German South-West Africa (now Namibia) was introduced in 1904 in the form of a State-funded social income grant for the so-called Schutztruppen or German soldiers who participated in counterinsurgency against the local ethnic groups from 1904 to 1908. This pension arrangement was non-contributory and non-means tested for beneficiaries and the only eligibility criterion was participation in the war of resistance as a German soldier (Werner, 1993). These compensatory pensions were paid from a designated compensation fund specifically created by the then German government in Namibia for this purpose. However, these compensatory pensions were racially exclusive since even those blacks who were coercively conscripted to fight on the side of Germany during the war were not eligible for compensatory pensions, which were only available to white German soldiers (Bley, 1996).

This formal social protection policy framework created a retirement safety net for many German soldiers who, instead of returning to Germany, opted to be resettled in Namibia and to accept an offer of arable land by the government as compensation for participation in the war (Goldblatt, 1971). The implication was that many German soldiers could fully integrate into Namibian society with the full support of the government of the time and under its socio-economic infrastructure (Bley, 1996). This provided a solid welfare policy foundation for socio-economic prosperity and upliftment of the German settlers in Namibia who, together with the soldiers, were the beneficiaries of various social security arrangements. On the other hand, the local ethnic groups that had fought in the war of resistance against the Germans continued to live in poverty and were unable to provide quality care for their frail older

persons (Gewald, 1999). According to Kaapama (2020), the implications and scars of material and land dispossession of black Namibians still persist in post-independent Namibia and have given rise to the current legal demands for compensation from the present German government (Weber & Weber, 2020). However, the legal case filed in the United States Supreme Court for German reparations to the affected communities in Namibia was lost due to lack of jurisdiction. Germany subsequently offered eighteen billion six hundred million Namibian Dollar (N$18,6 billion) as compensation, but this was considered inadequate and rejected by the affected communities. The main argument was made that the compensation offered by the German government was in the form of government to government aid and not targeted towards improvement of the living conditions of the affected communities of the German genocide (Reuters, 2021). Also, the affected communities were not directly involved in reparation negotiations with Germany (Ngatjiheue & Petersen, 2021).

### 2.3.2 South African colonisation and apartheid rule

After the defeat of Germany during the First World War, Namibia was handed over to South Africa by the League of Nations in 1919 for administration and preparation for political independence (Katjavivi, 1988). Under Article 22 of the League of Nations Covenant, South Africa was required to administer the territory in the best interests of the local inhabitants and ensure what was described as their economic, moral and social well-being (Zuijdwijk, 1973). However, apartheid South Africa ignored its mandate to, *inter alia*, provide adequate social welfare systems for local communities and instead made use of the opportunity to implement a policy of racial segregation underpinned by laws (Werner, 1993).

Shortly after taking occupation of Namibia, Apartheid was implemented in Namibia through the enactment and application of mainly two legislations that were operating in South Africa at the time, namely the Natives Land Act 27 of 1913 and the Native Administration Proclamation No. 11 of 1922 (Dierks, 2002). In practice, these laws aimed to keep blacks in designated rural villages or reserves while reserving the urban areas mainly for white Afrikaners. Most of these rural locations did not have access to basic amenities like electricity, running water and sanitation, making conditions unfavourable for the care of frail older persons. This occurred amidst rapid industrialisation and a demand for cheap labour in South Africa in the 1920s. As a result, many black workers left rural areas and flocked to emerging towns and cities in search of better economic opportunities to take care of their extended families, including frail older persons. According to Parnell (1991), the rapid rate

of urbanisation of blacks, who were flocking into towns and cities, was a serious concern to the apartheid government and hence the Stallard Commission was set up in 1922 to investigate ways of regulating the entry of blacks into urban areas in Namibia and South Africa. First, the Stallard Commission recommended that blacks should not own land or have citizenship rights in Namibia and South Africa. Secondly, it was recommended that blacks should only be allowed into towns and cities as labourers, solely there to satisfy the demands and needs of resettled whites (Frankel, 1979). Therefore, in executing these recommendations, the South African government enacted the Pass Laws Act of 1952, which required blacks to carry a pass book when entering cities and towns. Since these laws were applied to Namibia as well, the movement of blacks in urban areas was restricted to work under the mainly migrant labour system (Hishongwa, 1992). According to Smith (1986), the pass system was seen as the most oppressive symbol of apartheid and a violation of the inherent rights of blacks to freedom of movement in their own country. Emmett (1984) in fact argued that the pass system was never meant to be a genuine urban management strategy, but rather a racially motivated strategy to keep blacks out of towns and cities on the basis of a form of urban apartheid. As a result, the pass system was met with fierce resistance from blacks, many of whom refused to carry pass books (Emmett, 1984).

The impact of restricted movement for blacks had negative implications for the care of frail older persons in rural areas because in most cases blacks were separated from relatives and could not move in and out of urban areas freely without harassment or even outright imprisonment, which made travelling to rural areas difficult (Smith, 1986). This situation resulted in frail older persons who depended on migrant labourers for basic survival being cut off from an important social safety net. In this regard, Hishongwa (1992) averred that because of the accompanying restricted access, the migrant labour system in Namibia was antithetical to social security, social cohesion and social protection in general. Overall, the level of dissatisfaction with the pass system, together with the unsatisfactory living conditions of blacks, led to the rapid development of progressive political movements that spearheaded campaigns for change and solidarity on both national and international fronts.

Despite the growing poverty of blacks and persistent political pressures, the South African government established the Pienaar Commission in 1928 to look into the viability of a comprehensive social protection framework for white older persons (Deaton, 1997). This was done in an effort to formalise social security arrangements for whites in South Africa and remedy the social plight of white workers who were nearing retirement. As a result of this inquiry, the first old age legislation (the Old Age Pensions Act of 1928) was enacted to provide a formal legal framework for

the implementation of the recommendations of the Pienaar Commission. These recommendations mainly included the introduction of a universal and non-means tested old age pension for whites in South Africa and were applied to Namibia in 1940 (Devereux, 2001). However, blacks were still ineligible for participation in these social security arrangements.

In the 1940s the political environment was becoming more organised and the apartheid government was under pressure to bring about changes that would imply the inclusion of blacks in social protection arrangements. As a result, in 1943 the South African government established yet another commission, this time headed by Hofmeyer, to look into the possibility of extending old age pensions to blacks on a racially segregated basis (Sorensen, 2012). The recommendations of the Hofmeyer Commission were implemented through an amendment to the Old Age Pension Act of 1928, which effectively created a two-tier old age pension system for blacks and whites, with the latter receiving higher levels of income. The old age pension system took the form of monthly annuity payments to blacks who had reached the age of 60 years for males and 65 years for females on the basis of the view that women tend to live longer than their male counterparts (Etinzock & Kollamparambil, 2019). According to Ham and Sloane (1997), chronological aging is gender-specific, based on biological, social and behavioural factors. This emphasises that the elderly may have different needs to enable them to achieve quality of life. In other words, demographically, women tend to outlive men and create a longer-term liability for the fiscus. On the other hand, this differentiation on the basis of chronological age signalled unfair gender discrimination in old age policy and had serious implications for the care of frail older persons given the fact most black households were headed by females (Adamchak, 1995).

Paradoxically, in determining the eligibility of blacks to receive an old age pension, ownership of land was used as a criterion or limited means test for qualification (Devereux, 2001). This effectively meant that blacks who owned land would be excluded from receiving old age pensions. In fact, land ownership in rural areas was vested in the traditional authorities and no individual title could be registered to blacks; hence this requirement for the means test for old age pensions made no sense. Nevertheless, land ownership criteria were important because under the Hofmeyr Commission of 1943 a different pensions system was recommended for city, town and reserve dwellers (Van der Berg, 1997). This meant that older persons in urban areas would receive relatively higher pensions than those living in rural areas. Contrary to the policy intent of the Old Age Pensions Act of 1928, the different pensions for rural and urban dwellers led to many rural dwellers moving to the cities and towns for a better life, a fact which was recognised in the findings of the Hofmeyr

Commission Report of 1943 (Sorensen, 2012). Thus, the phenomenon of pension urbanisation or payment of higher pensions in towns in the 1940s created a negative situation for the intergenerational care of frail older persons, who were left behind in rural areas without younger caregivers. However, given the high levels of poverty and unemployment in the rural areas, coupled with a lack of decent infrastructure, it would have been difficult if not impossible for young people to look after their parents and grandparents (Cartmel & Furlong, 2000).

The 1950s signalled a very important milestone in the development of social policy in Namibia. These developments were catalysed by the passing of the infamous Population Registration Act 21 of 1950, enacted in South Africa, which used racial and ethnic discrimination as a basis for formal social service delivery (Patel, 2005). This law was applied in Namibia so that the first race-based social services departments were created separately for whites and blacks in Namibia as well. It was during this period that the first black social worker was appointed in Namibia (Ananias et al., 2016). This was a significant milestone because many blacks were confronted by many challenges for which social development was imperative. According to Devereux (2001), the extension of social services to black Namibians was not prompted by a genuine concern for their well-being, but was a deliberate political strategy intended to pacify communities by self-serving means, in order to avoid resistance and any possible uprisings.

In a manner similar to the legal enactments in South Africa in 1959, the Group Areas Act 68 of 1951 was enacted in Namibia. This law promoted separate social development policies based on race and blacks were forcefully uprooted from their urban settlements and relocated to newly developed townships. This created serious resistance and many blacks were killed for their defiance of relocation to these new neighbourhoods (Melber, 2020). At the same time, those blacks who refused to relocate to townships were forced to reside in the newly designated rural villages, which had been designated on the basis of ethnic backgrounds and were located outside the geographical boundaries of urban areas (Fritz & Schulze, 2019). Most of these rural villages had no formal dwellings or access to healthcare or public utility services like electricity, water and sanitation. With the exception of meagre old age pensions, frail older persons in these rural settings were denied a sustainable income, food security and access to comprehensive social welfare protection (Frayne, 2010). Even those black older persons who had retired as blue-collar workers on the railways, farms and mines had no formal retirement safety nets and relied on the government's old age pension for basic necessities (Dobler, 2014). During their working lives, the wages of most of these migrant labourers were

not sufficient to allow them to build up retirement savings, or even buy food and pay for hostel accommodation.

According to Tötemeyer (2001), these colonial rural villages or reserves were also uneconomic in that they were unable to provide subsistence living for black Namibians who had historically been pastoralists and crop producers before the German colonial occupation. The Report of the Odendaal Commission of 1962 (Republic of South Africa, 1962, p. 81), which promoted separate racial development, captured this situation in the following passage:

The communal land tenure system was not even succeeding with subsistence farming and was unable to provide a basic, decent living for these resettled black communities. Clearly, given the: levels of dispossession of land and livestock, black people were not left with much to live on and as such were left to their own devices while spread across the most infertile part of Namibia. The native reserve system did not achieve its intended purpose and simply worsened poverty levels in these resettled black communities.

The racially discriminatory policies and exclusion from social programmes continued with the introduction of the Pension Funds Act 24 of 1956, which regulates the occupational pension funds industry. According to Njuguna (2010), this legislation governing pension funds, which was passed in South Africa and applied to Namibia, became the very first occupational pension fund legislation in Africa. Under this statutory framework, employers could make financial contributions towards workers' retirement, death and disability benefits. However, membership was only for white workers and this deprived many black workers of a suitable vehicle for retirement savings and access to various statutory incentives (Ponting, 2000). According to George (2006), pension funds performed a very important social security function and Subramanien (2013) concurs and further highlights the value of these savings vehicles for older persons as a means of poverty eradication.

The level of escalating poverty, unfair racial discrimination and oppression of blacks by the apartheid government led to the formation of political movements in the late 1950s (Katjavivi, 1988). It was through increased international diplomatic pressure and the collective struggles of these political movements which consisted mainly of political parties, civil society organisations, churches, trade union and student organisations that Namibia's struggle for independence was waged (Geingob, 2004). In the 1960s the Aged Persons Act 81 of 1967 was enacted. This created the basis for the establishment of nursing and old age homes for whites in Windhoek (Ananias et al., 2016). In fact, as part of the state's welfare services many old age

homes were set up by the government across the country to accommodate white, frail older persons with paid formal caregivers to provide them with specialised care. For black person in need of frail care, the option of formal care as a service provided by the state was not available during this time. In 1974, however, a church donated an old building, which had originally been built by missionaries in the 1950s as a teacher's training college, to be used as the first old age home for black, frail older persons (Nangombe & Ackermann, 2013). According to Muinjangue (2020), this historic development signalled the first formal institutional care arrangements for blacks in Namibia to address the growing need for assisted living for frail older persons. During this period, the majority of black, frail older persons were still living in informal family care (Dima, 2003). The lack of old age homes for blacks meant that many black people who were in dire need of institutionalised care were denied access by law to formalised assisted living arrangements. In related actions, the apartheid states also legally denied health services to frail older persons, as evidenced in the case of blind older persons. Aging can sometimes lead to impaired vision and even outright blindness and for this reason the government introduced the Blind Persons Act 26 of 1968, *inter alia* to render financial assistance to white, blind older persons (Noyoo et al., 2021). This legislation also created an elaborate administrative machinery for the payment of social grants for visually impaired white older persons. During this period, many black older persons were suffering from cataract complications, a condition which is recognized as one of the major causes of blindness in Africa (Lewallen & Courtright, 2001). But, due to racial exclusion, most black older persons had to endure the agony of blindness without social protection under the law (Steinkuller, 1983).

Due to the growing dissatisfaction of blacks with the inadequate social protection arrangements for older persons, the government established the Pienaar Commission in 1973 to look into possible extension of benefits. The outcome of this commission was disappointing to many people as it found that Africans were largely excluded from comprehensive social protection mainly because of their cultural reliance on the informal extended family system to care for frail older persons. The commission report found that the extended family system based on kinship was sufficiently resourced to provide a safety net without the need for formal government policy intervention (Devereux, 2001).

Furthermore, in terms of the South African colonisation of Namibia, any law passed in South Africa prior to 1977 would have automatic application to Namibia as an annexed territory (Bogdan, 1999). However, Amoo and Skeffers (2008) explain that from 1977 onwards South African laws did not have automatic application in Namibia, but required specific application clauses in order to be implemented. To

this effect the Transfer Proclamations of 1977–78 were enacted; these contained the South African laws applicable in Namibia prior to 1977. The implication for the protection of frail older persons was that some limited welfare benefits, such as social grants, could be extended to blacks and the South African legal framework could create certain legally enforceable obligations to provide social welfare.

## 2.4 THE POST-INDEPENDENCE ERA AND THE CARE OF OLDER PERSONS

Namibia inherited a social welfare system characterized by racial injustice, segregation, poverty and inequality coupled with poor socio-economic conditions. The new Namibian government was confronted with the daunting task of transforming virtually all aspects of the life of the Namibian people, including the care of frail older persons (Nakuta, 2008). The break with the apartheid dispensation and the legal mechanisms for dealing with the needs of frail older persons are pertinently encapsulated in various clauses of the Namibian Constitution as well as related policies and laws.

The Namibian Constitution was the first law to be enacted by the Namibian parliament and provided the foundation for a free and democratic society in which everyone, including frail older persons, can enjoy a decent standard of living (Makiwane & Kwizera, 2006). According to Nakuta (2008), the Namibian Constitution is the supreme law of the country and creates the broader transformative framework for the recognition and protection of the fundamental human rights of all Namibians. In this context, issues of social equity, equality, freedom and justice are expounded as basic constitutional values for all, including frail older persons (Cottrell, 1991). This means that, as with all citizens, the well-being and human dignity of older persons in Namibia are protected as a basic constitutional right (Shulztiner & Carmi, 2014). While the Namibian Constitution does not specifically mention the needs of frail older persons, it provides the broader framework for the protection of this cohort. For example, Makiwane and Kwizera (2006) argue that human dignity under the Constitution can only be guaranteed if basic socio-economic rights like access to sanitation, safe water, housing, food, clothing, safety and transport are recognized and protected.

The articles of the Namibia Constitution that are relevant to the needs of frail older persons include the right to life, respect for human dignity, the right to equality, the right to privacy, the right to family, and the right to culture.

Under the right to life enshrined in the Constitution, every person has an inalienable right to life and hence every effort must be made in the care environment to protect

the life of frail older persons by addressing their various needs. In practice, this means that frail older persons under long-term care have a need to be protected against life-threatening health conditions (Kane & Kane, 2001). Another important issue is that under the Constitution frail older persons are entitled to human dignity in every aspect of their lives. According to Mundia (2016), the need for human dignity implies access to the necessities of life like quality and affordable healthcare, decent housing, nutritious food and transportation. Respect for human dignity also involves protection against any form of abuse (Klie & Ananias, 2021). The right to equality and freedom from discrimination creates a framework for the protection of frail older persons against prejudice arising from their condition (Doron & Apter, 2010). The need for privacy of frail older persons is also guaranteed by the promotion of the right to decent living conditions without overcrowding (Mégret, 2011). Under the right to family, the need of frail older persons to be part of their families is recognized. According to Vorster (2011), the separation from loved ones and family is an emotionally charged event for frail older persons and the loss of living conditions that include relatives leads to social isolation and possibly depression. To further enhance social bonding, the Namibian Constitution also acknowledges the need of frail older persons to freely practice the culture and religion of their choice in the care environment (Horn, 2011). According to Maharaj (2020), frail older persons need culture and religion in order to cope with, adapt to and make sense of their peculiar circumstances in care.

Under article 95, the Constitution defines the welfare needs of frail older persons in terms of affordable healthcare, adequate regular pensions and social benefits for the poor (Mosito, 2016). Although, the Constitution does not specifically address the social security needs of frail older persons, it requires compliance with ILO's social protection standards (Nyenti & Mpedi, 2012).

Despite the passing of the Namibian Constitution, which heralded a new dawn for democracy and human rights, all pre-independence South African laws that applied to Namibia remain in force until they are repealed by the parliament of an independent Namibian (Amoo & Skeffers, 2008). The implication of this provision for social development is that South African laws relating to social protection that were applied to Namibia prior to 1990 remain valid until repealed or declared unconstitutional by a competent court of law. According to Mubangizi (2006), the legacy of past South African laws has had a negative impact on the speedy delivery of social reforms relating to the care needs of frail older persons in Namibia.

In accordance with the Namibian Constitution, the National Pensions Act 10 of 1992 was passed as the first piece of legislation dealing with social issues (Devereux,

2001). This legislation was enacted as an instrument in the post-independence era in Namibia to reflect the income needs of older persons and provide for equal treatment in the provision of social pensions. As a result, the social pension eligibility age for males and females, which had previously been based on age discrimination, was equalized, thereby addressing the need for a gender balance in the provision of social grants (Barrientos, 2004). According to Devereux (2001), the passing of the National Pensions Act was the first significant piece of social welfare legislation in Namibia that introduced a universal, non-means tested and non-contributory old age pension system. Throughout its preamble, this law seeks to address the growing income needs of frail older persons, most of whom had endured socio-economic hardship under apartheid (Nangombe, 2003). Devereux (2001), avers, however, that although it is a commendable objective to reduce income inequality through redistributive social measures like social grants, this is inadequate given the wide income disparities created by apartheid.

To further enhance the social security needs of the Namibian people (including frail older persons), the Social Security Act 34 of 1994 was passed. According to Kalusopa et al. (2012), the care and protection of frail older persons falls within the broader social security paradigm. The Social Security Act regulates the management of various statutory compensation funds for the payment of social protection benefits, including pensions to retired members (Republic of Namibia, 1994).

In order to regulate the social services profession, the Social Work and Psychology Act 6 of 2004 was passed. This Act sets professional and governance standards for formal caregivers (including caregivers of frail older persons). According to Chipare et al. (2020), the social work profession is essential for the success of any social welfare programme, particularly a programme for the care of frail older persons. To date, Namibia has approximately 700 registered social workers, mostly employed by government.

Additionally, two other welfare laws were passed to regulate the broader social protection environment, which includes frail older persons. The Motor Vehicle Accident Fund Act 10 of 2007 was passed to deal with the income needs of victims of vehicular accidents. Compensation under this Act takes the form of both lumps sums and annuity payments to beneficiaries or victims of motor accidents or their dependants (Antindi, 2019). Under this law, effective compensation is provided to accident victims (including frail older persons) for income needs relating to medical expenses (Shikongo, 2013).

In order to create a compensatory framework for war veterans, the Veterans Act 2 of 2008 was passed. Many frail older persons who participated in the war of liberation of Namibia experienced enormous financial challenges after independence. As a result, the government passed the Veterans Act to provide regular pensions to war veterans (Republic of Namibia, 2008). According to Metsola (2010), a veteran's grant can be considered a rehabilitation and integration pension for aged war veterans who have been denied a social safety net due to historical circumstances. This acknowledges that veterans of the war of independence were denied an opportunity to work and earn a pension or save for a retirement safety net. Thus, the veterans' pension seeks to integrate them into society with additional earnings. However, the registration and eligibility criteria under this Act have excluded many potential war veterans from benefiting from its provisions (Theron, 2014). According to Metsola (2010), the definition of a war veteran under this Act, in which "veteran" is defined in terms of alignment to the ruling party, is unduly restrictive and creates capricious bias based on political considerations. This means that political allegiance impacts on whether war veterans qualify for grants or not. This situation has left some people dissatisfied with the veterans' compensation system. This applies especially to the former South-West Africa Task Force (SWAFT) and Koevoet soldiers who fought on the side of the South African government at the time (Bolliger, 2017).

A further problem is that the focus of this Act is on annuity payments rather than lump sums and this ignores the personal circumstances of frail older war veterans and their unique needs (New Era, 2016). For example, given their advanced age, some frail older veterans prefer to receive lump sums in cash to enable them to afford their chosen lifestyles while still alive. Some urgently need the lump sums rather than an annuity to afford chronic medications and expensive medical procedures. The implication is that the veteran's pension must target the needs of frail older persons based on their stage in the life cycle and historical background (Matshoba, 2017).

In addition to the legislative framework for social welfare described above, the Namibian government has created various social policies that affect frail older persons. These policies include the Harambee Prosperity Plan and Namibia's Draft Social Protection Policy. The Harambee Prosperity Plan 2019–2021 is a general policy instrument aimed at creating socioeconomic prosperity (Office of the President, 2021). According to Kornfeld-Matte (2017), the Harambee Prosperity Plan could serve as an effective broad framework for improved food security and provision of housing for older persons in Namibia. However, the broad nature of the Harambee Prosperity Plan deprives the policy of the necessary focus on delivery in respect of the needs of frail older persons. Although many frail older persons have received food parcels and once-off basic income grants as poverty eradication mechanisms

under this policy, it remains a drop in the ocean compared to the growing demands and unmet needs of this cohort (Crush et al., 2021).

The other social policy framework that followed was Namibia's Draft Social Protection Policy of 2019–2024, which was created by the Ministry of Poverty Eradication and Social Welfare (MOPESW). This policy serves as a basic framework for comprehensive social protection and aims to deal with the broader social needs of poor and marginalized Namibians (Republic of Namibia, 2019). According to Jauch (2019b), the main areas of focus of Namibia's Draft Social Protection Policy of 2019–2024 are food security, and access to basic necessities of life like housing, healthcare, sanitation, electricity and water. In assessing Namibia's social protection floors, the ILO reported that the current social protection mechanisms fail to deal with governance issues, such as lack of government coordination and administrative inefficiency (ILO, 2014). In addition, the draft social policy lacks specific implementation programmes of action, an integrated registry, performance benchmarks and assessments of the financial impact on the fiscus (Schade et al., 2019). Although the draft policy mentions the poor distribution of social workers, it does not specifically target improvement of the welfare of older persons or their unique needs, but serves as a general framework for poverty eradication. The failure of the draft policy to specifically address the needs of older persons is contrary to the policy of inclusive growth and sustainable old age under the principles of the AU's Social Policy Framework for Africa (AU, 2008). These principles state that social policy reforms must be bottom-up and participative processes based on elderly inclusion. Also, no reference is made in the draft policy to the plight of caregivers, especially informal caregivers who are unpaid and are confronted by multiple challenges due primarily to conditions of poverty (Jauch, 2019b). For example, informal caregivers are not recognized as care workers and no effort is made in the policy to assess their unique challenges and suggest possible remedial strategies.

## 2.5 CONTEMPORARY CHALLENGES AFFECTING OLDER PERSONS AND IMPLICATION

Based on the historical events described above, Namibia's social protection policies and legal frameworks are not comprehensive and law reforms to date have been piecemeal rather than following a radical law reform process aimed at moving away from the legacy of apartheid. Legislative amendments to social policy have been reactive instead of proactively addressing the needs of frail older persons. The implications of these circumstances have created conditions that have affected and continue to affect the lives of older persons. In particular, limited resource allocation,

policy fragmentation and administrative inefficiency continue to undermine attempts to meet the needs of frail older persons.

### 2.5.1 Resources

A comprehensive social welfare system requires adequate funding and must be carefully planned and progressively implemented if it is to be effective and efficient. Jauch (2019a) estimates that about 5% of Namibia's GDP is required to fund a comprehensive social protection programme. After independence, Namibia inherited a non-performing economy and a government that was in a very poor financial and fiscal situation (Christiansen, 2011). This situation had negative implications for the care of frail older persons, which required financial resources from government. To illustrate this, upon independence in the 1990s, Namibia's social expenditure was about 1.6% of GDP. By 2019 it had increased to approximately 9% of GDP (Ministry of Finance, 2018). This means that in 2018/19 N$5 billion was allocated to social protection and assistance spending, mainly in the form of grants. This underscores the relationship between economic growth and social development as basic conditions for the initiation of social welfare policy and legislative reforms (Kaure, 1994). This means that the ability to provide comprehensive social protection and insurance depends largely on the resources or level of economic growth of a country. According to Nghikembua (2019), the country's financial markets must also operate efficiently to generate adequate revenue to allow the fiscus to finance social services. The natural consequence of lack of economic resources is that policy reforms relating to old age are delayed due to the prevailing circumstances. On the other hand, social development and poverty eradication require progressive political will rather than economic resources alone (Mkandawire, 2004). The lack of structural social reforms in terms of policy in developing countries is evidence of an absence of political commitment to social progress (Gillian et al., 2000).

In the case of Namibia where no formal comprehensive welfare policy exists for older persons, the only mechanism for protection lies in the courts' exercising their broader rights-based constitutional mandate. Most of the country's inherited social policies were patently discriminatory in that they were based on race and gender and plainly unconstitutional, but the courts of law remain the right avenues to address this. In this way, refuge can be sought under the head of basic human rights and dignity rather than explicitly entrenched social security rights (Mubangizi, 2006). Despite these constraints, Namibia has done relatively well in showing some limited progress in social policy development and the allocation of meagre resources towards addressing some of the important needs of frail older persons (ILO, 2014).

### 2.5.2 Policy fragmentation

Given the segregation of government departments during colonial times, it was imperative for the new regime to consolidate functions optimally. Despite the racial integration of government departments, social welfare and the administration of social protection were spread across different ministries (Biwa, 2018). For example, while the basic social grants, funeral schemes and disability grants are administered by the Ministry of Poverty Eradication, most of the other maintenance grants fall under the auspices of the Ministry of Gender and Child Welfare, and social services fall under the Ministry of Health and Social Services. The rehabilitation grants for war veterans are administered by the Ministry of Veteran Affairs. This situation leads to poor planning and creates a lack of resource optimization as well as fragmentation due to the uncoordinated and bureaucratic nature of decision-making across the various government agencies (ILO, 2014).

The duplication of social welfare functions has resulted in a lack of coordination across government departments, specifically in service delivery. Policy fragmentation leads to confusion, complexity in interdepartmental coordination, inadequate monitoring and evaluation, and ambiguous social protection strategies (Shumba & Moodley, 2018). Clearly, this situation creates serious negative implications in terms of lack of coordinated delivery of care to frail older persons.

### 2.5.3 Administrative inefficiency of the social grant scheme

Operational efficiency of social policy relates to the ability of an organization to render administrative services in an optimal manner (Njuguna, 2010). This requires the removal of any barriers to timeous and accurate payment of old age pensions to beneficiaries so that income security can be ensured. However, access to the basic social grant for older persons has been constrained by various factors, including the vast size of Namibia, which required beneficiaries to travel long distances to pay points. This situation affected the payment of the basic income grant (Subbarao, 1999). As a result, older persons were exposed to undue delays in the registration and verification process. The systemic operational problems explain the initial low coverage rate of 49% in the early 1990s, which, according to the ILO, has since improved to about 90% of older persons in 2001 (ILO, 2014). This initial low coverage rate necessitated more reform measures, including privatization of administration, accelerated issuing of identification documents and improved awareness of the old age social programme (Subbarao, 1999). The private administration of social grant payments proved to be very costly and unsustainable over the long term (Bikker & De Dreu, 2009).

Furthermore, the administrative machinery for social pension grants was found to be uncoordinated, leading to corruption and financial losses (Chiripanhura & Niño-Zarazúa, 2013). This is also evident from the increasing number of cases of ghost payments of old age pensions due to inaccurate member records. Namibia is hailed as having one of the best national population registers, covering all vital information of potential beneficiaries under social protection programmes. However, no integrated social registry of social protection grants exists in Namibia and this leads to potential double payments (MPESW, 2018). Lack of administrative efficiency in the payment of social grants has negative implications for the care of older persons since most of them depend on this income for basic necessities of life. Thus, delays in payments due to maladministration can have catastrophic consequences for frail older persons.

### 2.5.4 Namibia's high unemployment rate

The Namibia Labour Force Survey of 2008 reported an official unemployment rate of over 50%, which had increased from 36% in 2004 (NSA, 2018). This implies that 50% of economically productive people are without jobs, which poses serious socio-economic and political challenges for the government. According to Mwinga (2012), Namibia has the highest unemployment figures in the SADC region, a rate which is above the average of approximately 12% in Sub-Saharan Africa. A country's unemployment rate is relevant and has a direct impact on the provision of social services to older persons for a number of reasons, one of which is the fiscal capacity to sustain adequate old age pensions given the burden of care associated with maintaining income security for many households in which older persons are the sole breadwinners (Case & Deaton, 1998). The high unemployment rate impacts negatively on the households of older persons. Although frail older persons may not themselves be able to participate in the labour market, their younger children or relatives could find employment and help to raise household living standards. However, youth unemployment and general unemployment can negatively impact the interests of frail older persons. Idahosa and Van Dijk (2015) argue that social grants create a disincentive for work amongst older persons who are capable of employment. This view suggests that older persons should rather be given an incentive to participate meaningfully in the labour market instead of dependency on universal social grants being promoted. But it should be remembered that with the high unemployment rate in Namibia and the increasing levels of frailty amongst older persons, it is doubtful whether the option of labour force participation is viable for them. In fact, this situation of unemployment has had a negative impact on the informal care networks of frail older persons. It is therefore not unwillingness to work that prevents increased labour participation by older persons in Namibia, but

mental or physical incapacity and poor economic conditions relating to employment opportunities (Godin et al., 2019). Budlender (2011) argues that despite the high unemployment situation in Namibia there might be opportunities for older persons to engage in informal employment through their own entrepreneurial initiatives. Also, even if labour participation by older persons were possible, this would not reduce the financial burden on the fiscus under the current universal and non-means tested social grant system in Namibia. In examining the reasons for structural unemployment in Namibia, Eita and Ashipala (2010) postulate that lack of adequate foreign direct investment in Namibia has been the major cause of economic slowdown and inability to increase social welfare expenditure. Based on the above, it is clear that unemployment has a negative impact on the care of frail older persons and also on the informal caregivers (Lundsgaard, 2005). In this regard, McClelland (2000) postulates that unemployment thwarts improved care outcomes for frail older persons because of lack of family or household income.Against this background, contemporary challenges of frail older persons are indeed impacted by historic events, which provide context to current policy and legislative reform interventions. This, knowledge gained from this investigation is necessary and important to inform appropriate responses.

## 2.6 CONCLUSION

This chapter described the impact that Namibia's history has had on the care environment for frail older persons. In so doing major policy and legislative developments affecting older persons were highlighted. Namibia's care system evolved from a more extended family system during precolonial times to the current nuclear arrangement. Historic circumstances including material dispossession and urbanisation played a major role in the paradigmatic change in the care system of frail older persons (Nwauwa, 2000). Despite these disruptive changes no formal welfare arrangements were instituted for Black frail older persons leaving them stranded and without social protection. It was only in the later years that the South African government introduced unequal old age pension for blacks with very limited impact on poverty eradication (Werner, 1993). As a result, the Namibian government equalized old age pensions as a tool to fight poverty and income security for older persons. Various other social upliftment programs were also introduced with little impact due to mainly limited funding and poor policy frameworks.

# Chapter 3: LITERATURE REVIEW

## 3.1 INTRODUCTION

This chapter provides a review of the relevant literature relating to the needs of frail older persons. In undertaking the literature review, the researcher classified current knowledge on the subject matter while remaining mindful of the implications of the research problem (Hart, 1998). According to Rowley and Slack (2004), the literature review process involves systematic investigation of the various facets of information pertaining to the research topic to ensure relevance and acknowledge relationships for critical analysis.

In terms of secondary sources, the data for the literature review were obtained from unpublished and published documents, including books, journals, conference papers, academic theses, the internet, newspapers and legislation (Randolph, 2009). In other words, the various literature sources were analysed to contextualize the research problem within the broader domain of the care environment and service delivery to frail older persons.

Regarding the development of the literature review, Randolph (2009) argues that a researcher is required to define the topic for clarity before searching the literature and analysing the information obtained for the write-up. Thus, through the literature review, the researcher was able to identify gaps in current knowledge that require further assessment.

Furthermore, Hart (1998) avers that the literature review is more than a summary of results and a means of understanding the topic; rather it is a critical analytical tool that is used to synthesize and evaluate the information relating to existing knowledge on the subject of study. This means that the researcher must reflect and develop his or her own arguments on an objective basis (Leite et al., 2019). In conformity with this reflective view, Galvan and Galvan (2017) state that, based on the literature results, the researcher must be able to express his or her own voice or adopt a position based on own knowledge and ideas about the research phenomenon.

This chapter fulfils these requirements and is presented in four parts as follows:

i. Theoretical perspectives

ii. Analysis of global, southern African and Namibian literature on the care needs of frail older persons from the perspectives of formal and informal caregivers

iii. Caregivers and frail care: global, southern African and Namibian perspectives on caregiver experiences

iv. Practical recommendations towards understanding the needs of frail older persons.

The literature review therefore identified significant issues relating to the needs of frail older persons and allowed the research to offer an alternative explanation of the Namibian situation.

Finally, the literature review process also creates a link between theory and practice and by so doing acknowledge the various methodological approaches that follow in similar studies (Rowley & Slack, 2004). This was important in highlighting the gaps in current knowledge.

## 3.2 THEORETICAL FRAMEWORK

This study is informed by various theoretical frameworks, which offer a contextual and systematic explanation for the existence of the research problem. According to Ritchie et al. (2013), the use of multiple suitable theoretical frameworks (as opposed to just one) enhances validity, relevance and reliability, thereby contributing to the success of a research project. Therefore, in this context, the theoretical models were used to anchor the study to establish concepts in the study of older persons in general and specifically concepts associated with the needs of frail aged persons. This implies that in choosing the various theoretical frameworks that are relevant to the study, the objective was to explore existing available models that could best explain the research phenomena, help develop research questions and frame the study in relation to existing literature (Osanloo & Grant, 2016). An analysis of many relevant theories allows the researcher to choose the framework that best answers the research questions (Kivunja, 2018). From the problem statement, the researcher was able to identify key concepts or ideas that best explained the situation. Then, by drawing on the extensive literature review, the researcher was able to identify previous similar work done on the subject and understand the theoretical frameworks used to frame those studies. A critical analytical parallel was drawn with

previous work to enable the researcher to use the relevant theoretical framework to interpret empirical data from the study. According to Jaccard and Jacoby (2019), this systematic mapping approach is essential to create a theoretical foundation for the study that will later aid analysis of empirical findings and ultimately answer the research questions.

In this regard, the discussion of the needs of frail older persons was conducted through the lens of three theoretical models (as described below), which framed the study in relation to existing knowledge on the subject matter. Although the theoretical models in the literature are generally embedded in gerontology, their application in the study focused on the study of frail older adults as a category of the adult population. This was done in an effort to understand the unique multiple needs of this cohort as revealed in the literature. Therefore, as explained above, based on relevance, connectivity and importance in exploring the phenomenon of the needs of frail older persons, the study draws on the following three theoretical frameworks, namely: the Self-management theory of well-being, Ecological systems theory and Inter-generational solidarity theory.

### 3.2.1 The self-management theory of well-being (SMW)

The self-management theory of well-being (SMW) was developed by Steverink et al. (2005) as a gerontological model to assess the needs of older persons in terms of a resource-based paradigm. This means that self-management can only be achieved through understanding and addressing their physical, psychological and social needs. In conceptualizing self-management, Cramm et al. (2013) argues that during functional loss of abilities to carry out activities of daily living, self-management becomes a very important aspiration of frail older persons despite physical and cognitive decline. However, the extent of frailty determines the adequacy of levels of self-management. According to Bandura et al. (1999) self-management of frail older persons is also about aspirations for self-efficacy and exerting some degree of control over their care and well-being. Thus, the self-management theory of well-being helps the study understand that despite progressive limitations in functional abilities, frail older persons can still take some initiative towards limited self-efficacy and well-being (Steverink & Lindenberg, 2008). For example, while inadequate levels of physical, social and cognitive functioning can compromise self-management, a person can still be physically frail, but mentally sharp to self-care in some decisional respects. In this case, self-efficacy in terms of cognitive functioning relating to his care and well-being can be achieved. Self-management is not only a geriatric concept, but also gerontological as well in that it takes into considerations the subjective aspirations of affected frail older persons relating to their care and well-being (Cramm et al., 2013).

Self-management theory of wellbeing encourages frail older persons not to give up easily because of conditions and still continue functionality towards self-efficacy albeit limited (Steverink et al., 2005). In this sense, the care environment has a duty to encourage personal competence despite frailty and aging for this contributes to wellbeing and quality care.

In illustrating this point, Malherbe (2007) asserts that self-management of wellbeing is part of the primary objective of social welfare for frail older persons, which is to ensure their functional independence. This view resonates with earlier work by Greenglass (2002), which suggested that successful aging also applies to frail older persons and largely depends on internal and external resources. Accordingly, internal resources refer to the capacity of the frail older person to self-manage activities of daily living within adequate levels of functional independence. External resources refer to basic necessities for the wellbeing of frail older persons, including shelter, food and health care (Greenglass, 2002). Therefore, self-management theory of wellbeing theory is relevant and important in the exploration of the needs or resources of frail older persons. It is also relevant because self-care is inextricably linked to wellbeing, which is one of the important aspects of a decent quality of life for frail older persons Malherbe (2007). Therefore, understanding the resources required to achieve this makes this theory very important.

The WHO defines self-care in terms of physical activities and health-enhancing attributes (WHO, 2009a) whereas the resource-based view of self-management as explained above is more holistic and covers multiple resources like social functional abilities required to achieve self-care. Thus, SMW theory extends the assessment of the needs of frail older persons beyond financial and physical resources to include social and psychological support as conditions for wellbeing. From the aforegoing, the rationale for the SMW model is both preventative and restorative (Steverink et al., 2005). In this sense, the model postulates that in order to prevent rapid chronological aging from compromising self-management, sufficient resources must be made available to enhance the quality of life of frail older persons. This will not only guarantee some degree of self-management, but also provide an opportunity to restore the overall wellbeing of older persons despite frailty (Cramm et al., 2014).

Additionaly, Ryan and Sawin (2009) have also established a significant correlation between power expressed in the ability to self-manage and overall wellbeing of older persons. Based on this theory, older persons with adequate resources are able to self-manage and deal more effectively with the functional deprivation associated with aging. The SMW theory of older persons is empirically supported by Frieswijk et al. (2006), who found it to be a suitable model to describe the resources required

to optimize aging, including frailty within the home environment, and proved useful as a strategy for effective self-management interventions in nursing homes. Hence, this theory is used in the study to explain and describe the resources needed for self-management in order to support the overall wellbeing and care of frail older persons. The application of this theory in the study aids understanding of the needs of frail older persons relating to self-management by providing better insight into effective remedial interventions. It also creates a systematic framework for use in the discussion and analysis of empirical data. This makes SMW a relevant and appropriate theory in the exploratory journey through which the research questions are answered.

### 3.2.2 Ecological systems theory (EST)

Ecological systems theory (EST) generally dates back to organismic biological ecology, environmental science, and sociology. Bronfenbrenner theory was initially designed to demonstrate the diversity of interrelated influences on children and the ecology of the family (Bronfenbrenner, 1986).

In the 1950s it found an application to social work as a tool for policy and planning in the improvement of the impact of social work practice (Pardeck, 1988). Thus, it was only natural that EST should expand to social gerontology, given the shared universe with social practice. In other words, the impact of social work practice on care beneficiaries gained prominence as a result of the academic work of authors like Lawton and Simon (1968), Hartman (1979) and Germain (1973). EST is therefore relevant in understanding the needs of frail older persons in the care environment. In this regard, Wilder (2010) asserts that EST is necessary to explore the level of social support required by frail older persons in the care environment. EST is now increasingly used in gerontology; one of its basic tenets is that fitness between the physical environment and older persons is cardinal to their overall wellbeing and quality of life (Alley et al., 2010).

Furthermore, Golant (2011a) postulates that an unfavourable care environment for frail older persons leads to unsuccessful aging and increased frailty. In practice, this means that ecological considerations or a conducive care environment for a frail older person are an indispensable condition for meeting their basic needs, making this theory relevant in this study (Bronfenbrenner, 1999; Stephens, Szabó, Allen & Alpass, 2019). In combining ecological theory with systems thinking, Bronfenbrenner and Ceci (1994) postulate that a good fit between the environment and the well-being of an individual depends on the interplay between various behavioural and biological factors. Noting the importance of the individual in the ecosystem,

Bronfenbrenner developed a four-tier framework for explaining this factoral interplay based on the nature of relationships in the microsystem, mesosystem, ecosystem, and macrosystem (Bronfenbrenner, 1999). In other words, the EST framework explains the impact of the individual's capacity to function in the environment in determining levels of fitness. From a gerontological perspective, this theory asserts that frail older persons can only effectively function in a care environment when supportive conditions exist for their overall well-being (Hinders, 2019). This view is in line with contemporary thinking, which argues that EST is one of the most effective tools in assessing whether adequate care is being provided to frail older persons in the care environment (Shields, 2010). In so doing, EST explains the extent to which people are influenced by the environment in which they live, as opposed to individual persons manipulating the environment. Using EST, Ungar (2002) describes the relationship between frail older persons and the care environment as symbiotic and interrelated.

At a practical level, Golant (2011a) further argues that familiarity with the care environment improves adaptation, and enhances confidence and a positive outlook on life, which reduces frailty associated with old age. Familiarity implies keeping frail older persons longer in their natural surroundings. However, Iecovic (2014) asserts that this familiarity aspiration of frail older persons is only effective when living conditions are conducive quality care and well-being.

Familiarity of environment is important, but frail older persons require privacy, independence, safety and functional autonomy. However, old age homes sometimes create anxiety for them because they have limited control over their surroundings (Dyck et al., 2005). According to Van Praag et al. (2003), a person's environment generally has a strong influence and direct impact on happiness and well-being. Against this background, this study used this theoretical approach in exploring the extent to which the care environment meets the needs of frail older persons.

### 3.2.3 Inter-generational solidarity theory

Conceptually, this theoretical model emerged from the earlier work of Landecker (1951) and Bowen (1960) in the context of family sociology within the limited focus on general family integration and solidarity. The theory explained the basis of solidarity in the family support system based on intergenerational obligations between family members. According to Bengtson and Schrader (1982), intergenerational relations between parent and child are influenced by six separate components, namely, associational, affectual, consensual, functional, normative and structural solidarity. Roberts and Bengtson (1990) have classified the six components into two

dimensions, namely the structural-behavioural (association, structure and function) and the affective-cognitive (affect, normative and consensus) dimensions.

However, the scope of this theory was modified by the later works of Bengtson et al. (2002), who argued for greater focus on family cohesion as cardinal to overall well-being and successful aging of older persons. According to Lowenstein and Ogg (2003), the intergenerational solidarity theory is relevant in explaining family relationships in diverse contexts. Thus, intergenerational solidarity theory is useful in a study seeking insights into complex family relationships and their impact on older persons and their overall life satisfaction (Wang, 2011). Similarly, Keith et al. (1994) argue that intergenerational solidarity postulates a cultural dynamic based on the notion that family solidarity is an acceptable norm in a given tradition and culture. In this regard, Kalmijn (2005) avers that normative and social norms are reliable predictors of intergenerational solidarity in family systems, making them relevant in understanding duties of societal care for frail older persons. Thus, intergenerational solidarity is a function of social perceptions about mutual expectations of care as a basis for social cohesion and cultural preservation (Keith et al., 1994). As part of cultural diversity in the care environment of frail older persons, it is important for caregivers to understand this intergenerational dynamic in relation to the needs of older persons (Harris & Moran, 1996).

Furthermore, it is held that intergenerational solidarity is not only a cultural and traditional concept, but also one that was founded on religion and the common law (Kirby et al. 2004). This means that, for example, the children's duty to look after their frail parents not only arose from cultural and religious obligations, but sometimes mandatory depending on a country's legal system. In terms of religion, intergenerational solidarity was used by parents to influence the perception of younger generations with regard to their religious duty of care towards older persons (Bengtson et al., 2009). Based on this, intergenerational solidarity theory is useful in explaining the importance of cultural, traditional, religious and other normative transmitters in the caregiving context.

According to Lowenstein (2010), intergenerational solidarity also enhances social cohesion and reveals the interdependent nature of families in the care of frail older persons. Against this background, intergenerational theory was used in the study to highlight the needs of frail older persons as care beneficiaries arising from reciprocal family obligations. In other words, the theory explained the basis and context for expectations of adequate care to ensure family continuity and adherence to societal values in providing for the needs of frail older persons (Bengtson et al., 2009).

## 3.3 GLOBAL PERSPECTIVE OF CAREGIVERS ON THE NEEDS OF FRAIL OLDER PERSONS

Globally, the care environment of frail older persons consists of formal and informal caregivers. According to Litwin & Attias-Donfut (2009), in understanding the care needs of frail older persons it is important to understand that the classification of the care environment is based on different experiences and challenges in the provision of care to frail older persons. Although different sets of circumstances prevail in the care environment of frail older persons, Peckham et al. (2014) argue that there are shared experiences in the formal and informal care environments of frail older persons. Nevertheless, the World Bank states that in terms of providing for the care needs of frail older persons, cooperation between formal and informal caregivers is necessary in order to ensure quality of life and overall well-being (WHO, 2008c). This means that barriers between the two segments of care must be removed and lines of collaboration established for the benefit of both the caregivers and the frail older persons (Lyons & Zarit, 1999). In support of this, Renyi et al. (2018) aver that information sharing between formal and informal caregivers about the care needs of frail older persons is one such important area of collaboration. Thus, the formal and informal caregivers of frail older persons complement each other in addressing the care needs of frail older persons (Denton, 1997). In an attempt to understand the care needs of frail older persons, the following discussion critically reviews current global knowledge on this topic from the perspectives of both formal and informal caregivers. In other words, the literature review also describes the similarities and dis-similarities in the two care systems and how they interact in relation to the needs of frail older persons.

In presenting this chapter, the formal and informal caregivers perspectives are conceptualized from a global, regional and local Namibian context. In each socio-geographic setting, the needs of frail older persons are described from the experiences of the formal and informal caregivers. Thus, in terms of structure, the discussion focuses on specific needs and relative experiences in the care environment of frail older persons as reflected in comparative literature.

### 3.3.1 Informal caregiver perspectives on the needs of frail older persons

It is estimated that 80% of care services to frail older persons in Europe and the US are provided by families in the informal home care environment (Birtha & Holm, 2017). According to Birtha and Holm (2017), the informal care environment of frail older persons is a growing phenomenon globally and most of the informal caregivers are women. This highlights gender imbalance in the care environment of frail older persons, which implies that women more than men are burdened with

care roles. The World Health Organization states that frail older persons in the informal care environment have multiple needs across the world, which, depending on the circumstances of each country, range from protection against ill-health and social exclusion to poor living conditions and poverty (WHO, 2009b). However, the literature review on the perspectives of informal caregivers has revealed the following important care needs of frail older persons globally:

**3.3.1.1 Palliative care.** Frailty in old age is often accompanied by multi-morbidities that not only impair functional independence, but also create continuous pain and discomfort, which necessitate the need for appropriate palliative care in the informal care environment (Boockvar & Meier, 2006). In this regard, a study conducted amongst informal caregivers in Europe found that palliative care is a basic component of the primary care needed to ensure quality of life and reduce suffering (Hall et al., 2011). According to Bone et al. (2016), many informal caregivers are of the opinion that palliative care should be an integral part of primary healthcare and community outreach programmes. On this point, Lloyd et al. (2016) argue that the perspectives of informal caregivers regarding the need for palliative care must be understood in the light of the fact that the majority of frail older persons are cared for at home.

**3.3.1.2 Home-based care.** Home-based care refers to the need of frail older persons to be provided with care in the home environment, mainly by family members (Mello et al., 2017). In the experience of informal caregivers, many frail older persons are far happier and have better health outcomes when cared for in a familiar environment with relatives (Kok et al., 2015). This is especially the case with married couples, who prefer the familiar, informal home-based care environment. According to Pruchno and Potashnik (1989), many informal caregivers are of the opinion that spouses who act as caregivers are often also old themselves and in poor health, so that they tend to be emotionally burdened (Brank & Wylie, 2016) in the role of providing care to their frail partners. Thus, the care experience for spousal caregivers has a negative impact on their own well-being and increases their reliance on psychotropic drugs to cope with the emotional burden of providing care for frail older persons (Pickard et al., 2000). Nevertheless, Sørbye et al. (2018) argue that the majority of informal caregivers recognize the importance of home-based care as a means of decreasing mortality among frail older persons. Despite the negative personal implications for the informal caregivers, home-based care remains one of the most effective models for providing care to frail older persons (Mello et al., 2017). Additionally, Kim et al. (2006) argue that the choice of care

environment is mainly influenced by the severity of the health condition of frail older persons. For example, those with chronic health conditions and acute disabilities require more specialised care, which is usually available outside the home-based care environment. Pande et al. (2007) also caution that for home-based care to work, the government must provide sufficient resources and access to adequate facilities and outreach social services supporting frail older persons. In addition, Wilde and Glendinning (2012) suggest that home-based care is appropriate when promoted under circumstances where frail older persons are able to carry out the activities of daily life independently. According to Gee et al. (2019), home-based care is ideal for frail older persons who given their specific physical and cognitive impairments do not necessarily need specialised care.

**3.3.1.3 Social insurance to cover costs of care.** According to the views of informal caregivers, the cost of care for frail older persons in the home environment is often exorbitant, which creates the need for some form of indemnity, such as through insurance policies (Kok et al., 2015). In the United States, this need is covered through private healthcare and social insurance like Obamacare under the Affordable Care Act (Hall & Lord, 2014). In order to provide for the insurance needed, the Japanese government introduced mandatory universal social insurance arrangements in terms of which frail older persons with physical and mental disabilities who are in home-based care are covered for these life risks (Campbell & Ikegami, 2000). This social insurance is non-contributory and pays no cash to frail older persons themselves, but directly covers 90% of the cost of both formal and informal frail care. According to Tamiya et al. (2011), many informal caregivers feel that social insurance to cover the cost of home-based care for frail older persons is a necessity for ensuring their successful aging and quality of life. To achieve medical care equity for older persons, this type of insurance pays for daily nutritional content, out-of-pocket medical costs, and the cost of treating dental, orthopaedic and other geriatric health conditions for which government welfare does not provide (Wallace, 2002).

**3.3.1.4 Improved outpatient support.** In the informal care environment especially, caregivers have expressed the need for outpatient support for frail older persons (Plöthner et al., 2019). This need is based on the fact that informal caregivers may not be adequately trained to provide basic nursing services to frail older persons. In the United Kingdom, this is done through the provision of multi-disciplinary care to frail older persons in terms of which various primary healthcare interventions are co-ordinated as part of outpatient

support for home-based care (Evans et al., 1995). According to Metzelthin et al. (2013), there is no conclusive evidence that this multi-disciplinary outpatient approach is effective in meeting the needs of frail older persons for outpatient support in the informal care environment. Nevertheless, outpatient support has become a vital need for frail older persons under informal care given their unique situation of being outside an institutional set-up where health professionals are often readily available (Plöthner et al., 2019).

**3.3.1.5 The use of technology in the care of frail older persons.** According to informal caregivers, technology plays an important role in the care of frail older persons and hence there is a need to utilise devices like smart phones, watches, bracelets, computers, etc. to improve the informal care environment (Magnusson & Hanson, 2005). Informal caregivers in Sweden, for example, have argued that technology and artificial intelligence can improve the quality of life of frail older persons in terms of monitoring health conditions, diagnosis and treatment of disease and assisted mobility. Some informal caregivers have argued for intelligent assistive technology to enhance the quality of life of disabled frail older persons (Stefanov, Bien, & Bang, 2004). Technology is also useful in meeting the health communication needs of frail older persons for improved care (Kreps, 2015). According to Demiris (2004), information technology is useful not only as a diagnostic tool, but also as a preventative tool for the early detection of health conditions in frail older persons. Furthermore, he argues that information technology can also be used to monitor the levels of job satisfaction of caregivers. However, according to Kreps (2015), some informal caregivers are of the opinion that although information technology may be useful in the home-based care of frail older persons, it is expensive and unaffordable for many informal households. On the other hand, according to Wang et al. (2019), argues that some informal caregivers contend that while there is merit in using technology in the care environment of frail older persons, there is no conclusive evidence of its efficacy, the adequacy of data protection or its remedial impact. According to Jarvis et al. (2020), more studies are needed to gather information on the perspectives of informal caregivers on the acceptance rate of frail older persons for the use of technology in their overall care. For example, some frail older persons may perceive technology as intrusive and a nuisance, especially because of the need for its repetitive use (Sánchez et al., 2017). In contrast to these views, given the more recent incidence of the COVID-19 pandemic, McDonald et al. (2021) aver that due to social distancing the need for the use of technology in the care of frail older persons is inevitable. This could take the form of remote monitoring and quick

response infrastructure for emergencies (Wang et al., 2019). However, Wild et al., (2008) caution that some informal caregivers feel that virtual monitoring may pose ethical issues around the privacy of frail older persons. Nonetheless, the balance of literature suggests that the use of technology in the care of frail older persons suggest more positive outcomes in general (Wang et al., 2019).

**3.3.1.6 Responsive healthcare systems.** Informal caregivers caution that aging and frailty often result in multi-morbidities, which necessitate a responsive healthcare system that is aligned to the unique medical conditions of the frail older persons (Platts-Mills et al., 2010). The literature found that informal caregivers across many territories are experiencing problems with access to healthcare systems that specifically address gerontological conditions of frail older persons under their care (Kuluski et al., 2013). According to Upshur and Tracy (2008), some of the problems with the healthcare system relate to the fact that some areas are only tailored to deal with single diseases and are not designed for the treatment of geriatric multimorbidities. Some informal caregivers opine that this lack of alignment between frail older persons and the healthcare system is based on lack of understanding of the unique health challenges they experience as a result of aging (Boeckxstaens, & De Graaf, 2011). In Canada for example, Glazier et al. (2008) say that some informal caregivers have described healthcare challenges around the overcrowded hospitals and emergency rooms in some remote locations, which create barriers to healthcare access for frail older persons in home-based care. Informal caregivers in Singapore have highlighted the requirements of affordability and easy access in addressing the need for a more responsive healthcare system for frail older persons (Mehta & Leng, 2017). According to Kespichayawattana and Jitapunkul (2008), the informal caregivers are also adamant that the provision of a more responsive healthcare system for frail older persons must be done by people who are adequately trained with a speciality in geriatric medicine.

**3.3.1.7 Assistive devices.** The World Health Organisation defines assistive devices as anything that helps to maintain independent functioning of frail older persons (WHO, 2019). Accordingly, an assistive device is anything that helps frail older people get around with relative ease and hence this may or may not interact with technology depending on the device. The geriatric condition of many frail older persons is characterized by limited mobility, impaired vision, hearing and dental loss and hence assistive devices for instance hand railings, portable toilets, walkers, wheelchairs etc., are needed to provide quality home-based care (Mann et al., 1993). In the experience of informal caregivers, during

the initial phases of the use of assistive devices by frail older persons they have problems with acceptance, but with repeated use they quickly realize that these tools are effective in improving their activities of daily living (Hedberg-Kristensson et al., 2007). However, according to Chen et al, (2000), some informal caregivers believe that frail older persons are more likely to use the assistive devices only with the involvement of their family caregivers for added confidence. Other informal caregivers have argued that the use of assistive devices impacts positively on the care environment as it alleviates the burden of care for them (Mann et al., 1993). For example, the use of electronic wheelchairs and the installation of lifts in homes have enormously improved the quality of life for Alzheimer frail older persons (Mann et al., 1996).

### 3.3.2 Formal caregiver perspectives on the needs of frail older persons

While some of the needs of frail older persons expressed above by the informal caregivers are somewhat similar to the ones described below by the formal caregivers, the literature review has highlighted important differences. The specific needs of frail older persons from the perspectives of the formal caregivers are discussed below.

**3.3.2.1 Family involvement.** Formal caregivers believe that frail older persons have a greater need for family involvement for their overall well-being (Geerts & Van den Bosch, 2012). According to Cohn and Sugar (1991), many formal caregivers felt that this need is more pronounced in formal care because of the major change in living circumstances occasioned by being placed in institutional care. The need for family involvement refers to basic requirements like regular visiting and general interest in the welfare of frail older persons (Geerts & Van den Bosch, 2012). According to Gaugler (2005), formal caregivers perceive the need for family involvement as even more important for the emotional and material support of frail older persons. Formal caregivers in Asia, for example, see family involvement in the care of frail older persons as an important cultural and traditional aspect (Lee & Hong-Kin, 2005). Formal caregivers are of the view that lack of family involvement in the care of frail older persons often leads to depression, isolation, anxiety and loneliness (Zeng et al., 2013).

**3.3.2.2 Psychosocial support.** The perspectives of formal caregivers point to the fact that frail older persons have a serious need for psychosocial support (Mason et al., 2007). This need is based on the fact that various psychosocial factors like loneliness, poor relationships and social isolation have negative effects on frail older person (McIntosh et al., 1989). Formal caregivers argue that many frail older persons without psychosocial support are prone to stress,

anxiety and depression, with concomitant higher risks of hypertension and cardiovascular health conditions (Everson-Rose & Lewis, 2005). According to Pitkälä et al. (2009), the use of psychosocial rehabilitation for frail older persons has reduced mortality rates and improved health outcomes. Formal caregivers are of the view that regular group social engagements are one effective way of improving psychosocial support for frail older persons (Tilvis et al., 2000). Meeting the need for psychosocial support also reduces cognitive decline in frail older persons. One effective way of providing psychosocial support is through group rehabilitation therapy, which has proved useful in reducing not only loneliness, but also early mortality in older persons (Pitkälä et al., 2009). On the other hand, formal caregivers acknowledge that they are not adequately trained in providing psychosocial care to frail older persons, given the specialised nature of this intervention (Isola et al., 2008).

**3.3.2.3 Cultural and religious sensitivity in the care of frail older persons.** Formal caregivers have expressed the need for cultural sensitivity as an important element of the care of frail older persons (Aranda & Knight, 1997). This view is based on the fact that in the formal care environment, frail older persons come from diverse cultural backgrounds, which influence their responses to care (Napoles et al., 2010). Formal caregivers believe that in consequence cultural sensitivity can help to get frail older persons to accept treatment and medications (Aranda & Knight, 1997). Additionally, formal caregivers perceive the need for religion in the care of frail older persons as vitally important in ensuring not only that their diverse needs are met but also that they gain a sense of personal satisfaction (Ardelt et al., 2008). According to Yeager et al. (2006) many formal caregivers have found that the practice of different religions in old age homes has had positive health outcomes for many frail older persons. This suggests some kind of correlative relationship between religion and the well-being of frail older persons (Lee, 2011). In the care environment, some frail older persons have survived open heart surgery due to the comfort and assurances provided by religion (Harris et al., 1995). Even when frail older persons have died, the experience has been more peaceful where there has been religious orientation (Ardelt et al., 2008). Given this positive experience, many old age and nursing homes have introduced mandatory prayer sessions as a means of practising religion, but also for social engagement (Zainab et al., 2014). According to Gans et al. (2009), religious adult children tend to render more family support to frail older persons in formal care than non-religious children do. In terms of this view, looking after frail parents is a religious duty rather than a moral or legal one. Also, frail older persons in formal care with

strong religious support tend to be happier and live longer than those who do not have this (Rizvi & Hossain, 2017).

**3.3.2.4 Nutritional support.** Formal caregiver perspectives regard nutritional support of frail older persons as essential for their overall well-being and positive health outcomes (Mentes & Gaspar, 2020). Keeping fit for life is part of successful aging of frail older persons under the geriatric food-based care standards of the World Health Organization (2002b). In other words, the nutritional needs of frail older persons involve maintaining the appropriate level of essential nutrients, which is necessary to ensure that they sustain optimal immune responses and reduce disease burdens (Beattie et al., 2014). According to Mentes and Gaspar (2020), many formal caregivers believe that the implications of poor nutrition of frail older persons lead to serious clinical consequences and increase frailty and disability. Some formal caregivers admit, however, that they do not have specific knowledge of the nutritional requirements of frail older persons (Liu et al., 2020). In practice, this means that meals are prepared without considering the energy homeostasis requirements of older persons. According to McIntosh et al., (1989) a balanced dietary intake is very important for the physiological and psychological well-being of frail older persons.

**3.3.2.5 Daytime activities of frail older persons.** Formal caregivers have endorsed the need for daytime activities for frail older persons (Chou et al., 2012) to enhance overall well-being and quality of life. Despite frailty, the pursuit of daytime activities allows frail older persons to engage with daily life and reduce sedentary lifestyles. Formal caregivers are of the view that the activities of daily living, which increase physical activity, are an important component of geriatric care (Miranda-Castillo et al., 2013). While these daytime activities are most useful for social engagement and participation, they are also important for cognitive vitality and lower rates of mortality in frail older persons (Kuzuya et al., 2006). In the experience of formal caregivers, some frail older persons with mental health conditions have reported improvement due to participating in daytime activities (Hancock et al., 2003).

## 3.4 A SOUTHERN AFRICAN PERSPECTIVE OF CAREGIVERS ON THE NEEDS OF FRAIL OLDERS PERSONS

Demographically, Southern Africa has a relatively younger population than the developed world, but aging is becoming a real concern (UN, 2019a). In fact, the population of older persons in Southern Africa is the largest on the African continent

(Van Staden & Weich, 2007). The population demographics are relevant in determining the needs of frail older persons because welfare issues of supply and demand are influenced by the number of people involved (UN, 2019a). While some of the needs of frail older persons in Southern Africa are similar, there are important differences in terms of the perspectives of caregivers since the developing countries are confronted by dire socio-economic circumstances (Van de Walle 2006).

### 3.4.1 Informal caregiver perspectives on the needs of frail older persons

In Southern Africa, the care environment of frail older persons is predominantly family-based, making the informal care system important in addressing their needs (Van Staden & Weich, 2007). While the needs of frail older persons are multi-faceted, the literature indicates that the informal caregivers have described the different needs as follows:

**3.4.1.1 Decent living arrangements.** In the study by Van de Walle (2006), found that many frail older persons are destitute and living under conditions of severe poverty and deprivation. According to Du Rand and Engelbrecht (2001), frail older persons, especially those in rural areas, are living in poorly built shelters that expose them to the elements and to unsafe conditions. Some of these shelters are overcrowded and are not even connected to basic utilities like water, sanitation and electricity (Perold, 2000). In this regard, living conditions and housing arrangements are interrelated as they both refer to the places where frail older persons live or are cared for, mostly by relatives (Ramashala, 2001). Informal caregivers believe that the need for decent living conditions constitutes the single most critical need of frail older persons and one that deserves urgent attention (Makiwane & Kwizera, 2006). Despite the poor living arrangements of many frail older persons, most governments in southern Africa do not have progressive policies in place to improve the situation of this cohort (Mukuka et al., 2002). This situation of poor policy-making continues to castrate efforts to provide adequate social protection and decent living conditions (Makiwane et al., 2020). It is viewed that the present situation still reflects the historic racial inequalities, which denied blacks access to decent living conditions (Booysen, 2000, January 22–24).

According to Ngome (1994), in most African cultures, the concept of old age homes is foreign and frail older persons prefer to live with their family towards the end of their lives (Strydom, 2011), but at least under decent conditions. Informal caregivers expressed the view that many households in which frail older persons live are not in a financial position to provide them with decent

living conditions (Ramashala, 2001). As a result, the expectation of informal caregivers is that governments should step in and fill the gap in living conditions through effective social welfare programmes (Cattell, 1997). According to Kalasa (2001), most of these social welfare policies are aspirational in any event since governments do not have the resources and possibly the political will to implement them.

**3.4.1.2 Income security.** In a study done by Makiwane et al. (2020) it was argued that many of the challenges faced by frail older persons in the care environment are due mainly to lack of money to provide for their needs. To this the united nations postulate that more than just money, the lack of income security in old age is the major problem in southern africa (un, 2013). Under this view, the problem of frail older persons is compounded by increasing poverty levels and inadequate social welfare systems in different countries.

However, some countries in southern Africa, such as Namibia, South Africa, Botswana and Mauritius, have a system of universal basic social grants, but nothing much else in the way of income security for frail older persons (Gillian et al., 2000). Notwithstanding the view that social pensions have uplifted many older persons from the poverty line, the reality is that these old age pensions are not enough to provide the basic necessities of life (Kakwani & Subbarao, 2005). The perspectives of informal caregivers suggest that the adequacy of social grants for frail older persons is also complicated by the fact that in most households these grants constitute the only source of income (Thrush & Hyder, 2014). In any event, some informal caregivers have argued that old age pensions are not meant to meet all the financial needs of older persons, but merely to assist in that regard (Lucas, 2015). Poor coverage of old age pensions for frail older persons is another aspect that creates barriers to financial security (Kaseke, 2004, July 27–29).

**3.4.1.3 Food security.** One of the critical needs of frail older persons expressed by informal caregivers relates to the provision of food or food security. Due to the rising cost of living, lack of food security is a barrier to the attainment of a basic quality of life for frail older persons (Cornelius, 2011). Many poor households in which frail older persons are cared for find it a struggle to provide basic nutritional content and are forced to go to bed without nourishing meals. According to Marais (2019), the problem of food security for older persons is not taken seriously by governments in southern Africa, and this results in limited interventions. Informal caregivers are of the opinion that food insecurity leads to rapid weight loss and other conditions associated with nutrient deficiencies

and increased mortality in frail older persons (Kaiser et al., 2010). Also, it has been found that higher food variety correlates with physical and mental enhancement (Clauso et al., 2005). According to Makiwane et al., (2020), informal caregivers feel that frail older persons are confronted with a shortage of basic foods and hence adequate nutritional content, balanced diets and food diversity are luxuries which they cannot afford.

**3.4.1.4 Access to quality health care.** According to Patel (2005) due to aging and frailty many frail older persons are in need of access to an affordable, quality healthcare system. The Institute of Medicine Report of 2001, defines quality healthcare in terms of primary health system that is safe, timely, effective, efficient, equitable and patient centred (Wolfe, 2001). Healthcare is important because many of the frail older persons under the care of informal caregivers have multi-morbidities and are in generally poor health (Breytspraak, 2016). However, the view of most of the public health systems in southern Africa are in a poor state and are unable to respond to the unique medical needs of frail older persons (Apt, 1996). On the other hand, the private health systems in some southern African countries like Namibia, South Africa and Mauritius have been described as world class, but are unaffordable to most frail older persons. The informal caregivers have cautioned that various other factors impact on access to healthcare for frail older persons; these include lack of availability of medications for chronic health conditions. These circumstances have been verified by Kelly et al. (2019 who argues that lack of access to essential medication compromises the health safety of older persons. Most of the frail older persons in southern Africa live in rural settings with a limited health infrastructure in the form of clinics and hospitals (Lombard & Kruger, 2009). As a result, most of the informal caregivers are forced to transport frail older persons to urban health centres, often without proper medical assistance (Apt, 1996). Equitable access to healthcare for frail older persons in particular is even more important because disease burden in old age is one of the biggest contributors to frailty across southern Africa (Prince et al., 2015). In addition to adequate infrastructure and sufficient medications and health professionals, the informal caregivers feel that the health system must also avoid administrative inefficiency in the admission and treatment of frail older persons (Vanderschuren et al., 2015).

**3.4.1.5 Social workers.** Many frail older persons in southern Africa are confronted by poverty and other social challenges for which informal caregivers believe interventions by social workers are required. In addition to providing counselling, social workers are also skilled at promoting policies that empower

and involve frail older persons (Lucas, 2015). According to the International Federation of Social Workers (IFSW), “social workers are in a unique position to create, implement, and advocate for policies, programmes, services, and research benefiting older adults” (IFSW, 2008, p.1).With the recent history of colonization across the southern African region, social workers are agents of change and critical in dealing with various developmental issues facing the care environment of frail older persons (Mwansa, 1992). For example, through the contribution of social workers, frail older persons can be reintegrated into society in terms of bottom-up assessments and an understanding of their needs (Yimam, 1976). Despite the important role they play, southern Africa has a general shortage of professional social workers and more so in gerontology. This leaves caregivers with the responsibility for dealing with gerontological and social developmental issues in the care environment of frail older persons (Mavimbela, 2015). The implication is that caregivers are burdened with the role of providing multidisciplinary care to frail older persons. According to Kangethe (2010), informal caregivers are actually doing social work in most instances and should be recognized as auxiliary care workers and remunerated just like other registered care professionals. On the other hand, Osei-Hwedie (1993) argues that the social work profession is generally out of tune with the social needs of Africans and hence ineffective in dealing with the numerous unique social challenges facing frail older persons.

### 3.4.2 Formal caregiver perspectives on the needs of frail older persons

Some frail older persons are receiving care at nursing and old age homes, making formal care an important aspect of caregiving in southern Africa. From the perspective of formal caregivers, the various needs of frail older persons have been described as follows:

**3.4.2.1 Socialization.** The formal caregivers stated that they view the need for socialization of frail older persons as important for their overall well-being and for coping with the daily demands of institutionalization in old age homes (Perold, 2000). The need for socialization involves important issues like social contact, mainly through daily recreational activities, and emotional support (Cohen-Mansfield et al., 2019). In the opinion of formal caregivers, frail older persons in old age homes regard social engagement as important for coping with stress and isolation due to the anxiety caused by separation from their families. According to Hoffman (2014), due to rapidly changing family structures, formal caregivers are calling for more intergenerational support for frail older persons. Formal caregivers have argued that family connections in the care of frail older persons are important not only for the preservation of

socio-cultural values, but also for the overall emotional well-being of the frail older persons (Langa & Pistorius, 2018).

**3.4.2.2 Protection against abuse.** Some caregivers have shared the view that frail older persons are sometimes abused in the institutional care environment (Patel, 2005). This abuse is perpetrated by some formal caregivers and even family members of frail older persons; the abuse is usually physical but it might also be financial and emotional (Lombard & Kruger, 2009). The perspective of formal caregivers is that the abuse of frail older persons sometimes happens because of lack of clear policy guidelines on what really constitutes abuse. According to Ferreira (2005a), over and above policy guidelines relating to the abuse of frail older persons, the law must also impose sufficient deterrents in the form of penalties. Formal caregivers are of the opinion that the phenomenon of abuse of frail older persons sometimes takes on a racial and gender bias given the socio-political history of southern Africa (Conradie, 1999). This means that, for example, post-apartheid integration of institutional care in South Africa posed its own challenges, resulting in cases of abuse of frail older persons (van Dokkum, 1996).

**3.4.2.3 Cultural and spiritual support.** Culture in the context of caregiving is fundamental for social solidarity, cohesion and moral order (Pharr et al., 2014). Culture is part of diversity and plays a pivotal role in caregiving to frail older persons. Aranda and Knight (1997) argue that culture serves as a persuasive motivation for caring for frail older persons. According to Maharaj (2020), culture is the connecting pathway of the social environment and ensures social cohesion. Leuning et al. (2000) indicate that cultural diversity and ethno-nursing are key to the effective care of frail older persons based on a full understanding of the beliefs, values and norms that are held by care beneficiaries. Since culture influences response to care, caregivers are required to have cultural competence, which speaks to ability to understand diverse cultural needs (Parker, 2010). This understanding is important in the African context where culture and traditions are diverse and act as vectors of identity. In this regard, Nugent (1990) argues that cultural competence is an essential tool for avoiding unfair discrimination and racial prejudice in the care environment. In Africa, religion and spirituality play an important role in ensuring coping abilities, resilience and sometimes healing in persons suffering from medical conditions, especially chronic conditions (Arrey et al., 2016). While religion refers to any belief system in some deity as the ultimate source of all divinity and healing (Puchalski et al. 2014), spirituality is an expression of personal emotional connectedness to a sacred power (Szaflarski, 2013). Thus,

religion and spirituality are related, but not necessarily the same thing. In fact, religion plays a very important role in satisfying the spiritual needs of frail older persons in the care environment (Kirby et al., 2004). In this regard, prayers, meditation or other liturgical rites are important for religious and spiritual well-being. However, Parker (2010) suggests that religion can also sometimes be an obstacle in the care environment, especially when a frail older person refuses appropriate medical interventions for religious reasons. Nevertheless, the preponderance of opinion in the literature is that spirituality and health outcomes are positively related (Dalmida, Holstad, Dilorio, & Laderman, 2011). Van Biljon and Roos (2015) postulate that spirituality complements the psychosocial needs of frail older persons and is a necessary condition that allows frail older persons to cope with geriatric stress and find a purpose for living. According to Langer (2004), spirituality and religious faith are central to a sense of being and holistic self. Thus, taking the spiritual needs of frail older persons into consideration has resulted in a reduction in stress levels in the care environment, especially under the formal care environment (MacKinlay, 2006).

**3.4.2.4 Person-centred care.** In a study by Aboderin and Beard (2015) it was found that frail older persons in southern Africa have a need for person-centred care, which requires their individual involvement in the development and implementation of their unique care plans (Aboderin & Beard, 2015). In terms of long-term care strategies for frail older persons in formal care, a person-centred care approach promotes equity and participation in decision-making (Amosun & Fahmida Harris, 2018). Therefore, the need for person-centred care implies that the caregivers have adequate information in order to determine unique care strategies for frail older persons (Essuman et al., 2018). According to Rosenmayr (1991), a person-centred care approach in the formal care system is necessary for optimized health outcomes of frail older persons.

## 3.5 PERSPECTIVE OF NAMIBIAN CAREGIVERS ON THE NEEDS OF FRAIL OLDER PERSONS

Formal and informal caregivers play a significant role in the care of frail older persons in Namibia. Since most of the frail older persons in Namibia have some form of physical or mental incapacity or both, the role of caregivers is important in ensuring that they are able to carry out the activities of daily living (Indongo & Sakaria, 2016). According to Nangombe and Ackermann (2013), frail older persons in Namibia have multi-faceted needs, which have implications for social welfare policy and practice.

The perspectives of informal and formal caregivers regarding the needs of frail older persons are therefore described below:

### 3.5.1 How informal caregivers perceive the needs of frail older persons

The informal care of frail older persons is the most prevalent form in Namibia, especially in poor rural settings where women are the predominant caregivers (Ananias & Strydom, 2014). According to the Namibia Statistics Agency (NSA) (2015), the majority of Namibia's elderly population are living in rural areas and those who are frail are usually cared for by relatives as informal caregivers. This means that Namibia's informal care system for frail older persons is mainly home-based and that the spouse, children, grandchildren or extended relatives usually serve as informal caregivers. Volunteers are sometimes also used to provide home-based elderly care in the informal sector (Steinitz, 2003). According to informal caregivers in Namibia, the following are perspectives on what they regard as the important needs of frail older persons:

**3.5.1.1 Adequate income.** According to Indongo and Sakaria (2016), most informal caregivers share the perspective that frail older persons in Namibia need additional income or money to enable them to afford the basic necessities of life. This is because most of the households caring for frail older persons in Namibia are poor and are entirely dependent on the old age pension system for survival (NSA, 2015). However, the social grants in Namibia are not considered adequate to satisfy the daily requirements of frail older persons (Kalomo et al., 2018). On the other hand, some older persons are alleged to be misusing their social grants (Shinovene, 2014, April 24). According to He et al. (2019), the abuse of old age pensions is a common problem in southern Africa.

Thus, while the need for money is real, some kind of financial literacy initiative is required to educate frail older persons about the optimization of old age pensions (Hamunyela & Nekongo-Nielsen, 2016). Nevertheless, Barrientos et al. (2010) argue that despite the limited purchasing power of old age pensions, they are still effective in contributing to the eradication of poverty. The shortfall in the income of frail older persons has been aggravated by the fact that in general financial support from their children has become infrequent or even non-existent over the years (Apt, 2000).

**3.5.1.2 Decent living conditions.** Many informal caregivers in Namibia have expressed the need for decent living conditions in terms of housing, sanitation, hygiene and other determinants of quality of life (Indongo & Sakaria, 2016). According to Dima (2003), informal caregivers regard the current living

arrangements of most frail older persons in the informal care environment as unsuitable because of overcrowding, poor housing and lack of basic services. According to Tjazerua (1995), the provision of decent living conditions for frail older persons would require investment in proper and affordable housing that is conducive to assisted living arrangements.

**3.5.1.3 Social Work services.** According to Ananias et al. (2016), informal caregivers feel the need for more social work interventions for counselling and social developmental work. The reason for this need is that many frail older persons live in communities facing serious socio-economic challenges. The current inadequate social work support to the informal care environment of frail older persons is the result of a general shortage of social workers and the lack of a social welfare policy in Namibia (Chiwara, 2015). According to Muinjangue (2020, p. 47), social workers have a responsibility to provide frail older persons with:

a wide range of social services in trying to meet the psychosocial needs of service users. These include medical social work, mental health, substance abuse, statutory work, gerontology, gender-based violence, correctional social work, aftercare and reconstruction services, among many others. These services are provided through the social work methods of casework, group work, community work, research and management.

**3.5.1.4 Primary healthcare.** Informal caregivers regard the need for access to primary healthcare as important in the care of frail older persons (De Beer, 2017). The need for primary healthcare refers to an affordable and quality healthcare system that is responsive to the geriatric needs of frail older persons (Aboderin, 2012). Informal caregivers are of the view that frail older persons are currently unable to enjoy proper medical treatment due to poor service and a limited pharmaceutical supply of chronic medicines and essential equipment (Allcock, Young, & Sandhu, 2019). Thus, the healthcare needs of frail older persons can only be addressed if Namibia's public health system is responsive to their needs and adequately resourced to provide quality health services. On the other hand, Van Rooy et al., (2015) argue that is pointless to provide health infrastructure if frail older persons are unable to access it due to transportation constraints. This implies that the primary healthcare needs of frail older persons must be addressed holistically to ensure access. Informal caregivers believe that the need for primary healthcare for frail older persons is even more prominent than ever now, given the incidence of COVID-19, which requires

the availability of oxygen and related medications (Amukugo, Nangombe, & Karera, 2020).

**3.5.1.5 Food security.** From their perspective, the informal caregivers identified a need for food security for frail older persons, which is largely due to the limited supply of food to households (Black, 2018). Even with social grants, the informal care environment is unable to satisfy the basic need for food security (Crush, et al., 2021). This means that Namibian households taking care of frail older persons are not in a position to provide them with adequate basic food, mainly because of poverty. Food security refers to the availability of food for basic sustenance to maintain body mass and stay healthy. To alleviate food insecurity in poor households looking after frail older persons, the government has provided various targeted social welfare programmes. However, food security in the informal settlements, where many frail older persons are cared for by families and the community, remains a serious challenge (Schade et al., 2019).

### 3.5.2 How formal caregivers perceive the needs of frail older persons

As described above in chapter 1 of the thesis, formal caregivers are a diverse group of persons mainly consisting of social workers, nurses and unregulated care workers. The diversity of formal caregivers merely points to their professional background and regulated nature of some of the care functions to frail older persons (Schulz, 2020).

While the professional backgrounds of formal caregivers might be diverse, the role in conceptualising the care needs of frail older persons remains largely the same Morgan, et al (2021). On the other hand, Zygouri, et al., (2021) argues that given the diversity of formal caregivers they are non-homogeneous with a diverse frame of mind and practice. In moderating these viewpoints, Bílková, (2022) postulates that adopting a human rights perspective implies that the caregiving role of frail older persons overall imposes similar quality outcomes. Formal caregivers continue to play an important role in the institutional care of frail older persons in Namibia. In this regard, their perspectives about the needs of frail older persons throw light on the situation in the formal care environment. According to formal caregivers, frail older persons in formal care have the following needs:

**3.5.2.1 Socialization.** The need for socialization was found to be one of the most important needs of frail older persons in formal care in Namibia (Kalomo et al., 2021). The formal caregivers define the need for socialization in terms of the creation of functional relationships with others who share the same

identity or circumstances (Vorster, 2011). Thus, the need for socialization is important since frail older persons are separated from their families and are being cared for by strangers in an unfamiliar place. Without socialization, the ability of frail older persons to adapt to the formal care environment is reduced. This often results in isolation and mental health problems for frail older persons (Watt & Konnert, 2007). Given the diverse backgrounds of frail older persons, socialization is generally considered an effective way of breaking down barriers and ensuring racial harmony in the formal care environment (Kleynhans, 2009).

**3.5.2.2 Family support.** Frail older persons in formal care need family support in many ways to ensure quality of life. According to Krause (2006), family support for frail older persons has material, psychological and social dynamics. Formal caregivers expressed the opinion that frail older persons with strong family support tend to be happier and better adapted to the care environment (Kalomo et al., 2021). With adequate family support, frail older persons are better able to cope with the challenges of receiving care in an institution (Vasileiou et al., 2017). Family relationships create a sense of identity and enhance human dignity for frail older persons.

**3.5.2.3 Cultural and spiritual intelligence.** Given the diversity of the backgrounds of residents in the formal care environment, frail older persons have a need for cultural and spiritual intelligence (Badger et al., 2009). In addressing this need, formal caregivers are required to show cultural and religious awareness in providing care to frail older persons. For example, some old age homes arrange regular prayer sessions for frail older persons to encourage them to embrace their spirituality (Kommel, 1981). Culture is all-encompassing and influences behavioural norms, beliefs, values, hopes, fears and responses to care (Indongo & Sakaria, 2016).

## 3.6 CAREGIVERS AND FRAIL CARE: GLOBAL PERSPECTIVES OF CAREGIVER EXPERIENCES

Formal and informal caregivers are experiencing various challenges in the care of frail older persons. Some of these challenges are impacting on their abilities to provide quality care to frail older persons. The literature has found that the experiences of formal and informal caregivers are not necessarily the same. Thus, the study will highlight the similarities and differences between the two care environments of frail older persons separately within a global, regional and local Namibian context.

### 3.6.1 Global experiences of formal caregivers

A review of the experiences of formal caregivers in providing care to frail older persons is important if we are to gain a better understanding of their situation since it impacts on the quality of their services to care beneficiaries. According to Evangelista et al. (2016), the perspectives of caregivers are aimed at seeking improvements in the care provided to frail older persons. By addressing the challenges raised in these perspectives, the important needs of frail older persons are also addressed (Timonet Andreu et al., 2015). The following issues are described as part of the care environment of frail older persons:

**3.6.1.1 Burden of care.** Formal caregivers of frail older persons describe their care role as burdensome and say that at times it impacts negatively on their mental and physical well-being (Mason et al., 2007). In this regard, the experiences of formal caregivers reveal that the care environment is stressful and depressing at times (Adams, 2008). This has a negative effect on the happiness and subjective well-being of formal caregivers. According to Miller et al. (2012), most formal caregivers experience care work as burdensome and demanding, with little appreciation shown. Sometimes it becomes overwhelming to the point of compromising quality care to frail older persons. When formal caregivers feel burdened by their role, the level of care to frail older persons is also compromised (Pinquart & Sörensen, 2011).

The formal caregiver experiences reported globally revealed that the burden of care largely depends on the phases or levels of impairment of the frail older persons in care (Mello et al. 2017). On the supply side, this means that the level of care offered by formal caregivers must respond to the specific demands of frail older persons (Miller et al., 2012). For example, frail older persons with more serious impairments will require more involvement and effort from formal caregivers in performing the activities of daily living. In this regard, the global experiences of formal caregivers also reveal that frail older persons with severe mental and physical disabilities contribute more to the work burden of caregivers (Yates et al., 1999). This situation results in negative implications for the care relationship and sometimes leads to mental health problems for the formal caregivers themselves (Wimo & Prince, 2010). In describing the burden of formal caregivers, Pinquart and Sörensen (2011) aver that the major cause of unhappiness and work stress is the long working hours, which create emotional distress. The hours also have a negative effect on the family life/work balance of caregivers. The other cause of a heavy work burden is the behaviour of some frail older persons, who make it impossible for formal caregivers to do their work effectively (McGarrigle & Kenny, 2013).

While some formal caregivers have found the work experience burdensome, others have shared positive experiences given the meaningful role they play in providing quality care to frail older persons (O'Shea & Kennelly, 1995). According to Toseland, Smith, and Zinoman (2004), provision of care is an expression of love, empathy and altruism towards frail older persons and that is perceived as the highest reward. This was confirmed by Cohen, Colantonio, and Vernich (2002), who reported that most caregivers enjoyed their care work and cited companionship and inner satisfaction as motivations for their vocation. Therefore, regardless of the burden of care, caregivers overall have a positive experience in providing care to frail older persons.

**3.6.1.2 Limited employment prospects.** Another major challenge experienced by formal caregivers in providing care to frail older persons is the poor prospects of employment outside the care environment (Bauer & Sousa-Poza, 2015). The competent, committed and experienced formal caregivers find that their dedication to caring for frail older persons mostly results in low job prestige, low pay and restricted employment prospects (Colombo, Llena-Nozal, Mercier, & Tjadens, 2011). According to Bauer and Sousa-Poza (2015), this means that commitment to caregiving roles is rewarded by poor levels of employability in other sectors given the limited vocational focus of the care work. The irony is that globally there seems to be a shortage of caregivers to care for the growing number of frail older persons in the world world (Schultz, 2016). This means that the demand for care services of frail older persons by far outweighs available caregivers. The irony is that despite the limited supply of caregivers, staff retention under formal care seem to be a problem (Bauer & Sousa-Poza, 2015). As a result of the high staff turnover of competent formal caregivers, most old age and nursing homes have settled for less qualified, incompetent and inexperienced paraprofessional caregivers who are unable to provide quality care to frail older persons (Stone & Harahan, 2010). This situation has negative implications for the care of frail older persons and there is a compelling need for interventions to guarantee the long-term availability of a workforce to care for frail older persons (Colombo et al., 2011).

**3.6.1.3 Inadequate remuneration of formal caregivers.** In the experience of caregivers, their level of remuneration is too low to allow them to afford the basic necessities of life. The low level of remuneration is aggravated by the lack of additional employee benefits such as a pension scheme or other deferred compensation schemes (Dosman & Keating, 2005).

Formal caregivers also have personal lives, but cannot afford the necessities of life due to inadequate remuneration (Aggar, Ronaldson, & Cameron, 2010). Despite the low remuneration they receive, some formal caregivers have used their personal resources to take care of the financial obligations of frail older persons in their care (Hong & Harrington, 2016).

**3.6.1.4 Limited time for social engagement of formal caregivers.** Given the demanding work and excessive working hours, many formal caregivers are finding it difficult to maintain a family/work balance, resulting in limited time for social engagement and recreational activities (Hynes, Stokes, & McCarron, 2012). According to Saunders (2013), in the experience of formal caregivers this could be reflected in simple things such as not keeping in contact with friends and family members due to care responsibilities, with resultant increased isolation and lack of life enjoyment. However, in Australia it was found that caregiving roles did not materially impact on family or friendship networks. This means that despite the demands of the care environment, formal caregivers could still experience a positive psychosocial outcome and find a good balance between care work and personal life (Duigenan, 2014).

### 3.6.2 Global experiences of informal caregivers

Informal caregivers in the home-based environment are presented with different challenges in regard to the care of frail older persons. Although some of their experiences are similar to those of formal caregivers, there are also experiences that are unique to the informal care environment. Some of these experiences are described below:

**3.6.2.1 Work burden.** Informal caregivers provide care to frail older persons under very difficult conditions and without remuneration. In the experience of informal caregivers, the amount of time required to care for frail older persons hardly leaves any time for self-care, especially when they are doing this part-time (Mehta & Leng, 2017). According to Alves et al. (2019), the burden of care creates a burnout syndrome in informal caregivers, which often results in stress and outright depression. Informal caregivers are expected to cope with care demands without any formal supporting structures to help alleviate the burden of care (Ikeda et al., 2015). Furthermore, many informal caregivers experience economic hardships in their caregiving role (Adelman et al., 2014). This makes sense considering the fact that they are not remunerated for services and often have to rely on their own resources.

Furthermore, Almberg et al. (1997) without suggesting gender specific roles argues that based on his research female informal caregivers were better able to cope with care burdens than their male counterparts based on specific circumstances. However, according to del-Pino-Casado, et al. (2012), the experience of other informal caregivers suggests that personal attributes and cultural orientation have a greater influence on ability to cope with care burdens than gender. Nevertheless, most informal caregivers experience the long-term psychological and physical effects of care burdens (Hori et al., 2011). According to Stobert and Cranswick (2004), care burdens of informal caregivers have resulted in high blood pressure and in sleep and immunological disorders. However, some informal caregivers have described various factors which in their experience have had a positive impact on reducing caregiver burden. These include strong personal attributes, social support and experience in managing stress and other care burdens (Harris, 1993). Nevertheless, in recent times, informal caregivers also believe that the incidence of Covid-19 has increased their burden of care (Budnick et al., 2021).

**3.6.2.2 Social support.** Many informal caregivers have expressed concern about poor social support from communities, social partners and other stakeholders in the care environment (Dellmann-Jenkins et al., 2001). Despite their burden of care, many informal caregivers continue to cope on their own without much-needed social support structures (Winslow, 2003), Social support for informal caregivers is necessary to alleviate the burden of care, but also to enhance their sense of purpose and confidence in providing quality care to frail older persons (Gray & Pattaravanich, 2020).

**3.6.2.3 Multidisciplinary nature of informal care support to frail older persons.** The care environment envelopes every aspect of the informal caregiver's life and hence they are required to juggle various caregiving activities irrespective of their limited relevant training, knowledge and skill (Strang, 1995). In addition to rendering assistance with basic activities of daily living, informal caregivers are providing frail older persons with other types of caregiving, sometimes cutting across multiple care disciplines. In terms of social services, informal caregivers are not trained in social work, but they are often forced by circumstances to deal with counselling and social development issues affecting frail older persons under their care. According to Lethin et al., (2016), social workers are important in supporting informal caregivers through counselling, training and rendering social welfare service to frail older persons. On nursing, as a first port of call, informal caregivers provide frail older persons with various nursing services like basic palliative care and administration of medications. Also, in terms of rendering psychological support informal

caregivers generally provide frail older persons with ongoing counselling and emotional support**.**

According to Szabo and Strang (1999), informal caregivers usually start by assisting with the basic activities of daily living, but their duties increase until they are covering most of the above services as the health and emotional conditions of the frail older person in care progress.

**3.6.2.4 Training and standard care guidelines.** Most informal caregivers find that they have insufficient training to carry out their duties (Weir et al., 2021). Equally, many informal caregivers are of the opinion that the lack of standard care guidelines makes their work harder since they are not able to assess the impact of care to frail older persons (Scholten et al., 2021). As a result, informal caregivers are unsure about whether they are providing adequate quality of life support to frail older persons. Many informal caregivers are not prepared for this role, haven't been inducted into it and don't have clarity about what is expected of them (Batista et al., 2014). This lack of preparation and role uncertainty create a problem with performance benchmarking (Mobily et al., 1992). They also create a degree of caregivers' anxiety about compliance with standard practice guidelines for geriatric care. At the moment, informal caregivers all over the world are doing the best they can to improve the quality of care for frail older persons (Scholten et al., 2021). Therefore, the training of informal caregivers is important in imparting essential knowledge and boosting their confidence, but also indirectly in reducing healthcare costs since government does not finance these costs.

**3.6.2.5 Increasing demand for informal care.** The experiences of informal caregivers indicate that changing family demographics globally are making more demands on family members to look after frail older persons (Szabo & Strang, 1999). This need for more informal caregivers is also fuelled by escalating healthcare costs and shorter hospital stays. Furthermore, in some countries, of which Canada is one, the governments are promoting formal incentives for family involvement in the care of frail older persons (Ward-Griffin, 2001). For example, in Austria, the informal care environment is being overwhelmed by the increasing demand for family caregivers, especially as a result of the impact of Covid-19.

## 3.7 CAREGIVERS AND FRAIL CARE: THE SOUTHERN AFRICAN EXPERIENCE

### 3.7.1 Experiences of the informal caregivers

In southern Africa, the informal care environment still remains the basic form of primary care for the majority of frail older persons (Aubeeluck & Luximon-Ramma, 2020). Thus, the informal caregivers in southern Africa form the backbone of the overall care environment of frail older persons (Schatz & Seeley, 2015). In fulfilling their role of providing care to frail older persons, informal caregivers experience enormous challenges. In some instances, the experiences of informal caregivers impact negatively on their ability to provide quality care to frail older persons (Nabalamba & Chikoko, 2011). Accordingly, the informal caregivers shared the following experiences relating to the provision of care to frail older persons:

**3.7.1.1 Burden of care.** Informal caregivers experience different kinds of burdens in caring for frail older persons, but the burden mainly takes a physical, social and emotional form. According to Aubeeluck and Luximon-Ramma (2020), the care burden of informal caregivers puts them in conflict with their roles at times. This results in negative implications for the care of frail older persons. A major burden of informal caregivers relates to lack of the necessary income to provide care to frail older persons (Schatz & Seeley, 2015). This speaks to the economic burden of informal caregivers. Those working part-time elsewhere end up using their own resources to pay for basic necessities for the frail older persons in their care (Akintola, 2008).

The experiences of informal caregivers also reveal that money issues are overshadowed by the enormous stress that comes with the role and puts a strain on personal life/work balance (Kim & Given, 2008). This stress is largely caused by working excessive hours and by the lack of essential resources. This is especially the case for those informal caregivers who are living with frail older persons in the same household (Yakubu & Schutte, 2018). Many feel that due to socio-economic circumstances it is often difficult to separate the informal caregiver and the care beneficiary (Akintola, 2008).

Furthermore, Dotchin et al. (2014) posit that informal caregivers also experience enormous physical burdens in the care environment, largely due to the physically demanding nature of providing care. This is true especially where the level of physical and cognitive impairment of the frail older person is of such a nature that they cannot perform activities of daily living without assistance (Diameta et al., 2018).

For example, frail older persons with Parkinson's and dementia patients demand a higher level of physical activity (Dotchin et al., 2014). In addition, Zegwaard et al. (2011) also argue that frail older persons with severe psychiatric impairments are more burdensome to care for given their relative propensity for violence and need for physical restraint. Nevertheless, it has been argued in the literature that caregivers must adapt to the unique conditions and demands of the care environment of frail older persons rather than the other way around (Garlo et al., 2010). This suggests that the burden of care may reflect the caregiver's inability to adjust to the care environment, with resultant burnout and depression.

The social burden relates to inadequate social engagement and recreational activities of informal caregivers due to limited time to devote to personal relationships. Many informal caregivers experience withdrawal symptoms and isolation due to their caregiving role. Some informal caregivers experience diminished sexual intimacy due to the excessive demands of care provision (Drummond et al., 2013). The care burden is worsened by the lack of psychosocial support for informal caregivers.

**3.7.1.2 Abuse of frail older persons.** Abuse of frail older persons in southern Africa has been found to be a serious problem. This phenomenon has manifested more prominently with the incidence of Covid-19, which has seen many frail older persons in southern Africa abused by informal caregivers (Arthur-Holmes & Gyasi, 2021). Generally, in the experience of informal caregivers, frail older persons are abused by family members and the community at large and the perpetrators often go unpunished (Splinter, 2009). According to Marais at el. (2006), abuse of frail older persons may take financial, physical, emotional and social forms**.**

Informal caregivers also ascribe the abuse of frail older persons to various factors, including poverty, a breakdown in social norms and poor legal frameworks (Marais et al., 2006). In the experience of informal caregivers, the abuse of frail older persons seldom gets reported to the authorities (Ferreira & Lindgren, 2008). This could be for different reasons, including the fact that some frail older persons are physically and mentally unable to report incidents or are afraid of reprisals by the perpetrators (Lindsey et al., 2003). According to Ferreira and Lindgren (2008), traditions and cultures also play a role in the abuse of frail older persons, at least to the extent of making the subject taboo.

In southern Africa most of the informal caregivers are female, and they are generally elderly themselves (Ingstadt et al., 1992). This increases the risk of gender-based violence and some caregivers have had to endure sexual

assaults and misogyny at the hands of the community and service providers (Lindsey et al. 2003).

**3.7.1.3 Lack of training.** The responsibility of informal caregivers is enormous and some basic skills are required if they are to be effective in that role (Aboderin & Hoffman, 2011). However, most informal caregivers experience a lack of training and a knowledge deficit in important areas of geriatric care. This implies that there is a lack of preparedness for the role of caregiving (Silver et al., 2004). Thus, greater reliance is placed on acquiring knowledge through experience than on systematic training. The current situation of poor training not only compromises the quality of informal care, but puts frail older persons at risk (Given et al., 2008). This is also frustrating for informal caregivers, who sometimes have no idea what to do in in situations that require specific skills (Okoye & Asa, 2011).

**3.7.1.4 Traditional family structures.** The experiences of informal caregivers reveal that traditional African family structures impact on the way care is provided to frail older persons (Nabalamba & Chikoko, 2011). Under the African conceptualization of family, support for frail older persons is intergenerational, but informal caregivers are experiencing a decline in traditional family support based on intergenerational solidarity (Aboderin, 2017). Accordingly, the care of frail older persons is not conceptualized anywhere in modern family systems. The implication is that the responsibility for care is shifting away from traditional family structures towards voluntary community members and non-governmental organizations (Nabalamba & Chikoko 2011).

### 3.7.2 Experiences of the formal caregivers

As a secondary system of care of frail older persons in Southern Africa, the formal caregiving system is also important (Perold, 2000). However, the formal caregivers are confronted by various challenges in providing care to frail older persons. These include, but are not limited to, the following:

**3.7.2.1 Burden of care.** Formal caregivers experience emotional, physical, psychological and social burdens as a result of providing care to frail older persons (Nabalamba & Chikoko, 2011). In the southern African experience, the burden of care has both an age and a gender impact (Ainamani et al., 2020). This means that the physical burdens are usually experienced by older formal caregivers who are unable to perform demanding care work. On the other hand, most of the formal caregivers are female, which sometimes makes the provision of personal care challenging for some frail older persons (Ross- Sheriff

& Swigonski, 2009). Nevertheless, the care responsibilities in the formal care environment often lead to fatigue and emotional distress (Kyei-Arthur & Codjoe, 2021). In some cases, formal caregivers have also had physical injuries cause by falling on duty, for example, and other health complications (Ainamani et al., 2020). This may be due to poor working conditions, excessive working hours and limited leisure time, which interfere with participation in social activities outside the care environment (Ross-Sheriff & Swigonski, 2009). The situation is aggravated by a shortage of qualified formal caregivers and poor salaries. The care role of formal caregivers often creates interpersonal conflicts arising from unrealistic work demands (Thornton & Hopp, 2011). Some caregivers have narrated experiences of avoidable irritability and anger arising from work burdens and unfavourable working conditions (Nabalamba & Chikoko 2011).

**3.7.2.2 Spirituality, religion and culture.** Given the work burden associated with the role of formal caregivers, many have reported positive experiences after relying on religion and culture as coping mechanisms (Masuku & Khoza-Shangase, 2018). In other words, when work demands become too much, formal caregivers rely on spirituality, religion or culture (Benadé, et al., 2017). This reliance is a source of greater patience, clearer perspective and a higher sense of purpose, which makes the care burdens lighter on the body, mind and soul (Gabriel at el., 2021). As a result, rather than seeing caregiving as merely remunerated work, some formal caregivers are experiencing the care environment as a calling that allows them to contribute to the greater good. Religious and spiritual rituals of prayer, meditation and liturgy have been found to be effective in uplifting the spirit and raising the morale of formal caregivers (Masuku & Khoza-Shangase, 2018).

**3.7.2.3 Remuneration.** Many formal caregivers are paid relatively low salaries compared to the work demands of providing care to frail older persons (Kim & Given, 2008). This situation is discouraging for many formal caregivers, who sometimes experience personal financial difficulties as a result (Aubeeluck & Luximon-Ramma, 2020). The experiences of formal caregivers reveal that care salaries render them unable to afford the basic essentials of daily life so that they are forced to borrow from unscrupulous credit providers (Navaie-Waliser et al., 2002). According to Kangethe (2010), despite the important social development functions performed by caregivers they are not remunerated proportionately to the work demands.

**3.7.2.4 Family involvement.** In the experience of many formal caregivers, the role of caring for frail older persons becomes less burdensome with family-

centred interventions (Thomas et al., 2017). Frail older persons with strong family involvement in their care tend to be more co-operative and responsive in the formal care environment (De Beer & Brysiewicz, 2017). The notion that formal caregivers and nursing homes have full responsibility for every aspect of the care of the diverse needs of frail older persons is contrary to their holistic well-being (Makiwane et al., 2004). The reality is that once frail older persons have been institutionalized, family involvement is often rapidly diminished, resulting in the isolation and social withdrawal of frail older persons (Peil, 1995).

**3.7.2.5 Abuse.** The phenomenon of abuse of frail older persons in the formal care environment is generally not investigated. The experiences of formal caregivers reveal that abuse is usually financial and is mostly perpetrated by family members (Lloyd-Sherlock et al., 2018). Financial abuse usually takes the form of extortion and mismanagement of the finances of frail older persons (Ferreira & Lindgren, 2008). Under most legal systems formal caregivers do not have the power to intervene in matters of this kind, which are often seen as internal family issues (Phelan, 2020a). The other aspect of abuse in the formal environment has an emotional dynamic to it. Emotional abuse often manifests in the form of insults and threats to frail older persons (Biggs et al., 1995). In the experience of formal caregivers, relatively few incidents of physical and sexual abuse of frail older persons happen in old age homes because robust systems of care and protection are in operation there (Ferreira & Lindgren, 2008).

## 3.8 CAREGIVERS AND FRAIL CARE: THE NAMIBIAN EXPERIENCE

The care system for frail older persons in Namibia is largely dependent on caregivers (Kalomo & Besthorn, 2018). Whether formal or informal, caregivers play a huge role and one that is fundamental to the human dignity and quality of life of frail older persons (Pretorius, 2019). However, both formal and informal caregivers experience the following challenges:

### 3.8.1 Experiences of the informal caregivers

Given the socio-economic, cultural and political dynamics, the informal care environment continues to dominate the landscape of care for frail older persons in Namibia (Ananias et al., 2016). This is especially true for blacks who, for historical, cultural and other reasons, have either not been exposed to or have not adopted formal care as a preferred choice of care environment for frail older persons

(Adamchak, 1995). Informal caregivers have experienced the following issues in providing care to frail older persons in Namibia:

**3.8.1.1 Burden of care.** The unmet needs of frail older persons contribute to the emotional burden of informal caregivers, who are expected to provide quality care without basic essentials (Van Groenou et al., 2006). In general, the phenomenon of caregiver burden is an under-investigated area and not much has been reported on this important aspect (Bastawrous, 2013). According to Brockmeyer (2012), whenever caregivers feel burdened by the care environment, this is reflected by their reduced level of care for frail older persons. The burden of care for informal caregivers also emanates from the fact that they do not have formal working hours because they sometimes live under the same roof as the frail older persons (Kalomo & Liao, 2018). The lack of fixed working hours while they are providing informal care usually results in fatigue, social isolation and long-term mental health issues for informal caregivers. Informal caregivers have a greater responsibility and accountability for the care of frail older persons, but apart from being a financial drain, this care also comes at a personal cost (Cacioppo & Hawkley, 2009). Despite the high level of responsibility and the personal sacrifices demanded, informal caregivers are not remunerated or recognized as care professionals under any framework in Namibia (Lai, 2012). According to Thomas (2006), the excessive work demands and the burden of providing care often result in the abuse of frail older persons.

**3.8.1.2 Abuse of frail older persons.** Although the old age homes are ideally intended to provide a safe environment of care based on sensitivity, compassion and empathy, in practice this is not always possible since caregivers are only human (Badger et al., 2009). Based on the experiences of caregivers, it would appear that the Namibian informal care environment is confronted with various incidents of abuse of frail older persons (Ananias & Strydom, 2014). According to Splinter (2009), while there is no global definition of elder abuse, each country follows local context to ascribe meaning to these phenomena on the basis of cultural, legal, political and historical circumstances. While Namibia does not have a regulatory framework for dealing with abuse of frail older persons (Teofelus, 2013), in general the concept refers to anything which creates physical, physiological, emotional and financial distress for older persons (WHO, 2003). Abuse of frail older persons in Namibia is mostly committed by caregivers (who are generally family members), community members and even government officials and others engaged in the delivery of essential social services (Klie & Ananias, 2021). According to Kotzé (2018),

abuse of frail older persons by family members is usually physical, financial and psychosocial. However, Kalomo et al. (2021) state that frail older persons living with HIV/AIDS in Namibia constantly face verbal abuse due to stigma and prejudice. Abuse of frail older persons in the informal care environment is triggered by multiple factors, including gender discrimination, age vulnerability, dependency, substance abuse and mental health issues (Ananias & Strydom, 2014). Alcohol and substance abuse by informal caregivers of frail older persons have been blamed for these escalating phenomena (Leuning et al., 2000). Abuse of frail older persons is also sometimes due to misinformation and cultural practices that defy logic and reason (Mariki, 2017). Mental health conditions such as dementia in some informal care environments have fuelled suspicions of witchcraft, resulting in isolation and physical violence against frail older persons. (Ferreira & Lindgren, 2008).

However, poverty is largely seen as the main cause of abuse of frail older persons in the informal care environment (Lombard & Kruger, 2009). Most of these incidents of abuse remain largely unreported and hence unprosecuted due to fear of further reprisals or of being ostracized by the perpetrators (Lachs & Pillemer, 2004).

**3.8.1.3 Government support.** Despite old age protection being the responsibility of every government, the informal caregivers are receiving very little government support in Namibia. This is largely due to the absence of a comprehensive social welfare programme to improve the care of frail older persons. Everything from health services to social services seems to be a challenge and the government's expectation is that home-based care should be the priority (Botes, 2002). This effectively shifts responsibility for the care of frail older persons to families and communities, who are already impoverished. The provision of care comes at a huge financial cost and the informal care environment is not sufficiently resourced to handle the ever-increasing demands of care.

**3.8.1.4 Shortage of basic skills and knowledge.** The role of caregiving to frail older persons is becoming more complex given the levels of multi-morbidities of many frail older persons (Aboderin & Hoffman, 2011). This demands more skills and knowledge from informal caregivers who are the first responders in different situations facing frail older persons under their care (Ananias, Ellis, & Strydom, 2015). In Namibia, there are no training programmes to prepare people for the role of caregiving to frail older persons in home-based care (Kloppers, 2011). Thus, family members often assume this role out of necessity

although they lack training and knowledge (Niikondo, Hoque, & Ntuli-Ngcobo, 2011). Equally, there are no performance management standards and care outcomes are subjectively based on own assessments. The unavoidable implication of this situation for the care practice is that due to shortage of skills many mistakes are made, resulting in fatal consequences for frail older persons (Kalomo et al., 2018).

### 3.8.2 Experiences of formal caregivers

Despite the secondary nature of formal care of frail older persons in Namibia, formal caregivers are at the forefront of institutional care provision (Leuning, et al., 2000). While the formal care environment is relatively resourced compared to the informal environment, there are still many challenges in the provision of care to frail older persons (Pretorius, 2019). These challenges are diverse and are often unmet, which creates a perilous situation for frail older persons who are absolutely dependent on formal caregivers for the activities of daily living. Formal caregivers have found the following issues to be paramount in care provision:

**3.8.2.1 Burden of care.** In Namibia formal caregivers are experiencing enormous burdens in caring for frail older persons (Kalomo et al., 2018). These mainly emanate from the excessive demands of care work, which sometimes compromise life/work balance (Ankri, Andrieu, Beaufils, Grand, & Henrard, 2005). In this sense and given the growing demands of care, the responsibility of caring for frail older persons negatively impacts the ability of formal caregivers to maintain personal relationships and enjoy their leisure time (Lloyd-Sherlock, 2014). Furthermore, formal caregivers are relatively poorly remunerated in Namibia and this makes it challenging for old age homes to attract and retain good workers with skill and experience (Kloppers, 2011). These different burdens of care create emotional strain for formal caregivers who are having to cope without any therapy or psychosocial support (Tjiroze, 2013). Most of the frail older persons are bedridden and rely on the physical and emotional strength of formal caregivers for the activities of daily life (ADL), which puts the increasing demands on the caregiving role in context (Kalomo & Besthorn, 2018). This also puts enormous pressure on the overall health of formal caregivers and highlights the burdensome nature of Namibia's care environment of frail older persons.

**3.8.2.2 Shortage of formal caregivers.** Formal caregivers constitute the backbone of institutional care, but Namibia is experiencing a serious shortage of qualified and experienced care professionals (Amakali, 2013). The duties

involved in caring for frail older persons are becoming more specialized and relevant skills are needed to provide quality care. Given the poor salaries and poor working conditions of caregivers, the profession has seen a very high turnover of qualified staff, with some staff members switching to other professions (Mabengamo, 2003). As a result, the formal caregiving environment of frail older persons is having to rely on the use of auxiliary workers for clinical social work practice (Chipare, et al., 2020). According to Amakali (2013), the shortage of formal caregivers also creates an additional workload for the remaining staff at care institutions for frail older persons.

**3.8.2.3 Lack of training of formal caregivers.** Formal caregivers in Namibia often lack the necessary skills and knowledge to handle the overall care practice of frail older persons given the complexity of geriatric care demands (Pieters & Matheus, 2020). Most of the formal caregivers are not trained professionals and have gained knowledge through on-the-job experience. In fact, the scarcity of formal caregivers has forced some care institutions for frail older persons to recruit people with limited experience and inadequate knowledge (Kloppers et al., 2015), Lack of specialized training and skills in the care environment leads to inappropriate interventions in providing care to frail older persons and exposes them to many risks (Pieters & Matheus, 2020).

## 3.9 PRACTICAL RECOMMENDATIONS TOWARDS UNDERSTANDING THE NEEDS OF FRAIL OLDER PERSONS

Various recommendations have been proposed to enhance the care of frail older persons. Among these, there are particular welfare models that have been identified as playing a critical role in supporting the care of frail older persons. These models include the Being, Belonging and Becoming model, the Broad Based Benefit Model, Bass and Noelker's model and Maslow's hierarchy of needs. According to Arts and Gelissen (2010), each model entails principles that can have an impact on the lives of frail older persons. Although welfare modelling is complicated by its very nature (Arts & Gelissen, 2010), various approaches have been expounded to improve our understanding of possible interventions in addressing the needs of frail older persons. Thus, the ability of welfare models to deal with the needs of frail older persons depends on the specific socio-economic circumstances of a given country (Huang et al., 2020). According to Low et al. (2011), for optimization of interventions, components of different models must be included to provide effective results. The welfare models provide principles for practice and therefore merit our attention. These models have been chosen to focus on because of their relevance to

caregivers of frail older persons. They have explanatory powers in guiding solutions to the challenges facing frail older persons in the care environment.

Therefore, these models are relevant to this study, which has as one of its main objectives the recommendation of practical proposals to meet the needs of frail older persons in Namibia. When examined, these models provide a framework to articulate the latter.

### 3.9.1 Needs coverage

In terms of intervention strategies for addressing the needs of frail older persons, it is important to first understand the needs coverage and the particular needs of these persons (Longo et al. 2015). This is exactly what the Being, Belonging and Becoming (BBB) welfare model seeks to do, as postulated by Watt and Konnert (2007). Under the BBB model the needs of frail older persons should be divided into physiological, spiritual, social and psychological dimensions. This means that the needs of frail older persons must be seen not primarily from a supply perspective, but also in terms of actual demands. For example, it is not enough to provide universal old age pensions and forget about the other diverse needs of frail older persons (Shabangu, 2011). According to Watt and Konnert (2007), under the BBB model the first B stands for Being and refers to physical and psychosocial needs. The second B stands for Belonging, which refers to fit with the care environment while the third B refers to Belonging, representing social engagement. Thus, at a basic level, the BBB welfare model postulates that issues of healthcare, living conditions and social engagement should be pertinent in providing quality care for frail older persons (Vankova, 2016). Thus, recommendations for interventions should not only be made in the arena of financing and policy-making, but should include evidence-based assessments of broader supply and demand issues affecting frail older persons (Barr, 2020). Additionally, gerontology literature abounds with many other models relating to needs coverage (Low et al., 2011). These include the successful adaptation of Abraham Maslow's hierarchy of needs for determination of the needs of frail older persons (Thielke et al., 2012). The basic hypothesis of this model is that the satisfaction of human needs is hierarchically based on evolution from the basic level of physiological needs to the level of safety and then to a sense of love/belonging, and finally to the level of safety, esteem and self-actualization (Maslow, 1943). This means that human beings in general are motivated by different needs, ranked in an order of priority, to achieve their full potential. Although originally sounded in human psychology, Maslow's hierarchy of needs has found application across many disciplines, from marketing to business and the social sciences (Zalenski & Raspa, 2006). Using Maslow's hierarchy of needs, Wang et al. (2016) were able to assess

the primary needs of frail older persons in Taiwan in terms of health (physiological), food, security, self-actualization (based on self-management) and love. Despite the relative success in the interdisciplinary use of Maslow's theory, Kiel (1999) cautions that there is a need to continuously reshape and modernize this thinking in line with the evolving nature of society.

### 3.9.2 Governance and regulation

According to Barr (2020), governance and regulatory models are important instruments of welfare reforms relating to frail older persons. They should provide the basic framework for structural improvements in their care. In this regard, welfare provision for frail older persons through regulation should be bottom-up, involving the caregivers and frail older persons themselves in policy-making. This intervention is related to the Broad Based Benefit welfare model, which was developed by Pradeep and Charan to explain the impact of stakeholder engagement in legislative intervention and policy making based on the empowerment of frail older persons (Pradeep & Raj, 2006). The basic premise of this model is that policies and legislation should reflect the real needs of frail older persons (Raj, 2017). The model therefore argues for the integration of laws and the underlying needs of frail older persons. Only if this is done will frail older persons be empowered to enjoy the benefits of laws and policies seeking to meet their needs. The empowerment aspect raised under the Broad-Based Benefit Model is important as it resonates with the human rights centred aspirations of social welfare policy based on equity and justice (Sepúlveda, Carmona, & Donald, 2015).

Furthermore, whether frail older persons are receiving care in the formal or informal care environment, adequate governance mechanisms must be established to ensure optimal utilization of resources (Bode, 2006). This means that allocation of social welfare services to frail older persons must be governed by effective standards that will ensure desired outcomes (Head, 2008). In this regard, caregivers must be engaged to participate actively in the delivery of welfare services. Governance issues are related to the overall planning, implementation and performance management of the allocated resources in the care of frail older persons (Barr, 2020). Effectively, governance and regulation models create the holistic legal framework for addressing the needs of frail older persons, while the BBB model brings together vital aspects of needs coverage.

### 3.9.3 Care service provision

Interventions to ensure that frail older persons receive quality care must be based on objective standards. The care services delivery process requires the involvement of care beneficiaries to provide regular feedback in order to ensure satisfaction levels. Thus, multi-dimensional criteria are required to adequately review the performance standards of caregivers (Buttle, 1996). This intervention is important as it reveals how care services are offered to frail older persons and policies are implemented. Although the care service literature indicates that services to frail older persons may differ, depending on settings, the basis for maintaining quality remains the same. In this regard, the SERVQUAL model (TM & GV, 2019) was used in various studies to determine priorities and satisfaction levels in the care of frail older persons (Curry & Stark, 2000). According to Parasuraman (1991), the SERVQUAL model is process-based and promotes five dimensions of service, namely tangibility (physical appearance), reliability, responsiveness, assurance and empathy. Quality care service provision is cardinal to the well-being of frail older persons and service organizations like old age homes must endeavour to measure satisfaction levels using objective criteria like SERVQUAL.

Furthermore, while service provision is one aspect, it is also important to determine the levels of satisfaction of caregivers with the care environment. For this, the Bass and Noelker welfare model suggests that behavioural characteristics of key stakeholders in the care environment should be considered (Bass et al., 1996). This is a strategy for understanding and alleviating the burden of care on caregivers. The model postulates that the interests of caregivers and the needs of frail older persons are interrelated (Mello et al., 2017). For example, it is not effective to improve the conditions of frail older persons while caregivers are experiencing various burdens themselves as a result of providing care. Thus, the Bass and Noelker model argues that intervention strategies to address the needs of frail older persons should be alive to the various burdens experienced by caregivers in the care environment.

## 3.10 CONCLUSION

This chapter presented the needs of frail older persons and the experiences of caregivers as they emerged from a review of relevant literature. It began by examining the theoretical foundations underlying the research problem; this was followed by a systematic outline of the global, regional and local Namibian perspectives on the needs of frail older persons and how these have been experienced by caregivers. Thus, a logical, comprehensive and critical analysis of previous literature in the field was carried out with a clear focus on the study objectives.

In terms of the theoretical landscape, the scholarly insights into these phenomena were expounded with various explanatory theories. For example, self-management was used to explain the need of frail older persons for self-care, ecological theory positioned the basis of sustained care relationships across generations. In terms of interventions, the study reviewed different welfare models to guide responsive strategies in addressing the needs of frail older persons.

The global situation has set the scene for an analytical discussion of the needs of frail older persons by creating a basis for the assessment of regional and local situations. The comparative literature found divergent and convergent views about the needs of frail older persons and this highlighted the research gaps, revealing the nuances of each situation. Broadly, the needs of frail older persons are found to be multi-faceted, the principal areas being physical and mental health, nutrition, accommodation and basic necessities of life. The experiences of caregivers involved in the care of frail older persons have revealed issues relating to work burden, abuse, training gaps and overall lack of support in providing quality care. While the experiences of formal and informal caregivers are similar, the literature review identified important areas of difference in the nature of the challenges they face in the care environment.

Finally, in describing the needs, the literature review also discussed the implications for the overall care practice of frail older persons.

# Chapter 4 RESEARCH METHODOLOGY

## 4.1 INTRODUCTION

The primary purpose of this study was to assess the needs of frail older persons from the perspectives of formal and informal caregivers. This chapter describes the research design and methodology used in the study and provides a definition of the scope of the research and its limitations. The research design covers the theoretical basis required to understand the type of information and analytical methods that were used to analyse and interpret data to answer the research questions (Creswell, 2014). It also covers the overall planning process of the study by providing the foundation which enabled the research to answer the research questions. The study design was based on a qualitative research method grounded in an interpretive paradigm (Stake, 2010). A qualitative research method was chosen for the study given the subjective and exploratory nature of the research objectives relating to the needs of frail older persons. A qualitative paradigm was chosen to increase the researcher's knowledge and gain more in-depth insight into the social phenomenon based on the perspectives of informal and formal caregivers (Babbie & Mouton, 2010). This paradigm proved useful and was the preferred approach when attempting to understand the personal perceptions of a situation by real people in a real context (Schutt, 2018). Thus, the qualitative data were collected mainly from focus groups consisting of formal caregivers, semi-structured interviews with informal caregivers and key informants. This methodological pathway has proved to be effective in seeking deeper subjective insights into a social phenomenon (Baxter & Jack, 2008), thus making a qualitative methodology relevant to a study of the needs of frail older persons in Namibia from the perspectives and experiences of caregivers.

Furthermore, the qualitative design was also a pragmatic and appropriate choice since no computation of numbers was envisaged as part of the study, which would have been better suited to a quantitative method. This qualitative approach was used to make sense of the textual data from caregivers in their social setting making this study interpretive. Thus, the theory of hermeneutics, which means " "interpretation" was used under the qualitative methodology (Smith & Davies, 2010).

Additionally, this chapter also includes an outline of the sampling strategy, pre-research process of instrument pre testing and piloting of participants is critical (De Vos et al., 2011). Also, various empirical data collection tools and analytical framework were used to achieve the research objectives. Ethical issues relating

to informed consent, confidentiality and voluntary participation by participants are described below.

## 4.2 RESEACH PHILOSOPHY

The research philosophy underscores the answer to the question why the research was conducted in the first place. It provides the basis for the researcher's assumptions about the contrast between nature, society and science (Burrell & Morgan, 2017). The philosophical assumptions guide the researcher into selecting the appropriate research design and methodology for the study. In providing a methodological foundation, various philosophical assumptions are associated with different sociological persuasions; for example, epistemology is grounded in knowledge, ontology covers the nature of reality while human nature predicates a predetermined philosophical assumption (Mills et al., 2009).

The philosophical underpinnings form the ontological and epistemological foundation for not only the theoretical perspectives but also the overall research methodology. According to Crotty (2003), it is important in any research to identify the philosophical ideas underlying the research practice even though these ideas are often hidden. These underlying ideas relate to the researcher's worldview or position about ontology or reality and the nature of knowledge or epistemology (Morgan, 2007). Given the qualitative design of this study, the ontological view is based on subjective experiences of human participants as reflected in their perspectives on the research phenomena. This ontological position informs constructivist epistemological assumptions about the relevant information and evidence for answering the research questions (Crotty, 2003). In other words, the worldview is interpretive and is based on the subjective views or personal experiences of caregivers in their natural care environment.

For a better understanding of this component of the research design and methodology in this study, it is important to illustrate the paradigmatic interrelationships between ontology, epistemology, theoretical perspectives, and methodology and research methods. Assuming a human subjective reality or ontology for the research, the relationships between constructivist epistemology, theoretical perspectives, and methodology and research methods are illustrated in Figure 1 below:

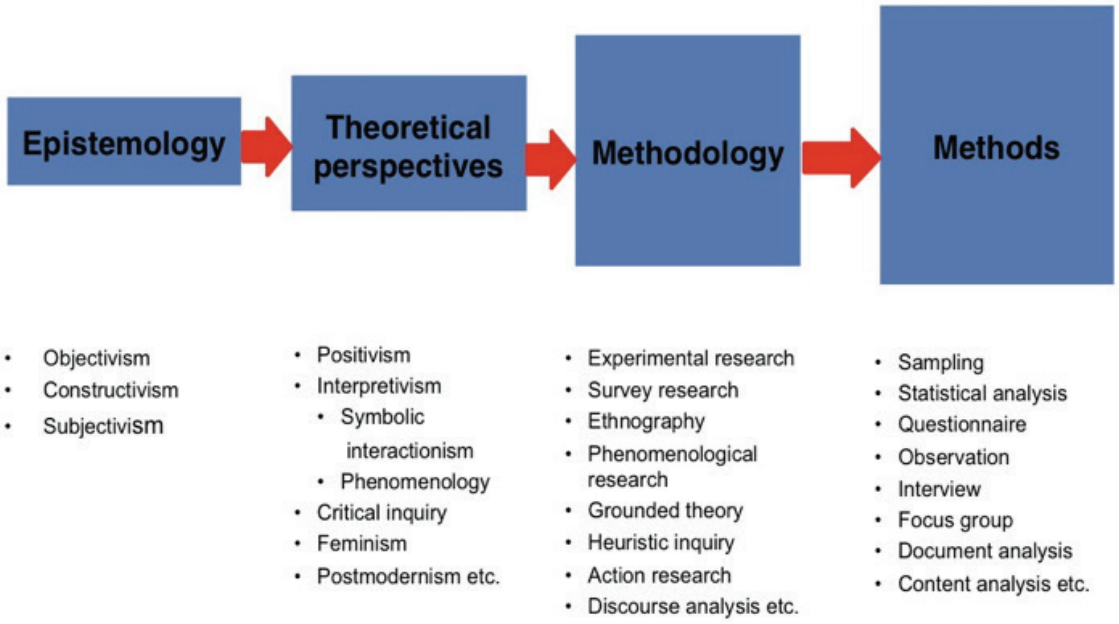


Figure 1: Relationship between epistemology, theoretical perspectives, and methodology and research methods (Source: Adapted from Crotty (2003, p. 5)

The above description in Figure 1 is an inclusive diagram of other views as well but it is used here to illustrate this research approach within the larger set of other approaches. According to Gray, Hahn, Thapsuwan, and Thongcharoenchupong (2016), an epistemological understanding of the research is essential to provide clarity and inform the choice of a suitable research design. This study follows a constructivist epistemology, which implies the formation of knowledge from the perspectives, interactions and ideas of study participants (Schwandt, 2000). In terms of theoretical perspectives as illustrated in Figure 1, the study was guided by interpretivism as part of the broader process of creating meaning that is embedded in a constructivist epistemology (Andrews & Okpanachi, 2012). In other words, knowledge is constructed through interpretation of the phenomenon from the perspectives of the caregivers of frail older persons.

According to Saunders et al., (2019), the research process mainly consists of deductive, which tests a theoretical proposition and inductive methods, which refers to theory development based on empirical experiences. However, in order to enhance the inferential rigour in answering the research questions a mixed method can be adopted consisting of both deductive and inductive reasoning (Creswell et al., 2011). Thus, given the exploratory purpose of the study, the theoretical approach chosen was both inductive and deductive in order to ensure a comprehensive data analytical approach (Saunders et al., 2019). Deductive reasoning because the existing theory informed the research construct to be explored (O'Reilly, 2009). This deductive conceptualization was then inductively analysed against the empirical data for improved understanding of the research phenomenon (Azungah, 2018). This is referred to as the "top down" and "bottom up" approach (Creswell & Clark, 2007, p. 23).

Following this dual approach, theory testing and development happen together as deductive reasoning looks for causality while the inductive approach reads data for emerging patterns that could lead to theory generation. According to Miles and Huberman, (1994), inductive and deductive reasoning are connected and may be used simultaneously to deliver valid and credible qualitative research. This view is consistent with that of other scholars, who have argued that under constructivist epistemology, both inductive and deductive approaches can be used in a single project to achieve the research objective (Bernard, 2017 and Stake, 1995). Additionally, Punsch (2005), argues that deductive and inductive reasoning are complementary as part of the overall systematic research methodological structure.

Under this dual methodological approach, research questions are broadly phrased to elicit deeper insights that would enable the construction of meaning from the enveloping data based on human experiences in a social setting (Creswell, 2007).

## 4.3 RESEARCH DESIGN

In social science, the research design refers to the overall map or strategic plan for obtaining reliable and valid evidence to answer the research questions and achieve objectives without ambiguity (Rovai, Baker, & Ponton, 2013). In other words, the research design is the most logical and systematic structure in social research for addressing a relevant societal problem (Creswell & Creswell, 2017). Accordingly, a qualitative research design was chosen for this study, given the subjective nature of research problems relating to an exploration of the needs of frail older persons in the formal and informal care environment. Leedy and Ormrod (2014) assert that a qualitative study is about answering questions relating to a phenomenon in a real-life setting in order to understand, explain, control and predict it better.

Based on this qualitative design, the study followed a hermeneutically interpretive approach to attributing meaning and explaining complex human experiences and perspectives (Baxter & Jack, 2008). This implies that the interpretive approach is usually appropriate when exploring and describing lived human experiences and perspectives about a phenomenon in its social and natural environment (Pietkiewicz & Smith, 2014). Although this study resonates with an interpretive phenomenological analysis (IPA), a more flexible and general interpretive approach grounded in constructivism was chosen to avoid the theoretical austerity of IPA in respect of sampling and robust analytical requirements. This made reasonable sense considering that despite common characteristics like description of lived experiences of the participants and interpretation, IPA extends social inquiry to particular hermeneutics and ideography (Larkin et al., 2006). For example, what is

important for textual interpretation here is the actual language (spoken or written) used by study participants in order to decipher the actual intended meaning. Thus, the more pragmatic interpretivist approach adopted in this qualitative study was specifically chosen to achieve the research objectives with greater efficiency and efficacy.

Throughout the study, this interpretive design, which is based on a constructivist epistemology, provided a strategic map for answering the research questions with theoretical and empirical rigor. An interpretive constructivist design ensured that the issue of the needs of frail older persons was explored through various perspectives for a more nuanced revelation and understanding of this phenomenon.

In finding systematic meaning from other qualitative data (embedded in legislative and policy documents), the study relied on qualitative content analysis as a coding frame for the interpretation of data (Schreier, 2012). As a reliable method for descriptive studies, qualitative content analysis was regarded as appropriate for data reduction and coding (Saldaña, 2016). This approach is discussed in greater detail later on in this chapter.

## 4.4 RESEARCH METHODOLOGY

While the research design covered the systematic action plan, the methodology becomes the theoretical foundation for achieving the strategy (Creswell, 2014). The methodology covered the various pathways and techniques in data sampling, collection, analysis and interpretation (Babbie, 2016).

### 4.4.1 Population and Sampling

A study population refers to the totality of all members with similar characteristics in a defined group forming the subject matter of the research (Saunders et al., 2016). In qualitative studies, a study population of interest essentially relates to a population that is representative of the group being investigated. According to Bryman and Bell (2007), the population refers to the overall units from which a subset can be chosen for purposes of representation in a study. Generally, there is no hard and fast rule exist for sampling size in qualitative studies of this nature and the approach is usually informed by the research objectives (Creswell, 2014). In this case, the study population was made up of all caregivers of frail older persons in Namibia, from which a representative sample of 23 formal caregivers and 50 informal caregivers in the Khomas Region. This sample provides a balanced input considering that the informal care system of frail older persons is by far the largest in Namibia.

The geographical spread for the research fieldwork covered the Khomas region of Namibia, which is the largest economic and political region of Namibia and has the highest concentration of frail older persons compared to the rest of the country (NSA, 2017). Within the Khomas region, the suburb of Katutura as a cluster is the largest and most diverse settlement in terms of population demography, area in square metres and number of inhabitants. Also, most of the frail older persons in receipt of the State's old age pension are resident in Katutura, making it the ideal site for the fieldwork relating to informal caregivers. Most of the informal caregivers were accessed from this ethnically diverse location. Katutura, illustrated on the map in Figures 2 and 3 below, is an important social, cultural and economic hub of the Khomas Region of Namibia. Based on the above characteristics, the choice of Katutura achieved sufficient representative balance from the different areas or suburbs within the Khomas region. In other words, the Khomas region was delimited to Katutura because of its unique position to access the population of interest to assess the care needs of frail older persons in Namibia.

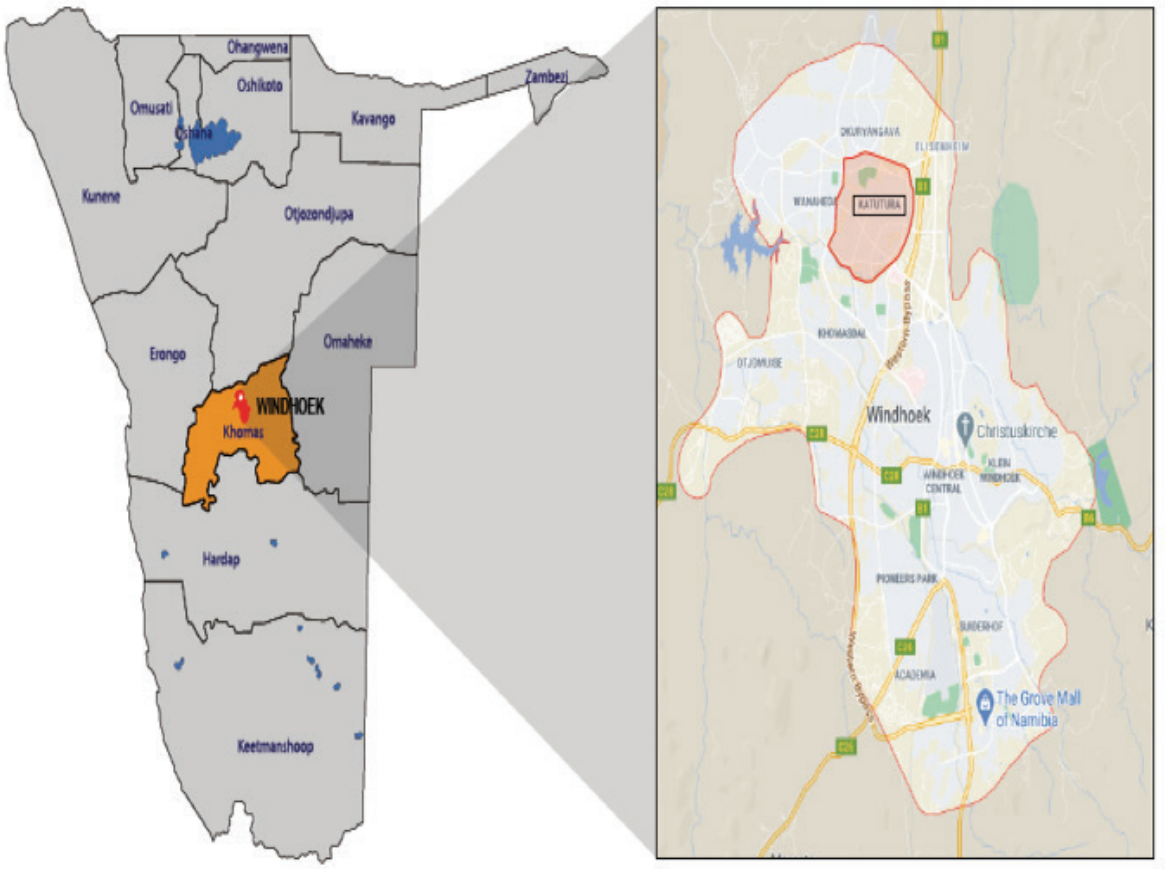


Figure 2: Map of Namibia with an insert of Khomas Region of Namibia
Source: Google Maps


Figure 3: Map of Katutura in the Khomas Region of Namibia
Source: Google Maps

Thus, the Khomas region of Namibia was selected for data collection. Similarly, the population for key informants was made up of a directorate from a non-governmental organisation (NGO) and all the officials dealing with social welfare issues in the four Namibian government departments, namely the Ministry of Health and Social Services (MOHSS); the Ministry of Justice; the Ministry of Labour, Industrial Relations and Employment Creation (MLIREC) and the Ministry of Poverty Eradication and Social Welfare (MPESW). Thus, sampling is an important strategy for ensuring a practical and optimal research process (Babbie & Mouton, 2010).

According to Saunders et al. (2016), there are two types of sample designs, namely probability and non-probability sampling. The former is where generalizability is important for participant selection, and the latter supports a specified non-random criterion for sampling. Non-probability sampling is commonly used for a qualitative inquiry with the focus on data saturation, which means that sampling continues until no new information is obtained from further data (Patton, 2002). Accordingly, this method is relatively cheaper and more pragmatic to apply in a qualitative study. The study combined two non-probability sampling designs, i.e. judgemental (purposive) sampling and snowball sampling (Babbie & Mouton, 2010). The study sampling strategy is illustrated below:

Table 1: Non-probability sampling

| Non-probability sampling | Participants |
|---|---|
| Purposive/Judgemental | Formal caregivers |
| Snowballing | Informal caregivers |
| Purposive/Judgemental | Key informants |

Each of these two non-probability sampling designs will now be discussed as they apply to specific research participants, i.e. formal and informal caregivers and key informants, as illustrated in Table 1 above.

**4.4.1.1 Sampling strategy for formal caregivers.** Purposive sampling as a form of non-probability method was used to select formal caregivers and key informants to participate in the study on the basis of their experience and knowledge of the research phenomenon. Focus group discussions were used with/for formal caregivers and interviews with the key informants. Based on this, the researcher's judgement informed the selection of participants in the study (Saunders et al., 2016). The selection criteria for these study participants included that they needed to:

- be the primary caregivers for frail older persons on a remunerated basis,
- possess first-hand knowledge of the subject-matter,
- reside in the Khomas Region of Namibia, which was the geographical location of the study,
- understand the purpose of the study and consent to it, and
- be willing to participate voluntarily.

Generally, there is no universal rule for the most adequate qualitative sample size (Creswell, 2014), but previous studies dealing with older persons have been successfully executed with from five to twenty five participants (Ananias, 2014). However, this research selected twenty three formal caregivers who participated in five focus groups of about five people at a time. The following diagrams illustrate the distribution of the formal caregivers.

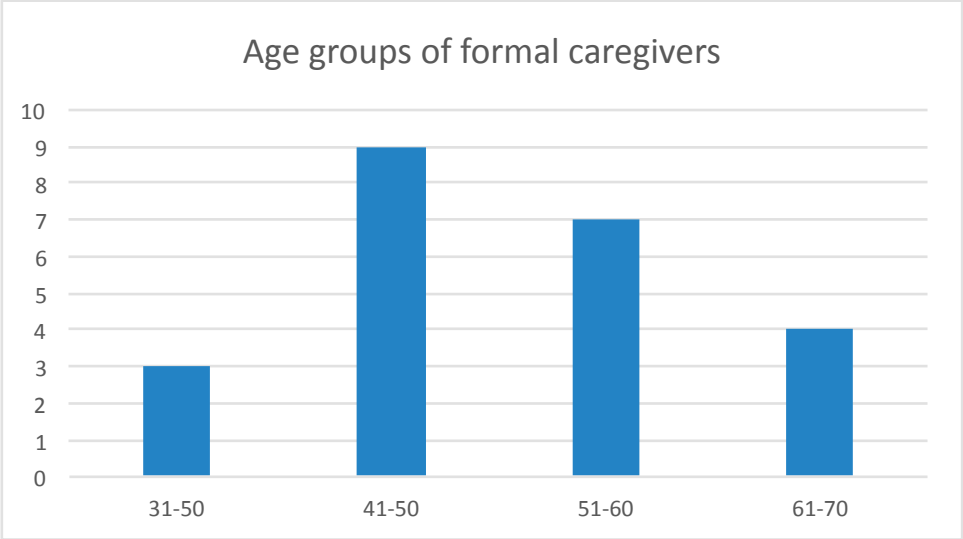


Figure 4: Age groups of formal caregivers

In terms of age demographics as illustrated in Figure 4 above, the average age of formal caregivers as illustrated in Figure 4 fell into the age bracket of 51–60, making up 48% of the sample population, followed by the 31–50-year age group, which made up 35% of sample. Only 17% of the formal caregivers were pensioners themselves, aged over 60 years, i.e. in the same age range as the group being investigated. No participant was below the age of 30 years. Apart from the age distribution, the length of combined service in the formal care environment was 24 years. This also highlights the relative experience and skills in carrying out service to frail older persons.

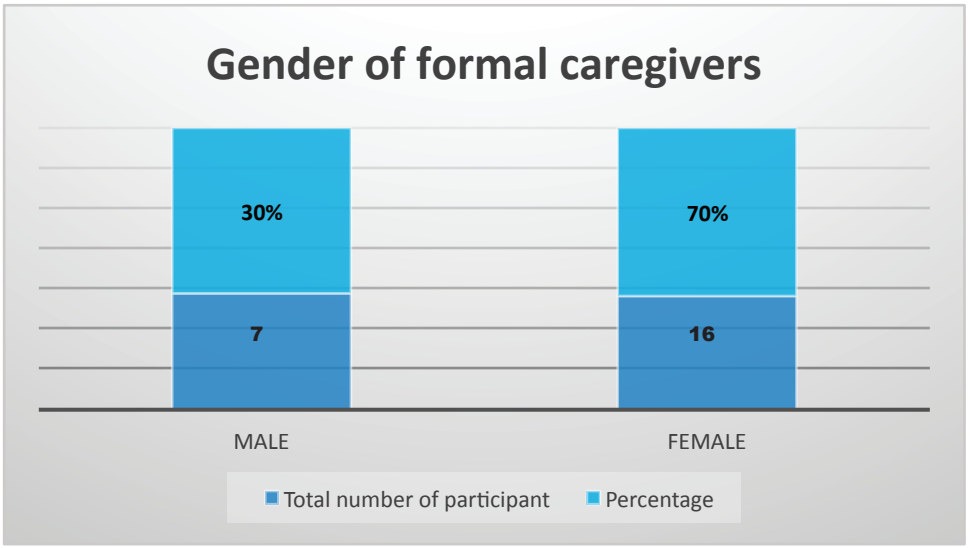


Figure 5: Gender of formal caregivers

As illustrated in Figure 5 above, the majority of formal caregivers were 16 female, making up 70% of the sample, with only 7 males making up the remaining 30% of the population of formal caregivers.

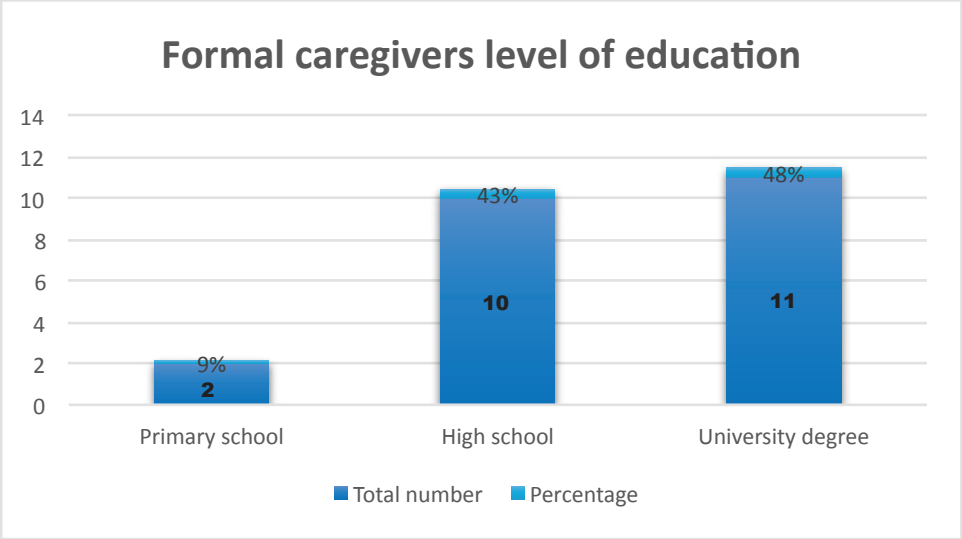


Figure 6: Level of education of formal caregivers

Figure 6 above reveals that almost half of the formal caregivers have a university degree while 43% have a high school diploma and only a meagre 9% have primary schooling.

Table 2 below displays the demographic data of the formal caregivers who participated in focus groups.

Table 2: Demographic data of formal caregivers

| Name | Gender | Age group | Race | Highest level of education | Formal caregiving (years) | Job description/ title |
|---|---|---|---|---|---|---|
| Participant 1 | Male | 41-50 | White | University Degree | 8 | Manager |
| Participant 2 | Female | 61-70 | Coloured | High school | 29 | Caregiver supervisor |
| Participant 3 | Male | 51-60 | Black | University Degree | 30 | Caregiver |
| Participant 4 | Female | 41-50 | Coloured | University Degree | 25 | Nursing Services Manager – Frail care dept |
| Participant 5 | Female | 51-60 | White | University Degree | 28 | Registered Nurse |
| Participant 6 | Male | 41-50 | Black | High school | 19 | Caregiver |
| Participant 7 | Female | 41-50 | Coloured | High school | 15 | Caregiver supervisor |
| Participant 8 | Female | 31-40 | Black | High school | 21 | Caregiver |
| Participant 9 | Female | 31-40 | Black | High school | 11 | Caregiver |
| Participant 10 | Female | 51-60 | Black | University Degree | 28 | Registered nurse |
| Participant 11 | Female | 41-50 | Black | High school | 20 | Assistant Nurse |
| Participant 12 | Female | 61-70 | Black | High school | 29 | Caregiver |
| Participant 13 | Female | 51-60 | White | University Degree | 27 | Registered nurse |
| Participant 14 | Male | 41-50 | White | University Degree | 22 | Manager |
| Participant 15 | Female | 51-60 | Black | High school | 32 | Caregiver supervisor |
| Participant 16 | Male | 41-50 | Coloured | University Degree | 17 | Assistant Nurse |
| Participant 17 | Female | 51-60 | White | University Degree | 35 | Matron |
| Participant 18 | Female | 31-40 | Black | University Degree | 18 | Registered nurse |
| Participant 19 | Female | 41-50 | Black | Primary school | 36 | Caregiver |
| Participant 20 | Male | 41-50 | Black | High school | 12 | Caregiver |
| Participant 21 | Female | 51-60 | Black | Primary school | 33 | Caregiver |
| Participant 22 | Male | 61-70 | White | High school | 14 | Manager |
| Participant 23 | Female | 61-70 | Black | University Degree | 42 | Relief Matron |

**4.4.1.2 Sampling strategy for key informants.** Key informants were also selected for the study using purposive sampling as part of non-probability sampling. Using the researcher's judgement, five key informants were selected based on their first-hand specialist knowledge of and involvement in old age policy and legislative development. Key informants are research participants who have first-hand knowledge of a phenomenon under investigation. Silverman (2020) indicates that a key informant must possess specific attributes that can support the qualitative data collection process. These attributes include expertise by virtue of the participant's role in an organisation, the possession of knowledge as well as the ability to absorb information meaningfully, and the ability to communicate intelligently and share relevant information without bias or partiality. In accordance with the above criteria, the key informants in the study were high level civil servants involved in policy formulation regarding older persons, stakeholder relations and functionally coordinated welfare law reforms in the Namibian government. Against this background, the key informants were selected to provide comprehensive insights into the policy and legislative environment as it relates to the care and protection of frail older persons in Namibia. This approach was imperative, given the overall lack of a comprehensive regulatory framework around older persons in Namibia (Kloppers, 2011). Based on the criteria described above, the researcher conducted five interviews with key informants with the following profile:

Table 3: Key informant profiles

| Role | Gender | Sector | Location | Highest level of education | Work experience | Age |
|---|---|---|---|---|---|---|
| Family Welfare | Female | Ministry of Health and Social Services | Khomas Region | Degree | 28 | 51-60 |
| Law Reform Development | Female | Ministry of Justice | Khomas Region | Degree | 19 | 51-60 |
| Pension Office | Male | Ministry of Labour, Industrial Relations and Employment Creation | Khomas Region | Diploma | 12 | 31-50 |
| Social Services | Female | Ministry of Poverty Eradication and Social Welfare | Khomas Region | Degree | 17 | 31-50 |
| Directorate | Male | Non-Governmental Organisation (NGO) | Khomas Region | Degree | 34 | 51-60 |

Given the limited knowledge of the regulatory framework of most caregivers (as indicated by the pilot study findings), the study also relied on the key informant technique to enhance the rigour of the data collection and analytical process relating to policy and legislative issues.

**4.4.1.3 Sampling strategy for informal caregivers.** The informal caregivers were selected through snowball sampling. Snowball sampling is frequently used to conduct qualitative research, primarily through interviews (De Vos et al., 2011). Given the informal nature of the care environment, it can be difficult to reach potential participants in any other way and hence this snowballing technique, also commonly referred to in social science as the chain referral technique, was the preferred means of locating them (Goodman, 2011). In practice, one of the major weakness experienced in using this method during the research was arriving at some participants who turned out not to be frail and outside the participatory frame of the study. However, overall the snowballing chain referrals yielded a credible sample for the study. The informal care of frail older persons is a role that lacks formal recognition and does not operate as part of a structured or professional service. Informal caregiving is often invisible in society, but can be better identified by those who have shared this social experience (Atkinson & Flint, 2001). By engaging with informal caregivers, the researcher was also able to access some other suitable participants who could participate in the study. Using snowball sampling, data saturation in this study was achieved when no new information could be obtained from respondent referencing (Strydom & Delport, 2011). Thus, snowball sampling procedure, allowed the researcher to collect qualitative data through semi-structured face-to-face interviews with 50 informal caregivers who were selected on the basis of referrals. The majority of the participants were females, making up 68% of the sample, with 28% males and 4% who identified themselves as “Other”.

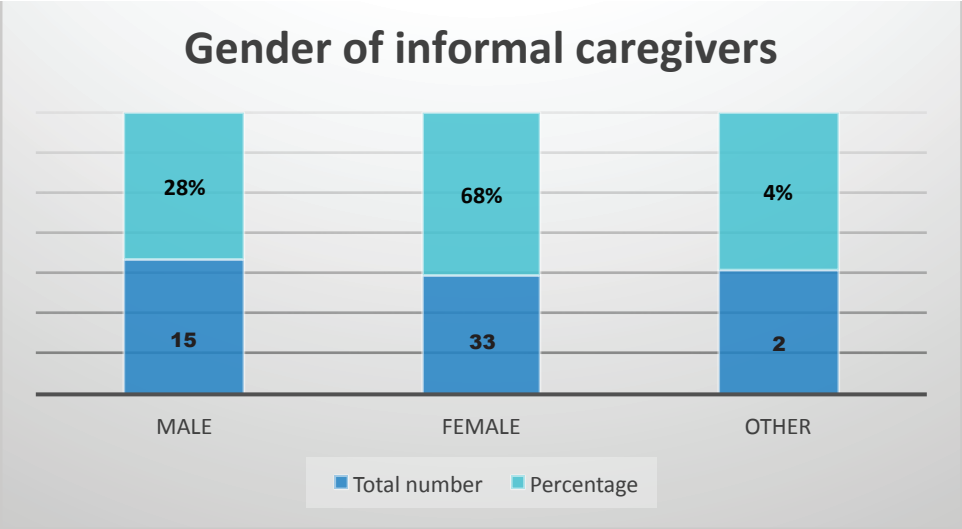


Figure 7: Gender of informal caregivers

Furthermore, as illustrated in Figure 8 below, the sample of informal caregivers revealed a 2% variance between the three main age groups, namely:

- Sixteen (16) participants were from the 18–30-year age group, which made up 32% of the sample,
- Fifteen (15) participants were from the 31–50-year age group, which represented about 30% of the sample,
- Fourteen (14) participants were from the 61–70-year age group, which made up 28% of the sample and consisted of people who were pensioners themselves.
- Five (5) participants from the 51–60-year-old cohort made up 10% of the total sample.

The average number of years of experience as informal caregivers was about 5 and a half years across the sample population.

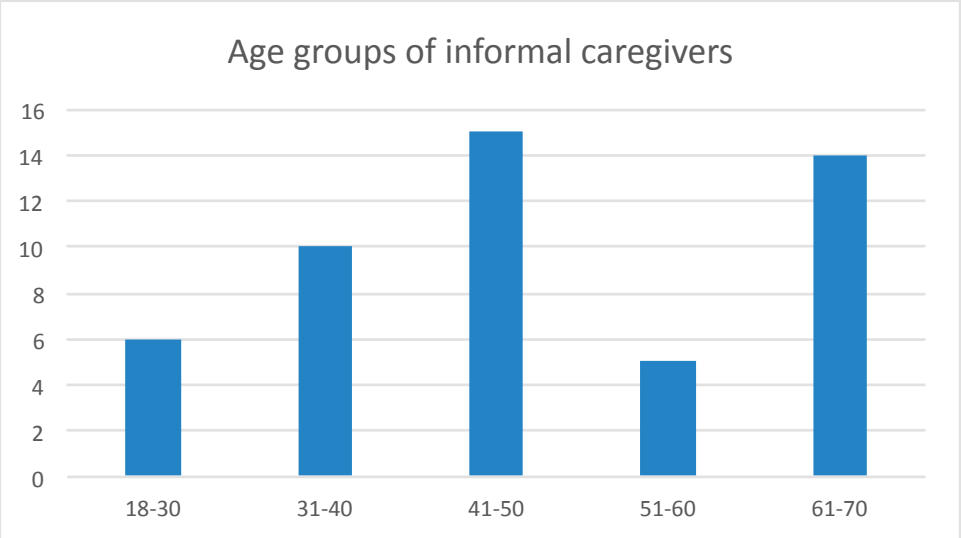


Figure 8: Age group of informal caregivers

A major take away from the data above in figure 8 is that some of the informal caregivers or about 30% are actually older persons themselves in terms of the WHO classification.This means that in terms of life cycle they themselves are also entering the arena of frailty and associated multi-morbidities affecting their care roles. It is also interesting to note that young people are taking on the role of caregivers. This may imply some degree of intergenerational solidarity in the care system of frail older persons. As indicated in Figure 9 below, the level of education of informal caregivers demonstrates that about 34% have no formal education compared to 40% with high school diplomas and 16% with tertiary qualifications. The informal caregivers with a basic level of education made up about 16% of the sample population.

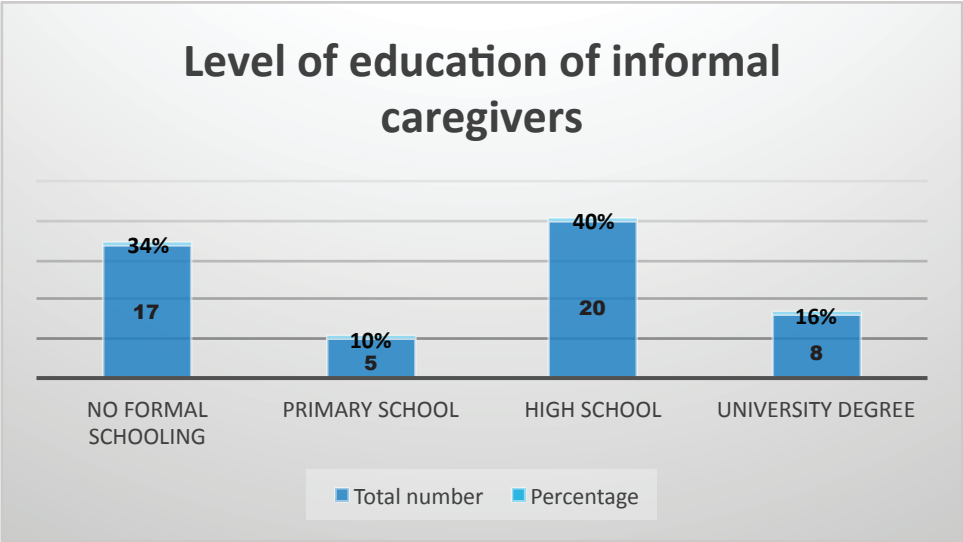


Figure 9: Level of education of informal caregivers

Figure 10 below demonstrates that the majority of about 86% of informal caregivers were unemployed, with only 14% of the sample population employed outside the care environment in low-wage jobs.

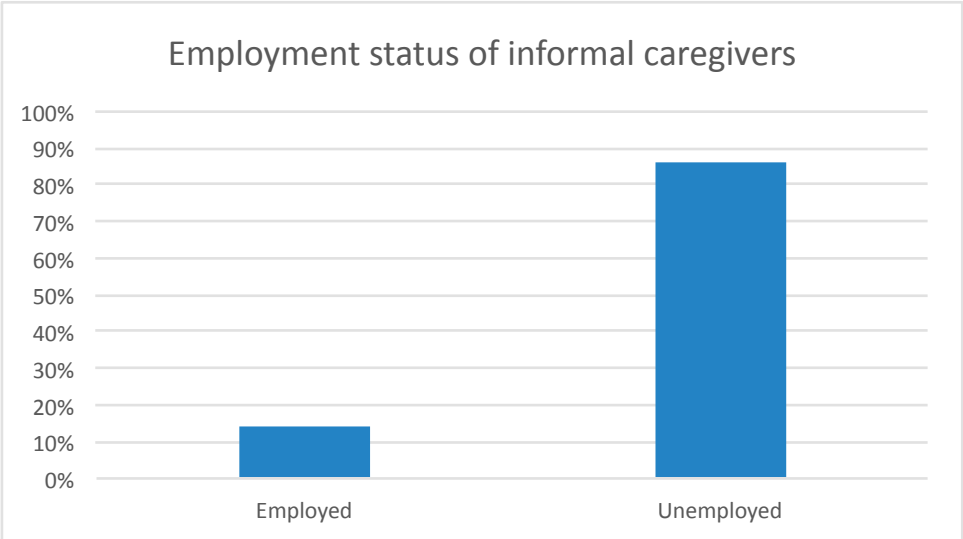


Figure: 10 Employment status of informal caregivers

The data illustration in figure 10 is worrying and reveals the levels of socio-economic deprivation of informal caregivers who are having to take care of frail older persons without any financial means of survival. The fact that they are unemployed implies that social grants constitute the major source of income for many of these households. Interestingly, it is not that the informal caregivers cannot be employed when jobs become available. The data shows in figure 9 that the majority of about 56% actually have some sort of high school and

varsity qualification and can be employed. However, the fact that they are taking care of frail older persons may deny them opportunities for employment.

Interestingly, in terms of family relationships, figure 11 below reveals that about 90% of informal caregivers were related to the frail older person, with only 10% made up of volunteers from the community.

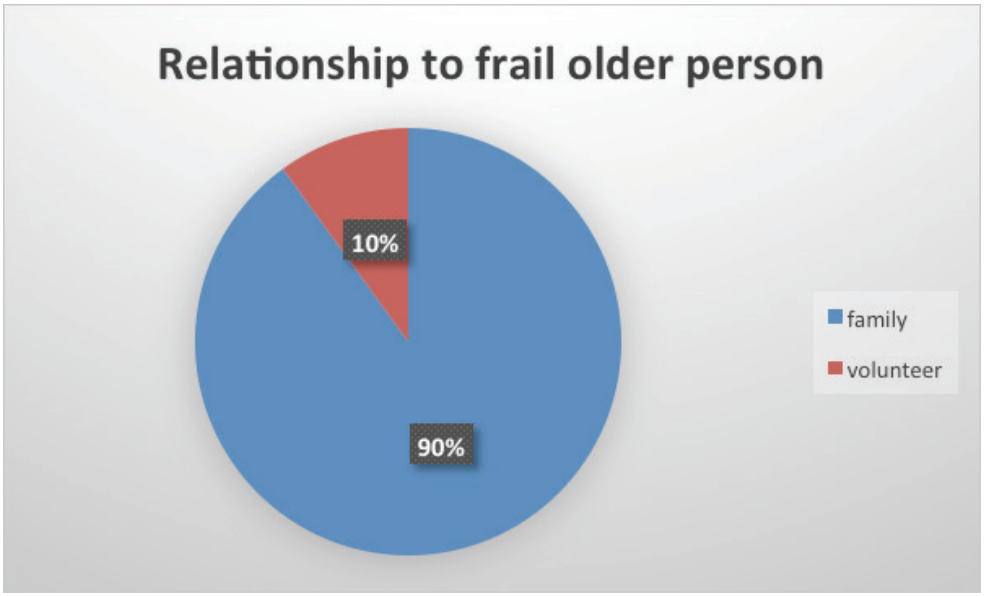


Figure 11: Relationship to frail older person

The above illustration in Figure 11 shows the interesting dynamic in Namibia in terms of the family relationship of informal caregivers. The family members reflected here are mostly extended and not necessarily part of the nuclear arrangements. Observationally, the data shows that despite the historic events leading to breakdowns in intergenerational family systems there seem to be some indication that extended family members are still operating as some kind of support and care system for frail older persons. As revealed above, only a small percentage of informal caregivers are not related to the frail older person meaning that families continue to perform an important role in the care of this group of people.

Table 4: Demographic data of informal caregivers

| Name | Gender | Age group | Marital status | Race | Highest level of education | Relationship to older person | Language | Experience as informal caregiver (years) | Residence | Employment status (current) |
|---|---|---|---|---|---|---|---|---|---|---|
| Participant 1 | Female | 61-70 | Divorced | Coloured | High School | Neigbour | Afrikaans | 7 | Rural | Pensioner |
| Participant 2 | Female | 61-70 | Single | Coloured | None | Daughter | Afrikaans | 4 | Urban | Pensioner |
| Participant 3 | Male | 51-60 | Divorced | Coloured | University Degree | Son | Afrikaans | 2 | Urban | Employed |
| Participant 4 | Female | 61-70 | Married | Coloured | University Degree | Sister | Afrikaans | 20 | Rural | Pensioner |
| Participant 5 | Male | 18-30 | Single | Coloured | High School | Grandson | Afrikaans | 1 | Urban | Student |
| Participant 6 | Other | 31-40 | Single | Black | College | Grandson | English | 3 | Rural | Unemployed |
| Participant 7 | Female | 31-40 | Single | Black | High School | Niece | English | 5 | Urban | Unemployed |
| Participant 8 | Female | 41-50 | Single | Black | None | Neigbour | English | 1 | Urban | Domestic worker |
| Participant 9 | Male | 31-40 | Single | Black | High School | Nephew | English | 4 | Urban | General worker |
| Participant 10 | Female | 41-50 | Single | Black | High School | Granddaughter | English | 3 | Urban | Unemployed |
| Participant 11 | Female | 61-70 | Married | Black | None | Wife | English | 10 | Rural | Pensioner |
| Participant 12 | Female | 61-70 | Married | Black | None | Wife | English | 5 | Urban | Pensioner |
| Participant 13 | Male | 41-50 | Single | Black | High School | Grandson | English | 8 | Rural | Unemployed |
| Participant 14 | Female | 31-40 | Married | Coloured | Technicon | Daughter in law | Afrikaans | 6 | Urban | House wife |
| Participant 15 | Female | 31-40 | Separated | Black | Primary school | Second cousin | English | 4 | Rural | Unemployed |
| Participant 16 | Female | 41-50 | Single | Black | None | Niece | Afrikaans | 2 | Urban | Unemployed |
| Participant 17 | Female | 51-60 | Married | Black | Primary school | Sister | Afrikaans | 2 | Rural | Domestic worker |
| Participant 18 | Male | 18-30 | Single | Black | None | Nephew | Afrikaans | 1 | Urban | Unemployed |
| Participant 19 | Female | 18-30 | Single | Black | Primary school | Daughter | Afrikaans | 7 | Urban | Unemployed |
| Participant 20 | Female | 61-70 | Widowed | Black | None | Son | Afrikaans | 3 | Urban | Pensioner |
| Participant 21 | Female | 61-70 | Divorced | Black | None | Sister | Afrikaans | 6 | Urban | Unemployed |
| Participant 22 | Female | 41-50 | Married | Black | College | Friend | English | 6 | Urban | House wife |
| Participant 23 | Female | 41-50 | Single | Black | None | Daughter | Afrikaans | 12 | Urban | Unemployed |

| Name | Gender | Age group | Marital status | Race | Highest level of education | Relationship to older person | Language | Experience as informal caregiver (years) | Residence | Employment status (current) |
|---|---|---|---|---|---|---|---|---|---|---|
| Participant 24 | Male | 41-50 | Single | Coloured | High School | Son | Afrikaans | 2 | Urban | Unemployed |
| Participant 25 | Female | 18-30 | Single | Black | College | Daughter | Afrikaans | 3 | Urban | Student |
| Participant 26 | Male | 61-70 | Single | Black | Primary school | N eigbour | Afrikaans | 5 | Urban | Pensioner |
| Participant 27 | Female | 41-50 | Single | Black | High School | None | English | 0,4 | Rural | Student |
| Participant 28 | Male | 31-40 | Single | Black | High School | Grandson | Afrikaans | 4 | Urban | Unemployed |
| Participant 29 | Female | 61-70 | Single | Black | None | Boyfriend | Afrikaans | 9 | Urban | Pensioner |
| Participant 30 | Female | 41-50 | Single | Black | None | Granddaughter | Afrikaans | 5 | Urban | Unemployed |
| Participant 31 | Male | 61-70 | Single | Black | None | Boyfriend | Afrikaans | 2 | Urban | Pensioner |
| Participant 32 | Male | 61-70 | Separated | Black | None | Husband | Afrikaans | 3 | Urban | Pensioner |
| Participant 33 | Female | 41-50 | Single | Black | High School | Granddaughter | Afrikaans | 5 | Urban | Clerk |
| Participant 34 | Female | 31-40 | Divorced | Black | None | Sister | Afrikaans | 6 | Urban | Unemployed |
| Participant 35 | Female | 41-50 | Single | Black | High School | Daughter | English | 11 | Rural | Unemployed |
| Participant 36 | Female | 31-40 | Single | Black | Primary school | N eigbour | Afrikaans | 1 | Urban | Unemployed |
| Participant 37 | Male | 41-50 | Single | Black | University Degree | Grandson | English | 8 | Urban | Unemployed |
| Participant 38 | Female | 61-70 | Married | Black | None | Wife | English | 10 | Urban | Pensioner |
| Participant 39 | Female | 31-40 | Single | Black | High School | Niece | Afrikaans | 9 | Urban | Unemployed |
| Participant 40 | Female | 31-40 | Single | Black | College | Daughter | English | 5 | Urban | Unemployed |
| Participant 41 | Female | 51-60 | Single | Black | High School | Cousin | English | 7 | Urban | Unemployed |
| Participant 42 | Female | 31-40 | Single | Black | None | Cousin | English | 7 | Urban | Unemployed |
| Participant 43 | Male | 18-30 | Single | Black | High School | Grandson | English | 2 | Urban | Unemployed |
| Participant 44 | Female | 61-70 | Single | Black | High School | Friend | Afrikaans | 0,7 | Urban | Pensioner |
| Participant 45 | Male | 51-60 | Married | Black | None | Husband | English | 8 | Rural | Pensioner |
| Participant 46 | Other | 61-70 | Single | Coloured | High School | Partner | Afrikaans | 6 | Urban | Cleaner |
| Participant 47 | Female | 51-60 | Married | Black | High School | Sister | English | 8 | Urban | House wife |
| Participant 48 | Male | 41-50 | Single | Coloured | High School | Son | Afrikaans | 5 | Urban | Casual worker |
| Participant 49 | Male | 18-30 | Single | Coloured | High School | Grandson | Afrikaans | 1 | Urban | Student |
| Participant 50 | Female | 41-50 | Single | Black | High School | Granddaughter | English | 3 | Urban | Unemployed |

### 4.4.2 Gaining access to research participants

According to Babbie (2016), planning for fieldwork includes various methods of gaining access to study participants. Therefore, the researcher established initial contact with study participants in different ways, depending on whether they were key informants, formal, or informal caregivers. With the formal caregivers, the researcher obtained a database of registered old age and nursing homes, as well as caregiving institutions that fall under the Ministry of Health and Social Services. These institutions receive government subsidies, and are therefore legally required to register with the state, so the data were readily accessible.

In order to gain access to key informants, the researcher wrote introductory e-mails (appendix 1) to the respective NGOs and government departments dealing with social welfare issues relating to older persons. In this way, the researcher was able to access the responsible individual who could make information available to answer the research questions with relative accuracy. The interviews were conducted at the offices of the responsible persons to ensure easy access to information (Bernard, 2017).

To access informal caregivers, the researcher contacted the Regional Councillor for the Katutura Central Constituency office for information on possible research participants in their communities. However, greater reliance was placed on the use of snowball sampling to ensure participation.

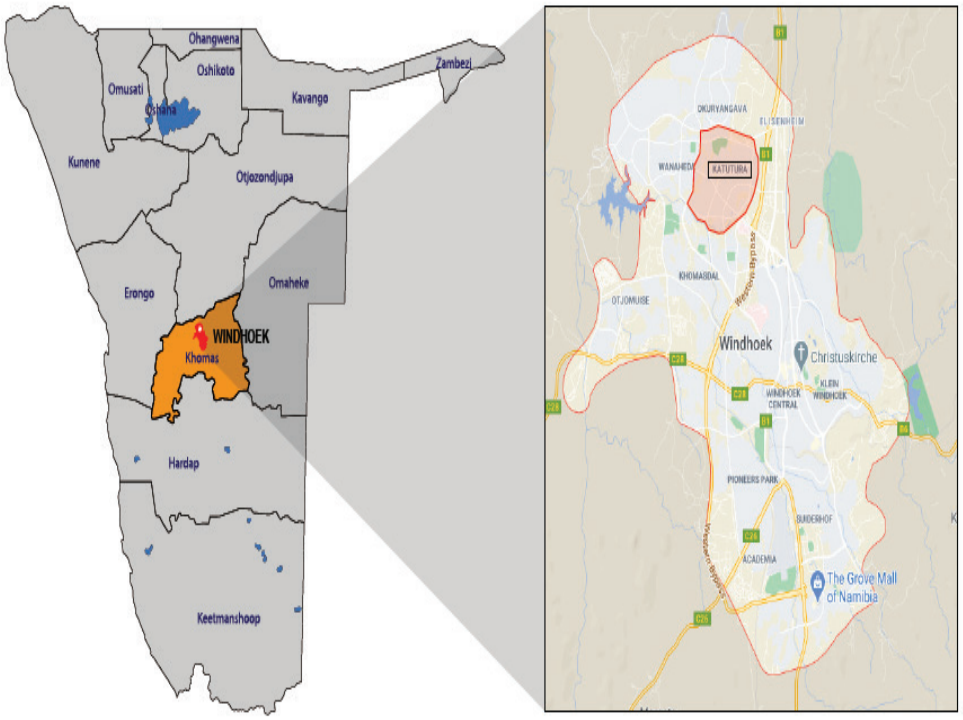


Figure 12: Map of Namibia with an insert of Khomas Region of Namibia
Source: Google Maps


Figure 13: Map of Katutura in the Khomas Region of Namibia
Source: Google Maps

### 4.4.3 Data collection

According to Creswell (2014), data collection refers to the interwoven information gathering activities necessary to answer the study questions. No specific method exists for data collection in qualitative methodology (Bernard, 2017). However, the study used the following instruments to collect qualitative research data:

**4.4.3.1 Pre-testing and piloting of interview instrument.** To improve the overall quality of the research and enhance reliability, the pre-research process of instrument pre-testing and piloting of participants is critical (De Vos et al., 2011). In terms of pre-testing, the interview guide (Appendix 2) was administered to five informal caregivers living in the researcher's neighbourhood based on convenience sampling to ensure that the wording and language were clear, logical and unambiguous. This led to minor changes in the language of the interview guide. The method of piloting in qualitative studies mimics the actual research by testing the usefulness of the interview schedule in achieving the research objectives, using a limited sample (Williamson & Lancaster, 2004). Overall, the research instrument verification process was preceded by a study with a separate, smaller sample of study participants consisting of formal and informal caregivers in Khomasdal (a contiguous neigbourhood in the Khomas Region with similar characteristics as that of Katutura). One focus group consisting of five caregivers (about 10% of the sample) was held as a pilot study to ensure an error-free and effective research process. During the pilot stage, the researcher also verified ethical considerations and checked the use of informed consent, which is useful in obtaining the required permission.

Overall, on average the pilot interviews lasted 35–70 minutes at a time. Importantly, the researcher also had a look at the logical flow of questions in the interview schedule, and this proved satisfactory. The pilot study ensured feasibility and guided the researcher in making the necessary adjustments to the research instrument for a credible research process. The pilot process also gave the researcher enhanced confidence and initial first-hand experience in conducting the research. The outcome of the pilot testing for both formal and informal caregivers was successful and contributed to the internal consistency of the study, ensuring that each question in the research instrument was covered with sufficient clarity and depth to elicit credible information from participants (Van Teijlingen & Hundley 2001). Based on the input of participants during pilot testing, the research instruments had to be revised to avoid duplication. For example, during pilot testing, it became apparent that some interview questions on legislation were too technical and difficult for informal caregivers to understand. Based on this outcome of the pilot study, some of the questions in the interview schedule dealing with legislation were adjusted for easier understanding by informal caregivers. Also, the use of legal jargon (such as references to statutes, etc.) was eliminated and replaced with appropriate vocabulary to ease and enhance understanding.

**4.4.3.2 Interviews.** Semi-structured interviews were used for informal caregivers as the data instrument promoting open conversation and improved understanding of the connections between people and their natural settings (Saunders et al., 2016). Interviews are convenient for purposes of clarification, and the semi-structured approach offers flexibility in the event of unanticipated scenarios and allows for more in-depth inquiry into the responses (Tanggaard, 2009). According to Kvale and Brinkmann (2009), the interview process consists of the following seven stages, as outlined in Figure 14 below:

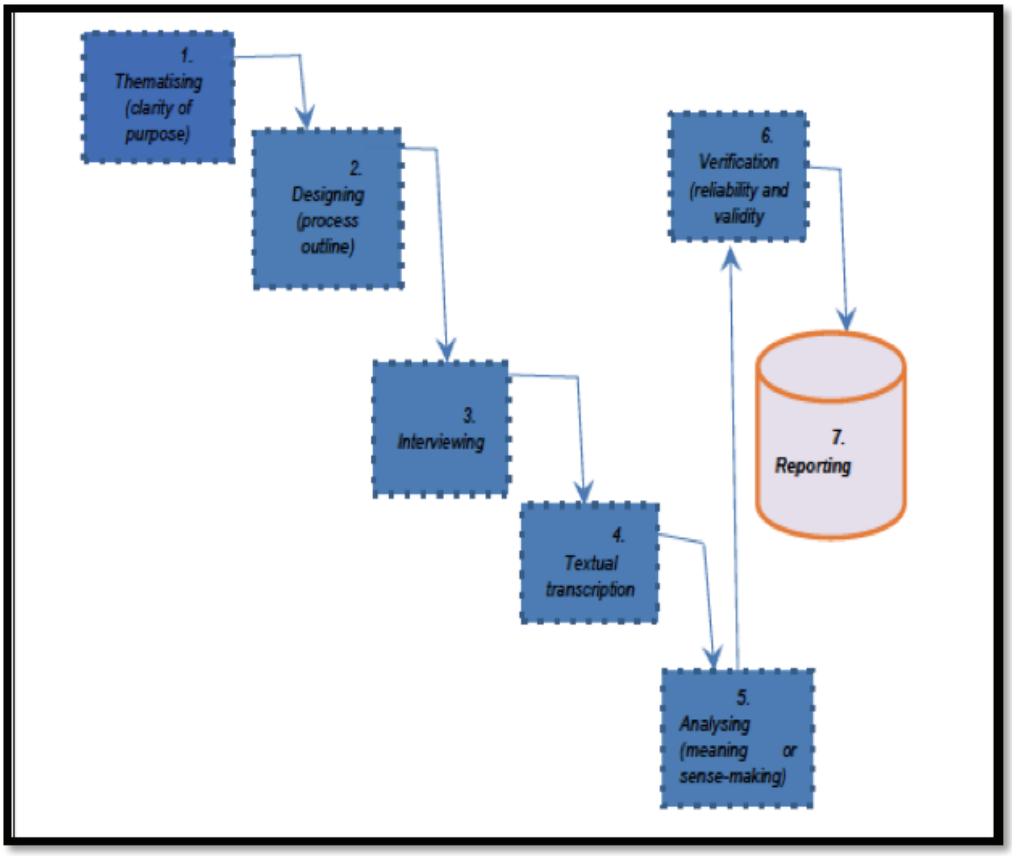


Figure 14: Seven stages of the interview process
*Adaptation from Kvale and Brinkmann (2009, p. 97)

Using the above stages, the researcher designed the interview schedule (see Appendix 3) based on the literature review and research questions. The research data were primarily obtained from semi-structured interviews and focus groups with formal caregivers, informal caregivers and key informants in Windhoek (which includes Katutura), within the Khomas Region of Namibia.

**4.4.3.3 Focus groups.** the focus groups were made up of formal caregivers and were used as part of a qualitative approach to gaining an in-depth understanding of the needs of frail older persons from the perspectives and experiences of formal caregivers. The focus groups served to develop ideas collectively on the needs of frail older persons. The purpose of the focus groups was to engage in guided semi-structured discussions facilitated by the researcher, using the interview schedule (Krueger, 2014). The focus group or group interviewing was semi-structured and created a systematic framework for collective interviewing of formal caregivers in a group (Saunders et al., 2016). Focus groups can consist of five to fifteen participants at a time (Krueger, 2014), but in this study, twenty three formal caregivers participated in five focus groups made up of five persons per focus group setting. The focus group participants were

a small group of five formal caregivers who had been purposefully selected by means of open-ended questions. The researcher acted as the moderator and facilitated the discussions between the participants.

**4.4.3.4 Data collection process.** Data were collected over six months from October 2019 to March 2020. The interviews and focus group were audio-recorded to capture the conversations in real time and with minimal disruptions. The data collection process was mainly carried out by the researcher with the backing of two research assistants whose responsibilities included assistance with logistical matters, processing informed consent from participants, assisting with audio recordings, keeping accurate records, assisting in actual fieldwork, acting as guides on visits to the townships, and assisting with translations during the interviews. There were, however, some areas in Katutura where the research team was assisted by members of the community to ensure safety, trust and goodwill towards the researcher's team. Furthermore, the referee informal caregiver (or person nominated by the informal caregiver) mostly accompanied the research team to the referred informal caregiver. The introduction and handover to the next informal caregiver ensured some level of trust, which was required to initiate contact. On average the interviews took between one hour and one-and-a-half hours to complete. During this process member checking was also an integral part of the research process. In this regard, member checking was essential to go back to participants where clarification of information was required from the informal caregivers to ensure accurate understanding of perspectives. The interviews took place at the residences of the informal caregivers. The interviews were conducted mainly in English but translations were sought where needed. Most informal caregivers preferred to speak in a language they were comfortable with and in which they found it easy to express themselves.

The focus group sessions were arranged in consultation with various care managers and took place at the agreed times and at the premises of the formal caregiving institutions. The focus groups consisted of invited participants, along with the researcher and two research assistants. The researcher acted as the moderator and the assistants helped out with the logistics, scheduled appointments, and obtained informed consent from participants, while managing the recordings and translations during the discussions, especially in the local languages. Most of the formal caregivers were conversant with English and Afrikaans, hence most of the focus groups were conducted in both languages; however, there were instances where translation was sought for other local languages. For this reason, the focus group interviews took much

longer and lasted between one-and-a-half and two hours compared to the shorter interviews with the informal caregivers. The design of the interviews and focus groups took into consideration the need for a study context and for participants to openly discuss their experiences relating to the research phenomena (Dante, 2015). The interview and focus group processes also allowed for continuous clarification and opportunities to make sure that there was consensus with participants at all times (Carlson, 2010).

Another important consideration for the interviews and focus groups was the requirement for a convenient, safe, comfortable and conducive environment in which participants could share information without interruptions and with honesty. The researcher was accompanied by various members of the community to ensure her safety, but also to help to give the participants a warm reception and help ease the research process by informing the participants of our roles and describing the nature of the research. The researcher is fluent in English, Otjiherero and Afrikaans, has a basic understanding of the Khoekhoegowab, Oshiwambo and Setswana languages and was able to keep translations transparent and credible. This means that minimal translations were necessary by the research assistants and accompanying community members for some of the translations. The arrangement with the research assistants was structurally formalised to ensure observance of the research ethical requirements like confidentiality, competence etc. Because the researcher is familiar with multiple languages, she was able to ensure that meaning was constant and no material information was lost in translation. In fact, there were not many instances where translation was needed since most of the older generation of informal caregivers were conversant with both Afrikaans and their mother tongue. On the other hand, the younger generation of informal caregivers could only communicate effectively in English, making translation unnecessary. Furthermore, the researcher checked and validated the interview responses by discussing and clarifying the answers with each participant. The same process was followed with focus groups to ensure that all the information had been correctly captured and nothing left out, especially in instances where translations were necessary (Onwuegbuzie et al., 2009). The process of clarification of interview responses is necessary and important to ensure clarity and a true reflection or representation of findings is being provided (Leedy & Ormond, 2014). The academic purpose of the study was explained to the participants and no incentives were provided to participants.

For formal caregivers, the data collection process started with the researcher first making phone calls and sending e-mails to the department of social

services, NGOs, places of worship and other civic service organisations to obtain the requisite database for registered frail older persons. Regarding the unregistered caregiving institutions (Mkhwanazi, 2015), the Ministry of Poverty Eradication shared a database of some frail older persons who were receiving either state old-age pensions or disability grants, and who were under informal care. This information was beneficial in that it directed the researcher to more informal caregiving institutions in the community. When conducting the focus group interviews, the researcher administered the consent forms, alerted the participants about the purpose of the study and informed them that it was voluntary and that withdrawal was an option at any time if the need arose. Additionally, the participants were informed that anonymity and confidentiality were guaranteed and that no harm would come to them as a result of participation in the study (refer to the discussion on research ethics under 4.5.7 below). Before the commencement of the interviews and focus group discussions, the researcher also obtained permission to start the process. Before ending the interviews and winding up the focus group, participants were asked whether they wanted to add anything further or subtract anything from the data provided. Participants were thanked for sharing their experiences of and information about the needs of frail older persons.

Using the specifically devised interview instrument (Appendix 5) to solicit answers on the legal and policy environment, the researcher conducted the semi-structured interviews with key informants. All five interviews with key informants were recorded verbatim and the process was characterised by an atmosphere of professionalism and cooperation. All the key informants had long service in their government and civic positions and had an adequate knowledge of the legal and policy developments relating to older persons. This was most useful in getting reliable information about the regulatory position and understanding government thinking on issues affecting older persons. In terms of capturing information, at the end of each interview a summary was made of relevant issues and themes that were raised by key informants in order to gain deeper insight into the legal and policy aspects relating to the needs of frail older persons.

The qualitative data collected from the interviews and focus group constituted the foundation for analysis in the study. Nevertheless, since the study set out to explore the perspectives of caregivers, it was necessary to keep memos to ensure a better understanding of the information derived from interviews and focus groups (Sherwood, 2011). This process of reflective journaling during fieldwork denotes the conceptual aspect of exploring complex research

phenomena in a social setting and is essential as a source of qualitative data. The concept of “memoing” was considered an important strategic tool during the entire research process. Furthermore, analytical notes may also reflect any relevant ethical dilemmas and important observations during the fieldwork, which could augment data interpretation and analysis (Birks et al., 2008). Although verbatim transcriptions of the interview data are not always necessary, especially in a thematic study (Smith & Davies, 2010), the researcher exercised caution in order to ensure that the subjective narratives of the participants were credibly recorded as part of data collection and therefore transcribed everything.

## 4.5 DATA ANALYSIS

According to Creswell (2014), the data analytical process clarifies the structural components of the collected data revealed by complicated relationships and emerging themes within the holistic and unified context of the research. In other words, data analysis affords systematic meaning to information on the basis of selected analytical methods (Leedy & Ormrod, 2014). Thus, the use of ATLAS-ti version 8.0 provided systematic structure to the collected data in order to allow better organisation and interpretation (Hyldegård, 2006). Given the unstructured nature of the large volume of textual data, the researcher would not have been able to effectively and successfully conduct an analysis without a powerful system like ATLA-ti.

As indicated, the primary data of the study were obtained in the course of semi-structured face-to-face interviews with key informants and informal caregivers, as well as interviews with focus groups with formal caregivers. The credibility of the study outcome depends largely on the cogency and veracity of the data analytical process (Stephan, Möhler, Renom-Guiteras & Meyer, 2015). Accordingly, this was mainly achieved by using ATLAS.ti as a reliable data analytical tool in addressing the research objectives described below.

### 4.5.1 Qualitative data analysis Atlas.ti 8.0 software

Atlas.ti 8 software was used to code and identify themes from raw data. This data coding process revealed patterns, relationships and themes which could be analysed to give meaning to the interview data collected from participants in answering the research questions (Stake, 2010). The study followed a staged data coding and theme identification process as fully described in the integrated analytical process under atlas.ti below. The process is integrated because the data

analytical tools automatically compare and identify common themes emerging from the data using constant comparative analysis (Elliott, 2018). The study used atlas.ti 8.0 software to conduct data analysis. The process computer software helped to achieve cost-effectiveness, simplify the coding process, ensure the robustness of emerging themes and enhance conceptual, theoretical understanding of the study phenomena (Barry, 1998). In so doing, the audio-recorded data were transcribed and coded using atlas.ti version 8.

Therefore, the interview data loaded into atlas.ti version 8.0 were first checked for accuracy by close reading and re-reading to ensure that all the relevant points capturing the essence of the research were covered in the narratives (Creswell, 2014). After the successful loading of the qualitative data into the computer-assisted software, the researcher started data analysis with the aid of the coding process. In social research, coding refers to the conversion of words into codes or data clustering to facilitate data analysis, interpretation and triangulation (Saldaña, 2016). Through the coding process, the data were converted or broken down to reveal patterns or themes in line with the research objectives and research questions (Elliott, 2018). In this way, coding becomes an analytical experiment to see what contours the data take on when taken apart and meaningfully put together again to explain the research phenomena. As a function of the automated software approach under ATLAS-ti, the coding process was at all times seamlessly anchored and informed by the exploratory purpose of the research (Creswell, 2014).

In terms of process, Fries at el. (2013) argue that the first step in the ATLAS.ti analytical process is creation of a hermeneutic unit (HU) or single project name within the system domain for all the imported research data. This is mainly used for better organisation and to give the data an initial structure. Therefore, all the research information and the entire automated process are saved under a single HU's digital universe for easier access, retrieval and backups. In other words, primary documents within HU consisting mainly of all transcribed text of interviews and focus groups were digitally created for easier computer-assisted analysis or data coding for interpretation. The consolidated data group manager and overall research project under HU on the ATLAS-ti actual outputs are diagrammatically illustrated in Figures 15 and 16 as follows in relation to study objectives:

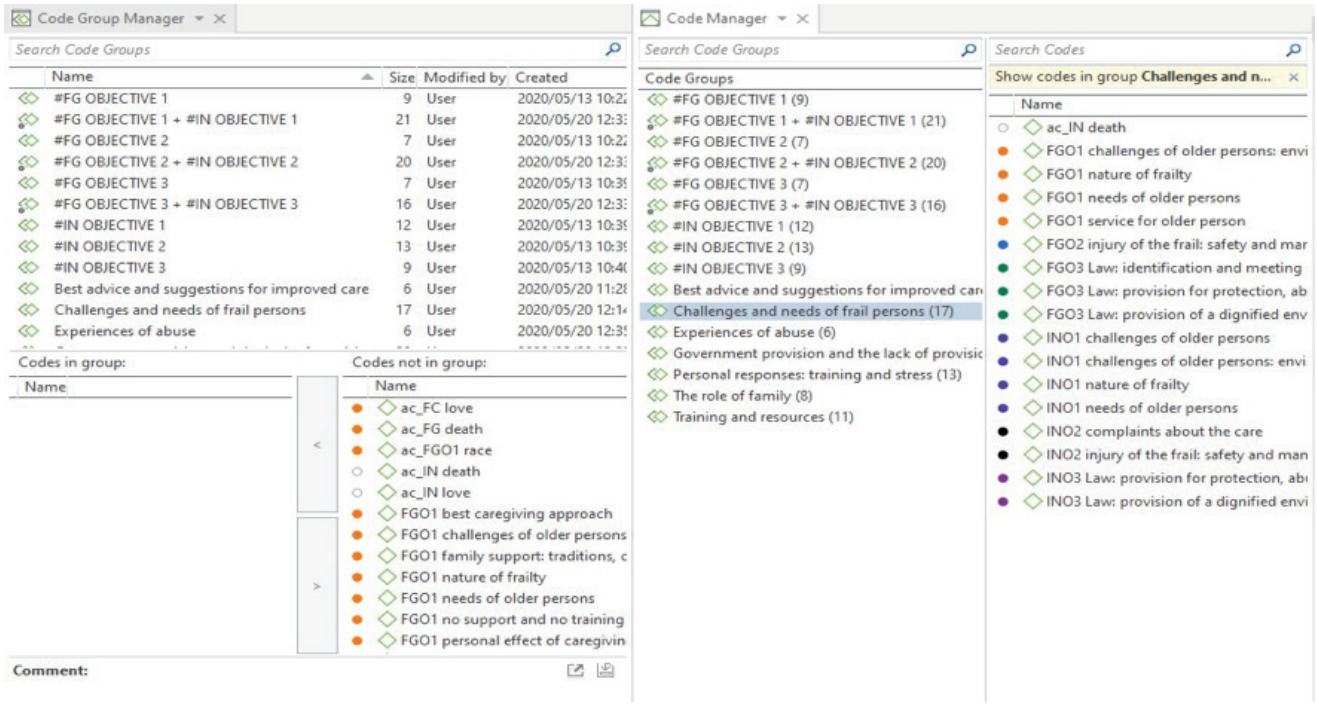


Figure 15: Code group manager under ATLAS-ti

The graphics above shows how the data is populated and coded or summarized in relation to the research objectives. In this regard, the sub-themes emerging from the coded data in answering the various research objectives are illustrated.

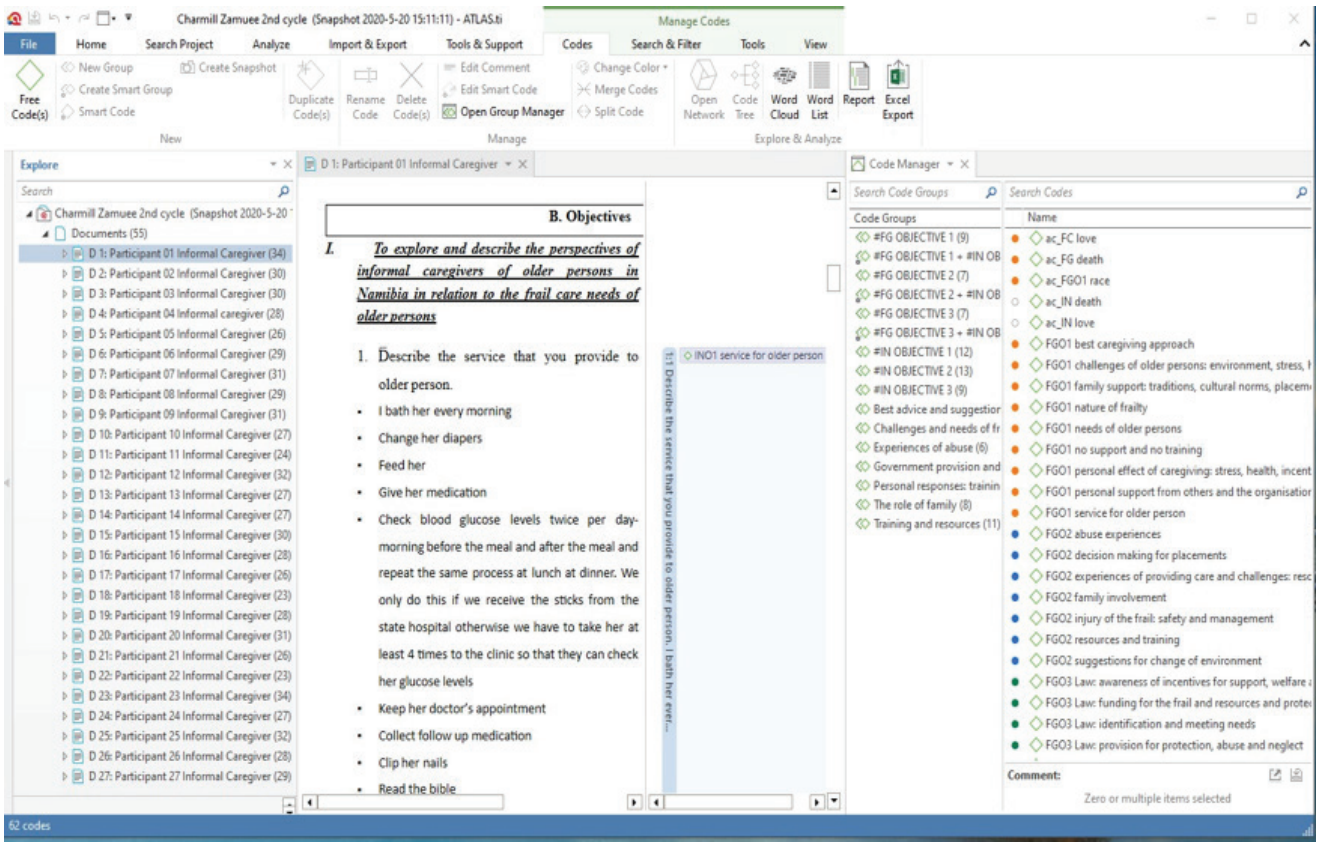


Figure 16: ATLAS-ti research project

Furthermore, the interview and focus group data were inductively coded using three distinct clustering approaches, namely selective coding, open coding and axial coding for meaningful comparisons, connections, classifications and interpretations (De Vaus, 2001). Through the data analysis, the researcher applied Saldaña's (2016) computer assisted coding strategy in stages.

Firstly, open coding was used as a strategy to fragment or split the data into individual parts or key points, from the participants narratives, through what is referred to as in vivo coding based on keywords or metaphors, which enables consideration of even the smallest segments of data to capture meaning (Saldaña, 2016). The process of separation allowed for the identification of separately distinct and yet holistically interrelated themes in the data from interviews and focus groups.

Secondly, to arrive at a representative core category, selective or theoretical coding was used to illustrate an umbrella of the words or core representative phrases used in the data to describe the needs of frail older persons (Theron, 2015). Data comparison is also about similarity, and selective coding was used to reveal mutuality of family relationships in the data.

Thirdly, axial coding was deployed to reconnect or put together the data that had been split under open coding to conceptualise dominant categories in a typological and symbiotic sense (Saldaña, 2016). This is important to highlight the connecting powers of themes arising from the data based on new directions and dimensions of emerging relationships. In other words, using ATLAS-ti, connections and linkages of the generated codes created mapping tools and thematic networks that explain the research phenomenon as follows:

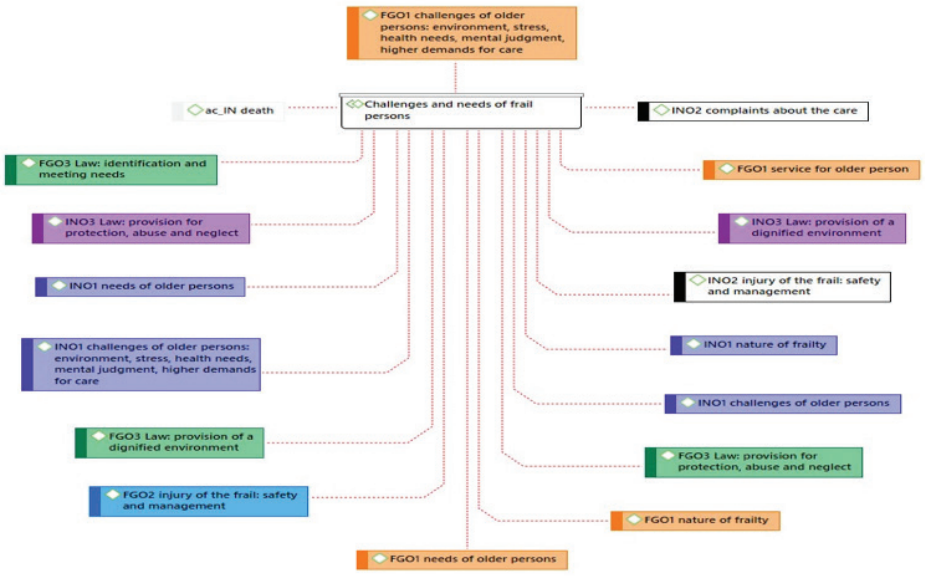


Figure 17: Thematic networks under ATLAS-ti

As is evident from Figure 15 above, at this point the data system output was organised for the interpretation of emerging key themes by using inductive thematic analysis for the research objectives and research questions (Denzin & Lincoln, 2011). In other words, the summarized themes and sub-themes arising from coding were examined for meaning in order to explain the needs of frail older persons in Namibia. Finding meaning in data is even more profound in qualitative studies as a core competency, given their subjectivity (Creswell, 2014). According to Schreier (2012), under qualitative content analysis, theory development is inherent in the process of summarising the patterns emerging from the data in explaining the research phenomena, as can be seen below. Also, Bryne (2001, p. 1) describes it as a "process of sorting a box of buttons". Therefore, the data coding process was also about making analytical comparisons to determine nuances, similarities and the discriminatory and unifying powers of the emerging themes from the data (Saldaña, 2016). In this way, inconsistencies and contradictions in interviews and focus groups were analytically assessed. Through analytical coding as an iterative process, the researcher was also able to highlight the nature of relationships or families in the data as they point to the deeper needs of frail older persons from the perspective of caregivers. Therefore, in meeting the research objective, thematic networks were developed on ATLAS-ti for each of the objectives, as illustrated by the example in Figure 18 below:

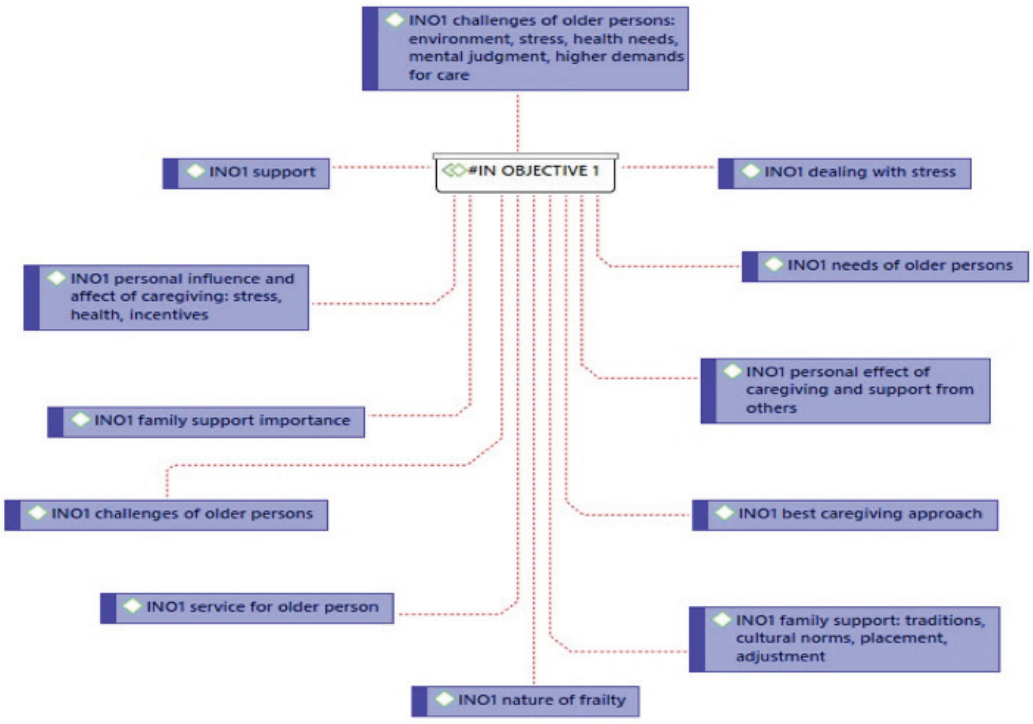


Figure 18: Thematic networks in ATLAS-ti based on study objectives

As a systemic, holistic and integral process, data analysis or coding under ATLAS-ti provided a fertile ground for not only comparisons and categorisations, but also theory development based on the patterns of the data and interpretation by the researcher (Saunders et al., 2016).

### 4.5.2 Qualitative content analysis (QCA)

Qualitative content analysis (QCA) is a data analytical technique used to systematically describe or construct the meaning of qualitative data through the transfer of parts of emerging data to the coding frame components (Schreier, 2012). In other words, the data-driven coding frame under QCA serves as the basis for description and interpretation of the iterative data in explaining the research phenomenon. Based on the above, QCA was an appropriate method of constructing meaning or interpreting data in a flexible and systematic manner around the complex societal problem of needs assessments of frail older persons, which does not in itself admit of a simple explanation or description. Overall, QCA is clearly data reductive (due to interpretation) and was operationalized in the study as described in the following discussion.

The researcher analysed and interpreted fifty interviews and five focus group discussions with the aid of qualitative content analysis, using the coding strategies described by Saldaña (2016). The researcher was guided by the research questions and the interview questions. To this end, the researcher engaged in data reduction, coding and decoding analytical processes to analyse and interpret each of these qualitative data forms in a consistent and systematic manner (Saldaña 2016). These processes unfolded through concurrent and iterative research processes: data collection, transcription of audio-recorded interviews and focus group discussions, and data analysis.

The researcher applied coding terminology and procedures, according to Saldaña (2016). Specifically, the researcher used descriptive codes, process codes and a few in vivo codes, which were created inductively (data-driven without preconceived ideas from theory or experience). In other words, in vivo codes depend largely on extracting or constructing meaning from data based on the actual spoken words of research participants in order to gain a nuanced understanding of the phenomenon (Schreier, 2012). These were later merged with further codes as they were created. In fact, the researcher created a code list or a codebook of 109 codes, which were reduced to 62, with 16 relevant categories, assigning 1856 quotations. This was all done in ATLAS.ti version 8.

This software adds value and sophistication to the coding process, and also provides an audit trail for transparency of the analysis process (Smit, 2005). Smit (2014) describes ATLAS.ti as a powerful workbench for the qualitative analysis of large bodies of textual, graphical, audio, and video data. In the course of the qualitative analysis, ATLAS.ti helped the researcher to explore the complex phenomena hidden in the data. All the responses were loaded into the project function, a container for all the data, for subsequent coding. Coding is the procedure of associating code words with sections of data or quotations; it is the association between a quotation in the text and a specific code. In linking data, and collecting and interpreting the data, coding is the basis for developing the analysis. The researcher clustered codes into 16 groups, referred to as categories in the literature, and created seven descriptive thematic outputs, which were reduced to four themes.

### 4.5.3 Key informant interview data analysis

The interview data from key informants were summarized and then classified using content analysis, which is a qualitative interpretive technique that helps with thematic deductions from the data (Bowen, 2009). Therefore, certain words from the interview were categorized and then assessed for common themes through conceptual analysis, which is a data summarizing technique that falls under content analysis (Patton, 2002). This means that the raw spoken words of key informants were summarized and then classified into common patterns to create conceptual synthesis in answering the research questions.

Using content analysis, the interview data from key informants were analysed with reference to the following information domains:

- Adequacy of policy for elderly care and protection
- Knowledge about legal incentives for promotion of elderly care
- Availability of government resources to meet elderly needs
- Participation of frail older persons in policy making
- Policy provisions on standards of elderly care

### 4.5.4 Data verification and trustworthiness

Data verification and trustworthiness. According to Saunders et al., (2016), data verification checks for reliability and validity are important in any study seeking to contribute to the body of knowledge. Although the concepts of validity and reliability are usually associated with quantitative studies (Stenbacka, 2001), contemporary

scholarship postulates that this type of triangulation strategy also extends to qualitative research (Golafshani, 2003).

Therefore, the concepts of triangulation and trustworthiness were used as separate tools to highlight the requirements of validity and reliability in qualitative methodology. According to Patton (2001), the concepts of validity and reliability in a qualitative study refer to their qualities of transferability and trustworthiness, respectively. Quality is measured by the ability of a qualitative study to provide a deeper understanding of a phenomenon that would otherwise be enigmatic (Eisner, 2017). In terms of reliability, the test is replicability of the study results, while validity embraces confirmability as a measure of the rigour of the study (Rolfe, 2006). Qualitative studies should be corroborated by the use of multiple methods of data collection, based on triangulation or trustworthiness (Stake, 2010). In this study, the various sources included face-to-face interviews with key informants, informal caregivers, document reviews and focus groups with formal caregivers. The concept of triangulation, like validity and confirmability, injects credibility into study findings and avoids the accusation of researcher bias (Noble & Smith, 2015). Triangulation added diverse viewpoints on the topic to enhance the credibility of the findings by providing deeper insights into the matter and avoiding potential researcher bias. Credibility in qualitative studies relates to the fit between the data collected from interviews and the interpretation of these data by the researcher (Tobin & Begley, 2004). In this case, multiple data sources were useful in giving the findings greater credibility. Additionally, triangulation of the study was also strengthened through the use of integrated analytical tools under ATLAS.ti that allowed for seamless thematic comparisons in the coding process and different sample sets.

In seeking validity and reliability, this study relied on multiple coding methods, as indicated above, in the construction of reality or the attribution of meaning to data. In this way, the study relied on QCA and ATLAS.ti 8.0 to increase study trustworthiness. For example, the use of these multiple coding approaches was intended to construct meaning through an iterative process of data interpretations and reductions and by so doing also enhance transparency and consistency (Schreier, 2012). Overall, as qualitative analytical software, ATLAS.ti 8.0, by linking and reducing data into descriptive themes and sub-themes, effectively ensured trustworthiness and triangulated the findings for reliability and validity (Saldaña, 2016).

Another aspect of enhancing trustworthiness that is used in qualitative studies is member checking, which prevents problems associated with misunderstanding of participants' responses and narratives from arising and potentially compromising the research (Carlson, 2010). To avoid any misunderstandings, the study relied on

brief clarifications of terms during interviews and focus group discussions and on making sure that there was agreement on what was conveyed. The use of multiple qualitative analytical methods under triangulation and trustworthiness as described above effectively achieved the objectives of credibility, validity and reliability of the study findings (Creswell & Creswell, 2017).

### 4.5.5 Observations

Usually in a qualitative study, general observation, which is similar to participant observation is a critical component of data collection, especially where the study involves complex social issues (Walshe et al., 2012). According to Kawulich (2012), participant observation provides a vehicle for recognition of nonverbal expressions and a window for the way study participants interact and communicate with each other. However, in this study it refers to general observations and not to participant observation, which is a specific research design (Birks et al., 2008). General observations of this kind are distinct from participant observations and are necessary to ensure that the full essence of a matter is captured holistically (Schensul et al., 1999). To capture these general observations during fieldwork, the researcher took notes on empirical observations of what transpired during fieldwork to help with her own understanding and interpretation rather than data collection strategy.

### 4.5.6 Limitations of the study

It is a common cause that there are certain limitations in all research. Some limitations have been experienced in this study and have been managed as follows:

- The study findings are based on a sample of 60 data sets, consisting of 78 participants, and hence not all caregivers' perspectives in Namibia are represented. However, a broader generalisation of the outcomes of the study can be arrived at on the basis of similar demographics and socio-economic conditions.
- In some instances, translation from African languages into English was required during the interviews with the informal caregivers and despite the precautions taken some bias may have entered the process given its qualitative nature.
- The study only used five key informants, which may be a limitation in the generalisation of key informant data although generalisations are usually not expected in qualitative studies.
- Purposive sampling which informed the selection of informal caregivers as study participants on the basis of judgement may have created some form of bias and increased inability to generalise outcomes. This type of potential bias is intrinsic to this sampling method in qualitative studies.

- The time factor in executing the research project and the cost involved operated as a limitation on broadening the scope of the study to other peripheral areas of elderly care.

Finally, while providing focus, the limited scope of the study may have excluded some areas of discourse or perspectives necessary to holistically understand broader phenomenological issues, such as verification of the perspectives of informal and formal caregivers by comparing them to the actual views and experiences of frail older persons themselves relating to their needs. This limitation can be an area for further studies.

### 4.5.7 Ethics

To enable sound ethical judgments, a study must observe a common standard of ethics or morality (Saunders et al., 2016). According to Vosloo (1997), ethical clearance is an absolute requirement for any study that impacts on human beings or society. Ethical clearance was duly obtained from the Research and Ethics Committee of the Faculty of Humanities (Department of Social Development) at the University of Cape Town before conducting the study. This study adhered to the following principles of research ethics:

**4.5.7.1 Informed consent.** Informed consent is critical in research (Coleman, 2009). The researcher obtained voluntary informed consent from participants through the signature of consent forms. A consent form (Appendix 4) that outlines the parameters of the research was designed and the researcher carefully explained the purpose of the study, data management and the ethical requirements before the form was submitted for signature by participants. This ethical approach was taken to avoid any perception of lack of understanding about the nature and purpose of the research and the way permission for participation was obtained. Thus, signature of the consent form by participants signified an understanding that no coercion had been used and participation was voluntary.

**4.5.7.2 The right to confidentiality.** A guarantee of utmost confidentiality is a necessary condition for the ethical credibility of any research (Saunders et al., 2016). From the outset, the researcher advised the participants that their transcribed responses would be kept confidential by her, stored in a safe place and used only for the research. All the transcribed data were password-protected to avoid any untoward electronic breach. Participants were also informed that the final thesis would be kept in the library of the University of

Cape Town for academic use. Reference to any identifying information was omitted, and participants were only referred to by codes or numbers.

**4.5.7.3 The right to anonymity.** Anonymity is an essential component of ethical research (Babbie & Mouton, 2010). The researcher gave guarantees that the personal details of the participants would not be made public. Instead, the researcher used pseudonyms to disguise their real identities and ensure data protection throughout the process. The researcher took every precaution necessary to protect and respect the anonymity of the participants. For example, to ensure absolute anonymity no mention of participants' names or addresses was made during data collection, analysis and reporting of study findings. Even for key informants, functional departmental roles were broadly mentioned in the study without reference to identifiable names or positions. This allowed the participants to retain control over disclosure of their identities and the extent of their contributions. Hence, the true identity of the research participants cannot be linked to the research. This provided a conducive climate for honest, full and frank disclosure of information in the study without fear of identification (Strydom, 2011).

**4.5.7.4 Avoidance of harm.** Avoidance of harm is a necessary guarantee to provide assurances that participation in the research and their narratives will not cause legal, social, physical or psychological harm to participants or reputational harm to their organisations (Cresswell, 2014). From the outset, the researcher informed the participants that the information provided would only be used for academic purposes and that no harm would come their way through participation in the research process (Babbie & Mouton, 2010). The assurance that no harm would result was based mainly on confidentiality, the specific academic purpose and the voluntary informed nature of participation in the research. The participants were given the assurance that upon final submission and approval of the thesis, the interview schedules and audio recordings would be destroyed. Generally, the interviews were conducted in a non-invasive manner and without any harm.

**4.5.7.5 Voluntary participation.** Participants must be encouraged rather than coerced to participate in research, and they have the right to end their participation at any stage, should they so decide (MacNeil & Fernandez, 2006). From the outset, the researcher provided assurances that no coercion would be used to induce participation and that no penalties would be imposed for withdrawal or non-participation in the research (Strydom, 2011). Therefore, after this important point had been explained, participation in the study was based solely on free and voluntary consent.

**4.5.7.6 Observance of human rights.** All participants must be assured that their basic human rights will be respected (Vanclay et al., 2013). Throughout the study process, the researcher respected the right to privacy of participants (by avoiding undue intrusion). For example, prior permission for audio recordings was obtained from participants and recordings were made at their convenience. Overall, the study ensured that the rules of academic ethics and data protection as laid down in the University of Cape Town ethics guideline were fully adhered to at all times. As for the professional nurses as a category of formal caregivers no ethical clearance was necessary from the Ministry of Health and Social considering that the participants were retired nurses employed directly by care institutions. Furthermore, the researcher ensured that throughout the research process no invasive procedures or unjustifiable experiments were carried out with participants (Petros, 2011). The practice followed was to meet the participants at a convenient time in the safety of their dwellings and support environment.

## 4.6 CONCLUSION

This chapter described the research methods, design and analytical process followed in conducting the study. The study embraced a constructivist approach grounded in a qualitative methodology. To this end, an interpretive epistemology was used to gain experiential understanding of the needs of frail older persons.

In terms of sampling, a purposive and snowballing techniques were used. Thus, semi-structured interviews and focus groups were deployed for data collection after piloting protocols were observed. The empirical data was transcribed and analytically coded using ATLAS-ti 8 based on qualitative content analysis. The data analysis yielded seven themes, which were analytically reduced to four themes to explain the needs of frail older persons. In addition, the secondary method of data collection consisted of reviewing various documents, including legislation, government policy and reports. The use of multiple methods of data collection ensured the validity and credibility of this qualitative research.

Finally, despite the limitations, the study outcome was able to explore and describe the social issues relating to the needs of frail older persons in Namibia and has achieved transferability within its bounded context. Furthermore, the ethical issues were discussed and there was overall compliance with standards of confidentiality, anonymity, avoidance of harm and voluntary participation.

# Chapter 5 RESULTS/ FINDINGS

## 5.1 INTRODUCTION

The previous chapter outlined the research design and methodology used in the study to answer the research questions. As explained, an interpretive constructivist study design was chosen to explain the phenomenon of frail care needs of older persons in Namibia. In other words, the case or unit of analysis pertains to the subjective views of participants as expressed in the focus groups and semi-structured interviews. However, these findings must be focused on comprehensive outcomes to achieve the research objectives. Following this approach, the study has opted to report the study findings on an integrated basis in accordance with the research questions and objectives. In other words, the empirical reflections of both the informal caregivers and the formal caregivers have been organised around the common emerging themes in the data. The emerging themes constitute the units of meaning in relation to the phenomenon raised in the study, based on an iterative process of data reductions or coding under qualitative content analysis (Saldaña, 2016). Therefore, this chapter describes the findings in relation to the frail care needs of older persons in Namibia from the perspectives and experiences of formal and informal caregivers.

The interview reflections of informal caregivers are presented under "*Participants*" while focus group participants are reported under "SFG" (computer generated acronym/code) with formal caregivers followed by reference decimals, as follows:

- *Participant* 01 (D1) (2537:3039) for example is an informal caregiver and is listed as **Participant 01.** In ATLAS.ti 8, the **(2537:3039)** numerals refer to the character counts of the verbatim quotations. **D1** refers to the first interview document: research participant 01, who is an informal caregiver, in the ATLAS.ti 8 project. This pattern was followed throughout.
- A similar process was followed with the focus group whereby the formal caregivers' focus groups were also labelled, viz (SFG) (D51) (7426:7653) – Formal caregivers focus groups are referred to as **SFG** in ATLAS.ti 8. The numerals (**7426:7653**) refer to the character counts of the verbatim quotations which consists of numbers . **D51** refers to the first focus group in the ATLAS.ti 8 project. This pattern is followed throughout.

Overall, the empirical data are presented and contextualized in accordance with the specific research objectives. Accordingly, the four significant themes that emerged from the data, which are presented as follows:

- Specific perspectives of caregivers relating to frail care needs
- Experiences of caregivers in providing frail care to older persons
- Regulatory support system
- Recommendations for the frail care environment

Each of these main themes is supported by sub-themes, which provide descriptive details on the research phenomenon. The sub-themes are followed by a number each which refer to the number of times the sub-theme has been quoted in the data overall. The themes and sub-themes are illustrated in relation to the research objectives as follows:

Table 5: Research findings: Themes and sub-themes

| Research objectives | Theme | Sub-themes |
|---|---|---|
| To explore and describe the perspectives of informal and formal caregivers of older persons in Namibia in relation to the needs of frail older persons. | *Theme 1:*<br><br>Perspectives of informal and formal caregivers on the needs of frail older persons | Need for food (152)<br>Need for hygiene, sanitation, water and electricity (147)<br>Need for family support (120)<br>Need for integrated care (95)<br>Need for improved living conditions and housing (92)<br>Need for access to healthcare (83)<br>Need for mental health support (82)<br>Access to information (67) |
| To explore and describe the experiences of informal caregivers and formal caregivers in providing care to frail older persons | *Theme 2:*<br><br>Experiences of caregivers in providing care to frail older persons | Abuse (92)<br>Care burdens (83)<br>Training for caregivers (69)<br>Traditions, cultures and religion (59)<br>Institutional placements in old age homes (55)<br>Falls by frail older persons (52) |
| To determine the extent to which the Namibian constitutional, legal and policy (regulatory) environment supports the needs of frail older persons | *Theme 3:*<br><br>Policy and legal framework for needs of frail older persons | Awareness of policy and laws dealing with needs of frail older persons (28)<br>Funding for frail care needs of older persons (48)<br>Policy to protect frail older persons from abuse and neglect (43)<br>Framework for a dignified care environment for frail older persons (65) |
| To recommend useful social welfare models towards understanding and addressing the needs of frail older persons in Namibia | *Theme 4:*<br><br>Recommendation for suitable frail care model for dealing with the needs of frail older persons | Improve overall welfare support (71)<br>Increase social grants (92)<br>Build more old age homes (53)<br>Provide dignified care to frail older persons (56) |

The combined data gave rise to four emergant themes. However, to reveal the unique perspectives and nuanced experiences of the caregivers, the study findings are presented separately for the formal and informal caregivers.

## 5.2 THEME 1: PERSPECTIVE OF FORMAL AND INFORMAL CAREGIVERS ON THE NEEDS OF FRAIL OLDER PERSONS

This theme is explained in terms of various sub-themes covering the needs of frail older persons. Based on the empirical data, the specific needs are expressed in terms of food, water and electricity, living conditions and housing, healthcare, emotional, social and cultural support. These needs are discussed as follows:

### 5.2.1 Informal caregivers

The various narratives of informal caregivers described the following as the most basic needs of frail older persons in the care environment:

**5.2.1.1 Sub-theme 1: basic food.** Most caregivers to frail older persons are finding it difficult to enjoy quality of life due to a shortage of food in their households. In explaining these circumstances, Participant 02 (D2) (1762:3108) speaking about an older man whom she was caring for stated:

> He survives on handouts from people. He is not properly nourished. His food is very expensive and we can barely feed him anything. The doctor prescribed all this fancy food that we can't afford. He has to eat 2–3 fruits and 3 vegetables every day, but our priority of maize meal to keep him alive.…

The general shortage of food was a repeated theme in the narratives of many informal caregivers. In the same vein, Participant 05(D 5) (2497:2696) said:

> "He is hungry and has no food to eat most of the time, but we are coping with what we buy with the pension monies we get from government."

On this issue, Participant 21 (D21) (2414:3004) said that:

> We are poor and unemployed and don't have enough to feed her. She can go for a day without eating anything if we don't' find food. She is lucky if she gets to eat one meal a day. She doesn't have food to eat and when we do get something it's not enough to nourish her and all of us at home. Although we need a balanced meal with veggies, meat and so on, the reality is we can't afford anything but only porridge at the moment …

Some informal caregivers described the food situation in the care environment as reaching starvation proportions due to a persistent lack of food. In the words of Participant 29 (D29) (2392:2673):

> "He is starving and has nothing to eat because we don't have any food in the house…his health is also getting bad because he is losing weight quickly".

Participant 34 (D 34) (9458:9514) concurred and said the following:

> "We are poor and the food is not enough to feed everyone in the household. We are eating anything that we can get our hands on because it is really tough here."

According to Participant 44 (D44) (7145:7312):

> She is poor and has nothing to eat on most days, but the real problem is lack of money to buy food. The shops are full of food, but we cannot afford to buy this, making us suffer from hunger.

It is clear from the direct perspectives of informal caregivers that there is a general shortage of food, as this was consistently referred to as compromising the wellbeing of the frail older persons.

**5.2.1.2 Sub-theme 2: access to hygienic sanitation, water and electricity.** The informal caregivers deprecated the current situation where there is lack of access to basic utilities like water, electricity and proper sanitation. From their perspective, many households providing care to frail older persons are in need of clean drinkable water, proper ablution facilities and electricity for cooking and lighting. Most study participants repeated the statements of Participant 06 (D 6) (2421:2497) that "we don't have access to clean water and electricity at home" and Participant 08 (D8) (2698:3146) that:

> I am collecting water from very far and it is costing lots of money every time I go there and it is also not safe, especially at night. The shack where we all live, including this older person I care for, does not have water and electricity and so for washing, cooking and cleaning water must be collected from the municipal taps.

The challenges relating to access to water in the informal care environment mean that frail older persons cannot take regular and proper baths or have access to adequate sanitation. This view was expressed by Participant 13 (D13) (1902:2059), who said:

> Because of lack of water, there is also no proper toilets and we use the bushes for relief. There is a definite need for ablutions, even mobile toilets for now will do…so that sick old people who cannot walk can use it. Our neighbourhood is not very safe for women and because of that it is not safe for her to use the bush even…

In support of this perspective, Participant 19 (D19) (1244:1464) said:

> This place is unhygienic and dirty where we stay and we urgently need water and toilets with proper sewerage. I do my best as caregiver and at the moment can only wipe her face with a cloth every other day. Water is also not free at the taps because of this I only bath her in a small tin basin when she needs to go somewhere like to the hospital.

The lack of access to electricity has meant that caregivers are forced to resort to firewood for natural energy for cooking, as explained by Participant 08 (D8) (2698:3146):

> All our food is cooked outside using firewood which we have to buy from vendors because I don't have anyone else to look after her if I go to the bush looking for wood…we need electricity for cooking and also lights.

Those informal caregivers who are connected to electricity and running water complain about the high cost of these services. According to Participant 22 (D 22) (2385:2892):

> Our water and electricity were cut off by the municipality long time ago, and we use candles for lights and nature for toilet……we need these services reconnected so that we can provide better care to the sick old person here… the house has electricity and water connected, but not working so how does it benefit the poor…you see even now she has no drinking water and this candle can even burn the house by accident.

On the same issue, Participant 18 (D18) (1277:3270) said that "life is very expensive in Katutura and we just can't afford water and electricity from the municipality*".* The data highlighted two different scenarios around access to basic utilities. The one is outright lack of access due to unavailability of infrastructure while the other is unaffordability, which creates barriers to enjoyment of utilities. This point came across very strongly whereas most of the other perspectives above referred to lack of toilet facilities, water and electricity.

***5.2.1.3 Sub-theme 5:*** improved living conditions and decent housing. Many informal caregivers described the relatively poor living conditions and inadequate housing under which care is provided to frail older persons. The first aspect of poor living conditions revealed by informal caregivers related to overcrowding in the care environment. This is largely due to shared accommodation between the informal caregivers, frail older person and other extended family members. Participant 18 (D18) (1277:3270) explained the overcrowding situation and the need for improved living conditions as follows:

> We are 10 people living together in a shack. He sleep with me, my step child and 2 nephews on one side of the shack and in the other corner sleeps my mother, my girlfriend, and my 3 children divided by just a bed sheet to indicate the boundaries of the house and keep the males to one end and for the privacy for the woman in the house. We need a bigger house and creation of more favourable living conditions that will make it possible for me to provide better care to him. Like this we can easily spread diseases to each other because there is hardly no space for keeping alone.

In describing the needs in relation to decent housing and the consequences of these poor living conditions of frail older persons, Participant 30 (D30) (7367:7552) stated that:

> There is no decent living when we are 9 people living in one room shack that serve as a complete house for us all. Over and above the small living space, it becomes tough for her in rainy season or in the winter, the floor gets too cold for her to sleep properly…the need for living conditions to improve is urgent and government must come to the assistance of frail older people and build proper and comfortable houses.

In addition, Participant 21 (D21) (2414:3004) stated:

> We are in dire need of proper and suitable houses for frail older persons to live comfortably…now due to overcrowding there is no privacy as we are forced to share a one-bedroom shack with the rest of the other family members.

The need for improved living arrangements and decent housing was repeated by Participant 14 (D14) (2225:2310), who made the following sharp comment:

> Yes, the current conditions do not even allow me to properly store her medication given the limited space. She needs a better house for more privacy and the current living arrangements can be a challenge, especially when the kids get home from school.

In making out a case for the need for improved living conditions and decent housing, most of the informal caregivers shared common perspectives and highlighted the fact that the current conditions are not conducive to providing quality care to frail older persons. Most of the actual dwellings in which frail older persons are cared for are structurally unsound and are located in other people's back yards. On this topic, Participant 47 (D47) (2579:3777) said:

> The shack is made with boxes and corrugated irons and lets in cold weather and during rainy season is unbearable for us. This is not how you give proper care to someone frail, ill and old…pensioners deserve to be treated better by government so that even me can also look better after him.

Participant 30 (D30) (1774:3444) agreed and stated that:

> This place is not built for caring for old people, but I have no choice because I don't have any other place I can look after him or money to rent a place. This shack was very poorly built outside with concrete flooring and covered in boxes and plastic where we sleep…there is a definite need to really look after the living conditions of these people with well-built houses that will not fall on them while [they are] asleep.

The same sentiments were repeated by Participant 21 (D21) (2414:3004), who made the following point:

> Demands for better housing and quality of life are not a privilege, but a human right. God created us all equal and why should some people live in a one-bedroom shack used also for kitchen, dining and lounge when others are living better. We need equality through better housing and overall improvement in the lives of caregivers and frail older persons they are looking after. According to frail older persons need proper housing to improve their living conditions.

#### 5.2.1.4 Sub-theme 6: healthcare

Informal caregivers have described the healthcare needs of frail older persons mainly in terms of the following components:

*a) Chronic medications*

The empirical data reveal that many frail older persons suffer from multi-morbidities and are in dire need of chronic medication. To illustrate this need, Participant 01 (3121:3566) said:

> She has Parkinson disease and is in need of chronic medications, but the State hospital is most of the time out of stock and we can't afford to buy it for her at the private pharmacies. Because of this her health conditions gets worse and she becomes unbearable to care for.

This sentiment was echoed by Participant 06 (D6) (2080:2303), who stated that:

> She constantly needs chronic medication for high blood pressure, diabetic and arthritis, and we do away with it [medication] because there is no money to buy the medication now ever since the State clinics don't have medication for the older people.

Similarly, the need for chronic medication was expressed by Participant 07 (D7) *(2155:2395)*:

> "We are entirely reliant on the government for chronic medications, but most of the times the state hospital runs out of stock."

Participant 26 (D26) (2337:2660) said, "he has severe diabetes and high blood pressure and always needs his chronic pills for high blood pressure and insulin".

*b) Transportation to health centres*

In addition to medication, the informal caregivers averred that the need for transportation to health facilities was important for frail older persons so that they could get medical attention. In describing this need, Participant 28 (D28) (3069:3749) said:

> The hospitals and clinics are far away from our house and she needs transportation and taxi money to go get there for medical treatment. The municipal buses are always full and there is no suitable space for frail older people. So, what can we do, just sit here and use herbs and traditional medications and hope for miracles?

This same perspective was shared by Participant 50 D50 (1819-1882), who said:

> Every time you need him to visit a doctor you must ask people for taxi money and even some of those taxi drivers don't want to take old people in their cars because they are slow and wasting their time they say. We need special transportation to clinics or government must build hospitals near informal settlements.

Participant 45 (D45) (2303:3251), Participant 38 (D38) (3490:4888) and Participant 10 (D10) (1227:1681) said, “he needs to be transported to the hospital for regular medical check-ups, but ends up staying at home because of no money or car to take him there”.

Participant 31 (D31) (2213:2850) concurred and added that:

> Due to lack of reliable public transportation she is not getting to the clinic for necessary treatment…the State must provide transport to sick older people because the municipal buses are overcrowded and only for young people who are fast and can move freely. There is also no provision for wheelchairs on the municipal busses...it’s a problem for older people.

*c) Occupational therapy and physiotherapy*

The informal caregivers are of the view that frail older persons under their care do not have access to occupational therapy and physiotherapy. In terms of occupational therapy, the informal caregivers have expressed the need for improvement in fine motor skills of frail older persons to enable them to cope better with frailty and aging.

Participant 01 (D1) (3121:3566) stated that:

> “Due to age and sickness, her speech is impaired and she needs speech therapy to improve her communication because at the moment it is a real challenge to understand each other with nods.”

Participant 46 (D46) (2803:3740) reiterated this need for occupational therapy and stated that:

> “It would make my job so much easier if there was someone professional who can stimulate or teach her the very basic things of life like even to dress and undress or unbutton clothes.”

According to Participant 47 (D47) (1552:2101):

> Sometimes when he falls he doesn’t know how to try and get back into bed without assistance from me, I think he can do it, but needs extra motivation. It is not safe for him like this and need someone to come do the right training here.

Regarding the need for physiotherapy, many study participants have expressed the need for this service to be made available to frail older persons. Participant 06 (D6) (1560:1752) said:

> "She has fallen and hurt herself badly on a number of occasions and now has no specialised support to get better with walking again."

This view was repeated by Participant 03 (E3) (5399:6087) in the following words:

> "She needs frequent physio or biokinetics sessions, but nothing at State hospitals, they only did it for a month and thereafter you will have to find private people to help you".

*d) Assistive devices*

Many informal caregivers are providing care to frail older persons who are in need of various assistive devices that could enhance their quality of life. Based on the empirical data, the need for orthopaedic devices was mentioned as important to ensure enhanced mobility for frail older persons. According to Participant 30 (D30) (1774:3444), the frail older person under her care:

> She needs orthopaedic support for her amputated limbs maybe they can provide braces, but the State does not have enough orthopaedic equipment and supplies and this makes it difficult for older persons to cope with their medical conditions. At least with prosthetic limbs she can have some movements.

Participant 50 (D50) (1170:1438) supported the above view and added that:

> He just needs a wheelchair to enable basic mobility and get a chance to at least get out of bed, but the State hospital is always out of stock and pensioners are expected to buy this from private orthopaedic specialist. A wheel chair will make a big difference in his life.

Some informal caregivers expressed the need for ambulatory devices like crutches (Participant 38 (D38) 3490:4888), walkers (Participant 09 (D9) 3104:3475) and canes (Participant 02 (D22) 2385:2892) to allow basic mobility and provide some relief for severe arthritis and other physical impairments.

Participant 46 (D46) (2803:3740) also highlighted the need for assistive devices in the form of hearing aids:

> Most of the time communication is a big problem, because you must constantly scream for her to hear what you are saying. This becomes very frustrating after a while because it feels like you yourself is also becoming deaf. She urgently needs a hearing aid device to improve her hearing even in old age it helps with better talking to other people.

*e) Social workers*

On the need for social services, Participant D45 (2303:3251) stated:

> "She needs social workers to talk because of poverty and many issues at home that can be fixed by government."

On the same issue, Participant 18 (D18) (1277:3270) said:

> "He needs social workers for counselling for himself and assistance for us to cope with many social problems we are facing in caring for him."

Participant 08 (D8) (3920:4082) said:

> At the moment, the situation here is very bad because of the many social problems we have with living here and taking care of him under these terrible conditions. He needs a social worker to intervene to for government to improve our living conditions with better help for welfare. I tried calling social service department there from the office of councillor to provide assistance but every time we are told they are not available to help because the staff is not enough in government.

**5.2.1.5 Sub-theme 7: mental health support.** The informal caregivers overwhelmingly reported that the need for mental health support for frail older persons was vitally important for their well-being. The mental health issues of frail older persons derive from various factors, including loneliness and isolation, but also more serious mental health conditions like Alzheimer's, Parkinson's and dementia.

According to Participant 02 (D2) (3196:3623), the aspect of loneliness stems from being "left alone in the house for extended periods during the day while we do other thing to get moneys*".* Participant 08 (D8) (2180:2508) said,

> I leave her all alone sometimes only the whole weekend also because I have a life also and other things to do with my life. I do not have time to be with her all the time, but do my best.

In some instances, loneliness is the result of bereavement. Participant 06 (D6) (3011:3090) said that the loneliness of the person she was caring for was largely due to the following:

> All her children died of HIV and I'm the only living relative. She is withdrawn and lonely because she misses her dead relatives. She needs professional help of psychologists maybe she will be able to cope better and maybe forget some of these things.

In relation to other mental health issues confronting frail older persons, such as depression, Participant 7 (D7) (2155:2395) said that:

> She's constantly depressed and anxious and needs therapy to cope with her circumstances. I am not a psychiatrist and cannot deal with all her issues in the head to know if it is real or not. It is enough to drive me insane. She really needs someone to help with her mind issues.

In support of this narrative, Participant 27 (D27) (2724:3169) also stated that:

> Due to chronic illnesses she's mentally depressed and needs professional specialist to talk to given that most of the time she is bed-ridden and very lonely and insecure…she really needs other people to talk to so that she is engaged and can feel better because she is closing up to me and not saying much most of the times.

In illustrating the need for mental health support, some informal caregivers' revealed that the problem is so serious that some frail older persons have suicidal thoughts. For example, Participant 30 (D30) (6352:6423) said:

> "I think she has depression because she always has suicidal thoughts because she talks about wanting to die or things like killing herself and that she sees no purpose to living anymore. She urgently needs professional help to make her change her mind about her situation."

Participant 37 (D37) (3139:3191) stated that:

> He attempted to end his life many times before and we got to believe that his falls and self harm must be all deliberate suicide attempts to end his life, which is why there is a need for people like him to get a therapist to talk to them to find peace and cope better with life.

### 5.2.2 The perspective of formal caregivers on the needs of frail older persons

Formal caregivers expressed the following perspectives regarding the needs of frail older persons in institutional care:

**5.2.2.1 Sub-theme 3: family support.** Because frail older persons are separated from relatives and friends in the institutional care environment, formal caregivers have described the need for family support as a basic condition for effective adaptation to this environment. According to SFG D51 (10087:10168):

> The need for family support is not only through supply of toiletries, medications, diapers, but also taking them out for a drink, drive, coffee or take them home with them for short stays at a time. Making them feel that they are part of the family despite being in an old age home with us. This also makes it easier for them to cope better outside the home environment that they are used to.

In support of this view, SFG D52 (13603:13698) expressed agreement and added that:

> Most of the frail older people here are in need of family support. This means that they must feel loved and appreciated…but some family members of frail older people feel that it's enough to just pay for their care here. The frail older people are sort of dumped with us and expecting us to do everything more than what we are paid to do. We have to be a nurse, friend and companion to their parents.

From the above perspectives it is clear that family support should not only take a financial and material form, but should also take the form of psychosocial support through expressions of love and companionship. This point was illustrated by SFG 52 (14019:14289) as follows:

> Some patients have not had family visits for years. They are still around because we still receive the much-needed snack, personal toiletries which is often time delivered by the supermarket and their accounts are paid well in advance, but what is missing is their presence. What some of these families don't realize is that frail old people need family support as a means to feel wanted and of value to their relatives.

In the same vein, SFG 53 (17473:17969) stated that:

> Older persons need constant care and affection despite their illness. They place high value in the importance of intergenerational relationships, extended family and relations with friends. They are encouraged to visit and be involved in the care of their person. The need for family support is essential and a necessity at our old age home because frail older persons want to engage and interact with their loved ones. This interaction increases endorphins and wards off loneliness, depression and to a certain extent anxiety as well. The happier the older person the easier it is for us to care for them.

**5.2.2.2 Sub-theme 4: integrated care.** Formal caregivers are of the view that, given their multi-morbidities, frail older persons need an integrated care approach. In illustrating this need, SFG 51 (16375:18525) stated that:

> At the moment, the focus of nursing homes for older people is on palliative care and ad hoc responses to their medical conditions based on visits to a general medical practitioner. In my opinion, palliative care should be part of an integrated care approach where all specialist medical areas are offered to frail older people in one solution. The reality is that frail older persons need integrated care that includes a single package of access to orthopaedics, geriatrics, pastoral care, oncology, social workers, psychologists etc. The integrated care is more affordable and can improve the lives of many frail older persons.

In clear support of this view, SFG 53 (18091:18682) averred that:

> Sometimes, the same frail older person who needs physio also requires occupational therapy or some other specialist care, which makes the need for integrated care beneficial. The current care approach is fragmented and ineffective in providing quality services to frail older persons. Right now, it feels at times as if you are performing multiple tasks meant for different medical professional services all in one session.

The views of formal caregivers highlighted the need for integrated care of frail older persons in the care environment based on access to various much-needed medical professionals as part of the overall care offering. This point was summarized by SFG 54 (11350:11758) as follows:

> Dealing with a single professional supplier like physiotherapist for a frail older person with mental health issues is useless without access to a mental health professional at the same time. The need for integrated care is based on this reality at the nursing homes. Given the shortage of specialist skills in

> Namibia it may be hard at the beginning to implement, but will improve with time. The care system of frail older persons must now already think about strategies for integrated care.

**5.2.2.3 Sub-theme 7: mental health support.** Similar to the informal caregivers, the formal caregiver perspectives found that many frail older persons in their care suffer from various mental health conditions. In describing the situation, SFG 52 (13229:13340) stated that:

> Many frail older persons in our care are mainly facing mental health related challenges. They are in need of mental health support for depression and other conditions. This is mainly due to aging itself, but also the frustration of being unable to care for themselves without help from us.

This view is repeated by various formal caregivers who highlighted Alzheimer's, dementia and Parkinson's disease at the top of the list of mental health issues facing many frail older persons.

The need for mental health support was further illustrated by SFG 55 (18374:19926), who stated the following:

> The need for mental health support for frail older persons is based on the fact that mental illness such as depression, anxiety, dementia, Alzheimer and other disorders are very common amongst our residents. They are often brought here because their children are not qualified to handle them at home…and some family members are too busy to be looking after their frail older persons with mental health problems.

According to SFG 54 (18060:18397), the need for mental health support for frail older persons meets a stumbling block because of the shortage of mental health facilities. This view was expressed as follows:

> Due to the current lack of specialist knowledge on mental health issues at the nursing home, mental illness in older persons is sometimes misdiagnosed and left as a prognosis of "old age". As part of mental health support, there is also a need for specialist facilities for early detection of conditions. Also, we are seeing the negative stigma and shame that comes with mental health for the frail older persons. These issues are important and must be properly addressed. The need for mental health interventions must include proper education and awareness of mental health issues. This is for the caregivers, family members and the entire community. In my opinion providing for the

need of mental health will also minimize abuse and neglect of frail older persons.

In support of the above perspective, SFG 52 (32046:33395) stated that:

> Namibia has a general lack of psychiatric facilities and hence the need for mental health support to the older age cohort is mostly ignored or underestimated. If I had the means and powers that government has, I would build more psychiatric centres that would specifically cater for the mental health support needs of frail elderly persons.

**5.2.2.4 Sub-theme 8: access to information.** Formal caregivers believe that frail older persons have a need for accurate information about their real medical conditions and prescribed treatment. This need of frail older persons was explained by SFG 52 21740:23961) as follows:

> The need for information is based on the fact many frail older persons are not well informed about their medical condition. This is usually the case because the family do not want to worry them and don't want to jeopardise recovery. In my view, keeping the information from them creates anxiety and sometimes refusal to get proper treatment…it's not good for the older frail persons to be kept in the dark. Currently, in most cases frail older persons are not informed or involved in their medical treatment plan and are expected to just go with the flow.

This view was endorsed by SFG 54 (18974:20424), who said:

> The right of access to information for frail older persons is neglected in the care setting and also at clinics or hospitals where they are getting medical treatment. This is based on the false belief that most of them are unable to make decisions about their own health. All major decisions are made for them and they have no say in the choice of medical care. It is very distressing for them and sad for us to see senior adults treated in this way…there's a definite need for access to information to enable frail older people themselves to decide on their care and treatment.

In endorsing this view, SFG 52 (32046:33395) stated that:

> Generally, frail older persons want to be recognized in their care and medical treatment. Therefore, a real need exists to keep them informed whenever practical to do so taking into account their cognitive abilities. If they have

all the information they will cooperate better with caregivers and health professionals.

The formal caregiver perspectives suggest that frail older persons have a compelling need to be adequately informed about appropriate care and medical treatment. They should be part of the overall decision-making process and implementation.

## 5.3 THEME 2: EXPERIENCES OF INFORMAL AND FORMAL CAREGIVERS IN PROVIDING CARE TO FRAIL OLDER PERSONS IN NAMIBIA

The caregivers are in the front line of care for frail older persons and have first-hand experience of their needs. The following sub-themes describe their experiences in providing care to frail older persons in Namibia:

### 5.3.1 Experience of informal caregivers

**5.3.1.1 Sub-theme 1: abuse.** The informal caregivers described different forms of abuse in the care environment of frail older persons, namely mainly physical, emotional and financial. Referring to sexual and physical abuse, Participant 07 (D7) (6296:6756) said that:

> "She has been physically attacked several times by family because she can't defend herself, and she was raped once too".

This view was supported by Participant 34 (D34) (8866:8934), who added:

> Rape of frail older people in our community is very common and we know who these offenders are but we mind our own business for our own safety. What is sad and most times difficult for me to accept is the fact that at most times these sexual abuse offenses are by close family members and not outside people. It often times goes unreported due to protection of the perpetrator and shame or harm to the frail older person.

Incidents of sexual violence against frail older persons seem to occur regularly, as explained by Participant 46 (D46) (4606:5103):

> She's been raped twice due to the fact that she was a lesbian and a homosexual and unable to defend herself given her physical weakness and old age…these older people are vulnerable and I can't be there all the time to look after her for safety. There's always a chance she will end up being sexually abused and victimized again.

In the experience of informal caregivers, abuse of frail older persons is perpetrated by family members who may or may not be caregivers. This point was aptly made by Participant 40 (D40) (9334:9432), who said:

> Abuse is mostly by the children themselves and not only some caregivers when it comes to the older people. I am taking care of him in everything, but other extended family members also take money from his pension savings account for their own personal things.

According to Participant 07 (D7) (6296:6756):

> Since most of the informal caregivers are relatives, it makes sense that different forms of abuse happen in the home-based care environment. People must also understand that what constitutes abuse differs from person to person and even from one culture to another culture. Putting older persons in a care home in my culture will constitute abuse, lack of love and compassion, and even abandonment. The problem is that Western cultures are imposed on us whereas we have our own ways of dealing with finances, our roles in society and general care. The Western culture for example would regard older people as being abused whereas with us it is our culture. Older people have duties and responsibilities towards the family. Generally, there's no abuse in my experience. We all have a role and a function within the family setting.

With reference to the abuse of frail older persons by informal caregivers, Participant 13 (D13) (4182:4268) admitted the following:

> Yes, I have slapped her once or so just to calm her down. Sometimes, she makes you very angry because of stubbornness. We are all human and you just lose it in the moment. It's not abuse, but a way of emotionally reacting to heated situations out of frustration. I just wish there was a better way to get support with frail older persons.

Participant 40 (D40) (5460:5658) concurred and explained the matter as follows:

> I have lost my patience with her on several occasions and would shake her up a bit, slap her and then lock her up in the house to get her to calm down. I would cry afterwards because I would hate myself for doing it…but I have no choice it's not easy to look after her.

This view is consistent with the following comments made by Participant 45 (D45) (7225:7348):

> She is very loud and I sometimes get to physically attack her by beating her. I do that only when I am drunk and because she doesn't want to keep quiet. I am not an abuser and it is the only way to have peace and quiet at home.

Conversely, informal caregivers also claimed to be experiencing abuse at the hands of frail older persons. According to Participant 14 (D14) (5795:5876), in the care environment:

> I am often exposed to verbal, emotional and sometimes physical abuse by the frail older lady I am looking after. She is the one doing the bullying and abusing me and not the other way around. I am doing nothing because I feel sorry for her and God will not forgive me if I do the same things back to her or harm her in any other way, but it is a real burden for me.

This comment was supported by Participant 15 (D15) (5652:5893), who said that:

> He is mentally ill and becomes very abusive towards me. I can understand if someone caring for a mentally ill frail older person ends up abusing or totally neglecting them. It's a tough situation because sometimes unprovoked and out nowhere you get abused by them…I know that I might do him more harm if I touch him.

Participant 23 (D23) (7233:7284) said:

> Abuse by old people, who like in his case, are old, frail and also very sick, make it difficult for me to care for them and enjoy anything else that I am doing for them for free and without expecting them to pay me. He is verbally and emotionally abusive and disruptive for me to help him better.

Participant 38 (D38) (8847:8927) said:

> "he still abuses me physically by throwing me with pillows and stuff and manipulates me emotionally as well and sometimes I fight him back out of frustration".

**5.3.1.2 Sub-theme 2: care burden.** The informal caregivers described the care environment as burdensome at various levels. This includes financial, emotional, physical and psychological burdens. According to them the

financial burden of care emanates from the fact that informal caregivers are not remunerated despite the heavy responsibility of caring for frail older persons. Participant 09 (D09) (6045:7250) explained this situation as follows:

> Taking care of your frail elder has no financial rewards for you and also nothing to make you want to do your very best all the time. The lack of salaries or even allowances from the welfare for me to do this care work is really putting me in serious financial problems. I also have personal needs and right now I can't even look for work because there's no one to look after him.

Most of the informal caregivers expressed dissatisfaction with the financial burden associated with caring for frail older persons. According to Participant 03 (D3) (2870:3442):

> I am really doing my best, but limited because we don't get any money for the many hours we are spending in care. For all these years, I have nothing to show for myself. At least, there must be something for me to forget the tough circumstances I am facing doing all this work for nothing.

In terms of the emotional burden, the informal caregivers experience enormous strain as a result of their care responsibilities. From the following account, it is clear that the emotional burdens of informal caregivers have a direct influence on their morale and ability to provide care to frail older persons. As explained by Participant 02 (D2) (6401:6730):

> In the role of a caregiver, I am doing a 24 hour shift every day and am available and on call to attend to his every single need. In my case it is worse because we live together in the same house. This role becomes very stressful and it can be also very emotionally draining.

From the above experiences of informal caregivers, it is apparent that shared living arrangements between the informal caregivers and the frail older persons under their care increase the care burden. This view was endorsed by Participant 38 (D38) (6515:6616), who said that:

> I am not able to take time off or go on leave from my responsibility and must be here all the time also because there are no other family members to take care of him. This causes me lots of stress and breakdowns sometimes.

The burden of care experienced by informal caregivers also relates to lack of employment opportunities and career prospects. As explained by Participant 02 (D2) (4426:4465):

> I have no opportunity to gain any skill or experience I can use in future after my informal care role. What happens after her death? Who will give me work because of just looking after someone at home. There are also no references of experience to put in my CV for jobs. In my experience this role is burdensome for me because there's no future to get a job and earn money.

According to Participant 07 (D7) (4255:4310):

> The lack of future employability is worrisome, but I don't have a choice at the moment. She needs me for basic life activities on a daily basis. I am coping with this burden, but some days it becomes a problem for me to focus on the role of caring for her. I have even developed stress-related symptoms like ulcers and high blood pressure because of this stressful conditions at home.

In terms of physical burdens, informal caregivers are having to do a lot of physically demanding work in caring for frail older persons. This experience was related by Participant 01 (D1) (6422:7422) as follows:

> She is frail and old to a point where I am doing daily all the lifting and turning to make her more comfortable. Although bed-ridden, she is very heavy and helpless, but I must do everything to help with movements. Because of these physical demands, I have now developed arthritis and I am in constant pains.

Participant 35 (D35) (4707:4772) concurred and added that:

> We don't have any equipment [assistive devices] at home and he is totally reliant on me for mobility and every single aspect of his life now for a very long time. I do everything for him. On top of old age, he has multiple health conditions making him totally dependent on my care. I am doing all the physical lifting and holding him since he has no balance also. This is daily routine even to go to the toilet I must help out all the time. It is really stressful to be in this situation and people don't understand our burdens.

**5.3.1.3 Sub-theme 3: training.** It is clear from the narratives of informal caregivers that most of them are conscious of a lack of skills and knowledge when it comes to providing effective care to frail older persons. Regarding lack of training, Participant 01 (D1) (7909:8122) said the following:

> I don't know anything about Parkinson's disease and never had training about how to care for someone with this disease. The medical personnel at hospitals went for training and are in a better position to take care of her be it medication, diet, care, nursing care, cleaning etc. As a result of lack

> of training I don't always understand her and don't know when she's being difficult, deliberate or is it really the mental health condition.

The same sentiment was echoed by Participant 41 (D41), who said:

> I am taking care of someone with a serious condition…they could have trained me on how to care for someone like her with Alzheimer. They did not even warn me on what I have to expect, how the disease affects her and how I should also behave. At the moment, I go by what I think and sometimes read on the internet. Even the nurses at the hospital are also not trained in mental illnesses of old age.

From the experiences of informal caregivers, it is clear that training is lacking in the informal care environment. As a result, many experience enormous challenges on a daily basis because of their limited knowledge and caring skills. For example, Participant 36 (4952:5414) said that:

> At the moment, I am just doing what I think is best in providing care to him, but never had any training in this role. Usually, the issue of lack of knowledge comes out when you have a problem and you can't provide proper response and proper care.

Participant 51 (D51) (21282:22284) said that she had never been invited to attend any required training to improve her standard of care to the frail older persons under her care. In this regard, she said:

> I have been providing care for years now and at no occasion has anyone from our government or social services have ever provided me with any training not even first aid in how to care for sick older people or do dressings. I just do everything with experience of trial and error and hope it works, but so far I am coping ok. Like now I have confidence and experience in how to turn or lift him out of bed in way that doesn't cause more pain and just hope that it is the right way.

**5.3.1.4 Sub-theme 4: traditions and cultures.** The informal caregivers expressed the opinion that culture and traditions sometimes impact the care environment of frail older persons. In clarifying this phenomenon, Participant 04 (D4) (64376518) said that:

> African cultures are sometimes making it hard for us to care for him effectively. For example, he doesn't want to take the medicines from the hospital and insists on going to the holy fire for healing. In my experience, this refusal is

based on the belief system in the spirits of ancestors. It is difficult to convince him that medicines from the hospital are going to make him well.

The same sentiments were echoed by Participant 30 (D30) (4300:4541), who said that:

> She is very traditional and still believes in the conservative ways that she was brought up with. Because of cultural beliefs, she struggles with me as her grandchild having to see her naked when bathing her. The reality is that she's totally reliant on me and I have to feed her and even take her to the toilet and clean after her. She's complaining every time this happen because she says according to culture this is unheard of and will bring us bad luck. She says she's better off dead.

The same experiences were narrated by Participant 25 (D25) (2818:3121) as follows:

> The cultural restrictions and beliefs of not having your child see you naked goes against the notion of care when you are unable to do it yourself and there's no one else willing to do it other than your children. Unfortunately, the current situation of me looking after her in this way is giving her so much stress, anxiety and sometimes outright lack of cooperation.

### 5.3.2 Experiences of formal caregivers

**5.3.2.1 Sub-theme 1: abuse.** According to formal caregivers, abuse in the care environment of frail older persons is often verbal, emotional and may even be physical. Abuse in the formal care environment has a twofold nature since it may be perpetrated by the family or by caregivers. According to SFG 54 (D54) (21195:22729):

> Family verbal abuse of frail older persons under our care is becoming a big problem and this happens mostly when they come visit them. As caregivers we have no control over this since we can't tell family how to talk to them.

In the experience of formal caregivers, various forms of abuse are a regular feature at nursing homes. SFG 51 (D51) (22396:24464) elaborated on this:

> Emotional and financial abuse of frail older persons by family members is common at our old age home. Unfortunately, there's nothing we can do about it if their children are yelling at them because they are family. The frail older people are badly affected by this and we as caregivers and staff nurses

must deal with them being unhappy by constantly complaining to us on how unfairly their own children are treating them. The matrons are also aware of these abuse cases by the family as well.

Specifically, SFG 55 (D55) (38267:39417) stated that:

> The financial abuse is sometimes in the form of when the children will come and get them to go to the bank to draw large sums of money. The older person is always sad about that in that they end up complaining to us about it because they feel the children only need them for their money but don't provide the necessary love, affection, visits and care they want from their children.

Furthermore, formal caregivers also described some instances of caregiver abuse at the old age and nursing homes. SFG 55 (D55) (26865:28497) said:

> Frail persons are sometimes verbally and emotionally abused by the people who have to care for them in our establishment, it is the staff here as well as their own families abusing them. Some of the frail older persons are very demanding and that sometimes irritates the staff and they take their frustrations on the frail older person by either ignoring their pleas or calls to change diapers and handling them harshly when working with them.

According to SFG 54 (22847:24242):

> "Those frail older people with mental health problems are mostly at risk of being abused. Abuse by caregivers is subtle and always goes unreported, but we can tell because they sometimes have bruises".

In the experience of formal caregivers, abuse by formal caregivers perpetrated against frail older persons is rare, and usually the result of frustration. This point was described as follows by SFG 55 (D55) (31004:32819):

> Sometimes we are required to restrain unruly frail older persons, especially those with mental conditions. They are held down by a number of personnel until they calm down. Someone walking in whilst we do that looks at times as if we are overpowering the older person. This may be seen to be abuse, but it is not. Caregivers generally don't use any force against care beneficiaries.

Another important aspect of abuse in the formal care environment is the issue of abuse perpetrated by frail older persons against formal caregivers. In illustrating this issue, SFG 53 (D53) (24841:25368) stated that:

> The work environment can be a bit emotional and challenging in that we have to deal with abuse against us by frail older persons that is at most times racially motivated. I can still deal with a difficult person, but to have an old, frail, rude and racist person at most times drive me to tears. I can't get used to that at all. Some of the old people still don't regard black people as human beings with feelings. The reality is that we have a majority of black workers and that is a challenge because 100% of all the older persons here are white.

This finding was corroborated by SFG 52 (D52) (24335:26437) as follows:

> We get racism treatments from the frail older persons and or their families. Racial discrimination at work is very common in my 30+ years of experience …We are somewhat forced to speak German as most older people here refuse to speak English or Afrikaans…some of the frail older persons here are very abusive towards us and are not corrected.

SFG 55 (25051:26732) described the phenomenon of abuse against formal caregivers by frail older persons as follows:

> Staying professional when physically attacked and abused, racist, verbal or being thrown with objects by frail older persons. Sometimes, we are also having to deal with angry and always complaining families. You always end up getting involved in family disputes regarding the care needs of the frail older person.

The empirical data revealed three levels of abuse, namely abuse perpetrated by family members, by caregivers and by the frail older persons themselves. In the experience of formal caregivers, abuse mainly takes financial, emotional and physical forms. Frail older persons are financially exploited and are often times physically and emotionally abused by their children and by extended families.

**5.3.2.2 Sub-theme 2: work burdens.** The varied experiences of formal caregivers reveal various forms of caregiver burden associated with providing care to frail older persons. SFG 55 (D55) (38505:39306) stated:

We are working long hours at an end without provision for even proper payment for overtime under the labour law. I get physically and emotionally drained when leaving this place every day…these long hours are not healthy and a definite work burden.

In describing the same situation, SFG 53 (32821:34148) stated that:

> The working conditions are not that good at all and most nurses have resigned. The normal nursing hours is 12 hours per shift but we have to work longer working hours, we don't get any payment for working overtime, the treatment by manager is so bad and inhumane, the old people are difficult and their families and matron are treating us very bad. The unit manager has never worked in nursing homes and does not have any experience in primary health care, no gerontological experience and is not clued up on what is going on and what the work entails.

This was borne out by SFG 51 (D51) (18785:20452), who said the following:

> Caregiving is very stressful and physically demanding because most of the time you are on your feet the whole day and we do not have enough personnel to help with basic caregiving chores like changing diapers, washing and feeding, and other related activities of daily living for the older persons who most are really frail, bedridden and can't do this by themselves.

In the experience of various formal caregivers, the long working hours are largely due to inadequate staffing levels. SFG 55 (D55) (23121:25049) described the situation as follows:

> "Caregivers are resigning because of poor working conditions and there's pressure to provide proper care with limited staff. People are just not coping here…"

Formal caregivers complained about the level of remuneration and, according to SFG D53 (32821:34148), felt that:

> The turnover of experienced caregiver nurses is very high because of the low salaries, morale of the staff is low…Our salaries are very low and we only get eighty five Namibian dollars (N$85) per month for nightshift that works out to six Namibian dollars (N$6.00) for the 12 compulsory night shifts and we don't get overtime as well. This creates financial burdens for us at work because we can't afford essentials things for our families. Overall, the working conditions are not that good, long working hours, no overtime, bad treatment by manager, older people, their families and matron.

In support of this view, SFG D54 (33094:33426) said the following:

> Sometimes we are not paid on time and this puts us in a bad credit record because we can't pay our personal accounts on time. The cost of living is expensive, but the care work gets more without more income for us. With this salary, I can't afford to buy the things I want. So really this situation creates economic burdens for us.

In addition, SFG 51 (D51) (21282:22284) said:

> We are not even paid a bonus for doing good work in looking after the old people and so whether you do more than expected there is no financial reward or even a thank you be it from themselves, their children or our superiors.

In addition to the experiences of physical and financial burdens they recount, formal caregivers are also emotionally burdened in the care work environment. SFG 53 (31004-32819) explained this as follows:

> Because even after knocking off, we still keep worrying about what is happening to the frail older persons on our off-days or when we go home in case something bad happens. Keeping a balance between personal and work life is sometimes a challenge…we get personally attached and it is a real challenge

**5.3.2.3 Sub-theme 3: training.** In the experiences of formal caregivers, the current care environment does not provide them with adequate training. This is described as a major barrier to providing quality care to frail older persons.

According to SFG 53 (D53) (24248:24736):

> There is not even induction training when you start the job as caregiver and everything you must learn from doing the work here. No formal training is given for even the most basic stuff to the most specialised care work. Because of this I have lost the speed and passion for the work as caregiver.

This experience was supported by SFG 51 (D51), who commented that:

> In the absence of formal training, we also do not have platforms where we can learn and share knowledge with others in the field to better serve the frail older person in our care. I mean for us to get together with other caregivers at other nursing homes and share experiences of care work and how to better deal with challenges. Sharing knowledge in this way is also part of training

each other. The reality is we don't even have the time to do this with current care pressures.

According to SFG 54 (54) (33551:33955):

> Our current care responsibility requires both basic and specialised skills to properly care for frail older persons with various chronic ailments and even mental health issues. We don't get formal training and very limited on-the-job training for us to get those necessary skills required for proper care. I am not talking to becoming a medical specialist or something, but just being able to know what to do in some complicated situations when alone with care beneficiaries.

Despite the limited training of formal caregivers, the on-the-job experience has had positive benefits for some formal caregivers. This point was made by SFG 52 (D52) (24335:26437), who said that:

> You get so many challenges that you have to think on your feet and as a result my people skills as well as my problem-solving skills have improved. Being an introvert, I have learned to be more sociable because whether you want it or not the older persons always finds way to engage you the whole day. It has increased my self-esteem in that I can talk about anything to anyone.

**5.3.2.4 Sub-theme 5: institutional admissions.** The formal caregivers shared some insights into their experiences relating to the admission of frail older persons into old age and nursing homes. Most of these placements are done by family members, whether members of the extended or direct family. However, SFG 54 (D54) (28440:29656) said the following:

> "Some of the elders in the old age home were placed here through the trust and church initiative for those who cannot afford to pay the monthly rental."

There seems to be a shortage of old age and nursing homes in Namibia to care for frail older persons, as illustrated by SFG 51 (D51) (39427:40021), who said:

> Many frail older people who need residential care will never get a place at government old age homes because of the general shortage of beds for them. Although government subsidized older persons, most of the existing beds at our hospital is all private and fully accommodated. We have a waiting list and it all comes to the older persons who can afford private nursing and

> caregiving at a premium rate. Our facility is managed in such a way that it cater for the old person up until his/her time in frailty and paid for in advance making availability of beds impossible for other old people outside our facility who turned frail.

Even more than the shortage of available places at old age and nursing homes, the financial aspect seems to be a definite barrier to admissions. This experience was related by SFG 53 (D53) (52929:53658):

> Our most affordable rooms are the ones with a single bed and basin and a shared bathroom for ten (10) people at a cost of fourteen thousand Namibian Dollars (N$14,000.00) per month. That is about 10-fold of the one thousand three hundred Namibian dollars (N$1,300.00) old age pension. Most of the black older people can never afford to be in a frail care facility at these costs.

According to SFG 55 (D55) (34361:36114):

> You get older persons who can afford to be here at our facility and come here by their own free will. They would have made financial plans whilst they were still young…In very special circumstances, institutional admissions are done free for those frail older persons who are very neglected and who in most cases are very poor. These older people usually apply through our trust fund and once approved, we provide them with free meals and accommodation but the family remain responsible for the medication, clothes and toiletries.

The above experiences of formal caregivers reveal that limited availability and financial resources create the barriers to institutional admissions into old age, hospital and nursing homes.

**5.3.2.5 Sub-theme 6: injuries and falls in frail older persons.** The experiences of formal caregivers have revealed many instances of falls by frail older persons in the care environment. According to SFG 53 (35214:36444):

> Most of the frail older persons under our care are bed-ridden and not risking falling by themselves. To avoid falls for those with limited mobility, we assist with walking rings and even wheelchairs to sit up or do basic movements… we normally also use mobile lifters to move those who are not able to turn around, but sometimes this is broken and we must still do it ourselves.

However, SFG 52 (D52) (24335:26437) disagreed and stated that:

> The falling of frail older persons is happening most of the time at the nursing home where I work because of negligence of some caregivers who are sometimes not even properly trained to walk the older and sometimes the frail person might be challenging in the sense that it takes skill to handle them and it is impossible to assist them on your own strength.

According to SFG 55 (D55) (26865:28497),

> "……even those few older people who are able to somehow wash themselves, they sometimes fall in the shower causing serious injuries even when the showers are equipped with hand-rails and non-slip shower mats."

SFG 52 (30516:31912) added that

> "Despite precautionary measures to avoid falling, some frail older persons still come up with all sorts of tricks and try to do things by themselves, and end up falling and sometimes even hurting themselves."

## 5.4 THEME 3: POLICY AND LEGAL SUPPORT TO FRAIL OLDER PERSONS

In answering the research question relating to the extent to which the Namibian constitutional, legal and policy environment supports the frail care needs of older persons, the empirical data revealed the following:

### 5.4.1 Sub-theme 1: Existence of policy and legal support to frail older persons

It was clear that both the formal and the informal caregivers do not enjoy any support under the existing policy or any legal provisions relating to frail older persons.

In terms of informal care perspectives on awareness, Participant 16 (D16) (9300:9328) said:

"No, I have never heard of any incentives for social welfare support to old people we care for."

This sentiment was also expressed by Participant 39 (D 39), who said:

"No, not at all. I am not aware of any government policy supporting us as caregivers of frail older persons."

The formal caregivers also raised concerns about lack of transparency in the development of the policies and law relating to frail older persons. On this point, SFG 53 (D53) (37953:38695) commented that:

“There is still no proper communication and transparencies in the law, which makes it difficult to understand what support the laws are giving to the older people in care homes.”

SFG 54 (D54) (43513:44573) agreed and stated:

“The Cancer Association of Namibia and other NGOs provide better support to older persons than what the government policies and law are saying about this.”

### 5.4.2 Sub-theme 2: Policy relating to funding of needs of frail older persons

Both the formal and the informal caregivers explained that no policy and legal environment exists in Namibia for the funding of the needs of frail older persons. Many responses to this question reveal that funding for frail older persons is mostly left to families, NGOs and churches. Regarding informal care, Participant 02 (D2) (11664:11851) said that:

> The only funds he receives from government is for the monthly old age pension. He has Alzheimer and demands a lot financially, but the policies and laws of the government do not help us with even medications or food for his special diet.

In support of this view, Participant 06 (D6) (8215:8295) added:

> We are struggling by ourselves to find money to buy the things he needs, even for transport monies we borrow from neighbours until his pension pays again. We are getting nothing from welfare to pay for the cost of taking care of him.

In further corroboration of the lack of policy and legal mechanisms for funding the needs of frail older persons, Participant 08 (D8) (11985:12383) said:

> “The government policies do not support families looking after old people and we have never been asked about how we feel about this at all.”

As far as the formal care environment is concerned, there is no evidence of public funding of the care needs of frail older persons under any government policy or law.

On this point, SFG 55 (D55) (37918:38627) stated that:

> The are no clear policies we must follow to get government to pay for some care needs of old people in our care home. It is very expensive to stay in old age homes and if the family is not well-off then they cannot be helped with admission of loved ones. Unfortunately, there is no public funding for old age homes. Even essential services like frailty and assisted living come at a cost that must be carried by private individuals.

SFG 54 (D54) (41167:41541) stated:

> Some of the sick old people in our old age home do not have money all the time for diapers and other goods they need daily in care. Except donations from the community, the government does not have a law in place that make it possible for these poor people to even get discounts or some of these things for free from welfare. I feel it is the responsibility of government to make such laws and look after the interest of senior citizens.

Clearly, the data show that the Namibian policy and legal environment relating to frail older persons does not provide for funding of the frail care needs of older persons.

### 5.4.3 Sub-theme 3: policy to protect frail older persons from abuse

An important theme emerging from the empirical data is the lack of policy and legal protection against abuse of frail older persons. Both the formal and the informal caregivers felt that the current policy and legal environment is not adequate and perpetrators of abuse against frail older persons are not prosecuted.

In explaining this phenomenon, Participant 20 (D20) (11098:11290) commented as follows regarding a frail older person:

> He was physically abused despite his frail condition and all the social services and police said was they did their part by giving warnings to suspects. They don’t have more powers under the law to handle abuse cases against frail older persons.

In the same vein, Participant 01 (D10 (12166:12459) said that:

> When I reported the abuse to the police I was asked to go to Children and Women Abuse Centre in Katutura because there was no place to report abuse of old people and they were asking too many questions so I left but the problem is it can happen again and nobody is doing anything about it to get people to jail who are doing this.

In the formal care environment, the lack of policy and legal protection for frail older persons against abuse is complicated by the fact that there is no effective response to allegations or complaints by those in the care environment. SFG 54 (D54) (37221:38333) made the following pertinent comment on this aspect of law enforcement:

> We have read reports on the abuse and neglect of older persons and nothing on the convictions. Old people including all stakeholder are not educated of what constitutes abuse and neglect. There are no platforms to report abuse and neglect. There are no care quality standards by the government. Caregivers get fired and no case is opened against the abuse; however, the older person is not protected as the caregiver will be employed elsewhere and would most definitely abuse the elderly. There is no mechanism to stop that abuse cycle. Neglect and abuse of the older person by the family are very high with us and we can't do anything. We are told to mind our own business.

## 5.5. THEME 4: SPECIFIC RECOMMENDATIONS FOR SUITABLE FRAIL CARE MODEL

In answering the research questions about the appropriate models that would be useful in addressing the needs of frail older persons in Namibia, the formal and informal caregivers responded with the following recommendations:

### 5.5.1. Increase social welfare support to frail older persons

The informal caregivers largely pointed out the important role government could play in supporting the needs of frail older persons. According to Participant 07 (D7) (7100:7667):

> The Health and Social Services (MOHSS) welfare should be more proactive in their support to community development programmes especially for their old frail vulnerable people. They must go into communities, identify the vulnerable old people, establish their needs and offer them the needed housing, feeding schemes and medical aid they need as vulnerable people within the community.

This view requires a welfare model where government is the major stakeholder in the delivery of social services, healthcare, basic utilities and food security based on progressive policy and law reforms. Participant 38 (D38) (10066:10593) said that:

> Government must employ physiotherapists, more nurses, buy enough medication and orthopaedic equipment, get all the old people to receive Harambee food and free transport to the clinic or hospital even if this will mean that we get one day a week for only checking up on all the sick older persons just like what they do with the weekly garbage collections.

In support of this view, Participant 02 (D2) (7574:7793) said the following:

> "Old people here have many chronic health conditions and government must provide free medication and treatments for them."

On the other hand, the formal caregivers recommended a case management welfare model where more social workers would be involved in developmental aspects in the community. This view was encapsulated by SFG 52 (41982:42459), who said:

> The government needs to identify and introduce primary community nurses and social workers that will manage the frail older persons condition from within their communities. Currently we don't have community-based care and support services for frail older persons in Namibia.

If any welfare model is to work effectively it must be evidence-based. SFG 53 (D53) (48982:49953) stated:

> Government must do research and collect information from the different care environment about the needs of frail old people within the country… additionally the role of government must also be to revise the laws on the care wishes of frail older persons (49955:51042).

SFG 54 (D54) (35828:36484) added that:

> "Government must look after the security and safety of old people in the care homes to create a conducive environment for them."

### 5.5.2 Increase social grants

The empirical reflections suggested an overwhelming need for old age pensions to be increased to allow frail older persons to have a better quality of life. Both the formal and the informal caregivers are of the opinion that old age pensions must be increased. In the informal care environment, Participant 02 (D2) (7574:7793) expressed the strong sentiment that government should do the following:

> Increase the pension money…Allow for disability grant and pension grant to be paid as different aspects of the care needs of the frail older person. Now what is happening is that the frail older person has to choose between disability or pension and both has the same value one thousand three hundred Namibian dollars (N$1300.00). It is very unfair because disability conditions have their own challenges and needs, and old age has its own challenges. Pay them as separate payments that has to meet a different need, just as government require you to sign up with different ministries.

This view was shared by Participant 20 (D20) (7443:7959), who said:

> Her old age pension is the only income in this house and everyone must survive from it. It is unfair on her because to look after her costs a lot of money too so government must pay more monies for this. What can I do there is no work and I am doing too much to look after her all the time.

On the other hand, while the formal caregivers supported the need for increased pensions they did not regard this as a material issue because most of their frail older persons were in a financial position to look after themselves. In support of this sentiment, SFG 53 (D53) (42681:43318) stated that:

> The frail older persons here can afford to pay for their care however it's not the same for the black people. Government gives every citizen over the age of 60 a pension irrespective if they have a private pension or are in a position to afford their medical care. Many black people have dependents and the money is not enough. State pension benefit should be for low-income recipients only.

The input of formal caregivers also suggested that government old age pensions should only be paid to needy frail older persons. SFG 54 (D54) (34957:35826) clarified their perspectives as follows:

> Increase old age grant only for the people who are needy. Change the laws to only afford state pension to people with a certain income bracket and for those who has no other means of income. The qualifying criteria should change to a means test as is the case in other countries and only used by the needy. Social development grants to be assessed according to critical levels of care as well. Disability grant to be paid upon disability and not old age. Change the scale to measure vulnerability in the poor communities.

### 5.5.3. Build more old age homes of a decent standard

Interestingly, most of the informal caregivers recommended a welfare model in which residential care is made possible for many frail older persons. On this issue, Participant 09 (D9) (8301:8644) simply stated that “government must build frail care facilities that house older people and their caregivers”. This view expresses a need for sufficient living space to allow for live-in caregivers for frail older persons who are totally dependent on others for the activities of daily living. Participant 18 (D18) (8236:8578) agreed and commented briefly that “government must build them big homes so that old people can feel free and get better when sick”. According to Participant 03 (D3) (8613:8686), “the government must provide suitable old age homes that are conducive to quality living that they deserve”. In the words of Participant 34 (D34) (6053:6207), “the old age homes must include frail care facility where they get free medical treatment and meals and from there to the graveyard”. For those frail older persons with mental health conditions, Participant 13 (D13) (7767:7934) said the following: “Instead of putting old people with mental health problems into old age homes or at home with family, the government must build mental hospitals that can look after Alzheimer or Dementia.”

The formal caregivers supported the building of more old age homes because, as SFG 55 (D55) (41906:42573) stated:

> The current frail and assisted living facilities are private and full already and the Government should build cheaper old age homes for mostly the black frail older people and they should also be allowed to take care of their grandchildren there as well.

The old age homes should be close to health facilities to ensure that frail older persons can access these when needed. SFG 54 (D54) (34957:35826) said that:

> It is pointless for old age homes to be built far away from hospitals and clinics because then it will serve no purpose for old people who are sick. The old age homes must have nurses and social workers employed by government to look after primary care of old people before they go to hospital.

### 5.5.4 Care environment for frail older persons must be dignified

Most of the empirical reflections recommended that the welfare models for the care of frail older persons should be capable of maintaining their inherent dignity. As explained by Participant 04 (D4) (9222:9390), “frail older people

must be given the kind of care that promotes human dignity and quality of life owed to them as of right and not to make them feel like a burden." Participant 19 (D19) (9442:9994) described "human dignity in terms of respect, compassion and provision of needs…only when poverty is dealt with can a life of dignity begin."

Participant 30 (D30) (15320:15392) agreed and said that the following:

> What gives dignity to frail older persons is when their have food to eat, decent living conditions since at the moment most of them live in shacks, most of their healthcare needs are met and their monthly pension is able to make ends meet.

These reflections provide a good basis for a welfare system that seeks to address the needs of frail older persons.

> The formal caregivers also expressed the view that even in a relatively better resourced residential care environment, there is a need to treat frail older persons with human dignity.

According to SFG 52 (44594:45242), human dignity for frail older persons means the following:

> Human dignity is a well-deserved life, with adequate social security benefits and a functional health care system that supports a positive end of life experience in the care environment, but I can't say that for the less fortune members of our communities.

Similarly, SFG 54 (D54) (39489:40550) stated:

> Frail older persons must be treated as citizens with human rights despite their physical and mental condition. To respect their dignity means they must be consulted or informed about what treatment they are getting when sick or what medications to take. It's also their right to refuse treatment whenever they want to. Things cannot just be forced or imposed on them as if they don't have dignity.

Respecting human dignity also means recognising cultural and religious beliefs and allowing frail older persons in the care environment to observe their customary rituals. SFG 52 (D52) (47263:47877) said that:

> In my experience as a nurse for many years, social support networks have been proven time and time again to uplift the elderly out of depression and loneliness…the care home sometime invites different religious groups to come sing and pray for our older people. This makes them very happy and part of the community of believers. Happiness is part of human dignity.

## 5.6 CONCLUSION

The study primarily aimed to answer four research questions relating to the needs of frail older persons in Namibia from the perspectives and experiences of the formal and informal caregivers. The empirical findings revealed four themes dealing with these perspectives and experiences, together with insights into regulatory support and possible recommendations for improvement of the care environment.

In describing the needs of frail older persons, the caregiver perspectives identified various needs, ranging from basic necessities of life like food, water, housing and electricity to healthcare and psychosocial support. From their experience of providing care to frail older persons, the caregivers also identified various challenges. These include work burdens, abuse and neglect, lack of training and the impact of culture, religion and traditions on the care environment. Generally, the care environment holds many barriers to effective provision of quality care to frail older persons.

In dealing with the study objective relating to policy and legislative support, the caregivers described the current shortcomings in the existing framework. These have mainly taken the form of a lack of transparency on the part of government that has hindered awareness about any new policy and legislative agenda.

Lastly, on the basis of the empirical findings, various recommendations for the improvement of the overall care environment of frail older persons were offered. The caregivers offered various practical suggestions, mainly concerning policy and legislative reforms relating to pension increases, enhanced welfare grants, the building of old age homes and a generally more dignified care environment for frail older persons.

The empirical findings have indeed produced deeper insights into and enriched the exploration of the needs of frail older persons as well as increasing our understanding of the challenges facing the care environment of frail older persons in Namibia.

# Chapter 6 DISCUSSIONS

## 6.1 INTRODUCTION

As indicated in the preceding chapters, the study logic is both inductive and deductive given the iterative analytical process inherent in qualitative content analysis (Saldaña, 2016). This methodology was adopted because the researcher approached the study with pre-conceived ideas from the literature and personal experience and evaluated them inductively against the emerging empirical data and theoretical observations (Saunders et al., 2019). Chapter 6 covers the synthesis or interaction between empirical findings and literature control, including the theoretical observations. The key findings in the preceding chapter were interpreted for meaning in terms of relationship with the research questions and also to resolve the issues raised in chapter 1 pertaining to, *inter alia*, the research problem and study impact (Gray, 2019).

This chapter is divided into four parts as follows:

1. Perspectives of formal and informal caregivers on the needs of frail older persons

2. Experiences of formal and informal caregivers in providing care to frail older persons

3. Regulatory support for frail older persons

4. Recommendations for useful caregiving approaches

This chapter includes the formulation of a new conceptual framework for the assessment and understanding of the frail care needs of older persons in Namibia, which also highlights the unique dimensions of the research.

## 6.2 PERSPECTIVE OF CAREGIVERS RELATING TO THE NEEDS OF FRAIL OLDER PERSONS

The foundation for dealing with the frail care needs of older persons is not only that this is a moral and social responsibility, but that it is also a common law and statutory duty that requires effective regulation and enforcement mechanisms. The following discussion illustrates the importance of understanding the underlying needs of frail older persons from a legal and policy point of view, but also describes

the mechanisms for addressing them. The legal principles were addressed in the Namibian High Court case of Barnes v. Union and SWA Insurance Co. Ltd. 1977 (3 SA 502). This case was about poor frail parents who sued their children for financial support to enable them to afford the basic necessities of life. The court confirmed the reciprocal common law obligation of support between financially able children and their frail parents. Furthermore, the Maintenance Act 9 of 2003 also provides for a reciprocal duty of maintenance between parents and their children (Cornelius, 2011). In other words, the basis for liability is the inability of persons to support themselves. In other words, the basis of financial support is needs-driven, which makes it even more important to understand the unique needs of frail older persons. Thus, the children of frail older persons have a duty in law to provide financial support to their parents provided they have the means to do so. The reciprocal duty of support in addressing the needs of frail older persons has the character of demand and supply. This means that frail older persons can demand support based on their needs, whereas the children should only supply based on capacity. Accordingly, this legal obligation is enforceable in courts of law. Furthermore, in terms of broader legal instruments, the Namibian Constitution, the AU Policy Framework and the United Nations' Principles for Older Persons also provide a legal framework for addressing the unique needs of older people. In support of these frameworks, Pillay and Maharaj (2013) argue that these instruments will not be effective by themselves unless there is a solid understanding of the unique needs of frail older persons. As the study has revealed, the multiple needs of frail older persons are similar, but not necessarily the same. According to Cornelius (2011), the socio-economic and political history of each context has an influence on the particularity and extent of the needs of frail older persons. Therefore, understanding the unique challenges and needs of frail older persons in every situation is cardinal for their adequate protection and inclusion in national development objectives. The specific needs of frail older persons in Namibia are discussed as follows:

### 6.2.1 Basic food

Access to basic food has been found to be one of the most cardinal needs of frail older persons, according to the informal caregivers. The informal caregivers have emphasized the need for basic food in the care environment. While the literature has generalized the need for food of older persons (World Health Organization, 2002b), the empirical data show a need for a specific type of food with nutritional content. For example, the need for basic food is expressed in terms of fresh produce, meat and even porridge. This finding provides a unique conceptualization of the need for basic food of frail older persons. In addition to identifying the types of food, the research has also revealed the pervasive nature of the need for the most basic foods

across the informal care environment. According to Marais (2020), the shortage of basic food in the informal care environment points to overall food insecurity for frail older persons. In contrast, access to basic food is not a problem in the formal care environment. In fact, the empirical data revealed that the food situation in the formal care environment is nutritionally balanced. This differentiation highlights the point that the needs of frail older persons in formal and informal care are not always the same. This empirical discovery also highlights the racial dimensions and the associated inequality in the two care systems of frail older persons in Namibia.

Food security is a critical need for older persons not only in Namibia, but also in the SADC region. According to Cornelius (2011), due mainly to historic circumstances and relatively poor socio-economic growth, the informal care environment of frail older persons in this region is faced with a shortage of food. This view is supported by Marais (2020), who says that lack of food in the informal care environment has impacted negatively on nutritional content. This has adverse consequences for frail older persons, resulting in undernourishment, weight loss and other diseases associated with nutrient deficiencies. Lack of adequate food in terms of proper nutritional value also exacerbates the health conditions of frail older persons.

The World Health Organization (2002b) argues that generally food insecurity is a violation of the fundamental human rights of frail older persons, which is contrary to modern international law. According to Carnow (2015), frail older persons must feel at home on this planet Earth and enjoy human dignity and food security. Thus, governments around the world are encouraged to make food available to the most vulnerable members of society. Beattie et al. (2014) concur, stating that food is essential for maintaining the appropriate level of nutrients, which is critical for optimal immune responses. Access to food has also been identified as essential in the face of the COVID-19 pandemic, where the corona virus opportunistically attacks the neurological and immune system of frail older persons in particular (Aliberti et al., 2021).

In Namibia, food security is discussed broadly at policy level without a specific focus on the underlying needs of frail older persons for basic food (Black, 2018). The extent of the problem is now evident from the reflections of many informal caregivers who are forced to survive without access to basic food and generally have to rely on hand-outs. According to Crush et al. (2021), the average Namibian household is facing a limited supply of nutritious food.

Various food distribution programs have been implemented, such as the food banks under the Harambee Prosperity Plan (Frayne, 2010). However, an interesting finding

of this research is that many of the intended beneficiaries, like frail older persons, have not been reached with success. Various reasons have been suggested for this in the empirical data, such as lack of policy prioritization of this older cohort and their lack of the physical mobility needed to access distribution points. According to Crush et al. (2021), government's food distribution programs are only effective when enough research is done about their coverage and impact on the most needy households. In other words, to verify that food is being distributed to the intended beneficiaries, including frail older persons.

Furthermore, Kaiser et al. (2010) argue that lack of access to basic foods has the potential to increase mortality rates in frail older persons. This makes sense in view of the high levels of multi-morbidities associated with frailty in old age which the research has revealed. On this aspect, Joubert and Bradshaw (2003) highlight the urgent need to investigate the relationship between food shortages in older persons and mortality experiences in this cohort. The lack of basic food that could provide the correct nutritional content for older persons is influenced by the limited financial means that older persons in informal care have to support themselves. The overwhelming need for financial support was identified in the research as a central matter in ensuring food security for frail elders. This is in contrast to the view that social grants or old age pensions are adequate to fund basic nutritional intake (MOPESW, 2019). Financial support is therefore a key enabler of a decent standard of living and to ensure the provision of basic foods for frail older persons in their homes.

### 6.2.2 Hygiene, sanitation, water and electricity.

Many informal caregivers have expressed the need for the provision of basic services like water and electricity. Although this is a local government service delivery issue, it was a recurring theme expressed by informal caregivers, which makes it relevant for discussion. Caregivers stated that in many cases, households with frail older persons were without a sufficient supply of water and electricity. In some instances, informal caregivers had to walk long distances to collect clean water from a central point, which also involved exorbitant costs. This created further problems related to safety and security as water had to be collected during the day as well as at night. Again, the empirical data found that this need is only uniquely relevant to the informal care environment. Perold (2000) avers that access to decent hygiene, electricity and water supply is considered a human right and one founded on upholding the human dignity of frail older persons. This means that African governments, especially given the history of colonialism, have an added obligation to provide decent living conditions for the care and protection of frail older persons (Mukuka, Kalikiti & Musenge, 2002).

The situation in Namibia with regard to the need for effective basic service delivery is common to informal caregivers across Southern Africa. This view is illustrated by Apt (1996), who argues that ageing in developing countries happens within a broader socio-demographic and socio-economic environment where limited resources are available to provide for improved living conditions of frail older persons.

The circumstances of frail older persons are negatively impacted by lack of access to basic utility services. Booysen (2000) postulates that the quality of life of frail older persons is dependent on the provision of access to clean, drinkable water, electricity and decent sanitary conditions. This is essential to allow frail older persons to carry out activities of daily living with dignity, such as bathing, cooking and flushing toilets (Dima, 2003). If these basic needs are not met, the overall care of frail older persons is compromised, as basic services are the foundation for fulfilling all other care needs. When basic services are absent, the care of frail older persons is negatively affected from the start. According to Latakgomo (2011), local governments should prioritize the needs of frail older persons in the provision of services. This means that a commitment must be made to address the specific plight of frail older persons. As a result, Ruiters (2018) argues for some kind of indigency program that could provide social surveillance of poor households in order to gather intelligence as a basis for adequate informed policy making. In this regard, the provision of free local government services to frail older persons has been proposed. However, Latakgomo (2011) asserts that this policy aspiration is only effective in an environment where the actual services are available, but serves no purpose in neighbourhoods where services do not exist. Under social policy development, this type of poor policy intervention become tokenistic and is of no positive use to affected indigent households caring for frail older persons (Bond, 2014). Thus, a different policy and legislative focus is required to address the needs of frail older persons. Interestingly, the formal care environment of frail older persons has not expressed the need for service delivery. This can be explained by the relative socio-economic inequality that has resulted from historic circumstances and race dynamics in the care system. This is the case because, as indicated before in the study, most of the formal care system in Namibia provides services to whites who are not necessarily facing the same socio-economic challenges as their black counterparts under informal care.

### 6.2.3 Family support

In the informal care environment basic service was found to be a fundamental need. In the formal care environment, however, family support was emphasised. The need for family support was highlighted by formal caregivers as a fundamental issue. This was understandable considering that frail older persons in the formal care

environment are separated from their families (Krause, 2006). This need for family support was reported at various levels, including the psychological, emotional, cultural and social levels. This is different from the informal setting where in most cases frail older persons live in a familiar environment, sometimes with relatives and friends, who are usually accustomed to their cultures and religions (Makiwane et al., 2020). According to Vorster (2011), frail older persons in institutional care have a greater need for family support and for the family to take an interest in their care at old age homes. On this aspect, Knodel and Teerawichitchainan (2017) postulate that often family support is primarily based on providing for the material wellbeing of frail older persons. In other words, making sure their financial needs are met, but formal caregivers in this study described family support in much broader terms as including actual family involvement in the care of frail older persons. In illustrating this point, formal caregivers have described the need of frail older persons to connect with their loved ones on a regular basis, such as being taken home on short stays. This makes them feel part of the family and appreciated as social beings.

According to Vasileiou et al. (2017), family support enables frail older persons to cope better with the challenges associated with institutionalized care. In describing the situation of older persons in Namibia, Kalomo et al. (2021), recently stated that residents of old age homes with stronger family connections tend to be happier and easily integrated under institutional care. The research confirmed this view since many formal caregiver reflections have pointed to improved co-operation of frail older persons with families that are involved in their care. In this regard, Geerts and Van den Bosch (2012) have argued for more physical family involvement in the care of frail older persons as an important intervention and predictor of how effective the support provided to them will be.

### 6.2.4 Culture and religion

Issues of cultural and religious sensitivity in the care environment were mentioned as important needs of frail older persons. The need for culture and religious sensitivity was recognized in view of the diversity of backgrounds of frail older persons in the care environment (Pharr et al., 2014). This need implies that cultural and religious awareness must be raised in the care environment. Cultural and religious orientation is a form of identity and lack of sensitivity denies human dignity and will elicit unfavourable response to treatment and care (Ang at el., 2020). The formal caregivers themselves may not always be educated regarding this aspect and it is incumbent upon the family to assist with cultural intelligence in the care practice (Bernado et al., 2020). In the opinion of Nabalamba and Chikoko (2011), each care practice for frail older persons should make a concerted effort to embrace cultural

and religious diversity for effective and quality care outcomes. However, the family of frail older persons can also play an important role in raising awareness about this aspect in the institutional care environment (Bernado et al., 2020).

In Namibia the need for religious and cultural sensitivity is even more important given the recent history of Apartheid and colonialism, as well as the cultural belief systems of different communities that intersect in the care environment. This study showed how cultural beliefs and customs emerge that could impede care relations, especially with regard to age differences and differences in the race and gender of formal caregivers, as was indicated by the male participant who refused to be cared for by a woman unless she was a relative or in cases where some of the participants refused to be cared for by a younger caregiver, or a caregiver with a different racial profile to the participant. Under these circumstances, cultural convictions can make the caring responsibility burdensome unless there is an understanding of culture and traditions. Thus, a lack of cultural sensitivity in a diverse care environment can be a source of frustration for caregivers, which can impact negatively on both the formal caregiver and the frail older person and ultimately the whole care environment (Ang et al., 2020).

In terms of the administration of prescribed medicines, some of the formal caregivers have related experiences where frail older persons refused to take prescribed medicines due to the fact that they believed in traditional herbs. This situation create conflict in the care environment and requires a caregiver to understand the cultural nuances before implementing a more effective approach. In highlighting the nuances of culture and religion in care, Ayete-Nyampong (2014) explains that a formal caregiver would not start caring for an African frail older person unless he or she understands African culture and spirituality at a basic level. Similarly, Nowitz, (2012) argues that culture and spirituality should form an integral part of geriatric care. Therefore, unless caregivers recognize the diversity of backgrounds of frail older persons, their supportive and caring role will be meaningless (Harris & Moran, 1996). According to Abdullah (2021), religious and cultural sensitivity in welfare service delivery is also important under kinship family arrangements. Although the informal caregivers in the data have not described the same degree of need for cultural and religious sensitivity as in the formal system, this aspect is also important given the challenges some of them have described in providing kinship care.

### 6.25 Socialization

Just as older persons in the formal care environment have a need for culture and religion, they have a need for socialization. This covers their desire for social

well-being, identity and interaction (Böger & Leisering, 2017). While the concept of socialization in aging is broader than the socialization dimension inferred in the empirical data (Gomes et al., 2013), the emphasis here falls mainly on social relations or societal connections. According to Böger and Leisering (2017), the absence of adequate socialization for frail older persons leads to social exclusion, which impacts negatively on their holistic well-being. Increased socialization of frail older persons also enhances their right to human dignity and social welfare (Mégret, 2011).

Thus, the context-specific conceptualization of the need for socializing frail older persons relates to social engagement, inclusion and connectivity with the social environment from which they hail. In other words, keeping close contact with the social environment through regular interaction with society from which they originate. Such specific focus is often overlooked in gerontological and social development research (Hokenstad & Restorick Roberst, 2016). This narrow empirical conceptualization of socialization also explains the intersection of broader and evolving specific social needs of different age cohorts across the life course (Börsch-Supan, Kneip, Litwin, Myck & Weber, 2015). According to Bunt, Steverink, Olthof, Van der Schans and Hobbelen (2017), the denial of adequate socialization to frail older persons increases the risk of social frailty, which is defined as the risk of losing the social resources necessary to fulfil social needs across the life span. It is apparent from this that socializing is an important resource in addressing the broader socialization needs of frail older persons.

Against this background, the need for socializing by frail older persons can be met by various inter-active experiences, including sensory stimulation (like music, visual arts, etc.) and one-on-one socializing (Mallidou & Babalola, 2020). While there are various mediums of social exchange, sensory stimulation has proved to be a successful intervention in socializing frail older persons in the care environment.

However, the reality on the ground as per the study outcomes is that many frail older persons in old age and nursing homes (formal caregiving environment) feel a sense of abandonment, and feel that they are being ostracized and shunned by family members and the community. This situation leads to loneliness in frail older persons, which results in negative health and social behavioural outcomes for this cohort (Gomes et al., 2013). Specifically, to avoid loneliness the empirical reflections described the need for regular family visits and church outreach services as an important aspect of addressing the need of frail older persons to socialize. In highlighting the importance of the need for socializing, Epps et al., (2021) aver that

church outreach services to old age homes should be adapted to meet the unique physical and mental health conditions of frail older persons.

On the other hand, it is postulated that the withdrawal symptoms of frail older persons from society are a natural consequence of aging as reflected in the disengagement theory of gerontology (Cumming & Henry, 1961). The argument underlying this approach is that aging and frailty are accompanied by automatic functional redundancy. This means that frail older persons are no longer seen as capable of adding constructive value and that this results in a progressive reduction in societal standing. Accordingly, both frail older persons themselves and society catalyse this withdrawal syndrome through disengagement (Powell, 2001). In this sense, accountability for avoiding loneliness is shared between society and the individual frail older person (Kwok & Tsang, 2012). In other words, frail older persons themselves must, emotionally and behaviourally, promote some degree of social engagement through role stability and continuity despite changing circumstances.

Some scholars aver that frail older persons have outlived their usefulness and cannot offer much in terms of development agency (Nankwanga & Phillips, 2009). However, Mégret (2011) argues strongly that frail older persons can contribute meaningfully to society, as they are a repository of wisdom and knowledge. Their experiences can be transferred to and shared with younger generations through various socialization interventions. In other words, care institutions are an integral part of society and hence frail older persons also have something to contribute to society through positive social engagement (Ramashala, 2001). As noted earlier on in the study, the contribution of frail older persons to society could take the form of sharing of wisdom, but also of reciprocal love and affection.

The empirical data have found that, based on the Namibian experience, the necessary socialization of frail older persons requires greater social inclusion through interaction and involvement. Despite their condition of frailty, they are alive and capable of giving and receiving love and affection. According to Mégret (2011), the need for socialization of frail older persons is even more important during the end-of-life period when socialization contributes to living with dignity.

Therefore, with greater social interaction frail older persons can experience some degree of quality of life and approach imminent death differently (Andersson et al., 2008). This is contrary to some scholarship in which it is argued that frail older persons are not capable of experiencing quality of life through socialization due to their vulnerable condition (Vanleerberghe et al., 2017). The data have indeed refuted this view and report that even during frailty, older persons can experience

quality of care if there is recognition for their unique contribution to society, along with greater social connectivity. While the study confirms reduced social functioning due to aging and frailty, a case is made for greater socialization of frail older persons through engagement and regular interaction.

According to Hemberg et al. (2021), socialization gives frail older persons a sense of self-esteem and purpose. If fact, Boreskie et al. (2020) argue that with the fact that the world is confronted by the Covid-19 pandemic and social distancing protocols is even more reason to ensure that frail older persons get opportunities to socialize to prevent frailty progression. Of course, socialization under these conditions must be done within margins of safety for all involved (Pérez et al., 2021).

In this sense, the socialization of frail older persons is important to provide a social context within which aging happens and is an integral part of their holistic overall well-being as senior citizens (McCallion, & Toseland, 1995). Also, Perman et al. (2021) argue that improved socialization of frail older persons significantly reduces the risk of mortality in the care environment. Against this background, the need for socialization is both subjectively and objectively important for the holistic well-being of frail older persons. Subjectively because the psychological impact of enhanced socialization is positive for them as a cohort and objectively as an essential evidence-based policy imperative. In supporting this view, Hemberg et al. (2021) argue that the physical and mental health conditions associated with frailty should not lead to social isolation, and reduced interaction and functioning of frail older persons. Their lived experiences suggest that frail older persons also have the necessary abilities and resources to make an enlightened contribution to society through greater socialization.

While there were far fewer reports of the need for socialization under informal care, there were still limited experiences of inadequate socialization of frail older persons. This arose mainly from loneliness due to the intermittent absence of some informal caregivers who leave the frail older persons unattended. Generally, the limited need for socialization among persons in informal care makes sense considering that in most cases they are cared for in community settings with the benefits of familiarity. This provides a relatively greater opportunity for social contact and engagement. Overall, the need for improved socialization is pervasive across the care domain of frail older persons with varying degrees of relevance, depending on circumstances.

### 6.2.6 Integrated care

While integrated care is regarded in the literature as a specific model of care, the empirical data simplistically conceptualize this in terms of basic access to multiple health services in the care environment. According to Mur-Veeman et al. (2003), integrated care refers to institutional coordination of a holistic, seamless and patient-focused delivery process of multi-disciplinary health services. Under the integrated care model, Leichsenring (2012) postulates that a more complex system based on social innovation is required, which create a functional interface between the health and social care of frail older persons. This means that as a model, the concept is not as simplistic as the one described by empirical experiences. In this regard, the reflections of caregivers merely limit integrated care to the narrow aspects of demand and supply of health services in the care environment of frail older persons. According to Steverink (2014), enhanced levels of holistic well-being of frail older persons can only be achieved through productive engagement with healthcare professionals.

The reality is that conventional healthcare systems for frail older persons are disease-based and not focused on their specific geriatric healthcare needs (WHO, 2018b). This results in harmful clinical consequences for multi-morbid frail older persons with complex health needs. This conventional approach has proved ineffective and has failed to address the unique medical needs of frail older persons (Palmer, Howard, Bryan & Mitchell, 2018).This is also the case because health professionals are often trained to deal with single diseases and do not proactively anticipate complex geriatric health conditions (WHO, 2018b). In this regard, common geriatric conditions like multi-morbidity and frailty are ignored in the health curriculum. According to Mateos-Nozal and Beard (2011) it is imperative in any healthcare system and especially in healthcare systems in the developing world to provide tailor-made specialist healthcare knowledge and training that target the geriatric needs of frail older persons.

The formal caregivers therefore expressed the need for integrated care in terms of availability of multi-disciplinary health professionals in the care environment. This health resource-based approach describes integrated care as a single package of access to specified professionals such as those working in the fields of orthopaedics, geriatrics, pastoral care, and oncology; social workers, psychologists etc. This is an important finding given the current scholarly debate on the appropriate package of integrated care for frail older persons (Kodner, 2009). On this point, Steverink et al. (2005) argue that the older and frailer people become, the more fulfilment of health needs becomes paramount. Therefore, adequate resources should be made

available to meet the integrated healthcare needs of frail older persons as described in the data.

Furthermore, in terms of context, the need for integrated care of frail older persons reflects the fragmented and inadequate nature of Namibia's healthcare system, especially in terms of geriatric needs fulfilment. According to Brockmeyer (2012), Namibia's healthcare system is unaffordable and unresponsive to the healthcare needs of the majority of the population. The World Health Organization ascribed the racially fragmented nature of Namibia's healthcare system to the past history of colonialism and inadequate focus on age demographics (WHO, 2010). Gobbens and Van Assen (2014) agree and state that lack of focus on age demographics in the delivery of healthcare services leads to adverse outcomes for frail older persons. This means that despite their chronic multi-morbidities, frail older persons are denied access to quality healthcare. Under these circumstances, the need for integrated healthcare delivery is evident if a multi-disciplinary healthcare solution is to be achieved.

### 6.2.7 Housing and living conditions

The majority of informal caregivers of frail older persons live in backyards, mostly in corrugated iron structures referred to herein as shack dwellings. These living conditions often expose frail older persons to the elements and to security threats. Many of these backyard dwellings are not structurally sound or connected to clean running water and lack adequate sanitation (Geyer & Louw, 2020). According to Sepúlveda Carmona (2013), lack of serviced land is a major barrier to housing delivery in general in Namibia. Also, given the limited amount of land available, the size and design of these backyard dwellings for frail older persons do not comply with acceptable social engineering standards. In most cases, these dwellings are one-roomed structures intended for sleeping only while the cooking is done on an open fire and dining takes place outside (Hickel, 2014). The concept of backyard dwellings is more than a reflection of the housing shortages for this age cohort; it also reveals the inequality in the overall distribution of the country's wealth and the impact of poverty (Nord, 2021). These poor living conditions, associated with a lack of decent housing for frail older persons, create many challenges to their well-being. The bottom line is that the condition of most of these residential dwellings is unsuitable for providing proper care to frail older persons.

From a policy perspective, this is significant as it highlights of the need to provide decent housing as a priority area in the improvement of the living conditions of frail older persons (Mathe, 2018). The study also described the specific housing

needs of frail older persons. In other words, the need for improved housing refers to suitable accommodation that meets acceptable standards for geriatric care. The provision of unsuitable houses will not address this specific need. The fact is that poor housing often exposes frail older persons to more falls and accidents (Tomas et al., 2021). Furthermore, shack dwellings and especially wooden or paper box structures are prone to opportunistic fires with serious fatalities (Chance, 2018). Thus, frail older persons living under these conditions are exposed to serious risks given their limited mobility and functional impairments in respect of the activities of daily living. The shacks where most informal caregivers render care to frail older persons are generally in flood-prone areas that pose a serious challenge during rainy seasons. The 2011 Namibia Population and Housing census reported improved living conditions for older persons (Indongo & Sakaria, 2016), but the reality on the ground is that most older persons are still exposed to substandard housing. Because of the inordinate levels of poverty in these informal shack settlements, Ndjembela (2018) says that they have come to represent the ugly face of social exclusion and marginalization in Namibia.

Furthermore, Mukuka et al. (2002) argue that the poor housing conditions of frail older persons are often exacerbated by poor policy and legislative frameworks. This is indeed a critical issue described in the data since no policy mainstreaming initiatives exist in Namibia for the provision of decent housing to frail older persons. In fact, no frail care policy can be referenced in Namibia (Pretorius, 2019). Equally, no specific policy or legislation that focuses on or addresses the residential needs of frail older persons exists (Mathe, 2018). According to Asino and Christensen (2018), the lack of appropriate policy focus also hampers government funding of housing developments for this demographic group. While the comparative research is not conclusive on the real extent of breakdown of intergenerational solidarity and its impact on the support system of frail older persons (Aboderin & Hoffman 2015), the data has described how in some instances many extended family members share the same dwelling. In fact, the study revealed that the average informal care household is overcrowded through the inclusion of various members of the multigenerational family (Indongo & Sakaria, 2016).This overcrowding affords no privacy to frail older persons and compromises their human dignity. Byrnes and Mattsson (2021) agree with this sentiment and aver that improved living conditions of older persons enhance human dignity. In terms of rights guarantees, some countries, of which South Africa is one, have entrenched constitutional entitlements to adequate housing (Momodu et al., 2018). On the other hand, the Namibian constitution is silent on the right to decent housing and merely articulates broader protection against poor living standards (Mathe, 2018). This means that in practice frail older persons cannot

approach any competent court for enforcement of the right to decent housing as a constitutional right. This proves that future policy and legislative developments are critical in addressing the need for decent housing and improved living conditions for frail older persons.

Given the fact that demand for decent housing for frail older persons outweighs supply, the Namibian government is promoting the informal family-based care system instead (Pretorius, 2019). The preferred care approach is based on aging in communities as opposed to aging in institutional settings, which demands more resources from government (Kelly et al., 2019). This situation is ironic given the fact that the informal care system is confronted by inadequate living conditions due to poor housing. This approach by government is seen by some as abdication of responsibility for delivery of social welfare services and denial of the constitutional right to human dignity (Nakuta & Mnubi-Mchombu 2015).

### 6.2.8 Access to healthcare

The provision of adequate, appropriate and quality healthcare to frail older persons is important for both society and government. In order for older persons to make a positive contribution to society they need to remain healthy. In other words, access to an affordable quality healthcare system will increase life expectancies and slow down frailty in this cohort (Lombard & Kruger, 2009). However, the reality is that many frail older persons are faced with multi-morbidities, but without access to a quality public healthcare system (Breytspraak, 2016). Advancing the health and well-being of frail older persons is included as part of the Draft Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa. Under this framework, free access to health services and medical insurance is promoted. In terms of Article 17 of the Charter, health personnel are also required to be trained in geriatrics and gerontology.

According to Kelly et al. (2019), while the health needs of frail older persons are generally the same, there are still nuanced differences in the formal and informal care environments. This view is confirmed by the data, which describe the differences in health needs in formal and informal care settings. In fact, the dynamics of needs are different across the care systems in Namibia. Most of the informal caregivers have expressed the health need of frail older persons in terms of access to chronic medication, transportation to health centres, assistive devices and specialized health services like physiotherapy and occupational therapy. On the other hand, the formal caregivers have described very few challenge in this area of health needs. Many frail older persons are multimorbid and dependent on chronic medication for some

degree of quality of life and well-being. Inevitably this situation puts a strain on any country's healthcare resource mobilization strategy (Pretorius, 2019). The shortage of chronic medication at most public health centres in Namibia is symptomatic of the limited budgetary provision for healthcare and lack of resource optimization (Shafuda & De, 2020). The situation has now been compounded by the Covid-19 pandemic. However, Mukuka et al. (2002) ascribe the situation of limited supply of chronic medications to poor planning, coordination and overall systemic failures in health care systems to prioritize the health needs of frail older persons.

On the other hand, the geographical location of health centres seems to be another barrier to access to healthcare. Many frail older persons experience mobility challenges and the location of available health centres impacts on their ability to get medical attention (Lombard & Kruger, 2009). According to Van Rooy et al. (2015), the lack of transportation is an integral part of the health needs of frail older persons. This view is supported by Kelly et al.(2019), who argue that the health care systems in developing countries are not generally designed to cater for the needs of the most vulnerable in society. However, the empirical data have added a different dynamic by demonstrating that even in some instances where private transportation is available, the cost is not affordable to frail older person. For most of them social grants are the only form of household income. Another aspect raised in the data is that even if frail older persons could afford any form of transportation to health centres, the vehicles in which they are transported are not designed for their various physical conditions. This challenge does not apply in the formal care environment since in most cases the chronic medications are supplied and general medical consultations carried out on site.

The need for health care was also expressed in terms of access to auxiliary health professional services like occupational therapy and physiotherapy. Restricted mobility and in some cases being bed-ridden for extended periods requires physiotherapy and related services. Unfortunately, these auxiliary health professional services are not readily available at State hospitals servicing frail older persons in the informal care environment. The need for multidisciplinary supportive professional health services is cardinal to the well-being of frail older persons (WHO, 2009b). According to Plöthner et al. (2019), even more than the availability of multi-disciplinary health care services, frail older persons need effective out-patient support, given the limited training informal caregivers have in providing nursing services. This view is supported by various informal caregivers who have expressed the need for more auxiliary professional health care services to be made available to support the care of frail older persons.

While the developed world is arguing for the enhanced use of technology in the health care of frail older persons (Magnusson & Hanson, 2005), the developing countries are confronted by the need for basic assistive devices like walking crutches, walkers, canes, wheelchairs, etc. Thus, in as much as the developed world is promoting the better utilisation of technological devices like smart phones, watches, bracelets, computers, etc. to improve the care environment (Bergström & Hanson, 2017), the reality is that most of the frail older persons in developing countries cannot afford the most basic necessities like food and primary health care (Makiwane et al., 2020). Besides, concerns have been raised about the intrusive and potentially unethical nature of modern technologies in the care of frail older persons (Wang et al., 2019).

Overall, the literature and empirical data are in agreement that generally healthcare systems are not designed to deal with multi-morbidity care and the unique gerontological needs of frail older persons. According to Kuluski et al. (2013), healthcare systems are primarily concerned with single diseases with no focus on multi-morbidities associated with aging and frailty. This situation is exacerbated by the general lack of specialised training of health professionals in geriatric medicine (Kespichayawattana & Jitapunkul, 2008). This situation is contrary to the guidelines of the WHO, which requires efficiency, efficacy, adequacy, but also equity in the provision of health care services (WHO, 2015b).The empirical findings have highlighted the fact that it is pointless to speak about access to healthcare when basic everyday needs are not met. This means that access to medicines, medical specialists and availability of assistive devices defines the need for access to healthcare. Thus, the need for healthcare should not be treated as a broad concept but contextualised to a setting in order to understand conditional dynamics (Wolfe, 2001).

Furthermore, the cost of healthcare in Namibia is very high and it is unaffordable for many frail older persons, which compromises their health and increases frailty (Brockmeyer & Stiftung, 2012). The empirical data also found that the State hospitals are very dirty and unhygienic and often the condition of frail older persons is aggravated at these facilities. Simple essentials like hospital beds and linen are not available and frail older persons have to sleep on the floor. According to Pretorius (2019), the Namibian health system is overburdened and is unable to cope with the growing demands of frail older persons in particular.

### 6.2.9 Mental health support

Both formal and informal caregivers have expressed the need for mental health support for frail older persons. Many frail older persons in both formal and informal

care are confronted by mental health related challenges like depression, anxiety, isolation, grief, illness, frailty, cognitive impairment, mental decline due to dementia and Alzheimer's etc. According to Pitkälä et al. (2009), old age and frailty and the associated multi-morbidities are often accompanied by mental health challenges. Aging in itself is an emotive process given the increased geriatric vulnerabilities and frailty that often make the life-span experience challenging (Charles & Carstensen, 2010). This whole experience is actually even more paradoxical since the transitional process is expected to be seamlessly adaptive for frail older persons. The empirical data also found that emotional breakdowns in frail older persons are derived equally from financial pressures and an inability to maintain household integrity due to diminished earning capacity and physical limitations. There is an overwhelming need for mental health support, as demonstrated by the frequency with which it is mentioned in the caregiver perspective reports. In any event, poor mental health especially in old age leads to poor functional capacity and reduced social relationships (Sparks, Zehr & Painter, 2004).

According to McIntosh et al. (1989), the mental health issues in frail older persons primarily emanate from psychosocial factors such as loneliness, poor relationships and social isolation. Mental health support, especially in the form of psychosocial support, is therefore needed in the care of frail older persons (Mason et al., 2007). According to Sandgren et al. (2021), lack of psychosocial support, aggravated by a limited capacity for self-management, is a major cause of mental health breakdowns in frail older persons.

According to the study outcomes, mental health problems often lead to suicidal thoughts that require counselling and sometimes appropriate medicines for frail older persons. Fleming et al. (2016) agree and argue that frail older persons with mental health conditions often have no fear of death. Due to limited training and lack of professional support, mental health conditions are often misdiagnosed and left untreated, which leads to increased work burdens in the care of frail older persons (Isola et al., 2008). The overwhelming empirical view is that due to the current lack of specialist knowledge on mental health issues in nursing homes, mental illness in older persons is mostly misdiagnosed.

Mental illness and associated geriatric conditions like dementia and Alzheimer's are fast becoming a growing global phenomenon with different levels of intensity and frequency (Watt & Konnert, 2007). This not only affects the quality of life of many frail older persons, but reveals the incapacity of the current health systems to respond to the growing mental health needs (Sparks et al., 2004). In terms of global comparative literature, the need for mental health is widely recognised and pharmacotherapy

has been used as one effective means of providing behavioural and psychological support to frail older persons with Alzheimer's and dementia (Seibert et al., 2021). However, Canevelli, Vanacore, Blasimme, Bruno and Cesari (2021) caution that the mental health condition of frail older persons is more serious and worse than it was a decade ago. Accordingly, evidence-based clinical interventions are required if we are to understand mental health in frail older persons and accordingly guide appropriate responses.

### 6.2.10 Access to health information

The need for access to health information is based on the fact that many frail older persons are not well informed about their medical conditions, prognosis and treatment interventions. This problem is created by health professionals, caregivers and family members. Generally, health information and prognosis are sensitive and confidential matters and are protected from shared traffic. Health professionals have to take cultural and family issues into account and sometimes the assumption is that frail older persons do not have the mental capacity to appreciate the full extent of health information that could be offered on their condition (McLennon et al., 2013).

As a result, this information is shared with close family members or caregivers who, according to the data, often fail to share it because they do not want to worry the frail older persons or jeopardise their recovery. This is especially true in cases of a terminal prognosis where death is sometimes attributed to the fatalistic nature of such information rather than to the health condition itself (Checton & Greene, 2015). According to Liau et al. (2021), maintaining truth barriers or keeping vital health information away from frail older persons creates anxiety and sometimes leads to their refusal to get proper treatment. It is therefore not advisable to keep the frail older persons in the dark about their situation and treatment plan. The findings revealed the need for older persons to be part of the overall decision-making process and implementation regarding their health.

However, Hansen et al. (2021) argue that the involvement of frail older persons in clinical care has great value in their recovery and the effectiveness of their treatment plans. In any event, Ahlström et al. (2021) say that the efficacy of any treatment plan in the care of frail older persons depends on collaboration and coordination based on informed consent. Providing frail older persons with honest and accurate information not only involves them in decision-making, but also ensures that they will respond better to treatment and care (Hansen et al., 2021). According to Liau et al. (2021), access to information enhances human dignity, but also leads to effective medical management in the care of frail older persons.

However, there seem to be reservations about sharing health information. The empirical reflection advised that dissemination and sharing of health information should be done whenever practicable to do so, taking into account the cognitive abilities of the frail older persons involved. According to Ekelund et al. (2014), access to health information is important for self-determination, but a person-centred approach must be followed, depending on the condition of the frail older person concerned. This suggests that in some cases it may not be possible for the frail older persons to understand the information provided due to cognitive impairments and that a different approach may therefore be required. In supporting a person-centred care approach, Forsman and Svensson (2019) argue that when health information is shared, the level of health literacy must be considered when communicating with frail older persons. Accordingly, communication strategies and methods used to communicate with frail older persons must ensure that information is clearly understood and culturally sensitive so that partnerships can be catalysed in their holistic care (Ahlström et al., 2021). Including the family for this purpose will therefore be most useful.

From the above discussion it is clear that the issue of sharing health information is complex and creates a moral, ethical and legal dilemma: a moral dilemma because every human being has a right to self-determination and cultural affinity; an ethical dilemma because professional ethics dictate patient-centred, open disclosure; and a legal dilemma because of the interplay between constitutional and legal rules around access to information.

## 6.3 EXPERIENCES OF FORMAL AND INFORMAL CAREGIVERS OF FRAIL OLDER PERSONS

Under theme 2 as described in chapter 5, the caregivers shared their experiences in providing care to frail older persons. The caregivers are at the frontline of care for frail older persons and have first-hand experience about their needs (Sims-Gould and Martin-Matthews, 2010). This is so because caregivers are providing the actual care to frail older persons and in some instances share household with them. In performing multiple tasks of daily living for frail older persons, caregivers have deeper understanding of their needs through various experiences. The following discussion examines their specific experiences relating to providing care to frail older persons in Namibia.

### 6.3.1 Abuse experiences in the care of frail older persons

According to Klie and Ananias (2021), the phenomenon of abuse of older persons in Namibia is becoming a regular manifestation. According to them, this issue requires urgent public awareness and policy interventions to steer measures for the protection and safety of frail older persons. In the view of the World Health Organization, elder abuse is considered a public health issue and defined as “a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person” (WHO, 2002, p.1). Therefore, Lachs and Pillemer (2004) aver that there is general agreement that the four types of abuse consist of sexual, financial, physical and emotional dimensions. According to Torres-Castro et al. (2018), the condition of frailty rather than merely aging enhances vulnerability to physical, emotional and sexual abuse. As described in chapter 5, both formal and informal caregivers have related experiences of abuse in the care of frail older persons. While the literature suggests that overall abuse of frail older persons happens more under formal care than in the informal care environment (Habjanič & Lahe, 2012), the empirical data have established that protection against abuse is inadequate in both care settings. However, the nature, frequency and type of perpetrators of abuse differ between the two care environments. According to Noyoo (2017), the issue of abuse of frail older persons has become a global phenomenon which has given rise to calls for dedicated international conventions to protect the rights of older persons. A concerning fact is that incidents of abuse of frail older persons often go unreported (Inelmen, Sergi & Manzato, 2019). Even when incidents are reported, in most cases the perpetrators go unpunished due to weak legal systems and onerous evidentiary requirements (Goergen, 2004).

Many incidents of physical abuse have been reported in informal care. This view is confirmed by Klie and Ananias (2021), who argue that in Namibia, economic and financial abuse of older persons happens more regularly than physical abuse. This situation is aggravated by instances of emotional abuse and neglect of older persons. Some cases of abandonment of older persons by family members have also been reported. According to Noyoo (2017), abuse of frail older persons has a negative impact on their overall well-being and denies them human dignity.

In support of this view, the study participants described the nature of physical abuse in terms of slapping, shaking and the use of forms of physical restraint by caregivers. The same experiences of abuse were reported in formal care as well. The data contain descriptions of instances where frail older persons who were not behaviourally cooperative, especially those with mental conditions, had to be physically restrained, thereby causing unintended abuse.

Comparative literature indicates that the extent of physical abuse of frail older persons by caregivers is sometimes more severe and includes burning, kicking and generally rough handling (Naughton et al., 2010). Abuse of persons in formal care is subtle and often unreported, but sometimes the frail older persons have bruises. According to Morley (2002), bruises in themselves are often not conclusive evidence of abuse since frail older persons can sometimes cause unintended self-harm due to falls. Contrary to the empirical findings, globally incidents of physical abuse happen more frequently in the formal care environment, accounting for some 14.1% compared to only 2.6% in the informal care setting (WHO, 2021).The global situation is different from the situation in Namibia, where the informal care environment of frail older persons is more extensive than the formal care environment and is naturally bound to report more incidents. The comparative discussion must also acknowledge the reporting bias in cases of abuse under a system like that of Namibia, where no policy and legal framework exists for this.

Furthermore, the empirical data have also uncovered more experiences of sexual abuse of frail older persons in the informal care environment than in formal care. This is reported by many study participants who described various incidents of rape of frail older persons. However, according to the World Health Organisation (2021), global incidents of rape of frail older persons in the informal care setting are very rare at 0.9% compared to 1.9% in the formal care environment. Nevertheless, Yon et al. (2019) argue that in many countries incidents of rape of frail older persons go unreported due to limited monitoring and surveillance systems.

Financial abuse of frail older persons also featured prominently in the empirical data. On this aspect, it is evident that in most cases financial abuse is inflicted by the children themselves or by other extended family members. Based on the experiences of informal caregivers, financial abuse also extends to misuse of social grants and over-reliance by extended family members on grants as the only source of household income. According to previous studies, financial abuse of frail older persons in informal care is a common occurrence and one that is usually attributed to poverty and lack of necessary resources for daily living (Marais et al., 2006). In fact, financial abuse of frail older persons in informal care globally makes up only about 6.8% of total abuse incidents compared to 13.8% in formal care (WHO, 2021). Interestingly, the situation in Namibia reveals a contrary outcome in that more incidents of financial abuse are experienced in the informal care environment. This is largely because the informal care environment is by far the largest care system for frail older persons in Namibia (Ananias, 2014). This situation is explained by historic circumstances where old age homes were generally not available for blacks (Kloppers et al., 2015). As a result, the informal care environment in Namibia is

facing poor socio-economic conditions. In addition, the legal and policy framework does not further the interests and well-being of frail older persons. This situation denies well-being to frail older persons and creates conditions for financial abuse.

It should be noted that both formal and informal caregivers have described incidents where they themselves suffered physical and psychological abuse at the hands of frail older persons. Abuse by frail older persons mainly takes the form of verbal, emotional and sometimes physical manifestations. According to Mehta and Leng (2017), abuse perpetrated against caregivers also involves spitting and behavioural tantrums. The motivation for abuse against caregivers has been described as partly racial, as some caregivers are deliberately forced by frail older persons to speak in German or Afrikaans. This situation is burdensome for caregivers who hail from other racial and ethnic groups and are not familiar with German or Afrikaans. While the broader Namibian policy and legal framework do not condone racial discrimination (Kisting, 2003) there is no specific protection afforded to caregivers of older persons against this form of racial abuse. In fact, the Namibian constitution only recognizes English as the official language (Erasmus, 2010). This situation of ethnic language abuse also highlights the racial dynamic in the care of frail older persons. According to the empirical data, not even the existing labour laws in Namibia have been effective in improving the overall working conditions of caregivers. As explained by some formal caregivers, the care of frail older persons involves an emotional component and under those circumstances it becomes impossible to invoke labour laws in addressing poor employment conditions. The work burdens are endured for the sake of prioritizing the interests of frail older persons.

According to Gorman (2000), physical abuse by frail older persons is hardly imaginable considering that they are relatively too weak even to defend themselves against perpetrators. This does not mean it cannot happen in care practice and in fact Özcan et al. (2017) refer to this as reciprocal abuse. The data have clearly described incidents of physical abuse by frail older persons against caregivers. As indicated, this mainly took the form of slapping, spitting and sometimes outright hitting. In fact, Brownell, Berman and Salamone (2000) argue that the characteristics of the victim of abuse have less predictive value than the pathology of the perpetrator in determining culpability under the criminal justice system. This means that the fact that caregivers themselves are not usually frail and old themselves does not mean that they cannot be physically abused by frail older persons. Based on this, the data have confirmed a new phenomenon, namely what can be referred to as reverse abuse against caregivers by frail older persons.

Nevertheless, despite limited literature on the subject, the abuse directed towards caregivers is becoming a growing phenomenon and is sometimes considered an occupational burden (Peckham, 2009). Abuse of caregivers by frail older persons is often triggered by the emotional burdens and frustrations arising from conditions of frailty and care dependency (Bursack, 2021). Weerd and Paveza (2006) argue that abuse against caregivers by those under their care often takes the form of verbal mistreatment. Furthermore, the empirical data also established that physical abuse of caregivers at the hand of frail older persons does also happen. However, incidents of abuse against caregivers are rarely reported and are often less severe than the abuse perpetrated against frail older persons. The infrequency, rarity and lack of relative severity of abuse against caregivers means that this phenomenon is often uninvestigated and unreported, although it is not unimportant as it causes severe emotional burdens for caregivers. According to Phillips et al. (2001), female caregivers have mainly borne the brunt of abuse by frail older persons. Although the discussion has highlighted important new insights into the phenomenon of abuse, the major empirical findings converge with the findings of the literature relating to abuse in the care environment of frail older persons.

### 6.3.2 Care burdens of formal and informal caregivers

The care environment of frail older persons is generally associated with well-being failures of significant proportions, largely because of the enormous burdens carried by caregivers (Keating, McGregor & Yeandle, 2021). However, despite some similarities in care burdens, the empirical experiences of formal and informal caregivers revealed important differences in the two care systems. Nevertheless, the study found that care burdens are largely caused by poor financial and working conditions and the consequent lack of psychological well-being.

Informal caregivers find the care role of frail older persons financially burdensome because no financial rewards are offered for this. Further, no other incentives are offered for informal caregivers to make them want to do their very best all the time. As a result, many informal caregivers have crippling financial problems. According to Ngome (1994), the role of caregiving to frail older persons should not only be motivated by financial rewards. Older persons are repositories of wisdom and possess valuable cultural and traditional knowledge for posterity. Taking care of them should not be seen as burdensome (Suzuki, 1993). In support of this view, Carnow (2015) argues that in terms of religious pastoral care, frail older persons should enjoy privileged positions of honour and respect and never be made to feel like a burden. However, the reality is that caregivers have bills to pay and cannot

afford the basic necessities of life without a reliable income and this underscores the financial burden of caring for frail older persons (Makiwane et al., 2020).

On the other hand, the financial burdens described by formal caregivers are somewhat different. Their experiences relate to inadequacy of salaries and lack of incentives. The low remuneration levels of formal caregivers, especially nurses, have increased turn-over rates and contributed to low morale. On the other hand, the cost of living is high, but the care workload is increasing without additional income for caregivers. Interestingly, some caregivers have taken a different approach to the way they view the working environment. In their reflections, the caregiving role was described as an awesome and pleasurable experience. Some even related instances of great compassion, forgiveness and love from frail older persons. These enlightening experiences of caregivers underscore the psychological rewards that can be derived from caregiving responsibilities (Ngome,1994).

Furthermore, Zainuddin et al. (2003) argue that irrespective of low salaries, caregivers who have had little work experience tend to feel the care burden more than those who have been working for a long time. On the other hand, Keating et al. (2021) state that the better coping skills of experienced caregivers do not necessarily take away the burden of care associated with looking after frail older persons. This means that interventions are necessary to alleviate the care burdens and ensure the well-being of caregivers of frail older persons.

Interestingly, both formal and informal caregivers have complained about the long working hours, but for different reasons. While informal caregivers detest the extended working hours due to cohabitation, the formal caregivers complained about the lack of overtime payment. The informal caregivers have a full-time role, a 24-hour shift every day in respect of virtually all activities of daily living. The excessive “working” or caregiving hours of informal caregivers required to provide care to frail older persons pose a serious threat to their overall well-being (Tai, 2014). This situation extends to their work/personal life balance and denies them opportunities for self-care (Mehta & Leng, 2017). The excessive working hours make the care environment burdensome, leading to burnout stress or even outright depression (Alves et al., 2019). Given the circumstances of cohabitation with frail older persons and their total dependence on care, the nature of informal caregiving is such that it becomes impossible to regulate working hours (Mehta & Leng, 2017). An adjustment to working hours could ultimately compromise the quality of care for frail older persons.

Some of the formal and informal caregivers spent so much time with the frail older persons in their care that they became emotionally attached. They began to feel empathy and associate with what the frail older persons experience every day. As described in the data, sometimes these experiences become unbearably burdensome for caregivers. Thus, to ensure their emotional and psychological well-being, there is an urgent need for more emotional support to formal and informal caregivers to enable them to cope better with these challenges in the care environment of frail older persons (Mehta, 2006). Regarding the informal caregivers, the data found that their situation of emotional attachment is somewhat intense because of shared households and the lack of structured working hours.

While the salaried nature of formal care is an advantage, the working hours are unduly long and in some cases overtime is not paid. According to Kloppers (2011), the Namibian labour laws require caregivers to be paid for authorised overtime in terms of the basic conditions of employment. However, caregivers are entitled to a personal life and time off to rewind and socialise. The long working hours of formal caregivers negatively affect their ability to care for frail older persons adequately. Despite the contractual normal working hours, the data indicated that the nature of care work makes it virtually impossible to remain within that time structure. In fact, staff shortages were described as major causes of the overtime hours worked by formal caregivers. Given the burden of care created by this situation, Shan (2013) has argued for a compulsory leave system to be introduced in the care environment to ensure time off for caregivers. Compulsory leave will also force the formal care system of frail older persons to recruit enough people to make it possible for them to alternate and provide continuous quality care to frail older persons (Tai, 2014).

Additionally, the care burden also manifests itself in social isolation and psychological and emotional burdens for both formal and informal caregivers. The role of caring for frail older persons is very stressful and demanding and often results in loneliness. Caregivers sometimes feel socially isolated because of their care responsibilities and this has a negative emotional effect on them (Carers NSW Australia, 2018). According to Pinquart and Sörensen (2007), due to this emotional burden caregivers are exposed to the risk of deteriorating health, which mainly manifests as depression and anxiety attacks. The care work is generally of such a nature that the there is no time for social interaction with the outside world or socialisation with peers to share memories and avoid loneliness.

The emotional burden of caregivers is worsened by the lack of therapy to enable them to cope better (Kalomo & Liao (2018). Some caregivers have resorted to faith and religion as coping mechanisms (Tjiroze, 2013). Overall, caregivers need

professional support to be able to focus better on providing quality care to frail older persons (Fernandes & Garcia, 2009). What is more concerning is the fact that loneliness and social isolation among caregivers can lead to cognitive impairments like reduced memory, deregulation of emotions and illogical reasoning (Cacioppo et al., 2010). The loneliness and social isolation are mainly due to the fact that caregivers are constantly occupied by their care responsibility and they do not have time to form and maintain personal relationships and social networks (Anderson et al., 2021). In some cases, social stigmatization (especially among those caring for frail older persons with HIV/AIDS) has also served as a barrier to the effective socialisation of caregivers (Kalomo & Liao, 2018). The impact of loneliness on caregivers often leads to negative psychological outcomes like low self-esteem and even outright aggression (Kloppers et al., 2015).

Care responsibilities are physically demanding and therefore burdensome. The empirical findings indicate that this is normally in the case of lifting and turning frail older persons who are heavy. This challenge is even more pronounced in the case of informal caregivers, who are themselves also old and weak. Physically impaired frail older persons demand more physical care to carry out the limited activities of daily living (Pillatt et al., 2019). This puts caregivers under added strain as they have to overextend their physical abilities in order to care for frail older persons. According to Chen et al. (2000), execution of caregiving responsibilities involving physical demands is burdensome if done without assistive devices. As a result of these physical demands, some caregivers have developed severe arthritis and joint and hip pain.

### 6.3.3 Lack of adequate training

The care environment of frail older persons is becoming more diverse and sophisticated and is evolving given their unique multi-faceted needs, which demand both basic and specialized knowledge (Mastel-Smith & Stanley-Hermanns, 2012). The study found that both formal and informal caregivers have had inadequate training in the care of frail older persons. This effectively leaves them unprepared to respond properly to the needs of frail older persons. According to Gorman (2000), relevant training is critical to equip informal caregivers with the necessary skills that enhance confidence in the execution of their care tasks and reduce anxiety. These include very basic skills like first-aid treatment, proper bathing, feeding and turning for bed-ridden frail older persons (Maphumulo & Bhengu, 2019). Basically, caregivers need to be able to recognise signs and respond quickly and correctly, especially in emergency situations. Most informal caregivers have had no basic training in that role and started providing care out of necessity rather than choice.

No informal on-the-job training is provided either. As a result, informal caregivers do not possess the basic skills they require to take better care of frail older persons.

According to Aksoydan et al. (2019), ongoing training of informal caregivers is one of the most effective strategies for improving quality of care to frail older persons. As a support intervention, training also ensures that caregiver burden is reduced and empowerment achieved. In this sense, training provides formal caregivers with a sense of recognition and pride in their caregiving role (Bevans & Sternberg, 2012).

Therefore, the role of providing care to frail older persons is largely experimental in that ongoing problems are solved through trial and error and not anticipated through effective training and knowledge. Inability to provide proper care due to poor training is not only a significant stressor for the informal caregivers, but increases the risk of mortalities and neglect of frail older persons (Aksoydan et al., 2019). In highlighting this significant risk further, Chisagiu (2015) avers that the health and safety of frail older persons are at stake when the informal caregivers do not possess the basic skills required to look after them. Interestingly, Peeters et al. (2010) argue that training informal caregivers in basic skills like managing medicines not only increases their confidence but also reduces the cost of healthcare in that basic nursing functions can be carried out at home. On this point, Look and Stone (2018) agree and further argue that basic medicine management skills are even more important for informal caregivers looking after frail older persons with mental health conditions and multi-morbidities. According to Shyu et al. (2010), the content of any training programme for informal caregivers must take into consideration the unique circumstances of the care environment. This is important because most of these informal caregivers are from low-skilled populations (Maphumulo & Bhengu, 2019).

On the other hand, the formal caregivers experienced a lack of training mainly in the areas of induction and relevant ongoing on-the-job training. The current care responsibility requires both basic and specialised skills in order to care properly for frail older persons with various chronic ailments and even mental health issues (Look & Stone, 2018). This highlights the fact that formal caregivers are experiencing a deficit in both the basic and the advanced or specialised training necessary to meet the diverse needs of frail older persons in the care environment. According to Engineer (2018), advanced training of formal caregivers covers more complex para-medical issues like choking, bleeding, asthmatic attacks and recognising the different stages of mental health conditions. This is important considering that according to the empirical data, most frail older persons in the care environment suffer from a decline in mental health, which requires specialist geriatric and gerontological interventions.

In practice, formal caregivers are salaried and are usually required to have a minimum qualification such as Grade 10 (Maphumulo & Bhengu, 2019). This is an important distinction between formal and informal caregivers, who are often circumstantially drawn into the caregiving role without any training or experience. Formal caregivers are not usually subject to any statutory registration requirement or additional training with the exception of social service professionals and qualified auxiliary workers (Marais, 2020).Therefore, it is hardly surprising that Dawud et al., (2021) argue that the notion of a professional caregiver hardly exists in Africa as many caregivers in nursing homes do not possess formal qualifications and need regular training. This view is confirmed by Kloppers et al. (2015), who found that many caregivers in Namibia lack the basic skills and training required to properly execute their functions. Thus, greater reliance is placed on acquiring knowledge through experience than on systematic training (Given, Sherwood & Given, 2008). In this regard, formal caregiving is provided by people who are themselves unsure about how to deal with unpredictable situations when they arise (Marais, 2020). At least the formal caregivers, unlike the informal caregivers, can sometimes seek advice from more experienced colleagues at the workplace (Okoye & Asa, 2011).

The formal caregivers also face many barriers to getting training one of which is inadequate staffing at many old age homes (Kloppers et al., 2015). This situation prevents formal caregivers from taking time off for training or leaving their caregiving duties to attend a skills development course (Mashau, Netshandama & Mudau, 2016). According to Gray et al. (2016), a well-planned training programme for formal caregivers could balance all of these competing interests in the care environment and guarantee a workforce that is able to meet the diverse and challenging needs of frail older persons.

### 6.3.4 Traditions, culture and religion in the care environment

In the experience of informal caregivers, issues of tradition, culture and religion impact the care environment of frail older persons. While the comparative literature views cultural and religious intelligence as important in the care of frail older persons (Young, 2003), the empirical reflections of formal caregivers have not described these aspects as relevant experiences. However, this in itself does not imply that these aspects are not important in the formal care environment of frail older persons. In fact, previous studies have found that formal caregivers themselves have relied in some instances on spirituality and culture as a coping mechanism to help them with care burdens (Masuku & Khoza-Shangase, 2018). According to Dilworth-Anderson et al. 2004), culture and religion have become important tools in ensuring sanity and a balanced perspective for caregivers. Religion and culture enhance the resilience

and courage required to care for frail older persons (Maneewat et al., 2016). Under the kinship system of caring for older persons, some caregivers perceive the care role as an opportunity to meet their religious and cultural obligations (Abdullah, 2021).

The informal caregivers raised the issue of traditions, culture and religion several times, citing it as a barrier to providing quality care to frail older persons. Some African cultures clearly create obstacles for caregivers who are trying to care for frail older persons effectively. This was mainly described in the context of refusal of help or treatment due to veneration of age based on traditional and cultural beliefs. Generally, in the social functioning of many African communities, tradition and culture play a significant role as enablers of cohesion and ethnic identity (Aboderin, 2017). In fact, the whole concept of the extended family system (which was important as a social protection safety net for frail older persons) is embedded in African culture and tradition (Nabalamba & Chikoko, 2011). However, in some instances tradition, culture and religion can become a barrier to providing care to frail older persons. One example is where, due to cultural beliefs, frail older persons are uncomfortable about their grandchildren having to see them naked when being bathed. This becomes a barrier when there is no alternative arrangement and as a result the effective care of the frail older person is compromised. Thus, a balance must be found between privacy considerations and the best interests and quality care of frail older persons. In my opinion, the necessity of quality care overrides irrational personal preferences based on perceived culture and tradition. Even in a democracy, guaranteed individual constitutional rights are limited by what is demonstrably justified and reasonable based on accepted broader societal values (Okpaluba, 2014).

Rationality in cultural and religious beliefs is therefore important in the care of frail older persons (Rogers & Fancourt, 2020). This means that while cultural competence is important in the care environment, frail older persons must also be constructively engaged so that they understand the value of care and its impact on their well-being without dissipating the beneficial effects of culture or religion. On this point, Bernado (2020) agrees and argues that cultural engagement helps frail older persons to gain a better understanding of the greater benefit of care and treatment for quality of life. According to Holroyd-Leduc et al. (2016), the choice of care rests with the individual frail older persons and hence fears based on beliefs must be acknowledged, but moderated by imperatives of quality care outcomes.

The empirical data suggest that ostracization of frail older persons sometimes has a cultural basis. For example, in some African cultures, when suspicion of witchcraft

arises, frail older persons are left to their own devices (Ayete-Nyampong, 2014). The data illustrated this by a description of a frail older person suffering from Alzheimer's who was perceived to be under demonic attack and hence ostracized by the family and the community. According to Ferreira and Lindgren (2008), in Africa frail older persons with severe mental conditions are often accused by society of witchcraft or of being witches. This type of irrational reliance on tradition or culture as a basis for ostracizing frail older persons is regarded as systemic abuse and contrary to their well-being (Donatelli, 2010).

However, there are conflicting theoretical views on the role of culture and tradition in the caregiving environment. According to Knight and Sayegh (2010), the role of tradition, culture and religion in the care environment is sometimes overplayed given the burdensome effect on caregivers, who are expected to understand the nuances of the beliefs of each care beneficiary to determine the appropriate care intervention. Against this background, normative concepts like culture and religion can become instruments of polarization, irrationality and absurdity in the care of frail older persons (Clarfield et al., 2001). Polarization because culture and religion have the potential to create divisions across tribal and ethnic lines while irrationality and absurdity can ensue when these concepts frustrate quality care outcomes for frail older persons (Donatelli, 2010).

Nevertheless, despite the impact of culture and religion on the care system, the empirical experiences of caregivers highlight the need for greater socialization of frail older persons. This is necessary for their overall well-being and dignity, especially when they are confronted with mental health challenges. As indicated before, culture and tradition play a catalytic role in the care of older persons. In fact, Indongo and Sakaria (2016) argue that many Namibian households that are caring for frail older persons uphold certain cultural and religious norms that impact on care interventions. Culture and religion are important tools, provided they are used to ensure quality of life for frail older persons. Equally, if care interventions are to be effective, they must include these aspects in a purposeful and meaningful manner, directed towards greater integration, socialization and collaboration (Donatelli, 2010).

In terms of religion, the caregivers are of the opinion that faith-based diaconic support not only brings peace to frail older persons, but gives them a sense of purpose, which is essential for a positive mindset. The empirical reflections abound with accounts of depression and suicidal tendencies in some frail older persons and religious faith has been mentioned as a source of hope for many. According to Kirby et al. (2004), religion ensures spiritual well-being, which in turn contributes to sound

geriatric care of older persons. This concept of religion or spiritual welfare is regarded as an important aspect of the holistic care of frail older persons (MacKinlay, 2006).

### 6.3.5 Institutional placement of frail older persons

According to the empirical data in sub-theme 5 (under theme 2 in chapter 5), placement refers to the experiences of caregivers with regard to the admission of frail older persons into nursing and old age homes. According to Caron et al. (2006), choosing to institutionalize or keep the frail older person under home-care is indeed a sophisticated and emotive process and one that is largely influenced by the health, safety and functional autonomy of the frail older persons. The discussion looks at the decision-making process, contributing factors and the implications for frail older persons in the care environment. This descriptive exploration of the phenomenon is important if we are to gain deeper understanding of institutional placement in nursing and old age homes in addressing the frail care needs of older persons (Jenkins, 2000).

There is a general shortage of old age and nursing homes in Namibia to care for frail older persons (Kloppers et al, 2015). As a result, many frail older people who need residential cannot be accommodated because of the general shortage of beds for them. However, issues of racial and ethnic exclusion have permeated the care system despite the government policy of prohibiting discrimination in institutionalized care (Strydom, 2019).

This situation makes it necessary to discuss the specific experiences of formal caregivers in the assessment of frail older persons and their placement in old age homes. The assumption is that institutional care offers better quality care than the informal care environment given the relative resource position and access to basic necessities (Young, 2003).

McFall and Miller (1992) argue that the reasons for placing a frail older person in a care institution often impact on the level of subsequent family support. For example, if the reason for institutionalization is abandonment of the frail older person, this reduces family support and increases the burden of care on the caregivers following this transition (Schick-Makaroff et al., 2021).

This means that although most of the reasons adduced for institutionalization in the raw data relate to the declining health of the older person, there is also an element of choice by some families to take the easy way out (Serrano-Gemes, et al., 2020).

In concurrence with the literature, the empirical data found that health considerations are also the main reason for choosing institutionalized care for frail older persons in Namibia. The study found that most of the frail older persons in Namibia who are placed in institutional care are so placed for health reasons. This is usually because of various ailments and the inability of frail older persons to care for themselves at home without assistance. According to Cramm et al., (2018), levels of frailty generally have a bearing on decisions to choose between home care and institutionalization in old age homes. In other words, the nature of their frailty influences the extent to which frail older persons are able to execute functions of daily living with autonomy. Thus, extent of frailty is a major determinant of domiciliary choices, at least where relevant (Oswald & Rowles, 2017).

Based on this, it is clear that the placement decision-making process is important considering that ideally frail older persons prefer to be in a home environment with loved ones rather than being institutionalized under the care of strangers (Dhemba & Dhemba, 2015).

Contrary to the findings of comparative literature, the empirical data found that in some cases institutional placements are racially motivated through indirect racial discrimination. This means that in some instances the choice of who to admit into institutional care is racially motivated. In other words, while unfair racial discriminatory criteria are not directly imposed as conditions for admission, the demography of residents in old age homes reveals a racial character (Indongo & Sakaria, 2016). This resembles a form of indirect racial discrimination based on impact.

Also, for mainly historic reasons and on account of the inequalities of the past, more white people tend to institutionalize their frail older persons compared to blacks (Ryke, Ngiba & Strydom, 2014). The literature inaccurately suggests that blacks prefer to keep their frail older persons in home care, but the reality is that more than limitations of space in old age and nursing homes in Namibia, subtle racial discriminatory practices also play a role in placement decisions (Indongo & Sakaria, 2016). The implication of this discussion is that race is indeed a silent operative determinant of placements of frail older persons in institutional care.

Another barrier to entry into old age homes for many frail older persons is the lack of financial resources. The nursing care system in Namibia is dominated by the private sector and is unaffordable for many poor, frail older persons (Pretorius, 2019). Namibia has one of the highest levels of economic inequality, which creates barriers of access to quality old age care. Given historic circumstances, many black frail older persons cannot afford admission into the private institutional care environment.

According to Indongo and Sakaria (2016), these private nursing homes and frail care facilities in Namibia are exclusive and beyond the reach of the majority of the population. Thus, black frail older persons are excluded from institutional care on the basis of race and income.

This background discussion highlights the need for more public old age homes to be made available for the care of frail older persons. Furthermore, as revealed in the empirical data, many frail older persons are affected by mental health problems. In many cases, disability and frailty in old age can be attributed to dementia (Guerchet & Aboderin, 2017).

This has had a negative impact on families and caregivers, who are often obliged to provide care without adequate resources and facilities (WHO, 2020). Generally, dementia demands enormous financial resources and specialised training for health professionals and caregivers (Chan, 2018). According to Kapitako (2017), despite the increasing numbers of frail older persons with mental health issues, there are no appropriate facilities in Namibia to provide care and the few private psychiatric hospitals that do exist are unaffordable. In concurrence with the empirical data, there is a dire need for fully resourced mental health institutions that can provide quality care (Holtzhausen, 2012).

In summary, the experiences of formal caregivers around institutional placements have revealed that cultural, financial, safety and health factors influence admission into old age and nursing homes. While many frail older persons, especially those with advanced frailty, would prefer a suitable nursing home, the reality is that the placement conditions are restrictive (Salive et al.,1993).

### 6.3.6 Falls and injuries in frail older persons

Although mobility and physical activity enhance quality of life, many frail older persons are at an increased risk of falling and injury due to advanced age and functional impairments (Chittrakul et al., 2020). In fact, Morley (2002) argues that falling in itself is one of the highest markers of geriatric frailty. The World Health Organization estimates that 35% of frail older persons above the age of 65 fall annually with mild to serious injuries (WHO, 2017).

Both formal and informal caregivers mention falls and injuries of frail older persons repeatedly. Many frail older persons in the informal care environment are afraid of falling and injuring themselves. This constant fear of falling is a challenge for frail older persons as they attempt to make progress towards some kind of assisted mobility. Interestingly, the literature confirms that falling by frail older persons is a

major public health issue (Schoene et al., 2019). According to Wadsworth et al., (2021), frail older persons and especially those with mental health conditions and comorbidities are at greater risk of falling incidents and injury. Therefore, falls and injuries in frail older persons are largely associated with a reduction in balance confidence as a result of functional impairments (Landers et al., 2016). Falling as experienced by most frail older persons is due to muscle weakness and loss of balance. It follows from this that balance confidence in frail older persons is greatly reduced due to loss of strength and gait. While physical activity is recommended, it is unfortunately true that frail older persons are most likely to fall during attempted walking activity (Berg et al., 1997).

In the informal care environment, the empirical data confirmed that frail older persons are subject to falls and injuries largely because of poor housing conditions. In most cases, the houses or shacks they live in are not suitable for the mobility needs of frail older persons. According to Magnusson et al., 2004), the lack of geriatric-friendly infrastructure can lead to falls and injuries. Under these circumstances, walking becomes hazardous. In supporting this argument, Lombard and Kruger (2009) commented that in underdeveloped communities with poor roads and housing infrastructure, the risk of falls and injuries is greatly increased. The impact of geriatric falling is sometimes very severe and in some cases falls result in speech loss and broken bones. The literature also records that falls by frail older persons have sometimes resulted in mortalities (Evitt & Quigley 2004). In fact, Scheffer et al., (2008) argues that falling is ranked as one of the major causes of poor health and injury-related deaths in frail older persons. Although fewer incidents of falling were documented by formal caregivers in this study compared to the informal care environment, falls still happen, as indicated by the empirical findings. For example, caregivers related incidents of dementia patients developing mobility problems such as loss of the ability to stand or walk. As a result, they tend to get very weak and even to injure themselves as a result of falling off beds. On this point, Landi et al., (2005) observe that certain psychotropic medications prescribed for mental health conditions can increase the risk of falling in this cohort. In the experiences of caregivers, weak hand grip, poor muscle tone and slow movements are all aspects that result in falls by frail older person. Some frail older persons are unable to sit, walk or stand due to disability or weak muscles and this tends to result in falling or slipping. They tend to fall a lot due to weak balance or weak muscles, all of which is related to aging.

Regarding the fatal impact of falls, the bruising caused by falls results in blood clots in some cases, which lead to pulmonary embolus with fatal consequences for frail older persons. Many incidents of falling that were described in the study were due

to gait and mobility complications and in some cases even caused severe head injuries. Carter (2020) concurs with this sentiment and observes that gait variability and loss of control can have severe consequence for frail older persons.

The above discussion has positioned falls as a major cause of injury and sometimes even death in frail older persons. Falls are mainly caused by physiological and mental conditions, but also by poor infrastructure. The phenomenon is prevalent in both the formal and the informal care environment, but perhaps with different levels of frequency and intensity.

### 6.3.7 Summary of experiences of formal and informal caregivers

Based on the analytical discussion above, the empirical and theoretical experiences of caregivers are illustrated below for ease of understanding. Figure 19 below also highlights the different and common experiences of formal and informal caregivers in the care environment of frail older persons.

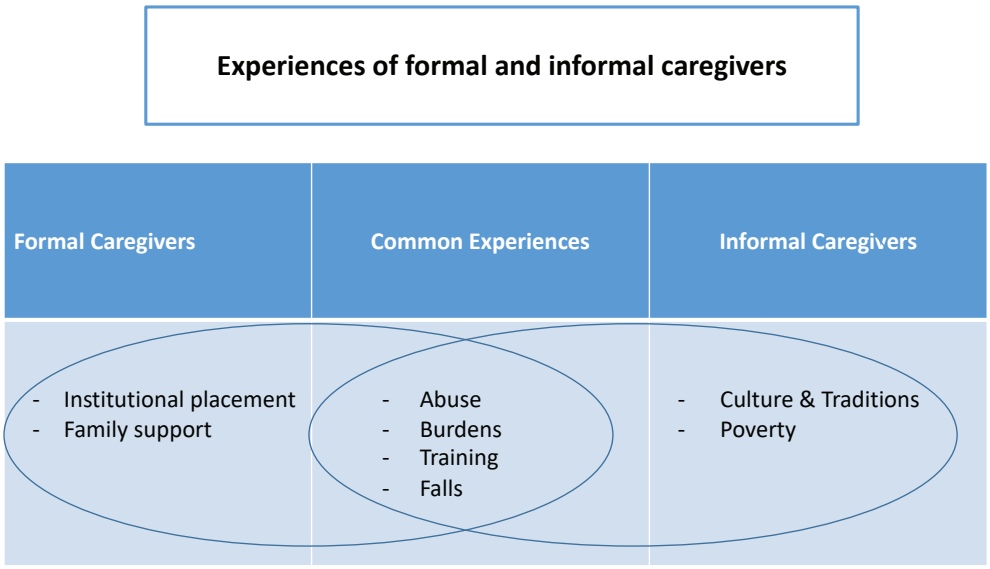


Figure 19: Summary of experience of formal and informal caregivers
Source: Own contrast (Zamuee, 2021)

While the formal and informal caregivers share common experiences relating to abuse, burden, training and falls, the extent differs in accordance with the setting. However, issues relating to institutional placements and family support take greater prominence in the formal environment. This means that the impact of culture, tradition and poverty issues was experienced more prominently in the informal care environment.

## 6.4 POLICY AND LEGISLATIVE SUPPORT TO FRAIL OLDER PERSONS

Based on theme 3 of the empirical findings, the following analytical discussion seeks to position the extent to which Namibia's policy and legislative framework supports the needs of frail older persons. This discussion starts with an inquiry into the level of awareness of existing policy and legislative framework and ends with recommendations and advice for regulatory reforms. Based on the integrated chronology of empirical findings provided in chapter 4, the following comparative discussion is offered: Awareness of policy and legislative support of frail older persons. In terms of the ILO's social protection safety nets, Namibia has a comprehensive social protection framework consisting of various social assistance and insurance arrangements (Schade et al., 2019). However, Kollapan (2008) vehemently argues that policy and legislative protection is meaningless if the envisaged beneficiaries are not made aware of its provisions.

The empirical data indicate that by far the majority of respondents replied that they are not aware of any legal incentives to support frail older persons. According to Caron et al. (2006), the absence of initiatives to raise awareness about policy stipulations is dangerous as it creates information asymmetry and exposes poor governance. Lack of awareness of policies and laws in general reduces stakeholder involvement in reforms, which is a key element of participatory democracy. In terms of social protection instrumentsunder broader international law, any country's law reform process should ideally be bottom-up and inclusive of the most vulnerable citizens (Kollapan, 2008). In addition, Nakuta and Mnubi-Mchombu (2015) warn that lack of broader stakeholder engagement in social policy and legislative reforms widens the inequality gap in Namibia. Consequently, Kalomo and Besthorn (2018) observed that in general lack of accurate, timeous and effective communication on policies and laws affecting vulnerable people can be seen as a human rights violation. The impact for frail older persons is that their needs are not addressed since information asymmetry denies them avenues for seeking a remedy. According to Hey and Brunetti (2020), the generally low level of understanding and awareness of policy leads to exclusions and create barriers to available health benefits for frail older persons. Lack of awareness also promotes financial abuse and exploitation of frail older persons since the avenues of redress under the policy and legislative framework may not be readily known (Rabiner et al., 2006). Awareness of their rights and the available welfare support mechanism under the law is the only effective way to implement legal instruments. In this way, the intended beneficiaries will be afforded an opportunity to extract benefits under the policy or laws. Thus, policy awareness impacts positively on frail older persons. In fact, Mchombu and Mchombu (2014)

argue that the ultimate impact of policy awareness is poverty eradication for the majority of frail older persons.

### 6.4.1 Adequacy of income protection under Namibia's policy and legislative framework

Addressing income poverty is one of the crucial aspects of social policy and legislative frameworks (Leisering, 2019). As a result, every frail older person in Namibia over the age of 60 years is entitled to a non-means tested social grant under the law (Devereux, 2007). While the Namibian Constitution broadly provides for adequacy of old age pensions, the enabling law does not define what this means in theory or practice. Neither does the law provide benchmarks for determining pension adequacy. The requirement of adequacy under the Namibian Constitution is linked to the concept of a decent standard of living, which in itself is not clearly defined either. The broader legal framework connects adequacy of social grants to achievement of a decent standard of living for older persons. Ultimately, old age grants target the government's policy objective of poverty eradication. On this point, Godard and Rossi (2021) agree and further argue that statutory social grants have the potential to reduce historic inequalities and ensure adequate income protection to the poor.

In terms of legislative budgetary appropriation, Indongo and Robinson (2021) postulate that social grants constitute a significant part of government's annual expenditure. However, Schade et al., (2019) argue that the impact of social grants must be enhanced without an additional burden on public spending. It is unclear how government can realistically achieve this objective under the law without fiscal adjustment.

Under the Namibian Constitution, the right to health care is guaranteed as a fundamental human right (Ekemma & Egwu 2021). This is a significant legal guarantee considering that, according to the empirical data, most frail older persons do not enjoy access to quality health care. Equally, under the policy and legal framework relating to social grants, where these grants are the main source of income they have been described as insufficient to procure essential medical suppliers and chronic medication (Shivolo, 2016).

Another perceived weakness in the National Pensions Act according to the empirical data is the issue of whether social grants should be universal and non-means tested. Most of the study participants felt that the multiple needs of frail older persons would be best served if a means test were applied to determine eligibility for social grants. The argument raised in the data is that from the money saved by applying the

means test could be used to increase the social grants paid to those in dire need of government's financial assistance. Currently, there is a non-means tested and universal social grants system (Pelham, 2007). This means that the law does not discriminate on the basis of personal financial circumstances and every person is eligible to receive social grants upon reaching the age of 60 years, However, payment is not automatic and eligible persons are required to register (Devereux, 2007).

In any event, the social grants system in Namibia is universal and is not targeted to individual needs and hence does not allow for double-dipping. According to Overbye (2005), a non-means tested social grant system is much simpler to administer and avoids the controversy of means tested regimes. In any event, attempts at policy reform to change the current approach to means testing in Namibia have been rejected due to the administrative complexity of such a system and the relatively poor wage data in Namibia (Schleberger, 2002). However, a lot has happened since 2002 and possibly the overwhelming views of caregivers merit some consideration as part of evidence-based policy making.

This discussion has contextualized the need for law reform at the level of social grants as a basis for income protection of frail older persons. This aspect of social grant reforms is very important in addressing the needs of frail older persons (Pelham, 2007). For this reason, it was the first policy and legal intervention undertaken after independence in an effort to address the needs of frail older persons. This is based on many arguments revealing current inadequacies in buying power to afford basic necessities of life despite the constitutional provision for adequate pensions aimed at providing a decent standard of living. This is amplified by the fact that despite the law reforms under the National Pensions Act of 2002, the majority of older persons and especially older persons with frailty, are experiencing enormous challenges, mainly in relation to inadequate financial means. It is held that a sound policy and legislative framework enhances the robustness of any welfare programme targeting social relief for frail older persons (Overbye, 2005). Additionally, Shivolo (2016) argues that the success of such a social welfare framework can only be measured by improvements in the living and health conditions of the marginalised. Needless to say, the Namibian situation speaks volumes about the unfavourable situation in which frail older persons find themselves because of ineffective and poor policy and legislative frameworks, especially in relation to income protection.

### 6.4.2 Policy and legislative protection of frail older persons

Further to the discussion above in relation to subtheme 1 (of theme 2 in chapter 5), this part only covers the policy and legislative aspects pertaining to the protection of frail older persons. The policy and legislative framework is inadequate in providing protection to frail older persons. The reason is that complaints involving frail older persons are not investigated on time to ensure speedy prosecutions and are often dismissed for lack of evidence (Ananias et al., 2016). Although some relief is offered under the Combating of Domestic Violence Act 4 of 2003, which broadly refers to physical, sexual, emotional and economic abuse, there is no focus on the situation of frail older persons. This study related how elderly abuse incidents have been reported to law enforcement, without proper investigations being conducted. In Namibia, a special abuse centre has been created by the police to investigate cases of women and child abuse and domestic violence. However, no such centre exists for law enforcement in cases of abuse of older persons. Even in the provisions of the Combating of Rape Act 8 of 2000, which defines sexual violence under coercive circumstances, there is no regard for the intrinsic power imbalance, unique circumstances and vulnerability of frail older persons. For example, the definition of coercive circumstances for determination of rape may take a different dynamic where a person is incapable (at least mentally) of consent.

Goergen (2004) argues that the issue of ineffective policy and legal protection in developing countries is aggravated by lack of understanding of the unique needs and condition of frail older persons. As a result, the prosecution and sentencing of perpetrators are poorly enforced. According to Kollapan (2008), in most countries the sound international human rights framework seeking to protect the rights of frail older persons is often not incorporated in domestic laws. Because of this, Nangombe and Ackermann (2012) argue that frail older persons are at the mercy of an ineffective policy and legislative environment.

Furthermore, Aboderin and Ferreira (2008) state that policy and legislative failure to adequately protect frail older persons is mainly due to lack of evidence-based knowledge on how to integrate geriatric needs into the broader development agenda. In support of this view, Issahaku and Neysmith (2013) argue that most of the issues affecting frail older persons have policy and legislative significance. Thus, without concerted initiatives towards targeted reforms, frail older persons will continue to suffer the prejudice and vulnerability arising from policy and legislative vacuums.

## 6.5 RATIONALE FOR NEW APPROACH TO EXPLAINING THE NEEDS OF FRAIL OLDER PERSONS

In answering the main research question about the needs of frail older persons, the analytical discussion concluded that a new perspective is important in understanding and addressing the needs of frail older persons. The rationale for this new approach is embedded in, *inter alia*, the following study outcomes:

a) There is no engagement or involvement of frail older persons in decision-making and policy development. The study revealed that there is no structured process to engage and safeguard the interests of frail older persons. This is contrary to evidence-based law reform development as conceptualized in the study.

b) Each country has unique needs based on local nuances and situational outlook. According to Huber and Hennessy (2005), each country presents unique socioeconomic, political and cultural circumstances which directly impact the specific needs of their formal and informal care environments. Thus, shared experiences and contexts offer valuable lessons that should prove useful in the overall improvement of the care practice of frail older persons (Mollenhorst et al., 2011). While some of the needs of frail older persons are similar, there are clear differences in the nature and extent of such needs. The study has shown that a country's level of socio-economic development impacts on the nature of the needs of frail older persons and the country's capacity to meet those needs.

c) There is no prescriptive policy and legal framework that specifically supports the diverse care needs of frail older persons. The study has captured this discussion in terms of lack of an appropriate legal and policy environment demanding a different approach. Specifically, issues of legal protection against abuse and the need to meet the constitutional aspirations of old age pension adequacy for a decent standard of living were analytically discussed. Evidence-based policy making is imperative for effective protection of frail older persons (Goergen, 2004).

d) Unique peculiarities and challenges have emerged in the care environment. Some examples are issues of reverse abuse of caregivers by frail older persons and the pervasive nature of poor living conditions associated with frailty and aging.

e) While the care environment of frail older persons was perceived as homogenous, the study described some significant differences in the nature and extent of needs from the perspectives of formal and informal caregivers. These differences require a new approach to make it possible to provide quality care to frail older persons in the two care systems.

It is clear from the above that the Namibian situation does not perfectly fit into existing theoretical models. In other words, existing models lack sufficient explanatory power to effectively describe the diverse needs of frail older persons in Namibia. Based on this, it goes without saying that the application of such comparative models would be difficult to implement in the Namibian context. This makes it imperative and appropriate to develop a model with a more indigenous basis. Thus, in addressing the rationale for a different approach to understanding and addressing the needs of frail older persons as highlighted above, a new model is presented. In addition to highlighting the diverse nature of the needs of frail older persons, the study also found that they are hierarchical. According to Searle et al., (2008), this hierarchical assessment of the needs of frail older persons is essential if we are to fully understand the priorities in making provision for appropriate interventions. This view is supported by Lambert et al. (2019), who postulate that the needs of frail older person are bottom-up and should be considered in that hierarchy of priority. On the other hand, Steverink et al., (2006) argue that the priority of needs depends on each unique setting and that the care environment and cannot be generalized to every situation. Against this background, while all the needs of frail older persons are important, this model illustrates their hierarchical nature as determined by the frequency of empirical reflections based on the research findings. In this regard, the various needs were categorized under three levels which represent low, moderate and primary needs. Low needs are those that are considered important, but not an immediate priority. In other words, while frail older persons would benefit from their redress, their impact is not as meaningful as that of the others. Moderate needs are equally important, but their priority and impact have to make way for another level of needs. In other words, the benefit of meeting moderate needs would not be felt unless primary needs were addressed. Primary needs are high-impact needs and are at the top of the hierarchy of needs. Addressing primary needs will provide the foundation upon which the satisfaction of other levels of needs can be developed. While the various needs are hierarchically categorized, there are also some needs that are common and these are illustrated on the basis of the same trichotomy of low, moderate and primary needs. Keating and Dosman (2009) argue that commonality of needs is important to enhance the social capital and care networks of frail older persons in securing policy and legislative reforms.

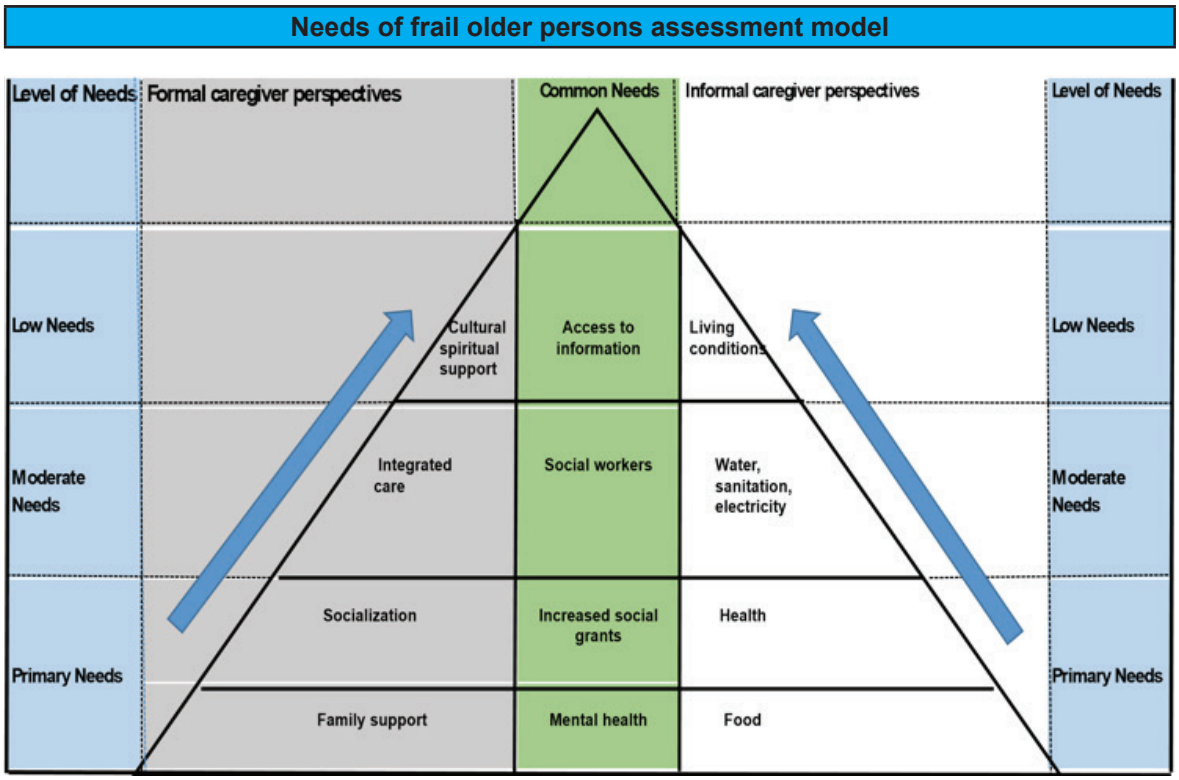


Figure 20: Needs assessment model for frail older persons
Source: Own construction (Zamuee, 2021)

The unique low-level needs of frail older persons in formal care are represented by culture and spiritual support. As for the frail older persons in informal care, the low-level needs are expressed under housing and living conditions. However, access to information about policy and legislative issues is described in the model as a common low-level need in both formal and informal care systems.

On the other hand, the need for integrated care was considered relatively more important for frail older persons in formal care. However, the need for access to basic utilities (water, sanitation and electricity) was ranked as moderate for frail older persons in informal care. The need for and access to social workers was ranked as a moderate need for both formal and informal care systems.

Finally, the need for increased socialization and family support was described as meaningful for frail older persons in formal care. This refers to the need for more socializing and interaction with frail older persons. On the other hand, the need for food and healthcare was ranked as a primary need for frail older persons in the informal care environment.

The above hierarchy means that quality of life for frail older persons in the formal care environment is greatly enhanced when they are adequately socialized and enjoy family support in their care. It is more meaningful for them to have a sense of

social affinity and family support than integrated care or the need for cultural and religious intelligence. Through socializing their voices are heard and their interests recognized. As for frail older persons in informal care, access to basic food and health care would ensure that their material well-being was addressed. In this way, issues relating to housing, living conditions or access to basic utilities would come after the primary need for food provision had been addressed. It is pointless to have a decent house when food and access to quality health care are not provided.

Despite the differences and commonalities expressed in the categorization of the various needs, most of these needs are interrelated in a symbiotic relationship. For example, in as much as food and health care are primarily meaningful for frail older persons under the informal care regime, the need for decent housing and living conditions is imperative. As for frail older persons in formal care, in informal care the needs for family support and socialization are interrelated in that issues of culture and religion in a way reflects their social orientation and basis for identity.

## 6.6 RECOMMENDATIONS FOR SUITABLE FRAIL CARE MODEL

In answering the research objective pertaining to a suitable care model for addressing the frail care needs of older persons, the study fully assessed existing literature in conjunction with the empirical findings. In the process a descriptive conceptual framework has emerged for improvement of the formal and informal care environment. This framework seeks to highlight the relationship between the needs of frail older persons and the experiences of caregivers in providing care to them. This outcome effectively integrates the perceived needs of frail older persons and the care experiences of caregivers. The framework also provides some evidence for the conjecture that the needs of frail older persons and the well-being of caregivers are correlated.

The main elements of the model, as illustrated by Figure 6 below, are government support, the care environment, family and friends, and the frail older persons. In terms of the first element, throughout the analytical discussion, government support was described as a major enabler of decent living conditions for frail older persons. Specifically, issues of income security, food security, health and social services together with safety and security were mainly covered in that discussion. This means that the well-being of the majority of frail older persons depends largely on the ability of government to provide access to basic essentials of life as mentioned above. This is so because the issues of food, health and social services all fall within the domain of government's developmental and welfare agenda. Government's response to the needs of frail older persons is a key enabler of quality care.

The second element is more internally focused and revolves around the care environment of the frail older persons. The analytical discussion describes issues of integrated care, cultural intelligence, use of technology, training and improved working conditions as critical for quality care. Most of the issues raised under the second enabler are capital-intensive and may not be within reach of every care environment. However, the model suggests an alternative integrated approach through the effective mobilization of various health disciplines to coalesce around the care needs of frail older persons. This strategy is based on resource optimization and would require structured collaboration across various health disciplines. This overarching objective of this approach is to make multi-disciplinary services available to frail older persons on a cost-effective basis. Equally, the use of technology under the model points to the utilization of basic electronic equipment like blood pressure and insulin monitors to aid in the care of frail older persons. Furthermore, the quality of care of frail older persons is significantly correlated with the working conditions of caregivers. Thus, happy and satisfied caregivers provide a conducive and nurturing care environment for frail older persons.

The third element in the model describes the role that the family and society (including a network of friends) can play in the care of frail older persons. Specifically, issues of socialization, engagement and involvement are conceptualized as important in ensuring the social well-being of frail older persons. Under the disengagement theory it was stated that frail older persons are often alienated from their family and society because of their physical or mental condition. This model suggests positive engagement of frail older persons by recognising their humanity and underlying need to be part of a family and society at large. This could be achieved through regular visits, support groups, obtaining their opinions on matters affecting them and organising social engagement events like concerts, plays, etc.

Finally, the fourth element was the role that frail older persons themselves can play in ensuring their own well-being. The study described being institutionalized as not only one of the most stressful transitional life events but also one that requires mental and attitudinal adjustment to cope in the care environment. Thus, in terms of emotional responses, frail older persons will need to acknowledge the transition required in this life cycle and understand the impact of frailty on the activities of daily living. This can be achieved through therapy and the availability of social services to support their life transition, behavioural and emotional adjustment. In the face of these changing circumstances, frail older persons must not only change their perception and behaviour about this life transition, but also replace frailty with usefulness in terms of making a positive contribution. This can be achieved by sharing life experiences with younger generations and volunteering suggestions on

how their interests can be better served. Thus, this proposed approach will lead to improved psychological well-being and easier adjustment to the care environment. Furthermore, attitudinal and behavioural change will elicit enhanced cooperation with caregivers and make their caring role less burdensome.

These elements are interrelated since government support creates a foundation for social welfare upon which the care environment can blossom. On the other hand, institutional placements are done by the family and as such they play a role in eliciting cooperation, a positive attitude and adaptability from frail older persons. These four factors in the frail care framework for Namibia are illustrated as follows:

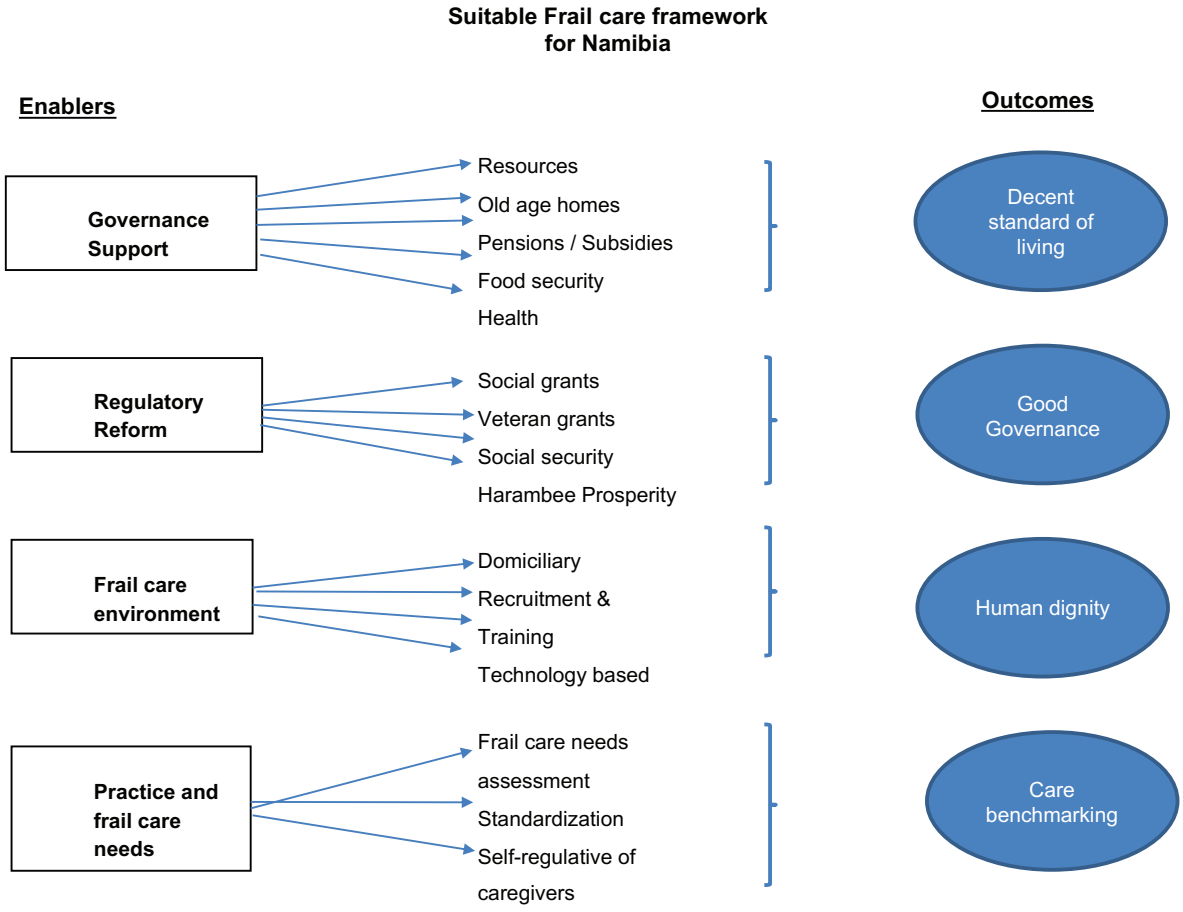


Figure 21: Suitable frail care framework for Namibia
Source: Own construction (Zamuee, 2021)

## 6.7 CONCLUSION

This chapter systematically discussed the empirical and literature synthesis around the frail care needs of older persons and the experiences of caregivers. In accordance with the research objectives, four primary themes emerged from the empirical data and these were discussed in relation to theoretical perspectives from the literature. From the perspectives of caregivers and comparative literature, a unique conceptual

model and study dimension were developed to explain the frail care needs of frail older persons in Namibia. Based on this model, various factors were highlighted as forming the constitutive elements of this new conceptualized model.

This chapter discussed a number of important findings, including rampant abuse of frail older persons by caregivers, family members and the community. In a few cases, the frail older persons themselves were found to be verbally, emotionally and physically abusing caregivers. The comparative literature has also highlighted incidents of abuse and neglect of frail older persons. Interestingly, despite the burdens of care the caregivers were found to have no real incentives to motivate high performance in providing care to frail older persons. The care environment was found to be very unsupportive and no relevant training was given to caregivers to execute their work with skill and diligence. The empirical data also described the enormous stress caused by providing care to frail older persons. The coping strategies used by distressed caregivers include substance abuse and dependence on religion. A discussion of the care environment has revealed a lack of safety features in the care environment, resulting in injury from falls caused mainly by and physical conditions. Equally, institutional placements and assessments of frail older persons in caregiving institutions reveal demographic, cultural and economic risk factors to be determinants of the decision-making process.

In terms of legal and policy support, the study discussed the various empirical and literature findings and argued for greater awareness of incentives for caregivers and support for frail older persons. This provided a context for a discussion about funding for frail care needs and highlighted the economic burden faced by frail older persons and their families, who are obligated to become caregivers. However, a discussion on social policy found that not much regulatory support exists for frail older persons, as evidenced by the growing number of incidents of abuse and neglect. Furthermore, the multiple challenges facing frail older persons revealed a lack of dignity in the care environment for most of them. Accordingly, various recommendations and advice were given to government to improve the situation, culminating in a suitable welfare model to address the frail care needs of older persons in Namibia based on a sound, relevant and progressive regulatory framework and sound practices. The conceptualized frail care model for Namibia also highlights the unique dimension of this study in achieving the research objectives.

# Chapter 7 CONCLUSIONS AND RECOMMENDATIONS ANALYSIS

## 7.1 INTRODUCTION

The conclusions are based on the study findings, which explored the needs of frail older persons in Namibia from the perspectives and experiences of formal and informal caregivers. The study examined the underlying needs of frail older persons and explored the way caregivers experienced their role. This concluding chapter contains the study summary and relates the discussions and outcomes of all the other chapters to the research objectives. The chapter also contains an overview of the practical implications and possible areas for future research. In other words, the conclusion integrates the research holistically and serves as a summary of key findings and analytical discussion in relation to the research objectives.

In examining the main research objective of determining the needs of frail older persons, the introductory chapter sets the scene for the other chapters by describing the historic circumstances that have impacted on the present situation of unmet needs of frail older persons. During the pre-colonial period, Namibia's system of caring for frail older persons relied on intergenerational solidarity based on extended kinship. Under colonialism, this extended family care system was denigrated and quickly replaced by a predominantly nuclear system, which focused mainly on the immediate family. As a result, frail older persons were left destitute without an alternative care system that would meet their needs. In effect, this meant that no formal social protection arrangements existed for Africans at the time. Upon independence, some limited social protection arrangements were promised in the Constitution, but without a real implementation framework. Given this limitation, Namibia has no formal national policy or legislative instrument to deal with the needs of frail older persons.

In view of the above, the structure for this concluding chapter is based on the five research objectives of the study:

### 7.1.1 To explore perspectives of formal and informal caregivers on the needs of frail older persons

In exploring this objective, the study demonstrated that frail older persons face multiple challenges, a finding which underscores their needs in the care environment. In the empirical perspectives they provided, the formal and informal caregivers described similarities and differences in the conceptualisation of needs. Clearly this suggests

a connection between the two care settings. At a global level, the literature revealed that welfare systems are subject to increasing demands for elderly care. As a result, there is a growing trend towards transitioning to informal care as the most reliable system of care for frail older persons. This provides a context for the need for home-based care globally. Given the multi-morbidities of frail older persons, palliative care and increased outpatient support were also found to be urgent needs. While the focus of care needs globally is on the use of technology and social insurance, in southern Africa the most basic needs for improved living conditions and healthcare remain unmet. The implication is that the nature and extent of the needs of frail older persons differ depending on local conditions. This is important in understanding the underlying needs of frail older persons.

In Namibia, the study has found that frail older persons in informal care are mostly in need of food, water, sanitation, electricity and healthcare. It is a fair assumption that when basic food is not available for frail older persons, nutritional balance becomes a luxury. It can also be concluded that when the needs revolve around basic necessities, freedom of choice as to what to spend social grants on is limited by circumstances. This is even more so in households where social grants are the only source of income. The implication is that generally poor living conditions result in denial of basic human rights and participation in development. The findings also demonstrated that poor living conditions often lead to a proliferation in opportunistic diseases, especially during the Covid-19 pandemic. A close relationship was therefore also established between poor living conditions and rapid deterioration in frail older persons.

On the other hand, the formal caregivers perceived family support and integrated care as the most urgent needs of frail older persons. The findings also revealed that family support is a broad concept and is not limited to material support alone. It includes involvement and commitment to support the holistic well-being of the frail older person. In this context, culture and traditions were discussed as possible barriers to care, but also as enablers if adequately understood. Access to information and family support can debunk traditional myths and focus attention on appropriate care interventions.

The formal caregivers conceptualized the need for integrated care in terms of one-stop shop access to all the health services required by frail older persons in care. At the same time, some doubts were raised about the viability of integrated care, especially in an environment like Namibia where there is a general shortage of specialised health professionals.

However, the analysis found increased social grants, the need for mental health support and more social workers to be common needs among frail older persons in both care settings. Regarding social grants, the broad consensus is that they are insufficient to address the multi-faceted needs of frail older persons, especially those in informal care. In highlighting the common need for mental health support, the empirical reflections found that frailty is mostly associated with Alzheimer's, dementia and Parkinson's disease. Based on this, the need for mental health institutions and specialised health professional support was expressed.

Overall, it can be concluded that the needs of frail older persons in informal and formal care are diverse and mostly remain unmet. This illustrates the urgency of devising a policy framework to address these needs. In the meantime, frail older persons continue to receive insufficient care; in fact the majority of this group are deprived of basic standards of care. This makes it difficult for them to enjoy quality living and successful aging despite frailty.

It is therefore reasonable to conclude that providing the most basic needs of frail older persons can go a long way towards improving the care environment. In any event, freedom is fundamental to development and this can only be achieved if living conditions reflect human dignity. As the study has found, the needs of frail older persons are diverse and will require time and resources for their realization. It is nevertheless useful to devise a pathway towards understanding and implementation of some remedial measures.

### 7.1.2 To explore the experiences of formal and informal caregivers in providing care to frail older persons

The caregivers are on the frontline of care and protection of frail older persons and are able to draw on first-hand experience in describing conditions in frail care for older person. This study therefore describes and examines the experiences of formal and informal caregivers in providing care to frail older persons. The experiences of formal and informal caregivers have again established similarities and differences in the two care settings. The common experiences relate to care burdens, abuse, training and falls. The differences in the care experiences were found to relate mainly to institutional placements and poverty. The experiences with institutional placements referred to the barriers to entry into old age homes experienced mainly by black frail older persons. Although there is a general shortage of old age homes, the conditions for placement in private homes are unduly restrictive. This mainly relates to the exorbitant cost of private frail care in Namibia. The implication is that many black frail older persons continue to depend on the informal care system for care.

As regards experiences in the informal care environment, the conditions of poverty have already been adequately analysed and described as a key differentiator.

In their accounts of their experiences caregivers described the care role as burdensome. However, their reasons differed, depending on whether they were providing formal or informal care. For one thing, the formal caregivers described the general poor working conditions while the informal caregivers said that they were burdened by excessive working hours and limited resources. This situation creates barriers to a personal life/care role balance. In these circumstances personal relationships are not maintained or sustained and this creates a socialization problem. Thus, the study findings have shown that both formal and informal caregivers are exposed to mainly financial, emotional, psychological and physical burdens. As a result, it can be argued that caring for frail older persons is generally stressful and burdensome. In terms of possible interventions, the study proposed recruitment of more staff, flexible working hours, performance incentives and general support in the working environment. There is a significant correlation between the level of happiness of caregivers and the extent of service they provide in the care role. This means that a decent working environment for caregivers is an important basic condition for improving the level of care to frail older persons. Conversely, the study found that a burdensome care environment often leads to abusive situations.

Abuse in its various manifestations was found to be present in both the formal and informal care environments. While the care systems is supposed to be a place of comfort and safety, the study established financial, emotional, psychological, sexual and physical abuse of frail older persons. According to the findings, abuse is committed by family members, caregivers and even members of the community and nursing staff at hospitals. The analysis found that abuse is more rampant in the formal care setting, but is largely unreported. Equally, the study described the limited investigation and prosecution of offenders as contributing to the problem. Many frail older persons continue to be traumatized by the abuse they experience. In this sense, their human dignity is seriously affected. On the other hand, mostly formal caregivers have described some scenarios of mostly verbal and physical abuse against them by frail older persons. Examples of caregivers having pillows thrown at them, and being slapped and racially abused were some of the abuses examined in the study. The implication is that caregivers are themselves also victimized in the care environment and are without recourse. Furthermore, the study found that care burdens and frustrations were also created by limited training. While informal caregivers expressed dissatisfaction about receiving hardly any basic training in the care role, the formal caregivers complained about limited on-the-job training. The implication is that frail older persons are exposed to all kinds of risks due to

the limited knowledge and skills of caregivers. Based on the study findings, it can be concluded that the current care environment is burdensome for caregivers and requires interventions. This is not only a care policy matter, but also ensures the application of fair labour practices in the workplace. From these study findings and analysis it is concluded that the experiences of caregivers revealed an unsatisfactory care environment for frail older persons.

### 7.1.3 To determine the extent to which the Namibian constitutional, legal and policy environment supports the frail care needs of older persons

The study concluded that addressing the needs of frail older persons will require social reforms. These can only be meaningfully achieved through progressive changes in Namibia's policy and legislative framework. Accordingly, this section of the study investigated whether the current Namibian constitutional, legal and policy environment supports the frail care needs of older persons. This was essentially an assessment of constitutional, legal and policy developments relating to older persons. The investigation was therefore carried out with reference to an assessment of the pertinent and relevant social instruments covering the whole spectrum of social protection of older persons.

Overall, the study revealed that social welfare legislation in Namibia is archaic, inadequate and ineffective in protecting frail older persons. "Archaic" in the sense that despite the negative effects of the colonial history, the few social welfare policies and laws available have remained out of touch with the present-day realities and needs of older persons. This means that the process of law reform has been unacceptably slow and out of touch with the plight of frail older persons. Although Namibia has ratified important regional and global social protection legal instruments relating to old age, the study revealed that no commendable progress has been made towards localising these in municipal laws.

Fundamentally, the Namibian Constitution has provided a solid foundation for progressive social law and policy making, but lacks the necessary enforcement and justiciable mechanisms to give substance to the sound social welfare aspirations. Despite care for older persons having been elevated to a human rights issue, the reality on the ground, based on empirical and theoretical evidence, suggests a disregard for this issue.

While legislation governing social grants has sought to target racial equality in terms of levels of income, no legal measures have been introduced to look at income adequacy and its impact on poverty eradication. The practical implication is that the social grants are not sufficient to buy basic necessities and older persons continue

to receive fixed flat pensions without guaranteed basic inflationary adjustments. Despite the high cost of living and exorbitant cost of healthcare in Namibia, there is no legislative instrument dedicated to alleviating this undesirable situation for frail older persons. It is concluded that the legal instruments relating to income support do not offer frail older persons a fair share in the economic prosperity of the country.

The investigation for the study also revealed that in the area of social protection Namibia's overall legal environment is not geared towards the support of frail older persons. For example, the social security legislation mainly benefits working persons and only makes provision for meagre pensions for frail older persons. This means that older persons are on the periphery of the social protection universe where income replacement benefits are concerned. It is concluded that income security and safety nets for frail older persons in Namibia remain a distant reality for many.

In terms of policy and legislative support for the care of frail older persons, the Namibian framework falls short in providing comprehensive coverage to this cohort. As a basic premise, the study found that without a policy and legal framework the necessary focus does not fall on the needs of frail older persons. The current legislation on old age only deals with administrative aspects of registration and limited subsidies to old age homes. Therefore, it is reasonable to conclude that the policy and legal environment in Namibia does not provide substantive support to frail older persons who are in dire need of decent housing, healthcare, food and other specialised requirements. The practical implication is that the suffering of frail older persons has not been relieved and they are without targeted remedies and recourse. In the interim, some issues affecting frail older persons are dealt with on an ad hoc basic. For example, special legislation was passed by Parliament to offer compensatory benefits to frail older persons who are veterans of the war of liberation. In any event, the study highlighted various shortcomings in the eligibility conditions for veteran pensions, shortcomings that lead to exclusions mainly due to unfair discriminatory practices. This intervention is not beyond reproach and has not done much to address the specific needs of frail older persons in general.

On the lack of a specific national policy on older persons, the study found that no government department has designated responsibility for this cohort. The functional areas are fragmented across different government departments. This means that issues relating to the interests of this vulnerable cohort are dealt with, if at all, in an ad hoc fashion without a holistic policy compass. As shown in chapter 3 of the thesis, issues relating to older persons can only be properly understood and effectively addressed if a progressive policy framework is developed. The existing policy vacuum implies that government initiatives towards protecting older persons are

uncoordinated and lack measurable targets against which to measure progress and highlight shortcomings. Overall, the study concluded that even with constitutional guarantees of social security, very little support is provided to frail older persons under the existing Namibian legal and policy framework. The findings found the current situation lamentable and deplored the lack of government transparency in policy and legislative reforms.

### 7.1.4 Suitable welfare model for addressing the needs of older persons

In answering the research question as to which social welfare models would be useful in addressing the needs of frail older persons in Namibia, the study developed a suitable care model to illustrate the diverse needs and challenges in the care environment. This model was based on an analysis of empirical findings with references to the literature and an examination of various social welfare models.

While the theoretical framework of the study as outlined in chapter 3 relied on intergenerational, ecological and self-management theories, various welfare models formed the basis for interventions in addressing the needs of frail older persons and the challenges facing caregivers in providing care to them. These models included the Being, Belonging and Becoming model, the Broad Based Benefit Model, Bass and Noelker's model and Maslow's hierarchy of needs. Each of these welfare models embodies principles that have an impact on the needs of frail older persons and the experiences of caregivers. These theoretical models were operationalised in the study to inform and better explain the experiences and perspectives of caregivers. In recommending a suitable welfare model, the study found that needs coverage, governance and care standards were key enablers in meeting the needs of frail older persons. The theoretical postulations were that any intervention targeting the needs of frail older persons should be cognizant of the supply and demand character of such needs. According to these findings, a suitable welfare model must be based on holistic wellbeing, which has its roots mainly in the physiological, spiritual, social and psychological domains. Governance under the welfare models refers to the process of stakeholder engagement in policy and legislative reforms. However, a care benchmark must be established to constantly monitor and review the performance of caregivers in providing care to frail older persons.

Against this background, the theoretical and empirical analysis has informed the development of a new conceptual model that addresses this research objective. The main elements of the model are embedded in government support, care practice, family involvement and the frail older persons as key stakeholders in any intervention approach. These elements are interrelated on the assumption that

government support creates a foundation for social welfare upon which the care environment can build and flourish. Furthermore, institutional placements in old age homes are done by family members and as such they play a role in eliciting cooperation, positive attitudes and adaptability from frail older persons.

### 7.1.5 To recommend practical proposals for implementation towards understanding and meeting the needs of frail older persons in Namibia

In addressing this research objective, various recommendations and proposals were made towards understanding and meeting the needs of frail older persons in Namibia and improving the situation of frail older persons.

These recommendations included increased government support to frail older persons through legislative and policy reforms. The study concluded that any law reform intervention or improvement in care practice must adopt a more nuanced approach towards understanding the needs of frail older persons in each setting. In this regard, issues of increases in social grants, means testing and doing away with benefit aggregation across segregated welfare grants were pivotal in this discussion. The study outcome also recommended the urgent development and implementation of a comprehensive old age policy in Namibia. Most caregivers are not aware of or informed about legislative incentives in the care of frail older persons and in this regard the study recommended greater transparency on the part of government and the dissemination of information about the rights of older persons under regulatory instruments.

The study also conceptualised specific advice to improve the care environment of frail older persons. These recommendations and proposals included the building of more old age homes and the use of technology to optimize caring for frail older persons and reducing the personal burden and stress of caregiving. The study proposed making greater use of technological devices to enhance the mobility of frail older persons and augment the outreach functions of social workers in a community-based care model. Regarding healthcare needs, the study found that the right to health without an opportunity for access is meaningless. Therefore, the recommendations around healthcare were addressed in terms of access to an affordable healthcare system of a high quality.

It is pointless to have a world-class health infrastructure if essential medical suppliers are not available. Equally, health centres should be within reach of frail older persons or reliable and affordable transport should be provided.

Religious and cultural normative aspects that hinder effective palliative care and treatment of frail older persons in the care environment should be discouraged. The study revealed that the fundamental human rights of frail older persons should supersede traditions and cultures at least in as far as they relate to ensuring good health and social protection. Thus, the study outcomes recommended that the care environment embrace cultural intelligence and provide a multidisciplinary approach to care. This intervention would address the need for more family support and specialised health professional support.

Recommendations for the care environment also include the provision of effective and relevant training to caregivers. Specifically, the study recommended that informal caregivers should undergo some kind of basic training to provide quality care. This could include first aid, basic kinetic skills, medicine management and general geriatric care skills. As for the formal caregivers, an induction programme for new recruits is recommended. Regular on-the-job training is also needed to ensure the development of the relevant skills and knowledge required to take better care of frail older persons. These training interventions must be standardised and assessed to ensure objective quality control.

On law enforcement, the study recommended better policing and prosecutorial powers to ensure that perpetrators of violence and abuse against frail older persons are brought to justice without fail. This will enhance confidence in and the reputation of the legal system as a champion of human rights and justice.

It is recommended that informal caregivers be adequately compensated and given time off to ensure a personal life/work balance. This will make it possible to provide improved care to frail older persons. To alleviate their emotional and psychological burdens, psychotherapy is recommended. Caregivers must also be exposed to emotional intelligence and conflict management programmes to ensure that abuse does not take place in the care environment.

Based on the above, the study has to a large extent met the main research objective of exploring the frail care needs of older persons in Namibia and adequately discussed the implications for practice and theory.

## 7.2 ORIGINAL CONTRIBUTION OF THE STUDY

More than the rationale discussed in 1.8, the study also made a specific contribution to the following areas:

### Social work

As some of the formal caregivers are social workers themselves, the study contributes to knowledge and social work practice since old age is in itself a social problem (MacIntyre, 2018). Also, the important role that social workers perform in the improvement of the holistic care of frail older persons was emphasized with greater clarity. According to Kumari and Dua (2020) older persons are faced with many social problems including abuse and neglect, which is an area extensively covered in the study.

### Social development

Social development in this context relates to the empowerment of frail older persons by way of giving them opportunities to enjoy socio-economic prosperity (Kumari & Dua, 2020). Given the history of colonialism and the consequent breakdowns in societal and family systems, social development has become a weasel word in the care of frail older persons. The study has provided important insights into the specific aspect of social development, which is required to address the multiple social needs affecting frail older persons.

### Social gerontology

Thus, the rationale in academia is broad enough to include specific contribution to knowledge in social gerontology and geriatrics. Since social gerontology is concerned with the changing needs of older persons and how society respond to them (Hooyman & Kiyak, 2005), the study outcomes support knowledge expansion in this discipline. This is done by the development of specific needs assessment tools described in the study and the various frameworks for addressing the specific care needs of frail older persons.

### Geriatrics

Specifically, this study contributes to geriatric knowledge in the sense of describing the healthcare interventions to improve the care needs of frail older persons (Woodford, 2022). Throughout the thread of the study various health challenges were identified as barriers of access to enjoyment of quality of life for frail older persons. The specific outcomes revealed possible interventions to improve the overall geriatric care of

frail older persons. For example, the need for specific geriatric focus on the multi-morbid conditions facing frail older persons and a more integrated care intervention.

## 7.3 FUTURE RESEARCH OPPORTUNITIES

Since the present study was limited to the frail care needs of older persons, no detailed discussion of the specific requirements for active aging was provided. This, together with gender roles in the care of frail older persons, is a potential area for future research.

The present study was also based on the perspectives of SSPs and informal caregivers and as such the views of broader stakeholders in the care environment were not included. The study limitations as described in chapter 4 above create opportunities for future research on the needs of frail older persons and ways to improve the care environment. Furthermore, the present study did not include an assessment of the financial impact of some of the intervention strategies proposed, which is an area for future research. Future studies could also examine the practical use of the newly developed conceptual model to assess the care needs of frail older persons under different conditions to evaluate its impact.

# Bibliography


Abdullah, S. (2021). Understanding kinship care of older persons: social constructions of family preservation and survival in a South African Muslim community. *Journal of Religion, Spirituality & Aging*, 1-16.

Aboderin, I. (2012). Global poverty, inequalities and ageing in Sub-Saharan Africa: a focus for policy and scholarship. *Journal of Population Ageing*, *5*(2), 87-90.

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

Aboderin, I. A., & Beard, J. R. (2015). Older people's health in sub-Saharan Africa. *The Lancet*, *385*(9968), e9-e11.

Aboderin, I., & Ferreira, M. (2008). Linking ageing to development agendas in sub-Saharan Africa: Challenges and approaches. *Journal of Population Ageing*, *1*(1), 51-73.

Aboderin, I., & Hoffman, J. (2011, June 5-8). Caregiving in contexts of poverty in sub-Saharan Africa: critical perspectives on debates and realities. In *Keynote paper presented at the Festival of International Conferences on Caregiving, Disability, Aging and Technology, Toronto, Canada*.

Aboderin, I., & Hoffman, J. (2015). Families, intergenerational bonds, and aging in Sub-Saharan Africa. *Canadian Journal on Aging/La Revue canadienne du vieillissement*, *34*(3), 282-289.

Adamchak, D. J. (1995). Pension and household structure of older persons in Namibia. *Southern African Journal of Gerontology*, *4*(2), 11-15.

Adams, K. B. (2008). Specific effects of caring for a spouse with dementia: differences in depressive symptoms between caregiver and non-caregiver spouses. *International Psychogeriatrics*, *20*(3), 508.

Adelman, R. D., Tmanova, L. L., Delgado, D., Dion, S., & Lachs, M. S. (2014). Caregiver burden: a clinical review. *Jama*, *311*(10), 1052-1060.

African Union (AU). (2008). *Social Policy Framework for Africa*. The 1st Session of AU Conference of Ministers in Charge of Social Development held in Windhoek, Namibia, 27-31 October 2008. Retrieved from https://www.un.org/esa/socdev/egms/docs/2009/Ghana/au2.pdf [Accessed 22 April 2021].

Aggar, C., Ronaldson, S., & Cameron, I. D. (2010). Reactions to caregiving of frail, older persons predict depression. *International journal of mental health nursing*, *19*(6), 409-415.

Ahlström, G., Hansson, J. Å., Kristensson, J., Runesson, I., Persson, M., & Bökberg, C. (2021). Collaboration and guidelines for the coordination of health care for frail older persons with intellectual disability: A national survey of nurses working in municipal care. *Nursing open*, *8*(3), 1369-1379.

Ainamani, H. E., Alele, P. E., Rukundo, G. Z., Maling, S., Wakida, E. K., Obua, C., & Tsai, A. C. (2020). Caring for people with dementia in rural Uganda: qualitative study of caregiving burden experienced by informal and formal caregivers. *Journal of global health reports*, *4*.

Akintola, O. (2008). Unpaid HIV/AIDS care in southern Africa: forms, context, and implications. *Feminist Economics*, *14*(4), 117-147.

Aksoydan, E., Aytar, A., Blazeviciene, A., van Bruchem-Visser, R. L., Vaskelyte, A., Mattace-Raso, F., ... & Kiziltan, G. (2019). Is training for informal caregivers and their older persons helpful? A systematic review. *Archives of gerontology and geriatrics*, *83*, 66-74.

Aliberti, M. J. R., Covinsky, K. E., Garcez, F. B., Smith, A. K., Curiati, P. K., Lee, S. J., ... & Avelino-Silva, T. J. (2021). A fuller picture of COVID-19 prognosis: the added value of vulnerability measures to predict mortality in hospitalised older adults. *Age and Ageing*, *50*(1), 32-39.

Allcock, S. H., Young, E. H., & Sandhu, M. S. (2019). Sociodemographic patterns of health insurance coverage in Namibia. *International journal for equity in health*, *18*(1), 1-11.

Alley, D. E., Putney, N. M., Rice, M., & Bengtson, V. L. (2010). The increasing use of theory in social gerontology: 1990–2004. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *65*(5), 583-590.

Almberg, B., Grafström, M., & Winblad, B. (1997). Caring for a demented elderly person—burden and burnout among caregiving relatives. *Journal of advanced nursing*, *25*(1), 109-116.

Alves, L. C. D. S., Monteiro, D. Q., Bento, S. R., Hayashi, V. D., Pelegrini, L. N. D. C., & Vale, F. A. C. (2019). Burnout syndrome in informal caregivers of older adults with dementia: A systematic review. *Dementia & neuropsychologia*, *13*, 415-421.

Amakali, K. (2013). *Investigating the need for a home-based health care programme in support of the parents/caregivers of children diagnosed with heart disease in the rural areas of Namibia* (Doctoral dissertation).

Amoo, S. K., & Skeffers, I. (2008). The rule of law in Namibia. *Human rights and the rule of law in Namibia. Windhoek: Macmillan Namibia*, 17-38.

Amosun, S. L., & Fahmida Harris, P. T. (2018). "What next now that you are sixty?"–Preliminary exploration of the self-reported aspirations of community-dwelling older persons in the Western Cape Province, South Africa within the active aging framework. *Physiotherapy theory and practice*.

Amukugo, H. J., & Nangombe, J. P. (2017). Quality health care delivery at health facilities in the Ministry of Health and social services in Namibia. *Nurse Care Open Acces J*, *2*(1), 13-24. DOI: 10.15406/ncoaj.2017.02.00026.

Amukugo, H. J., Nangombe, J. P., & Karera, A. (2020). Experiences of inadequate interpersonal relationships regarding quality improvement and quality assurance in the Ministry of Health and Social Services in Namibia. *Development Studies Research*, *7*(1), 50-58.

Ananias, J. A. (2014). *An evaluation of social work support groups with informal caregivers to prevent elder abuse and neglect: A Namibian perspective* (Doctoral dissertation).

Ananias, J., & Strydom, H. (2014). Factors contributing to elder abuse and neglect in the informal caregiving setting. *Social work*, *50*(2), 268-284.

Ananias, J., Ellis, S., & Strydom, H. (2015). A support group programme with informal caregivers to prevent elder abuse. *The Social Work Practitioner-Researcher*, *27*(2), 220-245.

Ananias, J., Salonika, L.A., Black, L., & Strydom, H. (2016). Social work engagement in the community-based care of older people in Namibia. In Gray, M.(Ed.). (2016). *The handbook of social work and social development in Africa,* (pp.145-155). Routledge, New York.

Andersson, M., Hallberg, I. R., & Edberg, A. K. (2008). Old people receiving municipal care, their experiences of what constitutes a good life in the last phase of life: A qualitative study. *International journal of nursing studies*, *45*(6), 818-828.

Anderson, S., Parmar, J., Dobbs, B., & Tian, P. G. J. (2021). A tale of two solitudes: Loneliness and anxiety of family caregivers caring in community homes and congregate care. *International journal of environmental research and public health*, *18*(19), 10010.

Andrews, N., & Okpanachi, E. (2012). Trends of epistemic oppression and academic dependency in Africa's development: The need for a new intellectual path. *Journal of Pan African Studies*, *5*(8), 85-104.

Ang, S. G. M., Wilson, A., & O'Brien, A. P. (2020). Caregivers' falls concern for older persons in the Singapore community. *GSTF Journal of Nursing and Health Care (JNHC)*, *5*(1).

Ankri, J., Andrieu, S., Beaufils, B., Grand, A., & Henrard, J. C. (2005). Beyond the global score of the Zarit Burden Interview: useful dimensions for clinicians. *International journal of geriatric psychiatry*, *20*(3), 254-260.

Antindi, H. (2019). Experiences of orphans and caregivers regarding services rendered by the Motor Vehicle Accident (MVA) Fund of Namibia.

Apt, N. A. (2000). *Rapid urbanization and living arrangements of older persons in Africa*. Population Division, Department of Economic and Social Affairs, United Nations Secretariat.

Apt, N.A. (1996) *Coping with old age in a changing Africa: Social change and the elderly Ghanaian*. Aldershot, England: Ashgate.

Aranda, M. P., & Knight, B. G. (1997). The influence of ethnicity and culture on the caregiver stress and coping process: A sociocultural review and analysis. *The Gerontologist*, *37*(3), 342-354.

Ardelt, M., Ai, A. L., & Eichenberger, S. E. (2008). In search for meaning: The differential role of religion for middle-aged and older persons diagnosed with a life-threatening illness. *Journal of Religion, Spirituality & Aging*, *20*(4), 288-312.

Arrey, A. E., Bilsen, J., Lacor, P., & Deschepper, R. (2016). Spirituality/religiosity: A cultural and psychological resource among Sub-Saharan African migrant women with HIV/AIDS in Belgium. *PloS one*, *11*(7), e0159488.

Asino, K., & Christensen, Å. (2018). Assessment of housing needs in Namibia.

Arthur-Holmes, F., & Gyasi, R. M. (2021). COVID-19 crisis and increased risks of elder abuse in caregiving spaces. *Global public health*, 1-5.

Article 16 of the AU'S Banjul Charter.

Article 17 of the Charter

Article 22 of the League of Nations Covenant

Article 95 of the Constitution of the Republic of Namibia

Arts, W. A., & Gelissen, J. (2010). Models of the welfare state. In *The Oxford handbook of the welfare state*.

Atkinson, R., & Flint, J. (2001). Accessing hidden and hard-to-reach populations: Snowball research strategies. *Social research update*, *33*(1), 1-4.

Aubeeluck, N. D., & Luximon-Ramma, A. (2020). The Burdens of Family Caregivers of Schizophrenia in Mauritius. *SciMedicine Journal*, *2*(3), 118-131.

Ayete-Nyampong, S. (2014). *A Study of Pastoral Care of the Elderly in Africa: An Interdisciplinary Approach with Focus on Ghana*. AuthorHouse.

Azungah, T. (2018). Qualitative research: deductive and inductive approaches to data analysis. *Qualitative Research Journal, 18*(4), 383-400.

Babbie, E. R. (2016). *The basics of social research*. Cengage learning.

Babbie, E., & Mouton, J. (2010). The practice of social research., Republic of South Africa.

Badger, F., Pumphrey, R., Clarke, L., Clifford, C., Gill, P., Greenfield, S., & Jackson, A. (2009). The role of ethnicity in end-of-life care in care homes for older people in the UK: a literature review. *Diversity in health and care*, *6*(1), 23-29.

Bandura, A., Freeman, W. H., & Lightsey, R. (1999). Self-efficacy: The exercise of control.

Barr, N. (2020). *Economics of the welfare state*. Oxford University Press, USA.

Barrientos, A. (2004). Cash Transfers for Older People Reduce Poverty and Inequality, WDR Background Paper (Manchester: IDPM/Chronic Poverty Research Centre).

Barrientos, A., Niño□Zarazúa, M., & Maitrot, M. (2010). Social assistance in developing countries database version 5.0. *Brooks World Poverty Institute Working Paper*.

Barry, C. A. (1998). Choosing qualitative data analysis software: Atlas/ti and Nudist compared. *Sociological research online*, *3*(3), 16-28.

Bass, D. M., Noelker, L. S., & Rechlin, L. R. (1996). The moderating influence of service use on negative caregiving consequences. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *51*(3), S121-S131.

Bastawrous, M. (2013). Caregiver burden—A critical discussion. *International journal of nursing studies*, *50*(3), 431-441.

Batista, M. P. P., Barros, J. D. O., Almeida, M. H. M. D., Mângia, E. F., & Lancman, S. (2014). Formal caregivers of older adults: reflection about their practice. *Revista de saude publica*, *48*, 732-738.

Bauer, J. M., & Sousa-Poza, A. (2015). Impacts of informal caregiving on caregiver employment, health, and family. *Journal of population Ageing*, *8*(3), 113-145.

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The qualitative report*, *13*(4), 544-559.

Beattie, E., O'Reilly, M., Strange, E., Franklin, S., & Isenring, E. (2014). How much do residential aged care staff members know about the nutritional needs of residents?. *International journal of older people nursing*, *9*(1), 54-64.

Becker, H. (2007). Making tradition: A historical perspective on gender in Namibia. *Unravelling taboos: Gender and sexuality in Namibia*, 22-38.

Beckman, B. & Sachikonye, L.M. (2001). Labour regimes and liberalization in Africa: An introduction. In Beckman, B. & Sachokinye, L.M. *Labour regimes and liberalization: The restructuring of state-society relations in Africa*. Harare,University of Zimbabwe Publications, 72–89.

Benadé, P., Du Plessis, E., & Koen, M. P. (2017). Exploring resilience in nurses caring for older persons. *health sa gesondheid*, *22*, 138-149.

Bengtson, V. L., & Schrader, S. S. (1982). Parent-child relations. *Research instruments in social gerontology*, *2*, 115-186.

Bengtson, V. L., Copen, C. E., Putney, N. M., & Silverstein, M. (2009). A longitudinal study of the intergenerational transmission of religion. *International Sociology*, *24*(3), 325-345.

Bengtson, V., Giarrusso, R., Mabry, J. B., & Silverstein, M. (2002). Solidarity, conflict, and ambivalence: Complementary or competing perspectives on intergenerational relationships?. *Journal of Marriage and the Family*, 568-576.

Berat, L. (1993). Genocide: The Namibian Case against Germany. *Pace Int'l L. Rev.*, *5*, 165.

Berg, W. P., Alessio, H. M., Mills, E. M., & Tong, C. (1997). Circumstances and consequences of falls in independent community-dwelling older adults. *Age and ageing*, *26*(4), 261-268.

Bergström, A. L., & Hanson, E. (2017). An integrative review of information and communication technology based support interventions for carers of home dwelling older people. *Technology and disability*, *29*(1-2), 1-14.

Bernard, H. R. (1995). Unstructured and semistructured interviewing Research Methods in Anthropology. *Qualitative and Quantitative Approach*, 208-236.

Bernard, H. R. (2017). *Research methods in anthropology: Qualitative and quantitative approaches*. Rowman & Littlefield.

Bevans, M., & Sternberg, E. M. (2012). Caregiving burden, stress, and health effects among family caregivers of adult cancer patients. *Jama*, *307*(4), 398-403.

Biggs, S., Phillipson, C., & Kingston, P. (1995). Elder abuse in perspective.

Bikker, J. A., & De Dreu, J. (2009). Operating costs of pension funds: the impact of scale, governance, and plan design. *Journal of Pension Economics & Finance*, *8*(1), 63.

Bílková, V. (2022). COVID-19 and Older Persons – In Need of a Comprehensive Human Rights Approach. *Journal of Human Rights Practice*.

Birks, M., Chapman, Y., & Francis, K. (2008). Memoing in qualitative research: Probing data and processes. *Journal of research in nursing*, *13*(1), 68-75.

Birtha, M., & Holm, K. (2017). WHO CARES? Study on the challenges and needs of family carers in Europe. *COFACE: Brussels*.

Biwa, E. (2018, August 21-23). Social Protection in Namibia Workshop. *Towards a comprehensive social protection system for Namibia.* 21-23 August 2018. Swakopmund: Namibia.

Black, H. N. (2018). *Food security and interventions: A glimpse at Windhoek's informal settlements* (Doctoral dissertation, University of the Witwatersrand).

Bley, H. (1996). Namibia under German rule (Vol. 5). LIT Verlag Münster

Boeckxstaens, P., & De Graaf, P. (2011). Primary care and care for older persons: position paper of the European Forum for Primary Care. *Quality in primary care*, *19*(6), 369.

Bogdan, M. (1999). The first decade of Namibian law. *Nordic Journal of international law*, *68*(3), 275-291.

Böger, T., & Leisering, L. (2017). *Social citizenship for older persons? Measuring the social quality of social pensions in the global south and explaining their spread*. World Bank.

Bolliger, L. (2017). Apartheid's Transnational Soldiers: The Case of Black Namibian Soldiers in South Africa's Former Security Forces. *Journal of Southern African Studies*, *43*(1), 195-214.

Bond, P. (2014). Tokenism in South African social policy. *Transformation: Critical Perspectives on Southern Africa*, *86*(1), 48-77.

Bond, J., & Corner, L. (2004). *Quality of life and older people*. McGraw-Hill Education (UK).

Bone, A. E., Morgan, M., Maddocks, M., Sleeman, K. E., Wright, J., Taherzadeh, S., ... & Evans, C. J. (2016). Developing a model of short-term integrated palliative and supportive care for frail older people in community settings: perspectives of older people, carers and other key stakeholders. *Age and ageing*, *45*(6), 863-873.

Boockvar, K. S., & Meier, D. E. (2006). Palliative care for frail older adults:"there are things I can't do anymore that I wish I could...". *Jama*, *296*(18), 2245-2253.

Booysen, D. (2000, January 22-24). Profiling those South Africans aged 65 years and older. In *WHO workshop to create a minimum data set for research, policy and action on ageing and older adults in Africa, Harare*.

Boreskie, K. F., Hay, J. L., & Duhamel, T. A. (2020). Preventing Frailty Progression during the COVID-19 Pandemic. *The Journal of frailty & aging*, *9*, 130-131.

Börsch-Supan, A., Kneip, T., Litwin, H., Myck, M., & Weber, G. (2015). 1 SHARE: a European policy device for inclusive ageing societies. In *Ageing in Europe-Supporting Policies for an Inclusive Society* (pp. 1-22). de Gruyter.

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative research journal*, *9*(2), 27.

Bowen, M. (1960). A family concept of schizophrenia.

Brank, E. M., & Wylie, L. E. (2016). Differing perspectives on older adult caregiving. *Journal of Applied Gerontology*, *35*(7), 698-720.

Brockmeyer, B. (2012). *The Health System in Namibia*, Friedrich-Ebert-Stiftung, Windhoek, available at: http://cms.my.na/assets/documents/p19p2lof2lsi2moqo2tsjfbp5a.pdf [Accessed July 2020].

Brockmeyer, B., & Stiftung, F. E. (2012). *The health system in Namibia: Deliberations about an affordable national health insurance for the low-income workforce in Namibia*. Windhoek, Namibia: Friedrich-Ebert Stiftung.

Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental psychology*, *22*(6), 723.

Bronfenbrenner, U. (1999). Environments in developmental perspective: Theoretical and operational models.

Bronfenbrenner, U., & Ceci, S. J. (1994). Nature-nuture reconceptualized in developmental perspective: A bioecological model. *Psychological review*, *101*(4), 568.

Browne, A. J., Varcoe, C., Lavoie, J., Smye, V., Wong, S. T., Krause, M., ... & Fridkin, A. (2016). Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. *BMC Health Services Research*, *16*(1), 1-17.

Brownell, P., Berman, J., & Salamone, A. (2000). Mental health and criminal justice issues among perpetrators of elder abuse. *Journal of Elder Abuse & Neglect*, *11*(4), 81-94.

Bryman, A., & Bell, E. (2007). Business Research Methods second edition Oxford University Press UK.

Bryne, M. (2001). Data analysis strategies for qualitative research.(Research Corner). *AORN journal*, *74*(6), 904-906.

Budlender, D. (2011). Informal Employment in Namibia 2008. Geneva: International Labour Organization.

Budnick, A., Hering, C., Eggert, S., Teubner, C., Suhr, R., Kuhlmey, A., & Gellert, P. (2021). Informal caregivers during the COVID-19 pandemic perceive additional burden: findings from an ad-hoc survey in Germany. *BMC Health Services Research*, *21*(1), 1-11.

Bujo, B. (2009). Ecology and ethical responsibility from an African perspective. In M.F. Murove (ed.), *African ethics: An Anthropology for comparative and applied ethics (pp. 281-297 )*. University of KwaZulu-Natal Press.

Bunt, S., Steverink, N., Olthof, J., Van Der Schans, C. P., & Hobbelen, J. S. M. (2017). Social frailty in older adults: a scoping review. *European journal of ageing*, *14*(3), 323-334.

Burrell, G., & Morgan, G. (2017). *Sociological paradigms and organisational analysis: Elements of the sociology of corporate life*. Routledge.

Bursack, C. B. (2021). *Elders who abuse their family caregivers*. An article published in Aging Care Forum. Retrieved from https://www.agingcare.com/articles/elders-abusing-their-adult-children-or-caregivers-137122.htm. [Accesses 19 August 2021].

Buttle, F. (1996). SERVQUAL: review, critique, research agenda. *European Journal of marketing*.

Byrnes, A., & Mattsson, T. (2021). Background paper: 20th Informal ASEM Seminar on Human Rights (ASEMHRS20) Human Rights of Older Persons 22-24 February 2021 Virtual/Seoul, Republic of Korea. In *20th Informal ASEM Seminar on Human Rights. Human Rights of Older Persons. 22-24 February 2021. Virtual/Seoul, Republic of Korea* (p. 1).

Cacioppo, J. T., & Hawkley, L. C. (2009). *Loneliness.* In M. R. Leary & R. H. Hoyle (Eds.), *Handbook of individual differences in social behavior* (pp. 227–240). The Guilford Press.

Cacioppo, J. T., Hawkley, L. C., & Thisted, R. A. (2010). Perceived social isolation makes me sad: 5-year cross-lagged analyses of loneliness and depressive symptomatology in the Chicago Health, Aging, and Social Relations Study. *Psychology and aging*, *25*(2), 453-463.

Campbell, J. C., & Ikegami, N. (2000). Long-Term Care Insurance Comes To Japan: A major departure for Japan, this new program aims to be a comprehensive solution to the problem of caring for frail older people. *Health affairs*, *19*(3), 26-39.

Canevelli, M., Vanacore, N., Blasimme, A., Bruno, G., & Cesari, M. (2021). Overtreating alzheimer's disease. *The Journal of Prevention of Alzheimer's Disease*, *8*(2), 234-236.

Carelse, S. Z. (2018). *Social work services provided by non-profit organisations to adult methamphetamine users: an ecological perspective* (Doctoral dissertation, Stellenbosch: Stellenbosch University).

Carers NSW Australia (2018). Carers NSW 2018 Carer Survey: Summary report, Carers NSW, Sydney. Retrieved from: http://www.carersnsw.org.au/research/survey [Assessed August 2021].

Carlson, J. A. (2010). Avoiding traps in member checking. *Qualitative Report*, *15*(5),

Carnow, J. J. (2015). *Older persons' care as life care: a pastoral assessment of the ecclesia praxis within the African Methodist Episcopal Church in South Africa* (Doctoral dissertation, Stellenbosch: Stellenbosch University).

Caron, C. D., Ducharme, F., & Griffith, J. (2006). Deciding on institutionalization for a relative with dementia: the most difficult decision for caregivers. *Canadian Journal on Aging/La Revue canadienne du vieillissement*, *25*(2), 193-205.

Carrieri, D., Peccatori, F. A., & Boniolo, G. (2020). COVID-19: a plea to protect the older population. *International journal for equity in health*, *19*(1), 1-4.

Carter, D. M. (2020). *Changes in gait variability and balance control during exertional walking in adults with chronic obstructive pulmonary disease* (Doctoral dissertation, University of Tasmania).

Cartmel, F., & Furlong, A. (2000). Youth unemployment in rural areas (No. 18). *York: York Publishing Services for the Joseph Rowntree Foundation*.

Case, A., & Deaton, A. (1998). Large cash transfers to the elderly in South Africa. *The Economic Journal*, *108*(450), 1330-1361.

Cattell, M. G. (1997). Ubuntu, African elderly and the African family crisis. *Southern African Journal of Gerontology*, *6*(2), 37-39.

Cesari, M., Calvani, R., & Marzetti, E. (2017). Frailty in older persons. *Clinics in geriatric medicine*, *33*(3), 293-303.

Chan, M. (2018). Ten years in public health 2007-2017: REPORT BY DR MARGARET CHAN DIRECTOR-GENERAL WORLD HEALTH ORGANIZATION. World Health Organization. ISBN 978-92-4-151244-2

Chance, K. R. (2018). Living politics in South Africa's urban shacklands. University of Chicago Press.

Charles, S. T., & Carstensen, L. L. (2010). Social and emotional aging. *Annual review of psychology*, *61*, 383-409.

Checton, M. G., & Greene, K. (2015). Elderly patients' heart-related conditions: Disclosing health information differs by target. *Psychology, health & medicine*, *20*(5), 594-604.

Chen, T. Y., Mann, W. C., Tomita, M., & Nochajski, S. (2000). Caregiver involvement in the use of assistive devices by frail older persons. *The Occupational Therapy Journal of Research*, *20*(3), 179-199.

Chipare, M. A., Mupazvihwo, T., Tapera, R., & January, J. (2020). The practice of clinical social work in Namibia. *Medical Journal of Zambia*, *47*(3), 235-240.

Chiripanhura, B., & Niño-Zarazúa, M. (2013). Social safety nets in Namibia: Structure, effectiveness and the possibility for a universal cash transfer scheme. *The Basic Income Grant as Social Safety Net for Namibia: Experience and lessons from around the world*, 13.

Chisagiu, L. 2015. Adult learning as a major challenge for an ageing population and workforce in the European Union. *Economic Science Series, 24*(2),66-74.

Chittrakul, J., Siviroj, P., Sungkarat, S., & Sapbamrer, R. (2020). Physical frailty and fall risk in community-dwelling older adults: a cross-sectional study. *Journal of aging research*, 2020.

Chiwara, P. (2015). *Social work's contribution in promoting social and economic equality: a Namibian Case study* (Doctoral dissertation, University of Pretoria).

Chiwara, P., & Lombard, A. (2017). The challenge to promote social and economic equality in Namibia through social work. *Social Work*, *53*(4), 563-578.

Chou, C. H., Hwang, C. L., & Wu, Y. T. (2012). Effect of exercise on physical function, daily living activities, and quality of life in the frail older adults: a meta-analysis. *Archives of physical medicine and rehabilitation*, *93*(2), 237-244.

Chow, E. O. W., & Ho, H. C. (2015). Caregiver strain, age, and psychological well-being of older spousal caregivers in Hong Kong. *Journal of Social Work*, *15*(5), 479-497.

Christiansen, T. (2011). Assessing Namibia's performance two decades after independence.

Clarfield, A. M., Bergman, H., & Kane, R. (2001). Fragmentation of care for frail older people—an international problem. Experience from three countries: Israel, Canada, and the United States. *Journal of the American Geriatrics Society*, *49*(12), 1714-1721.

Cohen-Mansfield, J., Golander, H., Iecovich, E., & Jensen, B. (2019). Social engagement care for frail older persons: Desire for it and provision by live-in migrant caregivers. *The Journals of Gerontology: Series B*, *74*(6), 1062-1071.

Cohen, C. A., Colantonio, A., & Vernich, L. (2002). Positive aspects of caregiving: rounding out the caregiver experience. *International journal of geriatric psychiatry*, *17*(2), 184-188.

Cohn, J., and Sugar, J. A. (1991). Determinants of quality of life in institutions: Perceptions of frail older residents, staff, and families. In *The concept and measurement of quality of life in the frail elderly* (pp. 28-49). Academic Press.

Coleman, C. H. (2009). Vulnerability as a regulatory category in human subject research. *The Journal of Law, Medicine & Ethics*, *37*(1), 12-18.

Colombo, F., Llena-Nozal, A., Mercier, J. and Tjadens, F. (2011). Help Wanted?: Providing and paying for long-term care. Paris: OECD Health Policy Studies, OECD Publishing, Paris. DOI: 10.1787/9789264097759-en. Retrieved from https://doi.org/10.1787/9789264097759-en [Assessed May 2019].

Conradie, G. (1999). Dealing with institutional abuse in a multicultural South African society. *Journal of Elder Abuse & Neglect*, *10*(1-2), 153-163.

Cooper, A. (2007). Reparations for the Herero Genocide: Defining the Limits of International Litigation. African Affairs, 106(422), 113-126. Retrieved from http://www.jstor.org/stable/4496418 [Assessed May 25, 2021].

Cornelius, C. (2011). Basic rights vs basic needs: the socio-economic needs of older persons in relation to social and food security: conference paper. *ESR Review: Economic and Social Rights in South Africa*, *12*(1), 30-32.

Carnow, J. J. (2015). *Older persons' care as life care: a pastoral assessment of the ecclesia praxis within the African Methodist Episcopal Church in South Africa* (Doctoral dissertation, Stellenbosch: Stellenbosch University).

Cottrell, J. (1991). The constitution of Namibia: an overview. *Journal of African Law*, 56-78.

Cramm, J. M., Hartgerink, J. M., Steyerberg, E. W., Bakker, T. J., Mackenbach, J. P., & Nieboer, A. P. (2013). Understanding older patients' self-management abilities: functional loss, self-management, and well-being. *Quality of Life Research*, *22*(1), 85-92.

Cramm, J. M., Twisk, J., & Nieboer, A. P. (2014). Self-management abilities and frailty are important for healthy aging among community-dwelling older people; a cross-sectional study. *BMC geriatrics*, *14*(1), 1-5.

Cramm, J. M., van Dijk, H. M., & Nieboer, A. P. (2018). The creation of age-friendly environments is especially important to frail older people. *Ageing and Society*, *38*(4), 700.

Creswell, J. (2007). *Qualitative inquiry and reseach design: choosing among five approaches,* (2nd ed.). London: Sage.

Creswell, J. W., & Plano Clark, V. L. (2011). Choosing a mixed methods design. *Designing and conducting mixed methods research*, *2*, 53-106.

Creswell, J. (2014). *Research design: qualitative, quantitative and mixed methods approaches.* (4th ed.). Los Angelas, LA : Sage Publishers

Creswell, J. W., & Clark, V. L. P. (2007). *Designing and conducting mixed methods research.* Sage Publications, Inc. ISBN 1-4129-2791-9

Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage publications.

Crotty, M. (2003). The Foundations of Social Research: Meaning and Perspectives in the Research Process, London: Sage Publications, 3rd edition, 10

Crush, J., Nickanor, N., & Kazembe, L. (2021). Urban food system governance and food security in Namibia.

Cumming, E., & Henry, W. E. (1961). *Growing Old: The process of disengagement.* Basic Books. New York.

Curry, A., & Stark, S. (2000). Quality of service in nursing homes. *Health services management research*, *13*(4), 205-215.

Dahany, M. M., Dramé, M., Mahmoudi, R., Novella, J. L., Ciocan, D., Kanagaratnam, L., ... & Jolly, D. (2014). Factors associated with successful aging in persons aged 65 to 75 years. *European Geriatric Medicine*, *5*(6), 365-370.

Dalmida, S. G., Holstad, M. M., Dilorio, C., & Laderman, G. (2011). Spiritual well-being and health-related quality of life among African–American women with HIV/AIDS. *Applied research in quality of life*, *6*(2), 139-157.

Dante, M. C. (2015). Exploring the lived experiences of seniors aging in place (Doctoral dissertation, Walden University).

Dawud, M., Kotecho, M. G., & Adamek, M. E. (2021). “It is all About Giving Priority to Older Adults’ Needs:” Challenges of Formal Caregivers in Two Old Age Homes in Ethiopia. *Ageing International*, 1-19.

De Beer, I. H. (2017). Engaging the private sector in public health challenges in Namibia.

De Beer, J., & Brysiewicz, P. (2017). The conceptualization of family care during critical illness in KwaZulu-Natal, South Africa. *health sa gesondheid*, *22*, 20-27.

De Vaus, D. (2001). *Research design in social research*. Sage.

De Vos, A., Strydom, H., Fouche, C. and Delport, C. (2011) *Research at Grass Roots: For Social Sciences and Human Services Professions* (4th ed.). Van Schaik Publishers, Pretoria.

Deaton, A. (1997). *The analysis of household surveys: a microeconometric approach to development policy*. The World Bank.

del-Pino-Casado, R., Frías-Osuna, A., Palomino-Moral, P. A., & Ramón Martínez-Riera, J. (2012). Gender differences regarding informal caregivers of older people. *Journal of Nursing Scholarship*, *44*(4), 349-357.

Dellmann-Jenkins, M., Blankemeyer, M., & Pinkard, O. (2001). Incorporating the elder caregiving role into the developmental tasks of young adulthood. *The International Journal of Aging and Human Development*, *52*(1), 1-18.

Demiris, G. (2004). Home based E-health applications. *Studies in health technology and informatics*, *106*, 15-24.

Denton, M. (1997). The linkages between informal and formal care of the elderly. *Canadian Journal on Aging/La Revue Canadienne du Vieillissement*, *16*(1), 30-50.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2011). *The Sage handbook of qualitative research*. sage.

Devereux, S. (2001). *Social Pensions in Namibia and South Africa*. Institute of Development Studies.

Devereux, S. (2007). Social pensions in Southern Africa in the twentieth century. *Journal of Southern African Studies*, *33*(3), 539-560.

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

Diameta, E., Adandom, I., Jumbo, S. U., Nwankwo, H. C., Obi, P. C., & Kalu, M. E. (2018). The burden experience of formal and informal caregivers of older adults with hip fracture in Nigeria. *SAGE Open Nursing*, *4*, 2377960818785155.

Dierks, K. (2002). Chronological History of Namibia: From Pre-colonial times to Independent Namibia. Windhoek, Namibia.

Dilworth-Anderson, P., Goodwin, P. Y., & Williams, S. W. (2004). Can culture help explain the physical health effects of caregiving over time among African American caregivers?. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *59*(3), S138-S145.

Dima, E. M. (2003). *Models of institutional care for the elderly in Namibia: with a case study of Sweden* (Doctoral dissertation, University of Namibia).

Dobler, G. (2014). *Traders and trade in colonial Ovamboland: Elite formation and the politics of consumption under indirect rule and apartheid, 1925-1990* (Vol. 8). Basler Afrika Bibliographien.

Donatelli, N.S. (2010). Elder abuse and neglect. In: Howard K.P.K. & R.A. Steinman (eds.), *Sheehy's emergency nursing principles and practice*, pp. 672-676, Mosby Incorporated.

Doron, I., & Apter, I. (2010). The debate around the need for an international convention on the rights of older persons. *The Gerontologist*, *50*(5), 586-593.

Dosman, D., & Keating, N. (2005). Cheaper for whom? Costs experienced by formal caregivers in adult family living programs. *Journal of aging & social policy*, *17*(2), 67-83.

Dotchin, C. L., Paddick, S. M., Longdon, A. R., Kisoli, A., Gray, W. K., Dewhurst, F., ... & Walker, R. W. (2014). A comparison of caregiver burden in older persons and persons with Parkinson's disease or dementia in sub-Saharan Africa. *International psychogeriatrics*, *26*(4), 687-692

Drummond, J. D., Brotman, S., Silverman, M., Sussman, T., Orzeck, P., Barylak, L., & Wallach, I. (2013). The impact of caregiving: Older women's experiences of sexuality and intimacy. *Affilia: Journal of Women and Social Work, 28*(4), 415-428. Retrieved from https://www.mcgill.ca/soc-gerontology/files/soc-gerontology/impact_of_caregiving_on_intimacy_and_sexuality.pdf [Assessed June 2021].

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

Du Vivier, E. (2007). Husbanding Tradition and Marching towards Modernity: Contrasting forms of resistance among the Ovaherero in Pre-Independence Namibia. *Irish Journal of Anthropology*, *10*(1), 48.

Duigenan, T. (2014). An Exploration of the Experiences of Individuals Caring for a Family Member and the Impact this Caregiving Role has on their Lives.

Durán-Valverde, F., Pacheco-Jiménez, J. F., Muzaffar, T., & Elizondo-Barboza, H. (2020). Global estimates and strategies for developing countries in light of the COVID-19 crisis and beyond. *ILO*.

Dyck, I., Kontos, P., Angus, J., & McKeever, P. (2005). The home as a site for long-term care: meanings and management of bodies and spaces. *Health & place*, *11*(2), 173-185.

Eisner, E. W. (2017). *The enlightened eye: Qualitative inquiry and the enhancement of educational practice*. Teachers College Press.

Eita, J. H., & Ashipala, J. M. (2010). Determinants of unemployment in Namibia. *International Journal of Business and Management*, *5*(10), 92.

Ekelund, C., Mårtensson, L., & Eklund, K. (2014). Self-determination among frail older persons–a desirable goal older persons' conceptions of self-determination. *Quality in Ageing and Older Adults*.

Ekemma, O. N. E., & Egwu, W. C. (2021). RIGHT TO HEALTH IN AFRICA: AN EXPOSITION. *Journal of African Studies and Sustainable Development*, *4*(4).

Elliott, V. (2018). Thinking about the coding process in qualitative data analysis. *The Qualitative Report*, *23*(11), 2850-2861.

Emmett, T. (1984). Popular resistance in Namibia, 1920-1925.

Engineer, R. (2018). Be prepared: 10 common medical emergencies & how to deal with them. *The Better India.* Retrieved from https://www.thebetterindia.com/155315/first-aid-medical-emergencies-news/. [Assessed 18 November 2020].

Epps, F., Heidbreder, V., Alexander, K., Tomlinson, A., Freeman, V., & Williams, N. (2021). A dementia-friendly church: How can the African American church support families affected by dementia?. *Dementia*, *20*(2), 556-569.

Erasmus, G. (2010). The Constitution: Its impact on Namibian statehood and politics. *State, Society and Democracy*, 77-105.

Essuman, A., Agyemang, F. A., & Mate-Kole, C. C. (2018). Long-term care for older adults in Africa: Whither now?. *Journal of the American Medical Directors Association*, *19*(9), 728-730.

Etinzock, M. N., & Kollamparambil, U. (2019). Subjective well-being impact of old age pension in South Africa: A difference in difference analysis across the gender divide. *South African Journal of Economic and Management Sciences*, *22*(1), 1-12.

Evangelista, L. S., Strömberg, A., & Dionne-Odom, J. N. (2016). An integrated review of interventions to improve psychological outcomes in caregivers of patients with heart failure. *Current opinion in supportive and palliative care*, *10*(1), 24-31.

Evans, L. K., Yurkow, J., & Siegler, E. L. (1995). The CARE Program: A nurse-managed collaborative outpatient program to improve function of frail older people. *Journal of the American Geriatrics Society*, *43*(10), 1155-1160.

Everson-Rose, S. A., & Lewis, T. T. (2005). Psychosocial factors and cardiovascular diseases. *Annu. Rev. Public Health*, *26*, 469-500.

Evitt, C. P., & Quigley, P. A. (2004). Fear of falling in older adults: a guide to its prevalence, risk factors, and consequences. *Rehabilitation Nursing*, *29*(6), 207-210.

Feldman, P. H., Nadash, P., & Gursen, M. (2001). Improving communication between researchers and policy makers in long-term care: or, researchers are from Mars; policy makers are from Venus. *The Gerontologist*, *41*(3), 312-321.

Feng, Z., Falkingham, J., Liu, X., & Vlachantoni, A. (2017). Changes in living arrangements and mortality among older people in China. *SSM-population health*, *3*, 9-19.

Fernandes, M. D. G. M., & Garcia, T. R. (2009). Tension attributes of the family caregiver of frail older adults. *Rev Esc Enferm USP*, *43*(4), 818-24.

Ferreira, M. (2005a). Elder abuse in Africa: what policy and legal provisions are there to address the violence?. *Journal of Elder Abuse & Neglect*, *16*(2), 17-32.

Ferreira, M., & Lindgren, P. (2008). Elder abuse and neglect in South Africa: A case of marginalization, disrespect, exploitation and violence. *Journal of Elder Abuse & Neglect*, *20*(2), 91-107.

Ferri, C., James, I., & Pruchno, R. (2009). Successful aging: Definitions and subjective assessment according to older adults. *Clinical Gerontologist*, *32*(4), 379-388.

Fleming, J., Farquhar, M., Cambridge City over-75s Cohort (CC75C) Study Collaboration, Brayne, C., & Barclay, S. (2016). Death and the oldest old: attitudes and preferences for end-of-life care-qualitative research within a population-based cohort study. *PloS one*, *11*(4), e0150686.

Folbre, N. (2014). The care economy in Africa: Subsistence production and unpaid care. *Journal of African Economies*, *23*(suppl_1), i128-i156.

Forsman, B., & Svensson, A. (2019). Frail older persons' experiences of information and participation in hospital care. *International journal of environmental research and public health*, *16*(16), 2829.

Frankel, P. (1979). The politics of passes: Control and change in South Africa. *The Journal of Modern African Studies*, *17*(2), 199-217.

Frayne, B. (2010). Survival of the poorest: migration and food security in Namibia. In *Agropolis* (pp. 49-68). Routledge.

Fries, K. S., Bowers, D. M., Gross, M., & Frost, L. (2013). Service learning in Guatemala: Using qualitative content analysis to explore an interdisciplinary learning experience among students in health care professional programs. *Journal of Multidisciplinary Healthcare*, *6*, 45.

Frieswijk, N., Buunk, B. P., Steverink, N., & Slaets, J. P. (2004). The effect of social comparison information on the life satisfaction of frail older persons. *Psychology and aging*, *19*(1), 183.

Frieswijk, N., Steverink, N., Buunk, B. P., & Slaets, J. P. (2006). The effectiveness of a bibliotherapy in increasing the self-management ability of slightly to moderately frail older people. *Patient education and counseling*, *61*(2), 219-227.

Fritz, M., & Schulze, J. (2019). 'That's the bad past we want to forget': Partial truths, reconciliation, and memory in Namibia's post-apartheid democracy. In *The Culture of Dissenting Memory* (pp. 87-104). Routledge India.

Gabriel, I., Creedy, D., & Coyne, E. (2021). Feasibility of a socio-spiritual intervention to improve quality of life of adult Nigerians with cancer and their family caregivers: Protocol for a randomised controlled trial. *Contemporary Clinical Trials Communications*, 100802.

Gade, C. B. (2011). The historical development of the written discourses on ubuntu. *South African Journal of Philosophy*, *30*(3), 303-329.

Galiana, L., Gutiérrez, M., Sancho, P., Francisco, E. H., & Tomás, J. M. (2016). Socio-demographic variables and successful aging of the angolan elderly. *Scientifica*, *2016*.

Galvan, J. L., & Galvan, M. C. (2017). Writing literature reviews: A guide for students of the social and behavioral sciences.

Gans, D., Silverstein, M., & Lowenstein, A. (2009). Do religious children care more and provide more care for older parents? A study of filial norms and behaviors across five nations. *Journal of comparative family studies*, *40*(2), 187-201.

Garlo, K., O'Leary, J. R., Van Ness, P. H., & Fried, T. R. (2010). Burden in caregivers of older adults with advanced illness. *Journal of the American Geriatrics Society*, *58*(12), 2315-2322.

Gaugler, J. E. (2005). Family involvement in residential long-term care: A synthesis and critical review. *Aging & mental health*, *9*(2), 105-118.

Gee, S. B., Cheung, G., Bergler, U., & Jamieson, H. (2019). "There's More to Frail than That": Older New Zealanders and Health Professionals Talk about Frailty. *Journal of aging research*, *2019*.

Geerts, J., & Van den Bosch, K. (2012). Transitions in formal and informal care utilisation amongst older Europeans: the impact of national contexts. *European journal of ageing*, *9*(1), 27-37.

Geingob, H. G. (2004). *State formation in Namibia: Promoting democracy and good governance* (Doctoral dissertation, University of Leeds).

George, D. T. (2006). *Analysis of South African pension fund conversions: 1980--2006. Developing a model for dealing with environmental change* (Vol. 68, No. 05).

Germain, C. B. (1973). An ecological perspective in casework practice. *Social Casework*, *54*(6), 323-330.

Gewald, J. B. (1999). *Herero Heroes.* Athens: Ohio University Press.

Geyer, S., & Louw, L. (2020). Generation Z Undergraduate Social Work Students' Knowledge of and Attitudes Toward Older Persons: Implications for Professional Training. *Journal of gerontological social work*, *63*(1-2), 92-113.

Gillian, C., Turner, J., Bailey, C., & Latulippe, D. (2000). *Social Security Pensions: Development and Reform*. Geneva, Switzerland: International Labour Office. Retrieved from: https://www.social-protection.org/gimi/RessourcePDF.action?id=7768. [Assessed July 2019].

Given, B., Sherwood, P. R., & Given, C. W. (2008). What knowledge and skills do caregivers need?. *Journal of Social Work Education*, *44*(sup3), 115-123.

Glazier, R. H., Moineddin, R., Agha, M. M., Zagorski, B., Hall, R., Manuel, D. G., ... & Kopp, A. The impact of not having a primary care physician among people with chronic conditions. ICES Investigative Report. Toronto, ON: Institute for Clinical Evaluative Studies; 2008.

Gobbens, R. J., & Van Assen, M. A. (2014). The prediction of quality of life by physical, psychological and social components of frailty in community-dwelling older people. *Quality of Life Research*, *23*(8), 2289-2300.

Godard, M., & Rossi, P. (2021). The Old-Age Security Motive for Fertility: Evidence from the Extension of Social Pensions in Namibia.

Godin, J., Armstrong, J. J., Wallace, L., Rockwood, K., & Andrew, M. K. (2019). The impact of frailty and cognitive impairment on quality of life: employment and social context matter. *International psychogeriatrics*, *31*(6), 789-797.

Goergen, T. (2004). A multi-method study on elder abuse and neglect in nursing homes. *The Journal of Adult Protection*, *6*(3), 15.

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. The Qualitative Report, 8(4), 597-607. Retrieved from http://www.nova.edu/sss/QR/QR8-4/golafshani.pdf. [Accessed October, 2019].

Golant, S. M. (2011a). The changing residential environments of older people. In *Handbook of aging and the social sciences*(pp. 207-220). Academic Press.

Goldblatt, I. (1971). *History of South West Africa, from the beginning of the nineteenth century*. Cape Town: Juta.

Gomes, B., Calanzani, N., Curiale, V., McCrone, P., & Higginson, I. J. (2013). Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers. *Cochrane Database of Systematic Reviews*, (6).

Goodman, L. A. (2011). Comment: On respondent-driven sampling and snowball sampling in hard-to-reach populations and snowball sampling not in hard-to-reach populations. *Sociological Methodology*, *41*(1), 347-353.

Gorman, M. (2000). The growing problem of violence against older persons in Africa. *Southern African Journal of Gerontology*, *9*, 33-36.

Government of the Republic of Namibia (2012). Republic of Namibia Report of the Auditor-General on performance audit on the Ministry of Labour and Social Welfare- Administration of basic state grants for the financial year 2008, 2009 and 2010. Government of Namibia, Windhoek, Namibia.

Gray, D. E. (2019). *Doing research in the business world*. Sage.

Gray, R. S., & Pattaravanich, U. (2020). Internal and external resources, tiredness and the subjective well-being of family caregivers of older adults: a case study from western Thailand, Southeast Asia. *European Journal of Ageing*, *17*(3), 349-359.

Gray, R. S., Hahn, L., Thapsuwan, S., & Thongcharoenchupong, N. (2016). Strength and stress: Positive and negative impacts on caregivers for older adults in Thailand. *Australasian journal on ageing*, *35*(2), E7-E12.

Greenglass, E. R. (2002). Proactive coping and quality of life management.

Guerchet, M. & Aboderin, I. (2017). Ageing in sub-Saharan Africa. Dementia in sub-Saharan Africa: challenges and opportunities. London: *Alzheimer's Disease International*. Retrieved from https://www.alzint.org/resource/dementia-in-sub-saharan-africa/ [Assessed August 2020].

Gureje, O., Oladeji, B. D., Abiona, T., & Chatterji, S. (2014). Profile and determinants of successful aging in the Ibadan Study of Ageing. *Journal of the American Geriatrics Society*, *62*(5), 836-842.

Habjanič, A., & Lahe, D. (2012). Are frail older people less exposed to abuse in nursing homes as compared to community-based settings? Statistical analysis of Slovenian data. *Archives of Gerontology and Geriatrics*, *54*(3), e261-e270.

Hall, M. A., & Lord, R. (2014). Obamacare: what the Affordable Care Act means for patients and physicians. *Bmj*, *349*.

Ham, R. J., & Sloane, P. D. (1997). Primary care geriatrics: A case-based approach (3r d ed.). *St. Louis. Mo: Mosby*.

Hamunyela, M., & Nekongo-Nielsen, H. (2016). Namibia. In *International perspectives on older adult education* (pp. 273-283). Springer, Cham.

Hancock, G. A., Reynolds, T., Woods, B., Thornicroft, G., & Orrell, M. (2003). The needs of older people with mental health problems according to the user, the carer, and the staff. *International Journal of Geriatric Psychiatry*, *18*(9), 803-811.

Hangara, H. (2017). *Otuzo twOvaherero*. University of Namibia Press.

Hansen, T. K., Jensen, A. L., Damsgaard, E. M., Rubak, T. M. M., Jensen, M. E. J., & Gregersen, M. (2021). Involving frail older patients in identifying outcome measures for transitional care—a feasibility study. *Research involvement and engagement*, *7*(1), 1-10.

Harris, P. B. (1993). The misunderstood caregiver? A qualitative study of the male caregiver of Alzheimer's disease victims. *The Gerontologist*, *33*(4), 551-556.

Harris, P. R., & Moran, R. T. (1996). *Managing Cultural Differences, Leadership Strategies for a New World of Business*. (4th ed). Texas USA.

Harris, R. C., Dew, M. A., Lee, A., Amaya, M., Buches, L., Reetz, D., & Coleman, G. (1995). The role of religion in heart-transplant recipients' long-term health and well-being. *Journal of religion and health*, *34*(1), 17-32.

Hart, C. (1998). The Literature review in research. *Doing a literature review: Releasing the social science research imagination*, 1-25.

Hartman, A. (1979). *Finding families: An ecological approach to family assessment in adoption* (Vol. 7). SAGE Publications, Incorporated.

He, Z., Bishwajit, G., & Yaya, S. (2019). Prevalence of alcohol and tobacco use among men and women in Namibia. *International journal of environmental research and public health*, *16*(1), 59.

Hedberg-Kristensson, E., Ivanoff, S. D., & Iwarsson, S. (2007). Experiences among older persons using mobility devices. *Disability and Rehabilitation: Assistive Technology*, *2*(1), 15-22.

Heisler, C. J. (2000). Elder abuse and the criminal justice system: New awareness, new responses. *Generations: Journal of the American Society on Aging*, *24*(2), 52-58.

Hellström, Y., & Hallberg, I. R. (2001). Perspectives of elderly people receiving home help on health, care and quality of life. *Health & social care in the community*, *9*(2), 61-71.

Hemberg, J., Näsman, M., & Nyqvist, F. (2021). Meaningfulness among frail older adults receiving home-based care in Finland. *Health Promotion International*.

Hey, N., & Brunetti, S. (2020). Wellbeing evidence at the heart of policy. *What Works Wellbeing*.

Hickel, J. (2014). Engineering the township home: Domestic transformations and urban revolutionary consciousness. In M. Healy-Clancy and J. Hickel (Eds*.), In Ekhaya: The Politics of Home in KwaZulu-Natal* (pp. 131-161). Pietermaritzburg, SA: University of KwaZulu-Natal.

Hinders, J. A. S. (2019). *Unmet Support Needs of Informal Caregivers of Older Adults* (Doctoral dissertation, Walden University).

Hishongwa, N. S. (1992). *The contract labour system and its effects on family and social life in Namibia: A historical perspective*. Gamsberg Macmillan.

Hoffman, J. (2014). Families, older persons and care in contexts of poverty: The case of South Africa. In *International handbook on ageing and public policy*. Edward Elgar Publishing.

Hokenstad Jr, M. C. T., & Restorick Roberts, A. (2011). International policy on ageing and older persons: Implications for social work practice. *International Social Work*, *54*(3), 330-343.

Holden, C. (2005). Social policy and political economy: a tale of (at least) two disciplines. *Social Policy and Society*, *4*(2), 173.

Holroyd-Leduc, J., Resin, J., Ashley, L., Barwich, D., Elliott, J., Huras, P., ... & Muscedere, J. (2016). Giving voice to older adults living with frailty and their family caregivers: engagement of older adults living with frailty in research, health care decision making, and in health policy. *Research Involvement and Engagement*, *2*(1), 1-19.

Holtzhausen, B. (2012). ADN: Caring for people with Alzheimer's and dementia in Namibia. Available: https://alzheimersdementianamibia.wordpress.com [Accessed 2015/07/19].

Hong, M., & Harrington, D. (2016). The effects of caregiving resources on perceived health among caregivers. *Health & social work*, *41*(3), 155-163

Hooyman, N. R., & Kiyak, H. A. (2005). *Social gerontology: A multidisciplinary perspective (7th ed.)*. Boston: Pearson education, Inc.

Hooyman, N. R., & Kiyak, H. A. (2011). The growth of social gerontology. *Social Gerontology: A multidisciplinary perspective (9th ed.). Upper Saddle River, NJ; Pearson.*

Hori, Y., Hoshino, J., & Suzuki, K. (2011). Physical and psychological health problems among Japanese family caregivers. *Nagoya Journal of Medical Science*, *73*(3-4), 107.

Horn, N. (2011). Religious freedom and intimidation in a secular state the Namibia experience.

Huang, Y. L., McGonagle, M., Shaw, R., Eastham, J., Alsaba, N., & Crilly, J. (2020). Models of care for frail older persons who present to the emergency department: a scoping review protocol. *Systematic reviews*, *9*(1), 1-6.

Huber, M. and Hennessy, P. (2005). *Long-term care for older people*. Organisation for Economic Cooperation and Development Publishing, Paris.

Huebner, G. (2016). *Review of legislation and policies that support the social service workforce in low- and middle- income countries. Global social service workforce alliance*. Retrieved from http://www.socialserviceworkforce.org/system/files/resource/files/Review%20of%20Legislation%20and%20Policies%20that%20Support%20the%20SSW%20in%20Low%20and%20Middle%20Income%20Countries.pdf [Accessed September 2019].

Hutt, R., Rosen, R., & McCauley, J. (2004). Case managing long term conditions. *What impact does it have in the treatment of older people*, 1-28.

Hyldegård, J. (2006, October). Using diaries in group based information behavior research: a methodological study. In *Proceedings of the 1st international conference on Information interaction in context* (pp. 153-161).

Hynes, G., Stokes, A., & McCarron, M. (2012). Informal care-giving in advanced chronic obstructive pulmonary disease: lay knowledge and experience. *Journal of clinical nursing*, *21*(7-8), 1068-1077.

Idahosa, L., & Van Dijk, J. (2015). South Africa: Freedom for whom? Inequality, unemployment and the elderly. *Development*, *58*(1), 96-102.

Idowu, S. B. (2000). Namibia from colonisation to statehood: The paradoxical relationship between law and power in international society (Doctoral dissertation, London School of Economics and Political Science (United Kingdom).

Iecovich, E. (2014). Aging in place: From theory to practice. *Anthropological notebooks*, *20*(1).

Iipinge, S. N. (2001). *Capacity building for home care in rural Namibia* (Doctoral dissertation, University of Johannesburg).

Iitoolwa, A. (2016). *Phsycosocial support and quality of life for elderly people in Namibia: informal settlements in the city of Windhoek*.

Ikeda, C., Terada, S., Oshima, E., Hayashi, S., Okahisa, Y., Takaki, M., ... & Uchitomi, Y. (2015). Difference in determinants of caregiver burden between amnestic mild cognitive impairment and mild Alzheimer′ s disease. *Psychiatry research*, *226*(1), 242-246.

Indongo, A., & Robinson, Z. (2021). An analysis of the impact of fiscal policy on income distribution in Namibia. *Acta Universitatis Danubius. Œconomica, 17*(1).

Indongo, N., & Sakaria, N. (2016). Living arrangements and conditions of older persons in Namibia. *Advances in aging research*, *5*(05), 97-109.

Inelmen, E. M., Sergi, G., & Manzato, E. (2019). Elder abuse: are we turning a blind eye to a crucial issue?. *Internal and emergency medicine*, *14*(4), 503-505.

Ingstad, B., Bruun, F., Sandberg, E., & Tlou, S. (1992). Care for the elderly, care by the elderly: the role of elderly women in a changing Tswana society. *Journal of Cross-Cultural Gerontology*, *7*(4), 379-398.

Institute of Medicine. ( 2001, March). Crossing the quality chasm: A new health system for the 21st century. 1-8. Available at http://www.nap.edu/html/quality_chasm/reportbrief.pdf [accessed: 06 July 2021].

International Federation of Social Work (IFSW). (2008). Aging and Older adults. Retrieved from https://www.ifsw.org/ageing-and-older-adults/ [Assessed June 2021].

International Labour Office (ILO). (2014). *Namibia Social Protection Floor Assessment.* Geneva: International Labour Office. Retrieved from *https://www.social-protection.org/gimi/gess/ShowRessource.action?ressource.ressourceId=47837.* [Accessed April 2020].

International Labour Organisation (ILO). (2011) Yaoundé tripartite declaration on the implementation of the social protection floor: The action plan. In: Discussion at 12th African Regional Meeting [Of the ILO], Johannesburg, South Africa, 11–14 October 2011. Retrieved from; https://www.ilo.org/wcmsp5/groups/public/@ed_norm/@relconf/documents/meetingdocument/wcms_164919.pdf [Retrieved January 2020].

International Monetory Fund (IMF). (2018). Namibia: Financial System Assessment Report. Country Report No. 18/77. Available at: https://www.imf.org/en/Publications/CR/Issues/2018/03/15/Namibia-Financial-System-Stability-Assessment-45723. [Retrieved 18 January 2020].

Isola, A., Backman, K., Voutilainen, P., & Rautsiala, T. (2008). Quality of institutional care of older people as evaluated by nursing staff. *Journal of clinical nursing*, *17*(18), 2480-2489.

Issahaku, P. A., & Neysmith, S. (2013). Policy implications of population ageing in West Africa. *International Journal of Sociology and Social Policy*.

Issahaku, P. A., & Neysmith, S. (2013). Policy implications of population ageing in West Africa. *International Journal of Sociology and Social Policy*.

Jaccard, J., & Jacoby, J. (2019). *Theory construction and model-building skills: A practical guide for social scientists*. Guilford publications.

Jacobs, M., Van Tilburg, T., Groenewegen, P., & Van Groenou, M. B. (2016). Linkages between informal and formal care-givers in home-care networks of frail older adults. *Ageing & Society*, *36*(8), 1604-1624.

Jacobzone, S. (1999). Ageing and care for frail elderly persons: An overview of international perspectives.*OECD.* Labour Market and Social Policy Occasional Papers No.38. 23 April 1999. Available at: https://www.oecd-ilibrary.org/docserver/313777154147.pdf?expires=1581087439&id=id&accname=guest&checksum=349041C29A13A8B550A39A3D605B30CB [Retrieved 5 January 2020].

Jarvis, M. A., Sartorius, B., & Chipps, J. (2020). Technology acceptance of older persons living in residential care. *Information Development*, *36*(3), 339-353.

Jauch, H. (2019a, September 20). Namibia's new Social Protection Policy: A chance to close the gaps. *The New Era Newspaper (*Windhoek) 20 September, Namibia. Retrieved from https://neweralive.na/posts/namibias-new-social-protection-policy-a-chance-to-close-the-gaps. [Retrieved September 2020].

Jauch, H. (2019b). Namibia's Draft National Social Protection Policy 2019-24: An assessment with a focus on social grants and labour market interventions, Windhoek, Namibia. Retrieved on the 18th of April 2021 at https://vivaworkers.org/sites/default/files/articlesworkshop/Social%20Protection%20Policy%20Assessment%202019.pdf [Accessed 18 April 2021].

Jenkins, C. L. (2000). Care arrangement decisions for frail older women: Quantitative and qualitative perspectives. *Journal of women & Aging*, *12*(3-4), 3-20.

Jivraj, S., Nazroo, J., Vanhoutte, B., & Chandola, T. (2014). Aging and subjective well-being in later life. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *69*(6), 930-941.

Johnson, R. W., & Wang, C. X. (2019). The financial burden of paid home care on older adults: Oldest and sickest are least likely to have enough income. *Health Affairs*, *38*(6), 994-1002.

Jordan, R. E., Adab, P., & Cheng, K. K. (2020). Covid-19: risk factors for severe disease and death.

Joubert, J. D. (2005). *A profile of informal carers in South Africa* (Doctoral dissertation, University of Pretoria).

Joubert, J., & Bradshaw, D. (2003). Health of older persons. *South African Health Review*, *2003*(1), 147-162.

Julius, E., Nuugulu, S. & Homateni, L. (2020). Estimating the Economic Impact of COVID-19: A Case Study of Namibia, MPRA Paper no. 99641, posted 15 April 2020.

Kaapama, P. (2020). 7 The continuities of colonial land dispossessions in Namibia under German and South African rule. *The Discourse of British and German Colonialism: Convergence and Competition*.

Kaiser, M. J., Bauer, J. M., Rämsch, C., Uter, W., Guigoz, Y., Cederholm, T., ... & Mini Nutritional Assessment International Group. (2010). Frequency of malnutrition in older adults: a multinational perspective using the mini nutritional assessment. *Journal of the American Geriatrics Society*, *58*(9), 1734-1738.

Kakwani, N., & Subbarao, K. (2005). Ageing and poverty in Africa and the role of social pensions.

Kalache, A., & Blewitt, R. (2012). Human rights in older age. *Global Population Ageing: Peril or Promise?*, 89.

Kalasa, B. (2001). Population and ageing in Africa: A policy dilemma. *Addis Ababa: UNFPA*.

Kalenga, B. N. (2015). *Evaluating the pre-retirement programme of the Namibian Government Pension Fund (GIPF)* (Doctoral dissertation, University of Pretoria).

Kalmijn, M. (2005). Intergenerational solidarity: A review of three theories and their evidence. *Department of Social Cultural Sciences, Tilburg University*.

Kalomo, E. N., & Besthorn, F. H. (2018). Caregiving in Sub-Saharan Africa and Older, Female Caregivers in the Era of HIV/AIDS: A Namibian Perspective. *GrandFamilies: The Contemporary Journal of Research, Practice and Policy*, *5*(1), 6.

Kalomo, E. N., & Liao, M. (2018). Burden of care among caregivers of persons living with HIV/AIDS in rural Namibia: Correlates and outcomes. *Social work in public health*, *33*(1), 70-84.

Kalomo, E. N., Jun, J. S., Lee, K. H., & Kaddu, M. N. (2021). Depressive symptoms among older adults with HIV in Namibia: The role of social support and spirituality. *African Journal of AIDS Research*, *20*(1), 25-31.

Kalomo, E. N., Lee, K. H., Lightfoot, E., & Freeman, R. (2018). Resilience among older caregivers in rural Namibia: The role of financial status, social support and health. *Journal of gerontological social work*, *61*(6), 605-622.

Kalomo, E., Lee, K. H., & Besthorn, F. (2017). Depressive symptoms among older caregivers raising children impacted by HIV/AIDS in the Omusati Region of Namibia. *Health Care for Women International*, *38*(12), 1327-1343.

Kalula, S. Z. (2011). The quality of health care for older persons in South Africa: Is there quality care?: Conference paper. *ESR Review: Economic and Social Rights in South Africa*, *12*(1), 22-25.

Kalusopa, T., Dicks, R., & Osei-Boateng, C. (2012). Social protection schemes in Africa. *Windhoek: African Labour Research Network*.

Kandjimbi, A. (2014). *An event history analysis of socio-economic determinants of adult mortality in Namibia* (Doctoral dissertation).

Kane, R. L., & Kane, R. A. (2001). What older people want from long-term care, and how they can get it. *Health Affairs*, *20*(6), 114-127.

Kangethe, S. (2010). Occupational care giving conditions and human rights: A study of elderly caregivers in Botswana. *Indian journal of palliative care*, *16*(2), 79.

Kapitako, A. (2017, 4 April). *Fins could tap into mental health sector*. The New Era, 4 April. Available: https://www.newera.com.na/2017/04/04/fins-could-tap-into-mental-health- sector/ [Accessed May 16, 2018].

Kaseke, E. (2004, July 27-29). An overview of formal and informal social security systems in Africa; Paper presented at the National Academy of Sciences and University of the Witwatersrand Workshop on Aging in Africa; July 27-29; Johannesburg, South Africa.

Kasseeah, H., & Tandrayen-Ragoobur, V. (2011). Assessing the formal social protection system in Mauritius. *The International Journal's Research Journal of Social Sciences and Management*, *1*(6), 82-94.

Kasuto, C. H. (2012). *The happiness of retirees from a mining industry in Namibia* (Doctoral dissertation).

Katjavivi, P. H. (1988). *A history of resistance in Namibia* (No. 15). James Currey.

Kaure, A. (1994). Provision of social services in Namibia. *Southern Africa political & economic monthly*, *7*(6), 25-26.

Kautz, T., Bendavid, E., Bhattacharya, J., & Miller, G. (2010). AIDS and declining support for dependent elderly people in Africa: retrospective analysis using demographic and health surveys. *Bmj*, *340*.

Kavari, J. U. (2001). Social organisation, religion and cosmos of the Ovaherero. *Journal of Religion and Theology in Namibia*, *3*(1), 116-160.

Kawulich, B. (2012). Collecting data through observation. Doing social research: A global context, 6(12), 150-160.

Keating, N., & Dosman, D. (2009). Social capital and the care networks of frail seniors. *Canadian Review of Sociology/Revue canadienne de sociologie*, *46*(4), 301-318.

Keating, N., McGregor, J. A., & Yeandle, S. (2021). Sustainable care: theorising the wellbeing of caregivers to older persons. *International Journal of Care and Caring*.

Keith, J., Fry, C. L., Glascock, A. P., Ikels, C., Dickerson-Putman, J., Harpending, H. C., & Draper, P. (1994). *The aging experience: Diversity and commonality across cultures*. Sage Publications.

Kelly, G., Mrengqwa, L., & Geffen, L. (2019). "They don't care about us": older people's experiences of primary healthcare in Cape Town, South Africa. *BMC geriatrics*, *19*(1), 98.

Kespichayawattana, J., & Jitapunkul, S. (2008). Health and health care system for older persons. *Ageing International*, *33*(1), 28-49.

Khoza, S. (2004). Promoting economic, social and cultural rights in Africa: The African Commission holds a seminar in Pretoria. *Afr. Hum. Rts. LJ*, *4*, 334-342.

Kiel, J. M. (1999). Reshaping Maslow's hierarchy of needs to reflect today's educational and managerial philosophies. *Journal of Instructional Psychology*, *26*(3), 167-167.

Kim, E. Y., Cho, E., & June, K. J. (2006). Factors influencing use of home care and nursing homes. *Journal of Advanced Nursing*, *54*(4), 511-517.

Kim, Y., & Given, B. A. (2008). Quality of life of family caregivers of cancer survivors: across the trajectory of the illness. *Cancer*, *112*(S11), 2556-2568.

Kimuna, S. R., & Makiwane, M. (2007). Older people as resources in South Africa: Mpumalanga households. *Journal of Aging & Social Policy*, *19*(1), 97-114.

Kirby, S. E., Coleman, P. G., & Daley, D. (2004). Spirituality and well-being in frail and nonfrail older adults. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *59*(3), 123-129.

Kisting, N. (2003). Respecting our elders: first national consultative conference of older people. *Sister Namibia*, *15*(5-6), 14-15.

Kivunja, C. (2018). Distinguishing between theory, theoretical framework, and conceptual framework: A systematic review of lessons from the field. *International Journal of Higher Education*, *7*(6), 44-53.

Klein, B. E., Klein, R., Knudtson, M. D., & Lee, K. E. (2005). Frailty, morbidity and survival. *Archives of gerontology and geriatrics*, *41*(2), 141-149.

Klie, T., & Ananias, J. (2021). Perceptions amongst university students about elder abuse in Namibia. *The Namibia CPD Journal for Educators*, *6*(1), 24-52.

Kloppers, J. M. (2011). *An educational, practice-oriented programme for caregivers of the elderly in old age homes in Windhoek and Rehoboth*. Windhoek: University of Namibia (Doctoral dissertation).

Kloppers, J. M., van Dyk, A., & Pretorius, L. (2015). The Experiences of the elderly and caregivers in respect of caring for the elderly in Windhoek and Rehoboth Namibia: An exploratory and descriptive study. *Open Journal of Nursing*, *5*(03), 246.

Knight, B. G., & Sayegh, P. (2010). Cultural values and caregiving: The updated sociocultural stress and coping model. *The Journals of Gerontology: Series B*, *65*(1), 5-13.

Knodel, J., & TEERAWICHITCHAINAN, B. P. (2017). Family support for older persons in Thailand: Challenges and opportunities.

Kodner, D. L. (2009). All together now: a conceptual exploration of integrated care. *Healthcare Quarterly (Toronto, Ont.)*, *13*, 6-15.

Kok, L., Berden, C., & Sadiraj, K. (2015). Costs and benefits of home care for the elderly versus residential care: a comparison using propensity scores. *The European journal of health economics*, *16*(2), 119-131.

Kollapan, J. (2008). The rights of older people–African perspectives. *South Africa's Human Rights Commission*.

Kommel, E. V. (1981). *The Role of the Social Worker in Registered Homes for the Aged* (Doctoral dissertation, University of Port Elizabeth).

Kornfeld-Matte, R. (2017). United Nations Human Rights (UNHR). *More can and needs to be done to fight old age poverty*. *Ageing in Namibia*. Retrieved from https://windhoek.sites.unicnetwork.org/tag/old-age-namibia [2018, September 18].

Kotzé, C. (2018). Elder Abuse—The Current State of Research in South Africa. *Frontiers in public health*, *6*, 358.

Krause, N. (2006). Social relationships in later life. In R. H. Binstock, & L. K. George (Eds.), *Handbook of aging and social sciences* (pp. 181-200). San Diego, CA: Elsevier.

Kreps, G. L. (2015). Health communication inquiry and health promotion: a state of the art review. *Journal of nature and science*, *1*(2), 1-12.

Krueger, R. A. (2014). *Focus groups: A practical guide for applied research*. Sage publications.

Kuluski, K., Gill, A., Naganathan, G., Upshur, R., Jaakkimainen, R. L., & Wodchis, W. P. (2013). A qualitative descriptive study on the alignment of care goals between older persons with multi-morbidities, their family physicians and informal caregivers. *BMC Family Practice*, *14*(1), 1-10.

Kumari, S., & Dua, K. (2020). Elder abuse: A social problem faced by elders in old age home.

Kuzuya, M., Masuda, Y., Hirakawa, Y., Iwata, M., Enoki, H., Hasegawa, J., & Iguchi, A. (2006). Day care service use is associated with lower mortality in community-dwelling frail older people. *Journal of the American Geriatrics Society*, *54*(9), 1364-1371.

Kvale, S. (1996). InterViews: An Introduction to Qualitative Research Interviewing, Thousand Oaks, CA, SAGE.

Kvale, S., & Brinkmann, S. (2009). Interviews: Learning the craft of qualitative research interviewing. SAGE.

Kwok, J. Y. C., & Tsang, K. K. M. (2012). Getting old with a good life: research on the everyday life patterns of active older people. *Ageing International*, *37*(3), 300-317.

Kyei-Arthur, F., & Codjoe, S. N. A. (2021). “Caring for the Elderly is Very Difficult”: Challenges and Coping Strategies of Caregivers in Urban Poor Accra, Ghana. *Clinical Nursing Research*, *30*(5), 662-669.

Lachs, M. S., & Pillemer, K. (2004). Elder abuse. *The Lancet*, *364*(9441), 1263-1272.

Lai, D. W. (2012). Effect of financial costs on caregiving burden of family caregivers of older adults. *Sage Open*, *2*(4), 2158244012470467.

Lally, F., & Crome, P. (2007). Understanding frailty. *Postgraduate medical journal*, *83*(975), 16-20.

Lamb, S., Robbins-Ruszkowski, J., & Corwin, A. I. (2017). Introduction: successful aging as a twenty-first-century obsession. In *Successful Aging as a Contemporary Obsession*(pp. 1-24). Rutgers University Press.

Lambert, A. S., Ces, S., Malembaka, E. B., Van Durme, T., Declercq, A., & Macq, J. (2019). Evaluation of bottom-up interventions targeting community-dwelling frail older people in Belgium: methodological challenges and lessons for future comparative effectiveness studies. *BMC health services research, 19*(1), 1-16.

Landecker, W. S. (1951). Integration and group structure: An area for research. *Soc. F.*, *30*, 394.

Landers, M. R., Oscar, S., Sasaoka, J., & Vaughn, K. (2016). Balance confidence and fear of falling avoidance behavior are most predictive of falling in older adults: prospective analysis. *Physical therapy*, *96*(4), 433-442.

Landi, F., Onder, G., Cesari, M., Barillaro, C., Russo, A., & Bernabei, R. (2005). Psychotropic medications and risk for falls among community-dwelling frail older people: an observational study. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, *60*(5), 622-626.

Langa, E. L., & Pistorius, A. G. (2018). *Transitioning to Old Age Homes: experiences of Older African People in Tshwane North Townships/by Emmanuel Lehlohonolo Langa* (Doctoral dissertation, Sefako Makgatho Health Sciences University).

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative research in psychology*, *3*(2), 102-120.

Latakgomo, C. N. (2011). *The experience and views of indigent older persons in Atteridgeville on the indigency policy/programme of local government* (Doctoral dissertation, Master's Thesis, Pretoria University, South Africa).

Lawton, M. P., & Simon, B. (1968). The ecology of social relationships in housing for the elderly. *The Gerontologist*, *8*(2), 108-115.

Lee, K. H. (2011). The role of spiritual experience, forgiveness, and religious support on the general well-being of older adults. *Journal of Religion, Spirituality & Aging*, *23*(3), 206-223.

Lee, W. K. M., & Hong-Kin, K. (2005). Differences in expectations and patterns of informal support for older persons in Hong Kong: Modification to filial piety. *Ageing International*, *30*(2), 188-206.

Leedy, P.D. & Ormrod, J. E. (2014). *Practical research: Planning and design*. Pearson Education.

Legal Assistance Centre (LAC). (2021). *Social welfare legal updates*. Windhoek, Namibia. Retrieved from http://www.lac.org.na/namlex/Social.pdf [Accessed 21 April 2021].

Leichsenring, K. (2012). Integrated care for older people in Europe—latest trends and perceptions. *International Journal of Integrated Care*, *12*.

Leite, D. F., Padilha, M. A. S., & Cecatti, J. G. (2019). Approaching literature review for academic purposes: The Literature Review Checklist. *Clinics*, *74*.

Lethin, C., Leino-Kilpi, H., Roe, B., Soto, M. M., Saks, K., Stephan, A., ... & Karlsson, S. (2016). Formal support for informal caregivers to older persons with dementia through the course of the disease: an exploratory, cross-sectional study. *BMC geriatrics*, *16*(1), 1-15.

Leuning, C. J., Small, L. F., & Van Dyk, A. (2000). Meanings and expressions of care and caring for elders in urban Namibian families. *Curationis*, *23*(3), 71-80.

Lewallen, S., & Courtright, P. (2001). Blindness in Africa: present situation and future needs. *British Journal of Ophthalmology*, *85*(8), 897-903.

Liau, S. J., Lalic, S., Sluggett, J. K., Cesari, M., Onder, G., Vetrano, D. L., ... & Bell, J. S. (2021). Medication management in frail older people: consensus principles for clinical practice, research, and education. *Journal of the American Medical Directors Association*, *22*(1), 43-49.

Lindsey, E., Hirschfeld, M., & Tlou, S. (2003). Home-based care in Botswana: experiences of older women and young girls. *Health care for women international*, *24*(6), 486-501.

Litwin, H. (2005). Correlates of successful aging: Are they universal?. *The International Journal of Aging and Human Development*, *61*(4), 313-333.

Litwin, H., & Attias-Donfut, C. (2009). The inter-relationship between formal and informal care: a study in France and Israel. *Ageing and society*, *29*(1), 71.

Liu, W., Kim, S., & Alessio, H. (2020). Mealtime Caregiving Knowledge, Attitudes, and Behaviors for Persons Living with Dementia: A Systematic Review of Psychometric Properties of Instruments: Instruments of dementia mealtime caregiving attributes. *International Journal of Nursing Studies*, 103824.

Lloyd-Sherlock, P. (2014). Beyond neglect: long-term care research in low and middle income countries. *International Journal of Gerontology*, *8*(2), 66-69.

Lloyd-Sherlock, P., Penhale, B., & Ayiga, N. (2018). Financial abuse of older people in low and middle-income countries: the case of South Africa. *Journal of elder abuse & neglect*, *30*(3), 236-246.

Lloyd, A., Kendall, M., Carduff, E., Cavers, D., Kimbell, B., & Murray, S. A. (2016). Why do older people get less palliative care than younger people. *Eur J Palliat Care*, *23*(3), 132-7.

Lombard, A. (2008). The implementation of the white paper for social welfare: a ten-year review. *The Social Work Practitioner-Researcher, 20*(2), 154–173.

Lombard, A., & Kruger, E. (2009). Older persons: the case of South Africa. *Ageing International*, *34*(3), 119-135.

Longo, F., Notarnicola, E., & Tasselli, S. (2015). A framework to assess welfare mix and service provision models in health care and social welfare: case studies of two prominent Italian regions. *BMC Health Services Research*, *15*(1), 1-12.

Look, K. A., & Stone, J. A. (2018). Medication management activities performed by informal caregivers of older adults. *Research in Social and Administrative Pharmacy*, *14*(5), 418-426.

Low, L. F., Yap, M., & Brodaty, H. (2011). A systematic review of different models of home and community care services for older persons. *BMC health services research*, *11*(1), 1-15.

Lowenstein, A. (2010). Caregiving and elder abuse and neglect—Developing a new conceptual perspective. *Ageing International*, *35*(3), 215-227.

Lowenstein, A., & Ogg, J. (Eds.). (2003). *OASIS: Old Age and Autonomy: the Role of Service Systems and Intergenerational Family Solidarity*. Final report. *Haifa: Center for Research and Study of Aging, University of Haifa, Israel*.

Lowry, K. A., Vallejo, A. N., & Studenski, S. A. (2012). Successful aging as a continuum of functional independence: lessons from physical disability models of aging. *Aging and disease*, *3*(1), 5.

Lucas, P. M. (2015). Old age pension as a social security initiative: the case of Botswana.

-Lundsgaard, J. (2005). Consumer direction and choice in long-term care for older persons, including payments for informal care: how can it help improve care outcomes, employment and fiscal sustainability?.

Luttig, H. G. (1933). *The religious system and social organization of the Herero: a study in Bantu culture*. Kemink en zoon.

Lyons, K. S., & Zarit, S. H. (1999). Formal and informal support: The great divide. *International journal of geriatric psychiatry*, *14*(3), 183-192.

Mabengano, C. M. (2003). *Factors that influence job turnover of social workers in the directorate of developmental social welfare services (DDSWS) in Namibia* (Doctoral dissertation, University of PRETORIA).

MacKinlay, E. (2006). Spiritual care: Recognizing spiritual needs of older adults. *Journal of Religion, Spirituality & Aging*, *18*(2-3), 59-71.

MacIntyre, S. (2018). Old age as a social problem: Historical notes on the English experience. In Health care and health knowledge (pp. 39-64). Routledge

MacNeil, S. D., & Fernandez, C. V. (2006). Informing research participants of research results: Analysis of Canadian University based research ethics board policies. *Journal of Medical Ethics*, *32*(1), 49-54.

Magnusson, L., & Hanson, E. (2005). Supporting frail older people and their family carers at home using information and communication technology: cost analysis. *Journal of Advanced Nursing*, *51*(6), 645-657.

Magnusson, L., Hanson, E., & Borg, M. (2004). A literature review study of information and communication technology as a support for frail older people living at home and their family carers. *Technology and Disability*, *16*(4), 223-235.

Maharaj, P. (Ed.). (2020). *Health and Care in Old Age in Africa*. Routledge.

Majumdar, B., & Mazaleni, N. (2010). The experiences of people living with HIV/AIDS and of their direct informal caregivers in a resource-poor setting. *Journal of the International AIDS Society*, *13*(1), 1-9.

Makiwane, M. (2011). The older persons and their relationship with younger generations in South Africa.

Makiwane, M., & Kwizera, S. A. (2006). An investigation of quality of life of the elderly in South Africa, with specific reference to Mpumalanga Province. *Applied Research in Quality of life*, *1*(3-4), 297-313.

Makiwane, M., Alubafi, M. F., & Gumede, N. A. (2020). “Understanding and Evaluating Older Persons Services: the Case of the Gauteng Province, South Africa. *Journal of Population Ageing*, 1-17.

Makiwane, M., Schneider, M., & Gopane, M. (2004). Experiences and needs of older persons in Mpumalanga. *South Africa: Human Sciences Research Council*.

Mallidou, A. A., & Babalola, T. K. (2020). What influences quality of life and healthy aging of older persons?. *Nursing Care & Research/Nosileia kai Ereuna*, (58).

Malherbe, K. (2007). Older Persons Act: Out with the old and in the with the older?. *Law, Democracy & Development*, *11*(1), 53-68.

Maneewat, T., Lertmaharit, S., & Tangwongchai, S. (2016). Development of caregiver resilience scale (CRS) for Thai caregivers of older persons with dementia. *Cogent Medicine*, *3*(1), 1257409.

Maniragaba, F., Kwagala, B., Bizimungu, E., Wandera, S. O., & Ntozi, J. (2018). Predictors of quality of life of older persons in rural Uganda: A cross sectional study. *AAS open research*, *1*.

Mann, W. C., Hurren, D., & Tomita, M. (1993). Comparison of assistive device use and needs of home-based older persons with different impairments. *American Journal of Occupational Therapy*, *47*(11), 980-987.

Mann, W. C., Hurren, M. D., Charvat, B. A., & Tomita, M. R. (1996). Changes over one year in assistive device use and home modifications by home-based older persons with Alzheimer’s disease. *Topics in Geriatric Rehabilitation*, *12*(2), 9-16.

Maphumulo, W. T., & Bhengu, B. R. (2019). Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review. *Curationis*, *42*(1), 1-9.

Marais, C. (2020). *Learning needs of caregivers of older persons in residential care facilities: an explorative case study* (Doctoral dissertation, University of the Free State).

Marais, S., Conradie, G., & Kritzinger, A. (2006). Risk factors for elder abuse and neglect: brief descriptions of different scenarios in South Africa. *International journal of older people nursing*, *1*(3), 186-189.

Mariki, M. S. (2017). *The tragedy of elder abuse and witchcraft accusations: A challenge to church’s mission in the ELCT, ELVD Sukumaland, Tanzania* (Master›s thesis).

Maripe, K. (2010). Modernization Of The Family Support System (FSS) and the Social Needs Of The Elderly (SNE): The Case of Botswana. *Journal of Sociology, Psychology and Anthropology in Practce: Int’l Perspective*, *2*, 1-3.

Marsden, J. P. (1999). Older persons’ and family members’ perceptions of homeyness in assisted living. *Environment and Behavior*, *31*(1), 84-106.

Mashau, N. S., Netshandama, V. O., & Mudau, M. J. (2016). Self-reported impact of caregiving on voluntary home-based caregivers in Mutale Municipality, South Africa. *African Journal of Primary Health Care and Family Medicine*, *8*(2), 1-5.

Maslow, A. H. (1943). A theory of human motivation. *Psychological review*, *50*(4), 370.

Mason, A., Weatherly, H., Spilsbury, K., Arksey, H., Golder, S., Adamson, J., ... & Glendinning, C. (2007). A systematic review of the effectiveness and cost-effectiveness of different models of community-based respite care for frail older people and their carers. *Health Technology Assessment (Winchester, England)*, *11*(15), 1-157.

Mastel-Smith, B., & Stanley-Hermanns, M. (2012). "It's like we're grasping at anything" caregivers' education needs and preferred learning methods. *Qualitative health research*, *22*(7), 1007-1015.

Masuku, K. P., & Khoza-Shangase, K. (2018). Spirituality as a coping mechanism for family caregivers of persons with aphasia. *Journal of Psychology in Africa*, *28*(3), 245-248.

Mateos-Nozal, J., & Beard, J. R. (2011). Global approaches to geriatrics in medical education. *European Geriatric Medicine*, *2*(2), 87-92.

Mathe, A. (2018). *A comparative analysis of housing policies of Namibia and South Africa* (Master›s thesis, Faculty of Commerce).

Matshoba, N. (2017). *Responding to the needs of South African military veterans through the provision of benefits*(Doctoral dissertation, University of KwaZulu-Natal).

Mavimbela, J. (2015). *Social work as a scarce skill: Exploring the views of social workers regarding the retention strategies used by the human resource managers to retain social workers within the Department of Social Development* (Doctoral dissertation), University of Witswatersrand).

Maximiano-Barreto, M. A., Moretti Luchesi, B., de Moura, A. B., Pavarini, S. C. I., & Chagas, M. H. N. (2021). What factors are associated with affective and cognitive empathy in informal and formal caregivers of older people?. *Australasian Journal on Ageing*.

McCallion, P., & Toseland, R. W. (1995). Supportive group interventions with caregivers of frail older adults. *Social Work with Groups*, *18*(1), 11-25.

McClelland, A. (2000). Effects of unemployment on the family.

McCormack, B. (2004). Person-centredness in gerontological nursing: an overview of the literature. *Journal of clinical nursing*, *13*, 31-38.

McDonald, A. P., Rizzotti, R., Rivera, J. M., D'Arcy, R. C., Park, G., & Song, X. (2021). Toward improved homecare of frail older adults: A focus group study synthesizing patient and caregiver perspectives. *Aging Medicine*, *4*(1), 4-11.

McFall, S., & Miller, B. H. (1992). Caregiver burden and nursing home admission of frail elderly persons. *Journal of Gerontology*, *47*(2), S73-S79.

McGarrigle, C., & Kenny, R. A. (2013). Profile of the sandwich generation and intergenerational transfers in Ireland. *Dublin: The Irish Longitudinal Study on Ageing*.

Mchombu, K. J., & Mchombu, C. M. (2014). The Role of Information and Knowledge in Poverty Eradication in Africa: a case study of Namibia.

McIntosh, W. A., Shifflett, P. A., & Picou, J. S. (1989). Social support, stressful events, strain, dietary intake, and the elderly. *Medical care*, 140-153.

McLennon, S. M., Uhrich, M., Lasiter, S., Chamness, A. R., & Helft, P. R. (2013). Oncology nurses' narratives about ethical dilemmas and prognosis-related communication in advanced cancer patients. *Cancer Nursing*, *36*(2), 114-121.

Mégret, F. (2011). The human rights of older persons: a growing challenge. *Human Rights Law Review*, *11*(1), 37-66.

Mehta, K. K. (2006). A critical review of Singapore's policies aimed at supporting families caring for older members. *Journal of Aging & Social Policy*, *18*(3-4), 43-57.

Mehta, K. K., & Leng, T. L. (2017). Experiences of formal and informal caregivers of older persons in Singapore. *Journal of cross-cultural gerontology*, *32*(3), 373-385.

Melber, H. (2010). Economic and social transformation in the process of colonisation: Society and state before and during German rule. *C. Keulder, State, Society and Democracy: A Reader in Namibian Politics*, 16-48.

Melber, H. (2020). In the shadow of apartheid: The Windhoek Old Location. *Southern Journal for Contemporary History*, *45*(2), 33-58.

Mello, J. D. A., Macq, J., Van Durme, T., Cès, S., Spruytte, N., Van Audenhove, C., & Declercq, A. (2017). The determinants of informal caregivers' burden in the care of frail older persons: a dynamic and role-related perspective. *Aging & mental health*, *21*(8), 838-843.

Mentes, J. C., & Gaspar, P. M. (2020). Hydration management. *Journal of gerontological nursing*, *46*(2), 19-30.

Merriam, S.B. (1998). *Qualitative research and case study applications in education: A conceptual introduction.* San Francisco: Jossey-Bass.

Metsola, L. (2010). The struggle continues? The spectre of liberation, memory politics and 'war veterans' in Namibia. *Development and Change*, *41*(4), 589-613.

Metzelthin, S. F., van Rossum, E., de Witte, L. P., Ambergen, A. W., Hobma, S. O., Sipers, W., & Kempen, G. I. (2013). Effectiveness of interdisciplinary primary care approach to reduce disability in community dwelling frail older people: cluster randomised controlled trial. *Bmj*, *347*.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook*. sage.

Miller, E. A., Rosenheck, R. A., & Schneider, L. S. (2012). Caregiver burden, health utilities, and institutional service use in Alzheimer's disease. *International journal of geriatric psychiatry*, *27*(4), 382-393.

Mills, A. J., Durepos, G., & Wiebe, E. (Eds.). (2009). *Encyclopedia of case study research*. Sage Publications.

Ministry of Finance (MoF) (2018). *Medium-Term Expenditure Framework 2018/19-2020-21.* Ministry of Finance, Windhoek.

Ministry of Health and Social Services (MoHSS). (1997). Situation on social welfare policies in Namibia. Volume 1, The Green Paper 1.

Ministry of Health and Social Services (MoHSS). (1997). Situation on social welfare policies in Namibia. Volume 1, The Green Paper 1.

Ministry of Health and Social Services (MoHSS). (2006). Report on the status and living conditions of older people in Namibia, Windhoek.

Ministry of Health and Social Services (MoHSS). (2010) *National Health Policy Framework 2010-2020*, Windhoek, Namibia.

Ministry of Health and Social Services (MoHSS). National Health Policy Framework 2010-2020. Windhoek, Namibia.

Ministry of Poverty Eradication and Social Welfare (MOPESW). (2019). Draft Social Protection Policy, Retrieved from http://www.mpesw.gov.na/documents/227474/740652/Draft+Social+Protection+Policy+Regional+Consultation+speech/63404238-56e0-4afa-9478-533ddcde01ef [April 2020].

Ministry of Poverty Eradication and Social Welfare (MPESW). (2018). Social protection policy, Windhoek, Namibia. [Online] Available at: www.mpesw.gov.na/documents/227474 [Retrieved 3 January 2020].

Miranda-Castillo, C., Woods, B., & Orrell, M. (2013). The needs of people with dementia living at home from user, caregiver and professional perspectives: a cross-sectional survey. *BMC health services research*, *13*(1), 1-10.

Mkandawire, T. (2004). Social policy in a development context: Introduction. In *Social policy in a development context* (pp. 1-33). Palgrave Macmillan, London.

Mobily, P. R., Maas, M. L., Buckwalter, K. C., & Kelley, L. S. (1992). Staff stress on an Alzheimer's unit.

Mollenhorst, G., Völker, B., & Flap, H. (2011). Shared contexts and triadic closure in core discussion networks. *Social Networks*, *33*(4), 292-302.

Momodu, A. M., Ralphs, C. J., Murillo, D. M., & Bedard, J. D. (2018). Perception of Housing Adequacy: A case study of the La Rochelle temporary relocation area in Stellenbosch, South Africa. *Perception*.

Morgan, D. L. (2007). Paradigms lost and pragmatism regained: Methodological implications of combining qualitative and quantitative methods. *Journal of mixed methods research*, *1*(1), 48-76.

Morgan, T., Wiles, J., Williams, L., & Gott, M. (2021). COVID-19 and the portrayal of older people in New Zealand news media. *Journal of the Royal Society of New Zealand, 51*(sup1), S127-S142.

Morley, J. E. (2002). A fall is a major event in the life of an older person. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, *57*(8), M492-M495.

Mosito, K. E. (2016). Emerging social security systems in Chile, Namibia, and South Africa: a quest for comparative critical benchmarks for Lesotho. *Lesotho Law Journal*, *24*(1), 1-45.

Mubangizi, J. C. (2006). The Constitutional Protection of Socio-Economic Rights in selected African countries: a comparative evaluation. *African Journal of Legal Studies*, *2*(1), 1-19.

Mukuka, L., Kalikiti, W., & Musenge, D. K. (2002). Social security systems in Zambia: Phase I Overview of social security in Zambia. *Journal of Social Development in Africa*, *17*(2),65-110.

Mundia, K. F. (2016). A constructive interpretation of the Namibian Constitution: transposing Dworkin to Namibia's constitutional jurisprudence. *Southern African Public Law*, *31*(1), 73-90.

Mur-Veeman, I., Hardy, B., Steenbergen, M., & Wistow, G. (2003). Development of integrated care in England and the Netherlands: managing across public–private boundaries. *Health policy*, *65*(3), 227-241.

Mwansa, L. K. (1992, March 27-29). Radical social work practice: the case for Africa. Paper presented at the *Department of Social Work's National Field Supervisors' Seminar. Ramatea, Kanye, Botswana* (pp. 27-29).

Mwinga, M. (2012). Unemployment in Namibia: Measurement Problems, Causes & Policies. Report by First Capital Working Paper Series, Windhoek, Namibia. Retrieved from: http://www.firstcapitalnam.com/cms/upload/First%20Capital%20Namibia%20Unemployment%20Report%20[May%202012].pdf [May 2020].

Nabalamba, A., & Chikoko, M. (2011). *Aging population challenges in Africa*. African Development Bank, Chief Economist Complex.

Nakuta, J. (2008). The justiciability of social, economic and cultural rights in Namibia and the role of the non-governmental organisations. *Human rights and the rule of law in Namibia.* Windhoek: Macmillan Education Namibia.

Nakuta, J., & Mnubi-Mchombu, C. (2015). Accessing government information in Namibia as a human right issue.

Namibia Population and Housing Census (NPHC). (2011). Namibia Population and Housing Census 2011.

Namibia Statistics Agency (NSA). (2015). *Namibia Household Income and Expediture Survey (NHIES) 2015/2016* Report, Available from: https://d3rp5jatom3eyn.cloudfront.net/cms/assets/documents/NHIES_2015-16.pdf [Accessed April 2020].

Namibia Statistics Agency (NSA). (2017). Available at: https://nsa.org.na/page/publications/. [July 2019]

Namibia Statistics Agency (NSA). (2018). The Namibia Labour Force Survey Report 2018. Windhoek, Namibia. Retrieved from: https://nsa.org.na/microdata1/index.php. [August 2020].

Nangombe, H., & Ackermann, L. (2013). Subsistence and protection needs of the elderly living in Katutura, Windhoek (Namibia). *Research on Aging*, *35*(2), 182-200.

Nankwanga, A., & Phillips, J. (2009). The root cause for the exclusion of older persons from participation in developmental activities in the society-African perspective.

Napoles, A. M., Chadiha, L., Eversley, R., & Moreno-John, G. (2010). Reviews: developing culturally sensitive dementia caregiver interventions: are we there yet?. *American Journal of Alzheimer's Disease & Other Dementias®*, *25*(5), 389-406.

Naughton, C., Drennan, J., Treacy, M. P., Lafferty, A., Lyons, I., Phelan, A., ... & Delaney, L. (2010). Abuse and neglect of older people in Ireland. *Report on The National Study of Elder Abuse and Neglect. Report Summary. Ireland: National Centre for the Protection of Older People*.

Navaie-Waliser, M., Feldman, P. H., Gould, D. A., Levine, C., Kuerbis, A. N., & Donelan, K. (2002). When the caregiver needs care: The plight of vulnerable caregivers. *American journal of public health*, *92*(3), 409-413.

Ndjembela, T. D. (2018). *The impact of exclusion of the urban ultra-poor from public housing on the lives of those excluded*(Master's thesis, Faculty of Commerce).

New Era (2016, July 28). National policy on older persons coming. *The New Era Newspaper*: Namibia. Available at: https://neweralive.na/posts/national-policy-older-persons-coming. [Retrieved 20 August 2018].

Newman, J., Glendinning, C., & Hughes, M. (2008). Beyond modernisation? Social care and the transformation of welfare governance. *Journal of social policy*, *37*(4), 531-557.

Ngatjiheue, C. & Petersen, S. (2021, May 24). Genocide: No Individual compensation. *The Namibian Newspaper.* Retrieved from https://www.namibian.com.na/211649/archive-read/Genocide-No-individual-compensation. Accessed [25 May 2021].

Nghikembua, E. N. (2019). *Consumer benefits squeezed out of limited sector reform: Namibia 1992-2019* (Doctoral dissertation).

Ngome, E. (1994). A Rapid Assessment of the Perception of the Elderly on the Problem of Ageing in Botswana. In *The Situation of the Elderly in Botswana: Proceedings from an International Workshop. NIR-SUM programme on Health, Population and Development, Report* (No. 1, pp. 103-108).

Nguluwe, M. S. (2016). *Extending access to social security to the informal sector in South Africa: challenges and prospects*(Doctoral dissertation, North-West University (South Africa), Potchefstroom Campus).

Nhongo, T. M. (2004a, August). The changing role of older people in African households and the impact of ageing on African family structures. In *African Conference on Ageing, Johannesburg, South Africa* (pp. 18-20).

Nhongo, T. M. (2004b, January). Impact of HIV/AIDS on generational roles and intergenerational relationships. In *Proceedings of the Workshop on HIV/AIDS and Family Well-Being, Windhoek, Namibia* (pp. 28-30).

Nicholson, N. R. (2012). A review of social isolation: an important but underassessed condition in older adults. *The journal of primary prevention*, *33*(2-3), 137-152.

Niikondo, H. N., Hoque, M. E., & Ntuli-Ngcobo, B. (2011). Home-based caregivers' knowledge regarding anti-retroviral therapy in Namibia. *Southeast Asian Journal of Tropical Medicineand Public Health*, *42*(2), 410.

Niño-Zarazúa, M., Barrientos, A., Hickey, S., & Hulme, D. (2012). Social protection in Sub-Saharan Africa: Getting the politics right. *World development*, *40*(1), 163-176.

Nishaat, B. Z. (2017). Achieving work family balance (WFB) among professional working women in Mauritius: A qualitative study. *PEOPLE: International Journal of Social Sciences*, *3*(2), 2053-5074.

Njororai, F., & Njororai, W. W. S. (2013). Older adult caregivers to people with HIV/AIDS in Sub-Saharan Africa: a review of literature and policy implications for change. *International Journal of Health Promotion and Education*, *51*(5), 248-266.

Njuguna, A. G. (2010). *Strategies to improve pension fund efficiency in Kenya.* (Doctoral dissertation, Nelson Mandela Metropolitan University).

Noble, H., & Smith, J. (2015). Issues of validity and reliability in qualitative research. *Evidence-based nursing*, *18*(2), 34-35.

Nord, C. (2021). Family houses–building an intergenerational space in post-apartheid Namibia. *Canadian Journal of African Studies/Revue canadienne des études africaines*, 1-25.

Nowitz, L. (2012). Incorporating a spiritual perspective into geriatric care management. In Cress, C. (Ed.). *Handbook of geriatric care management*. Jones & Bartlett Publishers.

Noyoo, N. (2017). Reflecting on the human rights of older persons in South Africa. *Journal of Human Rights and Social Work*, *2*(4), 108-116.

Noyoo, N., Seepamore, B., Ncube, M., & Sobantu, M. (2021). EVOLUTION OF SOCIAL WELFARE AND SOCIAL WORK IN SOUTH AFRICA. *Social Welfare and Social Work in Southern Africa*, 195.

Ntinda, R. N. (2013). The Namibian disability framework: A critical analysis for the effective implementation of the international convention on the rights of persons with disabilities. *Unpublished master's dissertation, University of Namibia, Namibia*.

Ntuli, M., & Madiba, S. (2019). The Burden of Caring: An Exploratory Study of the Older Persons Caring for Adult Children with AIDS-Related Illnesses in Rural Communities in South Africa. *International journal of environmental research and public health*, *16*(17), 3162.

Nugent, J. B. (1990). Old age security and the defense of social norms. *Journal of Cross-Cultural Gerontology*, *5*(3), 243-254.

Nwauwa, A.O. (2000). The Europeans in Africa: Prelude to colonialism. In T. Falola, (Ed.), *African cultures and societies before 1884* (Vol. 2). Carolina Academic Press.

Nyambedha, E. O., Wandibba, S., & Aagaard-Hansen, J. (2003). "Retirement lost"—the new role of the elderly as caretakers for orphans in western Kenya. *Journal of cross-cultural gerontology*, *18*(1), 33-52.

Nyenti, M., & Mpedi, L. G. (2012). The impact of SADC social protection instruments on the setting up of a minimum social protection floor in southern African countries. *Potchefstroom Electronic Law Journal*, *15*(1), 244-281.

O'Donoghue, C. E., Botha, A. D. H., & Van Rensburg, G. H. (2014). Culturally diverse care for older persons: what do we expect of caregivers? nursing. *Professional Nursing Today*, *18*(1), 3-6.

O'Reilly, K. (2009). Inductive and deductive. Key concepts in ethnography, 104-109.

O'Shea, E., & Kennelly, B. (1995). Caring and theories of welfare economics.

Office of the President (2016). *Harambee Prosperity Plan 2016/17-2019/20*, Windhoek, Namibia.

Okoye, U. O., & Asa, S. S. (2011). Caregiving and stress: Experience of people taking care of elderly relations in South-Eastern Nigeria. *Arts and Social Sciences Journal*.

Okpaluba, C. (2014). Protecting the right to personal liberty in Namibia: Constitutional, delictual and comparative perspectives. *African Human Rights Law Journal*, *14*(2), 580-608.

Onwuegbuzie, A. J., Dickinson, W. B., Leech, N. L., & Zoran, A. G. (2009). A qualitative framework for collecting and analyzing data in focus group research. *International journal of qualitative methods*, *8*(3), 1-21.

Osanloo, A., & Grant, C. (2016). Understanding, selecting, and integrating a theoretical framework in dissertation research: Creating the blueprint for your "house". *Administrative issues journal: connecting education, practice, and research*, *4*(2), 7.

Osei-Hwedie, K. (1993). The challenge of social work in Africa: Starting the indigenisation process. *Journal of Social development in Africa*, *8*(1), 19-30.

Oswald, F., & Rowles, G. D. (2017). Beyond the relocation trauma in old age: New trends in elders' residential decisions. In *New Dynamics in Old Age Individual, Enviromental, and Societal Perspectives* (pp. 127-152). Routledge.

Overbye, E. (2005). Extending social security in developing countries: A review of three main strategies. *International Journal of Social Welfare*, *14*(4), 305-314.

Oyserman, D., Coon, H. M., & Kemmelmeier, M. (2002). Rethinking individualism and collectivism: evaluation of theoretical assumptions and meta-analyses. *Psychological bulletin*, *128*(1), 3.

Özcan, N. K., Boyacıoğlu, N. E., & Sertçelik, E. (2017). Reciprocal abuse: elder neglect and abuse by primary caregivers and caregiver burden and abuse in Turkey. *Archives of psychiatric nursing*, *31*(2), 177-182.

Palmer, J. A., Howard, E. P., Bryan, M., & Mitchell, S. L. (2018). Physiological and psychosocial factors in spiritual needs attainment for community-dwelling older adults. *Archives of gerontology and geriatrics*, *76*, 1-5.

Pande, A., Laditka, S. B., Laditka, J. N., & Davis, D. R. (2007). Aging in place? Evidence that a state Medicaid waiver program helps frail older persons avoid institutionalization. *Home Health Care Services Quarterly*, *26*(3), 39-60.

Parasuraman, R., & Nestor, P. G. (1991). Attention and driving skills in aging and Alzheimer's disease. *Human factors*, *33*(5), 539-557.

Pardeck, J. T. (1988). An ecological approach for social work practice. *J. Soc. & Soc. Welfare*, *15*, 133.

Parker, V. (2010). The importance of cultural competence in caring for and working in a diverse America. *Generations*, *34*(4), 97-102.

Parnell, S. (1991). Sanitation, segregation and the natives (urban areas) act: African exclusion from Johannesburg's Malay location, 1897–1925. *Journal of Historical Geography*, *17*(3), 271-288.

Patel, L. (2005). *Social welfare and social development in South Africa*. Cape Town: Oxford University Press Southern Africa.

Patton, M. Q. (2001). Qualitative research and evaluation components.

Patton, M. Q. (2002). Two decades of developments in qualitative inquiry: A personal, experiential perspective. *Qualitative social work*, *1*(3), 261-283.

Peckham, A. (2009). *Caring for caregivers: Balancing formal and informal care for frail older persons* (Doctoral dissertation).

Peckham, A., Williams, A. P., & Neysmith, S. (2014). Balancing formal and informal care for older persons: how case managers respond. *Canadian Journal on Aging/La Revue canadienne du vieillissement*, *33*(2), 123-136.

Peeters, J. M., Van Beek, A. P., Meerveld, J. H., Spreeuwenberg, P. M., & Francke, A. L. (2010). Informal caregivers of persons with dementia, their use of and needs for specific professional support: a survey of the National Dementia Programme. *BMC nursing*, *9*(1), 1-8.

Peil, M. (1995). Family help for the elderly in Africa: a comparative assessment. *Southern African Journal of Gerontology*, *4*(2), 26-32.

Pelham, L. (2007). The politics behind the non-contributory old age social pensions in Lesotho, Namibia and South Africa. *Chronic Poverty Research Centre Working paper*, (83).

Penhale, B. (2010). Responding and intervening in elder abuse and neglect. *Ageing International*, *35*(3), 235-252.

Pérez, L. M., Castellano-Tejedor, C., Cesari, M., Soto-Bagaria, L., Ars, J., Zambom-Ferraresi, F., ... & Inzitari, M. (2021). Depressive symptoms, fatigue and social relationships influenced physical activity in frail older community-dwellers during the Spanish lockdown due to the Covid-19 pandemic. *International journal of environmental research and public health*, *18*(2), 808.

Perman, G., Prevettoni, M., Guenzelovich, T., Schapira, M., Infantino, V. M., Ramos, R., ... & Garfi, L. (2021). Effectiveness of a health and social care integration programme for home-dwelling frail older persons in Argentina. *International Journal of Care Coordination*, *24*(1), 28-34.

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

Petros, G. S. (2010). *The role of older persons in the management of HIV and AIDS: An assesment of their contribution and support needs in three South African Provinces* (Doctoral dissertation, University of Cape Town).

Petros, S. G. (2011). Supporting older caregivers to persons affected by HIV and AIDS: a policy framework: conference paper. *ESR Review: Economic and Social Rights in South Africa*, *12*(1), 25-28.

Pharr, J. R., Dodge Francis, C., Terry, C., & Clark, M. C. (2014). Culture, caregiving, and health: Exploring the influence of culture on family caregiver experiences. *International Scholarly Research Notices*, *2014*.

Phelan, A. (2020a). *Advances in Elder Abuse Research*. Springer International Publishing.

Phillips, L. R., de Ardon, E. T., & Briones, G. S. (2001). Abuse of female caregivers by care recipients: Another form of elder abuse. *Journal of Elder Abuse & Neglect*, *12*(3-4), 123-143.

Phoenix, C. (2018). Why qualitative research is needed in gerontology and how we can do it better. *The Journals of Gerontology: Series B*, *73*(7), e81-e85.

Pickard, L., Wittenberg, R., Comas-Herrera, A., Davies, B., & Darton, R. (2000). Relying on informal care in the new century? Informal care for elderly people in England to 2031. *Ageing and society*, *20*(6), 745-772.

Piercy, K. W. (2000). When it is more than a job: Close relationships between home health aides and older clients. *Journal of Aging and Health*, *12*(3), 362-387.

Pieters, W. R., & Matheus, L. (2020). Improving general health and reducing burnout of nurses in Namibia. *SA Journal of Human Resource Management*, *18*(1), 1-13.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological journal*, *20*(1), 7-14.

Pillatt, A. P., Nielsson, J., & Schneider, R. H. (2019). Effects of physical exercise in frail older adults: A systematic review. *Fisioterapia e Pesquisa*, *26*, 210-217.

Pillay, N. K., & Maharaj, P. (2013). Population ageing in Africa. In *Aging and health in Africa* (pp. 11-51). Springer, Boston, MA.

Pinquart, M., & Sörensen, S. (2007). Correlates of physical health of informal caregivers: a meta-analysis. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *62*(2), P126-P137.

Pinquart, M., & Sörensen, S. (2011). Spouses, adult children, and children-in-law as caregivers of older adults: a meta-analytic comparison. *Psychology and aging*, *26*(1), 1.

Pitkälä, K. H., Routasalo, P., Kautiainen, H., & Tilvis, R. S. (2009). Effects of psychosocial group rehabilitation on health, use of health care services, and mortality of older persons suffering from loneliness: a randomized, controlled trial. *Journals of Gerontology Series A: Biomedical Sciences and Medical Sciences*, *64*(7), 792-800.

Platts-Mills, T. F., Leacock, B., Cabanas, J. G., Shofer, F. S., & McLean, S. A. (2010). Emergency medical services use by the elderly: analysis of a statewide database. *Prehospital Emergency Care*, *14*(3), 329-333.

Plöthner, M., Schmidt, K., De Jong, L., Zeidler, J., & Damm, K. (2019). Needs and preferences of informal caregivers regarding outpatient care for the elderly: a systematic literature review. *BMC geriatrics*, *19*(1), 1-22.

Ponting, J. (2000). *Social responsibility and pension schemes administered by trade unions.(* Unpublished MCom research report, University of Johannesburg).

Pot, A. M., Deeg, D. J., & Knipscheer, C. P. (2001). Institutionalization of demented elderly: the role of caregiver characteristics. *International journal of geriatric psychiatry*, *16*(3), 273-280.

Powell, J. L. (2001). Theorising social gerontology: The case of social philosophies of age. *Sincronía*, (19), 4.

Pradeep, M. D., & Raj, C. (2006). Recent Trends of Socio-Economic Empowerment of Elderly-Interventions Towards Broad Based Benefits in India.*International Journal of Current Research and Modern Education (IJCRME) ISSN (Online):1*(1), 2455-5428. Retrieved from SSRN-id2817274.pdf [Assessed February 2020].

Pretorius, E. (2019). *Living with Alzheimer's disease in Namibia: the adult child, the older parent and the decision to institutionalise* (Doctoral dissertation, University of Pretoria).

Prince, M. J., Wu, F., Guo, Y., Robledo, L. M. G., O'Donnell, M., Sullivan, R., & Yusuf, S. (2015). The burden of disease in older people and implications for health policy and practice. *The Lancet*, *385*(9967), 549-562.

Pruchno, R. A., & Potashnik, S. L. (1989). Caregiving spouses physical and mental health in perspective. *Journal of the American Geriatrics Society*, *37*(8), 697-705.

Puchalski, C. M., Vitillo, R., Hull, S. K., & Reller, N. (2014). Improving the spiritual dimension of whole person care: reaching national and international consensus. *Journal of palliative medicine*, *17*(6), 642-656.

Punsch, K. F. (2005). Introduction to Social Research.

Rabiner, D. J., O'Keeffe, J., & Brown, D. (2006). Financial exploitation of older persons: Challenges and opportunities to identify, prevent, and address it in the United States. *Journal of aging & social policy*, *18*(2), 47-68.

Raj, C. (2017). Broad Based Benefit Model for the Elderly-Collaborative Approach.

Ralston, M. (2018). The role of older persons' environment in aging well: Quality of life, illness, and community context in South Africa. *The Gerontologist*, *58*(1), 111-120.

Ramashala, M. F. (2001). *Living arrangements, poverty and the health of older persons in Africa*. United Nations, Department of Economic and Social Affairs, Population Division.

Rampke, B. (2016). *Interconnectedness, Healing & Harmony: The Application of Ubuntu in Peace Research and in Namibian-German Postcolonial Disputes Emerging From the Return of Human Remains* (Master›s thesis).

Randolph, J. (2009). A guide to writing the dissertation literature review. *Practical Assessment, Research, and Evaluation*, *14*(1), 13.

Raniga, T., & Simpson, B. (2011). Poverty, HIV/AIDS and the old age pension in Bhambayi, Kwazulu-Natal, South Africa. *Development Southern Africa*, *28*(1), 75-85.

Rauhala, M., & Topo, P. (2003). Independent living, technology and ethics. *Technology and Disability*, *15*(3), 205-214.

Ravanipour, M., Salehi, S., Taleghani, F., & Abedi, H. A. (2010). Elderly self-management: a qualitative study. *Iranian Journal of Nursing and Midwifery Research*, *15*(2), 60-65.

Recker, J. (2021). Ethical considerations in research. In *Scientific Research in Information Systems* (pp. 197-214). Springer, Cham.

Renyi, M., Teuteberg, F., & Kunze, C. (2018, July). ICT-based support for the collaboration of formal and informal caregivers–a user-centered design study. In *International Conference on Business Information Systems* (pp. 400-411). Springer, Cham.

Republic of Namibia (1990). *The Constitution of the Republic of Namibia (Act 1 of 1990).* Republic of Namibia, Windhoek.

Republic of Namibia (1994) Social Security Act, 1994 (Act 34 of 1994), Government Gazette No. 992, pp.1-47.

Republic of Namibia (1999). War Veterans Subvention Act, 1999 (Act 16 of 1999), Government Gazette No. 2211.

Republic of Namibia (2004) Social Work and Psychology Act, 2004 (Act 6 of 2004), Government Gazette No. 3246, pp.1-67.

Republic of Namibia (2018). *Namibia demographic and health care expenditure survey 2018.* Namibia Statistics Agency, Government of the republic of Namibia. Retrieved from https://nsa.org.na/microdate1/index.dhc/catalog/19 [Assecced 16 April 2021].

Republic of Namibia (2019). *Draft national social protection policy 2019-2024*, Ministry of Poverty Eradication and Social Welfare, Windhoek, Namibia.

Republic of South Africa (1962), Report of the Commission of Inquiry into South West Africa Affairs, 1962–1963, R.P. No. 12/1964, p. 81.

Republic of South Africa. (1997). Department of Welfare and Population Development. White Paper for Social Welfare. General Notice 1108 in Government Gazette 18166 of 8 August 1997 para 19.

Republic of South Africa. (1997). White paper for social welfare. *Government Gazette Notice*, *386*(18166).

Reuters (2021, September 24). Namibian opposition criticises genocide compensation deal with Germany. Retrieved from https://www.reuters.com/world/namibian-opposition-criticises-genocide-compensation-deal-with-germany-2021-09-22/. Accessed [24 September 2021].

Riege, A., & Lindsay, N. (2006). Knowledge management in the public sector: stakeholder partnerships in the public policy development. *Journal of knowledge management*.

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (Eds.). (2013). *Qualitative research practice: A guide for social science students and researchers*. Sage.

Rittirong, J., Prasartkul, P., & Rindfuss, R. R. (2014). From whom do older persons prefer support? The case of rural Thailand. *Journal of Aging Studies*, *31*, 171-181.

Rizvi, M. A. K., & Hossain, M. Z. (2017). Relationship between religious belief and happiness: A systematic literature review. *Journal of Religion and Health*, *56*(5), 1561-1582.

Roberts, R. E., & Bengtson, V. L. (1990). Is intergenerational solidarity a unidimensional construct? A second test of a formal model. *Journal of Gerontology*, *45*(1), S12-S20.

Rodrigo, D. (2005). Regulatory impact analysis in OECD countries. *Challenges for developing countries. Dhaka, Bangladesh*.

Rodrigues, R., Simmons, C., Schmidt, A. E., & Steiber, N. (2021). Care in times of COVID-19: The impact of the pandemic on informal caregiving in Austria. *European journal of ageing*, *18*(2), 195-205.

Rogers, N. T., & Fancourt, D. (2020). Cultural engagement is a risk-reducing factor for frailty incidence and progression. *The Journals of Gerontology: Series B*, *75*(3), 571-576.

Rohleder, P., Braathen, S. H., Swartz, L., & Eide, A. H. (2009). HIV/AIDS and disability in Southern Africa: a review of relevant literature. *Disability and rehabilitation*, *31*(1), 51-59.

Rolfe, G. (2006). Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of advanced nursing*, *53*(3), 304-310.

Rosenmayr, L. (1991). Improving the health status of the rural elderly in Mali. *Journal of cross-cultural gerontology*, *6*(3), 301-318.

Ross-Sheriff, F., & Swigonski, M. (2009). Caregiving for the elderly: Personal and professional response.

Rovai, A. P., Baker, J. D., & Ponton, M. K. (2013). *Social science research design and statistics: A practitioner's guide to research methods and IBM SPSS*. Watertree Press LLC.

Rowley, J., & Slack, F. (2004). Conducting a literature review. *Management research news*.

Ruiters, G. (2018). The moving line between state benevolence and control: Municipal indigent programmes in South Africa. *Journal of Asian and African Studies*, *53*(2), 169-186.

Rusconi, R. (2008). South African Institutional Investments: Whose Money is it Anyway. *A Discussion Document, January*. Retrieved from https://www.gtac.gov.za/Researchdocs/South%20African%20Institutional%20Investments%20Whose%20Money%20is%20it%20Anyway.pdf [Assecced July 2020].

Ryan, P., & Sawin, K. J. (2009). The individual and family self-management theory: Background and perspectives on context, process, and outcomes. *Nursing outlook*, *57*(4), 217-225.

Ryke, E., Ngiba, T., & Strydom, H. (2014). Perspectives of elderly blacks on institutional care. *Social Work/Maatskaplike Werk*, *39*(2).

Saldaña, J. (2016). *The Coding Manual for Qualitative Researchers. 3rd Edition.* Los Angeles: Sage.

Salive, M. E., Collins, K. S., Foley, D. J., & George, L. K. (1993). Predictors of nursing home admission in a biracial population. *American Journal of Public Health*, *83*(12), 1765-1767.

Sánchez, V. G., Taylor, I., & Bing-Jonsson, P. C. (2017). Ethics of smart house welfare technology for older adults: A systematic literature review. *International journal of technology assessment in health care*, *33*(6), 691.

Sandgren, A., Arnoldsson, L., Lagerholm, A., & Bökberg, C. (2021). Quality of life among frail older persons (65+ years) in nursing homes: A cross-sectional study. *Nursing Open*, *8*(3), 1232-1242.

Saunders, M. N. K., Lewis, P., & Thornhill, A. (2019). Research Methods for Business Students (8th edn.) Harlow.

Saunders, M., Lewis, P., & Thornhill, A. (2016). Research methods for business students (Vol. Seventh). *Harlow: Pearson Education*.

Saunders, P. (2013). *Re-moralising the Welfare State*. St Leonards, NSW: Centre for Independent Studies.

Schade, K., La, J., & Pick, A. (2019). Financing social protection in Namibia.

Schatz, E., & Seeley, J. (2015). Gender, ageing and carework in East and Southern Africa: A review. *Global Public Health*, *10*(10), 1185-1200.

Scheffer, A. C., Schuurmans, M. J., Van Dijk, N., Van Der Hooft, T., & De Rooij, S. E. (2008). Fear of falling: measurement strategy, prevalence, risk factors and consequences among older persons. *Age and ageing*, *37*(1), 19-24.

Schensul, S. L., Schensul, J. J., & LeCompte, M. D. (1999). *Essential ethnographic methods: Observations, interviews, and questionnaires* (Vol. 2). Rowman Altamira.

Schick-Makaroff, K., Karimi-Dehkordi, M., Cuthbertson, L., Dixon, D., Cohen, S. R., Hilliard, N., & Sawatzky, R. (2021). Using Patient-and Family-Reported outcome and experience measures across transitions of care for frail older adults living at home: a Meta-Narrative synthesis. *The Gerontologist*, *61*(3), e23-e38.

Schleberger, E. (2002). Namibia's Universal Pension Scheme: Trends and Challenges", ESS paper no. 6. *ILO, Geneva*.

Schmuck, R.A. (1997). Practical action research for change. Arlington Heights, IL: IRI/Skylight Training and Publishing.

Schnegg, M. (2021). Becoming a Debtor to Eat: The Transformation of Food Sharing in Namibia. *Ethnos*, 1-21.

Schoene, D., Heller, C., Aung, Y. N., Sieber, C. C., Kemmler, W., & Freiberger, E. (2019). A systematic review on the influence of fear of falling on quality of life in older people: is there a role for falls?. *Clinical interventions in aging*, *14*, 701.

Scholten, E. W., Hillebregt, C. F., Ketelaar, M., Visser-Meily, J. M., & Post, M. W. (2021). Measures used to assess impact of providing care among informal caregivers of persons with stroke,

spinal cord injury, or amputation: a systematic review. *Disability and rehabilitation*, *43*(6), 746-772.

Schreier, M. (2012). *Qualitative content analysis in practice*. Sage publications.

Schulz, R., & Sherwood, P. R. (2008). Physical and mental health effects of family caregiving. *Journal of Social Work Education*, *44*(sup3), 105-113.

Schulz, R., Beach, S. R., Czaja, S. J., Martire, L. M., & Monin, J. K. (2020). Family caregiving for older adults. *Annual review of psychology*, 71, 635.

Schulz, R., Eden, J., & National Academies of Sciences, Engineering, and Medicine. (2016). Economic Impact of Family Caregiving. In *Families Caring for an Aging America*. National Academies Press (US).

Schutt, R. K. (2018). *Investigating the social world: The process and practice of research*. Sage publications.

Schuurmans, H., Steverink, N., Frieswijk, N., Buunk, B. P., Slaets, J. P., & Lindenberg, S. (2005). How to measure self-management abilities in older people by self-report. The development of the SMAS-30. *Quality of Life Research*, *14*(10), 2215-2228.

Schuurmans, H., Steverink, N., Lindenberg, S., Frieswijk, N., & Slaets, J. P. (2004). Old or frail: what tells us more?. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, *59*(9), M962-M965.

Schwandt, T. A. (2000). Three epistemological stances for qualitative inquiry: Interpretivism, hermeneutics, and social constructionism. In *Handbook of qualitative research* (pp. 189-213). Sage Publications Inc.

Schwarz, A. (2003). Old age security and social pensions. *World Bank: Human Development (Social Protection) Hub: Processed*.

Searle, S. D., Mitnitski, A., Gahbauer, E. A., Gill, T. M., & Rockwood, K. (2008). A standard procedure for creating a frailty index. *BMC geriatrics*, *8*(1), 1-10.

Seekings, J. (2019). The limits to 'global'social policy: The ILO, the social protection floor and the politics of welfare in East and Southern Africa. *Global Social Policy*, *19*(1-2), 139-158.

Seeleman, C., Suurmond, J., & Stronks, K. (2009). Cultural competence: a conceptual framework for teaching and learning. *Medical education*, *43*(3), 229-237.

Sefasi, A. P. (2010). Impact of HIV and AIDS on the eldery: A case study of Chiladzulu district. *Malawi Medical Journal*, *22*(4), 101-103.

Seibert, M., Mühlbauer, V., Holbrook, J., Voigt-Radloff, S., Brefka, S., Dallmeier, D., ... & von Arnim, C. A. F. (2021). Efficacy and safety of pharmacotherapy for Alzheimer's disease and for behavioural and psychological symptoms of dementia in older patients with moderate and severe functional impairments: a systematic review of controlled trials. *Alzheimer's research & therapy*, *13*(1), 1-20.

Sepulveda Carmona, M. (2013). Report of the Special Rapporteur on Extreme Poverty and Human Rights. Mission to Namibia. *Mission to Namibia (May 17, 2013)*.

Sepúlveda Carmona, M., & Donald, K. (2015). Beyond legal empowerment: improving access to justice from the human rights perspective. *The International Journal of Human Rights*, *19*(3), 242-259.

Serrano-Gemes, G., Rich-Ruiz, M., & Serrano-del-Rosal, R. (2020, December). Reasons for the Place of Care of the Elders: A Systematic Review. In *Healthcare* (Vol. 8, No. 4, p. 436). Multidisciplinary Digital Publishing Institute.

Shabangu, T. R. (2011). *An exploration of the experiences of older persons in an economically deprived residential care facility.* (Doctoral dissertation, North-West University).

Shafuda, C. P., & De, U. K. (2020). Government expenditure on human capital and growth in Namibia: a time series analysis. *Journal of Economic Structures*, *9*(1), 1-14.

Shaibu, S. (2000). Caregiving on the edge: the situation of family caregivers to older persons in Botswana. *Southern African Journal of Gerontology*, *9*, 15-19.

Sherwood, G. (2011). Data collectors' field journals as tools for research. *Journal of Research in Nursing*, *16*(5), 466.

Shields, L. (2010). Questioning family-centred care. *Journal of clinical nursing*, *19*(17-18), 2629-2638.

Shikongo, L. K. (2013). *An effective implementation of an enterprise resource planning system-The case of an oracle system at MVAF Namibia* (Doctoral dissertation).

Shimpanda, F. (2016). *Assessing the effects of social safety nets on poverty in Namibia: analysis of food expenditure of elderly persons* (Doctoral dissertation, University of Namibia).

Shivolo, S. (2016). *Investigating the operating factors influencing the high cost of private healthcare in Namibia: a case study of the medical aid funds industry in Namibia* (Doctoral dissertation, University of Namibia).

Shulztiner, D., & Carmi, G. E. (2014). Human dignity in national constitutions: functions, promises and dangers. *The American Journal of Comparative Law*, *62*(2), 461-490.

Shumba, T. W., & Moodley, I. (2018). Implementation of disability policy framework in Namibia: A qualitative study. *The South African journal of physiotherapy*, *74*(1).

Shyu, Y. I. L., Kuo, L. M., Chen, M. C., & Chen, S. T. (2010). A clinical trial of an individualised intervention programme for family caregivers of older stroke victims in Taiwan. *Journal of clinical nursing*, *19*(11-12), 1675-1685.

Silver, H. J., Wellman, N. S., Arnold, D. J., Livingstone, A. S., & Byers, P. M. (2004). Older adults receiving home enteral nutrition: enteral regimen, provider involvement, and health care outcomes. *Journal of Parenteral and Enteral Nutrition*, *28*(2), 92-98.

Silverman, D. (Ed.). (2020). *Qualitative research*. Sage Publications Limited.

Sims-Gould, J., & Martin-Matthews, A. (2010). We share the care: family caregivers' experiences of their older relative receiving home support services. *Health & social care in the community*, *18*(4), 415-423.

Smit, B. (2005). Computer Assisted Qualitative Data Software: friend or foe: reviewed article. *South African Computer Journal*, *2005*(35), 107-111.

Smit, B. (2014). Teaching Atlas. ti™ in South Africa: Reflections on doctoral preparedness. *Journal of Social Sciences*, *40*(2), 213-217.

Smith, K., & Davies, J. (2010). Qualitative data analysis. *Practical researcher and evaluation: A start-to finish guide for practitioners*, 145-158, Sage, London.

Smith, S. (1986). *Namibia a Violation of Trust*. Oxfam GB.

Soiferman, L. K. (2010). Compare and Contrast Inductive and Deductive Research Approaches. *Online Submission*.

Sørbye, L. W., Sverdrup, S., & Pay, B. B. (2018). Should frail older adults be in long-term care facilities?. *Journal of multidisciplinary healthcare*, *11*, 99.

Sorensen, P. (2012) South Africa's 1940s: World of Possibilities, International Journal of Environmental Studies, *69*(1), 184-191, DOI: 10.1080/00207233.2011.641240

Sparks, M., Zehr, D., & Painter, B. (2004). Predictors of life satisfaction: Perceptions of older community-dwelling adults. *Journal of Gerontological Nursing, 30*(8), 47–53.

Splinter, A. P. (2009). *An investigation into how elderly persons perceive elder abuse* (Doctoral dissertation, University of the Western Cape).

Shinovene, I (2014, April 24). Pensioner spend money on alcohol. The Namibian newspaper, on the 24th of April 2014, Windhoek, Namibia. Retrieved from [Assessed July 2022].

Stake, R. E. (1995). *The art of case study research*. sage.

Stake, R. E. (2010). *Qualitative research: Studying how things work*. Guilford Press.

Stefanov, D. H., Bien, Z., & Bang, W. C. (2004). The smart house for older persons and persons with physical disabilities: structure, technology arrangements, and perspectives. *IEEE transactions on neural systems and rehabilitation engineering*, *12*(2), 228-250.

Steinitz, L. Y. (2003). When spider webs unite: the work of volunteers in providing home-based care in Namibia. *Journal of HIV/AIDS & Social Services*, *2*(1), 45-62.

Steinkuller, P. G. (1983). Cataract: the leading cause of blindness and vision loss in Africa. *Social Science & Medicine*, *17*(22), 1693-1702.

Stephan, A., Möhler, R., Renom-Guiteras, A., & Meyer, G. (2015). Successful collaboration in dementia care from the perspectives of healthcare professionals and informal carers in Germany: results from a focus group study. *BMC Health Services Research*, *15*(1), 1-13.

Stephens, C., Szabó, Á., Allen, J., & Alpass, F. (2019). Livable environments and the quality of life of older people: An ecological perspective. *The Gerontologist*, *59*(4), 675-685.

Steverink, N. (2014). Successful development and ageing:Theory and intervention. In: N. A., Pachana, & K. Laidlaw (Eds). *The Oxford handbook of clinical Geropsychology*, Oxford University Press, Oxford, pp.84-103.

Steverink, N., & Lindenberg, S. (2006). Which social needs are important for subjective well-being? What happens to them with aging?. *Psychology and aging*, *21*(2), 281.

Steverink, N., & Lindenberg, S. (2008). Do good self-managers have less physical and social resource deficits and more well-being in later life?. *European Journal of Ageing*, *5*(3), 181-190.

Steverink, N., Lindenberg, S., & Slaets, J. P. (2005). How to understand and improve older people's self-management of wellbeing. *European Journal of Ageing*, *2*(4), 235-244.

Stichter, S. (1985). Migrant laborers. CUP Archive.

Stobert, S., & Cranswick, K. (2004). Looking after seniors: Who does what for whom. *Canadian Social Trends*, *74*, 2-6.

Stoltz, P., Udén, G., & Willman, A. (2004). Support for family carers who care for an elderly person at home–a systematic literature review. *Scandinavian journal of caring sciences*, *18*(2), 111-119.

Stone, R., & Harahan, M. F. (2010). Improving the long-term care workforce serving older adults. *Health Affairs*, *29*(1), 109-115.

Strydom, H. (2011). Ethical aspects of research in the social sciences and human service professions. In De Vos, A. S., Strydom, H., Fouche, C. B. & Delport, C.S.L., eds. *Research at grassroots: for the social sciences and human service professions* (4th ed. p.113-130). Pretoria: Van Schaik.

Subbarao, K. (1999). *Namibia's social safety net: Issues and options for reform*. The World Bank.

Subramanien, S. (2013). *Enhancing the wellbeing of older people in Mauritius* (Doctoral dissertation, Tilburg University).

Suzuki, D. (1993). *Wisdom of the elders: sacred native stories of nature*. BoD–Books on Demand.

Szabo, V., & Strang, V. R. (1999). Experiencing control in caregiving. *Image: the Journal of Nursing Scholarship*, *31*(1), 71-75.

Szaflarski, M. (2013). Spirituality and religion among HIV-infected individuals. *Current Hiv/aids Reports*, *10*(4), 324-332.

Tai, J. (2014). Halimah Calls again for mandatory eldercare leave. Straits Times, p. Home B2.

Tamiya, N., Noguchi, H., Nishi, A., Reich, M. R., Ikegami, N., Hashimoto, H., ... & Campbell, J. C. (2011). Population ageing and wellbeing: lessons from Japan's long-term care insurance policy. *The lancet*, *378*(9797), 1183-1192.

Tanggaard, L. (2009). The research interview as a dialogical context for the production of social life and personal narratives. *Qualitative inquiry*, *15*(9), 1498-1515.

Teofelus, E. (2013). Gender-based violence. *Sister Namibia*, 25 (3), 30.

The Namibian Newspaper (2018, March 26). Disability affairs' budget slashed by 40%, p.7. Retrieved from https://www.namibian.com.na/175802/archive-read/Disability-affairs-budget-slashed-by-40pct [Assessed August, 2019].

The Namibian Newspaper. *(2019, June 26). Namibia needs to strengthen social protection.* p6. Retrieved from https://www.namibian.com.na/190058/archive-read/Namibia-needs-to-strengthen-social-protection [Retrieved 2018, August 20].

Theron, J. (2014, June 11). We don't qualify for veterans' status. *The Namibian*. Retrieved from https://www.namibian.com.na/index.php?id=124349&page=archive-read [Retrieved November 2019].

Theron, P. M. (2015). Coding and data analysis during qualitative empirical research in Practical Theology. *In die Skriflig*, *49*(3), 1-9.

Thielke, S., Harniss, M., Thompson, H., Patel, S., Demiris, G., & Johnson, K. (2012). Maslow's hierarchy of human needs and the adoption of health-related technologies for older adults. *Ageing international*, *37*(4), 470-488.

Thomas, F. (2006). Stigma, fatigue and social breakdown: exploring the impacts of HIV/AIDS on patient and carer well-being in the Caprivi Region, Namibia. *Social science & medicine*, *63*(12), 3174-3187.

Thomas, P. A., Liu, H., & Umberson, D. (2017). Family relationships and well-being. *Innovation in aging*, *1*(3), igx025.

Thornton, N., & Hopp, F. P. (2011). "So I just took over": African American daughters caregiving for parents with heart failure. *Families in Society*, *92*(2), 211-217.

Thrush, A., & Hyder, A. (2014). The neglected burden of caregiving in low-and middle-income countries. *Disability and health journal*, *7*(3), 262-272.

Tilvis R.S., Pitkälä KH, Jolkkonen J., Strandberg T.E. (2000). Social networks and dementia, *The Lancet*, *356,* 76-78.

Timonet Andreu, E., Morales Asencio, J. M., Canca Sanchez, J. C., Sepulveda Sanchez, J., Mesa Rico, R., & Rivas Ruiz, F. (2015). Effects and consequences of caring for persons with heart failure:(ECCUPENIC study) a nested case–control study. *Journal of Advanced Nursing*, *71*(12), 2987-2997.

Tjazerua, Y.U. (1995). Research on Old Age: The Position of Old Age in Okahandja. (Unpublished doctroral dissertation, University of Namibia ).

Tjiroze, M. (2013). *Distress and coping in adult family caregivers of cancer patients in Namibia* (Doctoral dissertation, University of Namibia).

TM, S., & GV, K. (2019). An Empirical Study to Improve the Service Quality for Geriatric Patients in a Tertiary Care Hospital. Indian Journal of Public Health Research & Development, 10(1). Chicago

Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of advanced nursing*, *48*(4), 388-396.

Tomas, N., Ashipala, D. O., & Tomas, T. N. (2021). Falls and Fall Injuries as Societal Challenges in Namibia. In *Integrated Care and Fall Prevention in Active and Healthy Aging* (pp. 242-249). IGI Global.

Torres-Castro, S., Szlejf, C., Parra-Rodríguez, L., & Rosas-Carrasco, O. (2018). Association between frailty and elder abuse in community-dwelling older adults in Mexico city. *Journal of the American Geriatrics Society*, *66*(9), 1773-1778.

Toseland, R. W., Smith, T. L., & Zinoman, M. I. C. H. E. L. E. (2004). Social work practice with family caregivers of frail older persons. *Social work practice with the elderly*, 429-452.

Tötemeyer, G. (2001). Local government and administration in Namibia since the German colonial period till present.

Ungar, M. (2002). A deeper, more social ecological social work practice. *Social Service Review*, *76*(3), 480-497.

United Nations (2017). UN report on elder abuse, Retrieved from https://www.un.org/development/desa/ageing/world-elder-abuse-awareness-day/2017-2.html [Assessed October, 2019].

United Nations (2019a). *World Population Prospects 2019, Methodology of the United Nations Population Estimates and Projections*. Volume 1 Comprehensive Tables, (ST/ESA/SER.A/426). Department of International Economic and Social Affairs, Population Division, New York.

United Nations (8 February, 2019). Inclusive social development- essential to achieve the global goals, Retrieved from https://www.un.org/development/desa/en/news/social/57th-session-of-the-commission-for-social-development.html [Assessed April, 2019].

United Nations Economic and Social Affairs. (2010b). World Population Ageing 2009, New York

United Nations, (2018), 'World Economic and Social Survey 2018: Development in an Ageing World'. Retrieved from https://www.un.org/development/desa/publications/world-economic-and-social-survey-2018.html [Assessed August, 2019].

United Nations. (1991). United Nations principles for older persons. *Resolution 46/91*.

United Nations. (2002). Madrid International Plan of Action on Ageing 2002. Retrieved from: https://www.un.org/en/events/pastevents/pdfs/Madrid_plan.pdf [Assessed August, 2019].

United Nations (UN). (2010). Rethinking Poverty. Report on the world social situation 2010. Department of economic and social affairs. ST/ESA/324. Retrieved from: https://www.un.org/esa/socdev/rwss/docs/2010/fullreport.pdf [Assessed August, 2019].

United Nations (UN). (2013). Department of Economic and Social Affairs, Population Division. World Mortality Report. New York: UN, 2013

United Nations (UN) . (2020). World population ageing 2020. Highlights. Retrieved from https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/undesa_pd-2020_world_population_ageing_highlights.pdf [Assessed November 2021].

Upshur, R. E., & Tracy, S. (2008). Chronicity and complexity: is what's good for the diseases always good for the patients?. *Canadian Family Physician*, *54*(12), 1655-1658.

Van Biljon, L., & Roos, V. (2015). The nature of quality of life in residential care facilities: the case of white older South Africans. *Journal of Psychology in Africa*, *25*(3), 201-207.

Van de Walle, E. (Ed.). (2006). *African households: censuses and surveys*. ME Sharpe.

Van der Berg, S. (1997). South African social security under apartheid and beyond. *Development Southern Africa*, *14*(4), 481-503.

van Dokkum, N. (1996). Protection of the elderly: A need for activism. *Volume 5 Number April1996*, *5*(1), 15-19.

Van Groenou, M. B., Glaser, K., Tomassini, C., & Jacobs, T. (2006). Socio-economic status differences in older people's use of informal and formal help: a comparison of four European countries. *Ageing and Society*, *26*, 745.

Van Praag, B. M., Frijters, P., & Ferrer-i-Carbonell, A. (2003). The anatomy of subjective well-being. *Journal of Economic Behavior & Organization*, *51*(1), 29-49.

Van Rooy, G., Mufune, P., & Amadhila, E. (2015). Experiences and perceptions of barriers to health services for elderly in rural Namibia: a qualitative study. *SAGE Open*, *5*(3), 2158244015596049.

Van Staden, A. M., & Weich, D. J. (2007). Profile of the geriatric patient hospitalised at Universitas Hospital, South Africa. *South African Family Practice*, *49*(2), 14-14c.

Van Teijlingen, E. R., & Hundley, V. (2001). The importance of pilot studies.

Vanclay, F., Baines, J. T., & Taylor, C. N. (2013). Principles for ethical research involving humans: ethical professional practice in impact assessment Part I. *Impact assessment and project appraisal*, *31*(4), 243-253.

Vanderschuren, M. J., Baufeldt, J. L., & Phayane, S. (2015). Mobility barriers for older persons and people with Universal Design needs in South Africa. In *14th International Conference on Mobility and Transport for Elderly and Disable Persons, TRANSED, Lisbon, Portugal*.

Vankova, D. (2016). Conceptual and Methodological Approaches to Quality of Life-a public health perspective. *Scripta Scientifica Salutis Publicae*, *1*(2), 7-13.

Vanleerberghe, P., De Witte, N., Claes, C., Schalock, R. L., & Verté, D. (2017). The quality of life of older people aging in place: a literature review. *Quality of Life Research*, *26*(11), 2899-2907.

Vasileiou, K., Barnett, J., Barreto, M., Vines, J., Atkinson, M., Lawson, S., & Wilson, M. (2017). Experiences of loneliness associated with being an informal caregiver: a qualitative investigation. *Frontiers in psychology*, *8*, 585.

Vorster, C. (2011). *Impact: The story of interactional therapy*. Pretoria, South Africa: Satori

Vosloo, R. (1997). Back to virtue? Some remarks on the reappraisal of virtue in ethics. *Scriptura*, 299-310.

Wadsworth, D., Turnbull, J., & Lark, S. (2021). Psychological Effects of Whole-Body Vibration Training in Frail Older Adults: An Open, Randomized Control Trial. *Journal of Aging and Physical Activity*, *1*(aop), 1-11.

Wallace, L.S. (2002). Osteoporosis prevention in college women: application of the expanded health belief model. *American journal of health behavior*, *26*(3), 163-172

Wallace, M., & Kinahan, J. (2011). A history of Namibia. *London: C. Hurst & Co*.

Walshe, C., Ewing, G., & Griffiths, J. (2012). Using observation as a data collection method to help understand patient and professional roles and actions in palliative care settings. *Palliative medicine*, *26*(8), 1048-1054.

Wang, J., Du, Y., Coleman, D., Peck, M., Myneni, S., Kang, H., & Gong, Y. (2019a). Mobile and connected health technology needs for older adults aging in place: cross-sectional survey study. *JMIR aging*, *2*(1), e13864.

Wang, K. H., Chen, H. G., & Chen, G. (2016). On the priority of needs for home care services of older adults in Taiwan, as based on Maslow's hierarchy of needs. *Gerontechnology*, *14*(4), 239-243.

Wang, Q. (2011). Intergenerational Solidarity and Its Effects on Life Satisfaction among Chinese Elders.

Ward-Griffin, C. (2001). Negotiating care of frail elders: relationships between community nurses and family caregivers. *Canadian Journal of Nursing Research Archive*.

Watt, A., & Konnert, C. (2007). Quality of life in the nursing home: perspectives of younger and older residents. *Canadian Journal on Aging/La Revue canadienne du vieillissement*, *26*(4), 403-410.

Weber, H., & Weber, M. (2020). Colonialism, genocide and International Relations: the Namibian–German case and struggles for restorative relations. *European Journal of International Relations*, *26*(1_suppl), 91-115.

Weerd, C. V., & Paveza, G. J. (2006). Verbal mistreatment in older adults: a look at persons with Alzheimer's disease and their caregivers in the state of Florida. *Journal of Elder Abuse & Neglect*, *17*(4), 11-30.

Weir, R. L., Danilovich, M. K., & Hoover, D. L. (2021). Systematic review of the effectiveness of caregiver training with functional mobility tasks for informal caregivers assisting patients with neurological diagnoses. *Disability and Rehabilitation*, 1-8.

Werner, W. (1993). A brief history of land dispossession in Namibia. *Journal of Southern African Studies*, *19*(1), 135-146.

Westerlund, D. (1991). Insiders" and "outsiders" in the study of African religions: Notes on some problems of theory and methods. In J.K. Olupona (Ed.), *African Traditional Religions in Contemporary Society* (pp.15-24), St. Paul, Minnesota: Paragon House.

Wild, K., Boise, L., Lundell, J., & Foucek, A. (2008). Unobtrusive in-home monitoring of cognitive and physical health: Reactions and perceptions of older adults. *Journal of applied gerontology*, *27*(2), 181-200.

Wilde, A., & Glendinning, C. (2012). 'If they're helping me then how can I be independent?'The perceptions and experience of users of home-care re-ablement services. *Health & social care in the community*, *20*(6), 583-590.

Wilder, A. (2010). Ecological Systems Theory as Applied to Family Caregivers of Aging Adults. *Eco-systems Aging, ResearchGate,* 1-30. Retrieved from *https://www.researchgate.net/publication/242623839_Ecological_Systems_Theory_as_Applied_to_Family_Caregivers_of_Aging_Adults [Assessed August, 2019].*

Williams, C. (2007). Research methods. *Journal of Business & Economics Research (JBER)*, *5*(3).

Williamson, P. R., & Lancaster, G. A. (2004). STATISTICAL EDUCATION FOR PHD STUDENTS IN UK MEDICAL SCHOOLS 5. *SERJ EDITORIAL BOARD*, 72.

Wimo, A., & Prince, M. J. (2010). *World Alzheimer Report 2010: the global economic impact of dementia*. Alzheimer's Disease International.

Winslow, B. W. (2003). Family caregivers' experiences with community services: a qualitative analysis. *Public Health Nursing*, *20*(5), 341-348.

Wolfe, A. (2001). Institute of Medicine report: crossing the quality chasm: a new health care system for the 21st century. *Policy, Politics, & Nursing Practice*, *2*(3), 233-235.

Woodford, H. (2022). Essential geriatrics. CRC Press.

Woodhouse, K. W., Wynne, H., Baillie, S., James, O. F. W., & Rawlins, M. D. (1988). Who are the frail elderly?.

World Health Organization (WHO). (2008c). *The World Health Report.* Primary health care - now more than ever.
Retrieved from https://www.who.int/whr/2008/en/ [Assessed February 2020].

World Health Organisation (WHO), (2018a, June 15). What do we mean by self-care? Retrieved from https://www.who.int/news-room/feature-stories/detail/what-do-we-mean-by-self-care. [Assessed August 2020].

The World Health Organization (WHO). (2018b). Integrated care for older people: Realigning primary health care to respond to population.

World Bank (2018). The State of Social Safety Nets, Washington D.C., USA. Available: http://documents1.worldbank.org/curated/fr/427871521040513398/pdf/124300-PUB-PUBLIC.pdf [Assessed 17 August 2020].

World Health Organisation (2020). Supporting informal caregivers of people living dementia. Geneva. Switzerland. Retrieved from: https://www.who.int/mental_health/neurology/dementia/dementia_thematicbrief_informal_care.pdf.

World Bank. (2020). Leveraging Pension Fund Investment for Domestic Development: Namibia's Regulation 29 Approach. Retrieved from https://openknowledge.worldbank.org/handle/10986/34332 [Assecced May 2021].

World Bank. Country classification. World Bank. 2019. [Online] Available at: http://blogs.worldbank.org/opendata/new-country-classifications-income-level-2019-2020 [Assessed 17 November 2019].

World Health Organisation (2017b). Falls. Fact Sheet. Retrieved from https://www.who.int/news-room/fact-sheets/detail/falls. [Assesssed 26 September 2021].

World Health Organisation (WHO). (2021), Report into Elder abuse. Retrieved from https://www.who.int/news-room/fact-sheets/detail/elder-abuse. [Assessed 18th of August 2021].

World Health Organisation (WHO) (2017). Global strategy and actin plan on ageing and health. Retrieved from https://www.who.int/ageing/WHO-GSAP-2017.pdf [Assessed August 2018]. ISBN 978-92-4-151350-0.

World Health Organisation (WHO). (2009b). Definition of an older or elderly person. Retrieved 13 April 2021 from http://www.who.int/healthinfo/survey/ageingdefnolder/en/index.html

World Health Organisation (WHO). (2003) Abuse of the Elderly. Chapter 5 in World Report on Violence and Health. Geneva: WHO: 125 – 132.

World Health Organization (WHO). (2002b). Tufts University. School of Nutrition Science, Policy, & Tufts University. *Keep fit for life: meeting the nutritional needs of older persons*. World Health Organization.

World Health Organization (WHO). (1994). Public/private collaboration for health: report of an intercountry meeting, Windhoek, Namibia, 4-8 October 1993 (No. WHO/SHS/NHP/94.2. Unpublished). World Health Organization.

World Health Organization (WHO). (1998). The World Health Organization quality of life assessment (WHOQOL): development and general psychometric properties. *Soc Sci Med*, *46*(12), 1569-85.

World Health Organization (WHO). (2002). *Missing voices: views of older persons on elder abuse* (No. WHO/NMH/VIP/02.1). World Health Organization.

World Health Organization (WHO). (2008a). *Older persons in emergencies: an active ageing perspective.* Retrieved from https://www.who.int/ageing/publications/emergencies/en/ [November 2019].

World Health Organization (WHO). (2008b). WHO Global report on falls prevention in older age. [Online] Available at: https://extranet.who.int/agefriendlyworld/wp-content/uploads/2014/06/WHo-Global-report-on-falls-prevention-in-older-age.pdf [Assesses November 2019].

World Health Organization (WHO). (2009a). *Self-care in the context of primary health care* (No. SEA-HSD-320). Report of the Regional consultation Bangkok, Thailand, 7-9 January 2009. WHO Regional Office for South-East Asia. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/206352/B4301.pdf [Assessed July 2019].

World Health Organization (WHO). (2010). Namibia Country Cooperation Strategy. Retrieved from: www.afro.who.int/index.php?option=com_docman&task=doc_download&gid=6579. [Assessed 30 December 2021].

World Health Organization (WHO). (2013). *Oral health surveys: basic methods*. World Health Organization.

World Health Organization (WHO). (2015a). *Quality of care. A process for making strategic choices in health systems.* France. Available at: http://who.int/management/quality/assurance/QualityCare_B.Def.pdf [2018, August 20].

World Health Organization (WHO) (2015b). World report on ageing and health. Geneva: World Health Organization; Geneva, Switzerland.

World Health Organization (WHO). (2016). *World health statistics 2016: monitoring health for the SDGs sustainable development goals*. World Health Organization.

World Health Organization. (2017a). Towards long-term care systems in sub-Saharan Africa.

World Health Organization (WHO). (2018b). Integrated care for older people: Realigning primary health care to respond to population. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/326295/WHO-HIS-SDS-2018.44-eng.pdf. [Assessed January 2022].

Worldatlas (2021). Ethnic groups of Namibia. Retrieved on 24 May 2021 from https://www.worldatlas.com/articles/tribes-and-ethnic-groups-of-namibia.html [Assessed February 2021].

Yakubu, Y. A., & Schutte, D. W. (2018). Caregiver attributes and socio-demographic determinants of caregiving burden in selected low-income communities in cape town, South Africa. *Journal of Compassionate Health Care*, *5*(1), 1-10.

Yates, M. E., Tennstedt, S., & Chang, B. H. (1999). Contributors to and mediators of psychological well-being for informal caregivers. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *54*(1), P12-P22.

Yeager, D. M., Glei, D. A., Au, M., Lin, H. S., Sloan, R. P., & Weinstein, M. (2006). Religious involvement and health outcomes among older persons in Taiwan. *Social Science & Medicine*, *63*(8), 2228-2241.

Yimam A (1976) "The Need for Social Development Training in a Changing Africa" in *Journal for Social Work Education in Africa,* Vol 2/2 June

Yin, R. K. (2017). *Case study research and applications: Design and methods*. Sage publications.

Yon, Y., Ramiro-Gonzalez, M., Mikton, C. R., Huber, M., & Sethi, D. (2019). The prevalence of elder abuse in institutional settings: a systematic review and meta-analysis. *European journal of public health*, *29*(1), 58-67.

Young, H. M. (2003). Challenges and solutions for care of frail older adults. *Online journal of issues in nursing*, *8*(2).

Zainab, I., Wan-Ibrahim, W. A., & Baharuddin, E. (2014). The commitment of older persons in nursing homes in religious activities. *Middle-East Journal of Scientific Research*, *20*(12), 1734-1737.

Zainuddin, J., Arokiasamy, J. T., & Poi, P. J. H. (2003). Caregiving burden is associated with short rather than long duration of care for older persons. *Asia Pacific Journal of Public Health*, *15*(2), 88-93.

Zalenski, R. J., & Raspa, R. (2006). Maslow's hierarchy of needs: a framework for achieving human potential in hospice. *Journal of palliative medicine*, *9*(5), 1120-1127.

Zegwaard, M. I., Aartsen, M. J., Cuijpers, P., & Grypdonck, M. H. (2011). a conceptual model of perceived burden of informal caregivers for older persons with a severe functional psychiatric syndrome and concomitant problematic behaviour. *Journal of Clinical Nursing*, *20*(15-16), 2233-2258.

Zeng, W., North, N., & Kent, B. (2013). Family and social aspects associated with depression among older persons in a C hinese context. *International journal of older people nursing*, *8*(4), 299-308.

Zuijdwijk, A. J. (1973). The International Court and South West Africa: Latest Phase. *Ga. J. Int'l & Comp. L.*, *3*, 323. Retrieved from https://digitalcommons.law.uga.edu/cgi/viewcontent.cgi?article=2202&context=gjicl [Assessed February 2020]

Zygouri, I., Cowdell, F., Ploumis, A., Gouva, M., & Mantzoukas, S. (2021). Gendered experiences of providing informal care for older people: A systematic review and thematic synthesis. BMC health services research, 21(1), 1-15.

# Appendices

**APPENDIX 1**

**Sent**: Monday, 19 June 2020, 02.15 PM
**To**: Recipients
**Subject:** Request for interview

Dear Sir/Madam

To introduce myself first, I am a Namibian student registered for a PhD in Social Development with the University of Cape Town. My thesis is entitled "An exploration of the frail care needs of older persons in Namibia: perspectives and experiences of formal and informal caregivers."

The purpose of this e-mail is to request a meeting at your convenience for an interview about the policy and legislative framework in Namibia relating to frail older persons. The interview is expected to take no longer than 60 minutes of your precious time.

If you require more details about my research, I can gladly provide you with a copy of my research proposal. Also, upon completion arch I can provide a copy of the completed research document.

Thanking you in advance for your kind consideration.

Kind regards

Charmill Zamuee

## APPENDIX 2

***Interview schedule – Informal Caregiver***

**An exploration of frail care needs of older persons in Namibia: A study of the experiences of informal caregivers.**

| **A. Demographic data** |
|---|

Gender

| | |
|---|---|
| Male | |
| Female | |
| Other | |

Age group

| | |
|---|---|
| 18-30 | |
| 31-50 | |
| 50-60 | |
| Over 60 | |

Marital status

| | |
|---|---|
| Single | |
| Married | |
| Separated | |
| Divorced | |
| Widowed | |

Race

| |
|---|
| |

Highest level of education

| | |
|---|---|
| Primary School | |
| Secondary or High School | |
| College / Technicon | |
| University Degree or Diploma | |
| No formal education | |

Language

| |
|---|
| |

Duration of caregiving experience

| |
|---|
| |

Residence (Urban / Rural)

| |
|---|
| |

Employment status

| |
|---|
| |

## B. Objectives

***I. To explore and describe the perspectives of informal caregivers of older persons in Namibia in relation to the frail care needs of older persons***

1. Describe the service that you provide to older person.
2. What is the nature of frailty of the older person in your care?
3. Can you describe the specific needs of frail older person relating to the care environment?
4. Describe the main challenges experienced by the frail older person in your care?
    - Does the care environment provide enough comfort and convenience to the frail older person?
    - Does frailty cause personal stress and frustration for the frail older person
    - What is the specific health care needs of the frail older person in your care
    - Does the frailty of the older person affect their mental discernment and good judgement? If so, in what way.
    - Is there an increase in the utilisation of care resources?
5. How important is the family support system in meeting the needs of frail older person?
    - Does family traditions and cultural norms play any role in the placement and care of frail older persons?
    - What factors are affecting placement and care of frail older persons (social factors, changing family patterns, nuclearization)
    - How has the frail older persons adjusted to the caregiving environment?
6. Do you as an informal caregiver receive enough support in rendering care to frail older person?
7. How does your caregiving role affect you personally?
    - Person stress
    - Health concerns
    - How do you deal with this?
    - What incentives are available to improve the level of care
8. What caregiving approach or intervention would be the most suitable to effectively meet the needs of frail older person?

## *II. To explore and describe the experiences of informal caregivers in providing frail care to older persons*

1. Describe your experience as an informal caregiver in providing care to frail older persons?
    - What are the specific challenges you experience
    - Do you feel strained in your role?
    - Are caregivers adequately trained to undertake their role
2. Are you aware of any experiences relating to the abuse and/or neglect of frail older persons?
    - Are there sufficient mechanisms to prevent and deal with abuse and neglect of frail older persons?
    - Is the older person better cared for at home or in institutional care? Please explain.
3. Have you had any experience where a frail older person has hurt him/herself because of their frailty.
    - How can this situation be managed to avoid harm to the older person?
    - How can the environment be made safer and more secure?
4. If you have to change any aspect of the caregiving environment for frail older person, what would that be?
5. In your experience are family members of frail older persons involved in their care? Please explain.
    - Does intergenerational solidarity play any role in the care of frail older persons? Please explain.
    - How does the rest of the family relate to you as a caregiver?
    - Have you had any complaints about the standard of care relating to the frail older persons under your care? If so, please explain.

***III. To determine the extent to which the Namibian constitutional, legal and policy (regulatory) environment supports the frail care needs of older persons.***

1. Are you aware of any government policy, laws and regulation on the care of frail older persons? If so, please explain.
2. Is the current Namibian policy on the care of frail older persons conducive to identification and meeting the needs of frail older persons? Please explain.
    - Is the home-based care for the frail older person adequately monitored and regulated to ensure effective personal care and needed services?
    - Does the law afford enough protection and support to frail older persons? Please elaborate.
3. Do you feel the law gives you as an informal caregiver enough resources and protection to provide effective support to frail older persons? Please explain.
4. Is the law clear on your role and service standards as an informal caregiver in providing care to frail older persons?
5. Does the law provide sufficient guidelines for assessing the needs of frail older persons? Please explain.
6. If you were able to change any aspect of the law relating to caring for the needs of frail older persons, what would that be and why?
7. Does the law provide enough protection and deterrence against abuse and neglect of frail older persons? Please explain.
8. In you experience, does this caregiving environment afford older persons their dignity and quality of life as required under the Constitution?
9. In your view, is the level of government funding for frail older persons sufficient to deal with their needs? Please explain.
10. Given the exorbitant costs of healthcare in Namibia, are you aware of any incentives in the law to encourage people to care for older persons?
    - Are you aware of any policy initiatives to support and promote the welfare and care of frail older persons in Namibia?
11. Are there any social support services, collaborations or networks supporting the ongoing care of the older frail person in your care? If so, please elaborate and what are your recommendations?

- How did you feel doing the interview?
- Is there anything else you think would be helpful for me to know?
- Is there anything else you want to add that you feel has been left out?
- Do you have any 'advice' or room for changes
- Is anything else they would like to say?
- I should have all the information I need. Would it be alright to call you if I have any more questions?

Thank you for your participation and for taking the time out to see me.

## APPENDIX 3

### INTERVIEW SCHEDULE FOR FORMAL CAREGIVERS

**An exploration of frail care needs of older persons in Namibia: A study of the experiences of informal caregivers and formal caregivers**

| **A. Demographic data** |
|---|

1. Gender:

| | |
|---|---|
| Male | |
| Female | |
| Other | |

2. Age group:

| | |
|---|---|
| 18-30 | |
| 31-50 | |
| 51-60 | |
| 61< | |

3. Education:

| | |
|---|---|
| University degree | |
| College/ Technicon | |
| Secondary school | |
| Primary education | |
| No formal education | |

4. Years of experience as a formal caregiver:

| |
|---|
| |

5. Job description/ title

| |
|---|
| |

## B. OBJECTIVES

I. ***To explore and describe the perspectives of social service professionals of older persons in Namibia in relation to the frail care needs of older persons***

1. Describe the service that you provide to older persons.

2. What is the nature of frailty of the older person in your care?

3. Can you describe the specific needs of frail older persons relating to this care environment?

4. Describe the main challenges experienced by the frail older person in your care?

    - Does the care environment provide enough comfort and convenience to
    - the frail older person?
    - Does frailty cause personal stress and frustration for the frail older person
    - What is the specific health care needs of the frail older person in your care
    - Does the frailty of the older persons affect their mental discernment and
    - good judgement? If so, in what way.
    - Is there an increase in the utilisation of care resources?

5. How important is the family support system in meeting the needs of frail older persons?

    - Does family traditions and cultural norms play any role in the placement and care of frail older persons?
    - What factors are affecting placement and care of frail older persons (social factors, changing family patterns, nuclearization)
    - How has the frail older persons adjusted to the caregiving environment?

6. Do you as a caregiver receive enough support in rendering care to frail older persons?

7. How does your caregiving role affect you personally?

    - Personal stress

- Health concerns
- How do you deal with this?
- What incentives are available to improve the level of care

8. What caregiving approach or intervention would be the most suitable to effectively meet the needs of frail older persons?

II. ***To explore and describe the experiences of social service professionals in providing frail care to older persons***

1. Describe your experience as an formal caregiver in providing care to frail older persons?
    - What are the specific challenges you experience
    - Do you feel strained in your role?
    - Is your organization adequately resourced to meet the needs of the older persons?
    - Are caregivers adequately trained to undertake their role
2. Are you aware of any experiences relating to the abuse and/or neglect of frail older persons?
    - Are there sufficient mechanisms to prevent and deal with abuse and neglect of frail older persons?
3. Have you had any experience where a frail older person has hurt him/herself because of their frailty.
    - How can this situation be managed to avoid harm to the older person?
    - How can the environment be made safer and more secure?
4. If you have to change any aspect of the caregiving environment for frail older persons, what would that be?
5. In your experience are family members of frail older persons involved in their care?

Please explain.

- Does intergenerational solidarity play any role in the care of frail older persons? Please explain.

6. What factors are influencing decisions to place older persons in institutional care

   - What are some of the reason that older persons have been placed here?

***III. To determine the extent to which the Namibian constitutional, legal and policy (regulatory) environment supports the frail care needs of older persons.***

1. Is the current Namibian policy on the care of frail older persons conducive to identification and meeting the needs of frail older persons? Please explain.

   - Is institutionalised care of frail older persons adequately regulated to ensure effective protection for them as vulnerable people?
   - does the law afford enough protection and support to frail older persons?

   Please elaborate.

2. Do you feel the law gives you as a formal caregiver enough resources and protection to provide effective support to frail older persons? Please explain.

3. Is the law clear on your role and service standards as a formal caregiver in providing care to frail older persons?

4. Does the law provide sufficient guidelines for assessing the needs of frail olderpersons? Please explain.

5. If you were able to change any aspect of the law relating to caring for the needs of frail older persons, what would that be and why?

6. Does the law provide enough protection and deterrence against abuse and neglect of frail older persons? Please explain.

7. In you experience, does this caregiving environment afford older persons their dignity and quality of life as required under the Constitution?

8. In your view, is the level of government funding for frail older persons sufficient to deal with their needs? Please explain.

9. Given the exorbitant costs of healthcare in Namibia, are you aware of any incentives in the law to encourage people to care for older persons?

    - Are you aware of any policy initiatives to support and promote the welfare and care of frail older persons in Namibia?

10. Are there any social support services or networks supporting the ongoing care of the older frail person in your care? If so, please elaborate on the nature of the relationship between the different networks, i.e. service, nature of the relationship, collaboration; and what are your recommendations?

The end

- How did you feel doing the interview?
- Is there anything else you think would be helpful for me to know?
- Is there anything else you want to add that you feel has been left out?
- Do you have any 'advice' or room for changes
- Is anything else they would like to say?
- I should have all the information I need. Would it be alright to call you if have any more questions?

Thank you for your participation and for taking the time out to see me.

## APPENDIX 4

**UNIVERSITY OF CAPE TOWN**

**FACULTY OF HUMANITIES**

**DEPARTMENT OF SOCIAL DEVELOPMENT**

**REQUEST FOR PARTICIPATION & CONSENT FORM**

**Date: 19 June 2020**

**Name of Researcher**: Charmill Zamuee

**Student number:** ZMXCHA002

This research forms part of the qualification for a PhD degree in the Department of Social Development at the University of Cape Town

**Title of Study:**

An exploration of the frail care needs of older persons in Namibia: perspectives and experiences of informal caregivers and social service professionals

**Objectives of the Study:**

- To explore and describe the perspectives of informal caregivers and social service professionals of older persons in Namibia in relation to the frail care needs of older persons.
- To explore and describe the experiences of informal caregivers and social service professionals in providing frail care to older persons
- To determine the extent to which the Namibian constitutional, legal and policy, and regulatory environment supports the frail care needs of older persons
- To analyse the frail care needs of older persons in relation to existing theoretical models
- To recommend practical proposals for implementation towards understanding and meeting the needs of frail older persons in Namibia.

Please read the following and sign if you agree to participate in this study.

**Research Procedures:** I understand that I will be participating in an interview process to explore the frail care needs of older persons in Namibia: perspectives and experiences of informal caregivers and social service professionals. The interview will last approximately one hour and will be recorded with your permission using a digital recorder or by taking notes. The recording will be transcribed and the notes, the recorded information and the transcripts will be kept in a secure place. Once the research has been completed, this material will be only be used for academic purposes and the transcripts will be destroyed.

**Risks and Harm:** There are no foreseen risks or harm in participating in this research. However, in the event of any emotional distress by a participant, the researcher will make a referral for appropriate assistance.

**Benefits/Incentives:** I understand that this research will not benefit me directly and that I will not be paid for agreeing to do this interview. However, through my participation, the information gathered will provide important information on the frail care needs of older persons in Namibia and provide a scientific basis for government intervention strategies and other stakeholders in the field of the care of older persons.

**Participant's Rights:** I understand that I am free to withdraw from participating in this study at any time, without giving any reason and that there are no consequences should I decide not to participate at any stage.

**Confidentiality:** I understand that the interview process will be kept strictly confidential and that information will be available to the researcher and the supervisor. Extracts from the interviews will be included in the final research report without anyone being able to link my quotes to my identity. The final report will be examined by an external examiner and the findings will be made available to participating agencies. Under no circumstances will my name be revealed in the report or any other publications related to this research.

I understand that if at any time I would like any additional information about this research, I can contact my research supervisor, Dr.Somaya Abdullah telephonically at 021 650-4219 or by email at somaya.abdullah@uct.ac.za

**I confirm that I have read this consent form or the researcher has read it to me and that the study has been explained to me. I voluntarily participate in this study**

_____ _____

**Signature of Participant** Date (dd/mm/yyyy)

_____ _____

**Signature of Researcher** Date (dd/mm/yyyy)

## APPENDIX 5

**INTERVIEW SCHEDULE FOR KEY INFORMANTS**

**An exploration of frail care needs of older persons in Namibia: A study of the experiences of informal caregivers and formal caregivers**

| **A. Demographic data** |
|---|

1. Gender:

| | |
|---|---|
| Male | |
| Female | |
| Other | |

2. Age group:

| | |
|---|---|
| 18-30 | |
| 31-50 | |
| 51-60 | |

3. Level of education:

| |
|---|
| |

4. Years of work experience:

| |
|---|
| |

5. Job description/ role/ tittle

| |
|---|
| |

6. Sector:

| |
|---|
| |

7. Location:

| |
|---|
| |

## B. OBJECTIVES

***III. To determine the extent to which the Namibian constitutional, legal and policy (regulatory) environment supports the frail care needs of older persons.***

1. Is the current Namibian policy on the care of frail older persons conducive to identification and meeting the needs of frail older persons? Please explain.
    - Is institutionalised care of frail older persons adequately regulated to ensure effective protection for them as vulnerable people?
    - does the law afford enough protection and support to frail older persons? Please elaborate.
2. Do you feel the law gives the formal and informal caregivers enough resources and protection to provide effective support to frail older persons? Please explain.
3. Is the law clear on the role and service standards for the formal and informal caregivers in providing care to frail older persons?
4. Does the law provide sufficient guidelines for assessing the needs of frail older persons? Please explain.
5. If you were able to change any aspect of the law relating to caring for the needs of frail older persons, what would that be and why?
6. Does the law provide enough protection and deterrence against abuse and neglect of frail older persons? Please explain.
7. In you experience, does this caregiving environment afford older persons their dignity and quality of life as required under the Constitution?
8. In your view, is the level of government funding for frail older persons sufficient to deal with their needs? Please explain.
9. Given the exorbitant costs of healthcare in Namibia, are you aware of any incentives in the law to encourage people to care for older persons?
    - Are you aware of any policy initiatives to support and promote the welfare and care of frail older persons in Namibia?
10. Are there any social support services or networks supporting the ongoing care of the older frail person in your care? If so, please elaborate on the nature of the relationship

between the different networks, i.e. service, nature of the relationship, collaboration; and what are your recommendations?

The end

• How did you feel doing the interview?
• Is there anything else you think would be helpful for me to know?
• Is there anything else you want to add that you feel has been left out?
• Do you have any 'advice' or room for changes
• Is anything else they would like to say?
• I should have all the information I need. Would it be alright to call you if I have any more questions?

Thank you for your participation and for taking the time out to see me.