Lived experiences of old age people in Bahir Dar city, Northwest Ethiopia: A phenomenological study.

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Abstract

Introduction: Understanding ageing and how it is perceived from the perspective of aged people can help one gain a deeper and more accurate understanding of the phenomenon as well as of the demands and challenges that they face. However, this is rare in Ethiopia. Therefore, the purpose of the current study was to explore the living experiences of old age people in Bahir Dar City, Northwest Ethiopia.

Materials and methods: A hermeneutic phenomenological study design was conducted from January 1 to 15, 2022. An in-depth interview was conducted with 12 old age people chosen based on heterogeneous purposive sampling. In addition, a typical case of purposive sampling was used to select four key informants from different offices in Bahir Dar City. The data were analyzed using thematic analysis, following the recommended steps for qualitative data analysis. Lincoln and Guba's criteria were used to increase the trustworthiness of the findings. Finally, this research followed the standards for reporting qualitative research to report the findings.

Results: The study revealed nine main themes: definition of old age, perception of old age and healthy ageing; daily activities and community participation; health-related conditions; healthcare service utilization and barriers, nutritional concerns, availability and types of support. Participants observed old age a change of body appearance, physical and mental activities and/or expected social roles. Similarly, healthy ageing entails the absence of disease along with physical activity, spiritual wellbeing, and social interaction. The study participants complained about a variety of health related issues that interfered with their daily activities, community participation and dietary practices. Furthermore, participants reported receiving various forms of support from various bodies, but they were dissatisfied with the coverage and adequacy of support and they perceived that traditional values and norms were gradually eroding.

Conclusion: The study participants perceived the blessings and challenges of old age. They perceived that older people are seen as a burden to the family and society at large. Therefore, policymakers and stakeholders should offer comprehensive strategies to improve health outcomes and support effective ageing.

Keywords: Old age people, Lived experience, Perception, Healthy ageing, Ethiopia.

Introduction

Global ageing is accompanied and driven by fertility and mortality patterns, family structure, work and retirement habits, a shift in disease burden from infectious to chronic noncommunicable diseases and massive social and health reforms. How these concerns are resolved in different countries varies and is unique to each country depending on the demographics, economics, and cultural values of that society. High-income countries struggle with the challenges of funding and modifying and expanding already existing policies and programs, while low-income countries have difficulty coming up with new policies, programs, and services for ageing populations. It has been believed that high-income countries become wealthy before they grow old, while low-income countries age before becoming wealthy. It may also be true that low-income nations in poverty may never become wealthy [1].

Furthermore, since the old age population is made up of people with varying ages, capacities, and uneven traits, their growth will also result in a rise in the need for health services and support to deal with issues connected to chronic diseases and impairments. However, there is a scarcity of data on the livelihoods, health status, accessibility of healthcare for older people, and current situation of older people in Africa. In terms of public health and nutrition research, older adults have been a particularly underserved group of the population, making tailored intervention challenging [2].

The reported results in Ethiopia showed that old age people nowadays face various problems due to the limited governmental social security system and the weakening of traditional family and community support. Nonetheless, participants' perspectives and experiences of food and nutrition intake and the broad array of issues, challenges, and

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The reported results in Ethiopia showed that old age people nowadays face various problems due to the limited governmental social security system and the weakening of traditional family and community support. Nonetheless, participants' perspectives and experiences of food and nutrition intake and the broad array of issues, challenges, and opportunities associated with ageing were not identified. Moreover, a deeper and more accurate understanding of the phenomenon, as well as the difficulties and demands of older people, can be gained by looking at the experience of ageing from their point of view. Therefore, this study aimed to explore the living experiences of old age people in Bahir Dar city, Northwest Ethiopia [3].

Materials and Methods

Study setting

The study was conducted in Bahir Dar city, the capital of the Amhara regional state. The city is around 578 kilometers Northwest of Addis Ababa, the capital city of Ethiopia. Based on the 2007 Census of Ethiopia, Bahir Dar city has 155,428 inhabitants and is projected to have 332,856 as of July 2021. The city has three government hospitals, 10 health centers, and 10 health posts [4].

Study design and period

A hermeneutic phenomenological study was conducted from January 1 to 15, 2022.

Study population

The study population included both community dwelling old age people and key informants [5].

Eligibility criteria

Inclusion criteria: Community dwelling old age people aged 60 years and above who lived in the selected city for at least six months and able to understand and speak the local Amharic language were eligible for the study. Additionally, key informants who were coordinating the regional offices of Bahir Dar city labour and social affairs, Bahir Dar city health department, Belay Zeleke sub-city labour and social affairs, and Belay Zeleke health center were included [6].

Exclusion criteria: Those seriously ill and/or unable to communicate were excluded from the study.

Sample size determination

We first planned eight participants, but finally reached 12 based on the notion of data saturation, with no new issues emerging from the participants. In addition, four key informants coordinating the offices of Bahir Dar city health department, Bahir Dar city labour and social affairs, Belay Zeleke Sub-city social and welfare affairs officer, and Belay Zeleke health center were recruited to triangulate the data [7].

Sampling procedures

A heterogeneous and a typical case of purposive sampling were respectively used to select the participants of in-depth interviews and key informants. The community dwelling old age people have gender and educational level variations to give rich information. Similarly, the key informants serve as the profile for understanding the features of existing programmes [8].

Data collection

In-depth interviews and key informant interview methods were used to collect the data. Interview guides were used to elicit participants' perspectives and probes to trigger more exploration. The guiding questions were adapted from the documents of WHO and HelpAge International and refined further during the data collection period. Health extension workers helped us to select the study participants, and unique codes were assigned to each participant for anonymity. Both interviews were conducted in the Amharic language and translated into English during the data analysis. All conversations were audio recorded using a digital voice recorder with the permission of the participants. In addition, the investigator took field notes during the interviews to capture nonverbal communications. The duration of the in-depth interview was between 45 and 60 minutes, and the key informant interview took 30 to 45 minutes [9].

Data analysis

The data were analyzed using thematic analysis following the recommended steps for qualitative data analysis. The first was reading and developing an intimate relationship with the data *via* data immersion. The audio-recorded data from the interviews was transcribed verbatim [10]. Transcripts were verified for accuracy by listening to the audio records and reading the field notes. Scrutiny of findings and identification of patterns were performed. Then the second step was translation into English. Thirdly, generating codes and themes was done following an inductive code extracted from the study participants' words and deductive codes derived from previous literature review approaches. Multiple listening sessions to the audio recording, revising transcripts, and coding in an iterative manner were involved. The open code 4.02 software was used for the analysis aid. Once the categorization was completed, the sub-themes under each main theme were contrasted to find the highest homogeneity within the themes and the highest heterogeneity between the themes [11].

Trustworthiness

Lincoln and Guba's criteria were used to increase the trustworthiness of the findings. To confirm credibility, sufficient time was given to collect the data for a better understanding of participants' experiences, and prolonged engagement was taken in reading and analyzing the transcribed data. In addition, two data collection methods were used to triangulate and increase trustworthiness. Regarding dependability and confirmability, every activity of the study was documented for the audit trial.

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The authors also have previous experience in conducting and supervising of qualitative studies. They further tried to increase confirmability by being self-reflexive about their thoughts and assumptions [12]. The authors also have previous experience in conducting and supervising of qualitative studies. They further tried to increase confirmability by being self-reflexive about their thoughts and assumptions [12]. For data transferability, sampling with maximum diversity was implemented. Samples of both genders were selected at different age groups. The authors gathered sufficient information about the study participants to assure data transferability and to boost significance of the data and study setting. There were verbatim transcripts and a thick description of the research method and data analysis. In addition, the findings were evidenced with adequate evidence of quotes from the participants and key informant interviews. All records, data collection, and analysis processes were documented to facilitate the audit trial. Furthermore, research findings were reported following the Standards for Reporting Qualitative Research (SRQR) [13].

Results

Sociodemographic characteristics of the study participants

A total of 12 old age people and four personnel from different offices participated in the in-depth and key informant interviews, respectively. The average age of the in-depth interviewees was 72 years old, with a standard deviation of 7.5 years. Half of the study participants were females. Four-quarters (25%) of them did not read and write, while the other 25% were either secondary or above educational level [14]. Of their living conditions, 41.7% (n=5) lived alone, 33.3% (n=4) lived with their spouses, and the remaining 25% (n=3) lived with other family members (Table 1).

Table 1. *Sociodemographic characteristics of the study participants, Bahir Dar City, 2021.*

Sociodemographic characteristics		Number (n)	Percent (%)
Age	60-79	7	58.3
	80-89	5	41.7
Gender	Female	6	50
	Male	6	50
Marital status	Single	1	8.3
	Married	4	33.3
	Divorced	3	25
	Widowed	4	33.3
Educational level	Cannot read and write	3	25
	Able to read and write	3	25
	Primary education	3	25
	Secondary and above	3	25
Living arrangements	Lives alone	5	41.7
	Lives with spouse	4	33.3
	Lives with other families	3	25
House owner	Their privet-owner	7	58.3
	Children/Family owner	3	25
	Rent	2	16.7

Lived experiences of old age people

Participants shared a variety of experiences related to their perceptions of old age, their health issues, food habits, and the support they have. The findings of the study revealed nine primary themes and 20 subthemes [15].

Definition of old age

According to the results of an in-depth interview, determining whether or not someone is old is not difficult. The assessment of old age is based on four important variables: Change of body appearance, physical incapacity to perform certain activities, mental decline, and/or expected role in old age. However, the majority of respondents indicate that old age

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cannot be defined solely by one criterion, rather a combination of criteria or indicators could be used to determine how old a person is “when your face looks wrinkled like a boiled bean, when you lose everything, even when your hands and legs tell you to not obey, you will realize that you are in the hands of others; you know you are old enough” (an 80-year-old man). “When your body is weak and you start to forget things, you know that old age is knocking on your door” (a 60-year-old woman) [16].

Perception of old age

Participants explained two types of old age perceptions: blessings and challenges. One of the study participants said, “In these days when death is defiled and daily, I thank my God for enabling me to live longer and become an elderly person. As people get older, they have more time to reflect on the past and share their life experiences” (an 89-year-old woman) [17]. The other also explained this as, “I used to sit for a long time on stones outside of my compound. People give me peace, greetings with respect. I felt delighted to be getting the attention and respect I received from the clergy and community” (a 70-year-old man).

Old age people, on the other hand, acknowledged that growing older, with all of its ups and downs, was not simple. Physical disability, fatigue, stuttering, isolation, lack of respect, denial of rights and privacy, and dependency on others are all associated with old age [18].

"Old age is a problem by itself," said one of the respondents, who was dissatisfied with his existence. “Old age is a time of adversity. In many ways, I am suffering with pain. I would rather die than live (as an elderly guy) in this condition" (a 79-year-old woman). The other emphasized his worries as "I am now living alone in a large house. Look, I am encircled by darkness. I am in a dreadful situation. When I thought back to my golden years, I sobbed" (an 87-year-old man).

Perception of healthy ageing

According to the participants, healthy ageing entails the absence of disease along with physically active, spiritually wellbeing, and has social interaction. Independent living and self-care were also mentioned as important aspects of "healthy ageing" by the study participants. An 89-year-old man offered his opinion, “To me, good ageing is being able to participate in all working and social activities without difficulty, as well as taking steps to treat any pains or other challenges that develop.” The other 60-year-old woman said, “Healthy ageing means to me being able to care for yourself [19]. Exercising and tending to the lord while being sin-free. Participate in any activity without difficulty.”

Daily activities and community participation

This theme outlines the participants’ capacities for self-care, income-generating activities and community participation [20].

Self-care activities

Self-care tasks include things like dressing, washing, household cleaning, keeping one's health, and shopping. Participants' stories vividly revealed the feeling of not being able to carry out the tasks to which they had dedicated their lives. As a result, losing these activities meant losing their sense of self. "Wearing my trousers and getting my shoes on, lacing my shoes. Are difficult tasks” said an 89-year-old man. “It takes a long time. I have a little trouble lifting my leg in the morning, but I manage. I have to get up and dress, then prepare my own breakfast and dress decently to go up there, which takes time. I get by, but it is a struggle. I cannot do some things, like walking for a long time. I go a little off sometimes, but it is a battle".

Income-generating activities

The respondents were asked what their previous and present occupations were. Old age people previously engaged in a variety of jobs to sustain their needs. Females worked in petty trade, spinning cotton, selling handicrafts made of grass, green pepper, foods, and local drinks such as Tella and Areki (kinds of Ethiopian traditional homemade alcohol), while males worked as farmers, traders, judges, weavers, and religious teachers. Currently, none of the older participants are involved in any income generating activities. Indeed, several older women continue to work as housemaids and shepherd for their granddaughters. Some of the younger participants in the study valued the ability to still work and contribute productively. However, ill health, the stress of managing chronic conditions, and a lack of assistance in the workplace were alleged to have forced some of them to abandon their jobs. One of the interviewees stated this as "my previous source of income was my own business. I was a weaver. However, now, I am so old that I am unable to work. As a result, I am dependent on my children” (a 75-year-old man).

Access to employment

The study findings under this subtheme revealed that there are two groups of older people who face employment challenges: Older people who demand employment opportunities in order to generate income to meet their basic needs, but are unable to do so due to employer discrimination and a lack of attention from the community, city and kebele administrations in arranging employment opportunities and older adults who do not want to work because of a health concern.

"I always wanted to work as a day laborer to get money, but employers have discriminated against me because of my age. Employers claim that I am not as productive as younger employees” (a 67-year-old man).

On the other hand, the findings revealed that some old age people do not want to engage in any income generating activities. They also do not need any support from others since they have either a house to rent or a pension salary. Even though the pension recipients in the interview complained that the level of the pension benefits is too low, it is good to have it

and save them from seeing the hand of others. “I thank my God for giving this (pension) salary. Although I cannot do luxury things and it hinders my ability to plan, it saves me from asking others for my basic needs. It is obvious that the needs of human beings are unlimited” (a 68-year-old man).

Community participation

Old age participants are members of Iddirs (burial societies) and Mahibers (religious based service groups), which are local community based organizations. Some of them nowadays, however, are having difficulties due to financial hardships, health issues, and physical limitations. An 88-year-old woman revealed, "Many older individuals, including me, find that simply being elderly presents challenges. The decline of my physical power, money, and poor health conditions were the reasons for my shrinking social networks."

Other participants belonged to the society and were fully engaged in it. They had a firm grasp on the nation, but with time they realized they were drifting away and began to feel increasingly unwelcome. “Your influence is gone, nobody listens to you anymore, all things [axioms] fall away, you are not able to keep up. Increasingly, I lost connection with the surrounding world” (an 86-year-old man).

Health related conditions

This was a recurring theme in the participants' health and quality of life narratives. Two subthemes were identified based on this health problem classification system:

- Issues with physiological functioning and
- Feelings of burden and dependence on others

Issues with physiological functioning

The issues of physiological functioning subtheme describe the physical, mental, and social functions that individuals face. During the interview, a number of physical disabilities were mentioned. Pain, headaches, visual and hearing problems, hip fractures, HIV/AIDS, and several noncommunicable diseases were among them. Participants mentioned pain as their health problem, preventing them from maintaining physical function and completing their daily activities. "Because of my arthritis, I have had a bit of a faulty right knee for more than five years. Sometimes it prevents me from much walking, so I just stay at home" (a 70-year-old woman). "My back is the only thing that worries me. I believe it would deter me from pursuing my activities” (a 75-year-old woman).

Participants experienced vision and hearing impairment, with shock and fear accompanying the diagnosis. “I kept saying, ‘I do not believe it, I do not think so’ It was a bereavement. I am well aware that it will never return. I believe something has vanished and I will not be able to find it again” (a 79 year-old woman). "Since I do not hear very well, it affects my communication. Hearing loss can worsen my anxiety I am really unsocial, and it was having a significant negative impact on my life" (a 78-year-old woman).

Moreover, diabetes, high blood pressure, and heart attack were mentioned by interviewees when asked about the most common health concerns they confront as seniors. "I have been afflicted with a variety of health problems since I have got old," one participant said regarding chronic diseases. “Obesity, diabetes and high blood pressure are now considered normal” (a 69-year-old woman).

According to participants, the death of close relatives, physical disabilities such as frailty, loss of independence, or ill health, hampered their ability to maintain social relationships, thus contributing to social isolation. Some of them were unable to differentiate people and/or were involved in group interactions due to visual or hearing impairments. As a result, these participants became reliant on their close relatives for daily interests and social contacts. One of the study participants expressed, “I am one of the oldest residents in this village. My peers were no longer alive. I felt a lot of loneliness after my wife died. I wanted to talk to my family to alleviate my loneliness, but I was exhausted, had visual and hearing difficulties, and could not travel to a long distance” (a 77-year-old woman).

Feelings of burden and dependence on others

The gradual, irreversible decrease and subsequent need elicited intense aversion sentiments, including fear and guilt. Participants appeared to be constantly comparing their existing lives to their desired lives, as well as themselves to other situations.

"I am sick, and as a result, I am reliant on others I am a burden on others. Therefore, I am frequently upset. I have a sense of inferiority. There is nothing like independence (bends his head with bad feeling). Health is important, but I am not healthy. That is why I am sitting here” (an 89-year-old man).

Healthcare service utilization

All study participants received primary healthcare services for acute difficulties, chronic diseases, and/or regular follow ups. The majority of participants relied on public health services.

"Since I have a variety of health problems, I go to a nearby health center for checkups" (a 69-year-old woman).

Barriers to health service utilization

The verbal declarations of study participants resulted in the conceptualizing of seven subcategories of barriers to health care service utilization.

Access to age-friendly health facilities

Physical access was not a concern for the majority of study participants because primary health services are easily provided through health centers within the study area. Yet, the older study participants who did not have a caregiver found it difficult to arrive at the clinic as early as the younger participants and struggled with the physical challenges of waiting in line for hours. They pointed out the lack of age

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friendly facilities and transportation options, as well as the concentration of services in specific areas. An 87-year-old man said, "Because I have a visual impairment and a heart attack, I cannot even walk from the door of my house to the main road. However, I need to see a doctor. My legs are shaking and I am out of breath as I try to get to the taxi. This is because if I do not travel to the health centers with the assistance of others, no one, no health expert, will come to see me at home." The researchers also noted that this old age man was unable to go without the assistance of others.

Availability of services

The major needs of the participants are not met by the nearby health facilities. A 67-year-old woman said, "Compared with past times, I can say that the health centers are located near our community. I only go to hospitals when I am referred to them for specialized care. However, services in the health centers are few, mostly they refer you for your eyes, ears, and laboratory investigations."

Furthermore, all interviewed old age people stated that there are no separate geriatric centers or wards dedicated to providing medical care to the elderly. They all emphasized that the health care providers who treat them are not geriatric specialists. A 65-year-old man said, "I have visited a variety of health facilities, but I have never heard of such specialized wards or hospitals dedicated solely to the treatment of the elderly. Perhaps I am not sure if there is one at all."

Lack of information

Lack of awareness about existing services can sometimes be a barrier to health access for aged people. The interview participants stated that they do not receive information about available services in their healthcare institutions, nor do they receive training on health issues in general, let alone training on the health of elderly people. Some of the participants stated that they have received Human Immunodeficiency Virus and/or Acquired Immunodeficiency Disease (HIV/AIDS) related as well as personal and environmental hygiene information along with the rest of the community that has helped them preserve their health. Nowadays, Coronavirus Disease-2019 (COVID-19) is the major issue for old age people. A 75-year-old man stated, “I have never attended meetings organized by the old age association or government meetings. I have never received an invitation. And I am not sure what the old age associations are doing for us. I do not believe they will make a difference in our lives.”

"The meetings that I attempted to attend dealt with societal issues in general," a 64--year-old woman added. “Today, however, everyone is talking about the 19-virus (COVID-19). They (healthcare providers) told us the disease affects us (aged people) more so be careful of social interaction, safety, and vaccine. I also took vaccines two times.”

Waiting time

Another issue is that the study participants have to wait longer for appointments. Long waits to visit a doctor were an expected part of the treatment process for the participants.

“Long waiting is the primary barrier to access for those seeking specialist care through public health hospitals. Our hospital, Felege Hiwot (one of the near public hospitals in the study area), is a day hospital. You have to wait. You will stay for the entire day. That is why it is known as “the day hospital” (laughs). You must be patient” (a 60-year-old man).

Affordability of services

Along with the availability of services and waiting time, the affordability of services is another main issue that the study participants face. According to the study participants, many old age people are unable to access available services due to a lack of a source of income, rising economic prices, and basic insurance policies failing to cover the costs of many essential aged care services. This was especially the case of the most vulnerable seniors, those who had limited mobility and had no family support.

“You will suffer if you do not have money. I am poor and cannot even get by. What do you expect me to pay for costly diagnostic tests? Especially in the aftermath of the corona and the Tigray conflict” (an 85-year-old man).

One of the 65-year-old woman said that she has a hard time leading her life, let alone affording her medical costs. She lives with her two preschooler granddaughters with no one to help her. She explained, "I trade vegetables and charcoal in Gulit (it is an Amharic word for a little local market on the side of the streets). This income is insufficient to meet my medical costs and other needs, such as food and clothes. I believe I would receive better treatment at private health clinics, but I am unable to do so due to financial constraints."

Although it is claimed that poor people in Ethiopia receive free medical care, there are serious concerns about how the system functions. Old age people contacted for the study expressed their worry about a lack of openness in the definition and application of eligibility criteria, which they believe leads to the exclusion of many poor and vulnerable old age people. A 70-year-old woman explained the bureaucratic obstacle of acquiring the certificate as "Even though I know about the free medical treatment, I did not like the way the kebele officials treated me. I had to go to their office multiple times only to receive one letter (the certificate). As a result, I stopped going there. I used to attend to traditional medicine. I go to clinics on occasion when I can afford it".

Quality of care

While physical access and cost were not barriers to some elderly people, quality and age-friendly care had substantial difficulty in public health hospitals. Participants were dissatisfied with their care and expressed strong feelings that their health needs were being disregarded. A 70-year-old man

stated that, “I am not observing any improvement in my health situation. To take the medicines prescribed, we need to eat properly; otherwise, it is causing us to get another disease. Therefore, I prefer not to take these medicines and to use Taebel (wholly water as a religious treatment) and traditional medicine.”

Similarly, other older people interviewed said, "I am tired of spending money on a prescription that produces no improvement. When we lose hope with the medication, my children take me to church to apply Tsebel (wholly water as a religious treatment)" (an 80 old age woman).

Attitudes of healthcare workers

Study participants who visited public hospitals frequently expressed dissatisfaction with nursing staff’s attitudes toward patients, which were marked by apathy, disrespect and even aggressiveness if the patient was perceived to be acting inappropriately and missing an appointment.

“We are not given priority in health institutions, especially hospitals. We are terrified of the healthcare staff; when they catch you, they are like dogs. When they start shouting at you, you will feel like you are in a corner being bitten by dogs” (an 89-year-old man).

“At some hospitals, our children treat us horribly and do not seem to care. They are chatting over there until they encounter a doctor, at which point they go back and begin working” (a 75-year-old man).

Nutritional concerns

Study participants mentioned a variety of issues, but food concerns were lightly highlighted by everyone. Four significant subthemes emerged from the empirical data analysis.

Current and previous dietary habits

The respondents reported eating three meals per day: Breakfast, lunch, and dinner. These were the mealtime patterns of elderly people, which had often been established decades before. They rarely ate in between meals. Snacking was perceived as inappropriate or unneeded by the older people, and when they did, they ate “Fit-Fit” (broken injera with wot), soup, a cup of tea and plain bread, or “Nifro” (a cooked mixture of different pulses). Others eat two to three times a day, with one main meal and one to two side meals.

"It is the common one that does not change, three times a day from breakfast to dinner. I am never hungry, and I do not prefer to snack. However, if I took that, I would eat our traditional meals rather than anything sugary and processed" (a 67-year-old man).

"I do not take breakfast. I came from the church late. I ate lunch and dinner. There is no dinner; I present it simply by its name. There is nothing better than eating a whole lunch. Only lunch is enough" (an 83-year-old woman).

Decrease food intake

The significant change in eating habits seen among the participants was a reduction in the amount or portion size of food consumed during mealtimes. They stated that they ate less than half of what they had previously consumed. The subthemes relate to lower food intake due to three further subthemes:

- Earlier food preferences and habits
- Food access and availability
- Lack of appetite and loss of interest in food

A 72-year-old man described the situation as follows: "I used to take food for granted when I was younger; it was never a problem for me. However, around three years ago, I walked down the street begging for the first time in my life because I was hungry. I even asked the restaurant if they had any leftovers. It was the most horrible day of my life. Now, thanks to God, the community helped me and I have gained some resilience." Similarly, a 64-year-old woman described her food availability scenario as, "I was a married lady who, like most women, relied on her husband for financial support. However, sadly, our marriage ended in divorce. I had three children, but only one of them is still living, and he is too poor to support me. Therefore, (following the divorce), it was quite difficult for me because I had no experience of living outside of the house. I did, however, have to make some adjustments. I began my career as a domestic worker usually cooking food and doing laundry. This was how I lived until I lost my site and was unable to work as a result. The medical expenses were too much for me to bear. I could not even purchase food. That was the worst thing that could have happened to anyone."

The study participants acknowledged how growing older naturally causes a lower appetite, and many thought that portion sizes were excessively decreased. They just ate when they felt hungry, which was rarely, and believed their appetite had decreased.

“I eat less frequently and consume fewer foods. Now, a small lunch meal suffices perfectly. I recall from twenty years ago, we would go to a party, like a buffet nowadays, and eat a lot. I am not able to do that anymore. I am unable to handle the same volume. I need to cut back on my eating less” (a 76-year-old man).

There are study participants who tried to make dietary modifications, avoiding or choosing particular foods because of health problems or medications they are taking. Some health related problems that several individuals mentioned were dental issues, gastritis, and chronic medical illnesses. "There are certain foods that should be avoided due to illness; there are food restrictions. I make an effort to consume meals that are beneficial for my health. Since I used to just do it without giving it any thought in the past, I believe the diet alteration may have had some impact (laughs and slight silence)" (a 79-year-old man).

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Healthy food perceptions and consumption

We tried to investigate what healthy food is for old age people considering that perceptions of healthy foods and consumption influence dietary behaviors. Traditional foods were frequently stated by our respondents as being more "natural" and "healthy" than current foods that are not grown without fertilizer.

“I believe that cutting fatty meat and butter in your diet is beneficial to me. At our young age, fat, butter, honey, Tej, and Tella (traditional home-made alcoholic drinks) were healthy foods and beverages. Nowadays, everything has become the opposite. These things are now considered harmful to one’s health. Almost all agricultural products are currently dependent on fertilizer. That is why we are also developing unknown diseases” (an 87-year-old man).

Attitude to weight changes

The other key finding in this study is that older adults did not view being underweight as an issue. Even if participants had always been underweighted or had lost weight later in life, the majority did not see this as a problem and were more aware of the problems associated with being overweight. “I don't like being overweight. It’s so disgusting. It is also not good for your health. If you are obese (laughs) you will have to buy new clothes, which is difficult in this harsh life” (a 78-year-old woman).

Availability and types of support

Poor old age study participants reported that they received various forms of support from different bodies. Accordingly, this theme comprises three subthemes based on the three primary groups of people or organizations that arose.

Families and relatives

The most common and primary sources of support for poor old age people were family members, regularly children, immediate or extended relatives, and friends. These groups provide housing, food, financial support, and clothes. A 73-year-old woman emphasized that if not for the help of her children and other family members, she would have been in a challenging circumstance. She claimed that having her family by her side in times of need makes her feel comfortable. "When I need help, my children and my daughter-in-law are there to help. If I did not have kids or other family members, nobody would look after me. If not, I would have been left in bed.”

An 85-year-old man was dependent on his wife and sometimes his granddaughter. He said, “Today I am totally dependent on my wife and granddaughter. We live together. They assist me physically and financially. They had a significant impact on emotional support at times of change. My friends sometimes visit me and give me some material.”

However, economic difficulties strained family ties and reduced their ability to care for the elderly relatives. As one of the participants put it, "In the past, neighbours and family members offered assistance to one another. Now it is a challenging time. Due to the high cost of living, my relatives were unable to provide for my needs and those of others my age. As a result, elderly people might not receive the proper care and support from possible caretakers, which raises the risk of abusive circumstances” (a 75-year-old man).

Community members and religious institutions

Neighbours were the closest local source of support for those old age people without children or close relatives. They receive cash aid, food assistance, and occasional job opportunities. The study participants used the adage "a close neighbor is preferable to a distant relative" to emphasize the importance of neighbours over distant relatives as a source of assistance. “I have wonderful relationships with my neighbours”, a 69-year-old man said when describing the various roles that neighbors play in supporting old age people. “We exchanged salutations. When things go bad or well, we support one another. While I was ill, they came to see me and gave me money to cover the cost of my care. They clean my home for me.”

Government and NGOs

Interview participants rarely mentioned government and Nongovernmental Organizations (NGOs) among the various resources of assistance for the elderly. Here, the governmental institutions include the Kebele administration, the city administration of labour and social affairs, and the health department; and the nongovernmental associations are like the Voluntary Home Based Care Providers (VHBCPs), regional elderly and pensioners’ associations. The key informants classified these organizations under formal service providers, while the previous families, relatives, and community members were under informal groups. Although it is not for all, the Ethiopian government provides five types of support for old age people:

- A pension scheme
- Free health services
- Housing conditions
- Financial and material support
- Training and educational services

During the interview, it was, however, revealed that old age people lacked the opportunity to attend higher school, making it difficult for them to find formal jobs and, consequently, a pension. As was previously mentioned, under income generation activities, only two of the study participants have a monthly pension scheme. Whereas the Ethiopian government has initiated free health services which engage old age people. According to the key informant respondents from the Bahir Dar city health department and belay Zeleke health center, “The government addresses financial barriers through exempted services and fee waiver system for the indigents, including aged people. The government, with the help of supporting agents, provides exempted services for malaria, HIV/AIDS, and tuberculosis for all members of society,

regardless of their financial ability" (a 35-year-old man and a 33-year-old woman).

Furthermore, a representative from the Belay-Zeleke Kebele officer of labor and social affairs stated that they "have programs through which poor elderly people who do not have funeral families are financially sponsored on a monthly basis. Actually, Kebeles identify eligible beneficiaries, and the regional elderly and pensioners' association runs the program. However, the majority of old age people are not included in the program due to financial limitations."

On the other hand, older people have a number of issues about how the fee waiver system users are identified and selected. The Belay-Zeleke Kebele officer of labor and social affairs clarified the fee waiver system programme process as follows. "The screening and identification of eligible beneficiaries for the fee waiver system is conducted through community participation and vetted by community councils, Kebele, and district authorities. A committee of people from the Kebele administration would examine the means of livelihood of an applicant and grant a certificate that allows the individual to get free health care from public facilities. Although the system is not only intended for the old age people, it serves the poor, including them. After a year, the first procedure is repeated and individuals may continue or may be removed from the scheme. Moreover, the cost of accommodation, some drugs, and travel work as constraints for the elderly to receive services."

Old age people in need sometimes get food, cash, and clothing as alms and charities from different government offices and voluntary groups. However, they said that they are not getting the assistance they need in a sufficient manner. While a 74-year-old woman living with HIV/AIDS received different aids from Voluntary Home-Based Care Providers (VHBCPs) for the past three years. She explained this "they (VHBCPs) cook for me, wash my clothes and body, clean the house. They helped me a lot, and my disease is being treated by them." We thought these relationships were made because the individual had HIV/AIDS, not because she was old age person.

The key informant, however, from the city's administrative labour and social affairs said, "We are trying to support the group of society that has a low economic level and is even unable to make ends meet. With the help of volunteers, we provide materials and financial assistance to the poor, including the elderly, on various occasions such as new year, religious festivals, father's and patriotic days. People in our community do not disclose if they have received monetary transfers, and some have even expressed anger over this. Moreover, this period was plagued by internal wars, leading to significant population displacements and adding to the nation's economic burden. In addition, the COVID-19 pandemic clearly posed a threat to ongoing national reforms and relatively strong economic growth, with far-reaching and detrimental effects. However, only help-age International works with old age people in our region, while there are many NGOs that work with children and women."

This study also revealed that the availability of training for old age people is relatively minimal. The officer from the city administration health department also indicated that he did not remember having ever provided education or training for old age people with health related issues or other old age health care difficulties. He believed that older individuals frequently lack access to adequate information on health-related issues. A similar argument was made by the city's labor and social affairs officer: "It is impossible to say that training is delivered in a way that could reach the majority of the older population." He claimed that the only occasions when they could communicate with the elderly were at meetings of their organizations and during old age people's day celebrations.

Discussion

The present study tried to explore the living experiences of old age people in Bahir Dar city, Northwest Ethiopia. The results found seven themes, from the perception of old age to the availability and types of support. In the first theme, the findings suggest that a variety of indicators, extending from physical changes to psychological function, could be used to classify an individual as an aged person. This is related to the definition of old age, which is controversial and varies greatly from one culture to another as it lies in biological, psychological, and social frameworks. The most commonly accepted definition of elderly people in both developed and developing countries is found in social policy documents that define retirement ages.

On the second theme, participants explained their perception of the blessings and challenges of old age based on their personal experiences. Similar reflections of how Ethiopian society saw ageing were reported from Addis Ababa where both positive and negative assumptions and reflections on ageing and old age people are part of Ethiopian society's perception of ageing. Similarly, evidence from rural old age people described old age as a time when troubles come and go and it brings condemnation and blessing. Older individuals are frequently viewed as intelligent, capable of handling responsibilities, peacemakers who can settle disputes, community advisors, people with significant experience and authority and many other positive attributes. However, utilizing the lifelong experiences and knowledge they have collected has been accorded less value.

On the other hand, ageing and elderly individual, are also seen negatively, just as in other regions of the world. Nowadays, older generations have been stigmatized as being weak and even a burden on younger ones. There are some sayings that go too far and characterize older people as being useless, such as the Amharic proverb if you get old, do not customize in Amharic language. In addition, old age man and old age woman in Amharic language are two Amharic words that might refer to elderly people who are physically frail, prone to illness, less likely to engage in certain types of labour and in need of help, and so on. The results are also comparable with a study report from the Philippines, which recognized the participants' traumatic experiences as victims of unjust and harmful sociocultural and stereotypes. Moreover, ageism, a form of societal prejudice towards senior citizens, affects older people's quality of life. Studies indicate that ageism is currently

a major worry for the world, particularly in regard to health and social care difficulties.

The third theme describes the perception of healthy ageing as the absence of disease, along with being physically active, spiritually well, and having social interaction. The theme highlights the discrepancy between objective and subjective health status or clinical health versus self-perceived health status. This is similar to a holistic view of health and the theory of healthy ageing. Despite having numerous health problems, many old age people still believe they are in good health and are ageing more successfully than would be the case clinically.

The fourth phenomenological result of this study was the daily activities and community participation of old age people. Participants in this study were not homogeneous in their daily activities and community participation. Some participants frequently reported difficulty with dressing, washing and using the toilet. This is consistent with other studies that were mentioned in the scoping research about elderly people having trouble performing self-care and household activities. During the study period, some of the participants retired entirely from their prior jobs, while others left because of pension systems, physical limitations, or health issues. Similar to this, study participants in the Netherlands listed a variety of occasionally related causes of retirement.

In the meantime, retired old age people do not just sit around doing nothing. They offered assistance with housework, took part in housekeeping, took care of children and grandchildren, and gave advice to families and neighbours. Old-age monks and priests manage their households, carry out religious duties, and engage in small-scale trade in the study area and other places. In Thailand, old-age people who participate in the community feel a sense of belonging and competence. According to the informants, participating in the community events made them feel more part of the community and like they were contributing to the community. They discussed how vital it is to always encourage other aged people to take part in the events so that they do not feel isolated.

The fifth theme describes health related problems. This study revealed that old-age people suffer from a variety of medical conditions, including generalized bodily symptoms, vision and hearing impairment, arthritis, urinary incontinence, diabetes, hypertension, cardiac disorders, and the like. While older individuals, like everyone else, are susceptible to a variety of communicable diseases, they are oddly more prone to Chronic Non-Communicable Diseases (CNCDs). Although the health and adaptability of older people vary widely, the health issues facing this generation in Ethiopia remain serious. Similar results were reported from four Sub-Sahara African countries: Zimbabwe, Tanzania and Mozambique, where the respondents had at least one non-communicable disease and mental health problems. Likewise, the overall health status of older people in the majority of Asia-Pacific countries is mixed of non-communicable and communicable diseases, mental health problems, disability, and nutrition related problems.

The sixth identified theme describes health care utilization and barriers. All study participants received healthcare services for acute difficulties, chronic diseases, and/or regular follow-ups. In addition, study participants prefer public health facilities. This is in line with the HelpAge study from Addis Ababa, where 77.5% of respondents were receiving medical care. The majority of them attend governmental healthcare facilities. This might be due to the fact that health centers are the most accessible medical facilities in urban areas and the lowest tier where primary healthcare is offered. Another study in Addis Ababa, however, found that older people lack the bravery to visit health facilities unless they are very ill and/or are coerced to do so by their family or neighbours. This difference might be due to the economic difficulty of covering the medical fees.

The verbal declarations of study participants resulted in the conceptualizing of seven subdivisions of barriers to health care utilization: Access to age-friendly health facilities; waiting time; availability of services; lack of information; economic access; quality of care and attitudes of healthcare staff. It was also noted by the Ethiopian office of HelpAge international that there was inadequate human, informational and physical infrastructure and resources to provide adequate old age care at all levels of the system. Similar findings were reported from South Africa, which indicated that it was not sufficiently functional to meet the complicated healthcare demands of older people.

Likewise, most Africans reach old age after living in poverty, hunger and with limited access to medical treatments. This corresponds to a recent study of gerontology experts where the top five serious problems affecting older people in Sub-Saharan Africa include poverty, food insecurity, disability and health problems, a lack of geriatric professionals in the region, and the rising cost of long-term care. Comparable to the Iran study, the results of this study showed that old age people who are housebound and have low activity levels are denied access to health services since no systems has been created to make it easier for them to do so. Nevertheless, a study on aged care in India reveals that India has employed a group of skilled medical personnel to make house-to-house visits to aged people to facilitate their access to all primary healthcare services.

On the other hand, medicine is being expected to treat more chronic noncommunicable diseases that have nothing to do with infections as more individuals in all nations live to old age. As a result, older individuals are becoming less optimistic, even hostile, about modern medical professionals as they receive subpar treatment for their ongoing health issues. As a result, health care systems in African countries founded on the curative paradigm and clinicians trained and committed to that model are finding themselves increasingly unprepared to treat the chronic illnesses that are prevalent in old age. In addition, the profound impact of Coronavirus Disease-2019 (COVID-19) has had on older populations has drawn our attention to the impact that mitigation interventions have had on social isolation, safety, and access. COVID-19 has caused disparities in outcomes and suffering, and the burden has been even greater in these populations for those who are older.

The other emerging theme was nutritional concerns. The respondents reported the mealtime patterns of elderly people had often been established decades before, eating three meals per day: Breakfast, lunch, and dinner. It was common to skip meals. This is comparable to similar studies in Eastern Africa countries and Malaysia. Study participants in this perceived and want to consume traditional foods were frequently stated by our respondents as being more "natural" and "healthy" than current foods that are not grown without fertilizer. Others consider their health in the perception and consumption of healthy foods. Furthermore, Muslim participants also claimed that their attitudes of healthy eating were influenced by religious beliefs. This is comparable to the qualitative study conducted in the United Kingdom that discovered various perspectives on healthy eating among older people. Traditional foods were often seen by both sexes as good and healthful when compared to other foods, and home-cooked meals were frequently thought to be healthier than eating out.

Study participants did not consider weight change as a problem, while they perceived that their dietary habits and food choices had a direct impact on their ability to maintain their health and well-being. Furthermore, the current study discovered that age, living and health conditions, social support, and community participation all influence dietary behaviours. This is consistent with earlier research conducted in Malaysia, Australia, and the United Kingdom where personal, social and community factors affect the dietary habits of old age people. With advancing age, meeting the recommended daily energy and nutrient intake may be a challenge, as several factors combine to increase older adults' vulnerability to malnutrition. Not all old age people go through these changes in the same way; some display tenacity and get through their food-related obstacles. However, consulting medical professionals for information and assistance was uncommon and intermittent. While a study report from Australasian and western Spain participants commented on the uncertainty they felt about what constitutes a suitable diet for elderly people, given on the shifting and frequently contradictory dietary messages they had been exposed to over the years.

In terms of availability and types of support, the majority of the participants in this study depend on themselves and/or on their relatives for their basic needs. A variety of informal and legal social protection mechanisms, including cash transfers, safety nets, religious mahibers and senbetes are available to older individuals. The amount and coverage of these, however, were discovered and traditional values and norms are gradually eroding. This was also a problem in other parts of Ethiopia and countries, such as Tanzania, Mozambique, Zimbabwe and the Philippines.

In addition, the ministries of health and social welfare, the two main players in the elderly care system of Ethiopia, do not work effectively together. A similar case was also reported from Iran where the two ministries conflict with one another and do not work efficiently around each other. The supply of health services in Ethiopia and other African countries like Mozambique, Tanzania and Zimbabwe is low and limited in availability, accessibility, affordability and adequacy of health services. Likewise, staff in South Africa was overworked and demotivated, which leads to high levels of inadequate service delivery and burnout because of the high need for health services and the shortage of healthcare professionals.

However, the public policy and strategy for the European countries and in some low-and-middle-income countries is shifting to place the highest importance on healthy ageing. This tendency is largely due to the preference of most older people for ageing in place, which refers to receiving care at home or in the community rather than in the health institutions. Ageing policies and strategies in Mexico and Argentina, for instance, gradually changed from maintaining financial stability towards ensuring quality of life and social rights standards.

Strength and Limitations

The first strength of this study is that the study recruited participants are community dwelling old age people who would be hard-to-reach individuals due to health problems, immobility, family care responsibilities, or hesitation to participate in the interview. Secondly, the in-depth interviews were conducted in the participants' home compound. Thirdly, the in-depth interview was triangulated with key informant interviews for further information. However, it is important to take into account at least two limitations. First, selection bias, which states that motivated and interested people are more likely to participate than unmotivated and disinterested people. Second, the biases of the researcher will always intrude to some extent into qualitative research.

Conclusion

Ageing is perceived as a change in physical appearance, physical incapacity to conduct specific tasks, mental decline and/or expected duties in later life. Similarly, healthy ageing entails the absence of disease along with physical activity, spiritual wellbeing and social interaction. However, the study participants face different challenges in life. They are in continuous confrontation with health problems, lack of balanced diets and shelter, shortage of family and community support, limited social security services, absence of education and training opportunities, limited employment and income-generating opportunities. Further study is necessary for preventive measures that are specifically adapted to the needs of senior citizens.

Ethical Approval and Formal Consent

The Institutional Ethical Review Board (IERB) of Bahir Dar university, college of medicine and health sciences, approved all research protocols (IRB meeting No 001/2021; protocol no 002/2021; date January 6, 2021; and assigned no 003). An official letter of cooperation from Bahir Dar university, college of medicine and health sciences, research and publication office was sent to the respective selected offices. Furthermore, we strictly used the COVID-19 protection measures and verbal informed consent was obtained from each study participant and the key informants.

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Availability of Data

All data generated or analyzed during this study are included in this published article.

Conflict of Interest

The authors have declared that they have no conflict of interest.

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Author Contribution

Muhye A planned the research, collected and analyzed the data, and wrote the paper. Fentahun N was involved in the design, data analysis, manuscript preparation and critical evaluation of the study. Both authors read and approved the final manuscript.

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