American Journal of
Education and Practice
(AJEP)

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American Journal of Education and Practice
ISSN 2520-3991 (Online)
Vol.8, Issue 4, pp 55 – 69, 2024
www.ajpojournals.org

# Psychosocial Determinants of Healthy Ageing in Cameroon: Implications for Developing a Model for Resilience in Late Adulthood

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***Article history***

***Submitted 03.06.2024 Revised Version Received 10.07.2024 Accepted 13.08.2024***

**Abstract**

**Purpose:** In Cameroon, like in other African Countries, ageing is an emerging issue due to the erosion of the traditional family and cultural system that used to be very supportive to the old. More so, the presence of threats such as; disease outbreaks (infectious diseases, epidemics, endemics and pandemics), wars and violent occurrences, has placed persons in late adulthood to be more vulnerable. Prior research has established that social relationships and a sense of life satisfaction are not only predictive of longevity, but are also important for determining health-related quality of life among persons in late adulthood. This study investigated the psychosocial determinants of healthy ageing in Cameroon, the challenges faced by old people and its implications for developing a model for resilience in late adulthood.

**Material and Methods:** Both quantitative and qualitative research paradigms were taken into consideration to conduct this study (concurrent mixed method research design) to identify and explore the psychosocial determinants of healthy ageing in Cameroon, the challenges faced by persons in late adulthood and its implications for developing a model of resilience in late adulthood.

**Findings:** Based on data analysis, the variability explained by the model was significant (Omnibus Tests of Model Coefficient: Likelihood Ratio Tests: Chi-Square=79.221; df=5; P<0.001; N=300). The explanatory power of the model was 31.0% (Nagelkerke R Square =0.310). Though this predictive power was moderate, the predictive effect of all the indicators was significant, therefore indicating that, psychosocial determinants of healthy aging are important in the development of resilience among elderly persons.

**Implications to Theory, Practice and Policy:** It was therefore recommended that, since a significant number of older persons are not employed and, consequently, do not receive retirement benefits, policy focus should consider supporting the aged technically and financially, to engage in income generating activities.

**Keywords:** *Psychosocial Determinants, Healthy Ageing, Stressors, Adaptive Coping Skills, Model of Resilience, Late Adulthood*

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## INTRODUCTION

In Cameroon, like in other African Countries, ageing is an emerging issue due to the erosion of the traditional family and cultural system that used to be very supportive to the old. More so, the presence of threats such as; disease outbreaks (infectious diseases, epidemics, endemics and pandemics), wars and violent occurrences, has placed persons in late adulthood to be more vulnerable. Prior research has established that social relationships and a sense of life satisfaction are not only predictive of longevity, but are also important for determining health-related quality of life among persons in late adulthood. Social connectedness and feeling positive about one's life may be particularly important for quality of life in late adulthood when health-related quality of life has declined as a result of threats and adversities (Fomba, et al, 2023). United Nations (UN) agencies have been influential in shaping these global discourses. They have established a values agenda, with principles for people and their environments that set a moral compass for ageing. They have created a framework for healthy ageing that positions older people within these environments and articulated processes and outcomes. The UN Decade of Healthy Ageing (2021–2030) brings together these agendas toward a better future for older people. Its plan of action signals shared accountability for "concerted, catalytic and collaborative action to improve the lives of older people, their families and the communities in which they live" (WHO 2020a). Academics are held responsible along with governments, civil society, international agencies, professionals, the media and the private sector. The purpose of this chapter therefore is to discuss the psychosocial determinants of healthy ageing in Cameroon, the challenges faced by old people and its implications for developing a model of resilience in late adulthood.

Ageing has become a global concern. It is estimated that by the year 2050, people in the age ranges of 60 plus will be more than double (WHO, 2020b; UNDESA, 2014), especially in low- and middle-income countries such as Cameroon. In the year 2050, the number of people aged 80 plus is estimated to be 395 million, and 62% of them live in developing countries (World Bank 2020; UNDESA, 2014). This means that during those times, more children would know their grandparents and great-grandparents, especially their grandmothers, because they live longer than men on average. Because of improved health systems and other factors, people in Africa are also living longer than before. Ageing is a natural process; all are bound to age, but there are factors that may lead to unhealthy ageing, such as one's unhealthy lifestyle and the environment one lives in. Smoking, drinking alcohol and an unhealthy diet are considered health risks (Padrão et al. 2007:1–9). Non-communicable diseases such as cancer, heart disease, high blood pressure and diabetes add to a list of health risks and determinants of healthy ageing. They are, in fact, classified as the main causes of mortality in the African region (WHO 2020b).

As populations age, there is an increasing need to ensure that this segment of the population stays active and healthy. The World Health Organization (WHO) defines ageing as a gradual and irreversible process that involves changes in tissues and body functions over time. The ageing population will increasingly need special attention, in order to reach not only an increase in life expectancy, but above all, so that they can live with more quality, in line with the tenets of active ageing (Fernandes et al, 2016). The concept of "healthy ageing", which requires careful and focused emphasis on cities, has been related to terms such as "active ageing", "successful ageing", "productive ageing", "ageing well", "living well", "senior wellness", "compression of morbidity". These terms all subscribe to the radically non-traditional paradigm of human ageing, which includes gains as well as losses, and which posits possible improvement in future human health despite increasing longevity. These concepts also strive

to compress morbidity into a shorter period later in life, and decrease cumulative lifetime morbidity (Fries, 2012; Fries, 2020).

Healthy aging is a concept which in all dimensions aims to promote holistic well-being, whether it is physical factors, mental factors, spiritual factors, and psychosocial factors for the elderly to learn, understand, and accept the changes that occur naturally in order to live a quality and happy life (Hansen-Kyle, 2005). The concept of healthy aging is not uniform around the world; while biological processes of aging are shared between cultures, the social and cultural understanding of healthy aging varies (Wahl, 2020). As Wahl (2020) notes, there are also differences in the biological potential for healthy aging between individuals, with differences in genetics, earlier life experience of health and well-being, and behavioural practices leading to different healthy aging outcomes between individuals. Therefore, healthy aging should not be considered as a single, set outcome which all individuals can achieve, but one that varies a lot between individuals and between different social settings. Therefore, to promote good practices in healthy aging, all concepts must be integrated to be consistent and appropriate at the same time. Furthermore, from a behavioural science perspective, there is a need to identify psychosocial determinants that can be targeted to promote healthy aging (Santacreu et al., 2019). Some psychosocial determinants; including physical activity, risk avoidance, and others, have already been identified as influencing mental health and ultimately having an effect on healthy aging. At the same time, there are questions about how achievable successful and healthy aging is for everyone (Wahl, 2020). Therefore, to investigate the concept of healthy aging is not just a matter of investigating health behaviours, but also to examine how such behaviours and psychosocial determinants can be promoted. Thus, there is both a gap in the research on what factors influences healthy aging and how behaviours can be promoted within an aging population. This is a gap that can be addressed in the context of behavioural science.

There is also the question of what healthy aging means in the context of Cameroon. One previous study has established a model of healthy aging that identifies some specific conditions where healthy aging can occur, including physical and cognitive activity, socialization (or social interaction), social relationships and support with family members and others in the community (Thiamwong et al., 2008). Healthy aging also includes good levels of physical activities, which are influenced by mental and physical health, socio-demographics and other factors (Andrade de Sousa et al., 2021). There are also attitudes that can be identified as influencing aging, including self-awareness, self-care, acceptance of the aging process, and stress coping behaviours as well as being resilient when faced with adversities. Emotional functioning for example as well as a sense of belonging and hope is also, associated with healthy aging (Waldman-Levi et al., 2020). Perceptions of healthy aging are also important, with a growing distance between subjective and objective health as individuals age (Tseng et al., 2020). Moreover, self-sufficiency and living simply, as well as making merit and doing good deeds, are behavioural supports that impact the psychological and spiritual wellbeing of the elderly (Thiamwong et al., 2008).

In the past, care for the elderly was the responsibility of the family and the entire community. But because of social changes, this solidarity is now being put to the test. Today, the psychological wellbeing of the aging population in different communities in Cameroon has become a major cause for concern as they are at times victims of social disconnectedness (social isolation, social disengagement and lack of social support coupled with financial insecurity). The majority of them do not benefit from any pension and for those lucky enough to have one, it is too minimal to allow them to live decently. Many of the elderly retire without owning a house. In general, most of the housing where the elderly live has numerous hazards;

presence of mosquitoes, cockroaches, and ants and other pests and mice thus predisposing them to diseases.

More so, the aging population is often on the receiving end of the younger generations' negative attitudes, violence and marginalisation and some families are abandoning their elderly members. Care increasingly remains a crucial facet in the lives of older persons in Africa including Cameroon. Despite its relevance to social development, providing appropriate and effective care services to elderly men and women is still a major challenge in contemporary Cameroon. This is largely due to the weak institutional support system and poverty which estranges the elderly and jeopardizes their psychological wellbeing (Bantar, Nsagha and Asangha, 2024).

## METHODOLOGY

Methodologically, both quantitative and qualitative research paradigms were taken into consideration to conduct this study (concurrent mixed method research design) to identify and explore the psychosocial determinants of healthy ageing in Cameroon, the challenges faced by persons in late adulthood and its implications for developing a model of resilience in late adulthood. From the population of 3000 elderly persons, a 10% sample size was drawn constituting 300 respondents for the survey selected from the three selected study sites (Mendakwe, Mankon and Nkwen) of the North West region of Cameroon. To begin with, in order to collect quantitative data, the descriptive survey design with the aid of a questionnaire made up of close ended items was used in conducting this study. In this light, making use of purposive and incidental sampling techniques, data were collected only from some respondents (elderly persons of 60 years and above) who were considered relevant for this study.

In addition, in order to collect rich and qualitative data, the ethnographic/phenomenological design with the aid of a Focus Group Discussion Guide and an Interview Guide made up of open ended questions were also used in conducting this study. In this light information that were obtained from the Focus Group Discussion Guide and the Interview Guide made up of open ended questions were used to buttress the information that was obtained from the questionnaire made up of close ended items so as to get first-hand information and empirical evidence with regards to the psychosocial determinants of healthy ageing in Cameroon, the challenges faced by persons in late adulthood and its implications for developing a model of resilience in late adulthood.

The instruments were validated in two phases. That is face validity and content validity in order to ensure validity and reliability of the instruments and to ensure that the instruments used were actually measuring what they were intended to measure. Copies of the questionnaire were administered to 300 elderly persons who were purposively and incidentally chosen by the researcher, from three selected study sites (Mendakwe, Mankon and Nkwen) of the North West region of Cameroon. The copies of questionnaire were administered to participants of the study using the self-delivery technique. More so to easily administer the instruments to respondents, two devoted members of each of the communities were trained and used as research assistants to assist in the data collection process. In addition to administering copies of the questionnaire to respondents, a Focus Group Discussion Guide was also administered to respondents through the use of Focus Group Discussions to 60 elderly persons purposively chosen for this study. Six groups made up of at least 10 elderly persons each were selected for this exercise that is two of the groups were made of men only; two of women only and the other two were made up of both men and women. A maximum of 3 hours was used per day for each Focus Group Discussion. Probing and prompting were also used to get more information that was valid from

respondents and to redirect respondents especially when they were not answering some of the questions in track.

Finally, data were analysed following a triangulation approach in methodology, analytical process and statistical packages. The Epi-Data Version 3.1 and Epi-Info 6.04d were used for data entry and analyses with the support of SPSS 20.0. Two modelling approaches were used to establish the explanatory power of the predictor variable over the outcome variable and to appraise the effect of critical indicators of both variables. The models were Binary Logistic Regression Model (BLRM) and Log-Likelihood Ratio test. The relationship between indicators was appraised using the Chi-Square test of independence. Inter-item relationship or association was assessed using the non-parametric Spearman's rho correlation test. Reliability or internal consistency of responses was assessed using Cronbachs' Alpha reliability test. For the analysis of qualitative data; thematic, content and grounded conceptual modelling with the support of Atlas Ti 5.2 was used.

**Measures**

Items were measured using a 4 point Likert scale questionnaire. The questionnaire was made up of closed ended statements. For each of the statements, respondents were required to state how they feel about each item that is stating whether they strongly agree (SA), agree (A), disagree (D) and strongly disagree (SD). The questionnaire was made up of two parts that is part one and part two. Part one contained items on respondents' personal characteristics such as; sex, age, duration of stay in the village, respondents' schooling status, respondents' class, category of adversities faced by respondents, social network support systems that help respondents to overcome and cope normally with difficulties and by respondents' village. Part two contained items pertaining to the variables of the study that is psychosocial determinants of healthy aging, the challenges faced by elderly persons in relationship to the development of resilience. Table 1 and 2 below shows clearly the different measures that were used to measure psychosocial determinants of healthy aging, the challenges faced by elderly persons in relationship to the development of resilience.

**Table 1: Distribution of Psychosocial Determinants of Healthy Aging, the Challenges Faced by Elderly Persons in Relationship to the Development of Resilience**

| Psychosocial determinants of healthy aging | Strongly agreed | Agreed | Disagreed | Strongly disagreed | N |
|---|---|---|---|---|---|
| Spending time with my family and community participating in activities. | 125 (41.7%) | 152 (50.7%) | 21 (7.0%) | 2 (0.7%) | 300 |
| Confidence to express thoughts among others. | 157 (52.2%) | 124 (41.3%) | 12 (4.0%) | 7 (2.3%) | 300 |
| Good nutrition and hygiene. | 164 (54.7%) | 131 (43.7%) | 4 (1.3%) | 1 (0.3%) | 300 |
| Community support and availability and access to health services. | 139 (46.3%) | 145 (48.3%) | 5 (1.7%) | 11 (3.7%) | 300 |
| Good housing condition. | 197 (65.7%) | 96 (32.0%) | 3 (1.0%) | 4 (1.3%) | 300 |
| **MRS (Aggregated score)** | **782 (52.13%)** | **648 (43.2%)** | **45 (3%)** | **25 (1.66%)** | **1500 (100%)** |

From Table 1 above, psychosocial determinants of healthy aging proved to be an important in fostering the development of resilience among elderly persons. Considering the components that made up this indicator, 152 (50.7%) and 125(41.7%) respectively agreed and strongly agreed that the first component "Spending time with my family and community participating in activities" is a psychosocial determinant that is necessary for the development of resilience among elderly persons; meanwhile, 21 (7.0%) and 2 (0.7%) participants respectively disagreed and strongly disagreed against the importance of this component.

Concerning the second component "Confidence to express thoughts among others" as a psychosocial determinant in fostering the development of resilience among elderly persons, 124 (41.3%) and 157 (52.2%) respectively agreed and strongly agreed to the importance of this component; while 12 (4.0%) and 7 (2.3%) of the respondents respectively disagreed and strongly disagreed against the importance of this component.

Looking at the third component "Good nutrition and hygiene", 131 (43.7%) and 164 (54.7%) agreed and strongly agreed of its importance as a psychosocial determinant in fostering the development of resilience among elderly persons; whereas 4 (1.3%) and 1 (0.3%) disagreed and strongly disagreed against its importance.

As far as the fourth component "Community support and availability and access to health services" is concerned, 145 (48.3%) and 139 (46.3%) agreed and strongly agreed that it was an important psychosocial determinant in fostering the development of resilience among elderly persons; While 5 (1.7%) and 11 (3.7%) disagreed and strongly disagreed on the importance of the component.

Finally with regards to the fifth component "Good housing condition" had 96 (32.0%) and 197 (65.7%) participants who agreed and strongly agreed to the importance of the component as a psychosocial determinant that fosters the development of resilience among elderly persons; while 3 (1.0%) and 4 (1.3%) participants disagreed and strongly disagreed on the importance of the indicator to the development of resilience.

**Table 2: Distribution of Challenges/Adversities Faced by Elderly Persons**

| Challenges/adversities faced by elderly persons | Strongly agreed | Agreed | Disagreed | Strongly disagreed | N |
|---|---|---|---|---|---|
| Armed conflicts, wars and violence | 191 (63.7%) | 108 (36.0%) | 0 (0.0%) | 1 (0.3%) | 300 |
| Social isolation | 150 (50%) | 137 (45.7%) | 9 (3.0%) | 4 (1.3%) | 300 |
| Poverty | 99 (33.0%) | 101 (33.7%) | 64 (21.3%) | 36 (12.0%) | 300 |
| Lack of health care services | 66 (22.0%) | 89 (29.7%) | 79 (26.3%) | 66 (22.0%) | 300 |
| Disease outbreaks | 186 (62.0%) | 97 (32.3%) | 10 (3.3%) | 7 (2.3%) | 300 |
| Poor nutrition and housing conditions | 132 (44.0%) | 161 (53.7%) | 4 (1.3%) | 3 (1.0%) | 300 |
| **MRS (Aggregated Score)** | **824 (45.77%)** | **693 (38.5%)** | **166 (9.22%)** | **117 (6.5%)** | **1800 (100%)** |

Table 2 above, shows us the different challenges/adversities faced by elderly persons.Considering the components that made up this indicator, 108 (36.0%) and 191(63.7%) respectively agreed and

strongly agreed that the component "armed conflicts, wars and violence" stimulates elderly persons to resilient; meanwhile, 0 (0.0%) and 1 (0.3%) participants respectively disagreed and strongly disagreed against the importance of this indicator. Concerning the component "Social isolation" as a triggering challenge causing elderly persons to feel lonely and thus causing them to develop coping mechanisms and resilience, an overwhelming 137 (45.7%) and 150 (50.0%) respectively agreed and strongly agreed to the prominence of this component; while 9 (3.0%) and 4 (1.3%) of the respondents respectively disagreed and strongly disagreed against the importance of this component. Looking at the next component "Poverty", 101 (33.7%) and 99 (33.0%) agreed and strongly agreed to its pertinence of putting elderly persons at risk and thus enabling them to develop a resilient identity; whereas 64 (21.3%) and 36 (12.0%) disagreed and strongly disagreed against its importance. As far as the component "Lack of health care services" is concerned, 89 (29.7%) and 66 (22.0%) agreed and strongly agreed that this component is capable of putting elderly persons at risk of suffering from health related challenges and thus the need for intervention for survival; While 79 (26.3%) and 66 (22.0%) disagreed and strongly disagreed on the importance of the component. Taking the component "Disease outbreaks", 97 (32.3%) and 186 (62.0%) agreed and strongly agreed that they suffer from diverse medical conditions that necessitates interventions and the development of resilience; whereas the rest of the respondents 10 (3.3%) and 7 (2.3%) disagreed and strongly disagreed on the importance of the component. Finally looking at the last component "Poor nutrition and housing conditions" had 161 (53.7%) and 132 (44.0%) participants who agreed and strongly agreed to the relevance of this component as responsible for putting them at risk of developing heath related problems thus necessitating interventions the development of resilience; while 4 (1.3%) and 3 (1.0%) participants disagreed and strongly disagreed on the importance of the component to the development of resilient identity.

## FINDINGS

**Table 3: Likelihood Ratio Tests Predicting the Effect of Psychosocial Determinants on Resilience Development**

| Predictors | Score | DF | Sig |
|---|---|---|---|
| Spending time with family and community participating in activities. | 10.779 | 1 | .001 |
| Confidence to express thoughts among others. | 21.827 | 1 | .000 |
| Good nutrition and hygiene. | 36.110 | 1 | .000 |
| Community support and availability and access to health services. | 11.699 | 1 | .001 |
| Good housing condition. | 27.832 | 1 | .000 |
| **Overall Statistics** | 65.673 | 5 | .000 |

Table 3 shows that, Binary Logistic Regression Model was used to appraise the effect of psychosocial determinants on resilience development among elderly persons. The variability explained by the model was significant (Omnibus Tests of Model Coefficient: Likelihood Ratio Tests: Chi-Square=79.221; df =5; P<0.001; N=300). The explanatory power of the model was 31.0% (Nagelkerke R Square =0.310). The validity of the model is also confirmed by the Hosmer-Lemeshow Test. This test evaluates how the observed frequencies versus expected frequencies agree over the entire range of probability values. This test is a chi-square test that compares the difference between observed and expected frequencies for each of the 2 * 5 matrix.

With this test, a non-significant chi-square is desired as to confirm the assumption that the model being tested is not different from the perfect model therefore supporting the inference that the variability explained by the model is good. In the context of this model, this assumption is verified (Hosmer-Lemeshow test: Chi-Square=23.808; df =8; P=0.002; N=300).

The effect of the individual model indicator was equally computed as presented in the table 2 above. From table 2 above, it was realised that, all the indicators demarcated themselves as significant predictors of resilience (P<0.05) with "Confidence to express thoughts among others", "Good nutrition and hygiene" and "Good housing condition" (P=.000) as the most significant components, followed by "Spending time with my family and community participating in activities" and "Community support and availability and access to health services." (P=.001).

The variability explained by the model was significant (Omnibus Tests of Model Coefficient: Likelihood Ratio Tests: Chi-Square=79.221; df=5; P<0.001; N=300). The explanatory power of the model was 31.0% (Nagelkerke R Square =0.310). Though this predictive power was moderate, the predictive effect of all the indicators was significant, therefore indicating that, psychosocial determinants of healthy aging are important in the development of resilience among elderly persons.

**Table 4: Likelihood Ratio Tests Predicting the Effect of Challenges/Adversities Faced by Elderly Persons on Resilience Development**

| Challenges/adversities faced by elderly persons | Score | Df | Sig. |
|---|---|---|---|
| Armed conflicts, wars and violence | 21.585 | 1 | .000 |
| Social isolation | 8.405 | 1 | .004 |
| Poverty | 3.710 | 1 | .049 |
| Lack of health care services | 4.945 | 1 | .026 |
| Disease outbreaks | 4.164 | 1 | .041 |
| Poor nutrition and housing conditions | 7.071 | 1 | .008 |
| **MRS (Aggregated Score)** | 33.784 | 6 | .000 |

Table 4 shows that, Binary Logistic Regression Model was used to appraise the effect of the challenges and adversities faced by the elderly on resilience development. The variability explained by the model was significant (Omnibus Tests of Model Coefficient, Likelihood Ratio Tests and Chi-Square=35.411; df=6; P<0.001; N=300). The explanatory power of the model was however moderate, 14.8% (Nagelkerke R Square =0.148). The validity of the model is also confirmed by the Hosmer-Lemeshow Test. This test evaluates how the observed frequencies versus expected frequencies agree over the entire range of probability values. This test is a chi-square test that compares the difference between observed and expected frequencies for each of the 2 * 6 matrix. With this test, a non-significant chi-square is desired as to confirm the assumption that the model being tested is not different from the perfect model therefore supporting the inference that the variability explained by the model is good. In the context of this model, this assumption is verified (Hosmer-Lemeshow test: Chi-Square=4.277; df=8; P=0.831; N=300).

The effect of the individual model indicator was equally computed as presented in table 4. From Table 4, it was realised that all the indicators demarcated themselves as significant predictors of resilient development (P<0.05), with "Armed conflicts, wars and violence" (P= .000) as the most prominent challenges/adversities faced by elderly persons, followed by

"Social isolation" (P=.004), "Poor nutrition and housing conditions" (P= .008), "Lack of health care services" (P= .026), "Disease outbreaks" (P=.041) and finally "Poverty" (P=.049).

The explanatory power of the challenges/adversities elderly people faced In relation to resilience development was moderate, 26.5% (Nagelkerke R Square =0.265). However, the variability explained by this component was significant (Omnibus Tests of Model Coefficient: Likelihood Ratio Tests: Chi-Square=66.438; df =6; P<0.001; N=300) and more than half of the indicators significantly influenced the development of resilience. Therefore in conclusion, there is a significant relationship between the the challenges/adversities elderly people faced and the development of resilience.

**Discussions**

The aim of this study was to determine the psychosocial determinants of healthy ageing in Cameroon, the challenges faced by old people and its implications for developing a model of resilience among elderly persons in Cameroon. A look at the healthy aging of the elderly in the Bamenda, the chief town of the Northwest region of Cameroon, revealed that most of the elderly could be considered to have healthy aging at a very minimal level due to the fact that, most of them; suffer from social isolation, lack basic health care services, lack basic nutrition, live in abject poverty, suffer from the effects of armed conflict, war and violence and disease outbreaks. It can be explained that healthy aging of the elderly must consist of; being able to perform daily activities to keep oneself healthy, interacting and communicating with neighbours, and exchanging information to aid their memory. Having good relationships with family members and participating in community activities also helps seniors achieve higher life satisfaction. This, in addition to taking care of oneself, living a simple, self-sufficient life, and acknowledging that aging was a natural process and one that maintains good health, coping with cognitive processes, stress relief, development of resilience, optimism, and adherence to religious guidelines were other elements that contributed to healthy aging. Healthy aging is a cognitive process that prepares them to adapt and cope with changes which arise from aging to conduct oneself appropriately in society (HansenKyle, 2005).

The World Health Organization (WHO) considers healthy ageing as a process of developing and maintaining the functional ability that enables wellbeing in older age (Michel & Sadana, 2017; Fallon & Karlawish, 2019). Functional ability is having the capabilities to enable people to be and do what they value. It is referred to as the ability; to meet their basic needs, to learn, grow and make decisions, to be mobile, to build and maintain relationships, and to contribute to society (Beard et al, 2016). WHO describes this functional ability as being formed by interactions between intrinsic capacity and environmental characteristics (Beard et al, 2017). It is naturally understood that intrinsic capacity includes the mental and physical capacities of a person. The environmental characteristics are related to home, community and society as a whole. Healthy aging has been described as a lifelong process, optimizing opportunities for improving and preserving health, physical, social, mental wellness, independence, quality of life, and successful life-course transitions. It is emerging as a vital key concept, which according to the WHO (2022) Active Ageing Policy Framework implies a focus on the maintenance of health, often through lifestyle choices and preventive measures.

Active ageing follows closely from the concept of healthy ageing because only healthy persons both old and young can be active. To promote active ageing, health systems need to take a life course perspective that focuses on health promotion, disease prevention and equitable access to quality primary health care and long-term care. Active ageing is the process of optimizing opportunities for health, participation and security in order for people to attain a good quality

of life as they age (WHO, 2022). The ageing phenomenon is even more visible in growing cities where a large number of the human population is found. It therefore holds that addressing the issue of active and healthy ageing requires careful and focused emphasis on cities. WHO, in its bid to engage and assist cities to become more "age friendly", prepared the global age friendly cities checklist which consisted of eight domains of urban life: outdoor spaces and buildings, transportation, housing, social participation, respect and social inclusion, civic participation and employment, communication and information, community support and health services (Plouffe & Kalache, 2010).

**Model for Resilience in Late Adulthood**

Figure 2 shows that, resilience is a phenomenon seen at the individual, contextual, and larger socio-cultural levels. In later adulthood, it has been equated with successful or optimal aging. The present model is based on individual stress and coping processes, which are informed by resources and barriers at the community and sociocultural levels. However, this model is also informed by contributions from positive psychology including mindfulness, compassion, and self-transcendence. The model equally indicates that, psychosocial determinants, challenges and adversities as well as protective factors, influences healthy aging and thus leads to resilience development. Applying the model to healthy aging demonstrates that change and/or interventions are required at all levels. It is important to recognize the resilience in older adults contributes to resilience at the community and sociocultural levels. See figure 2.

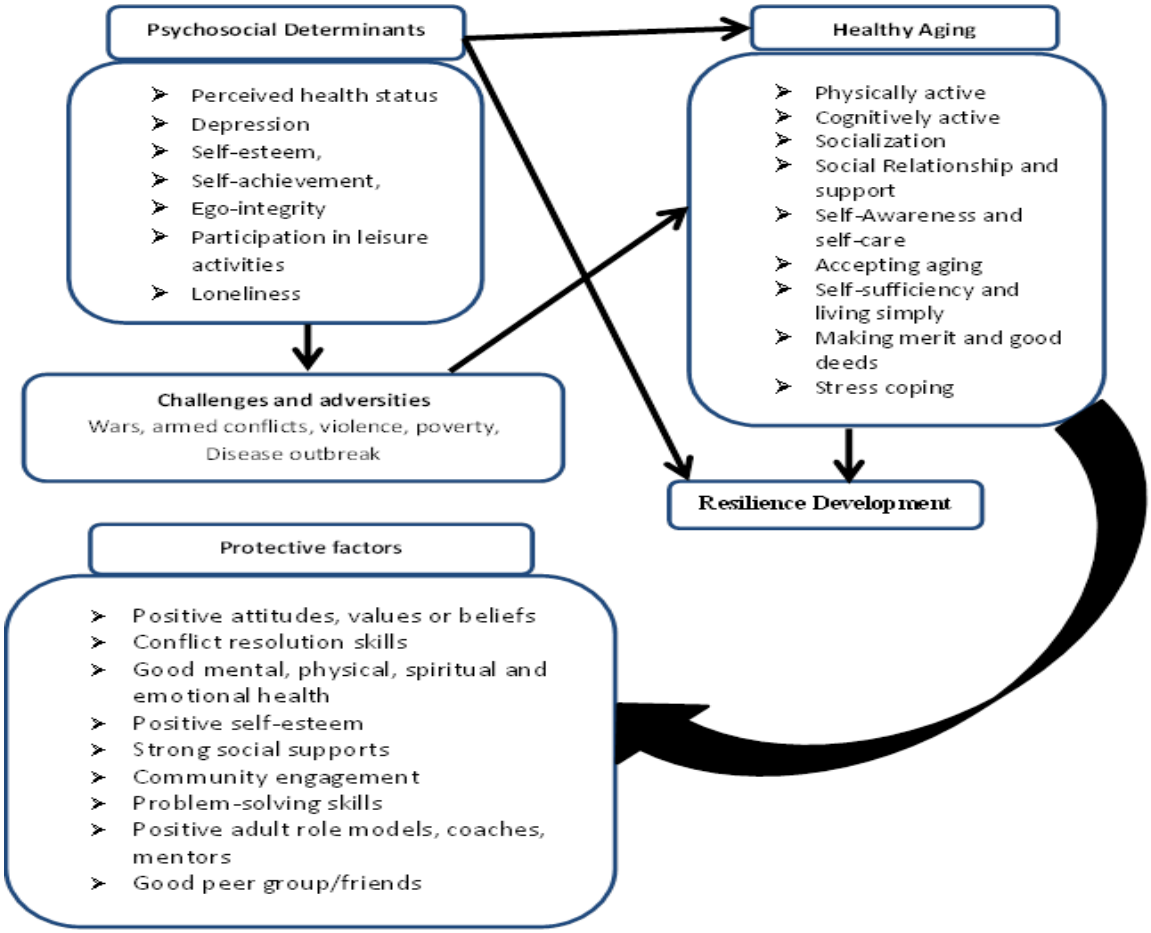


*Figure 2: Model for Resilience in Late Adulthood*

*Source: Asangha (2024) Adopted from the Study*

## Conclusion

Ageing is a very complex, multidimensional phenomenon. Different people from different cultures have their own understandings of what ageing entails. Their conceptions on ageing could either facilitate or impede successful and healthy ageing. On the other hand, ageing may be determined from the environment that people live in. Circumstances such as weather conditions, poverty or culture may impede healthy and successful ageing. The umbrella approach of dealing with challenges of ageing might not work in other societies. The word 'health' also has a multidimensional meaning. It is connected with a lack of sickness in the physical, economic, psychological, spiritual and emotional areas of life. Through spirituality, caregivers are able to determine challenges of the elderly and improve their well-being. We cannot aim at curing diseases and illnesses and leaving the psychological or spiritual being unattended. Theological, sociological and psychological insights are used to unveil the complexity of ageing and come up with solutions for the mitigation of health challenges encountered by older persons. This chapter argues that the necessary support should be coupled with training or orienting the elderly in coping and management strategies in the phase of challenges and adversities. This chapter sheds light on the key aspects that health care providers and academics should consider when implementing systematic reviews and programs to promote healthy aging. Moreover, it can also serve as a guide for the general public or those entering old age to prepare before they enter old age, and also as a driving force for policies to promote healthy aging appropriately.

## Implications of the Study for Ageing and Policy

The United Nations Sustainable Development Goals, specifically Goal 3, calls for the need to "ensure healthy lives and promote wellbeing for all at all ages". This goal can only be achieved through the setting and attainment of country specific targets. However, policy orientation to fill such gaps requires significant scientific research to unravel the patterns, determinants and challenges involved in designing appropriate policies for active and healthy ageing. This study therefore makes a contribution in this regard by highlighting the fact that, in the case of Cameroon, the health and wellbeing of its seniors greatly depends on the orientation of an ageing policy environment that provides gainful and age-friendly income generating opportunities, since older adults with no income were less likely to age actively when compared with adults with a monthly income flow.

Given that a significant number of older persons are not employed and, consequently, do not receive retirement benefits, policy focus should consider supporting the aged technically and financially, to engage in income generating activities. This should be championed by state actors, specifically, the Ministry of Small and Medium Sized Enterprises, Social Economy and Handicraft (MINPMEESA), in partnership with the city council. Seniors could also be empowered financially by improving their access to finance through Micro-Finance Institutions (MFIs).

Limited access to finance is a common barrier for older persons to start new enterprises due to discrimination which in part is because of their age and in a large part due to their lack of collateral assets. New policies or revision of existing policies should oblige MFIs to put programs into place that favor access to finance for older persons as part of their Corporate Social Responsibility (CSR). This will help older persons to integrate in the labor market through an income-generating activity either in the form of a start-up or through increased employability.

Targeted microcredit programs are needed to make microcredit more socially inclusive, as there are signs that microcredits in Cameroon do not adequately serve the needs of the elderly. The provision should be accompanied by proper guidance and follow up to ensure their effective investment in the business which the older person has indicated interest in. The focus group discussions revealed a strong connection between inadequate income flow and the increasing use of traditional medicine and self-medication which is very detrimental to the health of seniors. Government policies should focus on providing discounts for health bills of elderly persons, creating consultation days or hours dedicated to the elderly, create elderly waiting spaces in the hospitals, train geriatric nurses and doctors and integrate palliative care approaches into older patient care plans alongside active treatment.

This study concluded that a significant majority of older persons are less likely to age actively in the housing domain. They face challenges of modifying their homes to accommodate their changing needs as they grow older and, in addition, challenges of finding affordable houses that are age-friendly. It is therefore necessary for government and the city council to have policies directed towards increasing the supply of affordable, adaptive and accessible houses for the elderly and to modify existing accommodation for seniors to more age friendly living spaces. Building permits approved by the city council should consider age friendly housing. Policies to empower seniors should favour women more than men, because this study shows that women are less likely to age actively than their male counterparts.

Issues raised from focus group discussions that lead to the disadvantages position of ageing women and which could form a base for policy considerations include restriction of education of the female child, childbirth without adequate healthcare and support, caregiving responsibilities associated with mothering, grand mothering and looking after one's spouse and older parents that prevent or restrict working for an income and access to an employee based pension, widowhood which commonly leads to a loss of income and may lead to social isolation. Policies directed towards supporting female child education, healthcare and financial support associated with child bearing, financial support associated with care roles and policies that uphold the rights of widows could improve the quality of life of women as they age.

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