

Lived Experiences and Perceptions of Aging and Quality of Life Among Elderly People in the City of Buta (DRC): A Qualitative Study.

Masikini Ewale Faustin^{1*}, Bertine Mbongopasi Ekeni², Musenga Tshibangu John³, Emmanuel Kitete Mulongo⁴, Ngbolua Koto-Te- Nyiwa⁴, Jacques Lofandjola Masumbuko⁵, Mukandu Basua Leyka⁵

¹Higher Institute of Medical Technology of Buta, Buta, Democratic Republic of the Congo

²Higher Institute of Medical Technology of Bandundu, Bandundu, Democratic Republic of the Congo.

³Higher Institute of Medical Technology of Kananga, Kananga, Democratic Republic of the Congo

⁴Faculty of Science and Technology, University of Kinshasa, Kinshasa, Democratic Republic of the Congo

⁵Higher Institute of Medical Technology of Kinshasa, Kinshasa, Democratic Republic of the Congo

ABSTRACT

Background:

Population aging is a growing public health challenge in low-income settings such as the Democratic Republic of the Congo (DRC), where older adults face socioeconomic vulnerability and social marginalization. This study aimed to explore the experiences and perceptions of older adults regarding aging and quality of life in the city of Buta.

Methods:

A qualitative, descriptive-exploratory study with a phenomenological orientation was conducted from March to August 2025. Twenty older adults aged 60 to 87 years (12 women and 8 men), recruited from a nursing home (n = 6) and the community (n = 14) through purposive and snowball sampling, took part in face-to-face semi-structured interviews in Lingala. Interviews were recorded, transcribed, translated into French, and analyzed thematically using NVivo software.

Results:

Participants experienced aging with ambivalence: positively, as a source of wisdom and social status, but also as a period of chronic illness, sensory decline, and dependence for daily activities. The main factors influencing quality of life were economic precariousness (13 of 20 participants earned less than USD 30 per month) linked to the absence of pensions, costly and poorly adapted health services, and weakened family support. Socially, the migration of younger generations and the erosion of intergenerational solidarity led to isolation; psychologically, loneliness and a feeling of being useless were frequent; spiritually, Christian faith and community ties served as the main coping resources. Most participants rated their current quality of life as poor.

Conclusion:

Aging in Buta is shaped by the interplay of physical frailty, economic insecurity, eroding social support, and spiritual resilience.

Recommendation:

Local and national health authorities should integrate active-aging programs, free or subsidized age-appropriate care services, social protection for older adults, and community-based support initiatives into health policies to improve quality of life and reduce vulnerability.

Keywords: healthy aging; quality of life; older adults; experiential life; community health.

Submitted: September 19, 2026

Accepted: September 25, 2025

Published: September 30, 2026

Corresponding author: Masikini Ewale Faustin

Email: masikiniewale@gmail.com

Higher Institute of Medical Technology of Buta, Buta, Democratic Republic of the Congo

INTRODUCTION

Life expectancy is steadily increasing in developed countries and is approaching the maximum lifespan of the human species. As the population is aging more rapidly than in the past, all countries must address major challenges to prepare their social and health systems to make the most of this demographic shift. According to the World Health Organization, the number of people aged 60 and older will rise from 1 billion in 2020 to nearly 2.1 billion by 2050, with approximately 80% living in low- and middle-income countries (WHO, 2022). The United Nations (UN, 2023) states that this demographic transition in Sub-Saharan Africa is accompanied by new health, social, and economic challenges, particularly regarding dependency, poverty, and access to care.

The WHO (2015) defines healthy aging as the ability of older adults to maintain their functional, social, and psychological well-being despite age-related changes. However, in low-resource settings such as Buta, this concept remains largely theoretical.

In the city of Buta, aging occurs against a backdrop of socioeconomic vulnerability and structural deficiencies in the healthcare system. Despite the gradual increase in life expectancy, older adults continue to face limited access to care, social isolation, and a lack of specific care programs. These challenges undermine the possibility of healthy aging as defined by the WHO (2015).

According to the WHO, quality of life is defined as an individual's perception of their place in life (culture, values), in relation to their goals, expectations, and concerns. This multidimensional concept encompasses physical health, psychological well-being, level of independence, social relationships, and the environment (WHO, 2020).

This study is justified by the fact that it makes it possible to understand, based on the real-life experiences of older adults, the barriers that hinder their physical, social, and psychological well-being within the context of Buta. Such an analysis is essential to guide local decision-makers toward interventions tailored to the context and based on the needs expressed by older adults themselves (UN, 2023).

The WHO (2022) projects that the global proportion of people aged 60 and older will reach 2.1 billion by 2050. In the Democratic Republic of the Congo, older adults account for approximately 6% of the population, but this proportion is gradually increasing due to declining mortality rates and demographic changes (INS/DRC, 2021).

The rapidly changing city of Buta is characterized by a limited supply of specialized care for the elderly, increased reliance on family support, and low levels of social security coverage. Chronic diseases such as diabetes, hypertension, and degenerative conditions are becoming increasingly common, yet no adequate care system has been established (Kalambayi et al., 2020).

The DRC does not yet have an operational national policy on active aging; a few existing measures remain theoretical and are poorly implemented at the local level. In Buta, no specific municipal strategy addresses healthy aging, leaving families as the primary social safety net.

The overall objective of this study is to explore the experiences and understand the perceptions of older adults regarding aging and quality of life in the city of Buta.

The specific objectives of this study are to:

- Explore how older adults in the city of Buta experience aging,
- Identify the factors influencing their quality of life,
- Analyze the social, psychological, and spiritual dynamics of their well-being.

MATERIALS AND METHODS

Methodological Orientation and Theoretical Framework

The study adopted a qualitative, descriptive-exploratory design, conducted in the participants' natural setting, with triangulation of individual semi-structured interviews and field notes to explore the experiences and perceptions of older adults (OAs). Data were collected using a cross-sectional approach. The study applied the phenomenological method, which aims at a careful and systematic description of what older adults perceive regarding healthy aging and quality of life.

The approach is qualitative; that is, "a process or activity that allows an individual or a group of individuals to acquire precise knowledge about the cultural and social reality experienced daily" (McMillan & Schumacher, 1997). Accordingly, this is a qualitative study using thematic analysis as described by Braun and Clarke (2006).

This approach is justified by the fact that the study aims to explore how older adults in the city of Buta experience aging, to understand their perceptions of aging, and to identify the factors that influence their quality of life in a semi-urban context with limited infrastructure. Such a subject does not lend itself to simple quantification but requires an in-depth understanding of lived experiences, meanings, and emotions. By adopting an interpretive approach, the study acknowledges that social reality is not a neutral object but the product of living beings, which aligns with the principles of philosophical phenomenology and its focus on the understanding of "lifeworlds" (Lebenswelt).

The theoretical framework of the study is based on Engel's (1977) bio-psycho-social model and the WHO (2015) model of healthy aging. The bio-psycho-social model guided the exploration of the biological (physical health and functional autonomy), psychological (emotions, perceptions, and coping), and social (family, community, and economic resources) dimensions of aging. The WHO healthy aging model, which defines healthy aging as the process of

developing and maintaining the functional ability that enables well-being in older age, guided the analysis of participants' representations and perceptions of their aging and quality of life, as well as of the environmental factors that facilitate or hinder it. Both frameworks informed the interpretation of the themes.

Participant Selection and Sampling

The target population consisted of older adults aged 60 years or older residing in the city of Buta, either in the community or in a nursing home, during the period from March 18 to August 18, 2025. To be included, participants had to: (i) be 60 years of age or older; (ii) be a resident of the city of Buta; and (iii) have freely agreed to participate in the study after receiving full information.

A non-probabilistic, purposive sampling method was used. This method made it possible to select individuals who had directly experienced aging in the city of Buta. Participants were recruited partly at the nursing home (6 participants) and partly in the community (14 participants), depending on the availability and accessibility of the older adults. All residents of the nursing home participated in the study, while in the community, participants were recruited through purposive sampling combined with a supervised snowball technique.

The final sample comprised 20 participants. Thematic saturation was reached after the 15th participant, when several consecutive interviews yielded no new codes or analytical categories.

Study setting

This study was conducted in the city of Buta, the capital of Bas-Uélé Province, located in the northeast of the Democratic Republic of the Congo (DRC). According to available data, the population of Bas-Uélé Province was approximately 1.2 million in 2017, with an estimated 47% of the population living in rural areas.

Buta is a semi-urban setting characterized by a limited supply of specialized care for older adults, low social security coverage, and strong reliance on family support. No municipal strategy specifically addresses healthy aging. Data were collected in two types of settings: a nursing home located in the city and community households where older adults live with their families or alone.

Description of Study Participants

Twenty older adults participated in the study (Table 1). Twelve were women, and eight were men. Their ages ranged from 60 to 87 years (mean = 72.8 years; median = 72 years); seven were aged 60 to 69 years, nine were aged 70 to 79 years, and four were aged 80 years or older. Twelve participants were widowed, four were married, and four were single. Nine had a primary or elementary level of

education, eight had a secondary level, and three had a higher (superior) level. Thirteen participants reported an average monthly income below USD 30, five between USD 30 and 60, and two above USD 60. Twelve participants were not engaged in any income-generating activity, six were involved in small businesses or agriculture, and two were engaged in community-based care. Six participants lived in the nursing home, and 14 lived in the community.

Data Collection Methods and Procedures

Data were collected through face-to-face, semi-structured individual interviews, which allowed participants the freedom to express themselves openly while guiding the interview around key thematic areas. The interview guide was developed with suggested topics based on the study's objectives (perceptions of aging, physical health and autonomy, family and social support, access to health care, spirituality, and quality of life).

Interviews were conducted at the participants' places of residence to ensure confidentiality. They were conducted in pairs of interviewers, and a consent form was signed before each interview began. The interviews were conducted in Lingala, the language predominantly used by the population of the study area. Each interview lasted approximately 25 to 30 minutes and was audio-recorded using a smartphone. A field notebook was also used to record information that could not be captured by the audio recordings.

Data Management and Analysis

The audio recordings were first transcribed verbatim in the language of the interview (Lingala) and then translated into French, the working language of the research, prior to data analysis, while ensuring fidelity to the original meaning of the words. Audio files and transcripts were stored in a secure folder accessible only to the research team, and anonymous codes were used in all transcripts and analytical files. NVivo software was used to organize and code the field data.

The data were analyzed using thematic analysis (Braun & Clarke, 2006), which made it possible to identify recurring themes in the participants' experiences. The analysis was carried out in three stages. First, the recordings were listened to; next, they were transcribed faithfully; finally, coding was performed through a content analysis process in which meaning was assigned to each element of the transcript. Working from the verbatim transcripts, meanings, categories, and subthemes were derived and ultimately grouped into central themes. The analysis combined syntactic, thematic, and categorical reading of the data.

In the presentation of the results, each participant was denoted by the letter P followed by a number, in parentheses, to ensure anonymity while identifying the respondent. Thus, (P1) refers to the first participant, (P2) to the second, and so on.

Rigour and Trustworthiness

The trustworthiness of the study was addressed using the criteria of credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985). Credibility was reinforced through independent review of the transcripts and coding (Patton, 2015), verification of the translations by a second bilingual speaker to ensure the accuracy of the verbatim transcripts, and the achievement of thematic saturation. Dependability was supported by the use of the same semi-structured interview guide with all participants, the audio recording and verbatim transcription of all interviews, and the systematic coding of the data in NVivo, which provided a traceable record of analytical decisions. Confirmability was supported by reflective notes kept to minimize interpretive bias and by the presentation of participants' verbatim quotations, which ground the interpretations in the data. Transferability was facilitated by a detailed description of the study setting and of the participants' characteristics, allowing readers to judge the applicability of the findings to other contexts.

Ethical considerations

This study was conducted in accordance with the ethical principles of the Nuremberg Code and the Declaration of Helsinki, ensuring respect for the rights, safety, and dignity of the participants. To access the data and gain the trust of the resource persons, authorization was requested from their moral authorities, each head of household, or influential persons, and a favorable opinion was obtained from the Bioethics Committee of ISTM Kinshasa (No. 0034/CBE/ISTM/KIN/RDC/PMBBL/2023, dated November 23, 2023).

Informed consent was obtained from each participant prior to the interview, after the rationale for the study had been explained in the local language (Lingala or French), with the option to withdraw at any time, without any consequences, if they felt uncomfortable with the questions asked.

Confidentiality and anonymity were guaranteed: personal data will not be disclosed, and anonymous codes were used

for transcriptions and analyses. Audio recordings are stored in a secure folder accessible only to team members and will be destroyed after transcription or retained in accordance with current standards and the confidentiality protocol.

Protection of vulnerable individuals: given the advanced age of the participants, precautions were taken to respect their dignity, comfort, free consent, and freedom of expression. In the event of fatigue, the interview could be interrupted, with the option to resume or reschedule. Participants were informed that they could withdraw from the study at any time, without giving a reason, and that their data would be destroyed upon request.

Reflexivity

The research team is composed of health sciences researchers and academics affiliated with higher institutes of medical technology and a university in the DRC, including a principal investigator based in Buta. This professional background and familiarity with the local context facilitated access to participants and understanding of their language and culture, but may also have shaped the questions asked, the way participants responded (for example, through social desirability), and the interpretation of the data. To limit this influence, reflective notes were kept throughout data collection and analysis to document the researchers' assumptions and interpretive choices; interviews were conducted in the participants' own language and places of residence; the coding was independently reviewed; and interpretations were continually checked against the participants' verbatim accounts.

RESULTS

The following results are derived from the semi-structured interviews. The sociodemographic characteristics of the participants are presented in Table 1, and the thematic findings are presented in Tables 2 to 5, which include subthemes, categories, and significant verbatim quotes, followed by analytical comments.

Table 1: Sociodemographic Characteristics of Participants

Participant	Gender	Age	Marital status	Education level	Average monthly income (USD)	Current occupation	Place of residence
P01	M	60	Single	Primary	< \$30	Not working	Living with family
P02	F	76	Married	Elementary	> \$60	Small businesses/agriculture	In a community (family)
P03	F	81	Widow	Superior	\$30–\$60	Not working	Living with family
P04	F	73	Single	Secondary	< \$30	Community-based care	In a community (family)
P05	F	65	Married	Elementary	< \$30	Not working	Homestay
P06	M	71	Widow	Superior	< \$30	Not working	Living with family
P07	F	67	Widow	Secondary	< \$30	Not working	Living with family
P08	F	75	Widow	Elementary	\$30–\$60	Not working	Shelter
P09	M	68	Widow	Secondary	< \$30	Small businesses/agriculture	Living with family
P10	F	70	Widow	Secondary	< \$30	Not working	Shelter
P11	M	85	Single	Elementary	< \$30	No activity	—
P12	F	72	Married	Secondary	> \$60	Not working	Living with family
P13	F	77	Widow	Primary	< \$30	Small businesses/agriculture	Shelter
P14	F	64	Widow	Superior	\$30–\$60	Not working	Living with family
P15	M	78	Married	Secondary	< \$30	Not working	Living with family
P16	M	83	Widow	Primary	< \$30	Small businesses/agriculture	Living with family
P17	F	69	Single	Elementary	\$30–\$60	Community-based care	In a community (family)
P18	M	87	Widow	Secondary	\$30–\$60	Small businesses/agriculture	Shelter
P19	F	72	Widow	Elementary	< \$30	Not working	Living with family
P20	M	63	Widow	Secondary	< \$30	Small businesses/agriculture	Living with family

Note. M = male; F = female; USD = United States dollars; P = participant. Education levels are reported as stated by participants. — = not reported.

Table 1 illustrates the sociodemographic characteristics of participants, suggesting that the majority of the participants are female, consisting mainly of widows aged 70 to 79, many of whom have a primary school education, live on a monthly income of less than \$30, and are largely unemployed. This pattern reflects the feminization of aging observed in several African contexts, where older women face both economic insecurity and domestic burdens (Nsapu & Ilunga, 2023; WHO, 2021). The high proportion of widows exacerbates social dependence, confirming Sagna's (2020) findings on the gendered vulnerability of aging in sub-Saharan Africa.

As shown in Table 2, the results show that older adults in the city of Buta have a positive perception of aging based on their favorable view of the aging process (P11, P2, P20, P16, P18); the majority of them have at least one physical health issue (P3, P5, P6, P1, P10, P11, P9, P2); most of them are unable to perform their daily activities without the support of a third party (P1, P14); many of the strategies used by the respondents to maintain their health are considered good, although they are rarely implemented (P5, P14, P6, P12, P18, P1).

Table 2: Individual Perceptions of Aging and Well-Being

Subthemes	Categories	Verbatim
Perceptions of aging, perceived well-being.	Individual Perception of Aging	Aging means growing older, a sign of experience and wisdom (P11); living with my grandsons, everyone calls me the elder (P2); I still feel useful; I do a little farming and give my children advice (P20); Aging is normal; God intended it this way. I keep going out to the fields; it's my therapy (P16); Aging means accepting change and thanking God for every day (P18). It's a nightmare; the body doesn't obey like it used to (P1); death is scary (P9); you become dependent on young people for everything, even to go to the market—a humiliating stage of life I've always refused... (P10); If you're healthy, you can age well without suffering (P18); it's infantilization... (P7); Aging here means being isolated; no one comes to see you... (P13);
Physical health status and independence	Major health challenges encountered	I keep working and being productive even though my strength is waning (P5); I rarely get sick (P14); too much pain (P8); difficulty walking (P3); my vision is getting worse (P5); I am troubled by diabetes and high blood pressure (P6); malaria and typhoid fever bother me (P1); rheumatism and constant dizziness (P10); breathing difficulties and lack of appetite (P11); I forget things too often; sometimes I am afraid of death... (P9); I no longer sleep well at night; I think too much (P2).
	How daily activities are carried out	I do them on my own, without assistance (P1); I carry out most of my activities by myself, except for a few (P4). I can't see; I need someone to walk with me (P15); I have trouble seeing and hearing clearly, which makes me dependent on others for getting around (P7); I can't bathe properly on my own (P19).
	Strategies used to stay healthy	When I'm sick, I go to the hospital (P5); my children make sure I eat well (P14); I rarely eat red meat and I don't drink alcohol (P6); I'm in the habit of taking my concoctions (garlic + a small piece of cola nut + ginger + lemon juice + drinking water); this helps me avoid getting sick (P12); going to the fields regularly... (P18); fishing regularly... (P1). Since I have no means, I pray to God only to protect my health... (P10); only God knows... (P17); I let myself be too influenced by the advice of my neighbors and friends... (P19); eating maboque with plantains regularly... (P3)

Note. Verbatim quotes were translated from Lingala. P = participant (P1–P20).

As presented in Table 3, the results highlight a relational imbalance between the respondents and their families (P11, P15, P10, P12, P16, P18, P20); respondents experience a breakdown in community participation and intergenerational solidarity, thus experiencing true social isolation (P17, P7, P13, P9).

Table 3: Perception of Family and Social Support

Subthemes	Categories	Verbatim
Perception of relational dynamics and the support network	Family relationships	My family and society value me; they consult me whenever there's a major problem (P11); my family members even call me from afar to ask for my advice when facing major issues (P15); We get together on Sundays to talk, and that makes me happy (P10); Family gatherings put a smile back on my face (P12); I feel at peace when my children respect me (P16); I live with my granddaughter; she gives me courage (P18); I still enjoy helping other elderly people; it's my way of giving back (P20). Since my husband died, I've been living alone; I'm no longer treated the way I used to be (P13); many would rather I were gone (P2); family members don't come to visit me where I live (P9); when I was strong, I was consulted on major decisions, but today, nothing at all (P5); My children help me eat and get dressed (P1); Neighbors sometimes bring me food; it touches me (P4); I babysit my grandchildren when their parents go to work (P14); Family forgets you quickly when you get old (P6); I have many children who live far away and don't even look for me? (P7); When I get sick, it's my neighbor who takes care of me... (P8).
	Community participation, intergenerational solidarity, and Social isolation	I regularly go to church and morning services (P17); I'm a member of several local socio-cultural associations (P7); many people come to me for advice on their problems (P13); young people also approach me often to discuss various aspects of life (P9). My housing difficulties prevent me from going to church or even visiting my family members (P6); I am not active in associations because their members do not come to visit me at home (P19); I am left to my sad fate (P9); The way young people look at us sometimes hurts; they think we're no longer of any use (P4); Senior citizens' associations should exist here too (P11); Young people lack respect for the elderly (P18); Loneliness weighs heavier than illness (P16); The lack of support makes old age hard." (P3)

Note. Verbatim quotes were translated from Lingala. P = participant (P1–P20).

The field findings (Table 4) confirm that the respondents very rarely use public health services and have a negative perception of their care (P6, P7, P9, P5, P1, P4, P8, P17, P10, P13, P14, P15, P16, P3; P18, P20, P2, P19); many of the older adults surveyed stated that they are deeply committed to their Christian faith (P19, P10, P1, P7, P15, P18, P2, P8).

Table 4: Experience With Health Care and Spiritual Support

Subthemes	Categories	Verbatim
Access to healthcare	Use of health services and perceptions of care	Since I've been here, when I get sick, the priests' CSR provides us with free care, although we're often seen last, after a long wait (P4); when I'm sick, my child always takes me to the hospital for proper care (P5). We can't get to the hospital because we don't have the means (P6); the hospital is too expensive and the care isn't good quality (P7); I rely on my nutritional remedies, which help me better protect myself against illness (P9); my grandson treats me at home (P5); my neighbor treats me using traditional methods (P2); At the hospital, the tests use up the little money we bring, and then we have no money left to buy medicine (P1); I prefer herbal ; it's less expensive (P3); Healthcare providers don't listen to us enough (P4); Sometimes I don't go to the hospital, I just pray; when I go to the clinic, they make me wait too long (P8); Free healthcare for the elderly doesn't exist here (P17); The nurses in our neighborhood are kind (P10); Young people are treated before us (P13); Community care should include us more (P14); I go to the clinic when the pain becomes unbearable (P15); I'd like people to speak to us kindly, not like we're little children (P16); Healthcare workers lack patience with us (P3); We feel rejected in healthcare facilities (P18); If care were accessible and free, I would go often; the hardest part is the lack of care when we get sick (P20); We don't always eat well, which makes us weak; without medicine, old age becomes a suffering (P19).
Spiritual beliefs	Faith or religion in daily life	My hope is in God (P19); Jesus Christ is my only savior (P10); God is my redeemer (P1); all my hope is in Christ (P7); I live in communion with my God, even if I don't go to church (P15); Old age is a time of peace and prayer (P18); I hold onto my faith; that is what gives me the strength to live (P2); The Church is my second home; I feel surrounded there (P8). I don't believe in the afterlife (P12); I believe in my courage and my children (P20);

Note. Verbatim quotes were translated from Lingala. P = participant (P1–P20); CSR = Centre de Santé de Référence (reference health centre).

As shown in Table 5, the study shows that the majority of the respondents rate their current quality of life poorly (P5, P18, P3, P16, P4, P1), and most would like to see changes in their immediate environment to improve their quality of life (P9, P3, P20, P10, P15, P19, P4, P18, P16, P7).

Table 5: Perceptions of Improved Health and Quality of Life

Subthemes	Categories	Verbatim
Proposals for social and environmental services/support to improve	Quality of life assessment	I'm still doing well while waiting for my pension (P10); God is still looking out for us, with the hope of living longer (P13); life is still bearable; it's just a matter of having support (P8); I'm alive, but I still need a lot to live decently... (P15).
		At this stage, life is pointless; it's better to die (P5); life without money has no meaning... (P18); my health has become too fragile; I no longer need to keep living... (P3); when my wife was still alive, she took good care of me, but since her death everything has become complicated (P16); it would have been better if I had died before my husband (P4); it's my eyes that are causing me trouble; right now I don't have anyone who can take care of my basic needs (P1);
	Desired changes in one's environment for a better life	I want to remarry... (P9); as soon as I have my own plot of land, I'll take charge of my responsibilities as an adult (P3); that I be provided with the means to finish the work on my farm 8 km from the city here (P20); that when I'm sick, I'm treated well and that I eat well (P10); I need a bicycle, a machete, my own plot of land, and a small startup fund (P15); once I have my fishing gear, I'll be very comfortable working and producing (P19); go to the village regularly to see my family and relive our childhood memories (P4); eating well (often mbika maboke with bananas), accompanied by a little kongolo, makes me feel good (P18); I need to raise livestock and build small houses here to house tenants (P16); I need a decent house built for me to live in (P7).

Note. Verbatim quotes were translated from Lingala. P = participant (P1–P20).

DISCUSSION

This qualitative study provided insight into the experiences and perceptions of older adults living in the City of Buta regarding their aging and quality of life. The main findings are discussed below: (1) older adults have a positive view of aging; the majority of them have at least one physical health issue; most of them cannot perform their daily activities without assistance; the strategies they use to stay healthy are effective; (2) the respondents experience a relational imbalance between themselves and their families; they face a breakdown in community participation and intergenerational solidarity, and thus experience genuine social isolation; (3) Respondents very rarely use available health services, and those who do perceive their care negatively; many respondents state that they are deeply committed to their Christian faith; (4) Respondents rated their current quality of life poorly; and most wish to change their environment to improve their quality of life.

Individual Perceptions of Aging and Well-Being

The findings on this theme are summarized as follows:

- Study participants have a positive view of their aging: My family and society value me; they consult me whenever there is a major problem; my family members even call me from afar to seek my advice when facing major issues; we get together on Sundays to talk, which makes me happy; family gatherings bring a smile back to my face; I feel at

peace when my children respect me; I live with my granddaughter; she gives me courage; I still enjoy helping other elderly people; that's my way of giving;

- Most of them have at least one physical health issue: I keep working and being productive even though my strength is waning; I rarely get sick; too much pain; difficulty walking; my vision is getting worse; I'm troubled by diabetes and high blood pressure; malaria and typhoid fever bother me; rheumatism and constant dizziness; breathing difficulties and lack of appetite; I forget things too often; sometimes I'm afraid of death...I no longer sleep well at night; I think too much.

- Most of them cannot carry out their daily activities without assistance: My eyesight is failing; I need someone to accompany me when I walk; I have trouble seeing clearly and hearing well, which makes me dependent on others for mobility; I cannot bathe properly on my own.

- The strategies used to stay healthy are good: When I'm sick, I go to the hospital; my children make sure I eat well; I rarely eat red meat, and I don't drink alcohol; I'm in the habit of taking my concoctions (garlic + a small cola nut + ginger + lemon juice + drinking water), which helps me avoid getting sick; I go to the fields regularly...I go fishing regularly...

The findings here corroborate those from research conducted in certain African countries, where aging is

viewed positively on a symbolic level but as difficult on a material level (Sagna, 2020; Hounghbedji et al., 2019).

The same holds true for the results of research conducted in Senegal (Sagna, 2020) and Benin (Hounghbedji et al., 2019), where aging is perceived as a natural stage of life but is often marked by economic marginalization.

Unlike in Western contexts, where public policies provide greater support for older adults, the DRC suffers from a lack of social and health infrastructure, as confirmed by Kandolo et al. (2022). This absence severely limits the ability to implement the “active aging” framework advocated by the WHO (2015).

The finding of this study is that aging in Buta is experienced with ambivalence between physical decline and spiritual fulfillment: physical health and autonomy are fragile; most older adults report at least one health issue but seek to maintain their autonomy through healthy strategies and practices, which are unfortunately not significant.

Furthermore, the observations of this study indicate that although the respondents have a good understanding of the strategies needed to maintain good physical health, their lack of substantial resources and limited support from their immediate circle lead to instability in their physical health and a loss of autonomy—a situation that often causes them to resent aging.

Perception of Family and Social Support

The field findings of this study indicate that the respondents have a negative perception of the support they receive from their families and society:

- They experience a relational imbalance between themselves and their families: Since my husband died, I've been living alone; I'm no longer valued as I once was; many would prefer I were gone; family members don't come to visit me where I live; when I was strong, they consulted me on major decisions, but today, nothing at all; my children help me eat and get dressed; neighbors sometimes bring me food; it touches me. I look after my grandchildren when their parents go to work. The family quickly forgets you when you get old. I have many children who are far away and don't even look for me. When I get sick, it's the neighbor who takes care of me...
- They experience a breakdown in community participation and intergenerational solidarity, thus facing true social isolation: My mobility issues prevent me from going to church or even visiting my family members; I'm not active in community groups because their members don't come to visit me at home—I'm left to my own sad fate. The way young people look at us sometimes hurts; they think we're no longer of any use. Senior citizens'

associations should exist here too. Young people lack respect for the elderly. Loneliness weighs heavier than illness. The lack of support makes old age hard.”

Social isolation is often associated with increased emotional vulnerability (Antonucci et al., 2020). The results of the study conducted by Berkman et al. confirm the importance of psychosocial capital as a major determinant of quality of life for older adults (Berkman & Glass, 2000).

Psychologically, spirituality plays a central role but does not fully offset the effects of loneliness, confirming the observations of Pargament et al. (2011). However, the strength of community ties remains partially eroded, which reduces the protective scope of social capital described by Putnam (2000)

In rural areas of Cameroon, Mali, and Burkina Faso, studies have shown patterns similar to the findings of this study: symbolic valuing of the elderly, increased economic dependence, and the centrality of spirituality as a coping resource (Togola et al., 2021).

Compared to East Asia, where models of family solidarity remain more stable, the Congolese context shows a weakening of intergenerational solidarity, particularly in urban areas. These findings are nevertheless consistent with Baltes & Baltes' (1990) universal typology regarding selectivity and resource optimization in aging.

Theories indicate that older adults with a strong family network and community support often have stable morale and a positive outlook on aging; however, the absence of these important psychosocial supports in most families in the city of Buta appears to cause the respondents to feel hopeless about successfully navigating their old age.

Experience With Health Care and Spiritual Support

- Respondents very rarely use health services and have a negative perception of their care: We can't afford to go to the hospital; it's too expensive, and the care isn't good. I rely on my own dietary remedies to help protect myself against illness. My grandson takes care of me at home, and my neighbor treats me with traditional medicine. At the hospital, tests use up the little money we bring, and then we have no money left to buy medicine; I prefer medicinal plants—they're less expensive; healthcare workers don't listen to us enough; sometimes I don't go to the hospital—I just pray; when I go to the clinic, they make me wait too long; Free healthcare for the elderly doesn't exist here. The nurses in our neighborhood are kind. Young people are treated before us. Community healthcare should include us more. I go to the clinic when the pain becomes unbearable. I'd like them to speak to us kindly, not like we're little children. Healthcare workers lack patience with us. We feel rejected in healthcare facilities. If care were accessible and free, I'd

go often; the hardest part is the lack of care when we get sick. We don't always eat well, which makes us weak; without medicine, old age becomes a struggle.

- Most of them say they are deeply committed to their Christian faith: My hope is in God; Jesus Christ is my only savior; God is my redeemer; all my hope is in Christ; I live in communion with my God, even if I don't go to church; old age is a time of peace and prayer; I hold onto my faith—it is what gives me the strength to live; the Church is my second home; I feel supported there.

Often, psychological well-being is influenced by loneliness and faith: spirituality acts as a mechanism for emotional resilience.

Barriers to accessing care are multifactorial: high cost, distance, perceived lack of respect, and communication barriers. These factors align with the WHO's (2022) findings on the fragility of the healthcare system in Central Africa. Cross-analysis shows that people with family support seek medical care more often, while those who are isolated or poor often turn to traditional healing. This phenomenon illustrates the dual health and social exclusion described by Christine Cohen et al. (2017) among African older adults.

A critical reading of the data reveals that, even though older adults value autonomy, their ability to act remains limited by insufficient access to care, the absence of institutional care systems, and the limited availability of material resources.

It appears that the precarious financial situation of the respondents creates a financial barrier preventing them from accessing available health services; furthermore, ignorance coupled with negative attitudes among healthcare providers toward older adults in the course of their work likely underlies the respondents' negative perceptions of the established health services.

Perceptions of Improved Health and Quality of Life

- Respondents rated their current quality of life poorly: "Life is pointless at this stage; it would be better to die. Life without money has no meaning... My health has become too fragile, I no longer need to keep living "When my wife was still alive, she took good care of me, but since her death everything has become complicated; it would have been better if I had died before my husband"; "It's my eyes that are causing me problems; right now I don't have anyone who can take care of my basic needs";

- Most want a change in their environment to live better: I want to remarry...; as soon as I have my own plot of land, I'll take charge of my responsibilities as an adult; I need the means to finish work on my farm 8 km from the city here; when I'm sick, I need to be treated well and eat well; I need a bicycle, a machete, my own plot of land, and a small

startup fund; once I have my fishing gear, I'll be very comfortable working and producing, going regularly to the village to see my family and relive our childhood memories, eating well (often mbika maboke with bananas), accompanied by a little kongolo—that does me good; I need to raise livestock and build small houses here to rent out, and I need a decent house built for me to live in;

Since quality of life is heavily dependent on social support—intergenerational relationships, community respect, and so on—these are essential determinants of well-being.

Finally, economic insecurity appears as a cross-cutting determinant: it shapes access to care, influences perceptions of old age, and limits older adults' ability to integrate socially.

The qualitative analysis suggests that economic insecurity is a cross-cutting determinant influencing the well-being of older adults.

Furthermore, the theory of active aging proposed by the WHO (2015) highlights the importance of community participation and the maintenance of functional abilities. However, in Buta, these two components remain fragile due to a lack of adapted infrastructure and institutional disengagement.

From the perspective of this study, the total absence of a state policy to support older adults; limited family and community support for older adults; and the poverty of these older adults appear to be the root causes of the deterioration in the quality of life of the respondents, as demonstrated by the changes they expressed a desire to see in their living conditions.

Generalizability of the findings

As a qualitative study, this research did not seek statistical generalization but an in-depth, context-bound understanding of the lived experience of aging. The external validity of the findings should therefore be considered primarily in terms of transferability, that is, the extent to which the findings can be applied to other settings with similar characteristics (Lincoln & Guba, 1985).

Several features of the study limit the generalizability of the findings. The sample was small (20 participants), purposively selected, and drawn from a single semi-urban city; six participants came from a single nursing home, and community participants were partly recruited through snowball sampling, which may have favored older adults already embedded in social networks. The sample was also dominated by women, widowed persons, and people with very low incomes. Consequently, the findings cannot be extrapolated to all older adults in the DRC, particularly those living in large cities such as Kinshasa, where family structures, income sources, and access to

health services differ, or those living in remote rural villages.

Nevertheless, several findings are likely to be transferable to comparable settings. The absence of pensions and social protection, the financial barriers to care, the perceived negative attitudes of health workers, the weakening of intergenerational solidarity, and the role of spirituality as a coping resource are consistent with observations reported in other parts of the DRC (Kalambayi et al., 2020; Kandolo et al., 2022) and in other sub-Saharan African countries such as Senegal, Benin, and Mali (Sagna, 2020; Hounghbedji et al., 2019; Togola et al., 2021). This convergence suggests that the mechanisms identified in this study, in particular economic insecurity as a cross-cutting determinant and the interplay of physical, psychological, social, and spiritual dimensions described by the bio-psycho-social model (Engel, 1977), may apply to other low-resource, semi-urban settings in Central Africa characterized by weak social protection systems and strong family and religious traditions.

The detailed description of the study setting, of the participants (Table 1), and of their verbatim accounts (Tables 2 to 5) is intended to help readers and decision-makers judge the applicability of these findings to their own contexts. Mixed-methods or quantitative studies with larger, probability-based samples covering several provinces are needed to determine the extent to which these findings can be generalized to the wider population of older adults in the DRC.

CONCLUSION

The study aimed to explore how older adults in the city of Buta experience aging, to identify the factors influencing their quality of life, and to analyze the social, psychological, and spiritual dynamics that contribute to their well-being.

The results show that aging is experienced amid a tension between physical frailty, the pursuit of autonomy, economic precariousness, and spiritual grounding. This complexity confirms the role of Engel's (1977) bio-psycho-social model in the analysis of aging in Central Africa. Regarding the forms of support received by older adults, the study reveals that intergenerational support remains central but is gradually weakening due to the socioeconomic transformations observed in the DRC, which aligns with the conclusions of Kandolo et al. (2022).

Finally, three aging profiles were identified in this study: the spiritually resilient, the silent dependents, and community actors, thereby confirming the work of Baltes and Baltes (1990) on adaptive selectivity.

Strengths and Limitations of the Study

Strengths

An in-depth qualitative approach that captures the cultural complexity of aging.

Triangulation of sources (interviews, observations, community perceptions), strengthening internal validity.

Highlighting a phenomenon that is poorly documented in the DRC, contributing to national and regional literature.

Identification of typological profiles (spiritually resilient, silent dependents, community actors) enabling a better understanding of individual trajectories.

Limitations

Social desirability bias: some older adults may have exaggerated their autonomy to preserve their social image.

Limited representativeness: the sample does not reflect the full range of realities in the city of Buta

Partial transferability: the results remain contextualized within a specific area strongly marked by sociocultural specificities.

Lack of quantitative data prevents statistical generalization of correlations between health, income, and social support.

RECOMMENDATIONS

In light of these findings, the following recommendations are made:

To the national government and the Ministries of Public Health and Social Affairs: adopt and implement an operational national policy on active and healthy aging, and extend social protection mechanisms (pensions and social allowances) to older adults, including those who worked in the informal sector.

To the Provincial Health Division of Bas-Uélé and health zone managers: integrate age-appropriate services into health facilities, including free or subsidized care for older adults, priority reception, and screening and follow-up of chronic diseases and visual and hearing impairments, in line with the WHO Integrated Care for Older People (ICOPE) approach; and train health workers in respectful communication and person-centered care for older adults.

To the municipal authorities of Buta: develop a local healthy-aging strategy that supports the creation of senior citizens' associations, intergenerational activities, and small income-generating projects (agriculture, fishing, livestock, and petty trade) adapted to the capacities of older adults.

To religious and community organizations: build on the central role of churches and community networks to organize home visits, psychosocial support, and assistance for isolated older adults.

To families: maintain intergenerational solidarity by involving older adults in family decisions, visiting them regularly, and supporting their basic needs and access to care.

To researchers: conduct mixed-methods and intervention studies with larger samples in other provinces of the DRC to measure the quality of life of older adults and evaluate the effectiveness of active-aging programs.

LIST OF ABBREVIATIONS

CBE	Comité de Bioéthique (Bioethics Committee)
CSR	Centre de Santé de Référence (reference health centre)
DRC	Democratic Republic of the Congo
F	Female
ICOPE	Integrated Care for Older People
INS	Institut National de la Statistique (National Institute of Statistics)
ISTM	Institut Supérieur des Techniques Médicales (Higher Institute of Medical Technology)
M	Male
OAs	Older adults
P	Participant (followed by the participant's number, e.g., P1)
RDC	République Démocratique du Congo (Democratic Republic of the Congo)
UN	United Nations
USD	United States dollar
WHO	World Health Organization

Conflict of Interest

The authors declare that they have no conflicts of interest of any kind.

Data availability

Data supporting the findings of this study are available from the corresponding author upon reasonable request.

Acknowledgments

The authors express their gratitude to the elderly residents of the city of Buta who agreed in good faith to contribute to the completion of this research. Their gratitude also goes to all relevant authorities for facilitating this study in the city of Buta.

Author contributions

M.E.F: Conceptualization, formal analysis, project management, writing—original draft; **B.M.E:** Data curation, writing—review and editing; **M.T.J:** Data curation and editing; **KME:** Writing—review & editing; **NKN:** Methodology, Data curation, supervision, writing-review and editing; **JLM:** Methodology, supervision, writing-review, and editing; **MBL:** Methodology, data curation and analysis, supervision, and writing-review & editing,

Funding statement

No funding was received for this study.

Clinical trial number

Not applicable

Ethical approval

This research has been conducted in accordance with the ethical principles of the Nuremberg Code and the Declaration of Helsinki as endorsed by the Bioethics Committee of ISTM KINSHASA number No. 0034/CBE/ISTM/KIN/RDC/PMBBL/2023 dated November 23, 2023.

Consent to participate

Written informed consent was obtained from all participants.

Consent to publication

Not applicable

REFERENCES

1. Heather R Fuller, Kristine J, Ajrouch, Toni C. Antonucci (2020): The Caregiver Model and Family Relationships in Later Life, 12 (2): 126-146. <https://doi.org/10.1111/jftr.12376>
2. Baltes, P. B., & Baltes, M. M. (1990). Successful aging: Perspectives from the behavioral sciences. Cambridge University Press. <https://doi.org/10.1017/CBO9780511665684>
3. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77-101. <https://doi.org/10.1191/1478088706qp063oa>
4. Christine Cohen et al. Open Nursing Journal (2017). Acceptability among community health nurses of smart wireless sensor systems for the rapid detection of health problems in older adults living at home. <https://doi.org/10.2174/1874434601711010054>
5. Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. Science, 196(4286), 129-136. <https://doi.org/10.1126/science.847460>
6. CA Hounbedji, A. Galli, J. Utzinger, B. Bonfoh, 2019 Nutritional profiles of households in the Taabo Demographic and Health Surveillance System, in south-central Côte d'Ivoire: A pilot study
7. INS/DRC (2021) Report on living conditions and the elderly population in the DRC. Kinshasa: National Institute of Statistics

8. Kalambayi, T., et al. (2020) Social perceptions of aging and the well-being of older adults in Kinshasa. *African Journal of Gerontology*, 5(1), 23-39
9. Kandolo, J., Tshibanda, M., & Lumbala, P. (2022). Aging and quality of life in the Democratic Republic of the Congo. *African Journal of Public Health*, 14(2), 45-59
10. Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage Publications. [https://doi.org/10.1016/0147-1767\(85\)90062-8](https://doi.org/10.1016/0147-1767(85)90062-8)
11. McMillan, J.H. and Schumacher, S.S. (1997) *Research in Education: A Conceptual Introduction*. Longman, New York.
12. Nsapu, A., & Ilunga, K. (2023) *Community Initiatives in the DRC*
13. Nsapu, G., & Ilunga, D. (2023) *Community Health and Older Adults in the DRC: Challenges and Prospects*. *Tropical Medicine and Society*, 9(1), 23-34
14. WHO (2015) *World Report on Ageing and Health*. Geneva: World Health Organization
15. UN (2023) *World Population Prospects 2023*. New York: United Nations
16. World Health Organization (2022) *Ageing and Health: Global Data and Perspectives*. WHO
17. WHO (2020) University of Geneva, Institute of Environmental Sciences: *The Concept of Quality of Life, the New Definition*
18. Michael Quinn Patton (2015) *Qualitative Research and Evaluation Methods. A comprehensive book on theoretical and methodological approaches in qualitative methodology*
19. Pargament, K. I., et al. (2011) *Spiritually Integrated Psychotherapy*
20. Pargament, K. I., et al. (2011) *The Psychology of Religion and Coping: Theory, Research, Practice*. Guilford Press
21. Putnam, R. D. (2000). *Bowling Alone: The Collapse and Revival of American Community*. Simon & Schuster <https://doi.org/10.1145/358916.361990>
22. Sagna, M. L. (2020). *Aging in Africa: Health Issues, Solidarity, and Spirituality*. Presses
23. Togola, A., et al. (2021). *Chronic pain and traditional care in Mali*
24. WHO. (2021) **World Report on Ageing and Health**
25. World Health Organization (WHO). (2022). *Integrated care for older people (ICOPE): Guidance for community-level interventions*. WHO.

PUBLISHER DETAILS:

Student's Journal of Health Research (SJHR)
(ISSN 2709-9997) Online
(ISSN 3006-1059) Print
Category: Non-Governmental & Non-profit Organization
Email: studentsjournal2020@gmail.com
WhatsApp: +256 775 434 261
Location: Scholar's Summit Nakigalala, P. O. Box 701432, Entebbe Uganda, East Africa

