

REPORT

NEEDS & CHALLENGES OF OLDER PEOPLE

JUNE 2019

RESEARCHED BY

NATIONAL INSTITUTE OF SOCIAL AFFAIRS

HelpAge Cambodia

age helps

SUPPORTED BY

VOICE

Contents

Table iv

Figure iv

SUMMARY v

CHAPTER ONE: INTRODUCTION 1

1.1 Introduction 1

1.2 Problem Statement 2

1.3 Research Objectives 3

1.4 Research Methodology 3

CHAPTER TWO: OVERVIEW OF AGEING POPULATION 8

2.1 Elder global population and trend 8

2.2 Common elder needs and challenges 8

2.3 Elder-responsive programs 8

2.4 Cambodia's ageing population 8

CHAPTER THREE: STUDY RESULTS 11

3.1 Respondents' characteristics 11

3.2 General Functions 12

3.3 Katz Index of ADL and IADL 13

3.4 Vision and hearing of the elderly 16

3.5 Nutrition 17

3.6 Cognitive impairment 19

3.7 The Elderly Depression 20

3.8 The Elderly Abuse 21

3.9 Health care of the elderly 23

3.10 Economic support for the elderly 26

3.11 Social Supports 27

CHAPTER FOUR: RESULT DISCUSSIONS 29

4.1 Continuous trend of older population 29

4.2 Correlational analysis 29

4.3 Physical wellbeing 31

4.4 Mental wellbeing 34

4.5 Key health care challenges of the elderly 37

4.6 Economic wellbeing 38
4.7 Family arrangement 40
4.8 Community support 41
4.9 Policy interaction and gaps 42
CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS 44
5.1 Conclusion 44
5.2 Recommendations 44
Reference 49
Appendix A 51
Appendix B 58

Table

Table 1: List of selected OPAs 4
Table 2: Respondents' Characteristics 11
Table 2: General physical difficulties of the elderly 12
Table 3: ADL and IADL among the elderly 13
Table 4: ADL and IADL function assessment 14
Table 5: Dimensional structure of abuse 23
Table 6: Correlational analysis 29
Table 7: Physical impairments of the elderly 33

Figure

Figure 1: Projected elder population by 2030 in Cambodia 1
Figure 2: Map of the Study Areas 7
Figure 3: Percentage of ADL/IADL Independence Assessment (by age groups) 15
Figure 4: Vision and hearing challenges among the elderly 16
Figure 5: Vision and hearing challenges among the elderly by age groups 16
Figure 6: Percentages of daily meals taken by age gender and groups 17
Figure 7: Percentages of meal items consumed by the elderly 17
Figure 8: Percentages of food items by groups 18
Figure 9: Percentages of alcohol drink and smoking habit among the elderly 18
Figure 10: Percentages of cognitive impairment among the elderly 20
Figure 11: Percentages of depression among the elderly 20
Figure 12: Percentage of abuse cases by responses 21
Figure 13: Percentage of elderly abuse by gender 22
Figure 14: Percentage of elderly abuse by age groups 22
Figure 15: Abuse by gender and region 23
Figure 16: Percentages of diseases among the elderly by gender 24
Figure 17: Percentages of the elderly with diseases 24
Figure 18: Main caregivers for hospital treatment and sick elderly 25
Figure 19: Medical institutions visited by the elderly 25
Figure 20: Economic support for the elderly 26
Figure 21: Supports and expenses of the elderly 26
Figure 22: ID Poor family 28
Figure 23: Other supports 28
Figure 24: Disability by gender and age groups 33

SUMMARY

The study aims at understanding the needs and challenges of the older people regarding their health issues and health care, economic opportunities, family dependence, social protection, and community engagement. Findings will help educate the public about the current needs and what supports shall be prioritized to fulfill the essentials of the late-life people.

A mixed methodology is adopted for the study to capture the holistic views, concerns and recommendations or feedback from relevant stakeholders (including elders) and to understand the relation between different needs and challenges of the elderly. There are five locations selected for the detailed investigation – Phnom Penh, Battambang, Kampong Cham, Prey Veng and Kampot with at total samples of 316 older persons including 219 female ageing from 60 to over 90. Among these, there is no physically handicapped sample. The investigations explores different aspects of the elderly population in the study areas for instance their ADL/IADL performance, disabilities, cognitive and depression, dietary nutrients, family health care and economic support, and abuses. More in-depth analysis i.e. correlation is tested to understand certain relation and influence of some variables. Is that less or insufficient care leads to any depression among the elderly or education level determines the ADL/IADL performance for instance.

Physical well-being

Older people

- **Ageing with diseases** - The results indicate strongly that older people from 60+ experiences more physical and mental illnesses. Non-communicable diseases are reported most frequently such as joint pain, hypertension, diabetes, cough/respiratory diseases, back pain, low-sighting, osteoporosis and fatigue for instance.

- **Disabilities with ageing** – the ageing progress of the persons leads to the weaknesses of the physical functions. The older they get the more difficult they challenge in moving around. Most of the observed elders (70+) are facing the issues of general physical mobility (i.e. walking, seeing, hearing...). For ADL, the result confirms that people in the age of 70-90 for both males and females are risking their 4-5 ADL physical disabilities; particularly in the functions of getting up and managing their bowel movement.

- From the study finding, though 41 and 26 per cent are free from disability by gender and age groups, majority is struggling with their ageing disabilities at least two among the six domains for those between 60 and 80 years old.

- Health challenges are relatively linked to persistent disability of the elderly and this has proved the existence of such challenges and needs among the interviewed peoples.

Older women

- More women are noticed in the finding that they are more vulnerable in the physical and mental capabilities and they need assistance for performance of their daily tasks. The analysis on physical disability indicates the high percentages of older women with one to two disabilities on communicating with others and their sighting ability. The analysis further emphasizes that women have similar prevalence than males of 4-5 ADL disabilities (i.e. bowel movement, getting up from bed and toileting for instance).

Older people with disabilities

- This is referred to those elderly having disability with ageing in their late-life periods. Finding evidently proves that as they are getting older, they are more prone to disability and weaknesses in their ability to perform their basic activities. In terms of health and disability issues, there is no distinguished needs or challenges requested or faced by either male or female groups, or either in rural or urban areas. Across gender and areas, the elderly does not

see themselves living in the healthy ageing as their functional abilities are degraded and so are their insecure economic assets and supports.

Mental well-being

Older people

- The **depression** scale is quite high among the interviewed older persons. 83 per cent of the interviewed elderly is classified as being depressed while 47 per cents of this is in their mild depression, and 27 and 8 per cents are in their moderate and severe tensions.

- When analyzing their responses, three typical depression factors among old-aged people in the study areas are 1) **Chronic unexplained physical symptoms, 2) Memory loss, and 3) Behavioral changes** (i.e. more often talking about death, or isolation from others).

- The **abuses** over the elderly in the studied areas must not be ignored because the findings indicate the critical situation where they have been, are being and will be abused. Among the factors assessed against the elderly in the studied areas, the abusive situation is potentially existent among the elderly and this is clearly convincing that abuses usually happen at home than other places. Most of them has less privacy at home, feel not wanted or not being respected, and feel distrust with or afraid with some family members. Most common types of abuses observed are physical, emotional, and neglect. In daily engagement, family members tend to create some verbal assaults, insults, humiliation, intimidation or harassments on their elderly parents.

- One of the observations is that abusers particularly their children or other family members do not recognize that their acts towards the elderly are abusing the feeling and dignity of their older parents. Then such attitudes become non sensitive to the youngsters but not to the older. Also in Cambodia, the elderly does not report or share abusive cases with others because they do not want themselves or their family ashamed or harassed, or retaliated in the future.

- Two main factors causing abuses are *physical and mental impairments*, and *high financial dependency on the family members* – likely abusers. The survey results confirm that elderly is being affected by their ageing disabilities such as seeing, walking, remembering, and communicating. Their ADL and IADL challenge their living when they grow older. Such disabilities limit their active engagement with the family and require caregivers stay with and care those impaired people most often.

Older women

- As observed, female elders are challenging health difficulty harder and reaching more cognitive impairments and dementia than males due to their (1) longer life expectancy, (2) more attachments to the household responsibilities even though they are growing older (i.e. still taking care of the house and young children), and (3) low personal and family economic savings i.e. more remain in poverty, resulting in insufficient nutrients and economic support for a healthy well-being. Older women are assessed in the potentially abusive situation than men, meaning that the higher level of abuse, the more older women expose.

Older people with disabilities

- Old persons are found to get easily stuck or mental irritation disturbed by their life experience that pushes them to find it hard to solve problems in their communication. This is due to their living with trauma (PTSD), depression, cognitive impairment, or abuses. The study finding reveals that both older males and females have high prevalence of depression and abuse. There are a number of reasons to explain the factors and influences. Moreover, some older people are living in deprived socio-economic status as their family is poor and vulnerable to varied social and economic conditions. 44 per cent of the samples are ID Poor card holders

and other 53 per cent is not assessed but very potentially sensitive to fall under the assessment criteria of Poor I and Poor II.

- There is a shift of the family arrangement due to the local family economic catastrophe. Youngsters are migrating out of the village, looking for a better fortune and leaving behind their elder grandparents, parents and babies. This is a neglect abuse because the older people also require cares as well as the babies at the time of having no family members to handle the tasks.

- The finding and field logics prove that the older people are having complications in managing their cognitive capacity and protecting themselves from abuses especially at homes. It is evident that these people require more intensive cares and safe responses to reduce their mental disabilities.

Key health care challenges

- Income poverty – The key most concern among the older people interviewed is income. It is explicitly understood that the poor and poorest complain of having inadequate living incomes, that usually blocks them from seeking for the health care services from their local centers or clinics.
- Disease-nutrient – Diseases are threatening their ageing conditions. From the result analysis, they usually have one disease and 1-2 impairments when they grow older.
- Limited access to services and service quality – Analyzing the responses from the older peoples indicated that they are not satisfying with the health services in their localities in terms of accessibility and quality.
- Limited skill/knowledge and availability of caregivers – The study identifies that older people are very much dependent on their caregivers so that they can enjoy their healthy ageing. The responses from the available caregivers interviewed prove that they practice their caregiving activities based on their traditional knowledge passed through generations.
- Less mutual inter-generational relations – The sharing from all stakeholders in the study provides a clue that there is a missing match between the older people and their younger children – caregivers. Through the questions of abuse and depression, it is noted that older people are not well understood of their needs and challenges by their caregivers.
- Elderly's limited knowledge on health care – This is convincing that well-educated older people tend to manage their health care better. They tend to know what to do or not to do that may harm their health. The limited knowledge of a person is clearly linked to their health care situation and the study finding indicates that interviewed participants are not very much capable to overcome these challenges by themselves especially those aging from 70+.

Economic wellbeing

Older people

- Income of the elderly is mainly from the support of their family members and less from their own business activities. Typically, the older people are penniless as they already work for and share their assets with the family members. Majority of the elders interviewed entirely depend on being fed by the family members i.e. their children. There are fewer reports of male and female elders who can independently generate their own incomes in the study areas.

Older women

- Older women are less productive in the paid employment. For economic support, the finding notes that women depend on their family members almost as twice compared to men counterpart. Their work in the family does not earn any income but keeps them busy for a whole day.

Older people with disabilities

- Physical and mental disabilities among older population prevent them from certain employment. Their disabilities in their late-life render the incomes and limit access to other economic opportunities. The study analysis confirms that older people from 60-80 are having at least 1-2 disabilities (i.e. communicating, seeing or remembering). 14 per cent of the total older people have 1-2 diseases on hypertension, diabetes, or arthritis.

Community support

- Older people association (OPA) is also part of the health treatment for the elderly as the sick people feel warmer and periodically relieved or at peace once members visit and share grieves. However, the correlation result emphasizes that OPA's activities do not have positive relation or influence on the issues of the elderly. No cross-line with OPA to ADL, IADL, nutrient of the elderly is significant.

Policy gaps

- Polices are developed and their Action Plans are being designed to exercise the commitment of the government. The progresses towards achieving their objectives remain slow due to limited resources and multi-coordination among the responsible agencies.

Recommendations

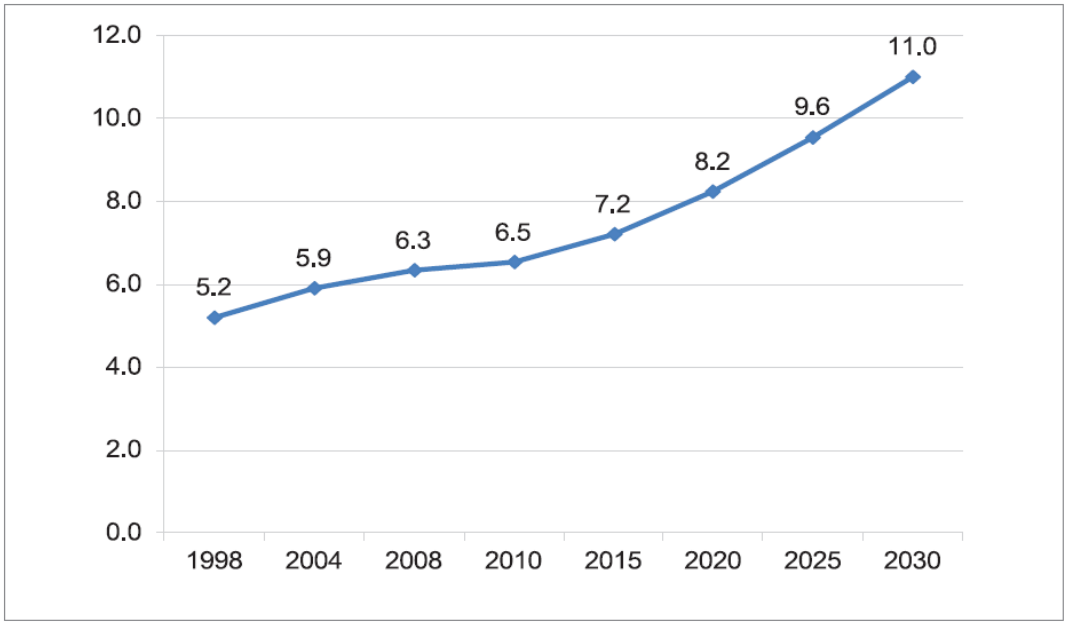
- It is recommended that the awareness and issues of the elderly shall be developed into the formal educational curriculums from the secondary schooling to high school.
- Non-governmental organizations and other stakeholders shall continue to work and cooperate with the Royal Government of Cambodia through Ministry of Social Affairs, Veterans and Youth Rehabilitation to achieve the first priority of financial security for the elder population as prioritized in the National Ageing Policy.
- It is recommended that OPA activity plan shall be revised to have certain activities that can inspire and console the members' feeling and other mental health and welfare.
- Temples remain the active institutions in healing the elderly's stressful mindset and therefore they are the evitable actors in improving the healthy ageing of the older people.
- The government continues to extend and improve better health services and accesses and encourages more specialized medical doctors to work in health centers and health posts where older people are seeking assistances.
- Since Cambodia has a culture of staying home and no nursing home or homecare which is a kind of institutional care settings, a public awareness to family caregivers, or family members of the elderly population must be promoted to understand about issues, needs and challenges of older adults as well as how to deal with their caregiving practices.
- A non-contributory cash transfer program shall be developed and approved to benefit the elderly population, particularly older women so that they are able to access health care and other social services.
- Assistive materials or equipment shall be given to those impaired older people to assist them in their daily living.
- Continue to promote more awareness among the family caregivers about the elderly's abuses, depression and other mental cares, so that they are performing their cares in more older-friendly manners, in expecting to reduce the incidences of abuse and depression among the disable older people.
- Work to assure that older people are in their assisted living conditions and if not possible, then regular visits should be paid by OPA members or local authorities.
- For a long-term reform, more specialized medical doctors are assigned to help diagnosis the symptoms of older people who seek services at health centers or posts.

CHAPTER ONE: INTRODUCTION

1.1 Introduction

National Institute of Statistics (NIS) in 2013 estimates that the 60+ population in Cambodia will increase to around 1.3 million (approximately 8.3% of total population) in 2015; while Ministry of Planning (MoP) in 2016 projects it to around 11% in 2030. Because the fertility rate is declining and that pushes up the curve of the elder population. Such trend is projected to continue. The projection is firmed that an average of 70,000 older people will annually increase from 2025 to 2030 in Cambodia (RGC, 2017, p.6).

Figure 1: Projected elder population by 2030 in Cambodia



Source: Population Projections 2008 Census Report 12

The elderly population, to be considered vulnerable for their frails and poverty, has increased noticeably in Cambodia which is seen as a concern among service providers, government, civil society, population planners and policy makers (MoP, 2016). MoP continues to echo that Cambodia will become an aging society by 2070 (ibid, p.3). The National Ageing Policy (2017-2030) recognizes two main causes for such increase – declining fertility and improving life expectancy (RGC, 2017, p.3). Interestingly, 55 per cent of the older population is female and >60 per cent of the oldest old (RGC, 2017, p.7). They are more vulnerable than men. Due to longer life expectancy (71 compared to men only 61) they are becoming the oldest old, challenging them for different and serious issues once they are growing older and older.

The National Social Protection Policy (2016-2025) notices that there is a high number of older women living in difficult conditions than older men. This is due to a number of reasons. The HAC documents that 80% of elderly women in Cambodia is illiterate and is living in rural areas. In addition, their economic insecurity and/or disabilities make them more vulnerable to social risks (as similarly echoed in the National Population Policy 2016-2030). However, 56.8 percent among older population in Cambodia is economically active, with high percentage of older men (MoP, 2016). Moreover, in terms of disability, the 2013 survey by the National Institute of Statistics indicates that more women than men have multiple disabilities including sight, speech, hearing, movement, mentality, and others.

In the present context of social development in the global society of Cambodia, family caregiving traditions and support from family members decreases, let alone older people to look after

themselves with less care and support (Cambodia Social Protection Policy 2016- 2025). Ministry of Planning (2013) finds that about 60% of non-migrant households are elder women and they are likely less educated than those who migrate. Government does not have elder population policy to help who are not civil servants in Cambodia but will access possibilities to support elderly people who are members of poor households holding an ID poor card (Cambodia Social Protection Policy 2016-2025).

In 2016, there are 394 older people associations (OPA) in Cambodia. It is also noticed that over 60% of OPAs members are women and over 60% of the leaders are over the age of 55+ which is moving toward elder population. This study is necessary to understand the present context of the different aspects of issues and need of older people, especially older women and older people with disabilities in HAC areas and other regions of Cambodia.

1.2 Problem Statement

More than 80% of older people live in rural areas, many particularly older women, are illiterate and around 25% live below the poverty line (1.25$ per day). There is currently no pension or other form of social benefit system other than for government employees. Older people are also vulnerable due to health problems associated with aging that can cause disabilities and often times are affected by poverty due lack of economic resources. Older people mostly isolate and left behind by younger generations, especially if their children migrate for work, or if they are too unhealthy to leave their homes.

Traditionally, in Cambodia, older peoples have left behind with negative effects when their older children migrate to work (Ministry of Planning, 2013). Their older children are important source of support and play key roles in psychological well-being of oldies. Moreover, older Cambodians face vulnerability when the support care system is not in place (Kol Hero et al. 2014). From the report, it is clear that MoSVY is responsible for providing basic services and protection to the elderly. Currently, MoSVY lacks the necessary information, manpower, facilities and equipment effectively response to the needs.

Generally, it is less attended from the national government and major international agencies to explore and respond to the needs of the older population. Noticeably, older women have worse health and more health symptoms and physical functioning problems than men. In case of Cambodia, the healthcare system does not sufficiently cater for older people's needs (Kol Hero et al. 2014). The National Health Care Policy and Strategy for Older People in 2016 aims at enabling the older people to have equitable access to a comprehensive package of quality health services for their active, productive, healthy, and dignified ageing. But, there is no specific strategy to assure the health needs of different elders' sub-groups for instance poor, disabled or female elders to access and enjoy the health services and its quality.

Elderly people in Cambodia have changed the ways they live and interact within their communities. The National Social Protection Policy Framework (2016-2025) recognizes the causes for such changes – due to current more modernized, urbanized and industrialized Cambodia, risking them (especially women and disabled elders) to access adequate and liable basic services including health care system or pension fund (RGC, 2016, p.18).

The 2016 publication on 'population ageing in Cambodia – current situation and needs' identifies four more overarching needs and supports for the older population in Cambodia (MoP, 2016). By far, they are 1) programs to enhance traditional systems of family support; 2) policy reform to encourage the economically-active elderly to remain in the workforce; 3) supportive institutions and systems to assure high levels of personal savings; and 4) public programs for instance pension schemes and national healthcare systems (ibid, p.8). The
Royal Government of Cambodia has progressed to strive to generate these benefits and other social benefits for the elder persons; however, the progress is slow and ineffective somehow. Moreover, the National Ageing Policy 2017-2030 attempts to continuously enhance and improve the life quality of

the elder people with equal rights and opportunities. It sets out nine priorities such as financial security, health and well-being, living arrangement, enabling environment, OPA, intergenerational relations, elder abuse and violence, and emergency situation. However, it is relatively insufficient to understand the needs and to design the supports for the elderly as society is changing. Thus, there is a need of regular study of the needs and supports of the elder peoples and how to best respond to their demands.

1.3 Research Objectives

1. To study the older people's perceptions in different aspects of their life, particularly their needs, including the needs for healthcare, social protection, social/community engagement, and economic opportunities and security

2. To identify and analyze different problems/needs between different subgroups of older people, such as older men and women and people with and without disabilities in diverse backgrounds

3. To produce a research report that can be used to effectively increase awareness of issues facing older women and older people with disabilities among civil society organizations, such as NGOs, and, other key stakeholders and the general public, as well for policy recommendation for the government.

1.4 Research Methodology

A mixed methodology is exercised for the study to capture the holistic views, concerns and recommendations or feedback from relevant stakeholders (including elders) and to understand the relation between different needs and challenges of the elders in order to address their needs of ageing communities in the target locations. The following is a description of the methodologies in responding to the objectives suggested in the term of reference.

Our general methodological approaches are:

- **First**, we employed a **desk study** to review the current documentations reflecting the state of the arts of the ageing population including needs and supports already provided; hardship faced by the elderly, existing government/NGOs or private responses and key important stakeholders in supporting the works of the elderly in Cambodia. The review also highlighted the present state-of-the-art knowledge on current ageing population, trends, efforts made and challenges by stakeholders to address remaining concerns.

- Through the desk review, the local statistics of the elder population profiles in different sub-groups were reviewed through critically reviewing the numbers and strata from the relevant ministries (Ministry of Planning, Ministry of Social Affairs, Veterans and Youth Rehabilitation), and local NGOs. From the list and strata, we could identify the particular areas of high prevalence rates of elderly population and their needs/supports required. This helped us narrow down the geographical scope of the needs/supports for more specific sub-groups and also helps us select the right responses or approaches to meet the needs of the needy elders.

- For **geographical scope** of the study, five regions were selected for instance Phnom Penh, Prey Veng, Kampong Cham, Kampot and Battambang provinces. Some logical reasons to determine these locations are based on :
  - 1) The 2014 national statistic of elder population in Cambodia indicates provinces from the lowest to the highest elder population. Logic is to select the most elder population in the locations including the female elders.
  - 2) The national statistic of disability from the Inter-censual database in 2013 indicates the national disability population by provinces. Therefore it is advised that selected locations shall reflect the highest disabled population for the study.

- 3) The presence of OPAs in the areas indicates the organized groups dedicating for the welfare of the elder population. Thus, the study targets these groups for an easy access to these elder groups to understand their needs and challenges in the communities.
- 4) Last reason to select these locations is also a consideration of the different geographical areas of Cambodia i.e. northeastern, floodplain, coastal and lower Mekong areas where at least we can primarily understand certain and specific needs and challenges of the elders.

- For **sample scope**, the study intended to understand the needs and challenges of the diverse groups and sub-groups as many as possible. But due to time and budget limits, it is designed to properly fit with locations and elder population characteristics as indicated above. Primary sub-groups are women and disabled elders.

- **Second**, in **consultation** with HAC and local authorities in selected areas, we selected five provinces upon agreement with HAC, and participants who have experienced having homecare for the elderly; who have worked for older adults, disabilities, gender and other related fields; who organize and involve in OPA (older people association); and the older persons themselves. The study strives its best to understand the current needs and challenges of the elders and how they suggest to be supported.

- **Third**, for each selected location, we exercised the **in-depth interviews** and **key informant interviews** with 1) around 60 active elders and his/her caregivers (in case elders are too weak to participate); 2) few OPA members (where OPA exists); 3) at least one OPA managers; 3) 2-3 individual local authorities and NGOs; and 4) 3 individual government officials, NGOs directly responsible or work for the elderly issues in their respective areas and at the MoSVY. The interviews intended to understand (a) functional status (using ADL/IADL including nutrient consumption – see detail explanation below), cognitive needs (using MMSE[1] methods), psychological needs (using GDS[2] tools and index); (b) social and community liaison and support for the elderly; and (c) elderly abuse. The dialogue also mined the views or perceptions from participants regarding the needs, supports, so-far challenges and future interventions to assure that older population remains important, active, and socially protected. Moreover, we also probed into understanding the available services to vulnerable older persons in their respective areas. The study also adopted a short set of functioning questions for disability assessment from the Washington Group on Disability which was also derived from the International Classification of Functioning and Disability of the World Health Organization.

Table 1: List of selected OPAs

No.	OPA	Location
1	Ang Sophy OPA	Ang Sophy Commune, Kampong Trach District, Kampot
2	Chum Kreal OPA	Chum Kreal Commune, Toek Chho District, Kampot
3	Sen Reak Reay OPA	Sangkat Khmouy, Khan Sen Sok, Phnom Penh
4	Phnom Penh Thmey OPA	Sangkat Phnom Penh Thmey, Khan Sen Sok, Phnom Penh
5	Prey Toeng OPA	Prey Toeng Commune, Sithor Kandal District, Prey Veng
6	Prey Veng Older People Saving Association	Sangkat Kampong Leav, Krong Kampong Leav, Prey Veng
7	Veal Vong OPA	Sangkat Veal Vong, Krong Kampong Cham, Kampong Cham
8	Anlong Tamey OPA	Anglong Tamey Commune, Ba Nan District, Battambang

[1] Mini-Mental State Examination – Dr. D. William Molloy. Molloy DW, Alemayehu E, Roberts R. Reliability of a standardized Mini-Mental State Examination compared with the traditional Mini-Mental State Examination. *American Journal of Psychiatry, 1991; 148*(1): 102-105.

[2] The **Geriatric Depression Scale** (**GDS**) is a 30-item self-report assessment used to identify depression in the elderly. The scale was first developed in 1982 by J.A. Yesavage and others. Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression screening scale: a preliminary report. *J Psychiatr Res*. 1982-83;17(1):37-49.

9	Prek Preah Sdech OPA	Prek Preah Sdech Commune, Battambang District, Battambang

- **Elder functional assessment (including ADLs/IADLs)** – according to Royal Government of Cambodia (2017) the term disability is defined as having a limitation or difficulty in at least one or the four tasks of activities of daily living (ADLs) such as getting up from lying down, eating, bathing and/or dressing while Verbrugge and Jette (1994) considered disability as difficulty doing activities due to a health or physical problem. ADLs as well as instrumental activities of daily livings (IADLs) are considered to be an indication of disability and inability on some function for elderly people (Verbrugge & Jette, 1994). ADLs and IADLs were asked whether elderly meet difficulties in doing their daily tasks and whether through these they need assistance. ADLs includes the abilities to eat, toilet, transfer in and out of bed or chair, dress and bath while IADLs includes the abilities to prepare own meals, do light house work, manage own money, use the telephone, and shop for personal items (Ibid, 4-5). This Katz Index of Independence in ADLs mentioned by Verbrugge & Jette (1994) is considered the most appropriate instrument to assess functional status as measurement of older adults in order to detect problems in performing activities and to develop planned care (Wallace & Shelkey, 2007). The index ranges adequacy of performance in six functions of bathing, dressing, toileting, transferring, continence, and feeding. Participants are scored yes/no independence in each of the six functions. A score of six indicates a full function, 4 indicates moderate impairment, and 2 or less indicates severe functional impairment (Ibid, p. 67).

- For the IADLs used in this study is for checking the independent skills that tends to be more complex than the basic activities of daily living of Katz Index of Independence (ADLs). It is critical in caring older adults while normal aging change they might have acute illness, worsening chronic illness and hospitalization that could decline in the ability to perform necessary tasks independently(Graf, 2009). There are eight domains of function measured with the Lawton IADLs scale. Women are scaled on all eight areas of function. For men the area of food preparation, housekeeping, and laundry are excluded. Participants are scored according to their highest functioning in that category. It scores 0 (low function, dependent) to 8 (high function, independent) for women, O through 5 for men (Ibid, p. 59).

- **Cognitive impairment** is a critical point for elder population. The cognitive impairment questions here is adapted from Mini-Mental State Examination (Tombaugh & McIntyre, 1992) in order to see the cognitive functioning of older adults that is likely declined due to old age or health conditions. Eight out of eleven questions of The MMSE is used to measure the five areas of cognitive function: orientation, registration, attention and calculation, recall, and language. So, the maximum score of 30 was changed to 27 since three questions which each gets one score was not used. The three questions are not used for the reason that many older adults, especially women more than men in Cambodia are low literacy and education level (Royal Government of Cambodia, 2017) and they are mostly the survivors of Khmer rouge. They do not have a habit of reading, writing and or drawing. Based on the original evaluation in MMSE, the participant with score of 20 or lower is indicative of cognitive impairment. Since the three questions were not used, it is determined that 21 or lower is assumed to have cognitive impairment. For 21-27 it is classified as no cognitive impairment, 0-15 as severe cognitive impairment, and 16-20 mild as cognitive impairment (Tombaugh & McIntyre, 1992, p. 931).

- Though depression is not related to changing is age, this **Geriatric Depression Scale** (GDS) was used to identify the depression of older adults that may results in physical, cognitive, functional, and social impairment as well as to decrease in quality of life and delay recovery from illness (Greenberg, 2012). The short form of 15 questions of GDS are used and the 15 questions, there are 10 indicating the presence of depression when answer positively, while the other five reveal depression when answer negatively (question numbers 1,5,7,11,13). The findings from the participants are interpreted that score from 0-4 are considered normal, 5-8

indicates mild depression, 9-12 indicates moderate depression, and 12-15 indicates severe depression (Greenberg, 2012).

- Fourth, we organized two **focus group discussions (FGDs)** for each province with 1) elder persons with separated genders (8-10 persons/group). The group discussions mainly focused on the how individual groups expressed their needs, concerns and suggestions for supports or intervene to improve access for marginalized older people (in particular older women and older people with disabilities) to public services and to foster space for their participation in economic, health and social policy making.

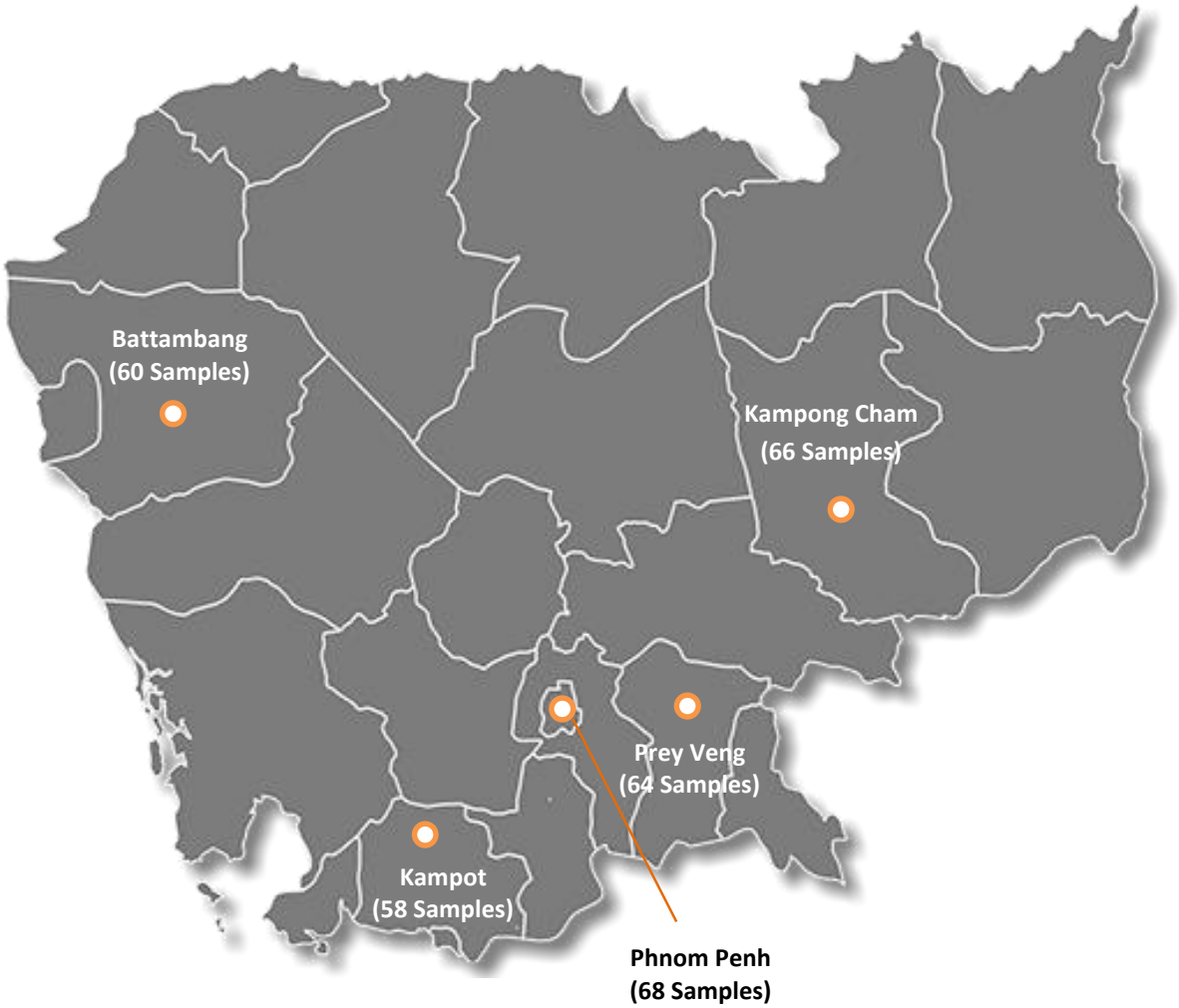
- Where possible, photographs were taken to tell the stories of how elder people lived, interacted and engaged in their society. While working with participants in each region, we took photos as possible to illustrate their daily lives.

- Last, after the initial findings are drafted, one **consultative meeting** was organized on 27 May 2019 in Phnom Penh to verify the results of the study and to further collect the feedbacks and comments to finalize the report. Participants were individual representatives from each province (preferably provincial department of social affairs, veterans and youth rehabilitation; NGO staff and NISA lecturers).

- For **quantitative approach**, we statistically selected the samples from identified strata in each region. For a quantitative analysis, 316 specific samples (in persons) were determined after we understood the population characteristics through reviewing the feedbacks from the authorities and stakeholders and the strata in the target area. Responded questionnaires were developed, coded and analyzed using simple frequency and other in-depth analytical tools to understand the relation between socio-economic or cultural variables of the elder population. The results were statistically displayed and described.

- It is essential that our strict **ethic and consent** must be applied before getting the elders and anyone to be interviewed. One of our rules with the elders is to quit or skip the interviews whenever the respondents are inactive spiritually and manually. Unless caregivers join the interviews. Moreover, an inform consent is attached to every questionnaire and interviewers read it out loud to interviewees and let he/she confirmed with the statement. If there was no agreement, then we moved to the next interviews.

Figure 2: Map of the Study Areas



CHAPTER TWO: OVERVIEW OF AGEING POPULATION

2.1 Elder global population and trend

In this second decade of the twenty first century, elderly population has been seriously taken into account in the world for its fast growing in comparison to the previous decades. (United Nations (2017)) reported that elderly people globally aged 60 years or over were more than twice increased between 1980 to 2017 from 382 million to 962 million older population. Moreover, elder people aged 80 years and over have noticeably been growing the overall number of elderly people which is projected to increase from 137 million to 425 million between 2017 and 2050. Regarding to sex between male and female, the report claimed that women live longer than men in average 4.6 years and the number of women aged 60 and over have 54 percent while those aged 80 and over accounted for 61 percent in 2017 (Ibid, p. 2). In addition, elderly people have been observed to have grown more in urban than in rural areas which is 58 percent of the world aged 60 years and over in 2015 compared to 51 percent in 2000 while 63 percent of those 80 years or over resided in urban by 2015 compared to 56 percent in 2000 (Ibid, pp. 2-3).

2.2 Common elder needs and challenges

Due to the growth of life expectancy among the aging, women were found to have chance of living alone, especially those aged 80 years or over which was accounted for nearly one in three elderly women compared to those women aged 60 years to 79 years old which was 15 percent in 2010; rather there was 15 percent of men aged 80 years or over lived alone compared to those aged 60-79 years old in the same year (United Nations, 2017). In America there are 35.2% of older adults aged 65 and over had a disability (Kraus, Lauer, Coleman, & Houtenville, 2018, p. 7) and it is more common for people age 65 and over than those younger age (Verbrugge, Latham, & Clarke, 2017). Mostly elderly people have a risk of non-communicable diseases such as joint pain, high blood pressure, diabetes, heart disease, and dementia (Rathny, Chhay, Choun, & Ok, 2018, p. 532). Older people very often need health care (Long & Sudnongbua, 2017), living support, and require intergenerational relations(Rathny et al., 2018). (Rathny et al., 2018) also showed that elderly people confront vulnerabilities, income insecurity, mobility, dependency, and decreasing support that is why some of them need to continue working. This report also described that elderly work has unsafe work conditions and need to spend for health care cost nearly four times as much more than children (p. 531).

2.3 Elder-responsive programs

“The 2002 Madrid International Plan of Action on Ageing (MIPAA), adopted during the Second World Assembly on Ageing, highlighted the need to consider older persons in development planning, emphasizing that older persons should be able to participate in and benefit equitably from the fruits of development to advance their health and well-being, and that societies should provide enabling environments for them to do so. As populations become increasingly aged, it is more important than ever that governments design innovative policies and public services specifically targeted to older persons, including those addressing, *inter alia*, housing, employment, health care, infrastructure and social protection (United Nations, 2017)”. In Hong Kong, long term care services for the elderly have been offered since 2000. The government’s policy has promoted it through “Residential care services” and “Community care services” (Research Office: Legislative Council Secretariat, 2015).

2.4 Cambodia's ageing population

Elder and Migration: Since, children or close relatives of older people who are supporters and caregivers migrates to work far from home, older adults needs to take care of themselves (MoP, 2013). Some elderly men and women are still economically active. 48.1 percent of older people of both sexes continued their labor activities in 2013 though there were slightly decreased from 54.5 percent in 2008. Older women tended to engage in economic activities less than older adult men in between 2008 and 2013 (NIS, 2013, p. 54). But Royal Government of Cambodia (2016) noticed that since the absent of data about both sexes of elderly people, it is difficult to evaluate whether they are working out of their will or due to economic compulsions.

Cambodian older adults have been considered the main sources on all aspects of Cambodian life for their sharing of experiences, skills, abilities and general knowledge before the war in 1975, rather they have been largely neglected in in development and democracy work as well as gender and disability due to their poverty and lives difficulties after Khmer Rouge regime (Rathny et al., 2018). Older people have contributed invisibly to community development through allowing their family members to seek employment while they are taking care of grandchildren and those family members living with HIV/AIDs (MoP, 2013; Rathny et al., 2018).

Elder and Disability: (NIS, 2013) found that the proportion of disabled among the oldest persons (age 75+), especially among women is as to be expected to be very high (p.95). The report showed that Cambodian disabled elderly people have increased from 2008 to 2013. The 60-64 age group has increased from 4.11% to 6.57%, while the 65-69 age group has increased from 3.73% to 6.40%. Moreover, there is an increase from 3.26% to 5.78% for the 70-74 age group and 5.02% to 9.19% for the 75+ group. Among each aged group of elderly population, women had been found having higher disability than men (NIS, 2013, p. 95).

The same report also detailed that people who were 60+ of both sex have increased their disability comparing from year 2008 to 2013. In year 2013, older people at age of 60+ have 32.07% in seeing, 7.53% in speech, 49.81% in hearing, 25.59% in movement, 8.35% mental retardation, 16.19% mental illness, 28.32% other and 27.64% multiple disabilities. When the data divided among male and female, it is shown that elderly women have more disabilities than elderly men (NIS, 2013, p. 56).
The CDHS 2014 also indicated that 44.2% of elderly people aged 60+ has some difficulty or a lot. Females are slightly more suffer from some level of disabilities and they were 10.5% of women living with disability than men which is only 8.5% (Cambodia DHS 2014).

Elder and Economic Earning: In year 2013, elderly people aged 60+ of both sex have 29.3% employed, 5.4% unemployed and 65.3% economically inactive. There were male elderly people 39.2% employed compared to 21.7% of female elderly, followed by 55% of male elderly economically inactive compared to 73.1% of female elderly (NIS, 2013, p. 98). According to (Gabrielle and Mauney (2018)) as cited from HelpAge (2015) mentioned that about 3 out of 4 older people in rural areas and half of them live in poverty. The report also noticed that the elderly health problems affected by poverty and the lack of economic resources (p. 25). Based on the 2018 national monitoring report on the implementation of the national sustainable development goals from 2016-2030, it is noted that there are 144,879 older peoples (including 56,353 public servant retirees and 88,526 veterans) in Cambodia who receive pensions in Cambodia (MoSVY, 2019[3]).

Elder and Health: According to Cambodia demographic and health Survey (2014, p.54) elderly people age 60+ has the highest percentage of illness or injury with is about 25%. The report proved that females and urban residents suffered slightly more illness and injuries than males and rural residents (Ibid, p.54). When realizing about their sickness Cambodia DHS (2014,p.55) people age 60+ had 93.1% seeking first treatment, while 21.4% seeking second treatment, and 7.4% seeking third treatment. It is noticed that the first and the second treatment seeking was high among elderly men but low in the third treatment than women. Moreover, older women face more challenges in receiving health care and having poorer health condition than men and they are more social isolation, economic censorship, and living longer with poor health and disability (HelpAge International 2013, in Gabrielle & Mauney, 2018, p. 27). Additionally, women have reported more health symptoms and physical functioning problems than men (Knodel & Zimmer, 2009). Moreover, Older adults who are survivors of Khmer Rouge have left with them the traumatic experience (Gabrielle & Mauney, 2018).

[3] MoSVY (2019). 2018 Monitoring Report on the Implementation of National Sustainable Development Goals from 2016-2030. Ministry of Social Affairs, Veterans and Youth Rehabilitation, Phnom Penh, Cambodia

Elder and Quality of Life: In the study done by Long and Sudnongbua (2017) on quality of life among elderly people in Kampong Cham found that income, education and social support are factors predicting the quality of life among elderly people. The finding also revealed that 69% of elderly people confronted low level of life quality followed by low level of autonomy 72.4%, past, present and future 58.6%, death and dying 65.5% and intimacy 95.9%. 71.7% reported had one or more non-communicable diseases (Ibid, p. 884). However, women found to live longer than there is likelihood of the problem shifting to old-old from young old categories and with the older women cohorts being more than older men cohorts, newer challenges in regards to welfare of elderly are going to be emerged(Royal Government of Cambodia, 2016, p. 11).

Base on some of the review above, this literature attempts to understand the conditions and needs of elderly people living in Cambodia, especially those under the program areas of HAC. This literature review has divided into some main points 1) physical and cognitive needs, 2) social support, 3) Psychological and spiritual well-being, 4) economic resources, 5) Health of older people, 6) elderly abuse, and 7) policy on elderly people.

CHAPTER THREE: STUDY RESULTS

3.1 Respondents' characteristics

It is principally inspiring to understand basic characteristics of the studied population so that needs and challenges can be better understood within each studied areas.

Table 2: Respondents' Characteristics

Characteristics	N	%	PHN		BTB		KC		PV		KPT
Age			*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*%*
60-69	*154*	49	38	56	33	55	26	39	40	63	17	29
70-79	*111*	35	23	34	22	37	31	47	12	19	23	40
80-89	*47*	15	6	9	4	10	8	12	12	19	17	29
>=90	4	1	1	1	1	2	1	2	0	-	1	2
Gender												
Male	*97*	31	15	22	15	25	30	45	21	33	16	28
Female	*219*	69	53	78	45	75	36	55	43	67	42	72
Disable*	*0*	0	0	0	0	0	0	0	0	0	0	0
Marital status												
Married	216	68	55	81	41	68	51	77	48	75	21	36
Divorced	12	4	3	4	4	7	1	2	2	3	2	3
Separated	70	22	5	7	12	20	12	18	14	22	27	47
Never married	18	6	5	7	3	5	2	3	0	0	8	14
Number of children												
None	*14*	4	1	1	3	5	2	3	0	-	8	14
1-3	*66*	21	15	22	9	15	10	15	19	30	13	22
3-6	*132*	42	28	41	32	53	30	45	22	34	20	34
>6	*104*	33	24	35	16	27	24	36	23	36	17	29
Living with whom												
Children	204	65	51	75	39	65	31	47	44	69	39	67
Spouse	56	18	15	22	11	18	18	27	8	13	4	7
Alone	27	9	2	3	5	8	6	9	5	8	9	16
Relatives	25	8	0	0	5	8	8	12	7	11	5	9
Others	4	1	0	0	0	0	3	5	0	0	1	2
Education level												
No schooling	*121*	38	27	40	26	43	21	32	16	25	31	53
Primary school	*117*	37	21	31	19	32	33	50	33	52	11	19
Secondary school	*43*	14	12	18	10	17	3	5	7	11	11	19

High school	*33*	10	8	12	5	8	8	12	7	11	5	9
Graduate school	*2*	1	0	-	0	-	1	2	1	2	0	-

Note: PHN=Phnom Penh, BTB=Battambang, KC=Kampong Cham, PV=Prey Veng, KPT=Kampot
*Disable = physically impaired persons (the handicapped)

The study conducts in-depth interviews with 316 individual elders in the five locations in Cambodia i.e. Phnom Penh, Battambang, Kampong Cham, Prey Veng and Kampot. Elders whose ages are from 60-79 years old account more than 80 percentages among the total and most of them resides in Prey Veng and Phnom Penh. There is no doubt that majority of the interviewees is female elders (69%) where Kampong Cham has the lowest female elders. Though the study randomly strives to balance the equal gender among respondents in understanding their needs and challenges in their old ages, the limited availability of male elders is due to women outlive men across the study areas. Regarding the marital status, 68 per cent is married and still lives together; while 22 per cent is separated. The divorce rate is quite low across the studied areas, but living separately in their old age tends to be higher and Kampot has the highest separated cases.

Child fertility rate is high among these interviewed elders. The primary statistic shows that 42 per cent has more than three children and other 33 per cent has more than six children. Battambang and Kampong Cham have more elders with many children than others. This reflects the fact that 65 per cent of the elders lives with their children in a traditional family arrangement. Yet there is also 18 per cent living alone or with other relatives. For education, half of the respondents complete only secondary school and other 38 per cent has no schooling at all. Kampot has the highest no-schooling category among other areas.

3.2 General Functions

The study explores the general functions of the interviewed elder persons in addition to the ADL and IADL to further understand their individual mobility. Regardless their age groups and studied areas, the table above indicates that not so many elder persons acquire the assistance from their relatives or family members or other caregivers. Otherwise, some assistance remains essential. 52 per cent has a certain difficulty in lifting materials. Also 27 per cent finds themselves difficult to crouch or squat when they move; while other 25 per cent complains of having a challenge to walk up and down the stairs. Other elder persons may require little assistance in walking, standing and using their fingers to grasp or handle things. From gender lens, the male and female elderly require similar assistance in all cases of general functions. Moreover, the elderly in Battambang and Kampot has higher needs in lifting in comparing with other studied areas. Based on the age groups, the older the people grow, the more needs are required to support their general functions. Basically, the table shows that the second and third quintiles of the age groups need more helps; while full support is necessary for the last quintile (i.e. >90). The young older persons remain active and do not need much care.

Table 3: General physical difficulties of the elderly

Physical Functioning	Total	Sex		Location					Age			
		M	F	PNH	BTB	KCH	PV	KPT	60-69	70-79	80-89	>=90
Total	316	97	219	68	60	66	64	58	154	111	47	4
General functions												
Walking	20%	21%	19%	15%	18%	15%	13%	40%	11%	23%	34%	75%
Lifting	52%	44%	56%	47%	60%	47%	45%	64%	42%	60%	62%	100%
Crouching or squatting	27%	26%	27%	32%	23%	18%	16%	45%	18%	30%	43%	100%
Standing	18%	18%	18%	15%	15%	11%	9%	41%	8%	20%	38%	75%
Using fingers to grasp or handle things	16%	14%	16%	15%	13%	3%	11%	38%	12%	14%	26%	50%
Walking up and down the stairs	25%	26%	24%	26%	30%	20%	13%	36%	14%	27%	49%	75%

Note: PHN=Phnom Penh, BTB=Battambang, KC=Kampong Cham, PV=Prey Veng, KPT=Kampot

3.3 Katz Index of ADL and IADL

The result shown in the table below indicates that there are not many older persons requiring assistance for their ADL. Among the activities, only 4 per cent and 7 per cent of the elderly is not able to feed and dress themselves. Feeding is the basic simple activity and if they are disabled, then older persons may challenges more other activities. Regarding their very personal ADL on toileting, bathing, urinating or bowel movement, 7-11 per cent of the interviewed older persons find themselves difficult in exercising and controlling these activities. Across gender, the female elderly has more challenges in managing their personal ADL than males. Also, the result confirms that 8-12 per cent of the female elders cannot do it or needs more supports on bathing, toileting, urinating and bowel movement for their daily living. By region, more than 20 per cent of older persons in Kampot province need assistance than other locations for their general ADLs. Self-feeding is low among other activities in Kampot but still higher when compared with others. By age group, it is observed that the elderly from 80-90 has a higher prevalence of exposing to different difficulties in their ADL such as toileting, dressing, and urinating/bowel movement. But 50 per cent of >90 older persons are more disabled in getting up from bed than other age groups.

Table 4: ADL and IADL among the elderly

Katz Index of Independence (ADLs)		Gender		Location					Age			
	Total	Male	Female	PNH	BTB	KCH	PV	KPT	60-69	70-79	80-90	>90
	316	97	219	68	60	66	64	58	154	111	47	4
Taking bath	8%	5%	9%	1%	5%	2%	6%	28%	6%	5%	**19%**	**25%**
Dressing	7%	5%	8%	4%	5%	0%	5%	22%	4%	6%	**17%**	**25%**
Toileting	9%	10%	9%	3%	8%	5%	6%	26%	6%	5%	**28%**	**25%**
Getting up from bed or hammock	11%	11%	11%	6%	7%	6%	6%	31%	4%	14%	23%	50%
Controlling urinating or bowel movement	11%	9%	12%	6%	12%	5%	9%	28%	7%	11%	**26%**	**25%**
Self-feeding	4%	4%	4%	3%	0%	3%	3%	12%	2%	5%	11%	0%
Instrumental Activities of Daily Livings (IADLs)												
Cooking	38%	51%	33%	28%	33%	39%	42%	50%	29%	40%	66%	50%
Financial management	34%	41%	30%	46%	33%	21%	23%	45%	30%	33%	47%	25%
Taking medication	14%	12%	15%	12%	8%	12%	9%	29%	11%	14%	19%	50%
Washing clothes	37%	47%	32%	40%	35%	36%	31%	43%	30%	41%	53%	25%
Doing housework	33%	38%	31%	35%	30%	20%	25%	59%	23%	40%	47%	75%
Going shopping	50%	42%	53%	41%	43%	55%	45%	67%	36%	57%	77%	100%
Self-transport management	46%	33%	51%	43%	40%	41%	44%	62%	31%	54%	68%	100%

Note: PHN = Phnom Penh, BTB = Battambang, KCH =Kampong Cham, PV = Prey Veng and KPT = Kampot

For IADL, in general, it is noted that 33-50 per cents of the older persons has suffered from the disability in the complex physical and mental activities; while only 14 per cent reports to be unable to take their own medication. It is remarkable to understand that the 70-90 and >90 age groups have higher percentages of the older persons requiring assistances in supporting their IADL. Also, the 60-70 age group tends to be more demanding in similar supports to the middle-old and old-old groups.

By gender, it is firmed that more male elders need assistance in cooking, shopping, washing, managing finance, doing the housework, and managing self-transport. But few males need assistance in taking medication. In comparison to males, 53 and 51 per cent of female elders have more difficulties in commuting to local markets and taking other means of transport. Still 30-33 per cent is disabled and needs assistance in cooking, managing finance, washing clothes and doing housework. Similar to the percentage of male elders, 15 per cent of females cannot take their own medication. Those who is >=90 years old cannot do anything at all with shopping and arranging their own self-transport. By region, Kampot remains the location with the highest prevalence of older persons demanding supports across the IADL. In short, across the region, the below graphs note that there is a little percentage of older persons requiring support for ADL, but more incremental percentages of them for the support of IADL.

This ADL/IADL assessment indicates the disability[4] among the interviewed elderly. There is no case found of the physically impaired persons (i.e. the handicapped). ADL provides a basic framework to evaluate older persons' ability to live independently, requiring assistance or dependence (Holland, Jenkins, Solomon & Whittam, 2003 as cited in Gebreyohannis & Kharel, 2012). Dependency or independency in activities of living depends on age, sex, health and illness status (ibid, p. 6). 80 per cent is free from any basic framework for their independent living.

The IADLs used in this study is for checking the independent skills that tend to be more complex than the basic activities of daily living of Katz Index of Independence (ADLs). It is critical in caring older adults while normal aging changes and they might have acute illness, worsening chronic diseases and hospitalization that could decline in the ability to perform necessary tasks independently (Graf, 2009). There are eight domains of function measured with the Lawton IADLs scale. Women are scaled on all eight areas of functions. For men the area of food preparation, housekeeping, and laundry are excluded. Participants are scored according to their highest functioning in that category. It scores 0 (low function, dependent) to 8 (high function, independent) for women, 0 through 5 for men (Ibid, p. 59).

Table 5: ADL and IADL function assessment

Function Assessment	Male (%)	Female (%)
ADL		
Full dependence (totally disabled)	0	3
Need assistance for 4-5 (disabled) activities • Getting up from bed or hammock • Controlling urinating or bowel movement • Toileting • Taking bath • Dressing	5	5
Need assistance for 1 (disabled) basic activities • Self-feeding	4	4
No need assistance (independence)	81	79
IADL		

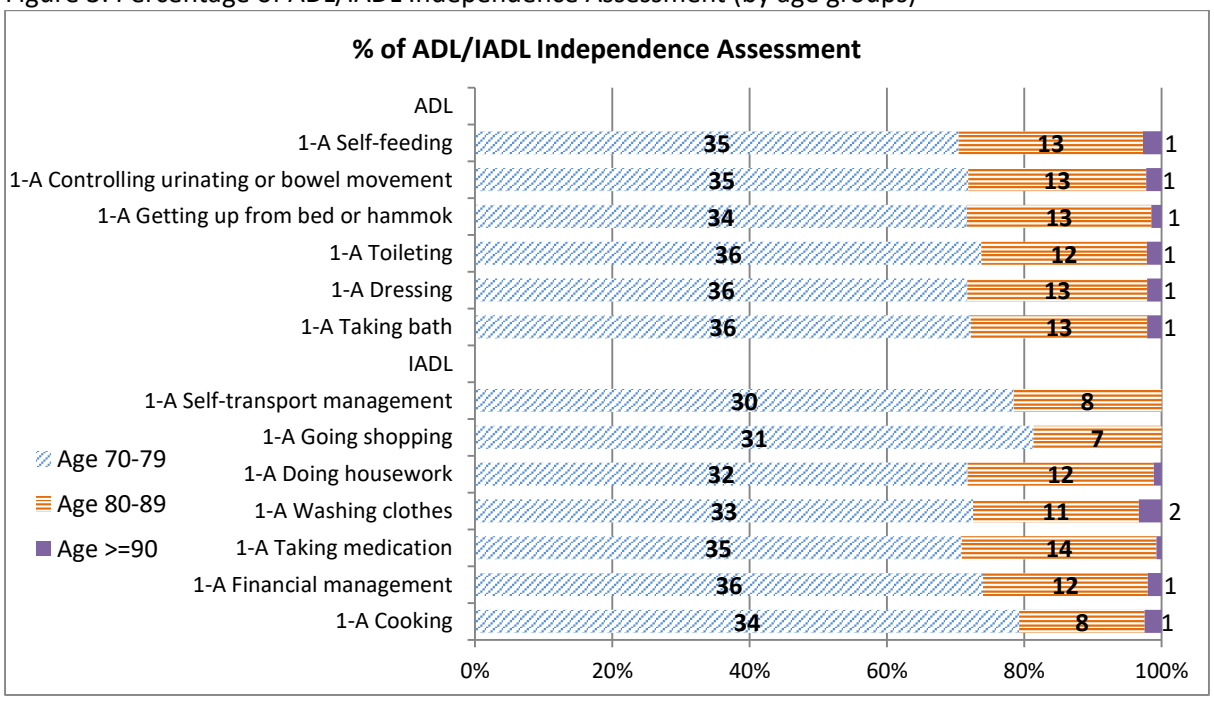
[4] Disability is an umbrella term, covering impairments, activity limitations, and participation restrictions. Disability is the interaction between individuals with a health condition (e.g. cerebral palsy, Down syndrome and depression) and personal and environmental factors (e.g. negative attitudes, inaccessible transportation and public buildings, and limited social supports) (World Health Organization, 2018).

Full dependence (totally disabled)	7	6
Mostly need assistance for 4-6 (disabled) activities • Shopping • Housework • Washing clothes • Cooking • Transport • Finance	26	30
Mostly need assistance for 1 (disabled) basic activity • Taking medication	12	15
No need assistance (independence)	28	32

The table above assesses the assistance needs of the older persons for their ADL and IDAL. It is clearly convinced that majority of the interviewed samples is able to manage their own ADL, but more male older persons are slightly independent than female ones. The same 5 per cent for each male and female group requires more assistance in 4-5 ADL activities; while only 4 per cent for the same groups needs more supports for their basic activity – self-feeding. However, for IADL, the result indicates that 32 per cent for females and 28 per cent for males do not needs intensive guidance for their interactions with things and people around. But more peoples in the two age groups (i.e. 26 and 30 per cent for males and females) are disabled for 4-6 activities; while only around 12 and 15 per cent cannot respond to their basic IDAL activity – taking medication. In compared with the same category in ADL, more older-persons in IADL are totally incapable to control their activities.

The below figure further indicates that majority of the interviewed older persons across the study areas and age groups are able to manage and control their ADL/IADL. More than half of total male and female elders show less signs of ADL/IADL disability. It is clearly noted that the young old group tends to be more active for their both ADL and IADL, but gradually the middle and old-old groups are becoming weak and need more assistances in their later stages. However, when examining the ADL/IADL scores, it results that both gendered groups demand supports for some activities, but the female group tends to be more demanding in the areas of cooking, financial management, washing clothes or doing the housework due to their longevity (i.e. being too old to handle things).

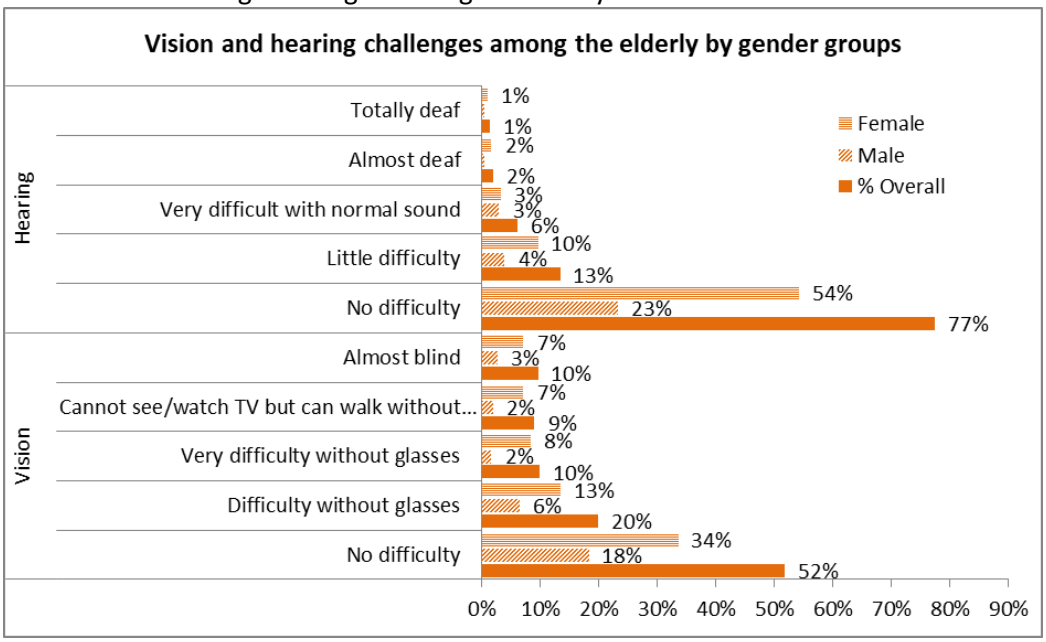
Figure 3: Percentage of ADL/IADL Independence Assessment (by age groups)



3.4 Vision and hearing of the elderly

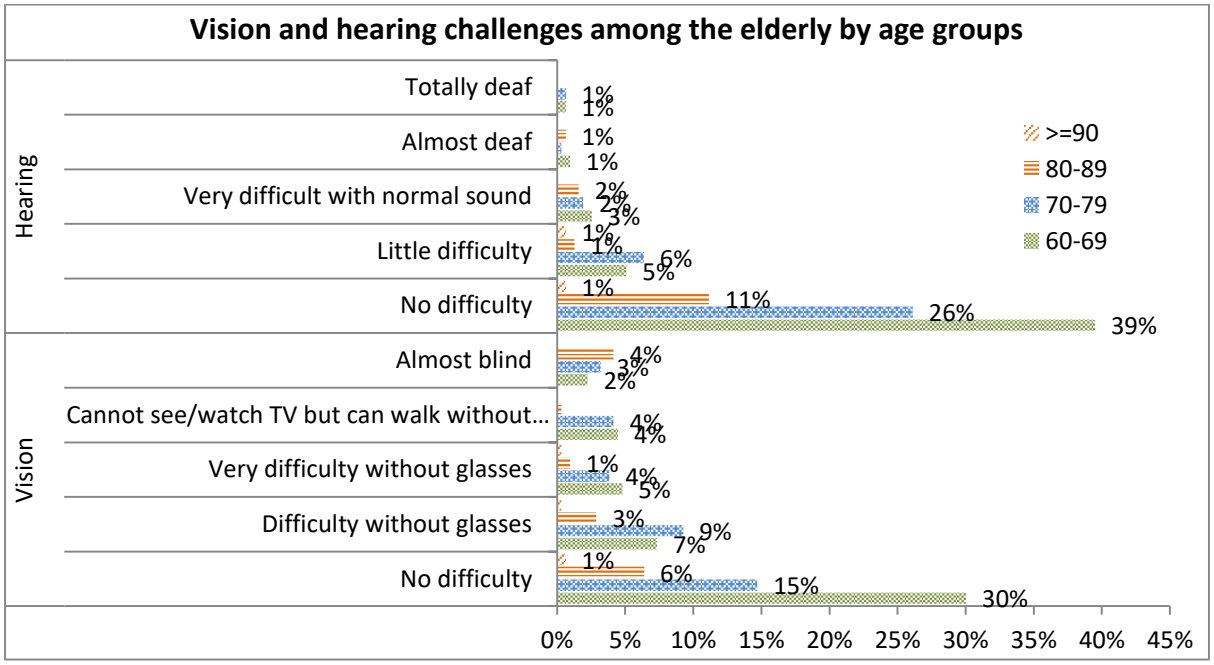
The elderly inevitably faces the challenges in their vision and hearing when they grow older. They tend to lose their sensory capacity in seeing and hearing things around and this incapacity distracts them from enjoying their healthy ageing lives. From the survey, out of the total interviewed older persons, 77 per cent remain active and strong in their hearing ability; while only 52 per cent are still good for their seeing talent. For both cases, more female population is free from such challenges. There are only one to two per cents of females who are almost deaf. For vision, more elderly people are experiencing all levels of difficulties and 10 per cents are almost blind. In short, more interviewed elderly are unable to see than to hear.

Figure 4: Vision and hearing challenges among the elderly



By age group, 39 and 30 per cent of the 60-69 elderly population and 26 and 15 per cent of the 70-79 age groups in the studied areas have no difficulty in their sensory capability i.e. hearing and seeing. Only one per cent of the elderly in the last two age groups (i.e. 80-90 and above) is free from the difficulty. This truly reflects that the older people grow the more likelihood of disabled seeing and hearing increases. Across all age groups, the elderly population is susceptible to more vision problems than their hearing challenges.

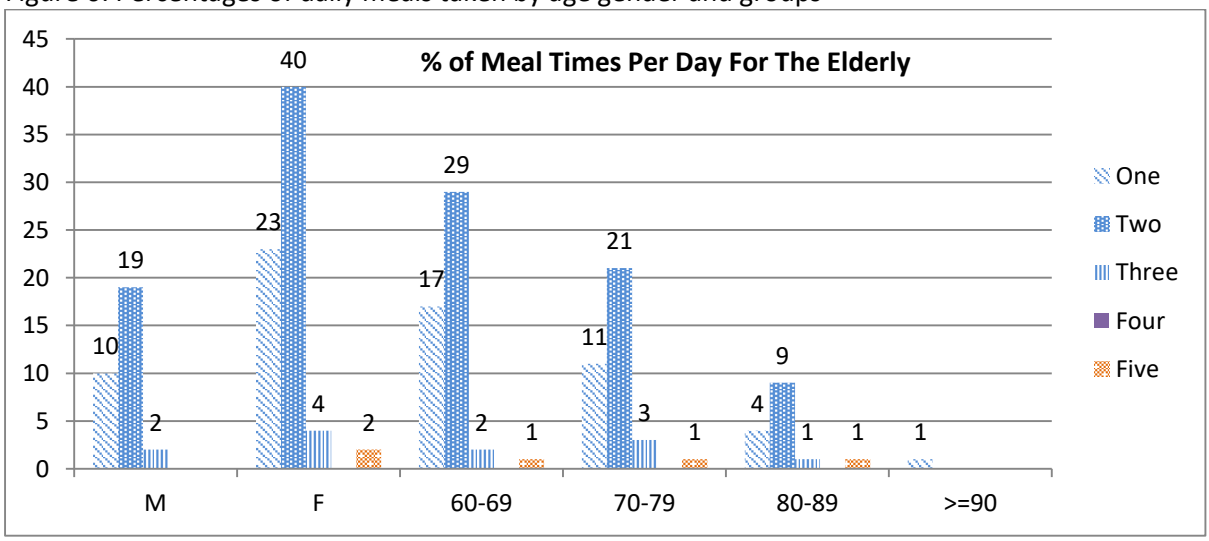
Figure 5: Vision and hearing challenges among the elderly by age groups



3.5 Nutrition

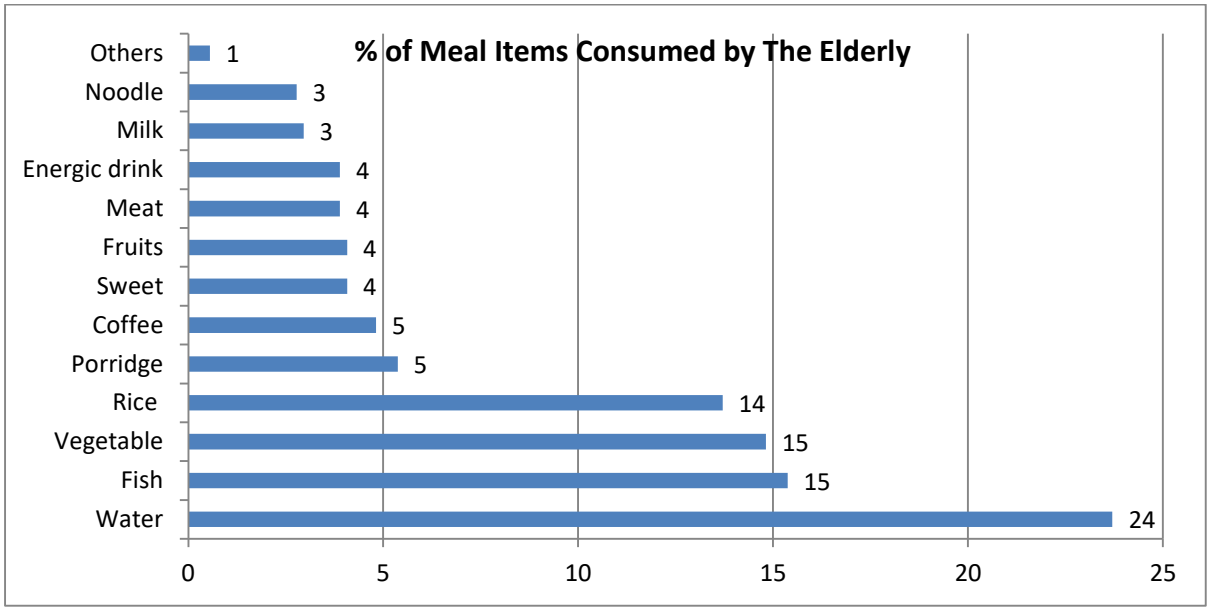
Nutrition is essential for the elderly to sustain their strength against certain diseases and ageing progress. Nutrition also determines the well-being of the elderly and this can be assessed through looking at their daily meals and their food compositions. The result from the survey indicates that both female and male older persons commonly take two meals per day, but female groups tend to take up to five times. This is right that women eat meals more often including their main and substitutes. By age group, it similarly confirms that the young old and middle old groups take two meals daily but the trend declines when they grow older and older. The last quintile of the group indicates only one meal as they are too old to take or chew food, or because they are struggling with certain diseases or other health conditions.

Figure 6: Percentages of daily meals taken by age gender and groups



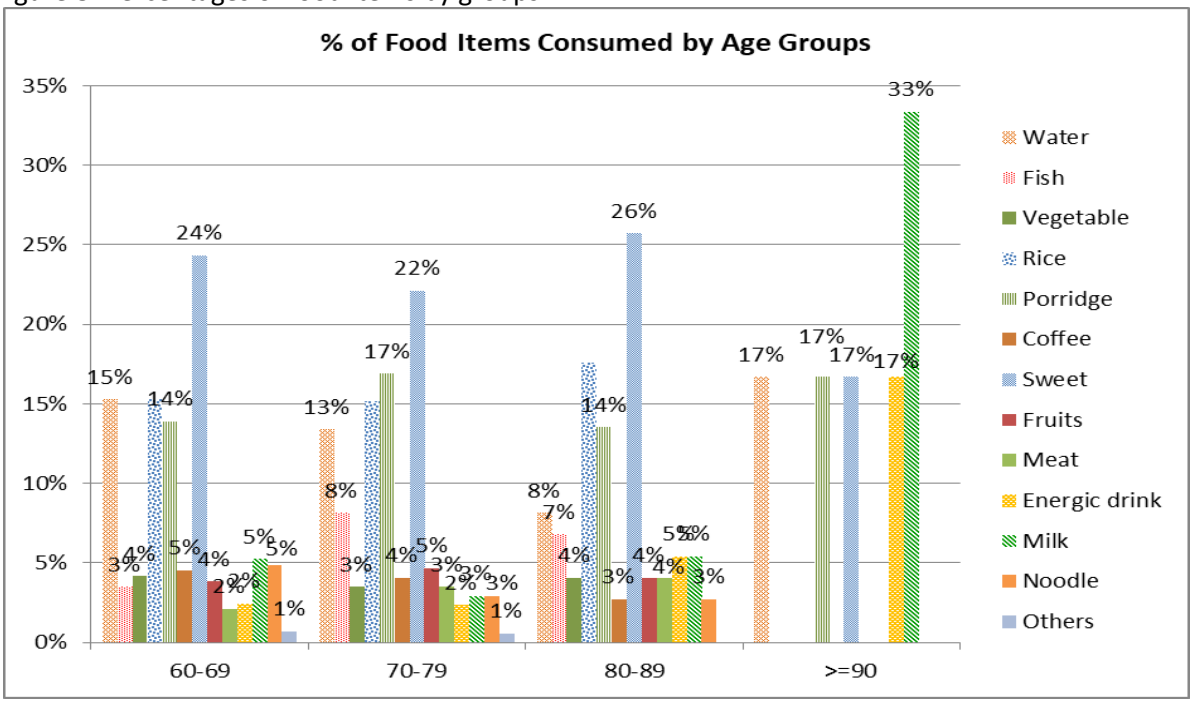
Once asked what and how much they are eating, most responses emphasize that fish, vegetables and rice are the most consumed food materials as these are accessible and available within their living locations. Without doubt, water is the main drinking item among these older persons as it is usually attached to their daily eating diets i.e. drinking water after each meal. Meat, fruits or milk which is classified as healthy items especially for the elderly are less consumed. This is due to their personal and family's poor economic savings to afford such expensive items.

Figure 7: Percentages of meal items consumed by the elderly



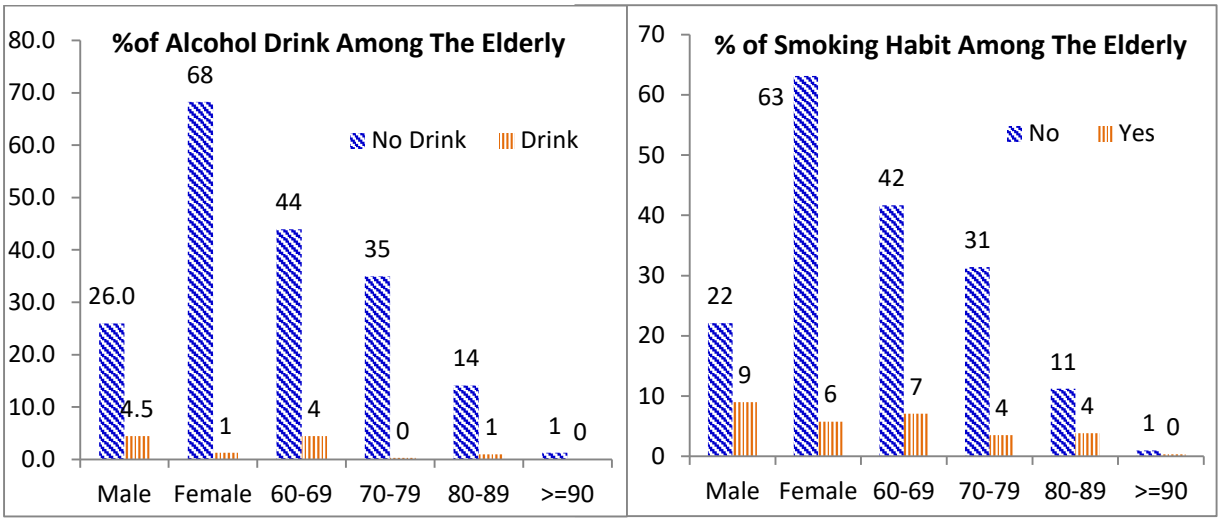
It is also interesting to note that what different age groups consume so that it intends to understand how healthy their ageing is. The young old, middle old and old-old groups consume quite similar diverse food items, but sweet is most consumed. As ageing progresses, the body does not function much and therefore the energy needs to balance the body operation are lower. Or some older persons are struggling with disease and thus taking regular meals or more meal items is impossible. Clearly, the very old-old group (>=90) seems consume less diverse items, but more constantly on certain liquid items such as milk, sweet, energic drink, rice soup (porridge) and water.

Figure 8: Percentages of food items by groups



Regarding their alcohol consumption and smoking habit, it is convincing that majority of the respondents does not drink and smoke.

Figure 9: Percentages of alcohol drink and smoking habit among the elderly



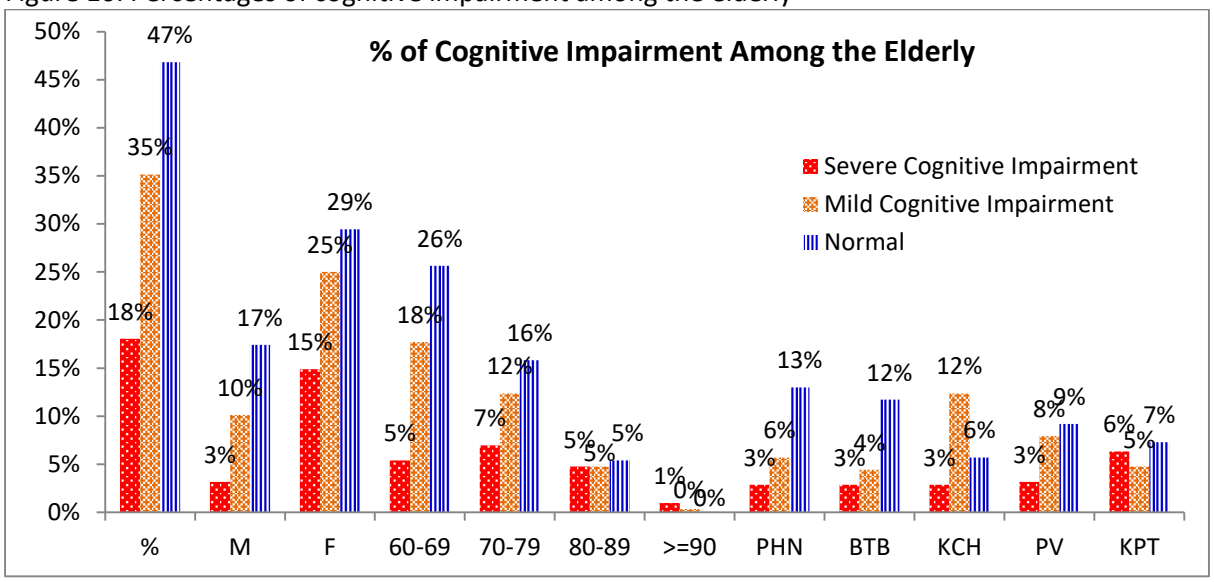
3.6 Cognitive impairment

Cognitive impairment is a critical point for elder population. The cognitive impairment questions here is adapted from Mini-Mental State Examination (Tombaugh & McIntyre, 1992) in order to see the cognitive functioning of older adults that is likely declined due to old age or health conditions. Eight out of eleven questions of the MMSE is used to measure the five areas of cognitive function: orientation, registration, attention and calculation, recall, and language. So, the maximum score of 30 was changed to 27 since three questions which each gets one score was not used. The three questions are not used for the reason that many older adults, especially women more than men in Cambodia are low literacy and education level (Royal Government of Cambodia, 2017) and they are mostly the survivors of Khmer rouge. They do not have a habit of reading, writing and or drawing. Based on the original evaluation in MMSE, the participant with score of 20 or lower is indicative of cognitive impairment. Since the three questions were not used, it is determined that 21 or lower is assumed to have cognitive impairment. For 21-27 it is classified as no cognitive impairment, 0-15 as severe cognitive impairment, and 16-20 mild as cognitive impairment (Tombaugh & McIntyre, 1992, p. 931).

The result indicates that 47 per cent of the interviewed elderly do not show any sign or symptom of cognitive impairment. However, more than half (i.e. 53 per cent) have expressed their impairment or problem with their cognitive capacity; while 18 per cent of the half have experienced severe challenges. By gender, 46 per cent of both groups are classified as normal and 25 per cent as obtaining mild cognitive problem. 15 per cent of females are rated higher than male as having serious cognitive impairment.

By age group, the young old persons (i.e. 60-69 years old) is the biggest group who has cognitive impairment who shares 23 per cent, but has lesser percentages of severe cases than those middle old group who shares 7 per cent in total severe cases. For the old-old and very old-old groups, either mild or severe cognitive cases are all present among them. Moreover, by area, Kampong Cham province has the highest proportion of cognitive difficulty, but Kampot shares the highest percentage of severe cognitive cases. The rest shares the same severe cases (i.e. 3 per cent) and similar shares of the mild cognitive problems which 6, 4, 8 and 5 per cent for Phnom Penh, Battambang, Prey Veng and Kampot respectively.

Figure 10: Percentages of cognitive impairment among the elderly



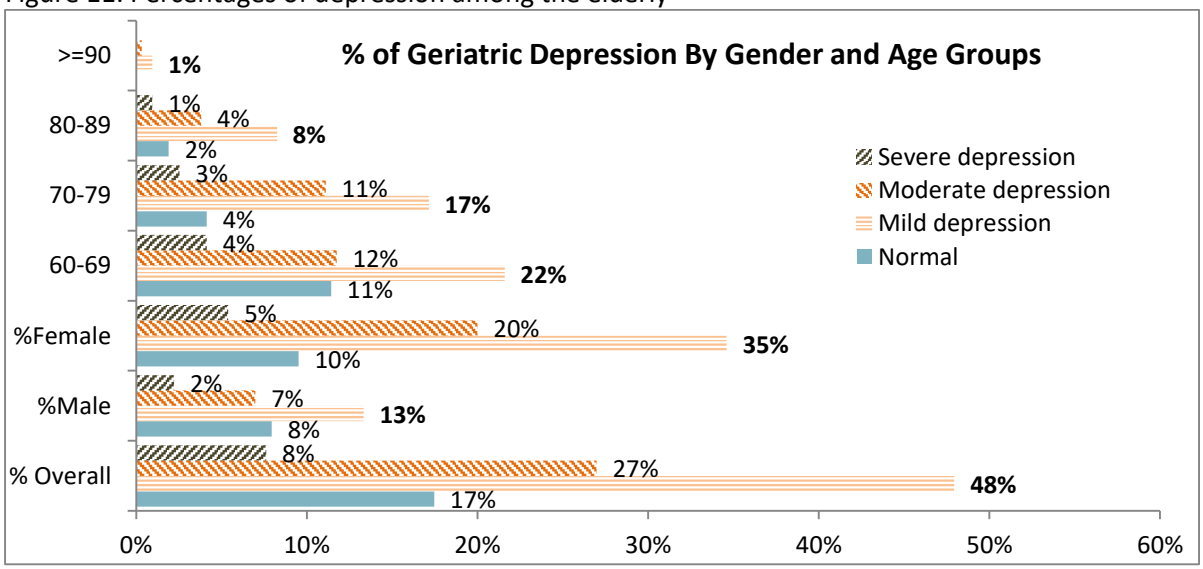
Note: PHN = Phnom Penh, BTB = Battambang, KCH =Kampong Cham, PV = Prey Veng and KPT = Kampot

3.7 The Elderly Depression

Depression is not related to changing is age, this Geriatric Depression Scale (GDS) was used to identify the depression of older adults that may results in physical, cognitive, functional, and social impairment as well as to decrease in quality of life and delay recovery from illness (Greenberg, 2012). The findings from the participants are interpreted that score from 0-4 is considered normal, 5-8 indicates mild depression, 9-11 indicates moderate depression, and 12-15 indicates severe depression (Greenberg, 2012).

Based on the figure below, it is noted that 17 per cent of the studied elderly is free from depression – meaning that they are living with least or without concern on their living and family. 83 per cent is living with depression mode. Out of this majority, 48, 27 and 8 per cent are rated as mild, moderate and severe depressions. By gender, more female than male older persons are depressed and this may be due to a combination of some reasons such as longevity, poor health, instable personal and family's saving and family/household responsibilities even they grow old. By age group it is observed that the older they grow, the lesser depression they obtain.

Figure 11: Percentages of depression among the elderly



3.8 **The Elderly Abuse**

Abuse is a common act performed both intentionally and unintentionally by the family members, neighbors and other strangers on the elderly. It does not only disturb physically, but also mentally through pressurizing and limiting the rights and mobility of the elderly. The result from the survey summaries that 19 per cent is free from any forms of the abuse and the other 81 per cent of the interviewed older persons have experienced the abuses or are being abused recently and male and female groups seem to have gone through similar numbers of abuse experiences. Amongst the abuse cases reviewed and surveyed, 25 per cent of the responses indicates that the elderly in the all studied areas and age groups feels sad or lonely for most of the times; while 12 per cent does not have sufficient privacy at home. The other 10 per cent is more often told to be sick or asked to stay in bed when they are not or still can move. This reflects a very traditional and personal way for typical Cambodian family to convince the elderly not to work or move too often as it will affect their health or ageing processes. However, there are also high numbers of responses regarding certain common abuses such as feeling distrust or not comfort or feeling afraid with the family members, feeling not being respected or feeling less wanted for instance.

Out of the twelve abuse levels defined by (Neale AV, 1991), the graph below confirms that there are more cases for the first two levels where old male persons are more mistreated than the female ones (i.e. 30.9% and 21.6% of males for level 1 and 2). But the percentage of abused male groups declines for the next five levels (i.e. 3 to 7). Such drop-off truly reflects that more female older persons; on the other hand, have suffered from serious cases from their surrounding peoples. Notably, there is one female who is 60-69 years old found to be affected severely.

Figure 12: Percentage of abuse cases by responses

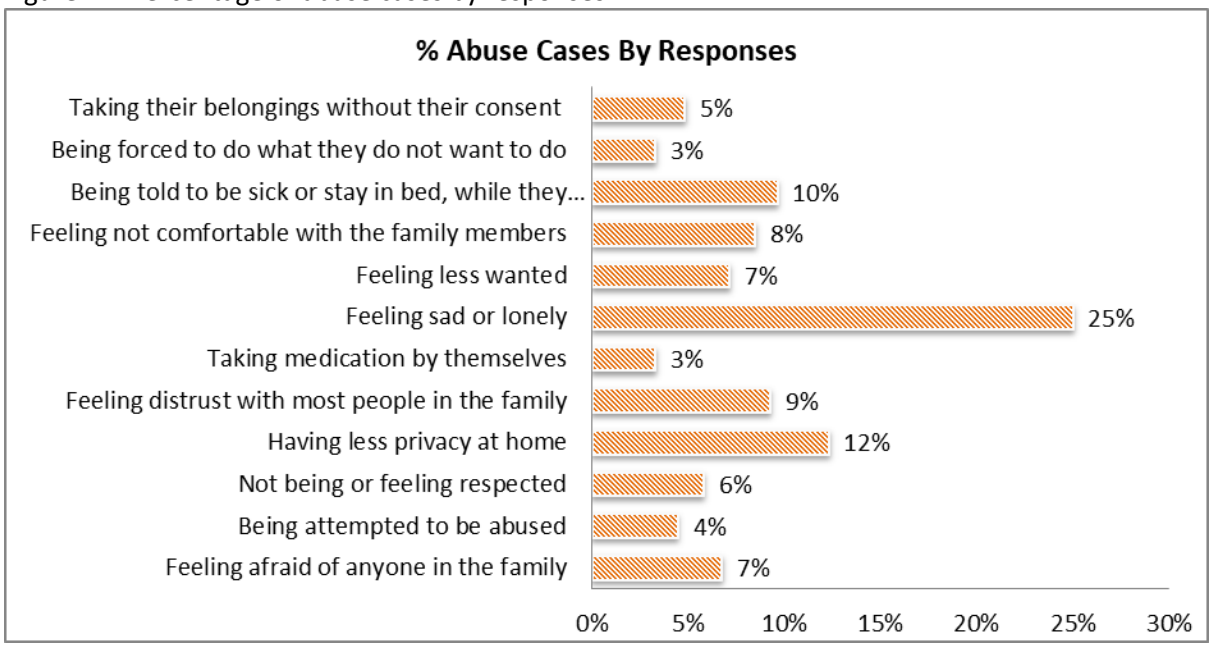
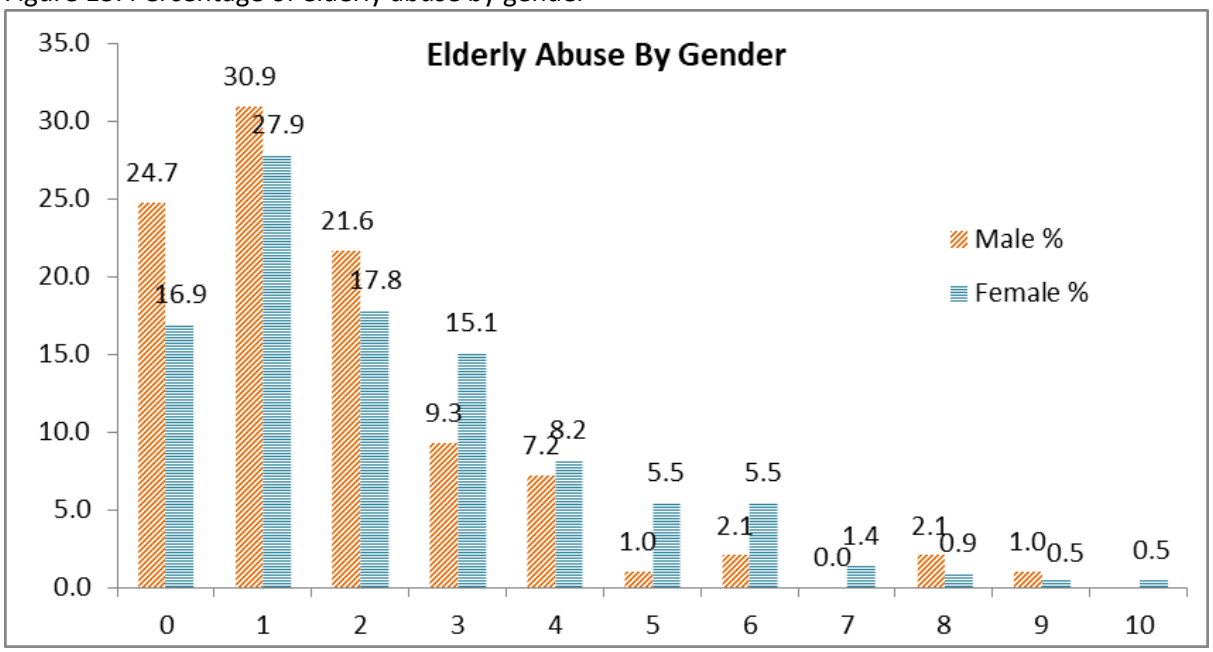
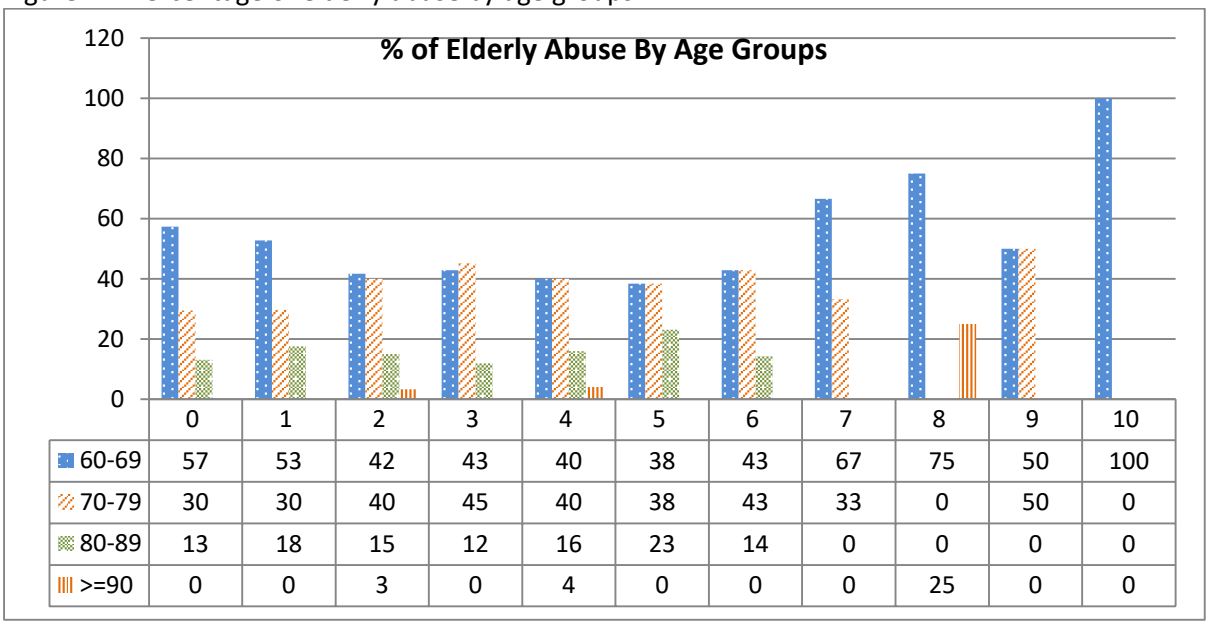


Figure 13: Percentage of elderly abuse by gender



By age group, it is convincing that those who are from 60-80 years old are the largest groups undergoing more abuse cases than other age groups. The >80 group seems to be less exposed to the violence. But 25 per cent of the total 90+ people are classified as highly abused (i.e. level 8).

Figure 14: Percentage of elderly abuse by age groups



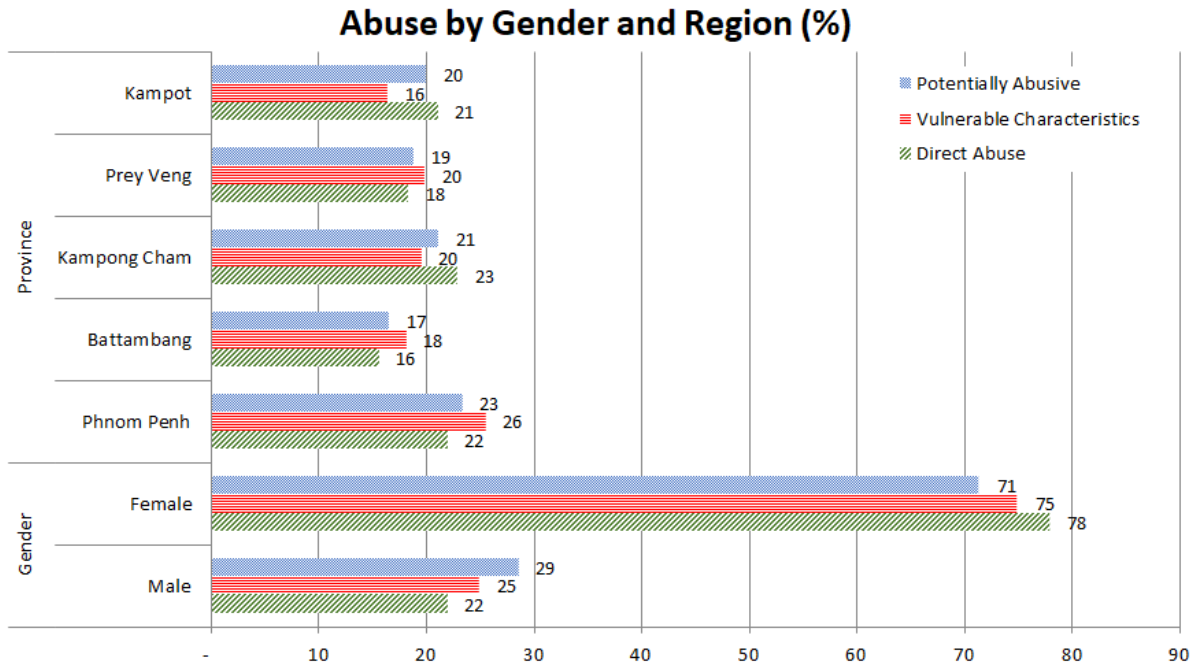
	0	1	2	3	4	5	6	7	8	9	10
60-69	57	53	42	43	40	38	43	67	75	50	100
70-79	30	30	40	45	40	38	43	33	0	50	0
80-89	13	18	15	12	16	23	14	0	0	0	0
>=90	0	0	3	0	4	0	0	0	25	0	0

Abuses over the elderly have been well investigated. (Neale AV, 1991) develops the abuse levels into the three dimensional structures – direct abuse, characteristics of the vulnerability and the potentially abusive situation. This hierarchy defines whether one person or a stratified population is at which dimension. The table below shows that out of the 81 per cent of the abuse cases, almost half i.e. 47 per cent is assessed to be in their potentially abusive situations. The most likely abuse cases are having less privacy at home, not being or feeling respected, feeling distrust with most of the people in the family, feeling less wanted, not getting on well with the family members, and feeling afraid of anyone in the family.

Table 6: Dimensional structure of abuse

Dimensional Structure	Percent
No abuse	19%
Abuse	81%
Direct Abuse	
• *Being attempted to be abused*	
• *Being told to be sick or stay in bed, while they are not or can move*	*23%*
• *Being forced to do what they do not want to do*	
• *Taking their belongings without their consent*	
Characteristics of vulnerability	
• *Taking medication by themselves*	*30%*
• *Feeling sad or lonely*	
Potentially abusive situation	
• *Having less privacy at home*	
• *Not being or feeling respected*	
• *Feeling distrust with most people in the family*	*47%*
• *Feeling less wanted*	
• *Feeling not comfortable with the family members*	
• *Feeling afraid of anyone in the family*	

Figure 15: Abuse by gender and region



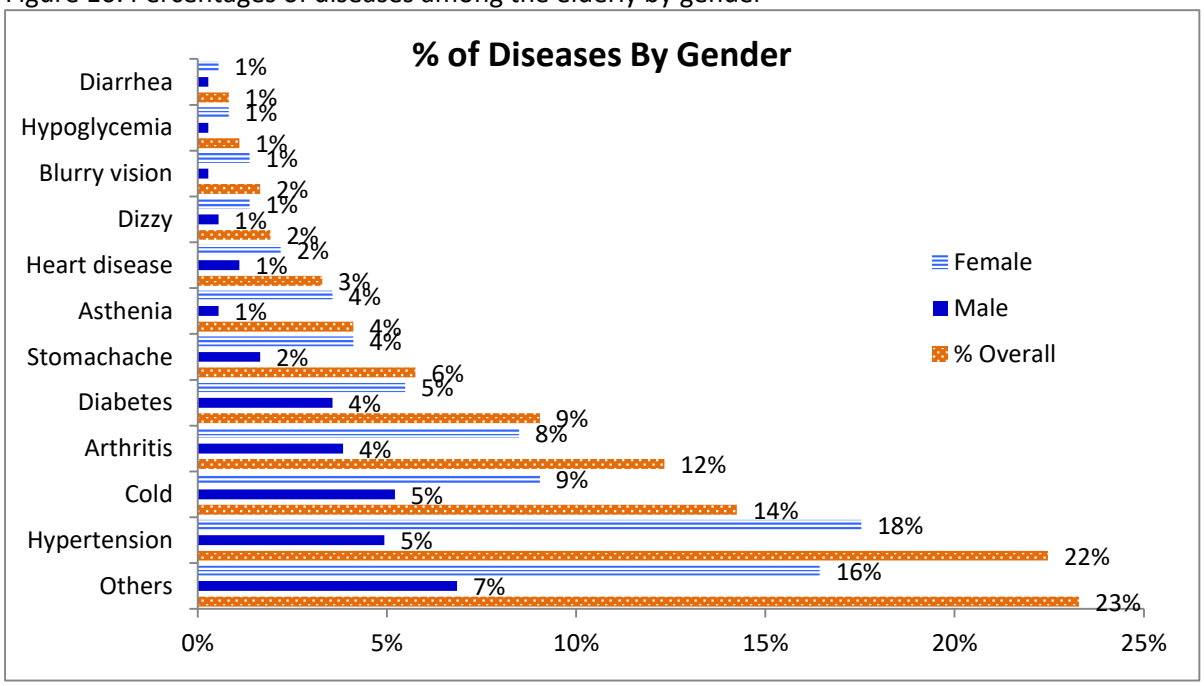
The above graph indicates that more female and male older people (i.e. more than twice) are experiencing different types of abuses. This is clearly explained that females have longer life expectancy and are more attached to the family than males. That is why they are more exposed to abuse risks at home. By region, the abuse cases exist similarly from 16-26 per cent.

3.9 Health care of the elderly

When discussed about their disease symptoms, enumerators are advised to seek the information from those older persons or their caregivers who can understand or remember the medical comments or feedback from doctors, nurses or medical staff who they visit recently. The list of the diseases presented in this section is those confirmed diseases from medical comments on their individual health cases. Of the total responses, other diseases that cannot be specifically classified in each single group due to its too many reported individual disease share the most percentages of all. These other

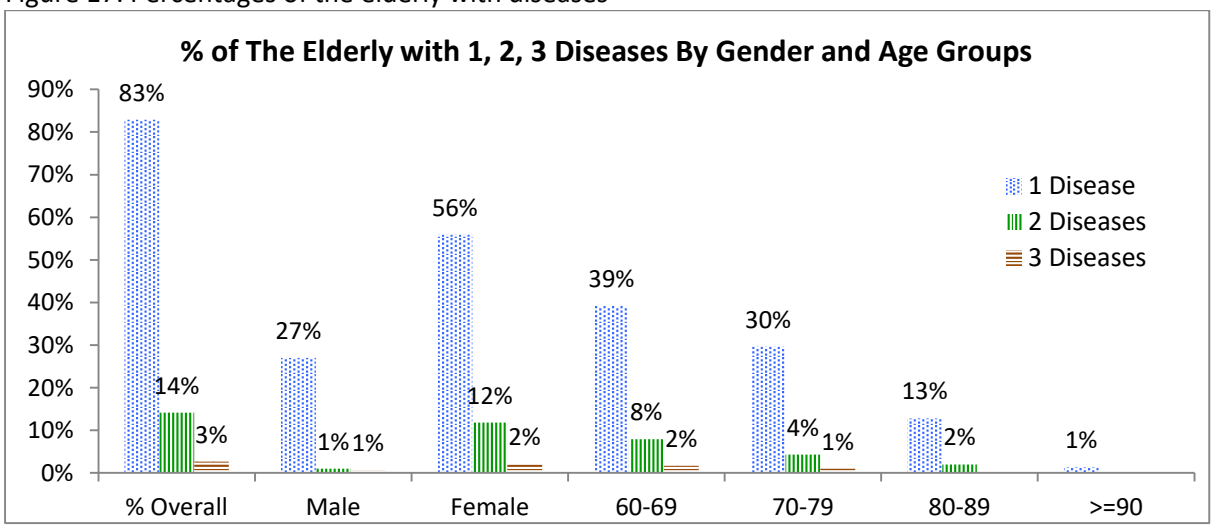
diseases are back-pain, cough, cataract, fatigue, tinnitus, dehydration, gastroenteritis, appendicitis, warts, mumps, myopia, psoriasis, scabies, osteoporosis, and periodontal disease. By order of higher percentages, the most commonly identified diseases among the elderly are hypertension, seasonal cold, arthritis, diabetes, stomachache, asthenia and heart diseases. The female older persons seem to be exposed and affected more often from these diseases.

Figure 16: Percentages of diseases among the elderly by gender



Further analysis reveals that majority of the interviewed elderly has one disease at a time; while 14 and 3 per cents have two to three diseases (Figure 16). Again, the female group remains the highly vulnerable group to diseases. Based on age group, older persons are lesser and lesser affected by the diseases.

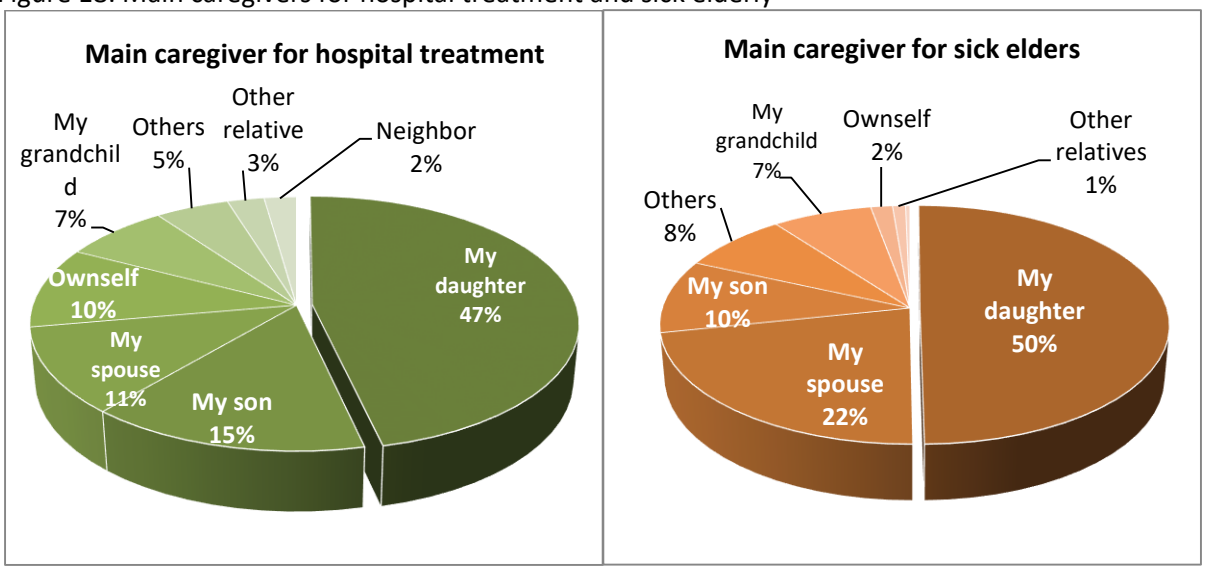
Figure 17: Percentages of the elderly with diseases



Once looking at who works the most to take care the elderly, either to bring them to hospital or caring them at home, the survey result indicates that daughter of the elderly is the most essential caregiver. Among the actors, the elderly mentions that his or her daughter the most as the only one who spends more times bringing them to hospital and serving them when they are sick or cannot move. 47 and 50 per cents are their daughters. Sons and their spouses are also those in handy help to bring them to health centers, private clinics or hospitals or bring medical staff to visit them at home for the treatment. Also 10 per cent of the caregiver is themselves who can walk or travel to seek services from the medical agents. However, during the sick period, their spouse (i.e. for those still living together) is

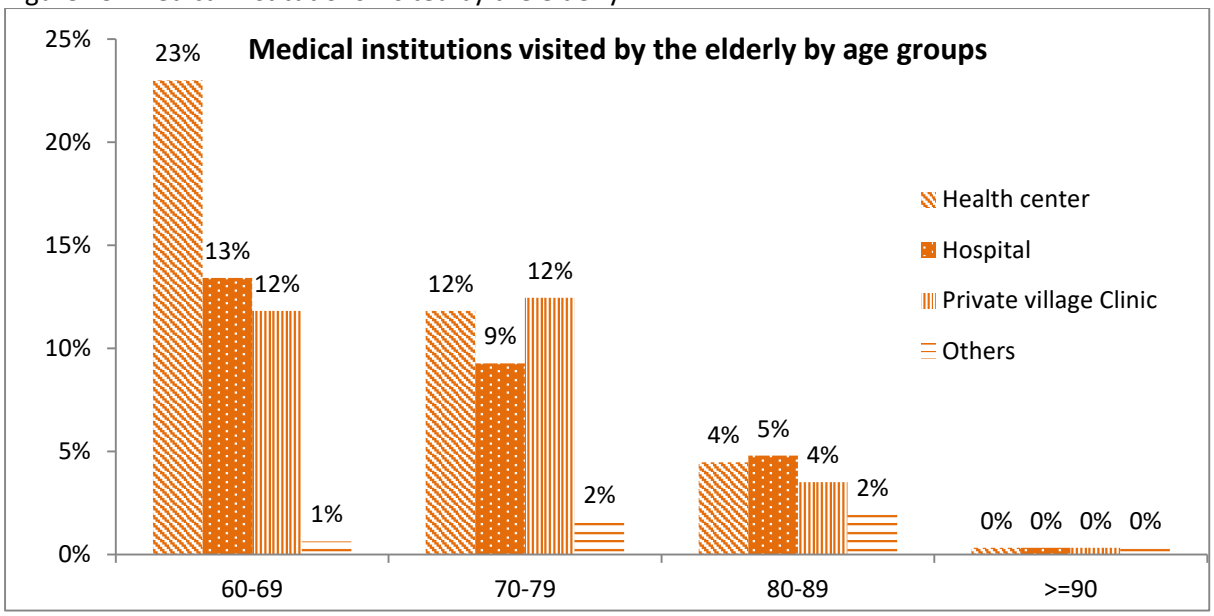
the most important caregiver after their daughters. When the elderly is sick, caregivers usually prepare food, wash their clothes, send them to hospitals for medical treatment, bring them around for tour visit, or even bathe them.

Figure 18: Main caregivers for hospital treatment and sick elderly



When asked where they seek medical services when they are sick, the elderly more often goes to health centers, hospitals, and private clinics nearby their homes. Based on the figure below health centers within their locations receive more elderly patients than other medical institutions, especially for 60-79 age groups. The visit frequency declines for the old-old and very old-old groups as they are too old to move further from their home. Private clinics or medical staff still plays active health care services for the elderly, particularly for the old-old groups.

Figure 19: Medical institutions visited by the elderly



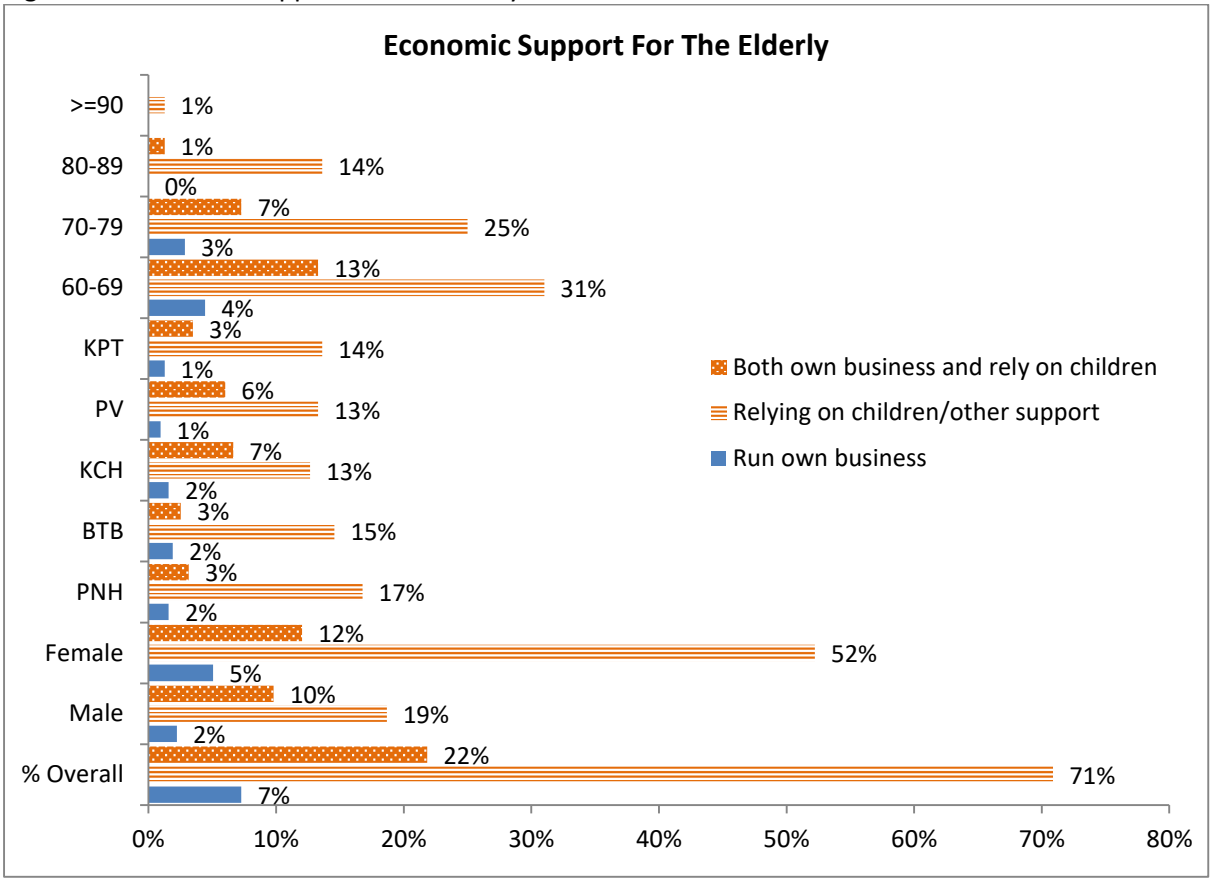
Once asked what and how the elders want to improve their current health conditions, they want more special cares and better access to health services. They express their disappointment of the treatment efficiency and quality of the local health centers or posts nearby and within their villages due to the shortage of curing materials and non-specialized medical staff. Moreover, elders are more sensitive to the treatment of health service providers in terms of inappropriate speeches or attitudes when they come for the services. They want more specialized doctors or nurses or services for the elderly

at the health centers within their locations. Or is there any possibility for the doctors/nurses or health volunteers to visit their homes for regular treatment or consultation, or once requested. We need also to work harder in the later to understand more needs and challenges of those ageing with disability[5] and design the assistance program to reduce their difficulty.

3.10 Economic support for the elderly

Economic support is essential for every individual person since his or her birth to their death. The survey seeks to understand economic support for the elderly from the age of 60 to 90 plus as this economic factor is always the worrisome of every elderly and most often in developing country like Cambodia it limits them from enjoying their healthy ageing.

Figure 20: Economic support for the elderly

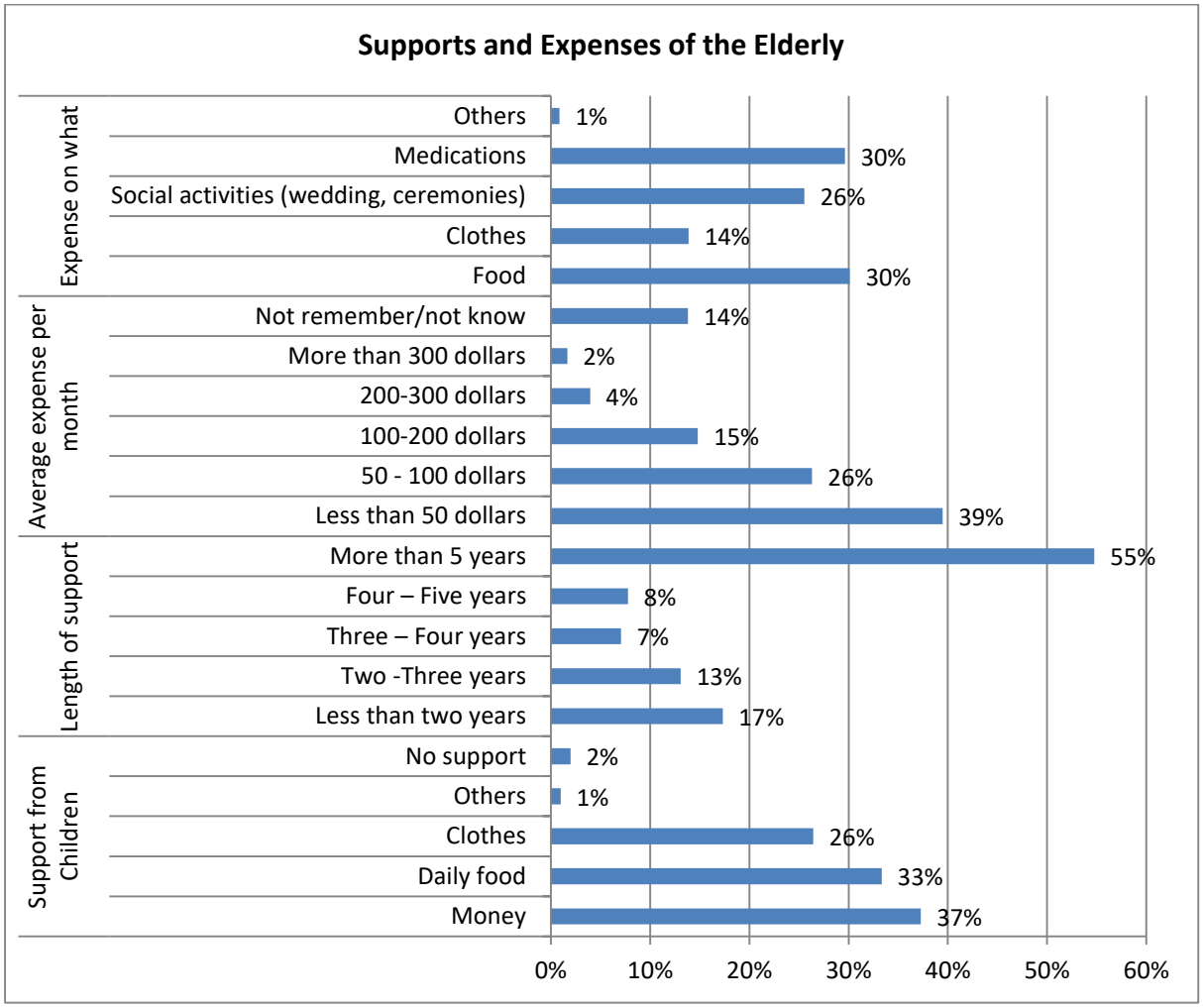


From all responses of the interviewed elderly, 71 per cent depends on the support from their family members including their children. Such dependency is all high across gender, study locations and age groups. Still some older persons run their own businesses and at the same time get supported from their children. This category shares 22 per cent of the overall and is also potentially high in other groups, particularly in the young old group. This confirms that at least 22 per cent of the elderly in studied areas remain active in their economic earning for their daily living, and female group seems to be more dynamic than men.

Looking at the family supports, it is noted that cash is a common commodity in general. Within the package of the support, cash, offering daily food and clothes share 37, 33 and 27 per cents respectively. 55 per cents of the elderly are supported for more than five years. In average, the elderly spend from 50 to 100 dollars per monthly and there is no difference among gender, areas and age groups. Food and medication are the most expensed items which share 30 per cents each. Also 25 per cents of the expense go to social relations for instance wedding and other religious events.

Figure 21: Supports and expenses of the elderly

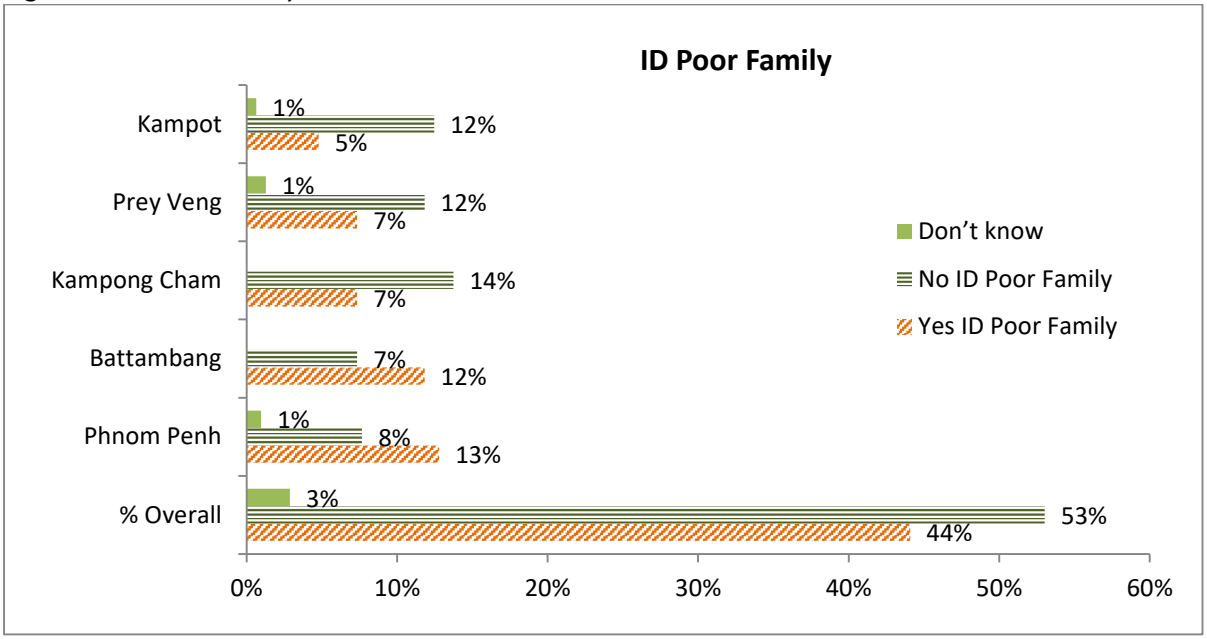
[5] According to Verbrugge (2002), "people who incur disability at birth or in childhood are said to 'age with disability', and those free of disability until mid- or late-life are said to experience 'disability with ageing (NDA & NCAOP, 2006)'"



3.11 Social Supports

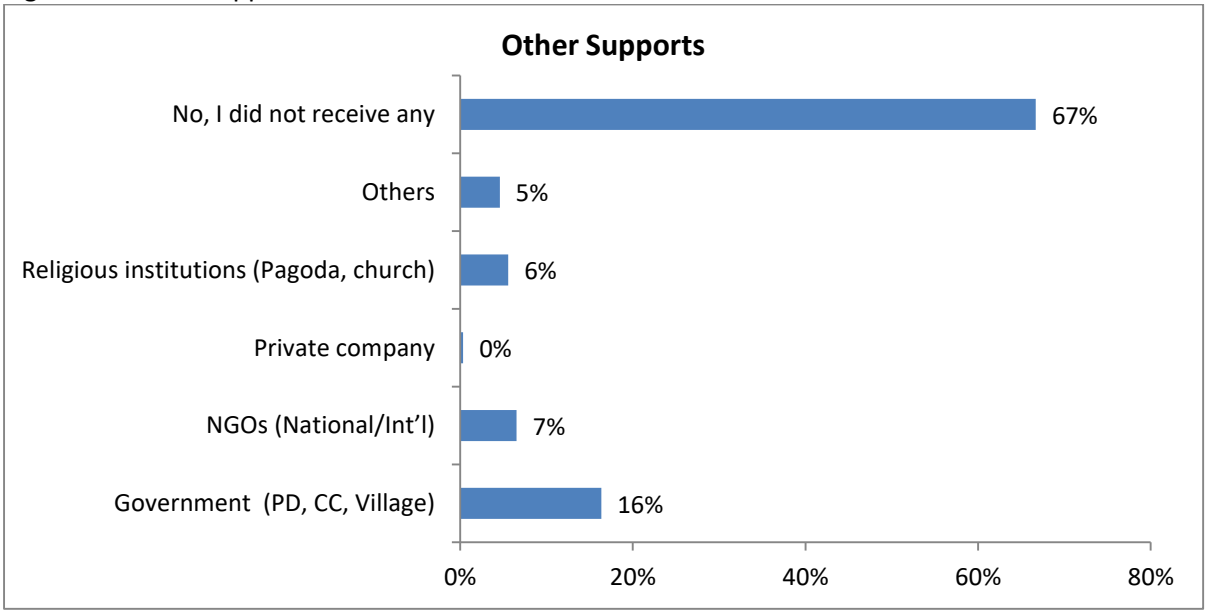
The study discovers that 53 per cent is not categorized as the privileged households to receive the ID Poor from the government, though their household characteristics fall within the criteria. Or because they are not yet covered in the ID Poor assessment. However, based on the study result, more households in Phnom Penh and Battambang i.e. 13 and 12 per cents receive the ID Poor cards; while more households in the other three provinces are not given. The ID Poor card helps assist the family in accessing to a free and subsidized health care services from the state medical institutions or agents in their vicinities. Moreover, 67 per cent does not receive any other supports and only 16 per cent is invited for gift-giving events from local authorities. Regarding OPA, 68 per cent is aware of this association, but only 57 per cent is the members.

Figure 22: ID Poor family



67 per cent of the elderly in the study areas expresses that they have not received any support from any group or institution. 16 per cent mentions the provisions from the government as they can remember through selections from the village or commune chiefs. Red Cross visits the areas and provides periodically assistances to the needy.

Figure 23: Other supports



CHAPTER FOUR: RESULT DISCUSSIONS

This chapter presents the discussions of challenges the elderly is facing. It starts from a general overview to each individual presentation of issues or challenges, followed by sub-group analysis.

4.1 Continuous trend of older population

The increasing of longevity is noticed throughout the globe currently, rather elderly people have shown the needs for care and support on their health care and various demand from individuals, families, communities and societies which is a concern (Rathny et al., 2018, p. 530). In Cambodia, presently there is 6% of elderly population aged 65 and older (Kosal et al., 2014) and the 65+ has increased and continued to increase from 2018 onward due to the higher life expectancy of the elderly population (Royal Government of Cambodia, 2016, p. 8) from 54 years for males in 1998 to 67 years in 2013 and 58 years for females in 1998 to 71 years in 2013 (Royal Government of Cambodia, 2017). There is 7.2% of older persons of total population in 2015 and this is expected to increase to 11% in 2030 and to 17.9% by 2050 (Ibid). The ratio of both sex of older persons in 2008 is 6.3 ratio for those of 60+ and 4.3 ratio for those of 65+ and this keeps on increasing in 2013 to 7.6 ratio for 60+ and 5 ratio for those of 65+ (NIS, 2013). Same report further emphasizes that the dependency ratio of the elderly people in 2008 has been increased from 6.9 to 7.5 in 2013 (Ibid).

4.2 Correlational analysis

The analysis strives to understand the influence and relation of key independent variables on and to the ADL, IADL, abuse, depression, nutrients and disability.

Table 7: Correlational analysis

Variable	ADL	IADL	Abuse	Depression	Nutrient	Disability
Education	*.137**	*.183***	*-.178***	*-.231****	*.085*	*-.295****
OPA member	*-.025*	*-.046*	*.126**	*.114*	*-.025*	*.119**
Age	*-.232****	*-.289****	*.034*	*.088*	*-.083*	*.301****
Sufficient care	*.052*	*-.138**	*-.258****	*-.103*	*.142**	*-.080*
Income	*.141**	*.337****	*-.074*	*-.176***	*.045*	*-.285****
ID Poor	*-.054*	*-.125**	*.059*	*.043*	*-.084*	*.111**
Disability	*-.504****	*-.543****	*.205****	*.252****	*-.132**	*1*

Note: Significant at ** p<0.05, ** p<0.01, and*** p<0.001*

The findings have shown that there are statistically significant correlations between education, age, and income on the performance of ADLs. This explains that the more education in higher level of older people received ($p<0.05$), increase the performance activities of daily living. Also in the negative significant effect shows that when people get older in age ($p<0.001$) they turn to be more vulnerable in the concert of their ADLs while the income ($p<0.05$) is also significantly influenced the ADLs. The study does not find it significant in the determinants between OPA members, sufficient care, and ID poor with the performance of ADLs.

Similarly, in the six factors mentioned above have five resulted in statistically significant with the routine of IADLs among the elderly both negative and positive effect. Education with ($p <0.01$) has positive notice on the IADLs which means the more knowledge older persons have, the more capable for them to manage their IADLs. Income is one among them which shows the very positive significance on IADLs ($p <.001$), providing that the elderly who is having higher income tends to better perform their IADLs much stronger than those who are less economic resources. This also proves in the negative statistically significant finding that those older persons who are having ID poor with ($p<0.05$) have lesser ability to manage their IADLs. However, OPA member is not found significantly in statistical analysis on both the performance of ADLs and IADLs.

The result also reveals that education, and sufficient care have negative significant statistically on abuse cases to old age, while OPA member found positive significant. This means that the more education older persons have ($p<0.01$), the more reduction in the abuse cases and the more care provided ($p<0.001$) to old age, the less abuse to be reported. In positive significant, OPA member is found to have abuse cases similar to non-OPA member ($p<0.05$). However, age, income, and ID poor have not found significant on the abuse.

For another health issues, the depression of older persons is found to be influenced negatively by education ($p<0.001$) and income (0.01) while it is not found among OPA member, age, sufficient care, and ID poor. This means that older people have more depressed when they have less education and more depressed when their income is low.

Interestingly, among the six variables there is only one proved to have positive significant impact on nutrition, the sufficient care ($p<0.05$) which means that the more care offered to older persons, the more and better nutrient they obtain. In contrast, the sufficient care is not found to have significance on the disability while the other five variables such as education, OPA member, age, income, and ID poor do. It is observed that the more education older persons receive, the less likely disabled they are ($p<0.001$). Income does have strongly negative significant relation with disability which the p value is bigger than .001 and this can be explained that those who have more income are able to cope with their disability through better access to health care and visual aids.

In positive influence, OPA member is significantly affected on the disability ($p<0.05$). This means OPA member does have impacts by disability as do the non-OPA members. Also, the age determinant is found to have influenced on disability ($p<0.001$) which means when people get aged, they are likely to have more disability. To be more evidence, ID poor does have linked to the disability among old age ($p<0.05$). Regarding to the finding on the determinants of depression and disability, it is observed that education and income has negative significant influence which means if older persons get more education, they tend to be less depressed and less disabled. However, sufficient care, OPA members, age and ID poor have found no significant influence on depression. This means that the older persons get depressed regardless they are OPA members or non-members.

From the correlation analysis, the ADL and IADL performance of the elderly is determined by the education, age, income of the individuals. The older, more educated and richer they are, the better they tend to perform the two. For IADL, sufficient care and ID Poor categories positively improve the IADL exercises. Besides, the dietary of the elderly does not have much relation with the independent variables (IAs) tested; but the rest is strongly correlated. Disability is much linked to all IAs, except sufficient care. No matter how well they are cared, ageing-related disabilities cannot be reduced or prevented. Education and income do influence on the depression of the elderly. The levels of abuses depend on how much the elderly is educated and how adequately the family members care.

The correlation table indicates that disability has negative influences on ADL, IADL and nutrient. This is confirmed that the older they grow, the more disabled they are in challenging their management of their daily and instrumental activities and their dietary. They cannot properly control their movement and nutrient intakes as their physical and mental abilities are weakened due to diseases or ageing processes. Moreover, the analysis further confirms a positive relation of disability to the increasing incidences of higher prevalence of abuse and depression among the older population. Losing part of their physical and mental functionalities, older people are more likely to be abused from their neighbors and they themselves feel also depressed due to impairment difficulties.

4.3 Physical wellbeing

Ageing process causes both poor physical and mental functionality of a person. Their intrinsic capacity[6] declines when they reach their ageing period (WHO, 2015). Together with their deprived socio-economic status, the health and well-being of the older population are weakening, leading to remarkable diseases and impairments. At the same time, their vulnerability increases as they grow older, no matter with whom or what conditions they are living with or in. Commonly, it is understood that enhanced physical activities could lead to a better wellbeing of the older adults as these help prevent them from chronic disease and improving their cognitive performance and disposition (Khaghani Far et al., 2015). Ageing issues attract more attentions to improve the understanding of gerontology[7] and how needs are efficiently addressed. Ageing challenges a healthy life of the elders. The World Health Organization defines *health as a state of completed physical, mental and social well-being and not merely the absence of disease or infirmity*. If this definition is really applied, then it is hard to find anyone free from frailty in the case of developing Cambodia.

A. Older people

1) **Ageing with diseases** - The results indicate strongly that older people from 60+ experiences more physical and mental illnesses. Non-communicable diseases are reported most frequently such as joint pain, hypertension, diabetes, cough/respiratory diseases, back pain, low-sighting, osteoporosis and fatigue for instance. There is a rare case of serious communicable disease, except seasonally infected symptoms i.e. flu or cough. On the other hand, the older people could not clearly explain their pains and symptoms of their sicknesses and this makes the local medical staff very difficult to identify their specific cases. Such unexplained chronic conditions[8] keep the elderly worry and anxiety. This can be explained that 1) the older people are not much capable to describe their illness symptoms due to their low literacy and ageing difficulties (i.e. memory loss and behavioral changes); and 2) health care staff they visit are not specialized at commune health centers and village private clinic or staff. Normally, there is limited specialized medical staff at the grass-root health institutions in Cambodia. Based on the 2017 Annual Health Report of MoH, there are 674 specialized medical doctors in 2017 (MoH, 2017, p. 136). Public expenditure for health care in Cambodia is around 5-7 per cents of the GDP which the target is to increase up to 30 per cents in public health sector (MoFA, 2018). Still there is a big gap in trust of the quality and services in public health institution both facilities and health professionals (ibid). At commune/sangkat level, there are health centers and health posts. By December 2018, there are 1,141 health centers[9] and 107 health posts in 1,633 communes/sangkats. These local health institutions are providing basic minimum package of activities (MPA) which mainly focuses on promoted, preventive and very basic curative services (MoH, 2017, p.3). These limited medial services are hindering the access and behaviors of the users including the elderly population. Accessibility, availability, and sufficiency of the medical facilities and professionals are posing critical barriers in providing the trusted quality and services.

   The disease challenge is also strongly acknowledged in the 2016 Cambodia National Health Care Policy and Strategy for Older Peoples about the increase of the non-communicable diseases among the older adults in Cambodia. Out of the diseases discovered, the most common chronic symptoms amongst the elders are diabetes and hypertension; while the two most mental illnesses are depression and dementia. Usually the elderly has fears of many things in relation with their health, personal finance, and other injuries that can easily create depression among the elders (Gurung & Ghimire, 2014). Through the National Health Care

[6] WHO defines ''intrinsic capacity'' as all the physical and mental capacities of an individual. This capacity peaks at the age of 20 and falls down instantly after the age of 60 (WHO, 2015).

[7] A study of the social, psychological and biological aspects of ageing

[8] Chronic condition is a disease, disorder, injury or trauma that is persistent or has long-lasting effects.

[9] Health center covers 10,000-20,000 people while the health post covers 2,000-3,000 people and have 15km closet to the health centers (MoH, 2017).

Policy for the Elderly and other primary and secondary health interventions, the government has recognized the demographic and epidemiologic transitions in Cambodia, resulting in the incremental increase of the 60 plus population and their struggle to a healthy ageing. The policy targets to bring more betterment to the late-life people through enhancing and improving the health accesses and diverse services at the doors of the needy elders. Such efforts are essential and must be achieved and progressed steadily.

2) **Disabilities with ageing** – the ageing progress of the persons leads to the weaknesses of the physical functions. The older they get the more difficult they challenge in moving around. Most of the observed elders (70+) are facing the issues of general physical mobility (i.e. walking, seeing, hearing...). For ADL, the result confirms that people in the age of 70-90 for both males and females are risking their 4-5 ADL physical disabilities; particularly in the functions of getting up and managing their bowel movement. Other aged physical impairments are found among the elder population including toileting, dressing, bathing and self-feeding. If compared to ADL, the same older people confront more IADL than ADL challenges in shopping, self-transport management, cooking, washing clothes, doing housework and financial management. The middle-old and old-old groups are risking the most. Thus they require more intensive assistance from their family members.

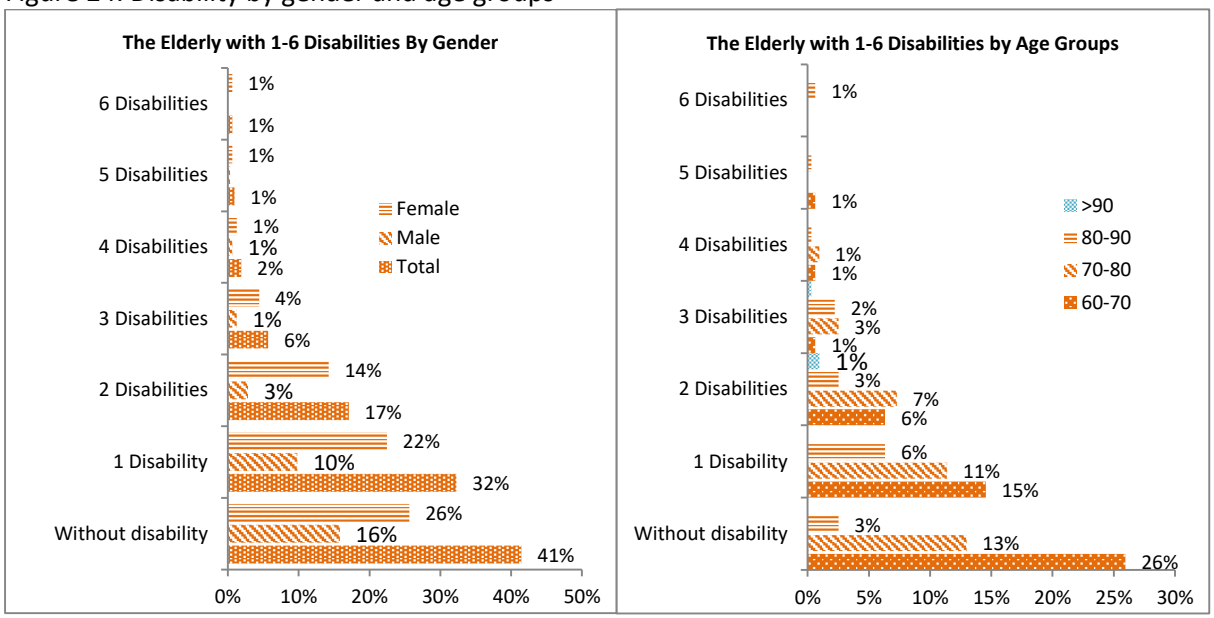
   Commonly, the physical and mental conditions of the older elders in the study areas tend to cause disability[10] in completing physical tasks, IADL and activities of daily living[11] and their personal cares. Such disabilities become both needs and challenges that require more intensive responses and care to those in need to relief certain critical situations. Health challenges are relatively linked to persistent disability of the elderly and this has proved the existence of such challenges and needs among the interviewed peoples. Regarding the disability, it is noted that the older they get and the more limited mobility they face. The Washington Group on Disability Statistic defines persons with disability as *"those who are at great risk than the general population of experiencing the limitations in performing specific tasks or activities or restriction of participation in society"*. From the study finding, though 41 and 26 per cent are free from disability by gender and age groups, majority is struggling with their ageing disabilities at least two among the six domains for those between 60 and 80 years old (Figure below).

   Moreover, the disability of the elder population is quite linked to the food diet and the nutrients. Food has an important influence on physical health and independence (Ministry of Health, 2013). Having good food for the older people is a bless as this help prevent them from malnutrition, support their physical functions, reduce the risk of chronic diseases, support their mental health and prevent them from the disability (ibid, p.12). Analyzing their food composition (based on Figure 8) reveals that many older people do not adequate calcium, folate, vitamin B6, vitamin B12 and vitamin C through the food they need. Such deficits hinder the health of older population and ageing with disability is a real challenge.

[10] An umbrella term of impairments, activity limitations, and participation restrictions, denoting the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors – environmental and personal factors

[11] Basic activities necessary for daily life, such as bathing or showering, dressing, eating, getting in or out of bed or chairs, using the toilet, and getting around the home (MoH, 2016)

Figure 24: Disability by gender and age groups



Based on the guidance of the Washington Group on Disability, the interviewed elderly is having disabilities in all the six domains, but communicating, seeing and remembering are the top three infirmities (table below). More females are exposed to these challenges. By age group, the young old and old-old groups share the most percentages of the total disabilities. This is truly convincing that the same age groups are tested to obtain one to two diseases (i.e. hypertension, arthritis) (Figure 16) and have mild percentages of cognitive impairment (i.e. 23% for 60-69 and 19% for 70-79) (Figure 10), and at least have 16 per cent and 14 per cent of a combined moderate and severe geriatric depressions (Figure 11) that deactivate them from better communicating, sighting and memorizing. However, the 28 per cent of the 80^{+} people are normally more affected by their poor ageing progresses.

Table 8: Physical impairments of the elderly

Disability Types	With Disability	Gender		Age Group			
		Male	Female	60-69	70-79	80-89	>=90
Seeing	28%	6%	22%	11%	11%	5%	0%
Hearing	9%	3%	6%	4%	3%	2%	0%
Walking	5%	2%	3%	2%	2%	2%	0%
Remembering	18%	3%	15%	5%	7%	5%	1%
Dressing	3%	0%	3%	1%	1%	1%	0%
Communicating	36%	9%	27%	11%	14%	9%	1%

B. Older women

Women share the majority of the elder population both in national proportion and in the studied samples. The high prevalence of older women with old age and long life expectancy in the previous literature is consistently found in this new finding that more women getting older and live longer than men counterpart. However, their existence does bring about many physical and mental health concerns. More women are noticed in the finding that they are more vulnerable in the physical and mental capabilities and they need assistance for performance of their daily tasks. The analysis on physical disability indicates the high percentages of older women with one to two disabilities on communicating with others and their sighting ability (Figure 24). The analysis further emphasizes that women have similar prevalence than males of 4-5 ADL disabilities (i.e. bowel movement, getting up from bed and toileting for instance). But the same group has a higher percentage of IADL disabilities than males in the areas of shopping, housework, washing clothes, cooking, financing, and transportation. For disease, 12 per cent of older women is exposing to 1-2 diseases at a time; while there is only 1 per cent of males (Figure 17).

Exercise is among the activities to improve their dynamic capacity in the old age. Usually the elderly is recommended for a certain physical exercise to keep their body configured. Still there is a limited practice of such activities found in the study areas, especially among the older women. "*We do not have time and I am sick*" is a most often reported excuse once asking for the reasons not to do it. Similarly, the study in 2018 by a group of researchers in Spain confirms that older women find themselves very difficult to do physical exercises due to their lack of time and poor health conditions and it is even harder to motivate these people to do it (López-Benavente Y, et, al, 2018).

C. Older people with disabilities

This is referred to those elderly having disability with ageing in their late-life periods. Finding evidently proves that as they are getting older, they are more prone to disability and weaknesses in their ability to perform their basic activities. In terms of health and disability issues, there is no distinguished needs or challenges requested or faced by either male or female groups, or either in rural or urban areas. Once they grow old and older these peoples express their similar dissatisfactions of their poor health conditions. Across gender and areas, the elderly does not see themselves living in the healthy ageing as their functional abilities are degraded and so are their insecure economic assets and supports. More interestingly, majority of the older persons do not have any visual aids or assertive technologies[12] for instance prosthetics or orthosis to support their mobility or lower their vulnerabilities to physical difficulty, except their home-made walking stick. There is no wheelchair found with the elderly in the areas, but certainly there are immovable peoples due to walking impairment.

4.4 Mental wellbeing

Mental illness regardless of light or severe cases is an epidemic condition of the ageing population. Depression or dementia is very common among the older peoples. Such problems are reported and correlational analysis confirms positively. Early diagnosis of the symptoms can prevent typical mental illnesses and reduce suffering in the late-life peoples.

A. Older people

The **depression** scale is quite high among the interviewed older persons. 83 per cent of the interviewed elderly is classified as being depressed while 47 per cent of this is in their mild depression, and 27 and 8 per cent are in their moderate and severe tensions (Figure 11). This encounter is critical for social workers and policy-makers. As observed, most of them feel hopeless due to the lack of personal and family savings and their poor physical and mental conditions. They also express their worry as a burden or a useless person for their family when they grow older. Depressions of the older people are usually under-reported and quite difficult to note their symptoms. The common signs of depression are difficult or poor sleep, isolation, tenacious thoughts of death, impaired sensory or poor concentration, or loss of interests in life or daily activities. When analyzing their responses, three typical depression factors among old-aged people in the study areas are:

> **1) Chronic unexplained physical symptoms** (usually no sufficient medical description found for signs like dizziness, constipation, insomnia, long-time aches and pains or weight loss): When interacting with the elderly, they most often complain of their pains and aches relation to their bodies and mental health. It becomes common stories the elderly told to very visitors but they cannot identify what types of pains or illnesses they are having. Key informant interviews with OPA manager and DoSVY mention similar sharing of the pains and suffering the elderly is facing. But there is no serious medical clue of any specific disease. Doctors have advised that their pains are usually a combination of many infections that need intensive diagnosis. In Cambodia, the elderly under-reports such symptoms as there are some reasons behind, for instance, limited knowledge to pinpoint exactly the effects and traditionally less sharing with the family members to avoid being felt as a burden. Then they seem to keep mum and learn to live these difficulties and therefore they are internally depressed. Unlike many

[12] Any device designed, made or adapted to maintain or improve an individual's functioning and well-being (MoH, 2016)

developed countries, there is no formal system that the elderly can turn to for some advices or counseling services in Cambodia when they feel depressed.

2) Memory loss – the elderly shows signs of forgetfulness or confusion that makes them difficult to communicate with others or discourages them from enjoying their ageing. Their cognitive capacity degrades and causes more distresses among the older persons and will eventually leads to dementia (Ballard, 2010). The state of a memory determines how good or bad their rational thinking is. In this study, memory loss happens for every older person but the middle and old-old age groups tend to have this quite often. The MMSE tool used in this study reveals that 43 per cents of the elderly experience the mild and severe cognitive impairment and this is due to ageing process and their poor health conditions. Another reason is that the elderly worries more for their family members and daily living activities of the household, as the economic saving is insecure. Poverty still rams the rural Cambodia and the economic status varies and strengthens their well-being.

3) Behavioral changes (i.e. more often talking about death, or isolation from others) – as ageing processes the sensory changes, pains increases, and memory is low. These contribute to changes of certain attitudes and behaviors. The interviewed caregivers, provincial DoSVY and OPA managers have all noticed that their older persons have irregularly changed their behaviors due to their struggles with diseases and apathy with their poor socio-economic lives. The changes may be the causes of their physical disabilities. The finding further confirms that every elderly challenge with at least one to two disabilities that may include hearing, seeing, walking or remembering. Such difficulty affects their ADL and IADL performance that may more or less changes their reactions to things and people around. One more important reason for their behavioral changes is the traumatic event from the genocide time (i.e. 1975-79) when they lose their beloved ones or lifestyles they have enjoyed, or undergo a chaos regimes. The study in 2011 by the DC-Cam notices similar conclusion that the elder survivors from that regime have post-traumatic stress disorder (PTSD) and depression (Boehnlein & Kinzie, 2011, p. 33).

The **abuses** over the elderly in the studied areas must not be ignored because the findings indicate the critical situation where they have been, are being and will be abused. Abuses take many forms. According to (WHO, 2016), elder abuse is the abuse and neglect of older persons and happens in the forms of physical, psychological or emotional, sexual, or financial abuses. Or the mistreatment of the older persons or intentional or unintentional acts of the caregivers, family members or any person that leads to harms of the elderly. The state of neglect or abandonment is also considered as the abuse too. Such abuse can happen once or repeatedly. Among the factors assessed against the elderly in the studied areas, the abusive situation is potentially existent among the elderly and this is clearly convincing that abuses usually happen at home than other places. Most of them has less privacy at home, feel not wanted or not being respected, and feel distrust with or afraid with some family members. Most common types of abuses observed are physical, emotional, and neglect. One Cambodian proverb says that "the plates on a tray will inevitably ram each other" which reflects a corporate acknowledgement that people living in the same family will somehow debate or argue over little things. In daily engagement, family members tend to create some verbal assaults, insults, humiliation, intimidation or harassments on their elderly parents. But such treatment especially for the elderly is sensitive to their thinking and attitudes, resulting in aggression, anger, or disappointment. The anti-ageing attitude exists most often in the poor families than the ones having more resources. It is always a blame that poverty distracts the well-being and happiness of the family members and conflicts are simply evolved. One of the observations is that abusers particularly their children or other family members do not recognize that their acts towards the elderly are abusing the feeling and dignity of their older parents. Then such attitudes become non sensitive to the youngsters but not to the older. Also in Cambodia, the elderly does not report or share abusive cases with others because they do not want themselves or their family ashamed or harassed, or retaliated in the future.

Many countries in the globe lack the formal system to log and receive the complaints from the abused elderly. And this shortage continues to keep the elderly in a more depressed environment.

Two main factors causing abuses are *physical and mental impairments*, and *high financial dependency on the family members* – likely abusers. The survey results confirm that elderly is being affected by their ageing disabilities such as seeing, walking, remembering, and communicating. Their ADL and IADL challenge their living when they grow older. Such disabilities limit their active engagement with the family and require caregivers stay with and care those impaired people most often. The treatment from the family is less sufficient due to the less personal availability and more needs of complicated cares. This scenario causes some verbal and emotional violence over the elderly, potentially upsetting them or finally isolating them from the rest. On the other hand, the result echoes further that 71 per cent of the elderly depends highly on the supports either in cash or in kind from their family rather than other sources of provisions (Figure 20). Such high reliance can easily create certain emotional exploitations through demanding cash support and intensive care when the family has limited necessities. Other abusive forms for instance sexual abuse is not reported, but self-neglect and abandonment are reported in the studied areas. Examining the present abusive situation notifies that there are less positive reactions from the family and people around due to the lack of formal education or awareness of potential abuse acts and its consequences at school and in the public. The current elderly abuse requires serious attentions from key actors around the elderly to offer better and safe environment.

B. Older women

Female elders outlive males across the areas in the study. Such longer living keeps women in more miserable health and socio-economic challenges than men. As observed, female elders are challenging health difficulty harder and reaching more cognitive impairments and dementia than males due to their (1) longer life expectancy, (2) more attachments to the household responsibilities even though they are growing older (i.e. still taking care of the house and young children), and (3) low personal and family economic savings i.e. more remain in poverty, resulting in insufficient nutrients and economic support for a healthy well-being. Older women are assessed in the potentially abusive situation than men, meaning that the higher level of abuse, the more older women expose (Figure 13). Similarly to the depression, 35 per cent is in their mild-depression scale while other 25 per cent is combined for moderate and severe tensions (Figure 11). This can be concluded that the older women have critical levels of mental challenges and that the depressions and abuses must not be ignored for these people.

C. Older people with disabilities

The study alerts the importance of mental disability as other disabilities including physical infirmity. Old persons are found to get easily stuck or mental irritation disturbed by their life experience that pushes them to find it hard to solve problems in their communication. This is due to their living with trauma (PTSD), depression, cognitive impairment, or abuses. The study finding reveals that both older males and females have high prevalence of depression and abuse. There are a number of reasons to explain the factors and influences. First, Cambodian older people experience the trauma (PTSD) from the genocide regime. Trauma and depression is quite linked as people expose to long-time stresses or disappointment or losses that may unexpectedly affect the feeling. Trauma generates comorbidity and this leads to certain depression among the beholders.

Some older people are living in deprived socio-economic status as their family is poor and vulnerable to varied social and economic conditions. 44 per cent of the samples are ID Poor card holders and other 53 per cent is not assessed but very potentially sensitive to fall under the assessment criteria of Poor I and Poor II. Moreover, focus group discussions and key informant interviews confirm that the majority of the elderly is struggling with their poverty due to unproductive agricultural farming and gardening. Such low economic profile keeps the elderly in a worrisome position and thus creates intense fear and confusion about their lives and family. Moreover, it is recorded that insufficient cares due to limited resources (i.e. less healthy food, limited access to health cares, no full-time caregivers available,...) are likely to create the abuses over and depression of the elderly.

Another reason is that there is a shift of the family arrangement due to the local family economic catastrophe. Youngsters are migrating out of the village, looking for a better fortune and leaving behind their elder grandparents, parents and babies. This is a neglect abuse because the older people also require cares as well as the babies at the time of having no family members to handle the tasks. Such limitations are building up the needs for lonely, hopeless, and depressed feelings among the left-behind older people. On the other hand, the responses from individual older persons reflect that they are most often feeling lonely, having less privacy at home or being told not do anything or feeling not comfortable with anyone of the family (Figure 12). The response raises a grave concern that abuse strongly exists and must be responded positively.

The finding and field logics prove that the older people are having complications in managing their cognitive capacity and protecting themselves from abuses especially at homes. It is evident that these people require more intensive cares and safe responses to reduce their mental disabilities.

4.5 Key health care challenges of the elderly

As people grow old, health is the priority due to the declining physical and mental functionalities. Health care is a forefront that the government, NGOs, and other stakeholders even the older people themselves must confront and seek appropriate solutions to assure their healthy ageing. The following discussion summarizes key challenges in achieving better health care for the older people. Based on the group discussions with the older people, key challenges are written in the order of the most to the least concerns:

1. Income poverty – The key most concern among the older people interviewed is income. It is explicitly understood that the poor and poorest complain of having inadequate living incomes, that usually blocks them from seeking for the health care services from their local centers or clinics. Majority of older people is living without their own-generated income and instead depends very much on the support from their daughters or sons. It may not be a big deal if they are from middle-income families but it is a real concern if they are from poor I and poor II families. Elder parents in Cambodia make no report of their early health symptoms to their caregivers because they do not want to feel as a burden in the family. If their family is poor, then they ignore the symptoms and may seek for treatment when the diseases are beyond the save of the doctors. Insufficient or limited income or cash is a main driver leading to serious diagnoses.

2. Disease-nutrient – Diseases are threatening their ageing conditions. From the result analysis (Figure 24), they usually have one disease and 1-2 impairments when they grow older. Moreover, the case of individual and family poverty has further affected the dietary of the older peoples. Nutrients are important and having inadequate or inappropriate intakes are instead deteriorating their immune system and infected organs are active and strong. Such circumstances have worsened their ageing healthy lifestyle.

3. Limited access to services and service quality – Analyzing the responses from the older peoples indicated that they are not satisfying with the health services in their localities in terms of accessibility and quality. Health centers and posts are quite incapable in diagnosing serious illnesses and usually patients are transferred to the provincial referral hospitals where it is far from their villages and service treatment is always costly. The quality is rated below the standard (i.e. based on their social thinking) as they compare with the private clinics or hospitals. On the other hand, hospitals have less specialized doctors and services for certain diagnoses of the elders.

4. Limited skill/knowledge and availability of caregivers – The study identifies that older people are very much dependent on their caregivers so that they can enjoy their healthy ageing. The responses from the available caregivers interviewed prove that they practice their caregiving

activities based on their traditional knowledge passed through generations i.e. through their personal experiences witnessing their parents take care of their elders and then the later young children follow the same habit. This is a family wisdom shared with their youngsters by the parents in expecting that they are treated the same ways when they grow older. The caregivers are most often their direct spouse and children – daughters and sons, who have not been made aware of or trained for the techniques or know-how for elderly's caregiving. Usually, it is a frustrating job for most of the interviewed caregivers as older people (i.e. 80+) are becoming babies that are not easy to listen to and obey what is told. Some are hot-tempered, sulky, resentful, or sullen, which obstructs the motivation of the caregivers. Such older characteristics are driving the abuses and this is similarly confirmed in the abuse section in Section 4.4. Sufficient and older-friendly care is essential to assure that older people are healthy and worry-free.

5. Less mutual inter-generational relations – The sharing from all stakeholders in the study provides a clue that there is a missing match between the older people and their younger children – caregivers. Through the questions of abuse and depression, it is noted that older people are not well understood of their needs and challenges by their caregivers; for instance, there are some potential cases of direct abuses over the elderly. Stakeholders engaged in the study admit that they are not performing caregiving better as they are also busy with their income-earning activities and the work is usually tiresome. The limited understanding of the caregivers regarding the techniques and know-how has hampered the healthy conditions of the older people and quite often does not respond to the actual needs.

6. Elderly's limited knowledge on health care – Table 1 indicates that 75 per cent of the interviewed older people complete only primary school and therefore their general knowledge regarding healthy eating diet is limited, especially for those low-income families. Table 6 further repeats that education has a strong significance or influence over the performance of ADL/IADL or even helps reduce abuses and depressions. This is convincing that well-educated older people tend to manage their health care better. They tend to know what to do or not to do that may harm their health. The limited knowledge of a person is clearly linked to their health care situation and the study finding indicates that interviewed participants are not very much capable to overcome these challenges by themselves especially those aging from 70+.

4.6 Economic wellbeing

Making a living among older people is found to be a challenging issue which leads to exhaustion and frustration. It is also a determinant of the quality of life of the elderly. The study comes with the figure that there is more reliance on economic generation of older persons from their children or relatives rather than from their own businesses.

A. Older people

Economic resource is essential across ages of the people. The elderly population in the study areas is found to be less participative in the workforce. Income is mainly from the support of their family members and less from their own business activities (Figure 19). Typically, the older people are penniless as they already work for and share their assets with the family members. Majority of the elders interviewed entirely depend on being fed by the family members i.e. their children. There are fewer reports of male and female elders who can independently generate their own incomes in the study areas. Many of them prove that they could earn less than 100 dollars while a very few claims to earn less than 200 dollars per month. That is why older persons need economic support from their family members in terms of money, daily food and clothes. However, their incomes and expenses are not balanced. In average they spend for themselves around 50-100 dollars per month for medication, food, social activities and clothing.

Also, there are cases of the elderly receiving pensions[13] but this is very minimal. Focus group discussions, key informant interviews and observation from the field reveal that older people engage more in the unpaid jobs including the subsistence farming and labor selling. Majority of the elderly in Cambodia remains active in the employment due to less support from family as youngsters are poor and migrating away, and also they are traditional farmers who still work on the farm during their 60+. The inter-censual population survey (CIPS) in 2013 (report no. 8) indicates that yet there is a significant proportion of the elder population in the workforce. The percentage is higher in rural area and there are more economically active male elders than the female ones. Instead, more female than male elders is engaged in the unpaid family work in both rural and urban. However, the share of the elderly in the workforce varies based on their ages. The older they get, the lesser share. The CIPS in 2013 further notes that there are 83.8 per cent of the rural and 62.3 per cent of the urban 60-64 age groups in the workforce and these percentages will drop to around 30.9 and 20.9 per cents when they are 75 plus (RGC, 2017, p. 7).

Family members or their close children are perceived to be the main breadwinner for the elders. Such finding confirms similar claims in the 2009 study by Knodel & Zimmer[14] that emphasizes the unique roles of children in feeding and taking care of their older parents. This has remained valid for Cambodian family arrangement and become habit for family members regardless of their poor or better economic status. In Cambodia, classically older parents are fed by the youngsters. They are old and cannot be more active for any employment and therefore are supported and taken care by the family members or relatives. It is not only practiced in Cambodia, but most countries in Asia where parents feed children and are fed back when they grow old and oldest. Regarding cash, their personal finance is not secured as they do not normally have personal possessions to spend for their old-age period. They spend their earning and saving for their children and in return become penniless elders. This cycle creates a high risk of poverty for the individual older persons.

The recent note on the potential support ratio[15] in Cambodia has proved that elders are facing with a shrinking decline for financial and care support. As highlighted in the National Ageing Policy, from 1998 to 2018, the two percentage point is clearly seen, falling from 15.5% to around 12.5% (RGC, 2017). The declining trend will continue to accelerate and by 2030 this remains only 9.3% (ibid.9). This particular falling situation indicates a concerning gap in financial and care supports from the family and that will become a burden for the government to tackle it.

Royal Government of Cambodia does not have program to financially support elderly people besides those who are retired civil servants. Rathny et al. (2018) found out that 7.4% of older adults retired received pension funds while instrumental, materials, and emotional support are from children, spouse, grandchildren or relatives (p. 537). However, the Social Protection Policy Framework is designing supports to those older people with the ID poor cards primarily due to the budget is limited.

B. Older women

Older women are less productive in the paid employment. For economic support, the finding notes that women depend on their family members almost as twice compared to men counterpart. Their work in the family does not earn any income but keeps them busy for a whole day. There are some reasons to explain this phenomenon.

[13] There are only 10 persons among the 316 older people. Only civil servants who serve in public sectors, around 7% of the total population, receive retirement pensions (RGC, 2017, p. 18).

[14] Knodel, J., & Zimmer, Z. (2009). *Gender and Well-Being of Older Persons in Cambodia.* USA: Population Studies Center, University of Michigan.

[15] PSR is defined as persons of working ages (15-64 years) per person aged 65 years and over. The potential support ratio provides a measure of the relationship between those more likely to be economically productive and able to provide support and care for those older persons more likely to be dependents and in need of support and care (RGC, 2017, p. 8).

Traditionally, older women are wives and mothers whose family roles are to be a keeper. Men earn a living and women manage all the incomes. This classic role is passed from generation to generation. When women get old, they remain active in supporting their younger family members in managing the household and other domestic belonging. They depend economically on their family and at the same time help manage it. NIS (2013) reports that elderly people in urban and rural areas have different dependency ratio which was 6.3 ratio in urban and 7.9 ratio in rural areas. Often the dependencies of elder people are the burden of supporters and caregivers who are family members such as spouses, children or close relatives rather than from formal assistance system (Bunly, 2011; Long & Sudnongbua, 2017; Ratha, 2018; Rathny et al., 2018; Sreyna, 2018). Particularly, key informants and focus group discussions admit that women are more attached to the family responsibilities i.e. looking after houses and grandchildren. Some women even cook meals and do the housework. This is an unpaid job and more women than men are spending much time wandering around their homes and markets.

Fewer shares in the workforce can be illuminated that women literacy is low if compared to men. Their low education and lack of skills disable them from getting the jobs. Elderly people in Cambodia has been noticed to have high levels of illiteracy and low income (Long & Sudnongbua, 2017; Rathny et al., 2018; Royal Government of Cambodia, 2016, p. 10). Among those, 16.2 percent of elder people aged 60 to 64 has no education while 47.4% has some primary education which is lower than elderly people who were 65+ years old whose 23.4% of them has no education and 40.5% has some primary education (Kosal et al., 2014, p. 37).

They cannot go out to make their own money due to health conditions like being frail from ageing, illnesses, and disabilities. The finding indicates that more women have at least 1-2 categories of disabilities which is 14 per cent higher than 3 per cent of men on seeing, remembering and communicating. Twelve per cent of women have 1-2 diseases on hypertension, diabetes, or arthritis. These are the challenges preventing older women from getting employed.

C. Older people with disabilities

Physical and mental disabilities among older population prevent them from certain employment. Their disabilities in their late-life render the incomes and limit access to other economic opportunities. Figure 24 from the analysis confirms that older people from 60-80 are having at least 1-2 disabilities (i.e. communicating, seeing or remembering). 14 per cent of the total older people have 1-2 diseases on hypertension, diabetes, or arthritis. As noticed in the literature and sharing from the field, cash is one of the main necessities that encounter older adults. Though they are old, they still need to spend on their daily activities i.e. coffee in the morning or other social relations. Since they are disabled, these inevitable challenges keep these people depressed and feel as a burden for the family. Moreover, no other support system found is stronger than the family care.

4.7 Family arrangement

Males and females are having different shares in the family's responsibilities though they are not very much active due to their old-age. In Cambodian culture, males are more responsible for earning the income for the family and women take care of the household belongings and children. When they are old, older males are no longer earning, but females remain taking care and support their young daughters and sons in taking control over the household's businesses. Lives of the older males are less occupied but unlike the female ones.

In a changing society, family arrangement has changed due to economic and employment reasons. Young adults tend to stay away from home and family for earning and working, leaving older people at home. For a developing Cambodia, outmigration is a cause of the elders' loneliness and a burden the left-behind older parents. Comprehensively, the study reconfirms that elders especially from 60-80 still take care the youngsters and belongings in the house. Across the areas – certain proportion of the interviewed elders less than 80 years old cook meal for children (who are usually less than 10), look after house, clean/wash clothes and other health cares for the youngsters in the family. This is

due to the fact that family members tend to be busy outside or migrate out of the village and leave their children at home with the elders. This becomes the consequences challenging the old-age population who have to take care for themselves and their grandchildren. Interestingly, female elders are more attached to the family than males. This is because females are more household-based people since they are young as living in the style of Cambodia's family arrangement. On the other hand, male elders in their early and middle ageing period from 60-80 remain influential and respected in the family as they are former household head.

It is also observed that elders especially females spend more times with houses and young children as they are left once their parents are busy earning a living outside. This is evitable that children or younger people are brought up and built in the environment or the characters that elders manage to give them. Their growth is potentially structured by what and how the elders perceive about life and society. Child education is more influenced through the elders and their times with the children. Engaging elders is a suggested approach for practitioners wishing to interact with the young people.

Family arrangement has changed and the care remains insufficient for the elders as family members report that elders more murmur, anxiety, sensitive. This happens most with the female elders as they expect more from everyone around them; and also due to the neglect from the members. Usually they do not really understand the schedule or life/work conditions of the family members.

Informal cares remain a unique and evitable services provided by the family members or relatives. From the study, it is again confirmed that majority of the elderly are dependent on such intensive cares from their spouses, older children (i.e. daughters or sons), or those living nearby. Family members need to dedicate and be patient to handle health cares for their elder parents. Such informal cares play crucial roles in supporting not only physical functions but also emotional needs as being united with family, reducing the old-age depression among them.

4.8 Community support

Older people association (OPA) is also part of the health treatment for the elderly as the sick people feel warmer and periodically relieved or at peace once members visit and share grieves. However, the correlation result emphasizes that OPA's activities do not have positive relation or influence on the issues of the elderly. No cross-line with OPA to ADL, IADL, nutrient of the elderly is significant.

The most common activities of OPA are collecting membership fees, visiting sick members and sharing condolences for the dead member. Such visit is not regular and visit is only when they are sick and dead. Instead members are not much engaged in the daily activities of the OPA. The elderly feel depressed or tired at home and has no one or groups to turn to for their sharing and relax. The key informants admit that OPA does not operate daily. Usually there is a month meeting among the members just to collect membership fee[16] or raise formal issues, not individual, but more collective issues. Older persons tend not share their personal grieves in the meeting and most often keep silent. It is very difficult for the OPA to respond to such feeling demands, except visiting them when they are sick or dead. Therefore OPA has limited role in consoling the elderly's depression or even abuse.

Buddhist or Muslim temples remain the unique place where the elderly visits and takes time away from homes and families. This is traditionally perceived that temples are designed to gather people especially the older persons for their religious merits and to meet their peers for their social relations. Usually temples have regular activities for instance the weekly gathering on the Buddhist Observance Day (i.e. four times per month) when monks preach and provide life advices – mainly on how to struggle with difficult mindsets, attempting to cast out all their anxieties and have a sense of peace. In spite of soft support, temples also offer some material provisions for instance food or household things for the poor and needy. The elderly in the study areas appreciates the roles and supports of the

[16] Most OPA's managers interviewed inform that fee is collected every six month due to there is no person to collect it monthly.

temples in occasionally coping with some social and economic difficulties of the marginalized groups in the locality.

Other supports have not been found except the gift-giving activities of the Red Cross for the poor and vulnerable families selected by the local authorities. Some other NGOs comes to the areas, but not specifically for the work of older persons. HelpAge Cambodia in Battambang province is a lead organization with its alliance to support the OPAs in their target areas.

4.9 Policy interaction and gaps

- Cambodian Government has prepared and approved the **National Aging Policy (2017-2030)** in order to promote the well-being of older population in Cambodia. There are nine priorities in the national aging policy 2017-2030 to meet objectives toward accomplishment of vision and mission of the aging policy. The nine priorities have set out the strategies to accomplish each objective. These nine priorities includes 1) ensuring financial security, 2) health and well-being, 3) living arrangement, 4) enabling environment, 5) older people's association (OPAs) and active aging, 6) intergenerational relations, 7) elderly abuse and violence, 8) emergency situations, and 9) preparing the younger population (RGC, 2017). However, the policy is stipulated to the general elderly population and does not mention about women and disabled elder condition beside mentioned in priority four[17] on the public building that should be built easily for the accessibility of elderly and disabled persons (ibid).

- The **National Health Care Policy and Strategy for Older People** in 2016 provides an overall guide to strengthen and support the health system that benefits older persons in Cambodia. The policy strives to ensure that elders manage to have equitable access to a comprehensive package of quality health services for their active, productive, healthy, and dignified ageing. However, there is no specific strategy to assure the health needs of different elders' sub-groups for instance poor, disabled or female elders to access and enjoy the health services and its quality. This is a concern that the policy responses will not benefit equally the disadvantaged groups amongst the elderly.

- The **National Social Protection Policy Framework (2016-2025)** recognizes the elderly people are the marginalized group that has to be taken care of and also acknowledges the limited health care and pension systems for them too. This is important as barriers to achieve healthy ageing, especially the poor older people. The framework proposes two strategic priorities – cash transfer for people with disabilities and elderly people protection program. In the initial stage, this policy will address those people with their ID Poor cards. Also the policy requests better procedures to identify people with disabilities to determine the assistance and proposes a similar cash transfer for family package as planned for pregnant women and children.

- The **National Population Policy (2016-2030)** targets to contribute to steady improvements in the quality of life of Cambodian people and to alleviate poverty through concerted effort in ensuring sustainable development and equitable economic growth. The policy directs the government and its line agencies to develop appropriate health care programs for the elderly and improve the capacity of health care personnel and community-based care providers, to expand and strengthen social security for the poor elderly, and to provide vocational training so that they can be self-reliant.

- The Royal Government of Cambodia has set up a national aging committee in 2011 in order to work on the issues and challenges of elderly population in Cambodia and in responding through preparing national aging policy. Ministry of Health has produced its national health

[17] Priority 4: **Enabling Environment** (4.1: To enable older persons to live independently if they can and wish to do so; and 4.2: To facilitate the mobility of the older persons) (Cambodia National Ageing Policy 2017-203).

care policy and strategy for older people in 2016 in response to how elderly population should be taken care of in their health sector.

- Moreover, the government under a technical assistance from HAC in 2013 produces the **guidelines for the establishment and management of older people's associations (OPAs)** in the purpose of providing services needed for older adults in Cambodia. This guideline encourages the establishment of OPAs in each commune throughout the country but the establishments have been slow due to limited resources and coordination. Some already established OPAs are weak and some are progressing well.

Polices are developed and their Action Plans are being designed to exercise the commitment of the government. The progresses towards achieving their objectives remain slow due to limited resources and multi-coordination among the responsible agencies. There is a long way to go for the policies to generate the desired outcome. The discussions with key stakeholders during the study also did confirm that the in-charge institutions for instance the interviewed OPA managers, older people and officials from provincial department of social affairs, veterans and youth rehabilitation are not very much aware of the above-mentioned policies. As echoed among the stakeholders, there have been inadequate disseminations of the approved policies to a more diverse population who may benefit from the implementation on the ground.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

Older people – Ageing poses challenges and needs are in hand to reduce further vulnerability. The study confirms that older people in this study have experienced with certain difficulties in their daily living. For physical wellbeing, it is understood that the interviewed older population are more challenging with IADL (i.e. shopping, cooking, self-transport and washing) rather than ADL (i.e. getting up and managing bowel movement). Disability is also found to be with the older people. Those who are in the age of 60-80 are risking 1-2 diseases and disabilities that require more assistance and support from government and other stakeholders. Moreover, depression and abuse are very indicative and this is a concern that interventions shall be responded. For economic challenges, both gendered groups are in their struggling effort to cope with poverty as almost half of the samples are ID poor card holders and the rest is potentially falling under the assessment criteria too. Such deprived situation makes the older people even more vulnerable to physical and mental health challenges and needs. The result explains that both older males and females do not have same ways of living and interacting with others. Older males are more engaging in economic activities than women. Older women are in-charge of their burden with household choir and their low literacy limits their employability. In terms of urgent need and challenge, the older people across gender require more supports for their physical and mental health cares, economy, and community engagement. Health care is always the priority among others. Income poverty, disease-nutrient, limited access to services and service quality, limited skill/knowledge and availability of caregivers, less mutual inter-generational relations and elderly's limited knowledge on health care are the key drivers blocking older people from accessing and using health care services.

Older women – The National Social Protection Policy (2016-2025) notices that there is a high number of older women living in difficult conditions than older men. However, there is no specific need or challenge different from the male group. Since women live longer, the vulnerability remains high and therefore more supports have to be allocated sufficiently. The older women are observed to have more healthcare need, social protection for their longer life, social engagement, and economic security than older men. However, both groups find it difficult to handle such cases. The female older persons recently outnumber in the ageing population i.e. 55 per cent of the total old population. Also their life expectancy increases and therefore exposes them to more economic, societal and health vulnerability. The issues of financial insecurity in their ageing period, increasing incidence of morbidity, being widow due to the loss of their spouses during the genocide regime, or workforce discrimination remain the challenges and prevents the older females from enjoying their healthy ageing. Finding from the survey and dialogues with individual informants and groups inform that female group has an overall high percentage in all the study variables for instance more females are prone to disabilities, depressions, abuses, and dependence more on the economic supports from their family members. This group shares the bigger proportion of the needs and challenges of the old-aged people.

Other people with disabilities – Finding evidently proves that as they are getting older, they are more prone to disability and weaknesses in their ability to perform their basic activities. In terms of health and disability issues, there is no distinguished needs or challenges requested or faced by either male or female groups, or either in rural or urban areas. Moreover, the study alerts the importance of mental disability as other disabilities including physical infirmity. Old persons are found to get easily stuck or mental irritation disturbed by their life experience that pushes them to find it hard to solve problems in their communication. This is due to their living with trauma (PTSD), depression, cognitive impairment, or abuses. The study finding reveals that both older males and females have high prevalence of depression and abuse. For economic challenge, physical and mental disabilities among older population prevent them from certain employment. Their disabilities in their late-life render the incomes and limit access to other economic opportunities.

5.2 Recommendations

General recommendations

- It is recommended that the awareness and issues of the elderly shall be developed into the formal educational curriculums from the secondary schooling to high school. This will help mainstream the built-up understanding of the elders' physical, mental and societal needs and challenges among the youngsters. Such intervention will help close the intergenerational gaps, so that minimizes the mistreatment both at home and in a wider society.

- ID Poor scheme helps reduce the elderly's vulnerabilities. Still there remain more families unidentified for the ID Poor scheme. It is recommended that a close working approach be developed to cooperate with the Ministry of Interior and its line groups – local authorities at the village, commune, district and the province to accelerate or reactivate the assessment process so that more ID Poor cards are distributed and benefits are at their doors.

- Non-governmental organizations and other stakeholders shall continue to work and cooperate with the Royal Government of Cambodia through Ministry of Social Affairs, Veterans and Youth Rehabilitation to achieve the first priority of financial security for the elder population as prioritized in the National Ageing Policy. The government strives to assure the active ageing workforce so that they derive the income benefits from their gainful employment. For those who are unable to work, then they must be covered by other social protection and welfare schemes.

- It is also evident that OPAs established by MoSVY have played fewer roles in entertaining and reducing the depression among the members. It is recommended that OPA activity plan shall be revised to have certain activities that can inspire and console the members' feeling and other mental health and welfare. Activities like regular meditation, home visit, body exercises, free medical check-up (with request to health centers or other NGOs), or other small income activities including home gardening or light handicraft shall be included in the plan and executed regularly. These activities not only reduce their worries or depressions, but also generate some revenues for OPA's uses. The agreed activity plan must be shared and supported by the family members to acknowledge the needs of the elderly with OPA's activity plan. OPA shall be more active to bring more benefits to their members and also to encourage others to join and enjoy similar assistances. This is essential to enable the elderly to fully participate in the OPA.

- The issues, needs and challenges of the elderly both OPA members and non-OPA members are less responded practically by the government or government program or OPA activity plan. Even many of the elderly are found to perform better in their ADLs and IADLs but more depressed among the samples, more micro level intervention is needed to be in place. So a social work program shall be developed to help alleviate the burden of older adults in needs. This program could be part of the assistance to the policy achievement of Cambodian government on the aging issues. The development of social work program is to work with OPA members and to produce it as model for government after the project phases out. The social work program would be more into the deeper level of practice with the elderly on elderly care both physical and mental well-being rather the program in the existing establishments. Social workers in the program would be able to do case management to all the OPA members and provide home based care or counseling services or else betters.

- The concept OPA shall be explored in different areas to understand how supports are shared and allocated for the elderly in the communities. For instance the case of the Muslim communities in Kampot province proves to be a strong case though they are non-OPA members. The Muslim community has a tight and helpful system to support each other and this is proved to be handy, similarly to the work of formal OPA. Such existing systems must be supported and enhanced to assure the needs of the elderly.

- Temples remain the active institutions in healing the elderly's stressful mindset and therefore they are the evitable actors in improving the healthy ageing of the older people. Relevant stakeholders shall work with temples to cultivate their religious schedules and personnel in promoting more awareness of the elderly's needs and also to close the intergenerational gaps in their villages.

- The relationship between local authorities and the OPA is essential and should be enhanced to further assist the needs of the older people in their localities.

- A telephone hotline of the health center or post or medical staff in their localities should be in used, especially for the caregivers to ask for immediate assistance when there are any urgent cases of older people i.e. fall, faint, or stroke.

- To improve the performance of ADL/IADL, it is suggested that assuring the quality of the education among the young adults now will help them manage their living better in the older lives. It is positively correlated that better education will help the older adults practically in designing their life styles much improved based on their needs and challenges in the time to come.

- To better advise and consult with the older people when they seek for the health services, it is recommended that the medical staff of health posts, centers and village health group are to be trained or made more awareness of the health issues of the elderly.

Physical well-being

- The government shall approve a free health care scheme (i.e. contributing to the achievement of the universal health coverage) for the elderly to assure the service access and address certain challenges or burden of the elderly.

- The government continues to extend and improve better health services and accesses and encourages more specialized medical doctors to work in health centers and health posts where older people are seeking assistances. This will take times but early commitment and practice shall be started.

- Since Cambodia has a culture of staying home and no nursing home or homecare which is a kind of institutional care settings, a public awareness to family caregivers, or family members of the elderly population must be promoted to understand about issues, needs and challenges of older adults as well as how to deal with their caregiving practices. Key topics should be nutrient for the elderly, elderly's abuse and depression, healthy ageing principles, hygiene living, and basic medical treatment.

- A regular medical check-up for the older people shall be organized through the work of the OPA or local authorities in cooperation with the district health centers or any donors. Also a peer OPA network in their areas is a practical mechanism to share lesson learnt and seek helpful supports in addressing certain issues related to the healthy ageing of the members.

- Continue to encourage more regular visits from village health volunteers or workers to older men and women for medical counseling. The volunteers and workers also assist in coaching the family caregivers for the care of the older people to recover their normal functions; at least they require less support for individual ADL.

For older women

- Continue to engage older women in every activity of the OPA or social relations to provide more opportunities for them to interact and communicate with others.

- For any social support, older women have to be prioritized and special treatment shall be given to assure that they are able to benefit equally from the assistance program.

- A reporting system or channel should be developed within the OPA or with local authorities for reporting abuses over the elderly especially older women.

- A non-contributory cash transfer program shall be developed and approved to benefit the elderly population, particularly older women so that they are able to access health care and other social services.

- Assistive materials or equipment shall be given to those impaired older people to assist them in their daily living. The older population is risking 1-2 disabilities in seeing, hearing or remembering. Gender-friendly equipment should be considered.

Older people with disabilities

- There is a need of a support service for the older people with disabilities to enable them to access to health services and other social services.

- Older people with disabilities can often be supported at home. Since Cambodia has a culture of staying home and nursing home or homecare which is a kind of institutional care settings, a public awareness to family caregivers, or family members of the elderly population must be promoted for them to understand about issues, needs and challenges of older adults and those with disabilities. A caregiving practice or model shall be developed as a guide to assist the family members in managing their older people.

Mental wellbeing

There are no distinguished needs or challenges among the older males and females. The following recommendations are directed to both gendered groups.

- Continue to promote more awareness among the family caregivers about the elderly's abuses, depression and other mental cares, so that they are performing their cares in more older-friendly manners, in expecting to reduce the incidences of abuse and depression among the disable older people.

- A non-contributory cash transfer program shall be developed and approved to benefit the elderly population, so that they are less dependent on their family members and further help reduce the rate of depression and abuse.

- There should be a mediator to help assess the potential older people to use their skills or talents that can help them generate some incomes.

- OPA activity shall include the touring trip for the older people at least once a year to nearby tourist areas for relieves and entertainment.

- Work to assure that older people are in their assisted living conditions and if not possible, then regular visits should be paid by OPA members or local authorities. This helps avoid older people from getting depressed or being abused, or helps them able to request for assistance.

- For a long-term reform, more specialized medical doctors are assigned to help diagnosis the symptoms of older people who seek services at health centers or posts, but this will take more times and efforts. This helps reduce the worries and concerns over the unexplained medical illnesses and also helps improve curative procedures. Or public health staff at local and operational levels should be trained at least to do the basic diagnosis of (mental) symptoms of the older people and connect them to a more specialized treatment.

5.3 Study gaps

- There is a strong relationship between local religious temples or institutions with the older peoples. It is suggested that there be a further study to look into their roles and contribution into building healthy ageing environment for the elderly in their localities.

- It is observed that older people take more cares of the youngsters while their parents are away for economic opportunity. The left-behind young children are very much influenced by the cares of the older people. It is suggested that there be a study to understand and support the roles of the elderly in bringing up these children and how the additional programs or assistance are proposed to support the caregivers – older people in expecting a positive parenting. Investing in the elderly means developing the young children.

- The study finding reveals that OPAs established by MoSVY do not perform very actively in providing more supports to the members. It is suggested that there be an evaluation study to diagnosis the issues and identify the solutions to optimize the roles and contributions of the OPAs.

- Elderly abuses are found to exist in every family. It is suggested that there be an investigative study to identify types, causes and levels of abuses and make more awareness among the public for a better treatment of their elderly parents and relatives.

- Nutrition for the elderly seems to be less documented in Cambodia. It is suggested that there be a study to record or identify the healthy diets and nutrients for the elderly.

Reference

- APA. (2012). *Elder Abuse and Neglect: In Search of Solutions.* Washington, DC: American Psychological Association.
- Ballard, J. (2010). Forgetfulness and older adults: concept analysis. *Journal of advanced nursing, 66*(6), 1409-19.
- Boehnlein, J. K., & Kinzie, J. D. (2011). The Effect of Khmer Rough on the Mental Health of Cambodia and Cambodians. In B. V. Schaack, D. Reicherter, & Y. Chhang, *Cambodia's Hidden Scars: Trauma Psychology in the Wake of the Khmer Rough* (p. 119). Phnom Penh, Cambodia: Documentation Center for Cambodia (DC-Cam).
- Bunly, K. (2011). The experience of family caregivers of older adults in Cambodia. (Master Degree Research report), Royal University of Phnom Penh, Phnom Penh.
- Elo, S. & Kyngäs, H. 2008, " The qualitative content analysis process", Journal of Ad-vanced Nursing, vol. 62, no. 1, pp. 105-117.
- Gabrielle, & Mauney, R. (2018). Exploring Cambodian Voices. Phnom Penh: Oxfarm Cambodia.
- Gebreyohannis, B., & Kharel, K. (2012). *Needs Assessment for Assisted Living Facilities Among Elderly Population.* Kokkola: Centria University of Applied Sciences.
- Graf, C. (2009). The Lawton instrumental activities of daily living (IADL) scale. Medsurg Nurs, 18(5), 315-316.
- Greenberg, S. A. (2012). The geriatric depression scale (GDS). Best Practices in Nursing Care to Older Adults, 4(1), 1-2.
- Gurung, S., & Ghimire, S. (2014). *Role of Family in Elderly Care.* Kemi: Lapland University of Applied Science.
- Khaghani Far et al. (2015), The interplay of physical and social wellbeing in older adults: investigating the relationship between physical training and social interactions with virtual social environments. PeerJ Comput. Sci. 1:e30; DOI 10.7717/peerjcs.
- Knodel, J., & Zimmer, Z. (2009). Gender and Well-Being of Older Persons in Cambodia.
- Knodel, J., & Zimmer, Z. (2009). *Gender and Well-Being of Older Persons in Cambodia.* USA: Population Studies Center, University of Michigan.
- Kol Hero et al. (2014): Cambodia Country Report on Social Participation and Contribution of Elderly. Prepared for the 12th ASEAN and Japan High Level Officials Meeting on Caring Societies and Human Resource Development. Tokyo, Japan
- Kosal, s., Satia, C., Kheam, T., chinda, P., Mondul, L., Phirum, L., . . . Kishor, S. (2014). Cambodian Demographic and Health Survey 2014. Phnom Penh: National Institute of Statistics, Directorate General for Health, The DHS Program.
- Kraus, L., Lauer, E., Coleman, R., & Houtenville, A. (2018). 2017 Disability Statistics Annual Report. Durham, NH: University of New Hampshire.
- Long, S., & Sudnongbua, S. (2017). QUALITY OF LIFE AMONG ELDERLY PEOPLE IN KAMPONG CHAM PROVINCE, CAMBODIA. Southeast Asian Journal of Tropical Medicine and Public Health, 48(4), 884-891.
- López-Benavente Y, Arnau-Sánchez J, Ros-Sánchez T, Lidón-Cerezuela MB, Serrano-Noguera A, Medina- Abellán MD. (2010). Difficulties and motivations for physical exercise in women older than 65 years. A qualitative study. Rev. Latino-Am. Enfermagem;26:e2989. DOI: http://dx.doi.org/10.1590/1518-8345.2392.2989
- Ministry of Health (2013). *Food and Nutrition Guidelines for Healthy Older People*: A background paper. Wellington: Ministry of Health.
- MoFA (2018). *Life Science and Health Care in Cambodia.* Ministry of Foreign Affairs, Kingdom of the Netherlands, Bangkok, Thailand
- MoH (2017). *Annual Health Report 2017.* Ministry of Health, Phnom Penh, Cambodia. Access through www.moh.gov.kh
- MoH (2018). *Health Information System Master Plan 2016-2020*. Department of Planning and Health Information. Ministry of Health, Phnom Penh, Cambodia
- MoH. (2016). *National Health Care Policy and Strategy for the Older People.* Preventive Medicine Department . Phnom Penh: Ministry of Health.

- MoP (2016): Population Ageing in Cambodia – Current Situation and Needs. General Secretariat for Population and Development, Ministry of Planning. Phnom Penh, Cambodia
- MoP. (2013). Aging and migration in Cambodia CRUMP Series Report. Phnom Penh: Ministry of Planning.
- NDA, & NCAOP. (2006). *Ageing & Disability: A Discussion Paper.* Dublin: National Disability Authority and National Council on Ageing and Older People.
- Neale AV, H. M. (1991). Validation of the Hwalek–Sengstock Elder Abuse Screening. *Journal of Applied Genrotol, 10*, 406-418.
- NIS. (2013). Cambodia Inter-censal Population Survey 2013 Final Report. Phnom Penh: National Institute of Statistics, Ministry of Planning.
- Ratha, C. (2018). Caregivers' perspective on caring the elderly in Battambang province (A case study in Watleap village, Sangkat Chamkasomrong). (Master Degree Research report), Royal University of Phnom Penh, Phnom Penh.
- Rathny, S., Chhay, L., Choun, C., & Ok, S. (2018). The Elderly's Living Situation in Cambodia: The Case of Population Aged 60+ in Veal Commune, Pursat Province (Vol. 67).
- Research Office: Legislative Council Secretariat. (2015). Challenges of population ageing. (1), 1-17.
- RGC. (2017). *National Ageing Policy 2017-2030.* Phnom Penh: Royal Government of Cambodia.
- RGC. (2017). *Social Protection Policy Framework 2016-2025.* Phnom Penh, Cambodia: The Council of Ministers, Royal Government of Cambodia.
- Royal Government of Cambodia (2017): National Ageing Policy 2017-2030. Council of Minister. Phnom Penh, Cambodia.
- Royal Government of Cambodia (RGC) (2016): National Population Policy 2016-2030. Council of Minister. Phnom Penh, Cambodia
- Royal Government of Cambodia (RGC) (2016): National Social Protection Policy
- Royal Government of Cambodia. (2016). National Population Policy. Phnom Penh: Royal Government of Cambodia.
- Royal Government of Cambodia. (2017). National Aging Policy 2017-2030. Phnom Penh: Royal Government of Cambodia.
- Sreyna, S. (2018). The need assessment of retired teacher's well-being and social support system in Cambodia (Case study: Smaong Khang Cheung commune, Kamchay Mear District, Prey Veng province). (Master Degree Research Report), Royal University of Phnom Penh, Phnom Penh.
- Tombaugh, T. N., & McIntyre, N. J. (1992). The mini-mental state examination: a comprehensive review. Journal of the American Geriatrics Society, 40(9), 922-935.
- United Nations. (2017). World Population Aging (Department of economic and social affairs population division, Trans.). New York: United Nations.
- Verbrugge, L. M., & Jette, A. M. (1994). The disablement process. Social science & medicine, 38(1), 1-14.
- Verbrugge, L. M., Latham, K., & Clarke, P. J. (2017). Aging with disability for midlife and older adults. Research on aging, 39(6), 741-777.
- Wallace, M., & Shelkey, M. (2007). Katz index of independence in activities of daily living (ADL). Urol Nurs, 27(1), 93-94.
- WHO. (2002). *World Report on Violence and Health.* Geneva: World Health Organization.
- WHO. (2015). *World Report on Ageing and Health.* Geneva: World Health Organization.
- WHO. (2016). *Elder Abuse: The Health Sector Role in Prevention and Reponse.* Geneva: World Health Organization.
- WHO. (2018, January 16). *World Health Organization*. Retrieved February 6, 2019, from Disability and Health: https://www.who.int/news-room/fact-sheets/detail/disability-and-health

Appendix A
Questionnaires

Code: [_____/_____/_____]

Questionnaire on Issues and Needsof Older people in Cambodia
(Elderly Person)

Agreement *(Please read the followings for participants)*

We are from National Institutes of Social Affair (NISA), under the support of HelpAge Cambodia (HAC). We are doing survey on the issues and needs of older people in Cambodia in some municiplities and provinces such as Phnom Penh city, Prey Veng, Kampong Cham, Battambang and Kampot. We collect some information for our understanding the issues and needs of older people.

We would like to request your participation for about 45 minutes to answer our questionnaire. Your contribution is beneficial for us to evaluate social, economical and mental factors as well as support system for elderly population in Cambodia.

You have the rights to refuse or to terminate the interview at any time inconvenience to you.

(Condition: No skip)

Participant: 1. Agree 2. Disagree (Reason_____)
Date interview:_____/_____/_____

Interviewer's name:_____Signature:_____
Location : Province_____
: District _____
: Commune_____
: Village _____

Checked by team leader: Signature [_____]
Date _____/_____/_____ (Time start: _____End:_____)
Data entry o1 [_____] date:_____/_____/_____
Data entry 02 [_____] date:_____/_____/_____

No	Questions	Answer		Note
I. General Information				
Q101	Sex	Male Female	1 2	
Q102	Age	[_____/_____] (must >= 60)		
Q103	Education	No education Primary education Lower secondary education High school education University education	1 2 3 4 5	Currently……
Q104	Married	Single Married	1 2	If Single, skip Q105 and Q106
Q105	Divoice	Divoice Not divioce Separate	1 2 3	 *(Live separately)*
Q106	Number of children	One child Two children Three children Four children Five children More than 5	1 2 3 4 5 6	
Q107	Live with	children Spouse Others _____	1 2 3	
II. Elderly people status				

2.1.	**Physical status**					
2.1.1	**Functional status**					
Older adult needs assistance when (last three months)		**1-A** **Independence** ***(If 1-A , no need to ask AA)***	**1-B** **Need some help**	**1-C** **Need help** ***(ฺ00%)***	**1-D** **Cannot do it**	**AA- Length of assistance** Less than a month 1 1-2 months 2 2-3 months 3 More than 3 months 4
Q108	Walking					1 2 3 4
Q109	Lifting or carrying something heavy					1 2 3 4
Q110	Crouching or squatting					1 2 3 4
Q111	Standing					1 2 3 4
Q112	Using fingers to grasp or handle things					1 2 3 4
Q113	Walking up and down the stairs					1 2 3 4
Katz index of independence (ADLs)						
Q114	Taking bath					1 2 3 4
Q115	Dressing					1 2 3 4
Q116	Toileting					1 2 3 4
Q117	Getting up from bed or hammock					1 2 3 4
Q118	Controlling urinating or bowel movement					1 2 3 4
Q119	Self - feeding					1 2 3 4
Instrumental Activities of Daily Livings (IADLs)						
Q120	Cooking					1 2 3 4
Q121	Financial management					1 2 3 4
Q122	Taking medication					1 2 3 4
Q123	Washing clothes					1 2 3 4
Q124	Doing Housework					1 2 3 4
Q125	Going shopping					1 2 3 4
Q126	Self transport management					1 2 3 4
2.1.2.	**Nutritient for elderly person**					

Q127	How many times do you have meal in a day?	One time Twice a day Three times a day Four times a day Five times a day Others _____ _____	1 2 3 4 5	
Q128	What do you eat the most in each meal? (1=little 2=moderate 3=more)	Rice Porridge Meat Fish Vegetable Fruits Water Sweets Noodle Milk Coffee Energy drink Others.....	1 2 3 1 2 3 1 2 3 1 2 3 1 2 3 1 2 3 1 2 3 1 2 3 1 2 3 1 2 3 1 2 3 1 2 3 1 2 3	
Q129	What kind of alcohol do you drink? 0. Not drink 1=Little (1 can or small cup/period) 2=moderate (2-3 cans or small cups/period) 3=more (more than 3 cans or small cups/period)	Beer Fermented wine white wine others.....	1 2 3 1 2 3 1 2 3 1 2 3	
Q130	Do you smoke cigarette? (1=3 cigarettes/day, 2=6-8 cigarettes/day, 3=8-1pack/day)	yes No	1 0	1 2 3
2.1.3.	**Vision (Only one answer)**			
Q131	I could see as normal. For instance I can read newspaper and watch subtitle on TV without difficulty (without glasses)	yes No	1 0	
Q132	I can read and watch subtitle on TV with some difficulty (without glassess)	Yes No	1 0	
Q133	I can read articles and watch subtitle on TV with very difficulty (without glasses)	Yes No	1 0	
Q134	I cannot read articles or watch TV subtitle with or without glassess, but I can see enough for my walking without any instruction	Yes No	1 0	
Q135	I cannot see enough for walking without instruction. I am almost blind.	Yes No	1 0	
2.1.4	**Hearing**			
Q136	I can hear as normal with normal speech(without any assistance)	Yes No	1 0	
Q137	I can hear talk with little difficulty	Yes No	1 0	
Q138	I hear normal sound with very difficulty. When communicating, I need loud voice than normal.	Yes No	1 0	
Q139	I cannot hear even there is loud voice. I am almost deaf.	Yes No	1 0	
Q140	I am totally deaf.	Yes No	1 0	
2.2.	**Cognitive needs**			
	Folstein's Mini-Mental States Examination (MMSE)			
Q141	What day is the date today? (Multiple choice)	Year_____ Month_____ Week_____ Season_____ Day_____ Others _____	1 2 3 4 5 6	

Q142	Where are you now?	Village _____ commune _____ District_____ Province_____ House_____	1 2 3 4 5	
Q143	Tell three names of things you remember clearly	Yes No	1 0	
Q144	Please count backward by 5 from a hundred	Yes No	1 0	
Q145	I tell you three objects, can you review it again	Yes No	1 0	
Q146	I show you two objects, Can you tell their names?	Yes No	1 0	
Q147	Responsible to do without pretex (when ask to do something he/she denies and has other reasons)	Yes No	1 0	
Q148	Take a piece of paper and fold it in half and put it on the floor.	Yes No	1 0	
2.3.	**Psychological needs**			
Choose the best answer for feeling that you have a week a go				
Q149	Are you basically satisfied with your life?	Yes No	0 1	
Q150	Have you dropped many of your activities and interests?	Yes No	1 0	
Q151	Do you feel that your life is empty?	Yes No	1 0	
Q152	Do you often get bored?	Yes No	1 0	
Q153	Are you in good spirits in most of the times?	Yes No	1 0	
Q154	Are you afraid that something bad is going to happen to you?	Yes No	1 0	
Q155	Do you feel happy most of the time?	Yes No	0 1	
Q156	Do you often feel helpless?	Yes No	1 0	
Q157	Do you prefer to stay at home rather than going out and doing new things?	Yes No	1 0	
Q158	Do you feel you have more problems with memory than most?	Yes No	1 0	
Q159	Do you think it is wonderful to be alive now?	Yes No	0 1	
Q160	Do you feel pretty worthless the way you are now?	Yes No	1 0	
Q161	Do you feel full of energy?	Yes No	0 1	
Q162	Do you feel that your situation is hopeless?	Yes No	1 0	
Q163	Do you think that most people are better off than you are?	Yes No	1 0	
2.4	**Health care of older adult**			
Q164	When getting sick, where do you go for treatment?	Health center Hospital Private village Clinic Others	1 2 3 4	
Q165	Who brought you for treatment when you get sick?	My spouse My daughter My son My grandchild Others_____	1 2 3 4 5	

Q166	What kinds of illness do you often have?	Cold Diabetes Hypertension Others_____	1 2 3 4	
Q167	Who is the main caregiver of you when you get sick in family?	My spouse My daughter My son My grandchild Others_____	1 2 3 4 5	
Q168	Have you been sufficiently taken care of?	Yes No	1 2	
Q169	What do they do when they taking care of you? (Multiple choice)	Prepare food for me Wash clothes Prepare my travel Bring me for treatment Take me a bath All the above mentioned	1 2 3 4 5 6	
2.5	**Economic status of elderly people**			
Q170	What do you do to support your daily living?	Run own business Relying on children support Others_____	1 2 3	If 2, Skip Q171
Q171	How much do you earn in average a month?	Less than 50 dollars 50 - 100 dollars 100-200 dollars 200-300 dollars ច្រើនជាង 300 dollars	1 2 3 4 5	
Q172	What kind of support do you receive? (Multiple choice))	Money Daily food Clothes Others_____	1 2 3 4	
Q173	How long has you received support?	Less than 2 years 2 -3 years 3 – 4 years 4 – 5 years More than 5 years	1 2 3 4 5	
Q174	What is your expense in average personally a month?	Less than 50 dollars 50 - 100 dolars 100-200 dollars 200-300 dollars More than 300 dollars Not remember/not know	1 2 3 4 5 6	
Q175	What do you normally expense on?	Food Clothes Social activities (Wedding, ceremonies) Medications Others_____	1 2 3 4 5	
2.6	**Social Support**			
Q176	Have your family received ID poor (last 12 months)?	Yes No Do not know	1 2 3	
Q177	Have you or your family ever used your ID to receive the following assistances (for last 12 months)? (More than one answers)	Medical services (Health Equity Funds) Foods assistances (ex: rice) Financial assistances Counseling/consultancy services Have ID, but never use it Others please specify.....	1 2 3 4 5 6	
Q178	Do members of this household receive free or subsidized health care that other people would normally have to pay for with in the last 12 months?	Yes, free Yes, subsidized No	1 2 3	

Q179	Do you or your family member receive financial assistance from the following institutions? Tell the institution you received the last 12 months.	Government (Prov dept, cc, Village) NGOs (National/Int'l) Private company Religious institutions (Pagoda, church) Others (specify.....) No, I did not receive any.	1 2 3 4 5 6	
Q180	If you or your family member received any financial assistance how much did you receive the last 12 months?	.....Riels		
Q181	Have you heard about OPA?	Yes No	1 2	If no Skip to Q184
Q182	Are you member of OPA?	Yes No	1 2	
Q183	What benefits do you receive from OPA?	.....		
Q184	What is your ideas about OPA?	.....		
Q185	If there is external assistance, what do you think you need the most to help you and other elderly persons? *(Look beyond the support of OPA)*	.....		
Q186	What is your recommendation to help you and other older adults?	.....		
2.7	**Elderly abuse**			
Q187	Are you afraid of anyone in your family?	Yes No	1 0	
Q188	Has anyone close to you tried to hurt you or harm you recently?	Yes No	1 0	
Q189	Has anyone close to you called you names or put you down or made you feel bad recently?	Yes No	1 0	
Q190	Do you have enough privacy at home?	Yes No	1 0	
Q191	Do you trust most of the people in your family?	Yes No	1 0	
Q192	Can you take your own medication and get around by yourself?	Yes No	1 0	
Q193	Are you sad or lonely often?	Yes No	1 0	

Q194	Do you feel that nobody want you around?	Yes No	1 0	
Q195	Do you feel uncomfortable with anyone in your family?	Yes No	1 0	
Q196	Does anyone in your family make you stay in bed or tell you you're sick when you know you are not?	Yes No	1 0	
Q197	Has anyone forced you to do things you didn't want to do?	Yes No	1 0	
Q198	Has anyone taken things that belong to you without your OK?	Yes No	1 0	

Questions for Interviewer

1. What is the quality of the interview do you think? 1. Not good 2. Normal 3. Very good
2. Do you think the interviewee answer questions with good spirit and feeling? 1. Yes 2. No
3. Are there any other persons coming to listen to your interview? 1. No 2. Husband 3. Wife 4. Son 5. Neighbor 6. Local authority 7. Others_____
4. Your comments on the respondents (if there is any)

_____
_____
_____

Appendix B

Survey Activities

Survey Activities in Phnom Penh



Household Interviews



Focus Group Discussion



Key Informant Interview

Survey Activities in Battambang



Household Interviews



Focus Group Discussion



Key Informant Interview

Survey Activities in Prey Veng



Household Interviews



Focus Group Discussion



Key Informant Interview

Survey Activities in Kampong Cham



Household Interviews



Focus Group Discussion



Key Informant Interview

Survey Activities in Kampot



Focus Group Discussion





Key Informant Interview