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Original Article

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

Expériences Vécues, Perceptions du Vieillissement et Qualité de Vie des Personnes Âgées dans la Ville de Buta : Une Étude Qualitative

Masikini Ewale Faustin[1], Bertine Mbongopasi Ekeni[2], Musenga Tshibangu John[3], Emmanuel Kitete Mulongo[4], Ngbolua Koto-Te- Nyiwa[4], Jacques Lofandjola Masumbuko[5], Mukandu Basua Leyka[5]

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Affiliations
1. Higher Institute of Medical Technology of Buta, Buta, Democratic Republic of the Congo
2. Higher Institute of Medical Technology of Bandundu, Bandundu, Democratic Republic of the Congo.
3. Higher Institute of Medical Technology of Kananga, Kananga, Democratic Republic of the Congo
4. Faculty of Science and Technology, University of Kinshasa, Kinshasa, Democratic Republic of the Congo
5. Higher Institute of Medical Technology of Kinshasa, Kinshasa, Democratic Republic of the Congo

Corresponding author
Masikini Ewale Faustin,
Email : masikiniewale@gmail.com

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ABSTRACT

Introduction. Aging presents a significant public health challenge in low-income regions like the Democratic Republic of the Congo, particularly in Buta, where older adults face socioeconomic vulnerabilities and social marginalization. This study investigates the lived experiences of older adults, focusing on their perceptions of aging and quality of life**. Methodology.** Utilizing a qualitative phenomenological approach, 20 participants aged 60 and above were interviewed to explore themes such as perceptions of aging, living conditions, family dynamics, and care access**. Results.** The analysis identified three primary themes: economic precariousness linked to a lack of pensions, social isolation resulting from younger generations' migration, and challenges in accessing care due to costs and staff shortages. Despite these adversities, some participants demonstrated resilience through spirituality, community support, and acceptance of aging, which contributed to their well-being. **Conclusion.** The findings indicate that social, economic, and institutional factors significantly affect the experiences of older adults in Buta and suggest the necessity for active aging programs, age-appropriate care services, and enhanced community support in local health policies to improve their quality of life and reduce vulnerabilities.

RÉSUMÉ

Introduction. Le vieillissement représente un défi majeur de santé publique dans les régions à faibles revenus comme la République Démocratique du Congo, en particulier à Buta, où les personnes âgées font face à des vulnérabilités socio-économiques et à une marginalisation sociale. Cette étude examine l'expérience vécue par les personnes âgées, en se concentrant sur leurs perceptions du vieillissement et leur qualité de vie. **Méthodologie.** Selon une approche phénoménologique qualitative, 20 participants âgés de 60 ans et plus ont été interrogés pour explorer des thèmes tels que les perceptions du vieillissement, les conditions de vie, la dynamique familiale et l'accès aux soins**. Résultats.** L'analyse a identifié trois thèmes principaux : la précarité économique liée au manque de pensions, l'isolement social résultant de la migration des jeunes générations, et les difficultés d'accès aux soins dues aux coûts et au manque de personnel. Malgré ces adversités, certains participants ont fait preuve de résilience à travers la spiritualité, le soutien communautaire et l'acceptation du vieillissement, ce qui a contribué à leur bien-être. **Conclusion.** Les résultats indiquent que les facteurs sociaux, économiques et institutionnels affectent de manière significative l'expérience des personnes âgées à Buta et suggèrent la nécessité de programmes de vieillissement actif, de services de soins adaptés à l'âge et d'un soutien communautaire renforcé dans les politiques de santé locales pour améliorer leur qualité de vie et réduire leurs vulnérabilités

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HIGHLIGHTS

What is known about the subject. Aging presents a significant public health challenge in low-income regions like the Democratic Republic of the Congo, particularly in Buta, where older adults face socioeconomic vulnerabilities and social marginalization.

The question addressed in this study. This qualitative phenomenological study interviewed 20 older adults aged 60 and above to explore their lived experiences, perceptions of aging, living conditions, family dynamics, and access to care.

What this study adds to our knowledge. The study reveals severe economic precariousness, social isolation, and healthcare barriers among older adults, mitigated only by resilience driven by spirituality, community support, and personal acceptance.

Implications for practice. Local health policies must integrate active aging programs, age-tailored care services, and community support networks to mitigate structural vulnerabilities and enhance quality of life for older adults.

INTRODUCTION

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

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

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

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

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

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

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

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

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

The specific objectives of this study are to:

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

METHODOLOGY

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

The study adopts a qualitative, descriptive-exploratory approach, conducted in the natural setting with triangulation of individual semi-structured interviews to explore the experiences and perceptions of older adults (OAs). Data collection was conducted using a cross-sectional approach. She applies the phenomenological method, which aims for a careful and systematic description of what older adults perceive regarding care for healthy aging and quality of life.

The approach is qualitative; that is, "a process or activity that allows an individual or a group of individuals to acquire precise knowledge about the cultural and social reality experienced on a daily basis" (SCHUMACHER R. 1997).

Therefore, this is a qualitative study using thematic analysis according to Braun and Clarke.

This chosen approach can be justified by the fact that the study aims to explore how older adults in the city of Buta experience aging, to understand older adults' perceptions of aging, and to identify the factors that influence their quality of life… in a rural/semi-urban context, in an area with limited infrastructure, which does not lend itself to

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simple quantification but requires a deep dive into the intelligibility of lived experiences, meanings, emotions, ... By adopting an interpretive approach, the study acknowledges that social reality is not a neutral object, but the product of living beings, which aligns with the principles of philosophical phenomenology open to the understanding of "lifeworlds" (lebenswelt).

The interview guide was developed with suggested topics based on the study's objectives, which allowed us to gather the views of older adults through syntactic, thematic, and categorical analysis

The target population consists of older adults (O.A.) aged 60 or older, residing in the city of Buta—either in the community or in a nursing home—during the period from March 18 to August 18, 2025, who must meet the following criteria: (i) be 60 years of age or older; (ii) Be a resident of the city of Buta; (iii) Have freely agreed to participate in the study after receiving full information.

The sampling method is non-probabilistic, using purposive sampling. This sampling method allowed us to select individuals who have directly experienced aging in the city of Buta for our study.

Recruitment of study participants took place partly at the nursing home (6 participants) and partly in the community (14 participants), depending on the availability and accessibility of these older adults. Thus, all residents of this nursing home participated in our study, while at the community level, participants were recruited through purposive sampling combined with a supervised snowball technique.

Our sample size was 20 participants. Thematic saturation was reached after the15thparticipant, when several consecutive interviews yielded no new codes or analytical categories.

Data collection was conducted through guided individual interviews, conducted face-to-face, allowing participants the freedom to express themselves openly. A semi-structured interview guide was used; each interview lasted approximately 25 to 30 minutes and was recorded using a smartphone.

Our interviews were conducted at the participants' homes to ensure their confidentiality. These face-to-face interviews were conducted in pairs, and a consent form was signed before each interview began. It should be noted that these interviews were conducted in Lingala, the language predominantly used by the population in our study area. We also carried a notebook to record certain data that could not be captured by our smartphones.

The collected information was analyzed using thematic analysis, which allowed us to identify recurring themes in the participants' experiences. The credibility of the results was reinforced through independent review of the transcripts and coding (Patton, 2015).

We conducted face-to-face, semi-structured individual interviews. This approach allows participants the freedom to express themselves openly, while guiding the interview around key thematic areas.

Since the interviews were conducted in Lingala, the verbatim transcripts were first transcribed in the language of the interview (Lingala) and then translated into French (the official language for our research) prior to data analysis, while ensuring fidelity to the original meaning of the words. The translations were verified by a second bilingual speaker to ensure the accuracy of the verbatim transcripts.

We kept reflective notes to minimize interpretive bias.

We used NVIvo software to analyze the field data.

The recorded information was analyzed in three stages. First, we listened to the recordings; next, we transcribed them faithfully; finally, we proceeded with coding through a content analysis process in which we assigned meaning to each element of the transcript. Thus, working backward, we derived from the verbatim transcripts: meanings, categories, and subthemes, and ultimately our central theme. The theoretical framework of the study is based on Engel's bio-psycho-social model and the WHO model of healthy aging, analyzing the respondents' representations and perceptions of their aging and quality of life. In the presentation of the results, each participant was denoted by P in parentheses to ensure anonymity, but also to clarify the respondent's identification. Thus, (P1), for example, refers to the first person, (P2) to the second, and so on.

This study was conducted in accordance with the ethical principles of the Nuremberg Code and the Declaration of Helsinki, ensuring respect for the rights, safety, and dignity of the participants. To access the data and gain the trust of the resource persons, requests were made to obtain authorization from their moral authorities, each head of household, or influential persons during the experiment, and we obtained the opinion of the Bioethics Committee of ISTM KINSHASA No. 0034/CBE/ISTM/KIN/RDC/PMBBL/2023 dated November 23, 2023.

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

Confidentiality and anonymity were guaranteed: personal data will not be disclosed; anonymous codes were used for transcriptions and analyses. Audio recordings will be stored in a secure folder, accessible only to team members, and will be destroyed after transcription or retained in accordance with current standards and the confidentiality protocol.

Protection of vulnerable individuals: Given the advanced age of the participants, precautions were taken to respect their dignity, comfort, free consent, and freedom of expression. In the event of fatigue, the interview could be interrupted, with the option to resume or reschedule.

Participants were informed that they could withdraw from the study at any time, without giving a reason, and that their data would be destroyed upon request.

RESULTS

The following results are derived from the semi-structured interview guide and are presented in thematic boxes that include themes, subthemes, categories, significant verbatim quotes, and analytical comments.

Sociodemographic characteristics of participants

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

TABLE 1: Sociodemographic characteristics of participants

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

Individual Perceptions of Aging and Well-being

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

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Table II: Individual Perceptions of Aging and Well-being

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

Perception of Family and Social Support

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

Table III: Perception of Family and Social Support

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

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Experience with Healthcare and Spiritual Support

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

Table IV: Experience with Healthcare and Spiritual Support

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

Perceptions of improved health and quality of life

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

Table V: Perceptions of improved health and quality of life

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

DISCUSSION

This qualitative study provided insight into the experiences and perceptions of older adults living in the City of Buta regarding their aging and quality of life. The main findings are discussed below: (1) older adults have a positive view of aging; the majority of them have at least one physical health issue; most of them cannot perform their daily activities without assistance; the strategies they use to stay healthy are effective; (2) Our respondents experience a relational imbalance between themselves and their families; they face a breakdown in community participation and intergenerational solidarity, and thus experience genuine social isolation; (3) Respondents very

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rarely use available health services, and those who do perceive their care negatively; many respondents state that they are deeply committed to their Christian faith; (4) Respondents rated their current quality of life poorly; and most wish to change their environment to improve their quality of life.

Individual Perceptions of Aging and Well-being

We found the following:

- Study participants have a positive view of their aging: My family and society value me; they consult me whenever there is a major problem; my family members even call me from afar to seek my advice when facing major issues; we get together on Sundays to talk, which makes me happy; family gatherings bring a smile back to my face, I feel at peace when my children respect me; I live with my granddaughter; she gives me courage; I still enjoy helping other elderly people; that's my way of giving;
- Most of them have at least one physical health issue: I keep working and being productive even though my strength is waning; I rarely get sick; too much pain; difficulty walking; my vision is getting worse; I'm troubled by diabetes and high blood pressure; malaria and typhoid fever bother me; rheumatism and constant dizziness; breathing difficulties and lack of appetite; I forget things too often; sometimes I'm afraid of death..., I no longer sleep well at night; I think too much.
- Most of them cannot carry out their daily activities without assistance: My eyesight is failing; I need someone to accompany me when I walk; I have trouble seeing clearly and hearing well, which makes me dependent on others for mobility; I cannot bathe properly on my own.
- The strategies used to stay healthy are good: When I'm sick, I go to the hospital; my children make sure I eat well; I rarely eat red meat and I don't drink alcohol; I'm in the habit of taking my concoctions (garlic + a small cola nut + ginger + lemon juice + drinking water), which helps me avoid getting sick, go to the fields regularly…, go fishing regularly…

The findings here corroborate those from research conducted in certain African countries, where aging is viewed positively on a symbolic level but as difficult on a material level (Sagna, 2020; Houngbedji et al., 2019).

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

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

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

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

Perception of Family and Social Support

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

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

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

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

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

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

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

Experience with Healthcare and Spiritual Support

- Respondents very rarely use health services and have a negative perception of their care: We can't afford to go to the hospital; it's too expensive, and the care isn't good. I rely on my own dietary remedies to help protect myself against illness. My grandson takes care of me at home, and my neighbor treats me with traditional medicine, At the hospital, tests use up the little money we bring, and then we have no money left to buy medicine; I prefer medicinal plants—they're less expensive; healthcare workers don't listen to us enough; sometimes I don't go to the hospital—I just pray; when I go to the clinic, they make me wait too long; Free healthcare for the elderly doesn't exist here. The nurses in our neighborhood are kind. Young people are treated before us. Community healthcare should include us more. I go to the clinic when the pain becomes unbearable. I'd like them to speak to us kindly, not like we're little children. Healthcare workers lack patience with us, We feel rejected in healthcare facilities, If care were accessible and free, I'd go often; the hardest part is the lack of care when we get sick, We don't always eat well, which makes us weak; without medicine, old age becomes a struggle.
- Most of them say they are deeply committed to their Christian faith: My hope is in God; Jesus Christ is my only savior; God is my redeemer; all my hope is in Christ; I live in communion with my God, even if I don't go to church, Old age is a time of peace and prayer; I hold onto my faith—it is what gives me the strength to live; the Church is my second home; I feel supported there.

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

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

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

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

Perceptions of Improved Health and Quality of Life

- Respondents rated their current quality of life poorly: "Life is pointless at this stage; it would be better to die. Life without money has no meaning… My health has become too fragile, I no longer need to keep living…; "When my wife was still alive, she took good care of me, but since her death everything has become complicated; it would have been better if I had died before my husband"; "It's my eyes that are causing me problems; right now I don't have anyone who can take care of my basic needs";
- Most want a change in their environment to live better: I want to remarry…; as soon as I have my own plot of land, I'll take charge of my responsibilities as an adult; I need the means to finish work on my farm 8 km from the city here; when I'm sick, I need to be treated well and eat well; I need a bicycle, a machete, my own plot of land, and a small startup fund; once I have my fishing gear, I'll be very comfortable working and producing, going regularly to the village to see my family and relive our childhood memories, eating well (often mbika maboke with bananas), accompanied by a little kongolo—that does me good; I need to raise livestock and build small houses here to rent out, and I need a decent house built for me to live in.

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

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

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

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

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

Strengths and Limitations of the Study

- **Strengths**

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

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

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Highlighting a phenomenon that is poorly documented in the DRC, contributing to national and regional literature.
Identification of typological profiles (spiritually resilient, silent dependents, community actors) enabling a better understanding of individual trajectories.

- **Limitations**

Social desirability bias: some older adults may have exaggerated their autonomy to preserve their social image.
Limited representativeness: the sample does not reflect the full range of realities in the city of Buta
Partial transferability: the results remain contextualized within a specific area strongly marked by sociocultural specificities.
Lack of quantitative data prevents statistical generalization of correlations between health, income, and social support.

CONCLUSION

The study aimed to explore how older adults in the city of Buta experience aging, to identify the factors influencing their quality of life, and to analyze the social, psychological, and spiritual dynamics that contribute to their well-being.
The results show that aging is experienced amid a tension between physical frailty, the pursuit of autonomy, economic precariousness, and spiritual grounding. This complexity confirms the role of Engel's (1977) bio-psycho-social model in the analysis of aging in Central Africa. Regarding the forms of support received by older adults, the study reveals that intergenerational support remains central but is gradually weakening due to the socioeconomic transformations observed in the DRC, which aligns with the conclusions of Kandolo et al. (2022).
Finally, three aging profiles were identified in our study: the spiritually resilient, the silent dependents, and community actors, thereby confirming the work of Baltes and Baltes (1990) on adaptive selectivity.

DECLARATIONS

Conflict of Interest

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

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Clinical trial number

Not applicable

Ethical approval

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

Consent to participate

Written consents have been by participants

Consent to publication

Not applicable

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