HEALTHY AGEING CONCEPTUALISATIONS

Older Malays in Malaysia

Submitted by
Noorlaili Mohd Tohit

A thesis submitted in total fulfillment of the requirements for the degree of
Doctor of Philosophy

School of Primary Health Care
Faculty of Medicine, Nursing and Health Sciences
Monash University

2015

Table of Contents

Statement of Authorship

This thesis is submitted to the Monash University, Melbourne, in fulfilment of the requirement for the Degree of Doctor of Philosophy.

The work presented in this thesis is, to my best of knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.
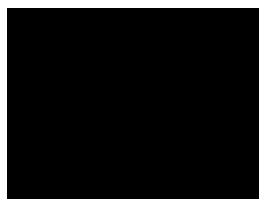
Signature: Date: 19th March 2015

Noorlaili M Tohit

Abstract

Population ageing is a worldwide phenomenon. Promoting healthy ageing is now firmly in the policy agenda of many countries.This thesis aimed to explore healthy ageing conceptualisations among older Malays in Malaysia. The thesis addresses two broad questions: What factors are important in conceptualising healthy ageing from the perspective of older Malays and how are the factors being expressed? What are the barriers to and facilitators of healthy ageing in the community studied?

This thesis comprises two consecutive studies. Study 1 involves focus group interviews to explore healthy ageing conceptualisations and facilitators of and barriers to the healthy ageing experience in older Malays. To further explore these issues, Study 2 examines six case studies, selected from Study 1 on the basis of a quantitative screening tool that identified participants as healthy and unhealthy agers. Study 2 focussed on the role of spirituality in healthy ageing. The cases were used to construct individual perspectives of healthy ageing using data from a structured interview and open ended qualitative responses, focus group interviews (Study 1), observation and reflections of the interaction with the participants throughout the study period.

Eight focus groups consisted of 38 older Malays aged 60 to 95 years participated in Study 1. In Study 2, six cases were selected via maximal variation sampling. Six interconnected themes captured the healthy ageing concepts in Study 1. Firstly, spirituality was the driving force followed by peace of mind as the ultimate aim for healthy ageing. Physical health and function, family relationships, financial independence, and living environment greatly affected the lives of older Malays in this study. The six themes were used as a framework to address facilitators of and barriers to healthy ageing in Study 2, in particular the role of spirituality in healthy

ageing. The older individuals have their own perception of their healthy ageing status and healthy ageing was seen as a process in balancing the facilitators and barriers to it. In Study 2, the spririituality was mainly experienced as connectedness to God (intrinsic spirituality) and as mutual responsibility in their relationship with others (extrinsic spirituality). The role of spirituality was not limited as a facilitator for healthy ageing; unfulfilled intrinsic and/or extrinsic spirituality can be barriers to healthy ageing. More importantly, Study 2 identified the need to listen to the perspectives of older people to address healthy ageing in a bio-psycho-social-spiritual framework. Based on the thesis findings a model of healthy ageing was developed: the Dynamic Adaptation, Prioritisation and Transcendent Acceptance (aDAPTA) model. Older people used the processes outlined in the model in balancing the barriers and facilitators to achieving healthy ageing.

In conclusion, the different cultural values explored in this thesis provided an avenue to expand healthy ageing concepts and make them relevant to the local context in Malaysia. Healthy ageing should not be restricted to a biomedical or a psychological model, the lay multidimensional bio-psycho-social-spiritual approach should be considered, particularly in addressing the needs and the adaptation experiences of older people in the local community.

Acknowledgements

I am profoundly grateful to all the individuals who contributed to the completion of this thesis project. Their support in so many ways has sustained me throughout this challenging journey. I offer my sincere thanks to:

Professor Dr. Colette Browning, my supervisor, for her patience and thorough guidance throughout this project. I have learnt enormously from her and her enthusiasm enticed me to continue in this journey.

Dr Harriet Radermacher, my co-supervisor, for her tremendous commitment, valuable comments and guidance in helping me to complete this thesis. She has dutifully demonstrated her unwavering support during the difficult times, in academic or in general life.

Staff and colleagues at Healthy Ageing Research Unit and Department of General Practice, Monash University, for their companionship and eagerness to share their knowledge to support me in this research journey.

Malaysians in Melbourne for their friendship and keeping us connected during our stay in Melbourne.

The Universiti Kebangsaan Malaysia (UKM) and Ministry of Higher Education Malaysia that provided living and study fees sponsorships.

The participants of this study for their generous contribution and without them this research would have not been possible. As English is my second language, I would like to acknowledge the help of a linguist, Dr Nor Suharti Karim for her editing work.

Last but not least, my deepest appreciation to the most important person in my life, my beloved husband, Mr Ropidi Mohd Noor for his unconditional love, sacrifice and enormous support in this journey by providing care for our four children, Izzuddin, Hanisah, Solehah and Imran. Thanks to my entire family members and friends who have endured all my years of study and remained at my side.

List of Figures

List of Tables

List of Appendices

Journal publications from the studies reported in this thesis

Tohit, N., Browning, C. J., & Radermacher, H. (2012). We want a peaceful life here and hereafter: Healthy ageing perspectives of older Malays in Malaysia. *Ageing & Society, 32*(3), 405 - 424.

Krishnapillai, A., Ramli, A., Suthahar, A., **Tohit, N**., Clearihan, L., Browning, C., 2011, Bridging the gap in ageing: Translating policies into practice in Malaysian Primary Care, *Asia Pacific Family Medicine [E]*, 10 (2), BioMed Central Ltd, UK, pp. 1-7.

Conference presentations from the studies reported in this thesis

1. Healthy ageing conceptualizations in older Malaysians. **N Tohit**, H Radermacher and C Browning, 2nd Malaysian Round Table 2008, Monash Asia Institute, Melbourne, Australia (oral presentation)

2. Healthy ageing – older Malays in Melbourne. **N Tohit**, H Radermacher and C Browning, 7th National Conference Emerging Researchers in Aging (ERA) 2008, Freemantle Australia (oral presentation).

3. Healthy ageing conceptualizations: Older Malays in Melbourne, Australia and Klang Valley, Malaysia. **N Tohit**, H Radermacher and C Browning, XIXth IAGG World Congress of Gerontology and Geriatrics, Paris, 5-9 July 2009 (poster presentation).

4. Healthy ageing conceptualizations: What do older Malays in Melbourne, Australia and Klang Valley, Malaysia, say? **N Tohit**, H Radermacher and C Browning, WONCA Asia Pacific, Hong Kong, 4-7 June 2009,(oral presentation)

5. Malaysia: Healthy Ageing in older Malays-'We want a peaceful life here and hereafter', **N Tohit**, H Radermacher and C Browning, International Federation of Aging (IFA) Melbourne, 2010 (oral symposium).

6. Cultural conceptualizations of healthy ageing: Older Malays in Malaysia. **N Tohit.** Australian Association of Gerontology (AAG) Victoria (invited speaker), Melbourne, Australia, June 2010.

7. Healthy Ageing in Asia Pacific – Malaysians' perspectives. **N. Tohit ,** Healthy Ageing Program for AUS Aid Australian Leadership Award Fellowship Scheme, Centre for International Health, Burnet Institute, Melbourne, Australia, 12-28 July 2010 (participant and invited speaker).

8. Healthy ageing perspectives of older Malays in Selangor, Malaysia –a qualitative study. **N Tohit**, H Radermacher and C Browning .3rd Asia Pacific Primary Care Research Conference, Malaysia, 2-4 th December 2011 (Consolation prize for oral presentation).

Chapter 1

Introduction

Population ageing is a worldwide phenomenon and the fact that people are living longer is a cause for celebration (Jackson, 2004). In many countries we have eliminated or reduced the causes of premature death such as infectious diseases. However, as longevity has increased, the number of people living with chronic illnesses and disability has also increased and governments worldwide are grappling with two of the drivers of health costs, namely population ageing and the "tsunami" of chronic illness (National Health and Hospitals Reform Commission, 2009). Promoting healthy ageing is now firmly on the policy agenda both in Australia and internationally (Government of Canada, 2006; O'Shea, 2006). The key policy priority for many governments who seek to address the needs and aspirations of older people is to promote older people's health, and facilitate their independence and participation socially and economically and reduce their reliance on government support.

Healthy ageing policy is a tool by which we can address the issues faced by older people and is in many ways a response to negative stereotyped views of ageing and older people. However, in order to design services, programs and interventions to promote healthy ageing, we need to improve the evidence base about healthy ageing. This project will contribute to this by examining conceptualisations and the perceived determinants of healthy ageing in older Malaysians. It should be noted that the research and policy literature in this area includes a number of terms such as healthy, successful, active, productive, optimal and positive ageing to describe ageing well.

The literature review provides an examination of these terms but the term healthy ageing will be consistently used in this thesis.

Despite being a relatively young country, Malaysia has its own policy for older people, one of the first in the Asia Pacific region. Consistent with the International Plan of Action on Ageing 1982, which was re-affirmed as United Nations resolutions in 1991, the National Policy for Older Persons in Malaysia was introduced in 1995 with the following policy statement: *'To ensure the social status, dignity and well being of older persons as members of the family, society and nation by enabling them to optimise their self potential, have access to all opportunities and have provision for care and protection'* (Department of Social Welfare, 2007, p.8). In 1996, the following objective was stated for the implementation of the health care program for older people in Malaysia, *'... ensuring that the older person has healthy physical, mental and social well-being, is able to care for him/herself and is able to contribute towards social family activity'* (Ministry of Health Malaysia, 2006). These statements illustrate how Malaysia has focused on promoting healthy ageing policy as a response to population ageing.

While policy makers are incorporating healthy ageing concepts into their policies, the question I ask is do older adults have similar perspectives about healthy ageing? I argue that in order to design effective programs and interventions to assist older people to age well, we need to understand the ageing experience in their own words (Iezzoni, 2006; Shapiro, Mosqueda & Botros, 2003).

Healthy ageing and its related concepts have been conceptualised in many ways in the literature. Most recent studies of healthy ageing and its related concepts have

recognised the need to include physical, mental and social health as indicators for healthy ageing, reflecting the World Health Organisation's definition of health (Bowling, 2008; Browning & Thomas, 2007; WHO, 1952). For example, the concept of successful ageing, in contrast to usual ageing, has been described from a biomedical model perspective as consisting of three dimensions: low probability of disease, high cognitive and physical functioning and active engagement with life (Rowe & Kahn, 1997).

The processes of Selection, Optimisation and Compensation (SOC) describe a psychological model of successful ageing (Baltes & Baltes, 1990). This model recognises the importance of adaptation in ageing well, where the older person is viewed as an active participant in their own ageing who can employ personal and social resources to compensate for the impacts of biological ageing (Baltes & Baltes, 1990). The WHO Active Ageing model also embraces the importance of adaptation but incorporates the impact of structural and environmental influences on active ageing (WHO, 2002). Bowling (1993) used positive and successful ageing interchangeably. New Zealand has adopted a positive ageing strategy since 2001, which covers financial security, health services, physical environment, safety, community attitudes and personal development (Office for Senior Citizen, 2007). Productive ageing usually refers to the capacity of older people to work and contribute to the nation's economic development as depicted in one report as '…the promotion and organisation of a lifestyle which enables seniors to participate actively in the economic and social advancement of the nation in a manner that will ensure they are contributors rather than dependants, while having the added benefit of enhancing their

own health and wellbeing' (Donatti, Moorfoot, & Deans, 2005, p.2). In contrast, Bowling and Iliffe (2006) argued that a multidimensional lay model of successful ageing is a better predictor of perceived Quality of Life in older people, as compared with biomedical, social functioning and psychological resource models. Crowther, Parker, Achenbaum, Larimore, and Koenig (2002) proposed positive spirituality as a fourth factor to Rowe and Kahn's model of successful ageing. Spirituality has rarely being explored in healthy ageing studies. This thesis is going to explore healthy ageing in a community with strong religious affiliations, hence it is expected that spirituality will be discussed.

In a review of successful ageing and its related concepts, Browning and Thomas (2007) concluded that there were two major deficiencies in the extant literature. First, while there are a number of studies that examine the definitions and predictors of healthy/successful ageing outcomes (Kubzansky, Berkman, Glass, & Seeman, 1998; Menec, 2003; Ng, 2009; Seeman, Bruce, & McAvay, 1996; Seeman & Chen, 2002; Strawbridge, Cohen, Shema, & Kaplan 1996; Vaillant & Mukamal, 2001), there are fewer studies that examine older people's own understanding and conceptualisations of the term successful ageing and its related concepts and the factors that contribute to ageing well (Bowling & Iliffe, 2006; Knight & Ricciardelli, 2003; Matsubayashi, Ishine, Wada, & Okumiya, 2006; Phelan, Anderson, LaCroix, & Larson, 2004; Reichstadt, Depp, Palinkas, Folsom, & Jeste, 2007). Secondly, most studies on healthy ageing are conducted in western countries and within relatively wealthy populations with a few exceptions (e.g., Jang, Choi & Kim 2009; Li et al. 2006; Ng, 2009). Even fewer studies have explored older people's perspectives of healthy ageing in Asian countries (Chong, Ng, Woo, & Kwan, 2006; Chung & Park 2008;

Hsu 2007; Nagalingam, 2007) and the majority of these were in Chinese populations. In summary, there is a need to examine different cultural understandings of healthy ageing, from older people's perspectives particularly in non-Western countries.

This thesis is concerned with investigating healthy ageing conceptualisations in older Malays living in Malaysia, as part of a larger healthy ageing research program currently conducted in China, Saudi Arabia and Australia by the Healthy Ageing Research Unit at Monash University. Malaysia is a country experiencing rapid demographic ageing and health challenges. This study focuses on the Malays, the main ethnic group in Malaysia, and given their Muslim traditions, the setting provides an excellent opportunity to explore cultural, spiritual and religious influences on healthy ageing conceptualisations.

About Malaysia

Malaysia is located in south-east Asia, covering an area of 329,847 km^2, and shares a border with Thailand, Indonesia, Singapore, Brunei and the Philippines (see Figure 1.1). The country is separated by the South China Sea into two regions of Peninsular Malaysia and East Malaysia, on the island of Borneo. It is a federation consisting of 11 states in Peninsular Malaysia and the two states of Sabah and Sarawak in East Malaysia. It has three federal territories, namely Kuala Lumpur as the capital city, Putrajaya as the government administrative centre and Labuan in East Malaysia as the integrated International Offshore Financial Centre (IOFC).

Figure 1.1. Map of Malaysia

Source: (http://www.malaysia-maps.com/images/map-malaysia600.gif, viewed 2 August 2013)

Profile of Malaysia's ageing population

According to the Population Census 2010, Malaysia's total population was 28.3 million as compared to 23.3 million in the year 2000 (Department of Statistics Malaysia, 2011). Older adults in Malaysia are defined as those aged 60 and above. In 1970, there were 592,000 older adults representing 5.4% of the total population and gradually increased to 6.2% by the year 2000 (Department of Statistics Malaysia, 2008). In 2010, there were more than 2.2 million older adults representing 7.9% of the total population (Department of Statistics Malaysia, 2011).

An ageing society, according to United Nations, is when 7% of the population is aged 65 and above. In 2010, 5% of the population were aged 65 and above. In the next three decades, the population aged 65 and above is expected to increase more than threefold (Table 1.1). Hence, Malaysia will become an ageing society by the year 2021, when the projected population aged 65 and above reaches 7.1% (Department of Statistics Malaysia, 2013). As Malaysia is moving towards an ageing society, there is

a need to prepare health professionals and people involved in health and aged care to identify and manage the needs of this group.

Table 1.1

Population projections by age group, Malaysia, 2010–2040 (Department of Statistics Malaysia, 2013).

Year	0–14 ('000)	%	15–64 ('000)	%	65+ ('000)	%	Median age
2010	7,822.1	27.4	19,341.4	67.6	1,425.1	5.0	26.3
2015	7,733.4	25.4	20,971.9	68.8	1,779.9	5.8	28.2
2020	7,780.7	24.0	22,445.9	69.2	2,214.6	6.8	29.9
2025	8,009.5	23.4	23,533.4	68.6	2,751.3	8.0	31.5
2030	8,087.9	22.5	24,542.0	68.2	3,335.7	9.3	33.0
2035	7,893.4	21.1	25,606.1	68.5	3,889.9	10.4	34.5
2040	7,537.2	19.6	26,615.6	69.0	4,405.1	11.4	36.0

Nearly two thirds (63%) of Malaysia's population reside in urban areas (World Health Organization, 2006). The rate of growth of the older Malaysian population demonstrates spatial variations, with a higher proportion of older adults in the rural areas as compared to the urban areas. A change in family structure towards more nuclear families following the rural to urban migration of younger people is another challenge presenting older people who have increasingly limited family support.

There is a decline in the sex ratio among older Malaysians, with increasingly more females particularly among those aged 75 years and above. The sex ratio among all older adults aged 60 and above, was 1.08 in 1970 and dropped to 0.90 in 1991, and is projected to further decrease to 0.85 in 2020 (Ong, 2002). Among the major ethnic groups, the decline is more prominent among the Indians, followed by the indigenous Bumiputeras and Chinese (Ong, 2002). As in other countries, this feminisation of ageing will pose further challenges in social security, family care and costs.

Malaysia, as a developing country has achieved a better socioeconomic and health status for its population over the last fifty years and hence has improved life expectancy (see Table 1.2). In 2008, the life expectancy at birth was 71 years for males and 76 years for females with a healthy life expectancy at birth for males and females of 62 and 66 years, respectively (WHO, 2010). In contrast, Australia as a developed country had an average life expectancy at birth of 79 years for males and 84 years for females in 2002-2004, which is among the highest in the world (WHO, 2010).

Cultural diversity, health status and ageing in Malaysia

There are three major ethnic groups in Malaysia, namely Bumiputera (67.4%), Chinese (24.6%) and Indian (7.3%) (Department of Statistics Malaysia, 2011). The Malays form the largest community in the indigenous group identified as Bumiputera. In Peninsular Malaysia, where this study was conducted, Malays constituted 63.1% of the population (Department of Statistics Malaysia, 2011). Figure 1.3 shows the ethnic distribution of Malaysia's population.

Table 1.2.

Life expectancy at birth in year 1990, 2000, 2008 for Australia, Malaysia and selected neighbouring countries. (WHO 2010)

	Men (years)			Women (years)		
	1990	**2000**	**2008**	**1990**	**2000**	**2008**
Australia	74	77	79	80	82	84
Malaysia	68	69	71	73	74	76
Singapore	73	76	79	77	81	83
Thailand	63	65	66	71	72	74
Indonesia	60	64	66	62	66	69

Population in million
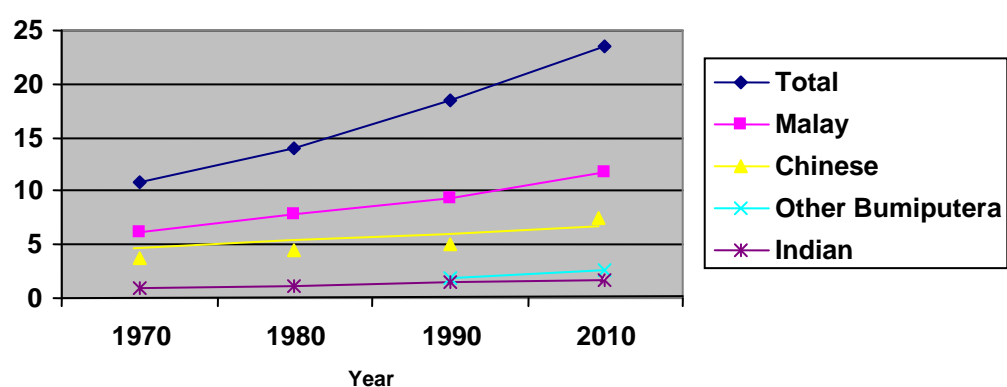
Figure 1.2. The population in Malaysia according to ethnic group from 1970 to 2010

Source: Department of Statistics Malaysia 2008, 2013

The rate of population ageing varies among the different ethnic groups in Malaysia and is significantly more advanced among the Chinese (see Figure 1.4). This is due to a lower mortality rate, longer life expectancy and low fertility rate among the Chinese (Ong, 2002).
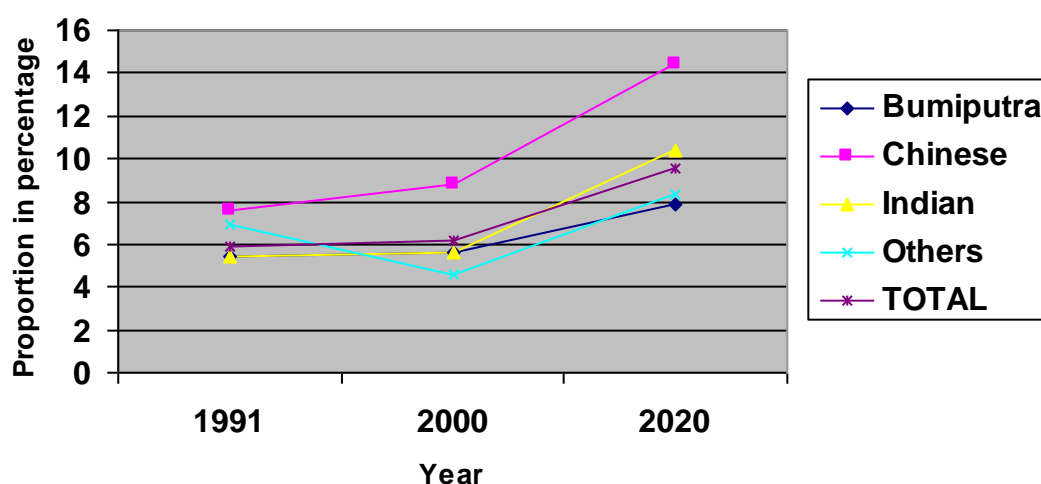
Figure 1.3. Proportion of older adults aged 60 years and above among different ethnic groups in Malaysia.

Source: Department of Statistics Malaysia 2008

Malaysia Third National Health and Morbidity Survey 2006

(NHMS III)

Few population studies have been conducted in Malaysia to assess the health status of older adults. An exception is the 10-yearly population health study in Malaysia that can be used to identify health problems in older people. The National Health and Morbidity Survey in Malaysia have been conducted every 10 years since 1986.

Domains covered in the survey include chronic diseases, disability and behavioural risk factors.

The Third National Health and Morbidity Survey 2006 (NHMS III) involved 56,710 respondents from all over Malaysia with 4954 (8.7%) of the participants aged 60 and above. Chronic diseases surveyed were bronchial asthma, hypertension, diabetes mellitus and hypercholesterolemia whereas health behaviours reviewed were smoking, physical activity and alcohol consumption. Physical disability was covered, including a specific question related to physical disability in older people (Institute for Public Health, 2008a).

The estimated prevalence of hypertension was 42.6% amongst more than 24000 respondents aged 30 and above, but there was no specific mention of its prevalence in older people. The prevalence of known diabetes mellitus amongst adults aged 30 and above was 9.5% and newly diagnosed diabetes mellitus during the survey was 5.4%, making the total prevalence 14.9%. By age groups, the prevalence of diabetes mellitus was highest amongst those aged 60-64 at 26.1% followed by 24.5% amongst those aged 65-69 and 22.8% in those 70-74 years. The prevalence amongst those aged 75-79 was 21.6% and 13.8% in those aged 80-84 years. The decrease in prevalence as people aged could be attributed to a survival effect whereby those with diabetes died younger.

Overall prevalence of physical inactivity amongst more than 34000 adult respondents aged 18 years and above was 43.7% with significantly higher physical inactivity among women (50.5%). Physical inactivity was defined as 'doing no or very little physical activity at work, at home, for transport or during discretionary time' as

compared to insufficiently active defined as 'doing some physical activity but less than 150 minutes of moderate intensity physical activity or 60 minutes vigorous intensity physical activity a week accumulated across work, home, transport or discretionary time' (Institute for Public Health, 2008b, p. 81). As expected, physical inactivity increased with age, with 47.5% inactive in the age group 60-64, 57% inactive in the age group 65-69, 63.1% inactive in the age group 70-74, 70.6% inactive in the age group 75-79 and 80.3% inactive in those aged 80 and above.

The national prevalence of being a current smoker was 21.5% with an average of 12 cigarettes smoked per day. The prevalence was highest amongst those in their twenties and early thirties. The prevalence for smoking was around 18% amongst those aged 60 and above. The national prevalence for being an ex-smoker was 5.4%, which increased with age to 14% for those aged 75 and above. Alcohol consumption information was reported from more than 20000 respondents aged 13 and above. The national prevalence of ever having consumed alcohol was reported at 16.2% with 7.4% being a current drinker. The Malays reported the lowest prevalence of ever consuming alcohol at 4.2% and only 0.7% was current drinkers.

Physical disability information was gathered from more than 55 000 respondents from all age groups. In the survey, physical disability was identified as any 'individual with physical impairment with or without limitation in functional independence or participation restriction' (Institute for Public Health, 2008a, p. 377). The overall prevalence of physical disability was 6.3 per 1000 people and increased with age particularly after the age of 50. The prevalence ranged from 18.4 to 22.6 per 1000 people between the ages of 60 and 74, then peaked to 40.7 and 41.8 per 1000 people

for age groups 75 to 79 and above 79 years respectively. Almost one third (31.9%) of those with physical disabilities lived in families earning below the national level of poverty of approximately RM 700 per month.

There were 118 older people with physical disability out of 4954 participants aged 60 or more, in this survey, resulting in a prevalence of 2.4%. This low prevalence of reported disability was most likely due to the definition of physical disability, which referred to physical impairment without consideration of physical function. Only half of older people aged 60 and above with physical disabilities were house bound, whereas interestingly up to 19.2% of older people without physical disability were considered house bound as they were unable to access public places without help. Dependency in personal care such as eating, bathing, dressing and use of toilet was mainly partial. Other findings reported were that 21.7% of older people without physical disability required a wheelchair and another 2.1% were bed bound. It seemed that physical function limitation was more prevalent than the reported physical disability and should be addressed in studies involving older people.

Studies of ageing in Malaysia

Studies of ageing in Malaysia have generally investigated a single domain (e.g. physical function, self-rated health etc.) and mainly comprised cross sectional designs (see Appendix 1).

Many studies have explored the health and social profiles of older Malaysians, and have found that the proportion of people reporting good and very good self-perceived health ranged from 35% to 78%   (Jariah, Sharifah, & Tengku Aizan, 2006 ;Low,

Khoo, & Tan, 2006; Shahar, Earland, & Abd Rahman, 2001; Tengku Aizan, Chai, Jariah, & Nurizan, 2006 ; Wu & Rudkin, 2000).

Social connectedness and living arrangement

Social connectedness and support has been studied in many different ways. Wu and Rudkin (2000) reported that there was no significant association between daily contact with parents and health status in any of the ethnic groups (Wu & Rudkin, 2000). In one rural area, more men participated in social or community activities compared to women (Shahar et al., 2001). A recent survey among 640 adult children in Peninsular Malaysia explored the emotional support received by elderly parents from their adult children. Around 90% of caregivers took care of their older parents by choice. Other than caregivers, regular physical and emotional support for the older parents was provided by around a third of the spouses of the caregivers (Alavi, Rahim, Khairuddin, Asnarulkhadi, & Chan, 2011a).

Sharifah Azizah et al. (2006) studied living arrangements and life satisfaction of 376 poor older people receiving welfare support in Peninsular Malaysia. Forty-five percent lived alone and 25% lived with adult child/children. About half of older people living alone reported low life satisfaction, compared to almost 60% of older people who co-resided with their children or with others (Sharifah Azizah et al., 2006). A recent study investigating living arrangements and life satisfaction among 1880 older people living in the community in Peninsular Malaysia reported 71.3% living with children and only 9.3% living alone (Kooshiar,Yahaya, Hamid, Abu Samah, & Sedaghat, 2012). Living only with a spouse, followed by living with children were both

associated with better life satisfaction (p<0.01) and social support function (p<0.01) as compared to living alone (Kooshiar et al., 2012).

Mental health

Mental health is another area that has been studied in various settings among older people in Malaysia. Depressive symptoms were reported in the range of 6.3% among older people in the community and up to 54% among hospitalised older people (Sherina, Rampal, Hanim, & Thong, 2006; Sherina, Rampal & Mustaqim, 2004b). Psychiatric morbidity was significantly higher among respondents aged 60 and above at 26% as compared to overall observed prevalence of 15.7% in the general population aged 16 and above (Ministry of Health Malaysia, 1997).

A survey reported that disability from chronic diseases, social support, religiosity and personality strongly influenced morale (Loke, Abdullah, Chai, Hamid, & Yahaya, 2011). Another recent survey of 1415 Malay Muslims aged 60 and above, investigated the moderating effect of religiosity on the relationship between chronic medical conditions and psychological wellbeing (Abolfathi Momtaz, Hamid, Ibrahim, Yahaya, & Abdullah, 2011). The study concluded that 'the relationship between chronic medical conditions and psychological wellbeing is statistically moderated by social religiosity and personal religiosity' (Abolfathi Momtaz et al., 2011, p.50).

Functional status

The functional status of Malaysian older adults has been studied in many settings, using different instruments. Among rural older Malays, the top three activities that caused difficulty were use of public transport (18%), cooking (13.7%) and managing money (10.3%) (Shahar et al., 2001).

About 27% of the older people in publicly funded shelter homes were functionally dependent (Zaiton, Nor Afiah, & Latifah, 2006). The three most common functionally dependent activities were ambulation, using the stairs and transfer (Zaiton et al., 2006).

Impairment in Instrumental Activities of Daily Living (IADL) was reported in 33.5% older people attending a community health center in Malaysia (Loh, Khairani, & Norlaili, 2005). The three most common impairments reported were inability to perform shopping (40%), climbing up stairs (36.6%), and taking medications (35%) (Loh et al., 2005). Another study reported 24.6% of older people in the community needed help in at least one of the 10 ADL (Hairi, Bulgiba, Cumming, Naganathan, & Mudla, 2010).

Data from a nationwide survey of 2980 community dwelling older people identified 400 participants (13.4%) who had difficulty with at least one personal or instrumental activity of daily living (Momtaz, Hamid, & Ibrahim, 2012). Among those with functional limitations, 18.3% had unmet needs. 'Unmet needs' was defined as inability to perform at all at least one personal or instrumental activity of daily living and did not receive human assistance or did not use an assistive device (14%). Those with bladder or bowel incontinence were also considered as having unmet needs (4.3%). Logistic regression analysis showed that male gender (OR=2.07, CI: 1.18-3.62) and number of chronic medical conditions (OR =1.32 CI: 1.14-1.52) were significant independent factors for unmet needs (Momtaz et al., 2012).

In sum, ageing research in Malaysia has investigated physical health and function, cognitive status, mental health, social, financial and lately even included religiosity.

The studies mainly reported prevalence and its associated factors with the researcher-derived definitions. This indicates a need for more exploratory studies to enhance understanding of the issues, for the benefit of older people in Malaysia.

Conclusion

Despite the early introduction of a national policy specifically for older people, more research in the area of gerontology and geriatrics is needed in Malaysia (Arokiasamy, 1997; Poi, Forsyth, & Chan, 2004). Published literature related to older people's health in Malaysia is limited. As described above, there are many studies on older adults in Malaysia that review some of the more commonly reported attributes of healthy ageing from researcher and practitioner perspectives. These studies predominantly employed standardised quantitative measures. However, there were no studies reporting the lay perspectives of healthy ageing among the older Malaysians. Research investigating lay perspectives includes qualitative research designs that do not have preconceived ideas about what is of importance to a population group (Bowling, 2009; Phelan & Larson, 2002). Identifying health status and healthy ageing attributes from the older adults' perspective will strengthen the evidence base and better inform the design and delivery of more effective aged care services and health promotion interventions for older people in Malaysia.

Thesis Rationale

It is projected that by the year 2020, 9.5% of the population will be aged 60 and above in Malaysia (Department Statistics Malaysia, 2008). Thus population ageing is forcing the government to think about better service provision for older people (Krishnapillai et al., 2011). With an increasing globalised world, nations across the world are being

faced with the challenge of addressing the needs of a multicultural population. To formulate appropriate locally oriented services, the specific multicultural background of the country should be taken into consideration, as demonstrated by the increasing emphasis and development of culturally responsive and competent care initiatives worldwide. It is important to study the needs and aspirations of the different cultural groups of older adults in Malaysia. Gaining their perspectives about healthy ageing offers a vital opportunity to evaluate whether they are consistent with the healthy ageing concepts upon which ageing policies and services are based.

From a governmental perspective, it makes economic sense to promote health, as the cost of managing older adults increases as people become less independent. Public health care in Malaysia is highly subsidized by the government and expenditure for health care has risen from RM 3.6 billion in 1996 to RM 9.9 billion in 2006 (Institute for Public Health, 2008a). Currently in Malaysia, family members are taking the primary and active role as carers for older people, however with changing family structures, government may need to take a bigger responsibility. Promoting independent older adults and assisting them to live in the community as long as possible is one approach to contain the costs.

Older people are a heterogeneous group with different life experiences affected by socio-cultural changes, either at a personal level or as a cohort. It is imperative to explore their current perspectives to identify any additional or missing criteria related to independent and continuous living in the community to promote healthy ageing according to their own standards and expectations. This will contribute new knowledge to better understand the experiences and aspirations of our older citizens.

The guiding concepts and principles outlined by the WHO in developing services for older adults include the rights of the older person and a life course perspective. A citizen should expect a high quality of life across the whole lifespan and, particularly as they become older, they should not be denied this right. The different cultural values explored in this thesis will potentially provide an avenue to expand these guiding concepts and principles and make them relevant to the local context in Malaysia.

As noted above, healthy ageing and its related concepts have been extensively studied in developed countries (Bowling & Dieppe, 2005; Browning & Thomas, 2007; Matsubayashi et al., 2006; Phelan et al., 2004; Rowe & Kahn, 1997; Seeman et al., 1996; Strawbridge et al., 1996; Strawbridge et al., 2002), but very limited information is available in developing countries, such as Malaysia. The many international studies of healthy ageing have not contextualised culture-specific issues; hence studying the cultural conceptualisations of healthy ageing among Malaysian older adults can go some way towards addressing this gap.

In conclusion, multidimensional concepts of healthy ageing are under researched in Malaysia. Therefore, there is an urgent need to examine healthy ageing issues in Malaysia. To expand the evidence base around healthy ageing in Malaysia, this thesis will explore how older Malays in Malaysia conceptualise healthy ageing and what factors influence perceptions of healthy ageing in older Malays.

Scope and aims of the thesis

This project explores older people's perspectives of healthy ageing. As this project is part of an international program of research examining cultural conceptualisations of healthy ageing in different immigrant groups in Australia, China and Saudi Arabia, expanding the study to include older people in Malaysia will enrich our understanding of cultural diversity and make an important additional contribution.

Healthy ageing concepts have been mainly defined by researchers and policy makers. Focussing on the importance of valuing the views of older people particularly to address their needs and aspirations, this project aims to explore healthy ageing conceptualisations and its related concepts amongst older Malays in Malaysia.

As a multicultural and multi-lingual country, it would be ideal to study at least the three main ethnic groups in Malaysia, namely Malay, Chinese and Indian. This ideal, however, is not practical given the limited time and resources available within the scope of a doctoral thesis. Hence, this doctoral project focuses on older Malays, the most populous group in Malaysia.

The thesis addresses the following research question, what is healthy ageing from the perspective of older Malays?

This broad question is comprised of two parts:

1. What factors are important in conceptualising healthy ageing from the perspective of older Malays and how are the factors being expressed?

2. What are the barriers to and facilitators of healthy ageing in the community studied?

The broad aims of the thesis are to:

1. examine conceptualisations of healthy ageing in older Malays living in Malaysia,

2. identify facilitators of and barriers to healthy ageing in older Malays living in Malaysia, and

3. translate the thesis findings into recommendations for service design for older Malays living in Malaysia.

This thesis comprises two consecutive studies. Study 1 involves focus group interviews to explore healthy ageing conceptualisations and facilitators of and barriers to the healthy ageing experience in older Malays. To further explore these issues Study 2 examines a number of case studies, selected from Study 1 on the basis of a quantitative screening tool that identified participants as healthy and unhealthy agers.

The researcher

As a Malay myself, I am in an ideal position to understand the language and cultural context of Malay communities. Yet, at the same time, I am aware of the potential challenges in managing diversity in local dialects and the cultural issues even amongst the Malays.

As a family physician from Malaysia, who has regularly assisted older people in the course of my practice and is aware of the issues older people face from a doctor's

perspective, I was keen to get involved in this project. As a family member, I also have older family members and aware of the challenges they face.

My involvement in this project was driven by a combination of personal, academic and clinical practice interests. Personally, I wanted to listen to older people outside of a clinical environment. A non-clinical environment would enable me to learn about issues that may not arise during a clinical consultation and would facilitate obtaining a more holistic perspective of the ageing experience. Academically, my broad research interest is in chronic diseases, care for older people, disease prevention and health promotion, and by being involved in this project it enables me to learn about these areas in more depth. Clinically, I anticipated that this research would strengthen my understanding of the individual, family, community and other factors that may affect each older person. I continually strive to improve care for older people in Malaysia, and with the experience gained from conducting the studies reported in this thesis, my intention is to develop a community geriatric service at the primary care level. This project provides the basis for my long-term vision to collaborate with a non-governmental organisation and set up a multigenerational complex in each state in Malaysia to cater for older people and other marginalised groups.

Organisation of the thesis

This thesis comprises of six chapters. Chapter 1 provides an introduction and overview of the thesis. This introduction covered the background to the thesis, the thesis rationale, the study context and the thesis aims. Chapter 2 provides a comprehensive review of the literature pertinent to the thesis, namely healthy ageing and its related concepts. Chapter 3 describes the methodological approach employed

in the thesis and Chapter 4 reports the findings of Study 1, the qualitative focus group study. Study 2 presents case studies of older Malays using a selection of participants from Study 1, and is presented in Chapter 5. Chapter 6 provides the conclusion to the thesis, its strengths and limitations, implications for further research and discussion of the application of the thesis findings to the development of services for older people in Malaysia.

Chapter 2

Literature Review

In order to address Aims 1 and 2 of the thesis it is first necessary to review the research and policy literature on healthy ageing and its related concepts in general, and more specifically as it relates to the Malaysian context. The review begins with differentiating the concepts of successful, healthy and active ageing. However, in order to simplify the discussion, thereafter the term "healthy" will be used to encompass these concepts.

Chapter 2 includes:

1. A review of the definitions and models of successful and healthy ageing;

2. A review of the healthy ageing literature in non-Western settings including Malaysia; and

3. The role of spirituality in healthy ageing.

The sources of the literature reviewed were from the following databases, namely the National Library of Medicine (PubMed), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Web of Knowledge, SCOPUS, Proquest and PsycINFO. The search terms used to identify relevant literature were: ageing, healthy ageing, successful ageing, positive ageing, active ageing, ageing well, and older adults. Abstracts in the English language were scanned, and if deemed relevant full text articles were retrieved either on line or manually. For each relevant article, I scanned the reference list and further articles were identified and retrieved accordingly.

Articles deemed relevant were those that addressed definitions, models, determinants and correlates of healthy ageing or its related concepts in the community. Articles were not relevant if they discussed healthy ageing related to laboratory investigations or intervention such as hormonal, genetic and biochemical measures or specific disease such as Alzheimer's, cerebro-vascular accidents and cardiovascular disorders.

The selected literature consisted of review articles, quantitative, qualitative and mixed methods research in journals, project reports or books covering conceptualisations, definitions, prevalence, and associated factors or predictors for healthy ageing or its related terms.

Definitions and Models of Successful, Healthy and Active Ageing

Healthy ageing and its related concepts such as successful, active, positive, optimal and productive ageing have been adopted as research concepts, and as policy responses to demographic ageing in many countries. In order to counter the potential "burden" of ageing societies, governments are keen to promote health and independence in old age (Browning & Kendig, 2004). Most researchers agree that healthy ageing and its related concepts are multidimensional entities. However, across disciplines, there is no universal definition and this is reflected in the diversity of domains used to measure healthy ageing. Various definitions and models of healthy ageing, and related concepts, have been used by researchers and policy makers. The review below focuses on definitions and models of successful and healthy ageing. The majority of the extant literature in this area is located in Western contexts. However, there is an emerging literature on the role of culture and social issues in different ethnic groups related to healthy ageing.

The answer to the question "What is successful ageing" will vary according to different theoretical perspectives including biomedical, psychosocial and lay perspectives. Based on a review of the literature, Bowling and Dieppe (2005) concluded that biomedical approaches focus on '… optimisation of life expectancy while minimising physical and mental deterioration and disability' (p. 1548) while psychosocial approaches '… emphasise life satisfaction, social participation and functioning, and psychological resources, including personal growth' (p. 1549).

So what does the literature tell us about how successful ageing is defined or conceptualised? A summary table of the review studies discussed in the following section is included in Appendix 2.

Phelan and Larson (2002) in a small review of 11 studies with different operational definitions of successful ageing identified seven major elements with five predictors described in four studies. Social contacts/supports, regular physical activities, freedom from chronic illnesses, high self efficacy and high educational level were reported predictors in the studies reviewed.

In a large-scale review of definitions of successful ageing Depp and Jeste (2006) examined 28 research articles and found a high degree of variability in the domains included in the definitions. Ten domains were categorised: disability/physical functioning, cognitive functioning, life satisfaction/well being, social/productive engagement, presence of illness, longevity, self-rated health, personality, environment/finances and self-rated successful ageing. Disability was the most frequent domain used in the definitions followed by cognitive functioning. Across the reviewed studies "successful agers" ranged from 0.4% to 95%.

Similarly, Peel, Bartlett and McClure (2004) found that "successful agers" ranged from 3% to 80% across studies that they reviewed. In a major content review of the definitions of successful ageing and its related concepts, Browning and Thomas (2007) reviewed over 200 research papers and policy documents in the area. They extracted content relating to 18 domains ranging from longevity and physical health to social health and positive attitudes. They proposed the definition for successful (healthy) ageing as *'a process whereby people can achieve or maintain the best possible state of physical, cognitive and mental health and well being, meaningful and positive engagement with people, community and institutions, and a personal sense of security, choice and autonomy, with active adaptation to ageing processes from the individual, familial and societal perspectives'.* This definition covers the following domains:

- physical and mental health and well being,

- meaningful and positive engagement with people, community and institutions,

- personal sense of security and autonomy

- adapting to changes associated with ageing (Browning & Thomas, 2007).

This comprehensive definition managed to capture the multidimensional perspectives of successful ageing and its related concepts, which is clearly lacking in many models of ageing, yet few studies include measures that will capture the breadth of domains incorporated in this definition. In addition, if older people score poorly according to successful ageing measures does this mean they have failed (Minkler & Fadem, 2002)?

This opens up further discussion about the definition of successful ageing which is arguably interpreted differently according to personal or policy goals (von Faber et al., 2001). At the individual level, assessment focuses on the individual needs and capacity to adapt to change, which can be very different from the priorities of policy makers. A decline in cognitive status in entering the fourth age, further challenges an individual's ability to adapt to changes, which can maintain autonomy and dignity (Baltes & Smith, 2003). As seen in the Berlin Ageing Study, at the age of 75, 80% of the participants were in good health (cognitively fit, active and involved in life) or average health (relatively healthy, still independent and satisfied with life) but only 30% were in good and average health at the age of 95 (Baltes & Baltes, 1990). Biological decline can be well tolerated due to high adaptive capacity, yet cognitive decline might denote loss of identity and a lower capacity to adapt to changes.

The ambiguity inherent in the definition of successful ageing and its related concepts has been noted in a recent review (Martin, Kelly, Kahana, Kahana, & Poon, 2012). Successful ageing has been used in the gerontological literature both as process and outcome for the past 50 years. The quest to arrive at a mutually agreed definition for successful ageing has still yet to materialise. Better understanding of multidimensional concepts in successful ageing particularly from lay perspectives resulted in attempts to integrate bio-medical and psychosocial concepts to define successful ageing. Martin et al. concluded the review with following questions for the future researchers to consider in understanding successful ageing; '1) What are the minimal definitions needed to describe successful aging? 2) How do we reconcile the various models of successful aging in our research? 3) How important are individual perceptions in the measurement of successful aging? 4) What are some of the primary interactions (e.g.,

gene and environment, environment and personality, etc.) that should also be emphasized?' (p.10).

Below, the key literature in the areas on successful, healthy and active ageing will be examined. Successful ageing is the most commonly used term in the research literature.

Successful ageing

Biomedical model of successful ageing

In order to characterise the diversity of ageing, Rowe and Kahn (1987) introduced the concept of successful ageing which comprises three dimensions of *low probability of disease, high cognitive and physical functioning, and active engagement with life*. Low probability of disease and disease-related disability was further divided into absence or presence of disease, and absence, presence or severity of risk factors for disease. High cognitive and physical functional capacity includes physical and cognitive components, whereas active engagement with life was divided into interpersonal relations and productive activities (Rowe & Kahn, 1997). The model was used extensively in the seminal MacArthur Studies of Successful Ageing, conducted from 1988 to 1996, of high functioning volunteers. The MacArthur Studies focused on measures of disease, functional capacity and social activity to test the Rowe and Kahn model (Berkman, Seeman, & Albert, 1993).

Critiques of this approach have questioned the assumption that non-adherence to these dimensions implies unsuccessful ageing, and it promotes negative attitudes towards older people if they cannot achieve successful ageing (Bowling & Dieppe, 2005;

Minkler & Fadem, 2002). While successful ageing is concerned with capacities across several domains including cognitive, behavioural, social and emotional, it has been argued that successful ageing does not take into account the varied context of the ageing experience and the broader psychosocial determinants of successful ageing (Holstein & Minkler, 2003). Critics argue that the imperative to achieve "successful" ageing is stigmatising, and reinforces negative stereotypes especially when ageing with an illness or disability (Angus & Reeve, 2006; Minkler & Fadem, 2002). Older people are more likely to self-rate themselves as successfully ageing compared to Rowe and Kahn's definition highlighting the need to take account of lay perceptions of the ageing experience (Strawbridge et al., 2002). Finally, understanding "successful" ageing needs to take into account the role of factors outside the individual's control.

Psychological model of successful ageing

Psychological models of successful ageing such as Baltes and Baltes' (1990) selective optimization and compensation model recognised the importance of adaptation in ageing well where the older person is viewed as an active participant in their own ageing who can employ personal and social resources to compensate for the impacts of biological ageing. This adaptation to biological and environmental changes reflects the general principle of selective optimisation with compensation, a prototype adaptation strategy as proposed by Baltes and Baltes (1990). Baltes, Dittmann-Kohli and Dixon (1984) first described cognitive ageing as a process of adaptation that includes three components:

• Selection: growing older may lead to restrictions in our functional capacities

- Optimisation: older people have the capacity to improve their level of functioning

- Compensation: older people learn to adapt when capacities are reduced or lost.

Baltes and Baltes (1990) expanded the model to apply to individual development in old age and the model became known as the SOC (selection, optimisation, compensation) model of ageing. Under the SOC model it is assumed that successful ageing occurs when an individual achieves the goals he/she has selected as important to them and uses the psychological processes of selection, optimisation and compensation to achieve these goals. The SOC model was used extensively in the Berlin Ageing Study (BASE), a study that involved 516 community-dwelling and institutionalised older people in West Berlin aged 70 to 103 who have been followed up seven times (Baltes & Baltes, 1990).

Lay views of successful ageing

A review of published literature reported that various definitions of successful ageing were mainly focused on maintenance of function with physical activity, social engagement and freedom from chronic disease as markers of successful ageing, but there was a lack of studies examining the views of older adults (Phelan et al., 2002). Some qualitative studies have been employed to explore successful ageing conceptualisations of older people. In depth understanding derived from the older person's own words has contributed to broader multidimensional models of successful ageing. As illustrated below there are differences in the interpretation of successful ageing from a lay view versus an objective functional view and this demonstrates the

need to incorporate lay views of successful ageing in models of ageing and policy approaches to ageing. Table 2.1 summarised the themes reported in the literature.

Table 2.1.

Reported themes of lay perception of healthy or successful ageing in the literature

Authors andyear	Participants and country	Themes
Chong et al. (2006)	Middle aged and older adults Chinese in Hong Kong	Six attributes of positive ageing: good health, positive life attitude, active engagement with an activity or society, feeling supported by family and friends, being financially secured, and living in a place with emotional ties
Hsu (2007)	Older people in Taiwan	Six themes of ageing well: physical health and independence, economic security, family and social support, engagement with life, spiritual wellbeing, and environment and social welfare policy
Knight and Ricciardelli (2003)	Older people aged 70 to 100 years in Australia.	Eight themes: health, activity, personal growth, happiness, relationships, independence, appreciation of life and longevity.
Tate, Lah and Cuddy (2003).	Male participants with mean age of 78 years in the Manitoba Follow-Up Study of Canadian Air-force recruits.	Content analysis revealed 20 themes such as keeping healthy, life satisfaction, staying busy, keeping physically active, having a positive outlook, having a loving family and friends. Acceptance was a theme used to describe spirituality, growing old gracefully, peace of mind and tranquillity.

Reichstadt et al. (2007)	Older people aged 60 to 99 years in the United State of America (USA)	Four main themes: attitude/adaptation, security/stability, health/wellness and engagement/stimulation.
Basset, Bourbonnais and McDowell (2007)	Older people aged more than 75 years old in Canada.	24 themes identified; which consisted of personal factors (12 themes), relationships with others (10 themes), and system influence (financial resources and social support services).
Bowling (2006)	People aged 50 years and above in United Kingdom	The commonly described themes: physical and mental health functioning, psychological factors, social roles, financial circumstances and living situation, social relationships, and neighbourhood and community
Bowling (2009)	Older people aged 65 and above in Britain.	Lay definitions of active ageing: exercising the body, good health and physical function, keeping physically active, exercising the mind, and psychological factors such as being in control or positive thinking.
Troutman, Nies, and Mavellia (2011)	Older Black aged 65 and above, in USA	Six categories: independence/ability, health, mindset, activity/service, family and spirituality.
Hung et al. (2010)	A review of 34 studies compared key domains in healthy ageing according to researcher or lay views	11 domains in lay views: Physical function, mental function, social function, independency, life satisfaction, happiness/wellbeing, family, adaptation, financial security, personal growth and spirituality.

Cosco et al. (2013)	A review of 26 qualitative studies of lay person perspectives	Psychosocial components (12 themes) , biomedical components (5 themes) and external components (2 themes).

Von Faber et al. (2001) explored successful ageing in the Leiden 85-plus study. They used the following definition of successful ageing: '… the optimal state of overall functioning and well-being' (p. 2695). Optimal functioning was operationalized as scoring in the top third in terms of physical and social functioning and showing no cognitive impairment or depressive symptoms, and optimal well being was operationalized as scoring in the top two-thirds in terms of quality of life and life satisfaction and showing no feelings of loneliness. Ten percent were classified as successfully ageing, 45% were classified as achieving optimal well-being and 13 % were classified as achieving optimal functioning. Twenty-two of the 27 participants in the follow up in depth interviews viewed themselves as ageing successfully despite limitations in some dimensions, illustrating their ability to adapt to personal and contextual changes. Older people in the follow up sample viewed successful ageing as a process of adaptation (see also Paul Baltes work discussed above). According to von Faber et al. (2001), they '… valued well-being and social functioning more than physical and psycho cognitive functioning' (p. 2694).

Tate, Lah and Cuddy (2003) explored successful ageing in the Manitoba Follow –up Study. This study included male Canadian Air-force recruits who were recruited to the study in 1948 and followed up in 1996 when their mean age was 78 years. Participants were asked to define successful ageing and to evaluate their own ageing. Twenty

themes were identified. Keeping healthy was the most commonly mentioned theme (30%) followed by life satisfaction (28.4%), staying busy (20.5%), keeping physically active (19.6%), having a positive outlook (18.8%) and having a loving family and friends (18.5%). Acceptance was a theme used to describe spirituality, growing old gracefully, peace of mind and tranquillity, which accounted for about 10% responses.

In a similar study Knight and Ricciardelli (2003) interviewed 60 people aged 70 to 100 years about their perceptions of successful ageing. Eight themes were identified including: health, activity, personal growth, happiness, relationships, independence, appreciation of life and longevity. The majority of participants only mentioned 1 or 2 themes and health, activity, personal growth and happiness were the most common themes elicited. When asked to rate the importance of ten domains of successful ageing contained in the research literature, health, happiness and mental capacity were rated the highest.

In a focus group study of 72 older people aged 60 to 99 years, Reichstadt et al. (2007) examined lay definitions of successful ageing and the necessary components of successful ageing. Four main themes were identified: attitude/adaptation, security/stability, health/wellness and engagement/stimulation. Having a positive attitude, being realistic and adapting to change were seen as necessary conditions to age successfully. In this relatively healthy sample, psychosocial factors were more important than health and physical factors.

In a sample aged 65 years and over selected from the Alameda County Study, Strawbridge et al. (2002) compared self-ratings of successful ageing (agreement with the statement "I am aging successfully") with Rowe and Kahn's criteria of absence of

disease, disability and risk factors, maintaining physical and mental functioning and active engagement with life. Using the self-rating method, 50.3% of the sample were classified as successful agers while using Rowe and Kahn's criteria, only 18.8% of the sample were classified as successful agers. Many of those with chronic conditions classified themselves as ageing successfully.

In another study, a very high proportion of self rated successful ageing (92%) was shown amongst 205 community-dwelling older people age 60 and above (mean age 80.4 years) in California (Montross et al., 2006). A large proportion of participants in this study were better educated and more financially stable, however only 15% had no physical illness and 28% were without any basic physical limitations which resulted in only 5% being classified as successful agers according to Rowe and Kahn's criteria (Montross et al., 2006).

In a national survey involving 854 community dwelling people aged 50 years and above in Britain, an open-ended question was asked about what was associated with successful ageing. The commonly described themes consisted of multiple domains such as physical and mental health functioning (66%), psychological factors (47%), social roles (35%), financial circumstances and living situation (30%), social relationships (26%), and neighbourhood and community (10%) (Bowling, 2006).

Bowling and Dieppe (2005) introduced the same study in their review of lay definitions of successful ageing. Most of the sample related successful ageing to good health and functioning but also mentioned enjoyment in life, making a contribution to society and having a positive outlook and sense of purpose. Three-quarters of the sample rated themselves as ageing very well or well. Many older adults regarded

themselves as happy and well, even in the presence of disease and disability. Successful ageing aspirations are not limited to physical health and function. Bowling and Dieppe (2005) contrasted biomedical approaches to successful ageing that emphasise life expectancy and minimising poor health with psychosocial approaches that '… emphasise life satisfaction, social participation and functioning, and psychological resources, including personal growth' (p. 1549).

Bowling and Iliffe (2006) tested five models of successful ageing to predict self rated quality of life using baseline data from the British longitudinal study of ageing, which involved 999 older people aged 65 and above. The biomedical model was assessed by measuring the number of chronic diseases, activities of daily living and use of GHQ 12 to describe psychological morbidity. Using this biomedical model, 31% of participants were classified as successful agers. Adding the social engagement score to the biomedical measures described as broader biomedical model resulted in only 23% of the participants being classified as successful agers. The social functioning model assessed social engagement, frequency of social contact and support in five areas of life, identified 34% of the sample as successful agers. The psychological resource model included measures of self efficacy, optimism and a single item from GHQ; identified only 16% of the sample as successful agers, the lowest of five models. The lay model consisted of multidimensional measures combining measures from all four models (except the single GHQ item from psychological model) plus annual income and perceived social capital. This model identified 24% successful agers. Each model was able to independently predict self rated QoL using separate logistic regression models. The lay model was the strongest predictor of QoL (OR =

5.49), followed by the broader biomedical model (OR = 3.25), biomedical model (OR= 2.60), psychological model (OR=2.41), and the social model (OR= 2.0).

Bowling and Iliffe (2011) conducted a further follow up of 496 survivors from a national random sample of 999 participants in 1999/2000. Two hundred and eighty seven participants responded (58%). The different successful ageing models were included with quality of life as the outcome measure, using the Older People's Quality of Life Questionnaire (OPQOL). The traditional dichotomous cut off score classification into successful and non-successful agers resulted in smaller number of participants attaining successful ageing in each model. Four models of successful ageing, namely the broader biomedical, psychological, social and lay models demonstrated significant association with OPQOL but the biomedical model was not associated with OPQOL. In contrast, using a continuous measure of successful ageing, the correlational analyses demonstrated a significant association between all five models and OPQOL scores. Further multiple regression analyses using the biomedical, social functioning and psychological successful ageing models to predict follow up QOL, found that only elements of the psychological model (self efficacy and optimism) remained significantly associated with OPQOL. The authors concluded that 'our findings suggest that healthy ageing is not simply about physical or mental health maintenance, but rather about maximising psychological resources, namely self-efficacy and resilience' (p. 9).

Despite the earlier study (Bowling & Iliffe, 2006) findings concerning the role of lay and broader biomedical models as stronger predictors of QOL, the follow up study did not confirm this finding (Bowling & Iliffe, 2011) . Lay and broader biomedical models of successful ageing were omitted in the regression analysis due to

overlapping variables with the other concepts. This omission might have contributed to the inconsistent results. The inconsistent findings demonstrate the complexity in assessing the role of both models, particularly the lay model, which usually involved a combination of multiple dimensions from the other models.

Phelan et al. (2004) investigated lay views of successful ageing in Japanese and White Anglo Americans. Participants were asked to rate 20 statements about successful ageing based on four domains, physical, functional, psychological and social, examined in the research literature. The following statements were rated by 75% or more of the sample as important: remaining in good health, being able to take care of one's self, remaining free of diseases, having friends and family, being able to make choices about diet, exercise and smoking, being able to cope with the challenges in later years and being able to act according to one's own values. the authors noted that '… none of the published work describing attributes of successful ageing includes all four dimensions' (p. 211).

In a study of 2783 community living and cognitively intact participants aged more than 75 years old, a subset selected for a healthy ageing study from the third wave of the longitudinal Canadian Study of Health and Ageing, participants were asked to share their account of successful ageing while interviewers wrote down their verbatim replies (Basset, Bourbonnais & McDowell 2007). One open-ended healthy ageing question was used, 'In this study I have talked with many seniors and learned something from each one of them. What do you think makes people live long and keep well?' (p.115). There were 24 themes identified; which consisted of personal factors in 12 themes, relationships with others in 10 themes, and another 2 themes

(financial resources and social support services) were categorised as system influences (Basset et al., 2007). Personal factors identified were positive attitude, autonomy, sense of self, self care, responsible living, nutrition, keeping active, work ethics, disciplined approach to health, longevity, informed consumers, and factors beyond one's control. Relationship with others involved quality relationships with family, friends, spouse, and children. Frequency of contact with family, friends, children, grandchildren, and reciprocity were other sub-themes for relationship with others. Despite many similarities, possible cultural differences which needed further exploration were reported between French and English speaking participants. The French group appreciated autonomy and quality of life whereas the English group identified the self and self care as important aspects of healthy ageing. The authors concluded '...despite decline and loss, these seniors make sense of their lives as active, moral, cognitively and socially engaged individuals. A remarkable pattern of folk wisdom emerges from the responses' (Basset et al., 2007, p.123).

One recent review of 26 qualitative studies of lay person perspectives which focus specifically on successful ageing highlighted the multidimensional nature and strong role of psychosocial dimension in successful ageing (Cosco, Prina, Perales, Stephan & Brayne, 2013). The review reported that psychosocial components were identified in all studies, 20 studies included biomedical components and 15 studies addressed external components of successful ageing. The constituents of psychosocial component were acceptance, adjustment, maintenance, spirituality, community, social roles, quality of life, independence, prevention and remediation, self awareness, perspective and engagement. The biomedical component consisted of cognitive and

mental health, general health, health maintenance behaviours, longevity and physical health and functioning. Living environment and financial factors were identified as external components. Engagement was the most frequently mentioned constituent followed by perspective and self awareness, whereas longevity was the least mentioned constituent of successful ageing. The review acknowledged that the studies included 'had a strong Anglophone bias' (p.8) and 'profound underrepresentation of non-Western countries' as most studies were from USA, Canada and United Kingdom (Cosco et al 2013, p.1).

In sum, despite describing a range of multidimensional approaches to successful ageing, most literature focuses on bio-psycho-social models. There is a need to explore other dimensions that may affect the life of older people. Crowther et al (2002) argued that positive spirituality be added as a fourth factor to Rowe and Kahn's model of successful ageing. As this thesis is going to explore healthy ageing in a community with strong religious affiliation, spirituality is expected to be discussed by the participants; hence it is one of the foci of the current thesis.

Healthy ageing

The concept of healthy ageing has been used both in Australia and Canada to develop frameworks to inform ageing policy. In Canada healthy ageing is defined as: 'A lifelong process of optimising opportunities for improving and preserving health and physical, social and mental wellness, independence, quality of life and enhancing successful life-course transitions' (Health Canada, 2001, p. 2).

In Australia the National Strategy for an Ageing Australia (NSAA) (Bishop, 1999b) included four themes - independence and self-provision, world-class care, healthy ageing, and attitudes, lifestyle and community support. The healthy ageing theme focused on maintaining health in old age through lifestyle management and the management of chronic illnesses. Bishop (1999a, p. 3) defined healthy ageing as an approach to ageing that aims '… to maintain and improve the physical, emotional and mental well being of older people'. This definition was updated in a revision of the NSAA to include '… disease prevention and optimal well being' and '… maximizing capacities to participate and contribute …' to society (Andrews, 2002, p. 52). Within the previous National Research Priorities (Department of Education, Science and Training, 2003), 'Ageing well, ageing productively' is a priority goal that recognises the role of both healthy and productive ageing (Donatti et al., 2005). However in a recent review by the Australian Government of the Strategic Research Priorities (SRP), the focu did not include aging. Promoting population health and well being is one of the five societal challenges outlined in the SRP. The research outcomes are expected to build resilient and healthy communities for all Australians (Australian Government, 2013). Despite the lack of focus on the ageing population, this broad outcome should also include older Australians.

A number of European countries collaborated to study healthy ageing in Europe and defined healthy ageing as *' the process of optimising equal opportunities for health in order to enable older people to take an active part in society and to enjoy an independent and good quality of life'* (European Commission 2007). This definition focuses on health, and active participation and independence for good quality of life at old age.

A recent review of 34 studies that compared key domains in healthy ageing according to researcher or lay views reported that researchers used fewer domains (up to a maximum of five) compared to lay people (up to 12 domains) (Hung, Kempen & De Vries, 2010). In this review, healthy ageing was used as an umbrella concept to include related terms of successful ageing, positive ageing, active ageing, robust ageing and ageing well. Physical function was consistently used by both groups, whereas longevity was never included in the lay views. Interestingly the review reported that family, adaptation, financial security, personal growth and spirituality were five domains used by lay people but were never included in academic/clinical domains of healthy ageing (Hung et al., 2010).

In sum, healthy ageing is the preferred term used in government policy contexts in many countries. Despite its inclination towards health related components such as physical, mental and emotional well being, its definition has been readily expanded to include psychosocial dimensions of ageing well. Hence, healthy ageing has embraced a multidimensional approach and can be used interchangeably or as the umbrella concept for its related term.

Active ageing

Active ageing was advocated by the Word Health Organization as a way of promoting health and well being in old age. Active ageing is defined as '…the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age' (WHO, 2002, p. 12). This approach has been widely adopted particularly in the United Kingdom and Europe. The WHO (2002) Active Ageing policy framework listed five determinants of active ageing with culture and

gender as cross-cutting influences: personal, behavioural, economic and social, the physical environment and health and social services. This approach recognises that environmental factors such as access to transport, housing and safe neighbourhoods impact on health actions such as physical activity, and the ability to access to services. Walker (2002) argued that while the WHO active ageing concept has a focus on assisting older people to work longer (productive ageing), the framework recognises the importance of promoting health and well being to support independence. He also advocated a life course approach to active ageing with different strategies required at different points of the life span. When approaching retirement older people need to be encouraged to continue their participation in society while in later life their needs to be an emphasis on supported self-reliance in collaboration with the health and social care systems.

Bowling (2009) compared lay definitions and self rated active ageing among older people aged 65 and above, in three groups in Britain, representative of minor ethnic (n= 400), more homogenous white population (n= 589) and follow up participants from the Quality of Life survey (n=302). The first two groups underwent face-to-face interviews whereas the latter group responded to a postal questionnaire. The minority ethnic participants consisted of Indians, Pakistani, Caribbean and Chinese and were younger than the white British population. An open ended question to gain participants' own interpretation of active ageing was, 'what, in your opinion, are the things associated with 'active ageing'?' The most common lay definitions of active ageing consisted of exercising the body, good health and physical function, keeping physically active, exercising the mind, and psychological factors such as being in

control or positive thinking. Interestingly, psychological factors were the only factors mentioned by a significantly greater proportion of ethnically diverse participants (15 percent) as compared to the white participants (7 and 8 percent respectively). A significantly higher proportion of white participants nominated all the other stated factors to define active ageing as compared to the ethnically diverse group. In the ethnically diverse participants, only 40 percent rated themselves as ageing actively according to their definition in contrast to 85 percent and 78 percent of the white participants, respectively. Within the ethnically diverse participants, a higher proportion of Chinese (27 percent) rated themselves as 'ageing very actively', compared to 9 percent of Pakistani, 6 percent of Caribbean, and 5 percent Indians. The diversity in interpretation of active ageing in the different cultures indicates the need for more exploratory research in the area as suggested by the author, the issue '...requires qualitative research to provide insight on values as well as reporting behaviours' (p.708).

A recent review on active ageing criticised the absence of consensus to define active ageing (Boudiny, 2013). Despite the clear description in the WHO framework that it covers three main areas of health, participation and security, the review explored the divided approach in active ageing. The uni-dimensional approach mainly addressed the economic framework of participation, whereas the multidimensional approach addressed the continuous participation of older people in a few domains of life mainly economic and social domains. This approach resulted in unrealistic expectations towards the old-old and vulnerable older adults. The third approach was criticized for including health and independence within the active ageing definition instead of as its

determinants, which resulted in further bias towards the youngest and healthiest. The review proposed active ageing as a life-course perspective upheld by three principles of adaptability, considering the human factor and 'the removal of structural barriers which are exclusively based on age or dependency which limit older adults in their ability to choose for a certain activity, or more generally, for continued engagement with life' (Boudiny 2013, p.1090).

In sum, policy framework and research discussion about active ageing focuses on active participation or continued engagement in life, which is advantageous to young-old and healthy older people. This may restrict the development of a multidimensional concept, which covers the full spectrum of ageing well domains and recognizes the heterogeneity of health and disability outcomes for older people.

Summary and conclusion

A comprehensive analysis of the definitions of the terms successful, healthy and active ageing used in the research practice and policy literatures has been presented. The term most discussed in the research literature is successful ageing largely in response to the model set out by of Rowe and Kahn (1987). Successful ageing approaches focus on the prevention of disease and disability, the promotion of high level mental and physical functioning as well as active engagement with life. However critics have pointed out the potential for stigmatisation to be increased if this term is emphasised in describing ageing experiences and outcomes. The term healthy ageing has its origins in the policy literature. Healthy ageing approaches focus on promoting health and healthy ageing is seen as a process linked to adaptation. The term active ageing was developed by the WHO and has been popular in policy frameworks in the

U.K. and Europe. The WHO Active Ageing framework highlights multiple determinants of active ageing and argues for multiple intervention approaches to achieve active ageing.

Models of successful, healthy and active ageing need to incorporate the role of diversity, particularly cultural diversity, in the ageing experience. In order to broaden our understanding of these concepts we need to engage with older people themselves in order to incorporate lay perceptions in our models of ageing and understand how life experiences influence outcomes in old age. For example, bio-psycho-social approaches are needed that recognise the life course experiences of older people (Depp and Jeste, 2006). While the focus has been on "escaping" illness and disability as a marker of successful ageing (Evert, Lawler, Bogan, & Perls, 2003), Depp and Jeste (2006) argued that we need to better understand the adaptive processes whereby older people with physical illness or disability maintain their cognitive and mental health and remain engaged with life.

Spirituality and adaptive processes in older people are commonly discussed as the use of religion or spirituality in coping with challenges in life (Cohen & Koenig, 2003). Spirituality as a way of coping in a stressful situation has been reported positively in a few reviews (Cohen & Koenig, 2003; Koenig, 2012). On the other hand, a few studies reported the negative effects of spiritual or religious coping (Hill & Pargament, 2003; Pargament & Brant, 1998). Spirituality as an inner resource to cope with stress and ageing has been reported among older Malays and Indians in Singapore (Mehta, 1997). Positive influences of religiosity/spirituality for adapting to ageing at a

personal and social level have been reported in Singapore (Mehta, 1997; Nagalingam, 2007; Ng, 2009).

It is possibly not feasible to come up with one model that fits the experiences and aspirations of all "older" people. In this thesis the focus is on older Malays and it is expected that healthy ageing in this cultural context will be conceptualised according to their cultural and lived context.

This thesis aims to explore healthy ageing conceptualisation among older Malays as our contribution to further understanding of lay perspective in healthy ageing. I am going to use the term healthy ageing because it is relevant to both research and policy literature. As described earlier, criticism of the term 'successful ageing' was mainly concerned with the interpretation of "successful" and "failure" as the opposite of it. For active ageing, the word 'active' by itself denotes a certain degree of expectation in terms of activity and participation which may affect the discussion to identify how older people in Malaysia conceptualise 'good ageing'. Healthy ageing encompasses a multidimensional perspective, incorporates lay perspectives as well as the environmental context (not just individual). It would also be best understood by the older Malays as *Penuaan Sejahtera* (healthy ageing) as compared to active or successful ageing which are difficult to translate into the Malay language. Hence, from here on I am going to use the term 'healthy ageing', unless another term is specifically used in the evidence presented.

The main concern in the studies reviewed was the lack of standardisation in the outcome measures. Healthy ageing and its related concepts have no standardised definition. The wide variability in the outcome measures with heavy inclination

towards a biomedical model restricted consistent comparisons across the studies. Without a standardised definition, outcome measures in some studies were also investigated as predictors in others studies. Despite evidence that the lay model of successful and healthy ageing involved more domains and arguably better represents the complexity of healthy ageing at an individual level, many relevant domains such as family, adaptation, financial security, personal growth and spirituality were rarely included as outcome measures or examined as predictors for healthy ageing studies (Hung et al., 2010).

Given the heterogenousity of the ageing process, we should focus more on identifying older people's conceptualisations of healthy/successful ageing from the perspectives of specific communities, cultures and individuals rather than seeking a "once size fits all" solution.

Most studies included in the reviews were conducted in Western populations. Despite a growing literature in non-Western settings (see below), more research is needed to understand these concepts in Asian contexts. Hence this thesis will further explore lay views of healthy ageing and the facilitators and barriers to healthy ageing in the specific cultural setting of older Malays in Malaysia. The next section examines studies of healthy ageing and related concepts in different cultural settings.

Successful, Healthy and Active Ageing in Different Cultural Settings

As previously noted, the majority of published studies on healthy ageing are located in Western countries. In this section I review the studies on healthy ageing and related concepts in different cultural settings.

Lamb and Myers (1999) reported an early study carried out in a non-Western setting. The WHO regional studies of Health and Social Aspects of Aging, in Indonesia, Thailand and Sri Lanka involved older people aged 60 and above. Successful ageing was defined by self reported functional status namely having no difficulties in any of the seven Katz ADL items (Katz, 1983) and at most one difficulty in five items on the Nagi scale (Nagi, 1976) for physical strength. Randomised sampling in each selected country resulted in the recruitment of 1202 participants from Central Java, 1199 from Thailand, and 1200 mainly Singhalese from Sri Lanka. The proportion of successful agers in each country was 79.8%, 74.4% and 46.6% respectively. Further logistic regression analysis identified male gender, younger age group, no morbid condition, high morale (measured by attitude towards ageing), and ability to handle money as correlates of ageing successfully.

Matsubayashi et al. (2006) replicated the US study by Phelan et al. (2004) in 5207 Japanese older community dwelling adults and compared the meaning of successful ageing across Japanese, Japanese-Americans and White Americans. There were differences in the number of attributes of successful ageing rated as important by the Japanese sample (7) compared to the Japanese-American (13) and the White American sample (14). Longevity was more highly valued in the Japanese sample compared to the American sample while the Americans valued more highly than the

Japanese being able to meet all their needs and wants. Perhaps not surprisingly Americans were more likely than the Japanese to rate highly attributes of successful ageing from the published Western literature. Matsubayashi et al. (2006) concluded that '… differences in ecology and culture may greatly influence higher dimensions of successful ageing such as intellectual, social and spiritual ones' (p. 186) and argued for further research about the concept of successful ageing in other cultures.

Fernandez-Ballesteros et. al (2008) used a questionnaire similar to that used by Phelan et al. (2004) and Matsubayashi et al. (2006) in three European and seven Latin American countries (n=1189). It was reported that up to 17 and 19 of the successful ageing attributes were rated as highly important in the respective regions. Longevity was considered as important by more than half of the participants in both European and Latin American regions, whereas ability to work after retirement and continuing to learn new things were rated by less than 75 percent European participants as important. The ranking of the five most important attributes for successful aging was consistent across the different groups in America, Japan, Southern Europe and Latin America and covered bio-psycho-social concepts such as good health, being satisfied with life, adaptation, being independent, and having good relationships with family and friends (Fernández-Ballesteros et al., 2008; Fernández-Ballesteros et al., 2010). The conclusion re-affirmed 'that a set of key components, such as health, psychological and social components of successful ageing, constitutes a quasi-universal conceptualisation in older people themselves' (Fernández-Ballesteros et al., 2010, p. 54) and 'supports that the scientific concept of successful aging seems to be disseminated around the world' (Fernández-Ballesteros et al., 2008, p. 952).

Some Chinese studies have examined the concept of successful ageing. In a study based in Hong Kong of 1106 people aged 60 years and over, Chou and Chi (2002) examined the relationships between successful ageing and various socio-demographic, social and illness variables. Chou and Chi (2002) noted: 'In the absence of a standard procedure for defining successful aging, we elected, within the constraints of our data, to adopt multiple dimensions of health and functioning …' (p. 3). This approach uses dimensions derived from previous studies of successful ageing and the authors note that '…much work remains to be done in specifying the optimal dimensions to measure…' (p. 12). The dimensions of successful ageing used in this study were functional status, affective status, cognitive status and productive involvement. Successful aging was scored on a 5-point scale (0 to 4) corresponding to the number of dimensions where the participant scored the highest level of functioning. Successful aging was defined as '… the number of criterion which respondents met the highest levels of successful ageing' (p. 8). In functional status domain, 43.9 % aged successfully, 37.7% aged successfully in cognitive status domain, 23.4% aged successfully in affective status domain, and only 4.4% aged successfully in productive involvement domain. Up to one third of participants fulfilled none of the highest levels of successful ageing criteria and only 0.7% fulfilled all four. Demographic characteristics, social contact, health status, financial strain and life satisfaction were some of variables assessed as potential predictive variables for successful ageing. Participants of younger age, male, with more years of education, less financial strain, better self rated health, and higher life satisfaction were more likely to be successful agers.

Chong et. al. (2006) conducted a qualitative study to explore the views of the Chinese population in Hong Kong towards positive ageing. The authors described, 'the term 'positive ageing' as preferred to 'successful ageing' in their study, because of its emphasis on 'positive actions available to the majority of people' (p.245). Two themes formed the positive ageing views of the participants in 15 focus groups conducted among middle-aged and older adults in Hong Kong. The first was that the attributes of positive ageing comprised good health, positive life attitude, active engagement with an activity or society, feeling supported by family and friends, being financially secure, and living in a place with emotional ties (Chong et. al 2006). The participants' view of positive ageing was concluded as '… subscribed to a less demanding definition of positive ageing, one that refers to a state of wellbeing that is attainable even by those who suffer from chronic illnesses or disabilities' (p.260). The second theme was the key factors that enabled positive ageing, namely adopting a healthy lifestyle, thinking positively, promoting family and interpersonal relationships, and building up financial resources (Chong et. al., 2006).

Li et al. (2006) examined successful aging in Shanghai in 1516 older people aged 65 years and over. Successful ageing was defined according to specified criterion scores on the Chinese Mini Mental State Examination (CMMSE), Activities of Daily Living, a mood self-evaluation and absence of physical disabilities. Fifty-six per cent of participants fulfilled the successful agers criteria for CMMSE score, 75.6% for ADL score, 91.6% for mood self evaluation and 97% with no disability. The proportion of participants who fulfilled all the four criteria and classified as successful agers was 46.2%. Males and participants of younger age were more likely to age successfully.

After controlling for age and gender, being currently married (OR =1.36), leisure activity levels (OR= 1.07) and life satisfaction (1.03) were important factors contributing to successful ageing.

A combination of open ended questions to elicit the essential components of ageing well and a list of 23 successful ageing criteria were used in a face to face interview of 584 older people in Taiwan (Hsu, 2007). The six themes identified from the open-ended questions to describe essential components of ageing well were physical health and independence, economic security, family and social support, engagement with life, spiritual wellbeing, and environment and social welfare policy (Hsu, 2006). No further exploration or comparison was carried out for the identified themes and the list of 23 successful ageing criteria. The most highly ranked descriptors of successful ageing from the list were physical health, independence, living without chronic disease, living with family, and receiving emotional care (Hsu, 2007). Factor analysis of 21 out of the 23 criteria resulted in five factors that accounted for almost 60% of the variance. These factors were family and social support, mastery over life, health, enjoyment of life and autonomy. The findings from these two methods demonstrate the needs to further explore the themes that were not included in the survey list such as spiritual well being, and environment and social welfare policy.

The domains of physical health and function, cognitive and emotional wellbeing, social function, and life satisfaction were used to define successful ageing in a study of over 1200 community-dwelling Chinese aged 65 years old and over in Singapore (Ng, 2009). This study reported that 28.6% of participants were classified as successful agers. Significant determinants of successful ageing were younger age,

being female, higher level housing, better education, physical activity and exercise, spiritual or religious beliefs as source of support or comfort, and low nutritional risk (Ng, 2009).

Summary and conclusion

The healthy ageing studies reviewed in non-Western contexts consisted of quantitative studies which were heavily influenced by the biomedical model and qualitative studies looking into healthy ageing concepts. Studies conducted in Asian regions are starting to demonstrate some diversity in the variables used consistent with the cultural influences in the population such as spirituality (Ng, 2009). The concepts of healthy ageing examined in Hong Kong and Taiwan Chinese communities, demonstrated some characteristics of Eastern culture in terms of family connection and spiritual wellbeing. Those findings, however, were not further explored in terms of its role in healthy ageing and its relevance to the culture or the traditions of the communities studied.

The paucity of healthy ageing studies and its related concepts in the Asian regions demonstrated the need to fill the many knowledge gaps concerning healthy ageing in non-Western populations. It would be good to explore both spirituality as well as the influence of family, however due to limitations in time and resources, we decided to focus on spirituality as the domain least understood in relation to healthy ageing. Family connection, despite not being extensively explored, at least has been included as part of the social connection/support in Asian healthy ageing literature (Chou & Chi, 2002; Hsu, 2007; Ng 2009).

In communities with strong cultural influences on everyday life either through family or religious traditions, where respect towards older people is considered an obligation, involvement of older people to inform healthy ageing concepts is critical. Having reviewed more general literature related to healthy ageing in non-Western regions, the next section reviews literature specifically related to healthy ageing in Malaysia.

Healthy and Successful Ageing in Malaysia

Research on ageing received little attention in the early years following Malaysian independence from the British in 1957. A concerted effort to improve maternal and child health services in addition to the control of infectious diseases were prioritised to improve overall life expectancy in the population.

The early research mainly involved surveys of the social and health status of older people. For example, financial strain, social relations and psychological distress were reported from a World Health Organisation funded survey of the "Social and Health Aspects of Aging in Fiji, Korea, Malaysia, and Philippines" in 1983-85 (Ferraro & Su, 1999). In Malaysia, where the Malay ethnic group formed the majority of the sample, the findings demonstrated that psychological distress was positively related to financial strain and receipt of family financial support, whereas involvement in voluntary associations, integration with family and friends, intergenerational exchange, and having a consultation role in community were negatively related to psychological distress (Ferraro & Su, 1999). Further regression analyses revealed that subjective health, IADLs and involvement in voluntary associations were significant predictors of lower psychological distress, but financial strain and other social measures were not (Ferraro & Su, 1999). Inclusion of psychological status, social

measures, financial strain, health and functional status provided valuable multidimensional information about ageing in Malaysia, however the weakness of the study was the use of non-probabilistic sampling.

More recently, the prevalence of successful ageing in a nationally representative survey of 2749 older people in Malaysia was reported as 13.8%. Successful ageing was measured using a multidimensional biomedical model, which consisted of no major chronic disease, without functional difficulty, and maintenance of good psycho-cognitive functioning. Self report for six major chronic diseases namely cancer, heart problem, diabetes, stroke, hypertension and chronic lung disease revealed 59% of the sample without any of these diseases. The proportion of respondents reporting no problem with both ADL and IADL was 75%, whereas only 22.6% had good psycho-cognitive function criteria. Good psycho-cognitive function means the participants were not depressed or demented (assessed using AGECAT-GMS diagnostic algorithm), had good quality of life and had good self-perceived health (assessed by a single question each with a 5-point Likert scale). The socio-demographic predictors of successful ageing were younger age, higher education level, higher income and Chinese ethnicity as compared to Indian (Hamid, Momtaz, & Ibrahim, 2012).

Qualitative studies of ageing in Malaysia

Merriam (2002) conducted in depth interviews with 19 multi ethnic older Malaysians (10 Malays, 5 Chinese and 4 Indians) and identified three themes to describe how cultural values shaped the nature of learning in older adulthood in Malaysia. Firstly, learning was informal and experiential as part of their daily activities in life, secondly it was communal as a social activity which involved interaction within the

community, and thirdly, it was spiritually and philosophically driven either among Muslim, Christian, Hindu, or Buddhist participants (Merriam, 2002). One of the challenges experienced by the researcher in doing the study was the participants' ability to understand the term "successful ageing" explored in the study. The researchers had to drop their initial intention to explore the meaning of successful ageing as the term was incomprehensible for the participants.

A qualitative study explored living arrangement preferences and family relationship expectations among older parents in Peninsular Malaysia (Alavi, Rahim, Khairuddin, Asnarulkhadi, & Omar, 2011b). The study used in depth interviews with 15 older parents from Malay, Chinese and Indian backgrounds. The participants were aged 60 and above from rural and urban localities. The main question asked was, 'What are the living arrangement preferences and family relationship expectations of the elderly during the last stage of their lives in the modern and challenging situation?' The older parents preferred to live in their own house, however when they become dependent, they preferred to live with family members instead of living in a care institution. There was a Malay respondent who could not imagine living in a nursing home and would rather choose to live in a spiritual retreat (*pondok*) to learn the Quran. They preferred that their children came to live with them rather than moving to stay with their children. The older parents expected their children to take care of them when they became dependent (Alavi et al., 2011b).The same study also explored the intergenerational relationships between ageing parents and their adult children from the perspective of older parents and their adult children (Alavi, 2013). Women (as daughters or daughters-in-law) usually shouldered the responsibility to care for the older parents. There was close intergenerational relationships between the caregivers

and the older parents; however there were some frustration experienced by the caregivers. Emotional support was important in their relationship mainly as a companion for conversation, persuasion, compassion and for spiritual or religious solace (Alavi, 2013). The authors concluded that despite the changing patterns in family structure in Malaysia, support to strengthen intergenerational relationships should be addressed as adult children were still expected to care for their older parents.

Summary and conclusion

Despite increasing general interest in healthy ageing and its related concepts, multidimensional concepts in healthy ageing were mainly investigated according to the researchers' definition. Many scholars in this area are aware of the lack of data from older people's perspectives and have called for more exploratory research. Limited studies have explored conceptualisations of healthy ageing from the perspectives of older people and none were reported from Malaysia. The construct of healthy ageing may demonstrate universality in its multidimensional interpretation, but there are gaps in our understanding of how it is being viewed in different cultures. The studies involving older people in Malaysia demonstrated a compartmentalised approach and were conducted in limited health and social contexts. Hence, two knowledge gaps were identified in the current healthy ageing literature broadly and in Malaysian studies of ageing: (1) there is a limited understanding of ageing from the perspectives of older people and (2) there are no studies of healthy ageing conceptualisations in Malaysia.

Spirituality, Health and Ageing

As alluded to in the earlier part of this literature review, the role of spirituality as part of multidimensional entity in healthy ageing is an issue in need of further examination. Crowther et al. (2002) argued that positive spirituality is added as a fourth factor to Rowe and Kahn's model of successful ageing.

In addressing spirituality, it is very important to distinguish it from religiosity or religion. According to Dalby (2006), religion refers to 'the external, institutionalized, formal and doctrinal aspects of a religious life, whilst spirituality has been used to refer to the personal, subjective experience' (p.5). This is in line with another opinion, '...distinction between religion as practices and beliefs about the sacred or divine and spirituality which came to mean something more closely related to emotional experience' (King & Koenig, 2009). 'Being concerned with a search for meaning in relation to the sacred' was used to describe spirituality (Dalby, 2006, p.5). Spirituality might be addressed or experienced by those without any religious affiliation. Hence, conceptually spirituality seems broader than religiosity. Religion has been described as part of spirituality. Spirituality can be mediated by religion, the arts, the environment and relationships with others and/or God (MacKinlay, 2006).

On the other hand, in a recent review, spirituality and religiosity has been used interchangeably as there was clear overlap in its definition (Koenig, 2012). Religion was described as an entity that '...involves beliefs, practices and rituals related to the transcendent' whereas spirituality 'includes both a search for the transcendent and the discovery for the transcendent' (Koenig, 2012, p.3). The interchangeable use reflects the use of similar instruments to assess spirituality or religiosity.

The role of spirituality and health has been investigated in a number of studies particularly in the United States. Much of the debate around the role of spirituality in health has focused on definitions and ways to measure religiosity and spirituality. While most researchers agree that spirituality comprises intrinsic, individual, subjective and emotional entities (Crowther et al., 2002; Hill & Pargament, 2003; Mowat & Ryan, 2002; Sadler & Biggs, 2006) spirituality is difficult to measure quantitatively due to the wide individual variation in the expression of spirituality. Themes identified as expressions of spirituality include integrity, humanistic concern, changing relationships with others and concern for younger generations, the relationship with a transcendent being, self transcendence and coming to terms with death (Dalby, 2006). Spirituality can also be seen as a motivational factor or a way of coping in a stressful situation (Hill & Pargament, 2003; Krause, 2006), even though some studies reported the negative effects of spiritual or religious coping (Hill & Pargament, 2003; Pargament & Brant 1998).

Many studies have explored the relationship between religiosity/spirituality and mental health. Parker et al. (2003) found better general mental health and fewer symptoms of depression among those high in all three measures of religiosity; namely organised religiosity (OR), non-organised (NOR) and intrinsic religiosity (IR). Ardelt and Koenig (2006) demonstrated that a sense of purpose in life, rather than religiosity, had a direct positive effect on subjective well being. They also reported that shared spiritual activities had an indirect positive effect on subjective well being (Ardelt & Koenig, 2006). Addressing religious or spiritual needs may help psychological healing among psychiatric patients (Koenig & Pritchett, 1998). Higher spirituality was also positively related to certain health-related behaviors such as being a non-drinker,

having never smoked and being a healthy eater but was not related to exercise (Teshuva, Kendig & Stacey, 1997).

A recent review of religion, spirituality and health, used religiosity and spirituality interchangeably and referred to it as "R/S" (Koenig, 2012). The review captured more than 3000 publications of quantitative studies examining the R/S-health relationship until 2010. The R/S relationship with mental health was the most studied as R/S was expected to boost positive emotions, serve as a life enhancing factor and a resource for coping. R/S and mental health reported many positive relationships particularly in the area of coping with adversities, wellbeing, optimism, hope, meaning and purpose, self-esteem and sense of control. Many studies reviewed reported inverse relationships with depression, substance abuse, anxiety, suicide and delinquency/crime. R/S demonstrated a positive relationship with health behaviours particularly cigarette smoking in addition to exercise and healthy diet. An inverse relationship was reported with risky sexual activities. Despite a lesser number of studies investigating the relationship between physical health and R/S, an inverse relationship was seen in coronary heart disease and hypertension. R/S was also associated with higher immune function, better self-rated health and longevity (Koenig, 2012).

The increasing importance of individual spirituality is evidenced by the incorporation of a spiritual component in a range of recent health promotion interventions. These interventions include Spirited Scotland (Mowat & Ryan, 2002) and an integrative health promotion model within selected communities in the United States of America (Parker et al., 2001; Parker et al., 2002). The long-term impact of these interventions, however, is as yet unclear due to their relatively recent emergence.

The role of spirituality in healthy ageing has been increasingly recognised (Koenig, 2006; McCann Mortimer, Ward & Winefield, 2008; Mowat, 2006; Ng, 2009). For example, Bowling and Dieppe (2005) and Hsu (2007) identified spirituality as a minor theme in qualitative studies of older people's perspectives of healthy and successful ageing. In other cases, spirituality has been proposed as the 'forgotten' fourth dimension of Rowe and Kahn's model of successful ageing (Crowther et al., 2002; McCann Mortimer et al., 2008). Despite these developments, spirituality has rarely been included within multidimensional definitions of healthy ageing (Bowling & Iliffe, 2006; Phelan et al., 2004).

Erikson's (1985) model of psychosocial development is one of the most notable psychological developmental theories in old age. The eighth stage was described as an attempt to achieve spiritual reconciliation towards the end of life (Sadler & Biggs, 2006). The ninth stage, introduced later (Erikson, 1997), was seen to incorporate an increasingly spiritual perspective, with the task 'to develop an attitude of retreat and retirement in relation to the world' (Dalby, 2006, p.5). This stage is consistent with Tornstam's (1997) Gerotranscendence theory, which states that living into old age is characterised by 'a shift in metaperspective from a materialistic and pragmatic view of the world to a more cosmic and transcendent one, normally accompanied by an increase in life satisfaction' (Tornstam, 1997, p.143). Although this theory did not specifically address spirituality, the 'shift' could mean a shift towards 'the sacred' (Dalby, 2008, p. 6). The three manifestations described in gerotranscendence theory are cosmic, self, and social personal relationships. This shift, described as 'intrinsic and culture free', also has the potential to be modified by specific cultural patterns (Dalby, 2006, p.6).

Qualitative studies among religious and secular Turks in Turkey and Iranians in Sweden demonstrated increased life satisfaction amongst all participants who demonstrated evidence of gerotranscendence (Lewin & Thomas, 2000). The studies used a life narrative approach followed by semi structured interviews. The Turkish study involving 12 religious and 17 secular Turks, found some participants particularly among the secular group demonstrated increased life satisfaction without evidence of gerotranscendence. Increased life satisfaction in participants without evidence of gerotranscendence was not seen in the Iranian study. The Iranian study involved 13 religious and 10 secular Iranian immigrants in Sweden. In both studies, gerotranscendence was demonstrable in both secular and religious participants, with evidence of life satisfaction clearer in religious participants (Lewin & Thomas, 2000). This supported the position that gerotranscendence resulted in life satisfaction.

Musick (2000), in his review, supports the role of religion/spirituality in physical health and ageing and proceeds to argue the need to better understand spirituality and ageing issues within non-Christian populations. Very few studies have explored ageing and spirituality issues among non-Christian respondents. Mehta (1997) reported lack of finances, loneliness, illness and other health related problems as the main issues causing stress among older Malays and Indians in Singapore. In the study, participants used spirituality as an inner resource to cope with stress and ageing and, for both groups; religion demonstrated positive influences for adapting to ageing at a personal and social level (Mehta, 1997). Another study comprising Indian Hindus, Christians and minority Muslims in Singapore reported that as one ages, praying to God resulted in peace of mind and better confidence in facing the vicissitudes in life (Nagalingam, 2007).

The role of spirituality in ageing well has also been demonstrated among the community-living older Chinese in Singapore (Ng, 2009). A single question used to assess spirituality was 'to what extent are your religious or spiritual beliefs a source of support and comfort to you?' with three options ranging from none or little, to some extent, and to a great extent. Almost a third (32.5%) of successful agers reported the role of spirituality to a great extent as compared to only a fifth (21.6%) of non-successful agers. Spirituality was identified as one of the significant independent determinants for successful ageing (Ng, 2009).

Another study in Taiwan, that incorporated the perspectives of older people aged 65 and above, identified spiritual well being as one of six essential components for an ideal and satisfactory life in old age (Hsu 2007). However, despite the finding and a discussion on the role of spiritual happiness and wellbeing (*Fu*), it was not included in a follow-up survey that sought to investigate the relative importance of 23 successful ageing concepts (Hsu 2007).

A study among older Malays in Malaysia used a modified internal/external religiosity questionnaire which involved two factors, personal religiosity and social religiosity (Abolfathi Momtaz et al., 2011). The personal religiosity, which includes items pertaining to private prayer and faith consists of eight statements. Participants have to describe varying levels of agreement or disagreement to the statements, which include 'I enjoy reading the Koran and Hadith', 'I have often had a strong sense of Allah's presence', 'My whole approach to life is based on my religion' and 'It is important to me to spend time in private thought and prayer'. In the social religiosity subscale the three statements included were: 'I go to the masjid [mosque] because it helps me to

make friends', 'I go to the masjid mainly because I enjoy seeing people I know there' and 'I go to the masjid mostly to spend time with my friends'. In the social religiosity subscale, the statements seem biased towards those frequenting the mosque, however both subscales demonstrated good reliability, with internal consistency of 0.82 (social religiosity) and 0.92 (personal religiosity). As described in Chapter 1, the study concluded that 'the relationship between chronic medical conditions and psychological wellbeing is statistically moderated by social religiosity and personal religiosity' (Abolfathi Momtaz et al., 2011, p.50).

In sum, spirituality and religiosity might be seen interchangeably in the Malaysian community, which has a strong religious tradition. This was evident in a qualitative study that reported learning in older adulthood was spiritually and philosophically driven amongst all Muslim, Christian, Hindu, and Buddhist participants (Merriam, 2002). While there is a great need for in-depth exploration of the meaning of religiosity and spirituality in this community, it is not within the scope of this project.

Conclusion

While healthy ageing has been extensively studied in Western and more advanced countries, there is a noticeable lack of standardised definitions of healthy ageing and its related concepts, as well as a lack of studies looking into older adults' perspectives.

Healthy ageing has been described in many different models using biomedical, psychological, social constructs and various combinations of these. Despite general agreement that healthy ageing involves multidimensional constructs, I argue that the variability and flexibility of multidimensional interpretations of healthy ageing is

important to allow for nuances in individual, cultural or policy-related goals. Studies of healthy ageing in different cultures are scarce. This major gap in understanding healthy ageing perspectives in different cultures is one of the foci in this thesis.

The circularity in identifying certain dimensions as predictors or components of healthy ageing constructs is another limitation identified in the studies reviewed. Causation is best studied in longitudinal research and it is not within the scope of this thesis. This thesis explores important correlates of healthy ageing in the population studied, particularly the role of spirituality, which was identified in the pilot study, but is a factor not consistently recognised in the healthy ageing literature.

Browning and Thomas (2007) described that conceptualisations of successful ageing and related concepts were largely researcher derived and argued for a more comprehensive approach that included lay perceptions. They also noted that most published studies were located in Western settings with few studies examining cultural issues in healthy ageing. Hence, this thesis examines lay perceptions of healthy ageing in an Asian setting, Malaysia. At the same time it identifies facilitators of and barriers to healthy ageing in older Malays living in Malaysia, particularly the role of spirituality in healthy ageing.

Hence, this thesis is expected to fill some knowledge gaps by studying the perspectives of older people concerning healthy ageing, and exploring the healthy ageing perspectives in a different culture, namely older Malays living in Malaysia. Further understanding of the potential role of spirituality in healthy ageing may contribute to the diversity of multidimensional approaches to conceptualising healthy ageing. As the study is being conducted in Malaysia, where most ageing studies are

limited by researcher driven definitions, exploring older people's conceptualisations of healthy ageing is imperative.

Older people are frequent users of health and aged care services and as such have a right to be treated appropriately. Their conceptualisations of healthy ageing should be seriously considered in the planning and development of services that meet the goals and aspirations of older people.

Chapter 3

Methodological Approach

This chapter reports on the methodological approach employed to answer the main research question: What is healthy ageing from the perspective of older Malays? This broad question is comprised of two parts:

1. What factors are important in conceptualising healthy ageing from the perspective of older Malays and how are the factors being expressed?

2. What are the barriers to and facilitators of healthy ageing in the community studied?

The next section begins with a description of the methodological rationale to answer the research questions. An introduction to Study 1, a qualitative focus group study and Study 2, a case study approach undertaken in this thesis are then described. Finally, the summary of the findings from a pilot study examining healthy ageing conceptualisation among older Malays in Melbourne, Australia, is reported. The full focus group study is reported in Chapter 4. Study 2, the case studies, is presented in Chapter 5.

Overview of the methodological approach used in Studies 1 and 2

This thesis explored healthy ageing perspectives and aspirations in older Malays and the barriers to and facilitators of healthy ageing. In order to answer the research questions posed in this thesis, my examination of the theoretical, empirical and

methodological literature led me to employ a qualitative method approach using focus groups, augmented by in depth case studies.

Existing theoretical frameworks for healthy ageing were mainly derived from researchers, clinicians or policy makers with a western or developed nation's orientation with little input from older people. For example, the Malaysia National Policy for Ageing while consistent with the Madrid Declaration in Second World Assembly on Ageing 2002 was drafted with virtually no input based on the experiences and aspirations of older people. Hence, to allow openness in understanding older people's perspectives of healthy ageing, I employed a bottom-up or inductive approach in Study 1 without a specific underpinning theoretical framework. Study 1 reported in this thesis explores healthy ageing conceptualisations and its related concepts amongst older Malays in Malaysia.

Healthy ageing is an under researched area in Malaysia and no previous study has investigated the views of older Malays about healthy ageing in the Malaysian community. One earlier qualitative study to explore the nature of learning in older Malaysians removed a question of what it meant to age 'successfully' as it was incomprehensible to participants involved in the individual interviews (Merriam, 2002). Hence, in the first instance, an exploratory qualitative approach was deemed an appropriate methodology to explore healthy ageing perspectives and aspirations. The experience of other researchers in their earlier attempts to address healthy ageing issues in older Malaysians identified the importance of the formulation of appropriate and comprehensible questions. A pilot study was carried out to address this issue before the full qualitative study commenced.

Individual structured interviews followed by in depth exploration according to participants' responses were conducted with a sample of the focus group participants from study 1; the results of which were used to create a sampling framework to select six participants for the case study analysis (Study 2). The strategic selection and analysis of these cases was used to further examine the role of spirituality (a major theme derived from Study 1) in healthy ageing. The case studies, which comprise Study 2, are reported in Chapter 5. The use of mixed methods in Study 2 is in line with the pragmatic approach to choose the method that works well to answer the research question. The main advantage of mixed methods is its complementary roles, utilising the strength of each method. For instance, in Study 2, the Geriatric Depression Scale (GDS) is an objective measure for possible depression and its score is used for case selection to further explore the experience of the respective participants. The integration of findings from both methods provides greater understanding in the area studied. One disadvantage of a mixed method approach is when researchers start arguing about which method is the main one or most important method (Creswell, 2009). This could be overcome by a mutual understanding that each method has its role to contribute according to the research question. Another disadvantage of mixed method is when there is a failure to integrate the findings (Creswell, 2009). As long as researchers are aware of the strengths and limitations of each method, and the associated debates about why or why not methods can be mixed, a mixed method approach can provide an appropriate and relevant option.

Figure 3.1 provides a visual depiction of the overall study design and Table 3.1 provides an overview of the research methodology used in this thesis.

Table 3.1.

Overview of the research methodology

Study	Methodology	Data Collected	Analysis
1	Focus groups	• 8 focus group interviews (n=38) – Interviews recorded, transcribed, and translated. • Observations and reflections were recorded as field notes.	• Thematic analysis – findings of which informed the focus of Study 2. • Observations/reflections informed interpretation of themes.
2	Case Studies	• Structured quantitative questionnaire (n=23), including open-ended qualitative responses. • Focus group data. • Observations and reflections were recorded as field notes.	• Quantitative findings used to select 6 cases for analysis. • Corroboration of multiple data sources. • Observations/reflections informed analysis and interpretation of case studies.

Figure 3.1. Flowchart of the thesis methods
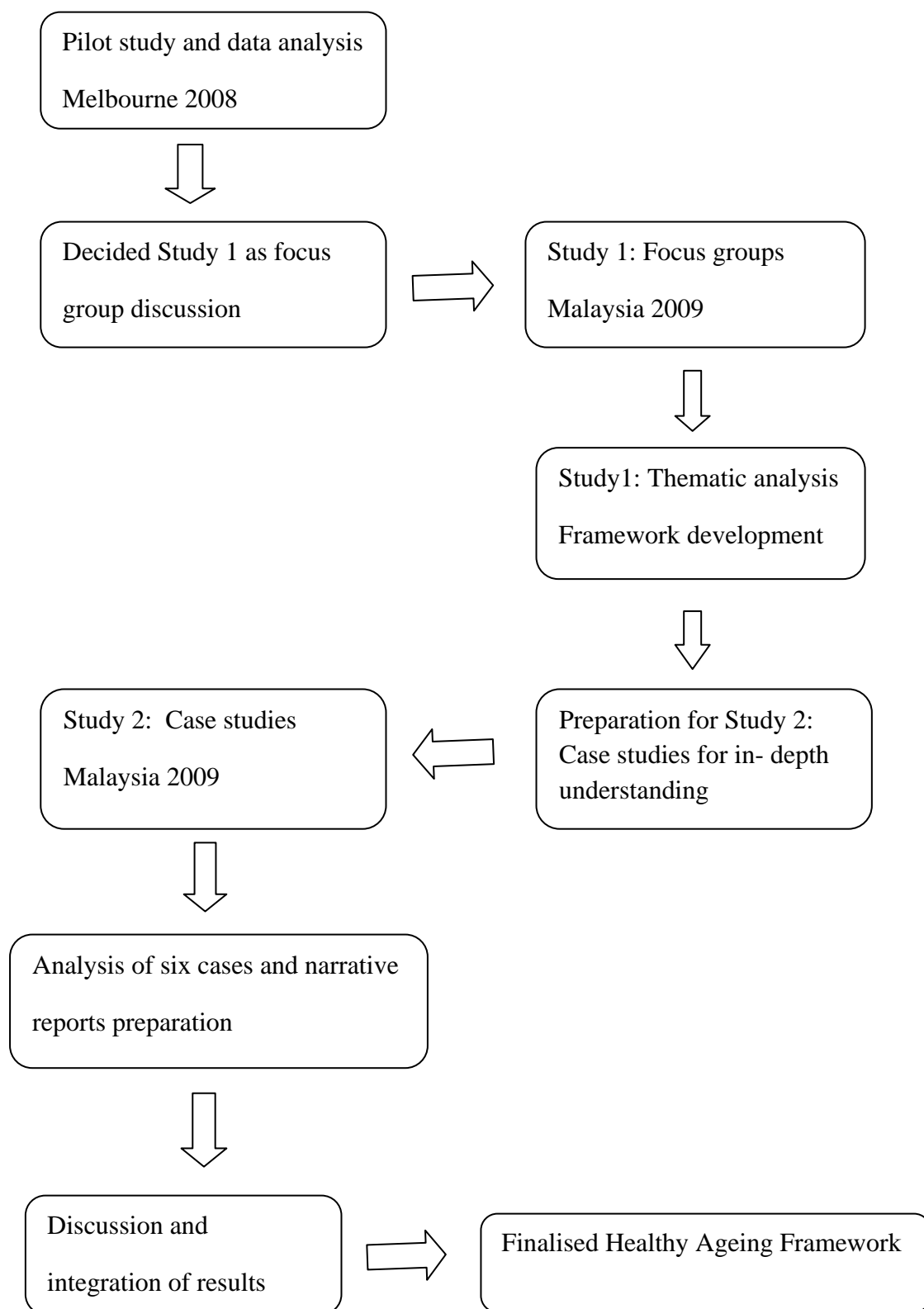
Methodological Rationale

    Epistemological framework

The qualitative research community usually subscribes to the constructivist paradigm whereas the quantitative community is mainly associated with the positivist or post positivist paradigm (Creswell, 2009; Guba & Lincoln, 2005; Patton, 2002; Teddlie & Tashakkori, 2009). Paradigm is defined as 'a basic set of beliefs that guide action' (Denzin & Lincoln, 2005, p.183). Paradigms are human constructions and 'define the worldview of the researcher-as-interpretative-bricoleur' (Denzin & Lincoln, 2005, p.183). Guba and Lincoln (2005) described constructivism as one of five major paradigms. Constructivist perspectives emphasise the subjectivity of individually and socially constructed realities as mainly seen in qualitative research (Guba & Lincoln, 2005; Patton, 2002; Teddlie & Tashakkori, 2009).

In my opinion, healthy ageing concepts are individually and socially constructed, hence I am using the constructivist paradigm as my underpinning orientation to answer the research questions in this thesis. In this qualitative approach, I seek to explore the meaning of healthy ageing based on the views of older Malays. Peel, Bartlett and McClure (2004) concluded in their review that related measures for healthy ageing should be culture and age specific. Culture is viewed as a social construct particularly to address the issues in the contemporary societies (Patton, 2002). In my opinion, the meaning of healthy ageing can be shaped by culture, hence I am taking the emic perspective. The emic perspective is an approach to develop insider's views of what is happening (Patton, 2002, p. 268). I am conducting the data collection by personally being in the context and setting with the participants during

the data collection. The emic perspective has been argued as the best way to describe 'meaningful distinctions' in ethnographic studies within a selected culture (Patton, 2002, p. 267). I am aware that my interpretation of their views can be influenced by my own experiences and background. As an inductive process, the generation of meaning from the data collected in the field is the result of interaction in the community studied (Creswell, 2009).

The purpose of this thesis is to explore healthy ageing conceptualisations among older Malays in Malaysia. To address such a purpose, I considered a range of research design frameworks or strategies of inquiry, including ethnography, phenomenology, case study and grounded theory. Despite my emic approach, typical of an ethnographic approach, ethnography is more suitable when studying the broader culture of a selected community instead of exploring the specific question of healthy ageing conceptualisation.

A phenomenological inquiry 'identifies the essence of human experiences of the phenomenon as described by the participants' (Creswell, 2009, p. 231). Healthy ageing is a phenomenon that has not being defined in this community; hence it would be a challenge to identify those experiencing healthy ageing. This approach would be more suitable if I was studying the ageing experience of the selected community. Case study is another potential strategy of inquiry; however, there is a need for 'prior development of theoretical propositions to guide data collection and analysis' (Yin, 2009, p.18). In this instance, a case study was not suitable as the initial exploratory study to conceptualise healthy ageing. Once a healthy ageing framework has been developed, however, a case study approach could be considered to further explore the healthy ageing concept.

The healthy ageing models available in the literature were mainly developed in western communities. To study healthy ageing conceptualisations in this community, a bottom-up or inductive approach without any specific underpinning theoretical framework is preferable. An inductive approach is expected to generate a culturally relevant healthy ageing framework specific for this community. To generate such a framework, a grounded theory approach was considered to be the most appropriate strategy. The grounded theory inquiry 'derives a general, abstract theory of a process, action or interaction grounded in the views of participants in the study' (Creswell 2009, p. 229).

Grounded theory was described as early as 1967 by Glaser and Strauss, and had objectivist underpinnings (Charmaz, 2000). It then evolved into a more prescribed, structured, didactic and prescriptive objectivist grounded theory popularised by Strauss and Corbin (Charmaz, 2000; Creswell, 2007). Charmaz (2000) advocated constructivist grounded theory as a middle ground between Strauss' postmodernism and Glaser's positivism stances. A constructivist grounded theory emphasizes an interpretive approach 'with flexible guidelines, a focus on theory developed that depends on the researcher's view, learning about the experience within embedded, hidden networks, situations, and relationships, and making visible hierarchies of power, communication and opportunity' (Creswell, 2007, p.65). A constructivist approach assumes multiple realities and viewpoints (Charmaz, 2000).

 Grounded theory can be a method with specific strategies or a general qualitative method which only adopts one or two grounded theory strategies (Charmaz, 2013). The grounded theory strategies include 'simultaneous data collection and analysis in

an iterative process, analyse action and processes, use of comparative methods, draw on data in developing new conceptual categories, develop inductive categories through systematic data analysis, emphasize theory construction rather than description or application of current theories, engage in theoretical sampling, search for variation in the studied categories or process, and pursue developing a category rather than covering a specific empirical topic' (Charmaz, 2013, p.301).

This thesis used a grounded theory framework as a general qualitative method which involved simultaneous data collection and analysis in an iterative process, drew on data in developing new conceptual categories, developed inductive categories through data analysis, and emphasized theory construction and purposeful (theoretical) sampling. The data were analysed thematically (Braun & Clarke, 2006; Wilson & Luker, 2006).

I am aware my thinking and theoretical perspective might influence this study. Being a medical doctor, my earlier thinking was very much towards a biomedical model; however, with years of experience interacting with older people, I know older people have broader perspectives in healthy ageing conceptualisation than the simple biomedical model. Constructivist perspectives emphasise individual subjectivity and socially constructed realities. The researcher being an instrument in qualitative study is an integral part of the process. As a researcher and an individual, I have my own values and perspectives which will always influence the way research is conducted, analysed and interpreted. Hence, it is important to ensure that the influence of the researcher is as transparent as possible. Transparency in this thesis has been enabled via measures to promote credibility and dependability which will be discussed later.

Existing theoretical perspectives agreed upon multidimensional entities of healthy ageing but did not comprise as many dimensions as expressed by the lay model (Bowling & Dieppe, 2005; Hung et. al. 2010). During the proposal preparation process, and due to the multiple perspectives of healthy ageing, it was imperative to employ an inductive process to identify the healthy ageing conceptualisation from the perspectives of the participants. During the pilot study, spirituality was identified as a key theme. This finding informed my study direction towards the proposed fourth dimension of positive spirituality in Rowe and Kahn's biomedical model (Crowther et al., 2002). Nevertheless, during the data collection process, I was careful to ensure the process allowed for additional perspectives to be raised by the participants.

Data collection approach

Study 1: Focus groups

In Study 1, focus groups were used to collect qualitative data to explore the meanings, experiences and aspirations of older Malays pertaining to healthy ageing. As already highlighted this is an under researched area in older Malays, and therefore required a research approach that examined the area from the bottom up. Exploratory qualitative approaches increase the depth in understanding of an issue but the findings of such studies are limited in terms of their generalisability (Patton, 2002). Generalisability of the study findings was not the main issue for the thesis at this stage, as the intended outcome of this study was to identify themes that reflected the healthy ageing perspectives of older Malays.

In qualitative research, there are three main methods for data collection including *observation* such as in ethnography, *interviews* either individual or focus groups, and

gathering data from available *documents or texts* (Patton, 2002). As the purpose of Study 1 was to explore older people's perspectives of healthy ageing, the best approach was to seek the opinions and experiences of the older people themselves via interviews.

Older people's views of healthy ageing may not necessarily be seen in their actual behaviour derived from direct observation. Their views are shaped by a complex interaction of their attitudes, their life experiences and health and experiences shared with others. Individual in depth interviews gather individual perspectives mainly through life stories. Focus group interviews stimulate the sharing and comparing of individual perspectives often resulting in broader and richer perspectives about the issue studied (Morgan, 1997). In my opinion, to explore various perspectives in healthy ageing, appreciating the unique features of focused but humanistic interviews to produce in-depth data from the group interactions is vital (Stewart, Shamdasani, & Rook, 2007). Hence, healthy ageing conceptualisations were seen as an appropriate topic to be discussed in a group rather than via individual in depth interviews.

A focus group is a carefully planned session '… to obtain perceptions on a defined area of interest in a permissive, non-threatening environment' (Krueger & Casey, 2000, p.5). Despite the influence of group dynamics, participants' interactions provided 'check and balance' that enhance data quality (Krueger & Casey, 2000). Focus groups have been used in research in three different ways, as a principal source of data for the study, as a supplementary source of data to the primary method and as part of multi-method studies (Morgan, 1997). In this thesis, focus group discussions were used as the principal method to assist the development of theoretical

propositions for the case studies examined in Study 2. Thematic analysis was the main technique used to analyse the data. Further details of the focus group study are reported in Chapter 4. However, possible cultural factors, such as the openness of participants to discuss issues in a group setting and the characteristics of participants for each focus group may affect the contribution of certain individuals. This issue was considered during the pilot study reported in the later section of this chapter and in Study 1 reported in Chapter 4.

Advantages and limitations of the methodology

Focus groups are cost effective and result in rich data generated within a short time (Krueger & Casey, 2000; Patton, 2002). This holds true particularly for the issue of healthy ageing conceptualisations investigated in this study. The participants enjoyed the benefits of sharing and exchanging their views. This experience widened their horizons to the extent that some participants even suggested a regular group session as a way to stimulate their thinking and group interaction.

Participants with similar backgrounds but are strangers to each other is considered to be the ideal situation for focus group composition as a prior established relationship may affect group dynamics (Krueger & Casey, 2000; Patton, 2002). On the other hand, in my opinion, well selected prior established relationships can encourage meaningful group dynamics, particularly due to having pre-established trusting relationships, and reassurance of confidentiality. Some people, particularly Asians, can feel considerable discomfort in sharing their personal experiences in a group (Mehta, 2011). Hence, I decided to involve groups of participants with established trust and willingness who respect each others' differences in perspectives. Another

limitation of focus groups is the potential for minority perspectives not being revealed (Krueger & Casey, 2000; Patton, 2002). This issue was addressed by inviting participants to take part in individual interviews (as part of Study 2), which gave them the opportunity to verbalise any individual perspectives or opinions that they felt uneasy about sharing within a group.

Study 2: Case study

This thesis attempts to answer the main research question; what is healthy ageing from the perspective of older Malays? Study 1, an exploratory study using focus groups as described above, identified propositions for further inquiry: how older people expressed healthy ageing, the barriers to and facilitators of healthy ageing, and how spirituality affected healthy ageing. These questions required further exploration; which informed my decision to use a case study approach in Study 2.

A case study method is a preferable approach to study contemporary events when the relevant behaviours cannot be manipulated or controlled by the researcher such as in an experimental study or even in participant-observation (Yin, 2009). Case studies should not be constrained by methods, time, complexity or the number in the sample (Simons, 2009; Stake, 2005).

A case study is a bounded, integrated system that involves '… an intensive description and analysis of a phenomenon or social unit such as an individual, group, institution, or community' (Merriam, 2002, p.8). The purpose of a case study 'is to gather comprehensive, systematic and in depth information about each case of interest' (Patton 2002, p. 447). The purpose of this case study was to explore healthy ageing

conceptualisation at an individual level, particularly in terms of spiritual expression, a key healthy ageing theme uncovered in Study 1.

There are at least three types of case study; intrinsic, instrumental and collective (Stake, 2005). An intrinsic case is examined just for its intrinsic interest without having a prior purpose to understand a certain construct whereas an instrumental case is chosen with prior intention to explore certain issues (Stake, 2005). Collective or multiple case studies investigate some phenomena using a number of cases (Stake, 2005; Yin, 2009). I would consider my case studies as instrumental and collective as they were strategically selected to further examine the role of spirituality in healthy ageing. The cases selected were instrumental with the intent to explore the role of spirituality in healthy ageing. They were also collective cases identified to investigate the healthy ageing phenomena among information-rich older Malays. Information-rich cases provide the best opportunity for us to 'learn a great deal about issues of central importance to the purpose of inquiry' (Patton, 2002, p.230). This will be further elaborated in Chapter 5.

Yin (2009) divided the technical definition of case studies into two areas; the scope of case studies, and other technical characteristics such as data collection and the data analysis strategy. The scope of a case study is an empirical enquiry, which 'investigates a contemporary phenomenon in depth and within its real life context, especially when the boundaries between phenomenon and context are not clearly evident' (Yin, 2009, p.18). Healthy ageing is a contemporary phenomenon, which needs further in depth understanding in the community studied.

The second part of the technical definition of case studies:

- 'Copes with the technically distinctive situation in which there will be many more variables of interest than data points,

- Relies on multiple sources of evidence, and

- Benefits from the prior development of theoretical propositions to guide data collection and analysis' (Yin, 2009, p.18)

The strength of a case study approach is the use of multiple methods to generate evidence. The use of multiple sources of data is characteristic of case studies and involves triangulation to increase credibility (Patton, 2002; Stake, 2005). Direct observation and interviews of people involved in the event studied are two common sources of evidence used (Yin, 2009). In this instance, Study 2 uses data from the focus groups, quantitative data from a structured questionnaire, and direct observation with the selected participants (see Table 3.1). Prior understanding of healthy ageing concepts in the earlier focus groups assisted the development of theoretical proposition for the case study. The case studies are presented in Chapter 5.

Strategies to enhance validity and rigour

Similar to validity, as a non-objective issue in qualitative research, generalisability is described as transferability and extrapolation in qualitative research (Patton, 2002). Transferability describes the degree of congruence between different contexts, where the findings in one setting may be applicable in another context (Guba & Lincoln, 1985 in Patton, 2002). Extrapolation involves logical and thoughtful application of the findings beyond the data, in similar but not identical situations (Patton, 2002). In this thesis, selection of three different geographical areas and a range of participant characteristics were employed to promote transferability and extrapolation. Further, in depth individual exploration in Study

2 was used to examine the degree of congruence in different contexts; in groups and at an individual level.

In this thesis, data from direct observation was used to assist further understanding of the issues explored and as a strategy to enhance rigour. The role of observational data has been well established (Kellehear, 1993; Merriam, 2000). Angrosino (2005) argued that even studies that mainly rely on interview data employ observational methods to note body language and other gestural cues. In this thesis, I have collected observational data as field notes to inform analysis and interpretation of the data in both studies (refer to the Table 3.1).

The method and interpretative rigour are two related issues regarding validity in qualitative research (Guba & Lincoln, 2005). In a qualitative study, I am aware of multiple realities (relativist), subjectivist epistemology and my role as a "passionate participant" (Guba & Lincoln, 2005). I believed the advantage of being a "passionate participant" would encourage the shared control between the researcher and

participants to promote the trustworthiness and authenticity of the studies. However, cautious of being judgmental or skewed in my interpretation, I ensured that I critically reflected on my role as a researcher. Critical subjectivity or reflectivity, 'the process of critically reflecting on the self as researcher, the human as instrument' (Guba & Lincoln, 2005, p. 210) was consistently carried out during my data collection and analytic processes via the use of a reflective diary and regular discussion with my supervisors.

Trustworthiness in qualitative research consists of four criteria, namely credibility, transferability, dependability and confirmability (Guba & Lincoln 1985 in Teddlie & Tashakkori, 2009). I will describe each criterion in turn and explain how each was addressed to promote trustworthiness in this study.

Credibility is equivalent to internal validity in quantitative research and can be strengthened by prolonged engagement, persistent observation, triangulation techniques, peer debriefing, negative case analysis, referential adequacy and member checks (Teddlie & Tashakkori, 2009). During the data collection stage, I regularly attended the morning exercise group activity organised by the senior citizens association in Hulu Langat (one of the sites for the data collection) as part of my prolonged engagement, persistent observation, and provided an opportunity for member checks. In the other locations, as the groups were not bounded by any regular group activities, I made another one or two visits to informally talk to some of the participants.

The thick description of the qualitative research process (both the pilot study presented in this chapter and Study 1 presented in Chapter 4) enhanced the

transferability of the study, enabling other researchers to compare their work in different contexts. Transparency was promoted by providing a clear and lengthy description of all stages of the study.

Dependability describes the ability of the researcher as 'human instrument' to yield consistent results (Teddlie & Tashakkori, 2009). In this thesis, piloting the semi structured interview guide and using a single researcher as the facilitator for each focus group and individual interviews promoted the dependability of the study.

Confirmability is the extent to which results are confirmable and grounded in the data with logical inferences (Teddlie & Tashakkori, 2009). Examination of the quotes and interpretation of the themes were consistently discussed with my supervisors and colleagues to support confirmability. Confirmability was further enhanced by clarifying the findings with participants as part of member checks in conversations following their group exercise or during the home visits for structured individual interviews. During the individual interview, some participants were requested to further clarify what they have said during the focus group via verbal interaction in reference to my personal notes. In the individual interview, participants were encouraged to express their views and they eagerly did so, which were noted as part of the data for cases in Study 2.

In Study 2, the data were collected using multiple sources; focus group data, quantitative data, and direct observation as part of a triangulation technique. My observations continued during the face-to-face interviews of the selected participants during which I identified negative cases (i.e. selection of cases included individuals

who perceived themselves to be both ageing well and not ageing well) to refine further understanding of individual spirituality in healthy ageing concepts.

The focus groups and individual interviews were conducted in places familiar to the participants to allow direct observation in their natural environment. To further enhance credibility, peer debriefing was used in presentations and discussions of the findings to other researchers and was carried out during data analysis.

A summary of Qualitative Pilot Study – Healthy ageing conceptualisations among older Malays in Melbourne, Australia

This last section provides a summary of the findings from a pilot study conducted among older Malays in Melbourne to test the methodological approach for Study 1. This pilot study explored the culture and group dynamics of older Malays participating in a focus group. The interviews conducted in the pilot study involved focus groups and individual interviews. It tested the semi structured questions developed in the preparation for Study 1. The interviews were transcribed and translated to test the analytical process. The preliminary themes identified from the pilot study are included in the full report. The full report of the pilot study is attached as Appendix 3.

The findings from the pilot study demonstrated the ability of the semi-structured interview to gain rich data particularly in the focus groups as compared to individual interviews. At the same time, it raised the importance of careful selection of participants to encourage group cohesiveness and positive group dynamics. The feasibility of the analytical process using thematic analysis was confirmed; however it

did raise concerns about the challenges in managing an extensive dataset. Hence, preparation for the data collection and analysis for Study 1 involved the consideration of getting professional transcription services to assist in handling large amounts of data.

Conducting a pilot study among older Malays in Melbourne may generate different issues and outcomes compared to a sample in Malaysia. The older Malays in Melbourne might differ in many ways compared to older Malays in Malaysia. The older Malays involved in the pilot study were those still in the close contact with the family and culture of the Malays in Malaysia. In my interaction and observation with the pilot study participants, the Malay culture in Melbourne has a strong religious underpinning. The themes derived from the pilot study were not used to structure the analysis or prescribe the themes generated in Study 1, nor inform the framework development for older Malays in Malaysia. Rather the primary aim of the pilot study was to assess the suitability of the focus group as a data collection method, to test the semi-structured questions and the feasibility of the analytical process. The flexibility in the qualitative study allows for changes in the semi-structured questions in response to the group dynamics as long as it is within the research focus (Patton, 2002).

Conclusion

The quest to explore older people's perspectives of healthy ageing, and its facilitators and barriers led to the construction of a two stage study design consistent with a constructivist paradigm. Focus group interviews and subsequent thematic analysis were used to describe healthy ageing conceptualisations in older Malays in Malaysia. The findings from the focus group study informed further theoretical propositions for

the development of case studies (Study 2). The case studies explore individual perspectives of healthy ageing, its facilitators or barriers and specifically investigate the role of spirituality in healthy ageing. The case study approach involved collective case studies selected from focus group participants involved in follow up structured interviews. The data for the case study involved multiple sources of evidence from focus groups, structured interviews and direct observation. Efforts to maintain validity and trustworthiness were carried out in various ways according to each method. A pilot qualitative study to explore the main research method and the lessons learnt from it was crucial particularly to manage potential challenges.

Chapter 4

Study 1

Healthy ageing conceptualisations: Older Malays in Klang Valley, Malaysia

Introduction

In Chapter 3, I described the methodological defence for the studies reported in this thesis. It also included a description of the methodological approach for the thesis, as well as the pilot study conducted among older Malays in Melbourne, in preparation for Study 1, the focus of this current chapter.

Study 1 was concerned with the perspective of older persons, in particular how older people view healthy ageing. The study aimed to explore the healthy ageing conceptualisation among Malays aged 60 and above, residing in Klang Valley, Malaysia. This chapter presents a description of the methods employed for this study, followed by the findings that comprise a description of the themes identified, and a discussion that relates the findings to the literature.

Method

Study Design.

This project is part of a larger cross-national study investigating healthy ageing conceptualisations across Australia, China and Malaysia. This study is a qualitative study using focus groups. The study design has been described in the previous chapter. The use of focus groups enabled an exploration of older people's experiences

and perceptions of healthy ageing in a group setting, and yielded rich qualitative data in the informants' own words.

Ethics

Ethics approval for the focus group study was received on 23 April 2008 from the Monash University Standing Committee on Ethics (refer Appendix 3A).

Study Setting

The study was conducted in Selangor, the most populous and urbanised state in Malaysia. It comprises five suburbs namely Hulu Klang, Lembah Keramat, Hulu Langat, Jenderam and Banghuris located from the east to southern area of Selangor, within a 15 to 75 kilometre radius of the capital city, Kuala Lumpur (refer Figure 4.1). The first two suburbs were the most urbanised, the third one comprised mixed urban and traditional housing, and the last two suburbs were semi-rural, consisting of traditional Malay villages.

There are three major ethnic groups in Malaysia, namely Malay, Chinese and Indian. Malays form the largest community and are included in the indigenous group identified as *bumiputera* (son of the soil). Malays are defined as Muslims under the Constitution of Malaysia. The total population in 2007 was 27.7 million with the proportion of Malay, Chinese, other *bumiputera* and Indian as 50.9, 22.7, 11.2 and 6.9 per cent respectively (Department of Statistics Malaysia, 2008). In terms of religious affiliation, 60.3 per cent of the population is Muslim, 19.2 Buddhists, 9.1 Christians, 6.3 Hindus, and 5 per cent from other faiths (Department of Statistics Malaysia 2008).

Older adults in Malaysia are defined as those aged 60 and above. In the year 2000, a total of 1.45 million of the Malaysian population (6.2 percent) were aged 60 or above. It is estimated that by the year 2020, this figure will rise to 9.5 percent (Department of Statistics Malaysia, 2008). In 2008, the life expectancy at birth was 71 years for males and 76 years for females with a healthy life expectancy at birth for males and females of 62 and 66 years, respectively (refer Table 1.1) (WHO 2010).

Sampling methods and group compositions

Purposeful sampling is the sampling method used for the in depth study of information-rich cases (Patton, 2002). The purposeful sampling is shaped and determined according to the study objectives. Hence, the participants were purposefully selected to answer the research question.

While Malaysia, the setting for this thesis, is a multicultural nation, it was beyond the scope of the thesis to include all the three main cultural groups. The three main cultural groups in Malaysia potentially may have different perspectives about healthy ageing. The need to focus on one particular cultural group, specifically older Malays, was decided in the process of refining the research inquiry.

This study explored the perspective of older Malays in selected communities in Malaysia. The Malay older people share a culture shaped by their ethnicity. However geographical locations and the diversity of Malay subcultures contribute to broader heterogeneity. In this study the participants were selected mainly from three areas near to Kuala Lumpur ranging from a more traditional or agricultural-based rural community ('rural'), to a mix of traditional/rural and urban lifestyles ('suburban') to

the more urbanised less traditional community ('urban'). This approach was designed to maximise the social and economic heterogeneity of the participants.

The purposeful selection of the study participants was employed in order to get a wide range of opinions. This included ensuring that there were a range of male and females, and people from different socio-economic backgrounds. During the data collection process, as the healthy ageing concepts were emerging, the purposeful sampling became more theoretical in nature in order to explore the various possible dimensions from the different groups of older people (Charmaz, 2000; Patton, 2002). This is consistent with the inductive approach adopted in this thesis.

Figure 4.1. Map of Selangor showing the location of the studied suburbs

![suburb icon] - The suburb

Source: http://www.maps-malaysia.com/selangor/map.htm

Group size and number of focus groups conducted

The focus group size was limited to a maximum of six participants to give adequate opportunity for each participant to share their views and encourage interaction within the expected 60 to 90 minutes session.

My initial intention was to conduct twelve focus groups from three different communities, at urban (Hulu Klang), suburban (Hulu Langat) and rural areas (Sepang) with a dedicated group for each gender in each community and two levels of socio-economic status from each community.

After conducting the first five focus groups, three of the groups consisted of participants from different socioeconomic backgrounds. They were mainly connected by their participation in community or spiritual activities and they mixed comfortably as a group. Hence, socioeconomic stratification was not used except for two female groups from an urban area as they were not involved in any established activities together. The stratification was then conducted according to gender, location and community group. By the sixth and seventh group, no new themes were identified which suggested data saturation. The eighth focus group was conducted to complete the female stratification and reaffirmed data saturation.

Data collection

Data collection for the whole study was limited to three months duration, which was the restriction imposed by the overseas living allowance outlined by the mother institution, Universiti Kebangsaan Malaysia (UKM), the scholarship provider for my PhD. Hence, I was under pressure to optimise the available time for the thesis data collection. Data collection for the focus group study was carried out from 14th

February to 8th April 2009. I facilitated all eight focus groups. The details of data collection process are described below.

Inclusion and exclusion criteria

All community-dwelling Malays aged 60 and above, and able to converse either in Malay or English were eligible for inclusion into the study. Those people unable to give informed consent and/or unable to communicate verbally were excluded.

Recruitment

As men and women, and people from different socio-economic backgrounds, may have different perspectives or priorities in healthy ageing issues, I attempted to recruit people into separate groups according to these characteristics. Awareness of the potential cultural preferences (e.g. preferring not to speak about certain issues in front of the opposite sex) was another reason for separating the groups by gender. Issues around accessibility were also considered in planning the location of the groups, to ensure that participants could get there easily with minimal costs incurred.

The potential participants were identified by the main informant from each community. They were invited to participate in the focus group interviews on a voluntary basis. Other than geographical location, gender and socio economic status, the other characteristics of participants were subject to further theoretical sampling. For example, following the interview with highly spiritual women (Group 6), I started looking for a group of women who might be less guided by spiritual values (Group 8). Participants were recruited using purposive sampling (Patton, 2002) through community groups or via a personal contact. I approached my personal contacts and community groups and asked them to introduce me to community leaders; who were

the main informants for the purposive sampling. The community leaders were asked to identify older men and women in their community from a range of socioeconomic backgrounds, geographic locations and to ensure a diverse representation; not just the prominent members in the community. Invitation letters were given to potential participants either by the community leader or by me. The community leader organised a suitable time and venue for me to conduct an information session for any interested older people. During this session, they were informed about the study and encouraged to discuss any uncertainties related to the study. At the end of the session, they were given invitation letters and written explanatory statements (refer Appendix 4A). Those interested in participating either informed me immediately, by telephone or posted the reply form. I contacted the participants to arrange for a suitable time to attend the focus group. On arrival at the focus group, participants were provided with a written explanatory statement to keep, a consent form to sign (refer Appendix 4B Consent Form) and a basic personal information form to complete (refer Appendix 4C Basic Data).

Four community leaders were involved. I started with a personal contact who is also a community leader and the oldest person in Banghuris, a traditional Malay village in Sepang district. He volunteered to participate and told me, once an older person is willing to participate, I should immediately proceed with the interview. The reason being, as I introduced the topic to them they would want to talk about it instantly and they were worried they may forget their ideas if it was not conveyed immediately. Deferring it to another time might also affect their availability to participate as they may have to attend other unexpected activities on the planned date as older people in their community are respected people who are usually sought after regarding any

family, community or religious issues. He then contacted another two potential participants, one of whom was able to participate, so Focus Group 1 was conducted with two participants.

Focus Groups 2, 5 and 8 were recruited in Hulu Klang, a suburb located about 15 kilometres east of Kuala Lumpur. The community leader approached was my personal contact, the chairman of the mosque committee. He invited mosque regular attendees to participate, and this formed Focus Group 2. Another group of potential participants was also organised among medium educated (i.e. completed secondary school) women to form Focus Group 8. His assistant helped to invite women in their 'Asnaf' list to attend Focus Group 5. 'Asnaf' consisted of mainly poor or destitute people eligible to receive the almsgiving according to Islamic regulations.

Further recruitment was done among socially active older Malays. A colleague of mine from the department of Public Health introduced me to the chairman of the Senior Citizen Association in Hulu Langat. I then met and joined the association members during their regular morning group exercise. I conducted the information session attended by about twenty interested members but many were not eligible to participate as they were below 60 years old. Focus Groups 3 and 7 were recruited following this session.

It was difficult to access women from the community to recruit a 'faith-based' group (i.e. known to each other via their spiritual activities). Therefore, I was introduced to women living in faith-based purpose built residential community about 60 kilometres from Kuala Lumpur in Sepang. The women were from many different places, and had voluntarily moved into the residential area mainly to learn and strengthen their

religious knowledge and practice. I met the person in charge of the residential area and was introduced to the leader of the women's group. I explained the study to her and she suggested a suitable time to conduct the focus group with the women, which formed Focus Group 6.

For Focus Group 4, I was introduced to a committee member for the Malay community in Lembah Keramat, within Hulu Klang suburb (Persatuan Kebajikan Melayu Lembah Keramat) to arrange an information session date. He immediately managed to gather four interested participants who were enthusiastic to have the focus group discussion at that time and not willing to postpone it to another date. So, I proceeded with the interview.

The interview schedule

The focus group interview started with the following general questions: "In your routine conversation, what words do you use to describe older people?" and "When do you say a person is "old" or an "older" person?" More specific healthy ageing issues were then solicited but not necessarily being asked in order as sometimes these issues were brought up by the participants through the course of discussion without being prompted. The healthy ageing issues explored in the focus groups were:

(1) how older people understood healthy ageing from their perspective,

(2) their definition of the ideal (expected) old age and how they prepared for it,

(3) how their life experiences affected their current life situation, and

(4) what they needed to achieve healthy ageing.

Appendix 3B lists the issues and questions for the focus group.

Procedure

I facilitated all the focus group sessions mainly in my mother tongue, Malay, except in Group 8, where the interview was mainly conducted in English with an occasional mixture of Malay language. I undertook training in focus group facilitation to prepare for this study, as has been previously described in the pilot study. The interview usually took about 60 to 90 minutes. Each session was audio taped using two digital voice recorders. Participants read through the explanatory statement, signed consent forms and completed the basic data information form themselves or with my assistance (Appendix 4A, 4B, 4C).

The session started with self introduction and each participant identified themselves according to their preferred name which they wrote on a card and put in front of them, so participants could easily address each other. The major contents of the explanatory statement were clarified; in particular about the study, its objectives, the voluntary nature of their participation, and reassurance of confidentiality. They were informed of the basic rules of conduct in the focus group session such as freedom to express their opinion, that there are no right or wrong answers, to value others' views and respect the confidentiality of issues discussed. The participants were then invited to clarify any uncertainties and the focus group session started once all participants were ready.

On conclusion of the discussion, I thanked the participants for their contribution, informed them of the expected time of the study completion, and asked whether they wished to review the transcript. Arrangements were made for any participant

interested in reviewing the transcript. I also asked whether it was acceptable to contact the participants again by phone or email to clarify any details at a later date. The participants did not receive any payment.

Focus groups were conducted until data saturation was reached (Guest, Bunce and Johnson 2006). By the seventh focus group, no new themes came out and I sought to conduct another focus group to confirm saturation.

Data management and analysis

The interviews were audio taped, transcribed, translated and analysed using thematic analysis (Braun & Clark, 2006; Liamputtong & Ezzy, 2005; Pope, Ziebland & Mays, 2000). I initially transcribed the first three focus groups. As the transcribing process took much of my time and energy, I attempted to get any organisation or individual providing transcribing services around Kuala Lumpur. However, I could not find an appropriate service.

By then, the audio recording for two groups was brought to Melbourne for transcription by a private company handling multilingual transcribing, unfortunately as the discussion used many local dialects, the transcripts prepared required extensive review, editing and corrections which took as much time as transcribing by myself, so I transcribed the remaining three groups.

English translation of each transcript was initially done for the whole interview. In the event where the literal translation did not adequately convey the intended meaning of the participants, contextual meaning was used to produce a meaning-based translation (Esposito, 2001). In the event where the meaning was not clear by reading the

transcripts, repeated listening to the recorded sessions were conducted to reassure the intended meaning was conveyed. The first two transcripts were translated to English in full and the themes identified were cross-checked with my two supervisors. For the remaining interviews, only the quotes used to illustrate the themes were translated. In group 8, participants spoke mainly in English; for these participants, their comments are presented verbatim in the text and therefore may contain grammatical errors.

I repeatedly read through each transcript to identify patterns and themes. The patterns were initially coded to describe the core issue. The codes were then grouped according to their similarities and a theme was applied to each group. The thematic analysis performed was an inductive approach (Patton, 2002) and consisted of six phases as described by Braun and Clarke (2006) (see Appendix 3). Table 4.1 illustrates an example of the data analysis process. Throughout data analysis, I consistently consulted my two supervisors to cross check the themes and sub themes assigned for each selected quotes.

The transcripts were analysed using thematic analysis, both manually and using Nvivo8. Nvivo8 software was used to electronically categorise the issues identified in the transcripts to individual free nodes. The listed free nodes were reviewed and re-categorised where necessary. The grouping of the free nodes was performed according to the patterns identified and moved to tree nodes.

Table 4.1.

Example of coding and themes identification

Data extract	Initial codes	Themes
'All my children are married, I am happy to see that. I have nothing to worry about. All the children and grandchildren are well, that is what I have been praying for day and night. I pray that all my children and grandchildren are healthy, protected from bad luck and always in strong faith' (Daud, aged 79, man, group 1).	Children - married	Family
	Grandchildren - well	Family
	Happy	Peace of mind
	Nothing to worry	Peace of mind
	Continuous praying	Spirituality
	Hope for future	Spirituality
	Healthy	Health
	Strong faith	Spirituality

Description of focus groups and participants

There were four focus groups for each gender with two to six participants per group (see Table 4.2 for group characteristics) and 38 participants recruited in total (see Table 4.3 for participant characteristics). The age range for female participants was 60 to 77 years, and 60 to 95 years for men. All participants lived in community.

Focus Group 1 was conducted on 14th February 2009 in one of the participant's houses in Banghuris, a Malay traditional village, located about 75 kilometres south of

Kuala Lumpur. Both participants lived in their own house; one married and one widowed. They currently considered themselves fully retired but still regularly visited their palm oil farms, and were financially comfortable with regular income from their farms.

Table 4.2.

Focus group characteristics

Group number (Interview date)	Gender	Predominant characteristic	Number of participants	Average monthly income in RM* (Income range)
1 (14/2/2009)	Men	Traditional Malay village	2	2000 (2000)
2 (18/2/2009)	Men	Faith based group	6	1417 (500-4000)
3 (16/3/2009)	Men	Senior citizen association	6	1833 (900-5000)
4 (31/3/2009)	Men	Community group	4	1815 (500-4000)
5 (4/3/2009)	Women	Low education (i.e. no school or primary)	5	264 (20-500)
6 (26/3/2009)	Women	Faith based group	6	963 (400-2000)
7 (18/3/2009)	Women	Senior citizen association	6	1833 (300-4000)
8 (8/4/2009)	Women	Medium educated (i.e. completed secondary school)	3	2167 (1000-3000)

* RM stands for Ringgit Malaysia (RM100 is about AUD30)

Focus Groups 2 and 5 were conducted in a meeting room at a mosque in Hulu Klang suburb, about 15 kilometres east of Kuala Lumpur, on 18th February and 4th March 2009, respectively. All the six men in Group 2 were regular attendees of the mosque, attending up to five times for daily prayer congregations. One of them was the mosque voluntary committee member, one was a regular worker for the mosque (widowed) and the other four lived in the surrounding area (three were pensioners and one had his own business).

Focus group 5 consisted of women listed as 'Asnaf' in the community. Of the five participants, three were widows, one never married and another one was the main carer of a husband recovering from stroke. None of them owned a house, one had never been to school, and the two most educated participants had completed 6 years of primary school. Two participants were not working, one participant ran her own food stall, another participant had a small grocery shop at her rented house, and the other one helped her son at their rented food stall. Focus Groups 3 and 7 were conducted on 16th and 18th March 2009, respectively, at the senior citizen's association in Hulu Langat suburb, which is located about 25 kilometres south-east of Kuala Lumpur. Participants for both groups consisted of mixed socioeconomic status and all considered themselves retired except two female participants who were committed to voluntary work. Since they have been regularly involved in the association activities, they intermingled well during the session. One male participant excused himself to attend to another commitment before the beginning of Focus Group 3. He later enthusiastically participated in my survey and explained that he chose not to get involved in the focus group as he felt uncomfortable sharing his unhappy earlier life, which was denied of educational opportunities due to family circumstances.

Focus group 6 was conducted on 26th March 2009 in one of the participant's units within a purpose built faith based residential area about 60 kilometres south to Kuala Lumpur. All of them currently lived within the residential area, in a Malay traditional village. Participants in this group came from different locations around Peninsular Malaysia, four of them from traditional Malay villages and another two from more urbanised areas in Selangor. They were either widowed or separated and very much comfortable in the group despite their different socio economic backgrounds.

On 31st March 2009, four men of mixed socioeconomic status participated in focus group 4 at the community meeting room. One of them was still working whereas the other three were government pensioners with one of them still doing part time work.

Focus Group 8 was conducted in one of the participant's houses on 8th April 2009. There were five participants, of which three of them were Malay pensioners (two widowed), one Chinese and one Indian. They knew each other very well as they had been neighbours for many years and were very excited to participate in the focus group. So, I continued with the focus group and identified the Malays during the transcribing process. As the views expressed by the participants in this group did not differ much from the other focus groups and no new major themes were identified in the discussion, no further focus groups were conducted.

Table 4.3.

Participant characteristics

	Men (n=18)	*Women (n=20)*
Age range (years)	61-95	60-77
Mean age (years)	72.7	66.6
Working status: Fully retired	72%	75%
Marital status:		
- married	89%	30%
- widow/widower	11%	55%
- single/separated	0	15%
Highest level of education:		
- no formal education	0	10%
- primary	22%	40%
- secondary	33%	30%
- certificate	22%	20%
- university	22%	0
Living arrangement:		
Alone	5.6%	25%
With spouse only	11%	20%
With spouse and children	44.4%	10%
As above and grandchildren	27.8%	0
With children	0	15%
As above and grandchildren	5.6%	10%

Findings

There were two main issues explored in the broader program of research upon which this study was based:

1. how participants understand the concept of ageing
2. how participants conceptualise healthy ageing.

While the focus of this study is the conceptualisation of healthy ageing, a summary of participants' understanding of ageing more broadly will be presented to provide an important context for their discussions about healthy ageing.

1. The concept of ageing

The concept of ageing as seen by the participants' is summarised in Table 4.4 and will not be described in detail in this report. However, it is acknowledged that older people's perspectives of ageing are important to understand, as they may affect how older people conceptualise *healthy* ageing.

The two main themes identified were terminology (i.e. terms used to describe older people) and the interpretation of older people (i.e. how older people are classified). The participants preferred the term *warga emas* (golden citizen) to address older people in the community instead of *orang tua* (older person) or *warga tua* (older citizen)*, even though the latter two terms were perceived by some participants to denote highly respected positions.

Older people were described with reference to chronological age, life stages and social roles, physical changes and illness, as well as the notion of wisdom (such as being mature, knowledgeable and skilful).

Table 4.4.

The concept of ageing - themes subdivision

Themes	Sub themes	Units
Terminology	Preferred terminology	
Who are 'older people'?	Chronological age and life stages	Chronological age Life stages e.g. grandparenthood and retirement
	Physical deterioration and morbidity	Physical changes Illness and infirmity
	Wisdom	Maturity Knowledge and skill

Chronological age was often described by participants as a marker of old age. The range of ages used to define old age was between 50 to 65 years old. The following quote supported maturity as the point of reference to decide chronological age.

> 'I would say age of 55 should be considered as older people. Our prophet was appointed after the age of 40; it means he was mature enough. For the lay person, we add another 15 years, and then we can say they are *Warga Emas* (Aki, man, aged 74, group 2).

Many participants talked about old age in relation to social roles and life stages such as retirement, grandparenthood, having no more family responsibilities, and time for

oneself. This classification of older age was illustrated in the following comments, 'for me, working people like us, when you retire, automatically you are *warga emas*' (Yup, man, aged 63, group 4) and 'old age means you have got grandchildren' (Rubi, woman, aged 64, group 6).

Physical appearance was also identified by participants as a marker of old age, as described in the following comment, 'I think you cannot run away from ageing…sometimes your appearance deceives you, when I go out, automatically somebody will call you not *kakak* (older sister), somebody will say *mak cik* (aunt) or *nenek* (grandmother)…that is the reality' (Piah, woman, aged 65, group 8). Related to physical appearance, being unhealthy was associated with older age, and in contrast being healthy was associated with a sense of denial about ageing, as illustrated by following quote, 'as for me, as long as I am healthy, I do not feel I am old. Once I am sick and infirm, that is old' (Hani, woman, aged 60, group 7).

Both men and women referred to the notion of wisdom to describe old age. They viewed their life experiences as invaluable and something that could not be replaced by any formal qualification. Wisdom, in this sense, comprised of maturity, knowledge and skill.

2. The concept of healthy ageing

This is the core component of the findings; participants' perspectives of healthy ageing. In this section, firstly, an overview of the general healthy ageing concepts shared by the participants will be introduced, followed by an elaboration of each theme. The last section in this chapter will discuss the important gender differences in relation to each key theme.

The participants' general views about healthy ageing were primarily derived from their responses to the question "what is a good or ideal ageing for you?" Their responses varied from a simple but meaningful statement as shared by this participant, '...more peaceful mind…' (Yup, man, aged 63, group 4), to much broader multidimensional concepts as will be further described below.

The following comment, encapsulates the general sentiments of this sample of older Malays' hopes and aspirations as they age, 'at this old age, we hope to be healthy, be able to care for ourselves, to perform *ibadah* (good deeds) and be active' (Rima, woman, aged 66, group 6). *Ibadah* (see end note) or good deeds, as depicted by this participant, described her spiritual expression. For many participants, spirituality was seen to be important for healthy ageing in addition to other commonly discussed dimensions, such as physical health, functional independence and participation.

Active engagement in life, health, functional and financial independence took precedence for some participants, 'remain healthy, do everything by yourself as long as you can and most importantly, must have money…must be sociable, must meet people, not stay in your house 24 hours' (Miah, woman, aged 64, group 8).Health, faith and wealth were further interconnected factors used to describe healthy ageing, as illustrated by this participant,

> 'Health and strong religious faith, good health so you can do good deeds, strong faith motivates you to do that. One more thing, our financial status, we should have pension money or anything similar, so at this old age we do not have to go anywhere, or open up a stall or wander around [to work] leaving the family…'(Aji, man, aged 62, group 2).

Basic needs for material and emotional shelter were a priority for those without much money, widowed, and living in the slum area, 'the ideal life is to have your own house, children and grandchildren, husband, nothing much to say, we have nothing' (Tina, woman, aged 73, group 5).

The above quote appears to suggest that those in the lower income strata give lower priority to spirituality/religion and this is an issue worthy of further exploration. This issue will be re-visited in chapter 5.

Healthy ageing was expressed as 'happiness' by the following participant, and consisted of five important dimensions, namely physical health, social, emotional, spiritual and financial. He concluded that a well developed spirituality was the essence of healthy ageing,

> 'If I can cover the five components of happiness as I described earlier, i.e. physical [health], social in term of family and friends, emotionally not stressed, spiritually well developed, that is the most secured. Financial is not as [important], there are times when we do not have enough money but not as stressful…' (Mat, man, aged 62, group 3).

In summary, and as illustrated by the comments above, six key themes were identified as important for healthy ageing:

1. spirituality ,

2. peace of mind,

3. physical health and function,

4. financial independence,

5. family relationships, and

6. the living environment.

The salience of these themes to healthy ageing varied somewhat across the groups. Health and functional independence was mentioned consistently across all groups, as well as spirituality, family and financial independence. Due to the significant role of spirituality in participants' conceptualisations of ageing, in the next section I will focus on examining the role of spirituality and its expression in the lives of this sample of older Malays. The concept of spirituality was not always discussed in isolation, and by examining how this theme interrelated with the other five themes, it allows me to further examine the role of spirituality. I will not be discussing the remaining five themes in isolation, but will incorporate an overview of participants' perceptions of what each theme comprised of, followed by the role of spirituality in each theme.

Spirituality

Spirituality in one way or another underpinned many aspects of the participants' lives. In this study, 'spirituality' was used as an overarching term to describe participant's references to their inner values and beliefs, their religious activities, their relationship with God, self transcendence, attitudes to purpose of life and coming to terms with death. As all participants were Muslims, there were some overlaps between religiosity and spirituality. As spirituality involves subjective individual inner feelings and

intentions, its interpretation in this study was limited to what was expressed by the participants to represent their feelings and actions.

In the Malay language, some specific terms such as *amal* (general word for charity, practice or habitual action) may or may not indicate spirituality whereas *ibadah* (more specific word means doing good deeds which will be spiritually rewarded, please refer to endnote) usually indicates spirituality, as it is part of relationship with God either directly or indirectly. Spirituality was intricately connected in some way to each of the other themes and, for many participants as they aged, they were aware of the need to prepare for the end of life. Spirituality appeared to become increasingly central to their lifestyle and well being as illustrated by women in group 8:

> Piah: We are more towards that [spirituality], we are already at this age, more towards that, we are inclining more to that, for example we go to all [Quran] learning, religious teaching, Yasin [Quran verses] recital, we attend more (aged 65) .

> Miah: We think of God more than anything else, we are more there now [afterlife], we know we are going already [going to die], it is already Isya'[night], not Maghrib [dusk], it is Isya'. We have nice friends, today we have this class, so we go, and then you get to know people. I think it [spirituality] comes naturally also (aged 64).

These participants described how their preparation towards end of life related to more spiritually related activities. The use of five daily obligatory prayers as a metaphor to describe their stage of life was a common occurrence, with '*Isya*' as the last prayer of the day denoting the last stage of life before death. Awareness of spirituality was seen

as part of the natural ageing process. Some of their spiritual activities were also seen as an opportunity to meet others and strengthen their social networks.

While the men were more likely to broaden their discussion of spirituality to issues related to the family and the community, the women talked primarily about how spirituality affected them personally and some extended it to their families. This difference may be influenced by the more significant role taken by the man in the community, as compared to women who traditionally focus mainly on their family responsibilities, particularly their husband and children. The role of spirituality in the participants' lives comprised three subthemes, which were further divided into eight units (Table 4.5). The three subthemes will be presented in turn were:

1. Continuous religious learning and practice – religious learning to strengthen their spirituality and guide their practice was actively pursued by the participants as their way of life, to fulfil the purpose of life, and to prepare them for afterlife.

2. Prayer and supplication – practiced regularly according to religious instruction particularly to express their hope and to cope with life either for themselves or for others.

3. *Ridho*: the highest level of acceptance – hope and wish were continuously expressed in their preparation for peaceful acceptance of death.

Table 4.5.

Spirituality theme subdivision

Theme	Sub themes	Units
Spirituality	Continuous religious learning	Death preparation Way of life Purpose of life
	Prayer and supplication	For own self For others
	Ridho – the highest level of acceptance	Hope and wish Acceptance Always be prepared

Continuous religious learning and practice

Efforts to strengthen religious knowledge and practice were regarded as lifelong responsibilities. Lifelong learning was considered to be part of their active participation in the community, and at the same time fulfilled a spiritual quest. Regular attendance to the mosque for prayer congregations or any activities to enhance religious understanding and practice, where ever it is held, were seen to be prompted and motivated by the awareness of unforeseen death,

'…so, there is something good about remembering death, it is coming, has the death angel forgotten me. So, if I feel lazy to go [to the mosque], what if I am going to die tomorrow. That is the good thing about it…' (Aki, man, aged 74, group 2).

Religious and spiritually enriching activities were not only motivated by thoughts of death, but appeared to take greater priority as they aged. Religious beliefs and spirituality may act as sanctions towards unfavourable behaviours and have become a way of life as described by this participant,

'When we go out, we do not go off tangent. We go out to the mosque, reading and learning [Quran], learning about *'fardh ain'* [fundamental principles in Islam], that is it. We do not go somewhere else, such as to cinema, watching whatever things, no more' (Ima, woman, aged 60, group 7).

The spiritual activities undertaken by participants appeared to be united by a common purpose, '…to get more knowledge, to get closer to Allah, that is the real purpose in life' (Ana, woman, aged 60, group 6).

Prayer and supplication

Muslims are expected to perform five daily prayers. Additional prayers and supplication are encouraged. Guidance from the Quran and prophet's *sunnah* (words, act and/or approval) provide the preferred time and way to perform them. Prayer appeared to be a common practice in this community. Prayer and supplication was used to cope with the trials and tribulations in life, and to express hopes and desires

for the future wellbeing of others, '…after each prayer, supplicate, open up [the ways] dear God, may these grandchildren be good people' (Sara, woman aged 65, group 5).

In accordance with religious guidance, some participants used prayer and supplication in their preparation and thoughts about death, as illustrated here,

> 'God willing, when it is time for our soul to be separated from the body, we must have our supplication, request for it while you are healthy, 'Allahumma timbissaaati aajalana laailahaillallah [Dear Allah, please let me at the time of death to say 'laailahaillallah'/ there is no god other than Allah]' (Budi, man, aged 95, group 1).

Understanding what participants prayed about was useful to understand what was of importance to them. Many participants advocated regular supplication, praying for their own physical well being, '…there is one thing we supplicate for, to be healthy; knees, back, leg can do everything…' (Ida, woman, aged 62, group 7) and for significant others as shared below:

> 'Yes there is a specific supplication for that, 'wasallimna wasallim diinana wasallim iimanana wasallim tauhiidana wasallim i'tiqadana wasallim arwahana wasallim ajsaadana wasallim aulaadana wasallim zurriyatana'. Ha...that is important, that supplication, the old people must recite it, everyday... (it means) security, peacefulness for the children, grandchildren, your wife, your own self, everything, for other Muslims men and women, all others' (Budi, man, aged 95, group 1).

Ridho- the highest level of acceptance

Death is unavoidable, and for the participants, they did not talk about defying death, but rather about their hope for a good death as clearly wished for by the following participant,

> 'If we have come to the end of life, it has been destined, God will take our life, we wish to end it with the name of Allah, saying *Laailahaillallah* [there is no God other than Allah], that is what we hope, we supplicate for that...' (Budi, man, aged 95, group 1).

Somewhere along the way, certain participants reached the state of acceptance (*ridho*) as illustrated here,

> 'For me, at this old age, Alhamdulillah God give me sustenance, God give me longer life to be with my children and grandchildren, that is my priority. The second thing, if God has decided that my time has come, I am ready [*ridho*]. The priority, healthy kin and kith, no bad luck for them...that is what I have been praying for' (Daud, man, aged 79, group 1)

Ridho has a deeper meaning than being ready, accepting death or coming to terms with death. It is a sense of acceptance of any event (not only death), whole heartedly (with a pure clean heart) and to feel at peace with it. This acceptance however, does not mean to surrender enjoyment in life to wait for death to come, '…it is not that we just sit there and wait, we do other things too but we remember [death] more' (Hani, woman, aged 60, group 7).

In another way, Muslims strive for *ridho Allah* (blessing from Allah) as the ultimate goal in life. *Ridho Allah* is the highest level of blessing and acceptance of the Almighty God towards all obedient believers. To achieve the ultimate goal, however, they have to fulfil their spiritual obligations towards others, comparable to their own personal spiritual quest.

Conclusion

In sum, as they are getting older, participants intensified their preparation to accept death by strengthening their spiritual endeavour. For some of them, enjoyment in life at their age was depicted by activities for spiritual enrichment. Not that they were all highly spiritual, but they were united in their efforts for continuous learning and desire to strengthen their spirituality, in addition to their spiritually guided role towards family and community. This growing preoccupation with a spiritual quest has served to divert their focus away from other matters (material needs such as wealth) once deemed essential, which have now become secondary. Active participation in spiritual activities, in combination with a determination to fulfil a spiritually related purpose in life may serve to support their healthy ageing process. Our appreciation of their chosen way of life is arguably much needed in our attempt to support this group of older people in their quest for a peaceful life.

Peace of mind

Peace of mind was the second key theme identified and used interchangeably with a peaceful life as expressed by the participants. Although peace of mind was very closely related to spirituality, its constituent units were sufficiently distinct to warrant it being a stand-alone theme. The desire to attain a sense of peace of mind was a very

prominent aspiration shared by most participants, so much so it seemed to be the ultimate goal of healthy ageing. However, it was also described in terms of a process, indicating that it could also represent the process of healthy ageing itself.

Peace of mind was divided into two main subthemes and eleven smaller units (Table 4.6).

Table 4.6.

Peace of mind theme subdivision

Themes	Sub themes	Units
Peace of mind	The meaning of peace of mind	Happiness
		Nothing to worry
		Free of fear and grief
	Prerequisites for peace of mind	Ability to focus on spiritual endeavours
		Free from responsibilities
		Contentment
		Optimum physical function
		Peaceful living environment
		Adequate financial resources
		Supportive spouse and filial children
		Being well prepared

The first subtheme describes the meaning of peace of mind and the second subtheme consists of eight prerequisites for peace of mind as discussed and conceptualised by the participants. Despite having the ability to focus on spiritual endeavours as a prerequisite for peace of mind, spiritual expressions are seen in many instances throughout the description of other units demonstrating the close interconnection between peace of mind and spirituality.

The meaning of peace of mind

Peace of mind was conceptualised by participants as having a peaceful life in older age. Peace of mind was not easy to define, nor was it readily identifiable, as illustrated by this participant, '…only those experienced it would know' (Ana, woman aged 60, group 6).

Three concepts were identified by the participants to describe peace of mind: happiness; having no worries; and having no fear or grief. Having peace of mind was associated with happiness. In the following quote, peace of mind was defined as living in one's own home with a supportive spouse, 'I am now at peace too, living in my own house, not alone, nothing to worry. I am happy as he is at home too, we go out together, no problem, *Alhamdulillah [thanks to Allah]'* (Dewi, woman, aged 65, group 7).

Many participants also described a peaceful life as being free from worries and distractions. The following expression is one example:

'Should have nothing to worry about, sometimes at this old age many things happen in the house, the wife keep blabbering, anything the husband does always not right. All of these disturb the mind. At this old age, we want a

peaceful life, when we wake up in the morning for prayer, to read, no interference' (Azmi, man, aged 85, group 2).

The third way to conceptualise peace of mind was being free of fear and grief, as described by this participant as he referred to a verse in the Quran,

'…Al Baqarah: 38 … whoever follows My [Allah's] guidance, walaa haufun alaihim walaa hum yahzanun, there will be no fear concerning them, nor will they grieve. Allah created us and He said that. Allah does not say look for happiness, there is no word happiness, Allah knows better, it is the core element of happiness, no fear, nor grief, it has been repeated 13 times in the Quran, one full cycle,…this value has no expiry date, when we talk about happiness, this person say this, the other says another thing…' (Ali, man, aged 72, group 3).

The prerequisites for peace of mind

Participants described several prerequisites that contributed to leading a peaceful life. The relationship between spirituality and peace of mind was well supported by many participants. Participants in group 8 did not spontaneously describe the role of spirituality in their life. Aware of the mixed nature of the group with three Malays, one Chinese and one Indian participant may have deterred them from expressing it, however when prompted, the group spontaneously linked spirituality to peace of mind, as seen in the following conversation:

Zie: I start my day with *subuh* [dawn] prayer followed by supplication (aged 77).

Piah: I recite *Yasin* [Quran verses] on Friday night (aged 65).

Miah: That's Friday night, for me I do it twice a day, since my husband passed away, *InsyaAllah* [with Allah's will] every morning and after *Maghrib* [dusk prayer] I read again, *InsyaAllah* you have peace of mind (aged 64).

Piah: After Maghrib, I am yet to finish reading the Quran, you read [the Quran] *Alhamdulillah* [thankful to Allah] you feel such relief.

Peace of mind was also suggested to be part of an ongoing cycle, with many participants describing a peaceful life as a prerequisite for greater spiritual endeavour as follows, 'I want a peaceful life, and to be able to do my prayer and *ibadah* without disturbance' (Ara, woman, aged 70, group 6).

For some participants, focusing on a spiritual path was the answer to a peaceful life, as illustrated here,

'…only two keys to it [peace of mind], faith in Allah and hereafter, there will be no fear nor grief, your happiness is eternal… that is the key, but we don't follow Allah's guidance, we face a lot of problems' (Ali, man, aged 72, group 3).

To a certain extent, despite their love for their children and grandchildren, some participants chose to dedicate their later life to find peace as described here, '…my soul just does not want to do what I used to, last time I used to bring my grandchildren everywhere, at this old age, do not want all that, looking for a peaceful place' (Lia, woman, 65, group 6).

In older age, participants appeared to strive for peace of mind, assuming that they have completed their main responsibilities and can now concentrate on themselves, ' we may have reached certain level, previously we have little kids, some were schooling, now we are resting peacefully' (Yup, man, aged 63, group 4).

Many participants described having worked very hard for their worldly acquisitions to support their families, but they also described a point, at which this desire for material gains became less important,

> ' …we are aware we are not after the materials gain…to take the meaning of contentment from the spiritual perspective, you have an old car, you use it, there is a desire to get a new one, but if you don't have it , it is okay, that is adequate, similar to financial…' (Mat, man, aged 62, group 3)

At this older age, their passion for self contentment superseded materialistic gains, but this seemed only to be the case if their minimum basic needs were met such as having a place to live and adequate financial means. Yet, basic needs for some may also be a luxury for others, so this was difficult to define. It was evident that participants were keen to establish a certain degree of family concord and financial means to move forward comfortably. In this study, participants advocated for religious guidance to achieve such a balance.

Deterioration in physical health and function appeared to adversely affect participants' quest for a happy, peaceful life as illustrated here,

> 'If you have knee pain it is difficult for you to meet others, it is difficult to go for prayer congregation, have to do the prayer at home, have to find end of

rows in the mosque, it is difficult to get around. Once bed ridden you will be unhappy, be it senior citizen or anybody' (Ima, woman, aged 60, group 7).

Living in a place where they can easily access continuous learning and practical religious knowledge also appeared to provide some participants with a sense of peace as illustrated here,

'This is the preparation for afterlife [*akhirat*], this is the preparation, we do not know when death will come, be it tomorrow or the day after, not a matter of age, this [place] is the essence of happiness' (Ana, woman, aged 60 , group 6).

Similarly, unsettled family and financial responsibilities appeared to affect participants' experience of achieving a peaceful life as shared by the following participant,

'Three of my grandchildren left by their father, the mother then re-married and did not bother about them, I looked after them, two were done, both married, this [last] one causing me headache, "grandma give me money", each time asking for money…'(Tina, woman, aged 73, group 5).

Another participant also expressed a similar sentiment, '…it is difficult for me, you see, I do not have any other income, I have to work, I have to rely on my own sweat and tears, no peaceful life for me' (Aman, man, aged 78, group 4).

Peaceful life at home can be achieved by having an understanding spouse or supportive children as expressed here, '…once retired we want a peaceful life, peaceful household, at this age we are sometimes a bit sensitive, sometimes we want peace at home, no misunderstanding...' (Azmi, man, aged 85, group 2).

The harmonious life of other family members was also essential as observed by this participant,

> 'I am always happy now; I don't feel sad as I am seeing the children live peacefully. But if the children are in conflicts, it is hurtful, however if it is peaceful, the husband and wife are not quarrelling, smiling, their children are doing well, we as older people we are happy too' (Budi, man, aged 95, group 1).

Preparation seemed essential to age well, as described by the following participant who said that good ageing is being '…well prepared to reach this stage' (Yup, man, aged 63, group 4). If being well prepared is the necessary prerequisite then achieving the state of peace of mind could be the final outcome of healthy ageing. Preparation as discussed by the participants comprised of three aspects:

1.   to prepare oneself ,

2.   to prepare others, particularly family members ,

3.   the importance of knowledge, awareness, and education (formal or informal).

To prepare oneself, it was thought that the attitude of being humble to others should be inculcated early in life as commented here,

> 'The most important thing is to be nice to people, even if you are young, be nice to people. Don't be selfish, try to help people, be friendly, don't be arrogant, be down to earth, when you are older you are so used to being nice

and friendly, you can talk to anybody, to a millionaire or a man who is a janitor' (Miah, woman, aged 64, group 8).

The spiritual preparation to prepare oneself and others was described as being parallel to financial preparation in term of its approach. However, to be well prepared in both, education seemed very important, both formal and informal, to develop the sense of awareness of one's own and others' needs as described by this participant,

'education and religious guidance, …those with higher education usually had stable position in the beginning and would be more secure at the end… by doing good deeds according to spiritual guidance, you get a more peaceful and organised life at this age' (Jak, man, aged 73, group 4).

Many participants talked about the importance of achieving peace of mind in later life and they believed that to attain this, one needs spiritual guidance. This spiritual guidance should be well inculcated by their parents, then supported by the formal education system, role models in the community and their own continuous effort to learn and practice expected values.

Conclusion

Peace of mind was described by participants as consisting of happiness, having nothing to worry about, and being free from fear and grief. Being in optimum health and physical function, living peacefully in one's own house, having adequate financial resources, having a supportive spouse or family member and responsible children all provided participants with a sense of peace of mind to a certain extent. However, it was in participants' descriptions of their search for spiritual enrichment that appeared to enable them to achieve the ultimate level of peace of mind. For those lacking in the

factors listed above, it was their spirituality that served to moderate their high expectations, and assist them to develop a better understanding about their purpose of life, contributing to their sense of contentment in life.

Physical health and function

Health and illness pose a conflict throughout the life span and become more prominent towards older age. An overview of issues in physical health and function as discussed by the participants has been summarised in Table 4.7. The primary aim of the following section is to examine the link between physical health and spirituality, which is preceded by brief descriptions of the other subthemes.

The participants highlighted the importance of good physical health to age well. Its importance was expressed in many ways by the participants, such as 'health is wealth...' (Piah, woman, aged 65, group 8) and '…health is important at any age, an invaluable asset' (Ana, woman, aged 60, group 6).

Regardless of their health, participants regarded maintaining their usual activities and having continuous learning opportunities as priorities,

> 'We should continue with previous activities, don't stop once aged 60. As long as there is opportunity [and] we are still capable, just continue. Now, there is opportunity to attend courses at the X University, learn more...While in good health, do it, once the health situation is not suitable then do it according to our capability' (Hani, woman, aged 60, group 7).

Table 4.7.

Health and physical function theme subdivision

Theme	Subtheme	Unit
Physical health and function	Spirituality	Hope and prayer
		Effort to maintain health
		Gratitude
		Health status as a test
	Health appreciation	Invaluable asset
		Support active participation
	Mobility	Restriction
		Adaptation
	Health behaviour	Physical activity
		Falls prevention
		Dietary habit

The description of expected health includes mobility and it was in the following participant's opinion that being in good health should be used for productive and wholesome ends, such as to fulfil spiritual quests,

> 'Health, it means you are old but still mobile. Then, your religious faith; if you are old but still going to disco, it is not acceptable. Once we retired, we should strive to prepare for afterlife. So, one is health and another thing is faith…' (Aji, man, aged 62, group 1).

Participants accepted physical health deteriorates with age. One important aspect related to health is mobility, '…when you are healthy, you can go anywhere, and

nobody can stop you' (Anis, woman, aged 63, group 6). They seemed ready to face a certain degree of physical illness and deterioration as long as it did not limit their mobility.

For many participants, mild illness was acceptable, but not limited mobility. 'We accept the fact mild toothache may occur, as long as we are mobile, when we become immobile that is worrying, we have to do something about it' (Aji, man, aged 62, group 2).

For another participant, however, his limited capacity to drive did not affect his life as there was an adequate supportive environment,

> 'I do not feel it restricting, when I have free time, I do go out, and nobody stops me. My son-in-law drives me to the mosque, so I do not have any restriction. When I want to go to the clinic, my children give me a lift on their way to work and go home by taxi. With those resources, I do not have to worry' (Azmi, man, aged 85, group 2).

Seeing the impact of poor physical health in others enhanced participants' health awareness and motivated them to promote their own health via maintaining physical activity as illustrated below:

> '…there are places where we can intervene, ageing well in terms of our own physical [health], some people are neglectful, and some need dialysis and felt marginalised, the physical [health] bestowed upon us should be well taken care of, maintain it as much as possible, we know the erosion factor is much more for us, be aware of it, do something physically not that demanding, move the

body, do exercise' (Mat, man, aged 63, group 3).

Participants in group 4 described exercise as part of preparation for good ageing. Some jogged or walked as individual activity, and others, mainly women, took part in more organised activities, such as daily aerobics sessions. Retirement affected their health behaviours, as for some participants it was seen as an opportunity for them to do activity more regularly as described in the following conversation:

> Jak: Regular exercise, walk in the morning. Exercise is something common for us, when we were working it was only intermittently, we don't do it as good as it is now, after retirement it is more intensified (aged 73).

> Zaki: Walk, jog (aged 79).

> Jak: Depends to your capability.

> Zaki: Once reached 60, cannot cope to jog, just walk.

> Jak: Around 3 km, jog or walk usually done individually.

> Zaki: Sometimes we bumped to each other, so just proceed together…for those who care for their bodies…The ladies doing aerobics, daily from 7 to 9 am. Women intensively look after their body; men just do it on their own, outside.

Some participants shared their worries of sustaining bone fractures at an older age or any other consequences which may limit their movement. They became more cautious especially in the bathroom but they were aware that falls could occur anywhere. Fear of falls was illustrated in the conversation in group 7:

Hani: Each time I want to do anything, I do remember I am aged, my bones are rusty, what if I fall [and] fracture, it is difficult, [always] cautious. At younger age last time, nothing to worry as there was a lot of calcium, we were daring, now have to be very careful (aged 60).

Ida: For me, soap in the bathroom is a concern, if I don't skid, my husband might, fear of stepping on it (aged 62).

Ros: Falls can happen at any time (aged 63).

Ida: That is the soap; you can even fall in the mosque.

Even in talking about their fear of falling, it was not limited to their home; the mosque was another place they use to frequent, which was also implicated.

Their diet was somewhat affected by their health, some becoming more cautious on food selection or amount taken but sometimes they desired unlimited choices:

'For me, I need to avoid many types of food following doctor's advice; do not take spinach, long beans, squid, cockle, crab, prawn; all those delicacies, but at times the craving was irresistible, then my gout strike back. That's it, I deserved it, I laughed to myself…' (Budi, man, aged 95, group 1).

Some participants were aware of their bodies and chose appropriate foods; other participants had no dietary restrictions. Many participants avoided eating too much, particularly at night as they thought it would make it more difficult for them to wake up early to attend to their prayer in the morning as seen in the following conversation related to eating habit among men in group 2:

Azmi : At this age, be selective with what you eat, the things that your stomach cannot accept, do not take it… Don't eat too much, it cause discomfort and poor sleep, you feel breathless. When we want to sleep with full stomach, the 'machine' cannot work…better eat less at night (aged 85).

Az: I don't care about food, anything goes (aged 67).

Aji: PJJ [an acronym for pot-bellied] <laugh> (aged 62).

Aki: In my observation, Az always had good appetite but it is not good for long term, we should try to control it. Previously I had gastric but managed to control it by myself. One day I ate until full, I felt discomfort, meaning that it will be difficult to wake up for dawn prayer, usually wake up at 5 it became 5.30am (aged 74).

Even in talking about food, the participants shared their experience of how the way they ate affected their spiritual commitment.

Health awareness, falls, diet and physical activity were common issues related to physical health; however, it is the link between spirituality and physical health that is the focus of this theme and will be discussed next.

Spirituality and physical health

Importantly, having good physical health allowed participants to fulfil their spiritual and religious obligations without hindrance, 'Health and strong religious faith, good health so you can do good deeds, strong faith motivates you to do that' (Aji, man, aged 62, group 2).

Being physically independent appeared to be very important to the participants, particularly for them to carry out their religious activities such as attending religious classes or prayer congregation and going to the mosque. As the following comment illustrates, poor physical health restricted their social and religious activities:

'If you have knee pain it is difficult for you to meet others, it is difficult to go for prayer congregation, have to do the prayer at home, have to find end of rows in the mosque, it is difficult to get around. Once bed ridden you will be unhappy, be it senior citizen or anybody' (Ima, woman, aged 60, group 7).

Spiritual determination, however, seemed to motivate some participants towards intensive positive solitude; strengthening their connection with God. The following participant claimed he aged well despite his sub optimal health and functional status:

'I am not strong enough to work, so religious activity is more important.[I] Wake up at night for *tahajud* [optional late night] prayer; we are encouraged to do the night prayers, if we cannot stand until the dawn, just for 2-3 hours would be enough. Recite the *Kursi* verses, the one easier to remember, I cannot see much to read the Quran, so just recite what I can recall, the *Yasin* verses...that is my priority now' (Daud, man, aged 79, group 1).

Despite limited physical ability, his spiritual determination gave him the strength to wake up at night to perform prayers for a few hours and at other times he recited the verses he could recall from the Quran. These activities could be considered as having a continuous engagement with life, despite the fact that he conducted all the activities alone; boredom and loneliness were alien concepts to him.

The participants demonstrated different ways of expressing spirituality in any health situation. Their connection to God with regard to their health seemed persistent at any health level, be it before, during and even after an illness experience. The following participant supplicated to God to be at their best health, and when he experienced illness, he sought medications while continuously praying to God for relief,

> 'Well, you supplicate to God for always 100% at good health but if God decided to let you experience some pain, you accepted it, but still continue supplicating to God to restore your health. *Alhamdulillah* when you supplicate, you feel relief then it comes back. It means, we are asked to continuously supplicate, to pray [for better health], in addition to hospital medications' (Budi, man, aged 95, group 1).

Illness experiences seemed to strengthen their connection with God. Despite complaints about their illness, they expressed their gratitude to God as they considered their health situation comparatively acceptable as expressed by this participant under medical follow up for hypertension with renal problems, '…if possible we do not want any kind of illnesses, thanks to Allah for what He has given, *Alhamdulillah* I have only this [illness]…' (Nori, woman, aged 72, group 5). For another participant, illness was seen as a test and reminder from God, yet he was thankful for those experiences, as illustrated here:

> 'When I was in my 50's, 60's I underwent surgical operations, I have been operated thrice, maybe it was due to the heavy work last time...*Alhamdulillah*, I have been tested 3 times, the God pity me, may be, so I can repent more. *Laa ilaha illallah...*' (Daud, man, aged 79, group 1).

Closely associated with physical health was the notion of good cognitive function. The following participant shared spiritually-related practices that he believed were useful in protecting cognitive health or delaying the emergence of cognitive impairment:

> 'Forgetfulness is not necessarily related to age, there is a supplication [you need to regularly do] to avoid this...I was being interviewed by one officer from the Selangor state religious affair department last month. He was so amazed, at this age I can speak really well, most people at my age, 90's, mostly demented. I told him God gives us the wisdom, pray for it' (Budi, man, aged 95, group 1).

Conclusion

All participants highly valued physical health and function to allow their continuous active participation in life. Despite restricted mobility, some participants managed to adapt well either through their access to a good support system or their strong spiritual determination. Spirituality appeared to strengthen participants' commitment and ability to cope through adverse health events. They prayed for perfect health and always turned to God to help them to cope well with any illness. A hopeful outlook and being grateful to God in any situation was seen to be a key strategy employed to face the vicissitudes in their lives.

Financial independence

Financial status has been traditionally related to wealth. In some contexts, the meaning of wealth extends beyond an economic focus; however, for the participants wealth means financial independence. Similar to the previous section, the link between

spirituality and financial independence is the focus of this section (the first subtheme).

To assist a more comprehensive understanding of the role of financial independence in

the lives of these participants, an overview of the subthemes (as listed in Table 4.8)

will be presented, followed by a discussion of the important link with spirituality.

Table 4.8

Financial independence theme subdivision

Theme	Subtheme	Unit
Financial independence	Spirituality	Work hinders spiritual development
		Education increases capacity for spiritual enhancement
		Spirituality lowers materialistic expectations
	The role of financial security	Promotes autonomy
		Reduces burden on others
		Promotes good family relationships
		Assists helping others
	Source of financial resources	Individual savings
		Pension
		Family members' contributions
		Welfare aid
		Employment income
	Working in later life	The only source of income
		Provides additional income
		Volunteering
		To fill up time
	Financial preparation	Role of a pension
		Expectation and reliance on children
		Sooner the better for preparation
		Responsibilities determine need for financial preparation

Financial independence was important for participants, and was regarded as important for healthy ageing as illustrated by this participant,

> 'If you have no money, you will be thrown out. We have to prepare for old age, put some saving adequate for ourselves, do not burden your children, they just need to manage it. Then it will be easy, that is what we want, should be prepared for ourselves, everybody [should do this], he did that too, our saving...anytime…' (Budi, man, aged 95, group 1).

In general, financial independence enabled participants to lead a more independent life, not to feel like a burden on others, it boosted their relationships with their family and enabled them to support others as required. The main sources of income for older people as described by the participants were their savings (including their assets), their own or spouse's monthly pension, their children or any close family member's voluntary contribution. For those less well off, they may get some financial support from welfare department or the alms committee; which they use for their basic needs, medications and even their death. Among women in the low socio economic group, one participant stated that, 'RM300 [monthly] would be enough for a person…not including medications and hospital visit' (Sara, women, aged 65, group 5). This was supported by another participant, 'fairly much for me, around 300-400, just for daily needs, not including utility bills and maintenance…the alms provide me 250 monthly, with little addition from my stall profits, that's it' (Tina, woman, aged 73, group 5).

Working in later life was seen as detrimental for some people and enjoyable for others. Of most importance for participants was to have the freedom to choose to work

at an older age. Participants worked in later life due to a few reasons, which included

supporting themselves as their primary income, as a supplement to their other income,

or as a way of passing time. Working, whether paid or unpaid, appeared to affect their

experience and preparation for peaceful ageing, as illustrated in the following

conversation among the men in group 4:

> Aman: It is difficult for me, you see, I do not have any other income, I have to
> work, I have to rely on my own sweat and tears, no peaceful life for me (aged
> 78).

> Facilitator: Somebody said just now, there are two types of older people...

> Aman: One with pension and one without pension, those with pension are
> more prepared.

> Jak: Nothing much to worry (aged 73).

> Aman: Have to work because have to struggle.

> Yup: Part-time work either volunteering or as a little addition [to income]
> (aged 63).

> Jak: At least there is an activity, feel swell up to stay at home…

Preparing financially for later life was vital to the experience of healthy ageing for

participants. In particular, the role of a pension was significant as highlighted in the

following comments, 'if you received pension money, people say you grow old

gracefully (Aji, man, aged 61, group 2), whereas older people in the other group may

have to struggle to make ends meet unless they have made adequate arrangements,

'If we do not prepare early while we were young, that means we have failed at this old age, we have to work… just like me for example, I may need to work to a certain extent, it is not a good sign. The old people should have prepared earlier, unless you receive pension money then that would be okay, you have your regular income…' (Aki, man, aged 74, group 2).

Without a pension, however, older people can still enjoy a good life with the presence of excellent social support and timely financial preparation. For many participants, there was an expectation and reliance on younger family members to financially support the older generation, as illustrated below,

'I do not have to prepare, I have many children and they give me [money]. The first time they gave, I told them, in the future when I live there [spiritual retreat], they have to pay the monthly fees, I am not going to cook, I want prepared food paid for' (Ida, woman, aged 62, group 7).

It was further perceived by participants that preparing for financial security should start as early as possible. However, their ability to prepare financially for later life was often dependent on participants' ongoing familial responsibilities; for example, if their children were financially independent.

Spirituality and financial independence

Having provided an overview of the importance of financial independence for healthy ageing, the focus of this section is to draw out the important links between spirituality and financial independence. As they age, most participants wanted to focus on their spiritual development and financial security was seen to enable them to do so, as described by this participant:

'Health and strong religious faith, good health so you can do good deeds, strong faith motivates you to do that. One more thing, our financial status, we should have pension money or anything similar, so at this old age we do not have to go anywhere, or open up a stall or wandering around[to work]leaving the family…'(Aji, man, aged 61, group 2)

Many participants spoke of the hard work they had done in the past, and in some cases still did, just to get by and live comfortably. The importance of being financially prepared for old age was seen by participants to parallel the importance of spiritual enhancement at this stage of life which enabled them to prepare well not only for later life, but also for afterlife as the following participant described:

'...as Muslim we can't avoid it, we are aware, at 62, 63 the age of the prophet, one more step to hereafter…we are aware material gains is not priority…no more 8 to 5 for me…to take the meaning of contentment from spiritual perspective, you have an old car, you use it, there is a desire to get a new one, but if you can't, it is okay, that is adequate. Similar to financial, I don't put high expectation towards family financial support by our children, not that I don't want it or look forward to it or look down at them' (Mat, aged 62, man, group 3).

In this case, it seems that Mat's spirituality has assisted him to lower his expectations, change his priorities and accept his material and financial circumstances. Thus, while participants emphasised that having enough money was important to fulfil material needs in life, spiritual endeavour was seen to balance this material desire and assist participants to experience a more peaceful life journey.

While it was agreed that concentrating on spiritual activities was a priority in later life, the extent to which participants were able to devote themselves to these activities may be determined by their financial circumstances. As the following conversation amongst the women in group 6 indicates, having higher educational attainment (and consequently the potential for higher financial security) was perceived to impact on the spiritual activities:

> Facilitator: How do you prepare for old age?

> Ana: Looking for a place where we can concentrate for *ibadah* (aged 60).

> Lia: I did not really prepare myself much earlier, with increasing age many of my friends attended religious classes, and I used to follow them when I had free time. At the same time I ran a small business, direct selling, I am not highly educated, those highly educated are different…gradually I went to the mosque more frequently …, then I decided to stay here [spiritual retreat] (aged 65).

A better education was perceived to lead to greater financial security, and therefore a greater capacity to dedicate more time to spiritual endeavours, as alluded to by Jak,

> '…those with higher education usually had stable position in the beginning and would be more secure [financially] at the end… with religious understanding and practice according to spiritual guidance, you get a more peaceful and organised life at this age' (Jak, man, aged 73, group 4).

Conclusion

To age well, adequate financial resources and preparation were deemed essential by participants. Those who received monthly pensions, and were well taken care of financially by family members as well as those had adequate savings or assets seemed to be sailing smoothly in their life journey and were thus able to focus on their other priorities in life (which included their spiritual endeavours). The need to work for survival at older age was not looked upon favourably and was considered as failing to age well. Financial independence was seen to be very important to fulfil material needs in life, whereas spirituality assisted participants to balance the material desire and to lead them towards a more peaceful life journey.

Family relationship

Family, particularly their wellbeing, as described earlier in Spirituality section, was perceived by the participants to be intricately related to their healthy ageing. In addition to that, having caring and supportive children (who provide instrumental, emotional and financial support) was also seen to promote healthy ageing.

An overview of the issues related to the role of family in healthy ageing will be presented first followed by the link between family and spirituality. Four subthemes with eleven units were identified in addition to its interrelation to spirituality (Table 4.9).

For many participants, to have filial children was seen to be the ideal. Traditionally, Malay communities have very close knit families; with family having a strong influence at each stage of life and where older people are highly respected within the family. The role of the older adult in the family can be as a spouse, a parent, a

grandparent and often as a great grandparent. There is an expectation, as a parent, to provide unconditional love and care for children; this may then extend to their grandchildren and even great grandchildren.

Table 4.9.

Family theme subdivision

Theme	Subtheme	Unit
Family	Spirituality	Continuous spiritual responsibility to family members
		Family support to enhance spirituality
		Intergenerational spiritual concern
		Parental role to inculcate spiritual awareness
	Parental responsibilities and expectations	Education provision
		Career choice support
		Raise filial children
	Family member as carer	Financial support
		Emotional support
		Physical support
	Spouse and intimacy	Retirement and income
		Tolerance
		Companionship
	Grandchildren	Source of happiness
		Caring relationship

Many participants talked about their role and responsibilities as parents to bring up
their children well, and particularly to ensure they have a good religious and academic
education which will stand them in good stead to lead a good and happy life, have

families of their own and earn a good income. There was general agreement that if children were brought up well, then their parents would not only revel in their children's success but could also rely on their children for support and consequently lead a happier and more relaxed later life.

However, often the actions and behaviours of children did not meet their expectations. The attitude of younger generations was actively discussed in all focus groups by almost all participants. Being parents, most of them expressed their frustration at how their children or other children treated their own parents. This source of stress was perceived to have a detrimental impact on their wellbeing.

As parents grow older and retired without any regular income or with minimal income, it is expected that the children's role is to provide financial support even though parents may still be physically independent. Emotional support was also important as expressed by this participant, '…just give us a call; as long as they [the children] remember us, that is good enough, not necessarily financial, we understand that…' (Nori, woman, aged 72, group 5).

Another participant expressed her gratitude for being well loved by her other family members despite being single, '…siblings, nieces and nephews, *Alhamdulillah*. They do remember my birthday, send me good wishes, they send text messages. When I went back, they prepared the room, cooked for me, entertained me, of course I was excited' (Ana, woman, aged 60, group 6). The emotional support provided by family members appeared to alleviate the potential feeling of loneliness in this participant's life.

While most participants welcomed and expected children to provide emotional and

financial support, some participants acknowledged their sadness to delegate a full caring role to their children. By way of example, one participant who was the main carer for her husband with stroke was distressed that she had to allow her husband to be cared for by their children due to her own deteriorating health. Many participants viewed it as the role and responsibility of a spouse to care for the less healthy partner. Yet when both experience deteriorating health, then there may come a point where they must hesitantly let others take responsibility for their care, and relinquish some of their pride and independence.

The spouse is the closest individual an older person usually relies upon; especially once children have grown up and left home to work or to have their own family. At this time, there is more reliance on a couple to support one another through everyday life, and any stressful situations that may arise. While retirement may be welcomed by some, as an opportunity to take part in activities and spend more valuable time with their spouse, it can also be a source of stress for marital intimacy. Less income following retirement was described by the following participant to negatively impact on love and marital relationship,

> '…there is a big difference in the way of life for older people nowadays compared to last time, …retirement age can be very different, while working, it was luxurious life, once retired, the income lessen, so is the love…less love due to reduced income. Last time, people had everlasting love, till death' (Adi, man, aged 75, group 3).

Yet, not all men observed a deterioration in their marital relationships as they aged. Rather, they perceived their loving and caring spousal relationships to be seemingly

stronger at this age, especially as they relied more on each other solely, and had reduced responsibilities. Importantly, the participants in group 4 acknowledged the role of tolerance, compromise and understanding to support their long term marriage,

> Jak: Try to understand each other (aged 73).

> Zaki: Have been married for long, say 40 years, should be understanding, do give and take (aged 79).

Companionship provided by a husband was very important to female participants, 'once husband left us we feel like there is no companion, at 60 my husband died' (Rima, woman, aged 66, group 6). Another participant who had been widowed for the last 4 years stated the loss of her husband has meant she is less active and motivated to go out, 'my late husband loved going out, seeing things, he loved window shopping, …now no more, gone, don't know what to buy, never go for shopping now, very occasionally, just follow them [friends]' (Ima, woman, aged 60, group 7).

While day to day life and preparation for older age were often seen as the husband's role, there was evidence to indicate that some female participants, once widowed, had started to think and make their own decisions '…when he was gone then I started to think to live here [*pondok*]' (Anis, woman, aged 63, group 6).

Furthermore, previous employment appeared to prepare some women to be more independent either with or without intention as experienced by this participant, 'I was in Penang alone. I used to be independent, I bought my own apartment, I used to pay my own bills, and he paid his' (Zie, woman, aged 77, group 8). For another participant, being married to military personnel prepared her for independent living,

'When I delivered my second child, I drove myself to hospital and came back 3-4 days later by taxi. Three to 4 months later, he comes home.' (Miah, woman, aged 64, group 8).

Despite the benefits of having to learn to be independent, to have a spouse around was perceived to be much better than to live alone, as shared by this participant, 'I am now at peace too, living in my own house, not alone, nothing to worry. I am happy as he is at home, we go out together, no problem, *Alhamdulillah*' (Dewi, woman, aged 65, group 7). Thus, the companionship provided by a spouse seemed imperative to contribute to peace of mind as part of healthy ageing experience for most participants.

Children and grandchildren, for many participants, were the source of bliss in life, as illustrated here, '…without children and grandchildren, we won't be happy' (Anis, woman, aged 63, group 6). In the community where grandparenthood is welcomed with joy and pride, many participants excitedly shared their experiences and gratification of their intergenerational relationships. However, while some participants reported to love being with their grandchildren, for others, to take care of their grandchildren was perceived to be a burden, '…not to take care for them we feel pity, but to care for them it then become a problem for us' (Ida, woman, aged 62, group 7). For the following participant, with the help of a paid helper provided by their children, he and his wife were able to help to look after their grandchildren when the parents went to work, but it was challenging at times,

'…when we had to do more than what we are capable of , for example, when there was no helper, my goodness, have to cook, even with the paid helper

sometimes we could not cope, can't do the washing. We accept this but if possible we don't want to do that' (Aji, man, aged 61, group 2).

So while some grandchildren may get the opportunity to be well pampered by their grandparents, as they grow older some participants reported that they preferred to limit the time they spend together despite their unconditional love. For these older people, the quality of the relationship often appeared to take precedence to the quantity of time spent together.

Spirituality and family

In talking about the important role of their families for ageing well, the participants' spirituality and spiritual activities seemed to be intricately connected to this relationship. Some participants regarded they have continuous spiritual and even material responsibilities towards their family members. Despite feeling less responsible for their children once they were happily married, participants still continued with regular prayers for the happiness and well being of their descendants. The well being as described by this participant included their health, safety and faith,

'All my children are married, I am happy to see that. I have nothing to worry about. All the children and grandchildren are well, that is what I have been praying for day and night. I pray that all my children and grandchildren are healthy, protected from bad luck and always in strong faith' (Daud, man, aged 79, group 1).

A harmonious family situation assisted their efforts to strengthen their spirituality. To find solace in this preparation, support from other family members was imperative. Some older people were happy to help to take care of their grandchildren, but it was a

cause for discomfort for certain older people as this participant commented, '…another thing is family disturbance, if the family understands us. If they don't, such as ask us to look after the grandchildren, it can be an agony' (Hani, woman, aged 60, group 7).

The changes in their relationship with their grandchildren were seen as part of the ageing process. For some participants, they feel old once they have grandchildren and it later progresses to the feeling of being unable to physically take care of their grandchildren, as seen in the following conversation among the women living in the spiritual retreat in group 6:

> Lia: When we feel we could not cope to look after the grandchildren, we are already old, the grandchildren all grown up, what else I am looking for (aged 65).

> Rima: Come and live in this place [spiritual retreat] (aged 66).

> Facilitator: Ara, when do you feel old?

> Ara: Since having great grandchildren, feel like to live peacefully without disturbance. When we want to perform *ibadah* not be disturbed, occasionally the children invited us to go back is acceptable (aged 70).

> Rubi: Once we are old, we want to be on our own to perform *ibadah*, till our time come (aged 64).

> Anis: That is the reality of older people, that is it (aged 63).

Family support is not limited to avoidance of additional responsibility; it does include further understanding of their feelings and their interest. Older people may prefer to stay at home and they expected a conducive environment as illustrated here, '…once retired we want a peaceful life, peaceful household, at this age we are sometimes a bit sensitive, sometimes we want peace at home, no misunderstanding...' (Azmi, man, aged 85, group 2).

A peaceful life at home was also seen to involve having a good relationship with a spouse and other family members including intergenerational members. During the discussions, participants talked about how their grandchildren and the current younger generation lack a caring and respectful attitude towards older people. They felt they have the mutual obligation towards their family and younger generations. Some participants used prayer and supplication to cope with it, 'We supplicate to Allah after each prayer, (we) even wake up for *tahajud* [late night] prayer and continue with supplication, and it is really a test, to test our patience…' (Seha, woman, aged 67, group 5).

The attitude of younger generation was seen by some participants as disrespect to the well preserved religious tradition. This sentiment was also shared by another participant as illustrated here,

> '…young or old now we can't say anything to them, when I was small, if I am not back by *maghrib* (sunset) my dad will say, 'even chicken know when to go back to their shed'. [Nowadays] a mum won't bother if the children don't come back for 2-3 days…number one, when there is a call for prayer, *Allahu*

Akbar, Allahu Akbar, can see even those in 60's going to night market…' (

Adi, man, aged 68, group 3).

The changing culture in the community disturbed them and they attributed it to a lack of a basic religious foundation. Some participants, mainly men, suggested that it was the parents' responsibility to inculcate exemplary religious attributes, and that this was often deficient:

> '…in the area where I lived, there are 16 houses in each lane, I have lived there for 30 years, only 3 people from one lane went to the mosque. Going back to religious faith, if the parents don't go to the mosque, what about their children?'(Adi, man, aged 68, group 3).

Religious guidance in parenting and parents' inadequate religious knowledge was also discussed in the same group,

> 'Children and grandchildren when they were small, before puberty, if we taught them to be obedient to Allah, *insyaAllah* [with Allah's will] once grown up, they will be respectful to their parents, this is what being said by the prophet, not my own words. So, if we taught our children to comply with parents first instead of Allah, *insyaAllah* once grown up, he will disrespect the parents. Believe it or not, this problem occurs because we don't believe. The problem was, our parents didn't know this, they were poor, [they] don't know, [it] was too late…' (Ali, man, aged 72, group 3).

This participant shared his religious understanding of parenting skills as described in the religious teaching. In his opinion, however, this knowledge was not available to

their parents during their time which then raised a lot of problems in his and current generations.

Despite much unhappiness towards how younger generations behave, there was a positive note too, '…not all, the good ones are good. Those with poor basic religious knowledge this will happen but those with a strong religious base, whatever it is, will respect the old people…religious education is important' (Budi, man, aged 95, group 1). As elaborated in the opening section about spirituality, most participants were convinced of the importance of a strong spiritual foundation for positive individual development of future generations.

Conclusion

Family had a great influence on the healthy ageing process of participants. Their role as a parent, their caring role within the family, and their spousal and intergenerational relationships were the main contributors. In this community sample, the family relationship and responsibilities were reciprocal, with 'give and take' in both directions. Parental responsibilities were very challenging, and this was seen to impact strongly on the attitudes and values demonstrated by the younger generations. Lifelong family relationships with mutual understanding, be it with a spouse, children or grandchildren, was essential for feeling happy and peaceful; especially if guided by strong spiritual foundation in each individual. Participants strove for harmonious family relationships through continuous intergenerational caring relationships either directly or through prayer and supplication, in addition to the parental role to inculcate appropriate spiritual awareness for the future generations.

Living environment

The living environment refers to the place where participants' lived, the people they lived with and their neighbourhood. Accessibility to certain facilities and the surrounding environment did not just affect their daily lives; it also influenced their healthy ageing experience. Male participants focused more on the neighbourhood issues, whereas female participants were deeply concerned about the former two, with a preference to own their own house and a wish to live alone in their own house as long as possible rather than move out to live with other family members. Deteriorating health status was the main reason for the participants to consider another living arrangement, but they were still inclined to age in place. Yet, for some participants, despite the comfort of their own house, their spiritual determination influenced their decision to relocate.

The Living Environment theme comprises of two sub themes as follows:

1. Neighbourhood - relates to preferred neighbourhood characteristics and how participants value their current vicinity.
2. Ageing in place - relates to the types of places preferred by the participants to age in place; reasons for specific preferences for living arrangement are also described.

In contrast to other themes, the link between spirituality and living environment will be integrated within the elaboration of each subtheme as participants seemed to make continuous links to spiritually related issues (Table 4.10).

Table 4.10.

Living environment theme subdivision

Theme	Subtheme	Unit
Living Environment	Neighbourhood	Spiritual support Friends Continuous learning activities Neighbours Security
	Ageing in place	Spiritual retreat for peaceful life Own home - sense of belonging Living with others – the support system

Neighbourhood

The importance of spirituality to healthy ageing appears to be enhanced in later life and this was seen in participants expressing their eagerness to live in an environment which supports their spiritual needs as illustrated below,

> 'I never married…After my mother died; I started to feel too insecure to go to the mosque at night. I hoped to find a place where I can feel closer to God, nearer to the mosque without worrying about my security…' (Ana, woman aged 60, group 6).

The mosque is the community centre for Muslims; it is not necessarily only meant for religious activities, it serves a multipurpose role, such as a place for them to learn and meet friends, as described by this participant when asked about the need for friends or

new friends, '…don't really need because we go to the mosque every day, in the mosque all are friends, friends are all those in the mosque' (Atan, man, aged 71, group 2).

Religious activities were not only restricted to the mosque, but being the community centre, many religious activities took place there. Hence, to live near a mosque or to have easy access to the mosque was a preferred choice for many participants, more so when they were regularly involved with the many activities provided as experienced by this participant,

> 'I initially just followed the others, really enjoyed it each time, friends brought me there [to the mosque], gradually I went to *surau*, mosque more frequent …then I decided to stay here [spiritual retreat]' (Lia, woman, aged 65, group 6).

Even when travelling, the accessibility of a mosque affected participants' decisions as illustrated here, 'I do agree with Aki, when I went back to my home town I stayed in a hotel and a hotel near to a mosque was my priority' (Aji, man, aged 61, group 2).

In this Malay community, *surau* is usually a smaller place than mosque which is built for smaller groups. Other than religious or community gathering or learning activities, the five obligatory daily prayers were usually conducted in congregations both in mosque and *surau*, while the weekly Friday prayer congregation is usually performed in the mosque or selected *surau*. For Muslims, the five obligatory daily prayers can be performed anywhere but preferably in a mosque for men; it can be conducted alone but group prayer is encouraged.

A positive relationship with neighbours was important for participants; especially because caring for neighbours, and other 'creatures' (means anything that God created), is an integral part of the Muslim tradition. Receiving assistance from neighbours was also much appreciated, '…for me, I don't have enough strength to go to the shop, so when they pass by, they will ask whether I want to buy anything' (Nori, woman, aged 72, group 5). However, neighbours were not always perceived positively, as illustrated in this statement, '…neighbour can be pain in the neck' (Piah, woman, aged 65, group 8). Furthermore, when neighbours do not meet expectations, with regard to spiritual practices, it can be perceived as problematic, as illustrated by this participant,

> 'For us, we regularly go to the mosque, I always live near to a mosque, but the neighbours, the people living in the surrounding area, wherever it is, there is always more people who do not go to the mosque, this is worrying… we can accept if their kids make noise, when we want to sleep, they work on their noisy bikes, that is still acceptable, but [the neighbours] not going to the mosque is a burden [for us] (Aki, man, aged 74, group 2).

Some participants were concerned by the challenging scenario within their neighbourhood which sometimes disturbed their spiritual journey as expressed here,

> '… my neighbour once asked me, will you be assured of heaven by going to *surau*, I don't know, that is not my job, Allah will decide but I am aware I am nearer to the grave. Ask me that without embarrassed, no shame at all, this kind of person, at the age of 60 cannot be reminded, how about the children then?' (Adi, man, aged 68, group 3).

Another participant recalled how the caring neighbourhood attitude had diminished and suggested appropriate religious teaching to remedy the situation,

' …this caring attitude vanished in the 50's, we were all sincerely shared caring reminder to whoever children…then as the country was developing, there were trans migration… it happens everywhere, with this mixture they don't know each other, that is the culture now, you don't acknowledge the neighbour next door. That is why the current culture is causing problem. First and foremost, the religion just now, submits to Allah first, insyaAllah [with Allah's will] once grown up he will be faithful to the parents, devoted to Allah, not disobedient…' (Ali, man, aged 72, group 3).

In addition to spiritually related matters, the benefit of neighbourhood community watch (known as *Rukun Tetangga*) was also suggested as a way to reduce neighbourhood crime, '…*Rukun Tetangga* should be re-introduced, during that time neighbours know each other, less thieves and robberies, easier work for police' (Adi, man, aged 68, group 3). The issue of safety and security in the neighbourhood was of concern particularly with increasing frailty as illustrated,

'We are now not that fragile, meaning that we are still able to look after ourselves. There will be time when we need a cane to walk, then that's it, so now we are less suspicious of the surrounding as we are still capable' (Jak, man, aged 73, group 4).

Hence, it seemed accessibility to certain facilities may be restricted by physical capacity and fear for safety. Therefore, at any age where some older people wish for

more frequent learning opportunities and other activities, residing in a place where this desire can be fulfilled is both preferable and important.

Ageing in place

Many older people prefer to age in place; the place that they are emotionally attached to, with familiar surroundings. While they are physically healthy, they may have the autonomy to choose where to live; conversely, this freedom may become limited once help from others is required to continue living independently day to day.

In this Malay community, care for older people was mainly provided by family members; whilst for those better off financially, having a paid helper was an alternative. Going to a private nursing institution was generally not considered as an option due to the exceptionally costly and inappropriate nursing homes which do not support their spiritual needs. So much so, as long as they are functionally independent, to live in their own house as long as possible was the priority. The decision to move out to live with their children was mainly due to health reasons, but, interestingly as has been reported earlier, driven by ultimate spiritual needs, some healthy older people decided to leave the comfort of their own house in the quest for peace of mind.

The decision to live in certain places was influenced by spiritual needs, a strong sense of belonging and the need for support. Most participants preferred to live in their own houses whereas some accepted the need to move in with their children once the need arose. Some female participants, however, decided to move to a spiritual retreat.

Spiritual retreat for peaceful life

The decision to move into a spiritual retreat, traditionally known as a '*pondok',* was seen as part of their preparation for a peaceful life as expressed by this participant , '…this is the preparation for afterlife, this is the preparation, we do not know when would death comes, be it tomorrow or the day after, no matter of age. This [place] is the essence of happiness' (Ana, woman, aged 60, group 6).

Particularly for women, they talked about wanting to live in a place they feel like home and a decision to uproot from their usual place at this age has to be driven by a strong quest for spiritual knowledge and education as illustrated,

> 'I have told my children about my wish when I am older, I am not old yet now. When your mum is older, your mum and dad want to live in J [spiritual retreat]. Living in J [spiritual retreat] is like living in Medina, there is a lot of teaching sessions in the mosque, you do not have to take care of us' (Ida, woman, aged 62, group 7).

This spiritual retreat provides an avenue for them to focus their efforts to learn more about religious teachings and to observe their spiritual commitment in a supportive and safe environment, without much interference as described here,

> '…my children ask me to live with them, I don't want to, living alone here at J we can [concentrate to] do *ibadah*, but having grandchildren around, *nenek* I want that, *nenek* I want this, however, to be with grandchildren occasionally is acceptable" (Anis, woman, aged 63, group 6).

A *pondok* in the Malay language is a popular place to reside for those wishing to strengthen their spirituality by living in the community where religious teaching and practices can be intensified as illustrated here, '…at this old age we want to detach ourselves to concentrate on *ibadah*, till end of our life' (Rubi, woman, aged 64, group 6). Ability to perform as much *ibadah* as they wished was perceived to generate a sense of peace and pleasure as expressed by this participant, 'during Ramadhan month was more enjoyable, [going to the mosque] at 3 am, no fear at all (Ana, woman aged 60, group 6) and another participant describe it as, 'that is real pleasure' (Anis, woman, aged 63, group 6).

Feeling that they had inadequate religious knowledge and previous religious education in their earlier life, made some older people more determined to find ways to learn more to attain blessing from Allah [*ridho Allah*]. Moving to a place where they could optimise or maximise their religious education was seen to be the best option as described by this participant,

> 'We don't have much knowledge or performed many good deeds … last time, we have to work...while working and once retired is a different feeling then…when you live alone at home, feel like living next to a grave, so quiet. Thus, look for a comfortable place to learn, can acquire more knowledge, can be closer to Allah…that is the real purpose of life. Not that there is none out there, but time is so limited, we went out for one hour then back home you are alone again, in here it can be said as 24 hours, sleep is the only distraction…' (Ana, woman aged 60, group 6).

In this study, focus group 6 was conducted in a modern *pondok* run by a nongovernmental organisation. It consisted of a multigenerational complex mainly for orphans and older women without husbands; and surrounded by houses for families. Older people can buy a unit there and live alone or if they cannot afford to buy a unit there, they can apply to share with another resident in a *wakaf* unit with a minimal monthly fee applicable to all residents. *Wakaf* is a kind of endowment, donated possession for the benefit of the community and as long as it is used for a noble purpose the donor is believed to reap spiritual rewards even after death.

> *In addition to furthering their spiritual education, participants discussed other reasons for living in a pondok which included: being in closer proximity to the mosque; alleviating the burden and concerns of children; and it also provided a way of finding more time for themselves without the responsibilities of day to day life.*

As one female participant explained, 'who is going to bring me to the mosque if I stay at home?' (Lia, woman, aged 65, group 6). A *pondok* provides the environment and support suitable for women without easy access to the mosque, especially for those women who have been widowed and do not have the support of their husbands. For a widowed woman, despite being independent and highly capable to travel even using public transport; to live alone in the rural village may stir some qualms for the adult children living far. In the *pondok*, the residents enjoyed the feeling of security and being well supported by the community, '…my children have no worry now, last time I lived alone in the village since my husband died 6 years ago. Went on a bus to go here and there, my children have to regularly come back…' (Ara, woman, aged 70, group 6).

Another participant described her decision as a proactive effort to provide fair treatment to all her children and herself,

> '…we don't want to disturb the family, we have many children, I have many children, 8 children. If they want to take turn, we will become like a ball, stay a month in this house…then they will not say, mum just stay at that sister's house only, don't want to come to ours…[so here] if they remember their mum, they will come, if they have the time…'(Rima, woman, aged 66, group 6).

The decision to live in *'pondok'* seemed beneficial from many perspectives.

In a society where the children are expected to look after the older family members, a few participants had to make a difficult decision to leave their grown-up children to live in a place to fulfil their spiritual quest:

> 'The children feel bad as we leave the house, as though we are being neglected by the family members. They said to me, you have gone through all the difficulties caring for us but once you are older we are not capable to care for you. I told them it is not that, if I live in this house, I cannot be consistent in my spiritual obligations, it is difficult to go to religious classes, the mosque is far from the house, when there is a call for zuhr [noon] prayer, I may still be in the garden, during maghrib [dusk] time, I may still watch the television…In here we wait for the time but out there, the time has to wait for us. I want to live here till the end of my life' (Rima, woman aged 66, group 6).

In Malay community, the woman's role is traditionally centred on the family, while the husband is the leader and main breadwinner. If a husband dies, the wife needs to bear responsibility towards their dependent children. It is a great challenge and sacrifice to single-handedly raise children, so having an opportunity to fulfil their own spiritual desire in later life was something to look forward to as illustrated here,

> 'My husband died 9 years ago; I live here since 2004, almost 4 years. Really determine to live in '*pondok*', a clear intention. I didn't come immediately after he died because the children were still in school, three of them…' (Rubi, woman, aged 64, group 6).

Own home – sense of belonging

Not all participants wanted to move into a *pondok*, as illustrated by the following participant,

> 'Not for me, I am not going anywhere; I want to live in my own house 'til I am gone because I have made the preparation since I was much younger. I don't want to disturb my children. If God decides I am to fall ill, there will be a person to look after me, I am not going anywhere' (Ros, woman, aged 63, group 7).

All women in group 5 felt that to have their own house was the essence of good ageing; may be for a simple but meaningful reason as expressed here, 'I wish to die in my own house' (Nori, woman, aged 72, group 5). For the following participant, her protective role towards her neglected grandson despite appropriately preparing him for vocational education, override her own needs,

'I wish for a house, my responsibility towards this grandson is not over yet, that is why I keep applying, what is going to happen to him once I am gone, he is 17 years old, doing engineering vocational training…' (Tina, woman, aged 73, group 5).

For another participant, who was caring for her husband with stroke, the experience of losing their house to the planned development in her slum area was not only extremely painful but generated deep concerns about her future,

'Our house was being bulldozed, where else to go, just live in temporary camp. We applied for hire-purchase [for the replacement unit] but rejected, we are *warga emas*, not eligible to apply for loan, they want RM35000 in cash' (Sara, woman, aged 65, group 5).

The emotional satisfaction to own a house is supported by another participant, 'in our life, house is number one, if possible our own house. We do not want to be a lodger at old age, lodge in our children's house; if possible we want to be in our own house' (Sal, woman, aged 61, group 7).

Moving out to another location was not regarded as a good thing at their age for some participants who currently received some financial support from a formal agency, as they need to face challenging bureaucratic process as expressed here, '…not easy [to move out] as the support we are receiving are here, you have to apply for it there and it is very difficult to get' (Tina, woman, aged 73, group 5).

Living with others – the support system

The decision to leave one's own house to live somewhere else, even with their own children seemed to be the last resort for many participants. It was intolerable to some, particularly women, as illustrated by this participant who described her reason to stay alone in her own house,

> 'That is why, I don't stay with my children, because of their behaviour, attitude. They have their own lifestyles, our style is different. When they say anything which we don't like, we feel hurt, because as I said, we are sensitive. I rather stay in my own house; I am free in my own house than their house' (Miah, woman, aged 65, group 8).

Deteriorating health was the main reason for an older person to live with their children, particularly for the support they can provide, as stated by the following participant, '…firstly if his health is not stable, secondly when his vision, hearing deteriorates, so it is better to live with the children, living alone could be dangerous' (Budi, man, aged 95, group 1).

Some participants, particularly those more wealthy, were in favour of receiving formal support in their own homes, rather than moving in with children, '…but then we prefer a maid to them. I prefer to pay money for maid for RM600-700 per month rather than staying with my daughter or daughter in law' (Piah, woman, aged 64, group 8). Another participant supported this view with following statement,

> 'Once I am old and my children can't afford to look after me, I will ask them to get me a paid helper, I am going to pay for it as I have prepared myself, I have my pension, my own house (Ros, woman, aged 63, group 7).

Despite this evidence to suggest that participants preferred not to live and be cared for by their children, it was also apparent that if the children do not offer to look after their parents then it demonstrates a lack of respect, as following comment illustrates:

> 'That is if there is a willing daughter or son, nowadays when the older people become dependent, the children send them to public old folk homes, let the people there to care. He is getting high salary, never bother to care for the parents, there are so many...These people have forgotten, have no respect towards old parents, if the old parents pray to God, then they will receive ill fate. Do not be like that, don't...' (Budi, man, aged 95, group 1).

Conclusion

In summary, spiritual needs seemed to significantly affect participants' decisions about where they chose to live, clearly illustrating the importance of the living environment for these participants. In their neighbourhood, participants desired a feeling of comfort in terms of their relationships with others, as well as a sense of security and easy accessibility to places where they could fulfil their spiritual needs. The participants appreciated house ownership and they wished to live in their own house as long as possible, preferably with their spouse, or even alone or with anybody they felt comfortable with, in spite of deteriorating health. On the other hand, some decided to live in another place for spiritual or health reasons.

Gender Differences

This section draws out the gender differences in the themes identified. The themes described in each group can be seen in Table 4.11.

All groups conversed to a certain degree about issues related to spirituality, physical health, family, and financial, yet there were some differences in their approach. Spirituality, peace of mind, financial independence, family, physical health and function were the main themes mentioned during the discussion in all male groups (group 1 to 4).Interestingly, the women in group 6 and 7 discussed interrelated issues moving from physical health, spirituality, family, living place then financial independence, while the women in group 5 and 8 focused on physical health and financial, followed by family and living environment. It was apparent that the emphasis of their discussion appears to vary according to their socioeconomic needs. For example, the women from group 8 talked mainly about how to keep healthy and active despite having chronic diseases, whereas the women from group 5 talked more about the financial burden associated with their illnesses. Furthermore, for the former group, financial independence was conferred in relation to their purchasing power; whereas the latter group was more concerned about their ability to fulfil their basic needs (particularly housing).

Table 4.11.

Focus groups and themes

Themes	Focus group number							
	Men				**Women**			
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Spirituality	++++	+++	+++	+++	++	++++	+++	+++ prompt
Peace of mind	+++	+++	+++	++++	++	++++	+++	++
Physical health and function	++	+++	++	++	+++	++	+++	++++
Financial independence	+++ prompt	+++	++	++	+++	++ prompt	++	+++
Family	+++	++	+++	++	++	+++	+++	++
Living environment	++	++	++	+	++++	++++	+++	++

Key: A '+' denotes the intensity of the discussion on a scale where '+' reflects that the topic was mentioned and '++++' reflects that the topic was discussed at length.

Spirituality

Spirituality was discussed in relation to most themes in all groups except in group 5 and 8 where the description of spiritually related activities was the main focus to express spirituality. Specifically for group 5, spirituality was mentioned to describe their way of coping. The differences seen in the way focus groups 5 and 8 expressed their views as compared to women in group 6 and 7 might be contributed by participants' characteristic and the group dynamics. Women in group 6 and 7 have

been together for some time with similar purpose, they basically knew each other but not close enough between individuals, hence the focus group session was an avenue to share individual stories related to the issues brought up.

The men's groups were in similar situation as women in group 6 and 7, except for group 1 where both participants were best friends. The women in group 5 knew each other very superficially and they shared similar financial disadvantages. They preferred to talk about common issues and may have some reservations to expose more about their spiritual endeavour. Whilst the women in group 8 knew each other very well and were all financially comfortable, their eagerness to express their unhappiness towards attitude of younger generations, may limit their time to share their spiritual expression. Spiritual inclination sometimes is contained exclusively within their personal quests and accepted circle of friends. This was observed when each of them eagerly shared their spiritually related activities which they carried out routinely either on their own or with their selected friends. On the other hand, the two men in group 1 were contented with their family and financial state; they relate spirituality in every aspects of their life and eagerly include the others.

Peace of mind

Male participants directly expressed their aspirations to achieve peace of mind whereas this was indirectly ascribed by the female participants. Whilst women easily shared their personal journey towards achieving peace of mind, only a few men were comfortable to do so; the men preferring to generally describe what was expected and how to do it.

The male groups stressed the importance of good preparation to achieve peace of mind at older age. They reiterated the core parental role in educating their children at home which was supported by formal education to cover both aspects in preparing oneself financially and more importantly, spiritually. Female participants, however had a more diverse range of views; a few of them thought preparation was unnecessary as somebody will always be responsible for them, some were prepared without intention and some were fully aware of the needs to actively prepare and had done so, whereas a few others struggled to do so.

Physical health and function

Despite differences in expressing the other themes, all groups unanimously described their wish to be in the optimum health and functionally independent as long as possible. The impact of deteriorating physical health towards their daily religious activities was of concern, yet some male participants shared their ways of strengthening their spirituality even with health or functional restriction.

Financial independence

The men focused on elaborating the importance of being financially independent and the associated preparation, whereas the female participants approached this topic from various viewpoints. This may be related to the active or passive financial role undertaken by the women, where some were dependent on their husbands or children, some had shared responsibilities and in some cases, they were the sole breadwinner. Of note is that all the male participants had their own income whether they were retired or still working.

Family relationship

Most female participants actively mentioned their family in the discussions whereas the men preferred to talk more generally about family and only a few shared their own family stories. The women in group 8 spoke a little about family issues and similar to the men in group 3, they were generally unhappy with the attitude of the younger generations and attributed it to poor parenting. Grandchildren were not mentioned by groups 3 and 8, whereas it was brought up fondly by the other three male and two female groups. Group 5 expressed their unhappiness towards the attitudes held by some of their grandchildren and the younger generations in general. Some participants in group 3 blamed women for being ineffective spouse, mother, or grandmother causing the problems in the younger generations, however the participants in group 4 described both parents held responsibility to educate their children.

Living environment

As described earlier, women discussed intensely where they wanted to live and to a certain extent with whom they wanted to live, whereas the men delved deeper into the issue of neighbourhood and community. This may be related to women's traditional role mainly within the house whereas men, working outside the house, were expected to be more involved with the community. Widowhood experiences may have contributed to their worries about housing; greater proportion of female participants was widowed, whereas only two men (one each in group 1 and 2) outlived their spouses. The housing issue was either not a concern for these men or they preferred to discuss other issues which they thought as more important.

House ownership status is another possible explanation for the differences observed; all male participants except two of them (one each from group 2 and 3) lived in their own houses, whereas, all the five women who did not own a house were in group 5. Women in group 7 and 8 were all living in their own houses, whilst women in group 6 lived in purpose designed spiritual retreat residential in some way or another own houses either back in their hometown or bought a unit there or have both. Only women in group 6 and 7 talked about the spiritual retreat but as this option was also mentioned by individual participants in my later survey, its significant role in life of older people needs further investigation.

Discussion

The findings reported here were not homogenous across all 8 groups. I have reported the general sense of the findings, but there were noteworthy differences in the experience of the role of spirituality for healthy ageing relating to gender, age, income and education. For example, for much older participants who may be less mobile and in poorer physical health, spiritual activities may take up more of their time, have more priority in their lives, and influence their decision about where they choose to live. The younger participants appeared more self-oriented and didactic in addressing spirituality whereas older participants were humble and much inclusive to invite others to cherish spirituality together. However, it was not clear whether spirituality became intensified with increasing age. Furthermore, it appears that those participants who enjoyed a better education, and were able to get better jobs and gain more financial stability, were those that were now able to dedicate more time to their spiritual endeavours. And for women, access to ongoing learning opportunities and

spiritual development appeared to be of great importance, while for the men regular attendance at the mosque was a priority. The different emphases in participants' experiences provide important insights into our understanding of how older people experience growing older.

In this Malay community, healthy ageing was viewed more broadly than the definition originally proposed by Rowe and Kahn (1997). The role of spirituality identified in this study supported Crowther *et al.*'s (2002) proposal of spirituality as the forgotten fourth component in Rowe and Kahn's model. Crowther *et al.* (2002) argued that spirituality be included in a multifaceted definition of successful ageing, in addition to the interdependent role of biological, psychological, and social elements.

In my study, spirituality was a core factor for healthy ageing in this community. For example, even though physical health and function was a primary concern for the participants in this study, the strongest motivation to maintain physical health appears to be derived from the desire and commitment to fulfil their spiritual obligations. Moreover, in the event of deteriorating physical health and function, participants demonstrated yet stronger determination towards spiritual fulfilment. This adaptation to biological and environmental changes reflects the general principle of selective, optimisation and compensation, a prototype adaptation strategy as proposed by Baltes and Baltes (1990). Most participants in my study did use this strategy to achieve healthy ageing. They selected to concentrate more on their spiritual identity, optimising it by doing as many good deeds (*ibadah*) as possible, thereby achieving peace of mind despite all vicissitudes in life. In term of physical and cognitive health, plasticity has its limitation at fourth age (Baltes & Smith, 2003). In this study,

spirituality seemed not to be limited by increasing age, which deserves further exploration.

Spirituality was a key resource for these participants, particularly in assisting them to adapt and respond to the ageing process. The results also support Mehta's (1997) findings in her study of Malays in Singapore. The new knowledge that this study offers is a deeper understanding as to how spirituality guides older people to appreciate or feel contented with what they have, in the face of various challenges, and yet at the same time motivates them to continue to learn and pursue their own personal development.

Figure 4.2 illustrates how participants described their spiritual path. Participants revealed their spirituality by describing their connection with God and/or others according to religious guidance. Their connectivity with God can be demonstrated as a direct connection such as prayer, meditation, recitation of the holy Quran and supplication. At the same time, spirituality was also expressed by developing mutual responsibility in their relationship with others as part of their endeavour to gain blessing from God. This mutual responsibility demonstrated in many ways such as their caring attitude, active involvement in the community activities, attendance at prayer congregation and group learning. Participants' expression of mutual responsibility can be towards family and friends or broader to their neighbourhood and further extended to the wider community.

The changes that participants spoke about in relation to their social and personal relationships demonstrated evidence of gerotranscendence as described by Tornstam (1997). While Tornstam did not specifically discuss the role of spirituality, the three

dimensions in his gerotranscendence theory namely cosmic, self and social personal relationships did seem applicable to some extent, particularly the broadmindedness, tolerance, positive solitude, being more selective and redefinition of social relations (Tornstam, 1997). As this study was not specifically designed to investigate evidence of gerotranscendence, further exploration of this phenomena and its impact in this community may be warranted.
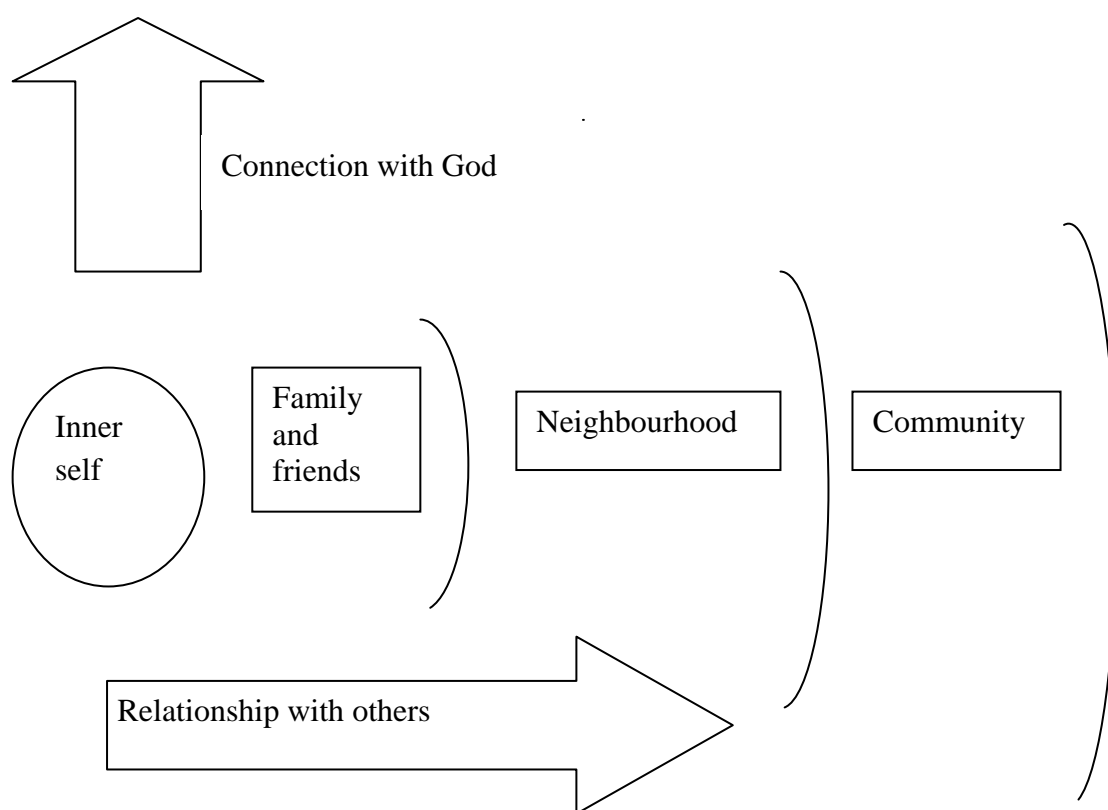
Figure 4.2. Participants' spiritual path

For this Malay community, spirituality was fundamental to healthy ageing. Other factors were identified to be important for healthy ageing, and often their expression was influenced by their spirituality. Using a tree as the analogy for healthy ageing, in

this community, spirituality and peace of mind represents the roots and trunk, whilst the other factors represent the main branches. For a strong and healthy tree, the roots need to be well grounded in the earth. For each individual, the branches may look different or consist of different entities, but the tree still requires the well supported roots and trunk (i.e. spirituality and peace of mind) to supply the necessary nutrients for a good life, and more specifically, healthy ageing. Figure 4.3 provides a pictorial representation of the fundamental role of spirituality for healthy ageing, as identified by participants in this study.
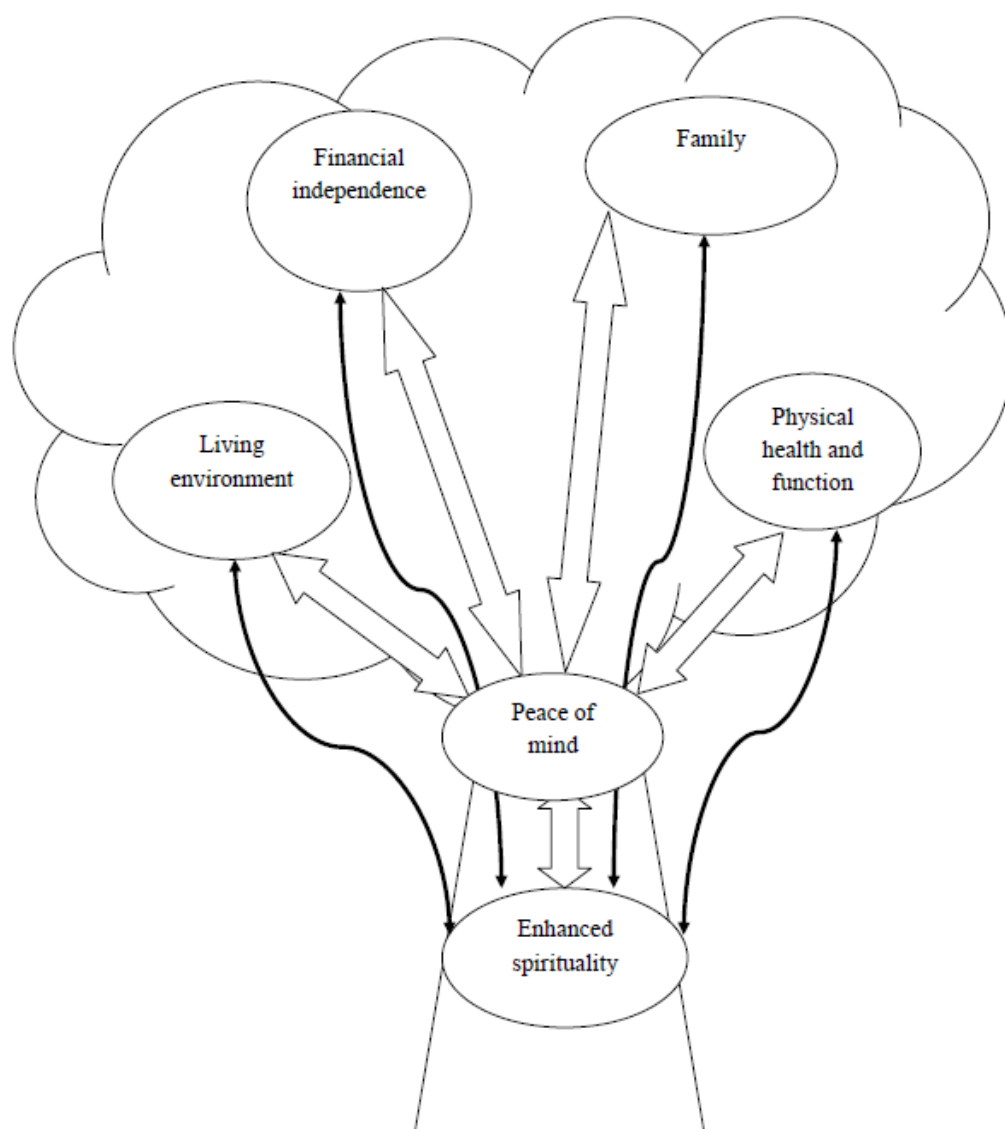
Figure 4.3.The fundamental role of spirituality in healthy ageing

The role of spirituality in life has also been described in qualitative responses in a study amongst ethnic minorities in the United Kingdom, where 2 per cent of the 400 participants included a description of active ageing as 'being able to fast during

Ramadan/pray/ not missing my five prayers a day/observe religious/cultural festivals/ being closer to God' (Bowling, 2009). Despite Muslims comprising 30 per cent of the studied sample, only a fraction of them expressed their active spirituality needs in relation to active ageing.

Qualitative studies in Hong Kong, Taiwan and Canada also reported the importance of spirituality for healthy ageing in a smaller proportion of participants (Chong et al., 2006; Hsu, 2007; Tate et al., 2003). In contrast, almost all older Malays in my study described spirituality at one point or another as having an impact in their life. The use of interviews in this study provided opportunities for the facilitator to prompt participants about spirituality related issues, yet, as outlined in the earlier description, it was only necessary to use this prompt in one focus group (see Table 4.11).

Active engagement in life as outlined by Rowe and Kahn (1997) comprises interpersonal relationships and productive activity. Interpersonal relationships were defined by Strawbridge (2002) as monthly contact with three or more close friends whereas productive activity was determined by having an involvement in either paid employment, caring for a child or grandchild, active volunteering or cleaning the house (Strawbridge et al., 2002). This limited interpretation of active engagement was used to avoid problems with measurement and a lengthy questionnaire. However, in real life, humans being as social creatures enact active engagement in many more ways. In this study, for example, participants intentionally and actively described their efforts to do good deeds, and they often talked about participating in individual activities such as night prayers, personal supplication or reciting Quran. These solitary

activities should also be considered as active engagement in life, but are not often identified as such in quantitative studies due to limitation in the measures used.

Happiness and peace were the main feelings associated with the experience of wellbeing (Wilcock et al., 1998). This is related to the peace of mind theme identified in this study. Desire to attain peace of mind at older age appeared to be the ultimate aim for many participants in this study. Peace of mind in this study corresponded to feeling happy, having no worries, and being free of fear and grief, and may be equated with terms such as positive psychological well being, and having a sense of well being. Yet, it is difficult to measure quantitatively. Sense of well being has been seen to be equivalent to successful ageing (von Faber et al., 2001); however quantitative measurement of quality of life, life satisfaction and no marked loneliness may not represent the whole sense of well being. Qualitatively, broader and deeper issues involved to describe wellbeing including factors such as adaptation, being grateful and contented despite certain limitations (von Faber et al., 2001) were also similarly seen in our participants to describe peace of mind.

Conclusion

Healthy ageing as conceptualised by the older Malays in this study demonstrated similarity to the biomedical model in terms of physical health and function but the unique role of spirituality deserves further exploration. Peace of mind as the ultimate aim in healthy ageing supported the importance of using a psychological framework to better understand the experience of ageing in older Malays. The inclusion of financial independence, living environment and role of family as main social supports strengthens the argument for a broader lay perception of healthy ageing. It seems that

the older adults in this study do share similar perspectives to policy makers about healthy ageing – particularly around maintaining 'healthy physical, mental and social wellbeing', the ability 'to care for him/herself' and 'to contribute towards social family activity' (Ministry of Health Malaysia, 2006). Spirituality, however, was not included in the stated government objectives; perhaps it may have been considered unnecessary to mention due to spirituality being so engrained within everyday life.

While the findings of this study were not generalisable to the whole population of older Malays in Malaysia, purposeful sampling has provided access to information-rich participants to increase our understanding of some important issues to consider in promoting healthy ageing within the population studied. Given the important role of spirituality as a resource for healthy ageing, it may be in policy makers and practitioners' best interests to be more explicit about its role – by stating that older people, in addition to the other key elements, require opportunities to enhance their spirituality. Further study to determine the role of spirituality in healthy ageing for older Malays is imperative.

Many studies in healthy ageing have focused on the role of physical health and function, cognitive function, mental health and social wellbeing. The role of spirituality in healthy ageing is rarely reported. Hence, its contribution for healthy ageing is in need of investigation, particularly with respect to how it may be enhanced, or is in turn enhanced by, the living environment, family and financial status. The next chapter reports six cases in detail to demonstrate healthy ageing perspectives at an individual level, in particular the role of spirituality in the community studied.

Note

'*Ibadah*' in Islam is any good deeds that would be rewarded by Allah. It is divided into two, specific and non-specific. The specific '*ibadah*' is doing specific religious obligations as a Muslim (be it compulsory or optional) such as prayer, pilgrimage and fasting. The non-specific '*ibadah*' is practicing any good values such as being kind, having a caring attitude, being trustworthy, working to feed one's own family, not doing any harm towards oneself and others.

Chapter 5

Study 2 – The role of spirituality for healthy ageing in older Malays in Malaysia.

Introduction

Study 1 used focus groups to explore the perspectives of healthy ageing among older Malays in Klang Valley, Malaysia. Study 1 concluded that spirituality was a key factor in participants' conceptualisations and experiences of healthy ageing. In Study 1, the participants described the vital role of spirituality and peace of mind in healthy ageing which is closely interconnected with physical health and function, family, financial independence, as well as living environment.

This chapter reports the findings of Study 2 which employs a case study approach to examine facilitators of and barriers to healthy ageing and the role of spirituality in healthy ageing among older Malays in Malaysia in more detail. Additional structured interviews were conducted individually with members of each focus group from Study 1. The results from selected health and well being measures were used to identify information-rich cases for in-depth analysis using integrated data from multiple sources. The cases were selected to demonstrate how the domains measured were congruent or not congruent with their self rated healthy ageing status and the role of spirituality in their healthy ageing experiences.

Study 2 addresses the following research questions:

1. What are the facilitators and barriers to healthy ageing in the selected information rich cases drawn from Study 1?

2. What is the role of spirituality in healthy ageing in the selected information rich cases drawn from Study 1?

The first section of this chapter (see Overview below) presents a synthesis of the qualitative results from Study 1 with the existing literature on selected factors associated with healthy ageing. The progression towards adopting case study research will be elaborated, followed by a description of the cases selected, concluding with a narrative presentation of the findings.

Overview

Healthy ageing was conceptualised by the older Malays in Study 1 to comprise six major themes, namely spirituality, peace of mind, health and physical function, financial independence, family, and living environment. This concept was broader than a biomedical definition of successful ageing which consists of the absence or avoidance of disease and its risk factors, maintenance of physical and cognitive functioning, and active engagement in life (Rowe & Kahn, 1996). Inclusion of peace of mind did support a psychological approach to healthy ageing, but the strong role of spirituality is not commonly seen in healthy ageing concepts in the research literature except as a minor topic in studies of lay perspectives (Bowling & Iliffe, 2005; Crowther et al., 2002; Hsu, 2007). Consistent with the data generated in the focus groups within Study 1, various personal expressions of spirituality were observed during the individual structured interviews and throughout the three months of data collection in the community. This observation supported the decision to employ a case study approach, and interpret findings from a combination of other sources and methods (Simons, 2009).

Spirituality

Spirituality was an important primary factor implicated in achieving healthy ageing outcomes among older Malays in Study 1. The ability to strengthen spirituality through continuous learning and other activities, to cope with the vicissitudes in life, and the peaceful acceptance of life and death were part of the findings relating to the participants' spiritual attributes. Spirituality has also been found to be a component vital to healthy ageing amongst older people in United Kingdom, Canada and Taiwan (Bowling and Dieppe, 2005; Hsu, 2007; Tate et al., 2004). However, the role of spirituality was not explored in detail in these studies. This could be due to cultural factors where spirituality was not viewed as central to healthy ageing.

Spirituality has been examined in many ways. Spirituality has been proposed as the 'forgotten' fourth dimension of Rowe and Kahn's model of successful ageing (Crowther et al., 2002) but its specific role in healthy ageing had been rarely reported (McCann Mortimer et al., 2008; Ng, 2009). The role of spirituality has been actively investigated in the area of chronic diseases, mental health, and end of life care, with increasing interest in examining its effect on subjective wellbeing (Bekelman et al., 2007; Koenig, 2012; Koenig et al., 2004; Lawler-Row & Elliot, 2009).

The inability to capture the generic construct for spirituality may explain some inconsistent findings in the literature. It is difficult to measure spirituality in people. Spirituality, which was measured using the Spiritual Perspective Scale in older adults in an Australian study, demonstrated no relationships with negative affect or depression and had a very weak effect on life satisfaction, meaningfulness and positive affect (added 2, 4, and 1 % to the variance respectively) (Teshuva et al.,

1997). This may be due to lack of a valid tool to measure all the aspects of spirituality. Current scales focus on the expression of spirituality according to religious behaviour. However, the depth of spirituality could be contributed to by many other factors such as personal views about the meaning of life, the relationship with God and other people.

The spiritual well-being scale used in the study by Lawler-Row and Elliot (2009) consisted of two subscales, which are existential well-being and religious well-being. Religious well-being is related to organised religion or practice, whereas existential well-being is not necessarily tied to organised religious practice. Existential well-being was reported as a strong predictor of psychological well being, subjective well being, physical symptoms and depression in older people in United States (Lawler-Row & Elliot, 2009). However religious well-being was not associated with the above aspects.

In Koenig et al.'s (2004) study, spirituality was measured using a self-rated spirituality scale (SRS), an observer-rated spirituality (ORS), as well as a daily spiritual experience scale (DSE). When spirituality and religiosity were measured separately, they were both found to predict greater social support, fewer depressive symptoms, better cognitive function, and greater cooperativeness among medically ill hospitalised older adults (Koenig et al., 2004). In particular, social support was consistently strongly linked to religion. Intrinsic religious motivation and daily spiritual experience were strongly correlated to social support (Koenig et al., 2004).

In Bekelman's study (2007) among older patients with heart failure, spiritual well being was assessed using the Functional Assessment of Chronic Illness Therapy - Spiritual Well-Being (FACIT-Sp) scale which consisted of two subscales; meaning/peace and faith. The meaning/peace subscale assessed sense of meaning, peace and harmony, and purpose in life. The faith subscale addressed faith, spiritual beliefs and how one finds solace in one's faith in relation to their chronic illness. Bekelman found that meaning/peace was strongly correlated with less depression (r= -0.60, p<0.0001), whereas faith was only moderately associated (r= -0.38, p<0.01). Although the overall spiritual well-being was found to be significantly associated with depression, multivariate analysis showed that only meaning/ peace subscale significantly contributed to this effect and accounted for7% of the variance in depression (Bekelman et al., 2007).

In conclusion, factors associated with spirituality were dependent upon the spirituality subscales used. This highlights the lack of a clear relationship between spirituality and other factors. Spirituality has been interpreted in many ways and these scales were mainly used in Western populations, which may not be culturally equivalent in Asian populations. Hence, there is a need to identify spirituality expression in other cultures in relation to healthy ageing concepts examined in Study 1.

Aim of Study 2

Study 2 aimed to further examine healthy ageing concepts, particularly the role of spirituality. In contrast with Study 1, which tapped into a more collective understanding of healthy ageing, Study 2 looked into individual and specific examples of older Malay experiences of healthy ageing.

Study 2 examined how the major themes identified in Study 1 both facilitate and hinders healthy ageing in selected individuals. In addition, the role and nature of spirituality is examined by asking the question, "Can spirituality explain participants' perceptions of healthy ageing or ageing well?" As there was no standardised acceptable lay term to describe "healthy ageing" in the community studied (see Chapter 3), the terms "good ageing" or "ageing well" were used to represent "healthy ageing" to the participants in this study.

A case study approach

Research inquiries need a deliberate decision to identify the most appropriate and feasible research method. Case study approaches were originally developed as a methodological evolution in educational evaluation programmes (Simons, 2009). Case study as a research method is used to contribute knowledge towards further understanding individuals, groups, organizations or social phenomena (Yin, 2009). It allows researchers to describe complex events or behaviours in a real-life context (Yin, 2009).

In order to further understand how older Malays expressed spirituality in relation to their healthy ageing, a case study approach was deemed the most suitable approach. This approach enabled me to examine the experiences of healthy ageing, including spirituality, at an individual level, using various data sources. In-depth exploration at an individual level allowed better understanding of the spirituality concept in healthy ageing.

As mentioned in Chapter 3, a case study can refer to either the process of analysis or the product of analysis or both (Patton, 2002). In this thesis, the case study involves both. The process of analysis occurs as a continuous interpretation of the expression of healthy ageing and the role of spirituality during the focus group discussions, individual structured interviews, and direct observation while in the field either during the interview or as part of interaction in the community studied.

The product of analysis involves data integration from the focus groups (Study 1) and other methods. The study of cases has been described in many ways and not solely as a qualitative method (Simons, 2009; Stake, 2005). In this case study, the results of a structured interview were tabulated to identify suitable cases for further analysis. The integration of quantitative and qualitative data supports the complementary role of each method; and acknowledges the importance of appropriate selection of methods in order to optimise understanding of the research inquiry (Stake, 2005).

Study 2 uses multiple case study design to investigate healthy ageing at an individual level. The evidence from multiple case study design is more compelling, more robust and allows application of replication logic (Yin, 2009).

Methods

Recruitment

Study 1 focus group participants were invited to take part in a further structured individual interview. After the focus group sessions, they were invited for a follow up individual interview and provided with Explanatory Statement for the individual interview (Appendix 5A and 5B). Participants who agreed to the individual interview

were requested to suggest a suitable time, date and venue for the interview. For those who declined, reasons for refusal were sought and they were informed that if at any time they changed their mind, they could always contact me.

Data collection

As described earlier, Study 2 uses data from a follow up structured interview of focus group participants, complemented by direct observation and comprehensive field notes. The aims of the structured interviews were to identify suitable cases for further exploration of healthy ageing concepts identified in Study 1, particularly the role of spirituality in healthy ageing, which emerged as a major theme from Study 1.

A follow up quantitative structured interview was conducted with 23 of the 38 focus groups participants. The characteristics of the 15 participants who did not take part in the follow up interview are described in Chapter 5, and analysed to identify whether the Study 2 sample was representative of the Study 1 sample.

> *I conducted face-to-face interviews using a structured questionnaire which included self rated healthy ageing status and a number of health related domains including functional status, self rated health, mental health, social interaction and spiritual activities (More details about the questionnaire content are provided below).* ***The purpose of this data collection method was not to use the data to conduct quantitative analyses of the responses but to use the responses and the participant's understanding of their responses to select case studies for further analysis.***

Most of the interviews were conducted at the participants' houses which gave me the opportunity for direct observation of the setting and context in their own environment by which the participants described their healthy ageing perspectives.

Prior to the interview day, I read through the transcript and/or the audio-taped focus group session involving the participants to identify any contents or issues which need further clarification. Before the interview, the major contents of the explanatory statement were clarified; in particular about the study, its objectives, the voluntary nature of their participation, and reassurance of confidentiality. Those who agreed to be interviewed were provided with consent forms to sign (Appendix 5C and 5D).

Twenty three of the original 38 participants were interviewed. Characteristics of both the participants involved and not involved in the individual structured interviews are tabulated in Table 5.1. Fifteen participants did not participate in the individual interview. There were no significant demographic differences between those who participated and those who did not, in term of gender, mean age and income (p>0.05).

Table 5.1.

Characteristics of Study 1 focus group (FG) participants according to their involvement in structured interview

Participation in structured interview	Participated (n=23)	Did not participate (n=15)	p
Gender : Male	11	7	> 0.05
: Female	12	8	
Mean age (years$\pm$SD)	68.0$\pm$8.7	70.7$\pm$7.5	> 0.05
Income range (RM)	200-5000	20-4000	
Mean income$\pm$SD	1465.2$\pm$1337.4	1444.0$\pm$1051.9	> 0.05
Focus group membership			
FG 1 (Traditional Malay village)	1	1	
FG 2 (Faith based group)	5	1	
FG 3 (Senior citizen association)	5	1	
FG 4 (Community group)	0	4	
FG 5 (Low education)	4	1	
FG 6 (Faith based group)	2	4	
FG 7 (Senior citizen association)	6	0	
FG 8 (Medium education)	0	3	
Total	*23*	*15*	

 None of the participants in focus groups 4 and 8 were involved in the individual interview. During the focus group session, they were very open and active in expressing their different views. Generally, they were not keen to take part in an individual structured interview, having preferred the free flowing discussion in the group interview. The feeling that they had expressed all their views during the group discussion constituted the main reason for not participating in the individual interview (n=10). The remaining five participants were not at home (out of the state or the country) due to health or family reasons.

Ethics

Ethics approval for the individual interview was received on 27 March 2009 from the Monash University Standing Committee on Ethics (refer Appendix 5E).

The interview and observation

This study involved face-to-face interviews using a structured questionnaire followed by in depth exploration according to participants' responses and related data from the focus groups.

About ninety minutes was allocated to explore each participant's perspective. Data from these individual interviews, as well as their responses during the focus groups, and field notes were used as data sources. Direct observation of the setting provided confirmatory data, as participant behaviour and their living environment can serve as additional sources of evidence (Merriam, 2002; Yin, 2009). For example, during a focus group interview, one participant expressed the difficulty she faced in taking care of her small grandchild. This was confirmed by observation during the individual

interview in her house. The observations were easier to standardise as I was the sole interviewer in the study.

The structured questionnaire (Appendix 5F and 5G)

There were two sections in the structured questionnaire. The first section consisted of background information and the second section addressed the healthy ageing domains in turn.

The questionnaire was constructed using existing surveys that reflected the key healthy ageing themes identified in the focus groups. Major studies on healthy ageing and related concepts were reviewed to identify relevant individual scales for each domain (See Table 5.2).

The structured questionnaire consisted of:

- Background demographic data

- Self assessment of health and healthy ageing status

- Assessment of functional status using IADL and ADL (Fillenbaum, 1985; Lawton & Brody, 1969)

- Assessment of emotional status using Geriatric Depression Scale (GDS) (Sheikh & Yesavage, 1986).

- Assessment of social support and interaction using Duke Social Support and Interaction (DSSI) short version (Koenig et al., 1993)

- Assessment of spiritual practice and attitude using Spiritual Perspective Scale (Reed, 1986) with minor modifications to suit the local practice.

Self-rated healthy ageing (SRHA)

Self-rated healthy ageing was an important measure used to identify appropriate cases for analysis. An overall measure of healthy ageing was assessed using the self-rated healthy/ successful ageing item, "In general, would you say you are ageing successfully (or ageing well)?" (Strawbridge et al., 2002) The Malay translation used was *"Secara keseluruhannya, adakah anda merasakan anda melalui alam penuaan dengan baik/ sejahtera?"* The response options provided were 'strongly agree', 'somewhat agree', 'somewhat disagree' and 'strongly disagree'.

As described earlier, good ageing or ageing well was the term used in this study to describe healthy ageing as there was no standardised acceptable lay term to describe healthy or successful ageing in the community studied (see Chapter 3). Participants were then invited to elaborate their reasons for the selected option.

The following sections correspond to domains measured in the structured interview and the items and/or scales used are described in turn:

Financial satisfaction

Participants were first asked to estimate their monthly income both for themselves and for his/her spouse. This was followed by the statement 'thinking about your money situation, would you say': and participant was given three options of responses, i.e.

- I cannot make ends meet

- I have just enough to get along on

- I am comfortable

Table 5.2.

Healthy ageing domains and respective measures used

THEME	DOMAIN	MEASURE
Financial	Financial satisfaction	Monthly income
		Financial satisfaction
Living environment	Living environment	House ownership
		Living arrangement
Physical health and functional status	Health	Self rated and self report illness
	Health behavior	Smoking
		Physical activity
		Alcohol intake
	Functional status	OARS PADL and IADL (Fillenbaum, 1975; Lawton & Brody, 1969)
Peace of Mind	Psychological wellbeing	GDS 15 (Sheikh & Yesavage, 1986)
Family	Social Support	DSSI short version (Koenig et al., 1993)
	Social Interaction	
Spirituality	Spiritual Attitude	Modified SPS (Reed, 1986)
	Spiritual Practice	

Living arrangement and house ownership

This information was gathered as part of the background data. Housing status was assessed with three options: 'your own house', 'rental house', and 'other (specify)'. Further information was gathered about the total number of household members and who usually lives with the participants. This variable was useful in directing further conversation to explore facilitators and barriers to healthy ageing in the individual interview. At the same time, this knowledge was helpful to explore any social or spiritually related issue, such as their relationship with the household members.

Physical Health and functional status

The key data used for the physical health and functional status were self-rated health (SRH) and personal and instrumental activities for daily living (PADL and IADL). The other data were collected to assist in understanding the individual in terms of their health perspectives, medical conditions and health behaviours, which may relate to their healthy ageing.

Physical health

Self rated health and comparative health,

- Self-rated health as in SF36, "How would you rate your present state of health?" The options given are 'excellent', 'very good', 'good', 'fair' and 'poor'.

- Self comparative health using a statement, "How would you rate your health compared to the past 1 year?"

- Relative health using a statement, "How would you rate your health compared to the other people of your age?" For (b) and (c), the options are 'better', 'about the same' and 'worse'.

Medical history, (regular) medications history, previous hospitalisation and number of clinic visits for the past one year. The information was gathered directly from the participant.

Health behaviours

Health behaviours assessed were smoking status, alcohol intake and physical exercise. These information serve as background data in exploring the individual during the interview and were not used for case selection.

Functional status

Functional status was assessed using personal activities of daily living (PADL) and instrumental activities of daily living (IADL) scales from the Older Americans Resources and Services (OARS) ADL instrument (Lawton & Brody, 1969; Lawton, 1971).

Both scales are valid and reliable (Fillenbaum, 1985). A study conducted on 30 community residents comparing item-based summary ratings with physical therapist personal observations in assessing their ADL demonstrated good agreement (Kendall's tau =0.83, Spearman's correlation of 0.89, $p < 0.001$). Five-week test-retest reliability was conducted among the residents demonstrated good reliability (Pearson r = 0.71 for IADL, 0.82 for PADL). One study showed an inverse relationship between IADL with survival rate which provides some evidence for the predictive validity of the scale describes as 'death rate tended to decline as performance capability increased', however r value was not included in the report (Fillenbaum, 1985, p.704).

The OARS IADL was developed following a series of adaptations to Lawton and Brody's IADL measure (Lawton & Brody, 1969). It consists of seven items namely telephone use, travel, shopping, meal preparation, housework, taking one's own medication and handling personal finances. OARS IADL was more user friendly compared to Lawton and Brody IADL scale as there was a consistency in the performance level assessed. The responses were divided into three-levels: (1) whether

the task can be performed unaided or (2) whether the person needed some help with the task or (3) the task cannot be performed at all. Another advantage in OARS IADL was that all items were validated for use with both men and women, however the scale may need some modifications to for use in specific cultures (Fillenbaum, 1985). For this study, IADL was assessed using the seven items in OARS IADL and one additional item on the ability to climb up and down stairs as this was important functional activity usually performed in Malaysia. A maximum score of 16 indicates full independence in performing all eight instrumental activities.

Physical activities of daily living (PADL) included seven items whether one can feed oneself, dress, groom, walk, get in and out of bed, and to take bath. For each task, the available options are 'without help', 'with some help', and 'totally unable' with the score of 2, 1, and 0 respectively. A maximum score of 14 indicates full independence in performing all seven physical activities in daily living.

Psychological well being

Although the GDS was not developed to provide a direct measure of psychological wellbeing, there were a number of desirable characteristics of items from this scale for the purposes of the current study. For example, it has been argued that psychological well-being reflects aspects of both positive and negative affect (Ranzijn & Luszcz, 2000), and the GDS includes both types of items in its scale. For example, the GDS includes items asking about feeling wonderful to be alive, being in good spirits, happy, and full of energy. These items closely represent positive affect and also share overlap with constructs such as life satisfaction. In contrast, negative affect is also represented in the GDS in items about feeling that life is empty, being afraid of

something bad happening, feeling hopeless, helpless, or worthless, and that other people are better off. As such, the scale has specific coverage of constructs including happiness, feeling that there is nothing to worry about, and feeling free from fear and grief, all of which were related to peace of mind as uncovered in the focus groups from Study 1.

GDS-15 is valid and reliable instrument to screen for depression in the older population (Sheikh & Yesavage, 1986). GDS-15 was selected for its brevity and ease of administration. The 15 items consisted of ten items with 'Yes' answers suggestive of depressive symptoms and five items (item 1, 5, 7, 11, and 13) with 'No' answer to suggest depressive symptoms. The total scores range from 0 to 15, the higher the score indicates more depressive symptoms. The cut off point to suggest possible depression was a score above 4 (Almeida & Almeida, 1999).

In Study 2, GDS score variability was used in determining the selection of cases. The participants' perception of self rated healthy ageing was assessed to look at its incongruence with high, low or borderline scores in GDS. The interview then further explores the individual's perception to describe the inconsistency.

Social support and interaction

The abbreviated 11- item Duke Social Support Index (DSSI) was used in this study to assess the social interaction and subjective support among the participants. The 11-item abbreviated DSSI consisted of a 4-item social interaction subscale and a 7-item subjective support subscale (Koenig et al., 1993). This scale demonstrated strong evidence for concurrent and construct validity in community dwelling older people. It

has good internal consistency and reliability with Cronbach alpha of 0.77 and test-retest reliability ranged from 0.70-0.81 (Goodger, Byles, Higganbotham & Gita, 1999).

DSSI's total score ranges from 11 to 33 with increasing score indicates higher levels of support (Goodger et al., 1999). DSSI allows the use of total score and two subscale scores (Koenig et al., 1993). In the 7-item subjective support sub scale the options provided were' most of the time', 'some of the time' and 'hardly ever' were scored as 3, 2, and 1, respectively. In the 4-item social interaction subscale, the responses were divided into three groups of 0 to1, 2 to 3, and 4 or above, which were scored as 1, 2 and 3, respectively.

The two subscale scores were calculated to trigger further discussion for participants in Study 2, particularly to explore any inconsistency between their SRHA status and DSSI score. In DSSI, if respondents indicate different responses for family members and friends, the best response should reflect the most support perceived. Hence, in Study 2 the responses in both subscales were then further clarified to differentiate their social interaction and support within the family and with their other social network.

Spiritual attitude and practice scale

It was a challenge to identify suitable instruments to measure spirituality. Spirituality and peace of mind are broad constructs, which require extensive measurement tools. However, I was cognisant at the same time that the instruments should not overly exert participants. Thus, a compromise was made between ensuring the chosen instruments were feasible and user friendly, and also adequately captured participants'

own interpretation of the constructs. The spiritual Perspective Scale (SPS) was used to measure individuals' perspectives of spirituality in their lives and their involvement in spiritually-related interactions (Reed, 1986). The 10-item SPS demonstrated acceptable reliability and validity in research involving terminally ill and healthy adults (Reed, 1986).

Many spirituality or religiosity questionnaires were developed to suit Western countries or to address certain religious group. The advantage of SPS was its suitability to be used by any person, as the interpretation of spirituality was open to an individual's personal understanding (Reed, 1986). As many older people in Malaysia received very limited formal education, simplicity and brevity in the chosen questionnaire was thought to facilitate better responses to the questions. The SPS used in this study consisted of five questions for spiritually related activities and six items relating to spiritual attitude. Each question concerning spiritually related activities had six options except the fifth question. Minor modifications to SPS, as detailed below, for this study were done to suit the local culture. In SPS, originally there were four questions related to spiritual activities. The first two questions addressed their interaction with family members or other people in talking about spirituality where as the residual questions assessed their personal spiritual quest via reading and meditation. Despite little formal educational exposure, some older Malays were able to read the Quran in its Arabic language even though they do not fully understood the detailed meanings. Other than reading this spiritually-related material, many older Malays said they listened, watched or attended spiritually-related programs to enhance their spiritual understanding. Hence, an additional and relevant fourth question was included as follows:

How often do you take part in religious or spiritually related activities?

(for example, listening to radio or recorded program, watching television or video, and attending religious classes/activities)

- *Not at all*
- *About once a year*
- *About once a month*
- *About once a week*
- *About once a day*
- *More than once a day*

An additional option was added for question number five, 'How often do you pray or meditate privately?' Muslims are expected to perform five daily obligatory prayers. The first six options were maintained similar to the original questionnaire (as above), however the seventh option was added ('more than five times a day') to differentiate those doing extra prayers or meditation. The sixth option was maintained rather than being changed to five times a day, as a way to encourage participants' responses to be truthful. This question was not meant to assess participants' submission to the obligatory five daily prayers.

Selection of cases

The cases were not selected for generalisation or representativeness. Rather, the cases were chosen to explore individual variations in healthy ageing and to explicate the role of spirituality in healthy ageing. Maximum variation sampling was used to select individual cases for further examination (Patton, 2002).

This involved identifying cases which covered the whole spectrum of responses in relation to the phenomenon under investigation – in this instance, self-reported healthy ageing (SRHA). This selection was based on their response to the question:

'Do you agree that you are ageing well?'

The four options for responses include *'totally agree, somewhat agree, somewhat disagree and totally disagree'*.

Study 1 revealed that spirituality was important for ageing well. Therefore, the aim was to select individuals who perceived they are ageing well as well as those who think that they are not. In this way it may provide insight into the specific role of spirituality, and in particular whether spirituality might be able to explain why some individuals perceive themselves to be ageing well and others not.

Assessment of spiritual practice and attitude using the Spiritual Perspective Scale (Reed, 1986) was initially planned to differentiate participants' spirituality to further guide the selection of cases. Those with high spiritual scores were expected to demonstrate high spirituality, and those with low scores demonstrating low spirituality. A selection of both was anticipated in order to further interrogate whether spirituality could explain why participants perceived themselves to be ageing well or not. However, the spiritual attitude subscale was positively skewed and demonstrated a ceiling effect; hence it was not able to differentiate between the participants in terms of their spiritual attitude. The six statements to describe their spiritual attitude were all answered as 'Agree' or 'Strongly Agree' in the Likert scale giving a total score ranging from 24 to 30 for all participants.

Similarly for the spiritual activities subscale, for each question a score of 1 was given for first option *'Not at all'* and a score of 6 was given for the sixth option which was *'more than once a day'*. Thus the score could potentially range from 5 to 31.The score for spiritual activities for the participants in the structured interview ranged from 23 to

31. For question five, all participants chose either option six or seven. Those with lower total scores of 23 or 24 were mainly due to their inability to read, hence giving them 1 mark for the fourth question. Even for those who can read, the minimum score for any single question was 4. Similar to spiritual attitude, this subscale was unable to differentiate spiritually-related activities among the participants, hence was not used to guide selection of the potential cases to study. Due to this unexpected finding, the original plan for selection of the case studies was amended.

The data or observation from focus groups also informed the selection of cases, particularly by identifying those with limited involvement during the session or those with unexplored expression.

The construction of the cases

A case study can refer to either the process of analysis or the product of analysis or both (Patton, 2002, p.447). The unit of analysis defines the case; which allows other type of studies to be combined with case studies (Merriam, 2002). The unit of analysis in Study 2 Case Studies would be the participants' healthy ageing perspectives and individual expression of spirituality within the bio-psycho-social-spiritual framework. The case studies involved a continuous analytical process of the various sources of data collected including the focus group interviews.

The analytical strategies for the case studies involved the use of theoretical proposition as well as the use of qualitative and quantitative data (Yin, 2009). The facilitators of and barriers to healthy ageing in the cases were identified according to themes constructed in Study 1. The role of spirituality in healthy ageing involved my interpretation of the multiple data sources.

The advantage of doing all the interviews on my own was the consistency gained in observation and reflections, in addition to having the opportunity to get to know each individual participant. The individual interviews were not audio or video recorded which may have assisted participants to willingly express their feelings without inhibition.

Participants were also encouraged to give comments and explanations of their answers while responding to the domains in the questionnaire to assist my interpretation The questionnaire at times provided prompts for the participants to express their views, related to the three further issues that were then explored in the data of selected cases using the following questions:

1. What makes you think that you are or are not ageing healthily,

2. What are the facilitators or barriers to healthy ageing as you experience them?

3. How has spirituality affected your experience of ageing?

Despite the use of the structured questionnaire, the data gathered were not limited to quantitative information but allowed further understanding of each participant's views of healthy ageing and the factors that influenced it. The focus group data were also used to describe the facilitators of and barriers to healthy ageing.

I gained access to some important additional information from my observations, interactions with the participants and my reflections concerning each interview. These data were recorded as field notes. My role was not restricted to that of an interviewer; rather, I was the main instrument in data gathering and interpretation. Towards the end

of data collection, I had identified a number of cases to describe the individual variability in the conceptualisations of healthy ageing in the community studied.

Construction of case studies firstly involved collection of relevant information of the raw case data, followed by an optional step of condensation of the raw case data depending on the complexity of the data or the case (Patton, 2002). In Study 2 the collection and condensation of the raw data were done at the same time. The last step was to write a final case narrative 'presented in any context necessary to understand the case in all its uniqueness' (Patton, 2002, p.448).

Data analysis

Yin (2009) described four general analytical strategies for case studies, namely theoretical proposition, development of case description, use of qualitative and quantitative data, and examination of rival explanations.

The theoretical proposition that led to this study was the findings from Study 1; that spirituality, peace of mind, health and physical function, financial, family and living environment were key constructs in conceptualising healthy ageing in the community studied. In Study 2 the facilitators of and barriers to healthy ageing were constructed according to the theoretical framework using the multiple data sources from the focus groups and individual interviews.

This case study also used qualitative and quantitative data as described below:

1. Quantitative data (Table 5.3) - for each potential case, the structured interview datawere tabulated and classified using scores of physical function, psychological well being, financial satisfaction, spiritual perspective domains, self rated health and self rated healthy ageing. A higher physical function

(IADL and PADL) score is indicative of better functioning whereas a higher GDS score indicates a poorer psychological status. Financial satisfaction was categorised into "comfortable", "had just enough financial support" and "unable to make ends meet". Increasing score in DSSI indicates higher social support. A higher score on the Spiritual Perspective Scale (SPS) indicated higher spirituality.

Thirteen participants strongly agreed that they aged well and another eight participants somewhat agreed on the same element. Only two participants somewhat disagreed that they aged well. IADL scores ranged from 12 to 16 with 18 participants able to do all eight tasks independently. All participants are fully independent in all seven tasks in PADL. Self rated health ranged from fair to excellent with 13 participants reporting 'good' self rated health and seven participants reporting 'fair' self-rated health. In term of financial satisfaction, eight participants reported they were financially comfortable, eleven participants just had enough to get by, and four participants felt financially they could not make ends meet. Two participants scored 9 for GDS and were referred for further assessment for possible depression. All other participants scored 0 to 2 in GDS except one participant who scored 4. The DSSI score in the participants ranged from 20 to 33. The spirituality score demonstrated a ceiling effect and was not used in the selection of cases.

2. Qualitative data - Further strategies to identify the individual expressions of spirituality were applied by using qualitative data from the focus groups (Study 1) and, during the individual interview, by direct observation and the elicitation of open-ended qualitative responses by the participants. The

qualitative responses and observations were then reflected as a field note to guide analysis and interpretation of the case studied. The sole interviewer prepared the field notes and was fully responsible for interpretation of the comments and observation. However, the comments and observations were discussed beforehand with my supervisors and peers to inform the interpretation.

Table 5.3

Characteristics of participants in the structured interview

No.	Initial/age/ gender/ marital status	SRHA	SRH (IADL /16)	Financial satisfaction (monthly income)	Mental health (GDS/15)	Spiritual activities (Score/31)	Spiritual attitude (score/30)
1.	Lia/65/F/d	1	Good (15)	Comfortable (400)	1	28	30
2.	Anis/ 63/ F/ w	1	Good (15)	Comfortable (2000)	1	30	30
3.	Aki/ 74/ M/m	1	Good (16)	Just enough (1000)	0	25	30
4.	Az/ 67/ M/ m	1	Good (16)	Just enough (1000)	0	31	30
5.	Budi/ 95/ M/w	1	Good (16)	Comfortable (2000)	1	27	30
6.	Adi/ 68/ M/ m	1	Excellent (16)	Comfortable (1200)	4	27	30
7.	Mid/ 63/ M/ m	1	Fair (16)	Comfortable (1500)	2	23	30
8.	Idi/76/M/m	1	Excellent (16)	Just enough (900)	0	27	30
9.	Ros/63/F/w	1	Good (16)	Comfortable (3000)	1	26	30
10.	Sal/61/F/m	1	Good (16)	Just enough (2000)	0	31	26
11.	Ima/ 60/ F/ w	1	Good (16)	Just enough (800)	1	30	24
12.	Ida/ 62/ F/ m	1	Good (16)	Comfortable (900)	0	27	30
13.	Sam/87/M/w	1	Very good (16)	Just enough (500)	0	30	30

14.	Nori/72/F/w	2	Fair (12)	Not enough (200)	1	27	30
15.	Mat/62/M/m	2	Good (15)	Comfortable (5000)	1	27	24
16.	Seha/67/F/w	2	Fair (15)	Not enough (300)	9	23	30
17.	Atan/72/M/m	2	Good (16)	Just enough (1000)	0	27	30
18.	Aji/62/M/m	2	Good (16)	Just enough (4000)	0	27	30
19.	Din/65/M/m	2	Fair (16)	Just enough (900)	0	23	28
20.	Hani/60/F/m	2	Good (16)	Just enough (4000)	0	24	26
21.	Jan/63/F/s	2	Fair (16)	Not enough (300)	2	27	30
22.	Dewi/ 65/ F/ m	3	Fair (16)	Just enough (300)	2	23	30
23.	Tina/ 73/ F/ w	3	Fair (16)	Not enough (500)	9	23	30

Demographic data: M=male, F=female, m=married, w=widowed, d=divorced, s=single

SRHA *(Self rated healthy ageing):* 1= *strongly agree aged well,* 2= *somewhat agree aged well,* 3 = *somewhat disagree aged well,* 4 = *strongly disagree aged well*

SRH *(Self rated health): options provided were 'excellent', 'very good', 'good', 'fair', 'poor'.*

IADL *– ability to independently perform eight tasks, each task was given 2 marks if able to perform independently, 1 mark if need some help and 0 mark if completely unable to perform the task.*

Financial satisfaction: *options interpreted as 'comfortable',' just enough' and 'not enough'.*

GDS *(Geriatric Depression Scale): Cut off point more than 4 suggestive for possible depression and need further assessment.*

In chapter 4, Figure 4.2 illustrated how participants described their spiritual expression. Spirituality was described by their connectedness to God and relationship with others according to religious guidance. Their connectivity with God can be demonstrated as a direct relationship such as prayer, meditation, recitation of the holy

Quran and supplication. At the same time, spirituality was also expressed by developing mutual responsibility in their relationship with others, demonstrated in many ways such as their caring attitude, contribution in the community activities and developing healthy relationships with others. Participants' expression of mutual responsibility can be towards family and friends or more broadly to their neighbourhood and further extended to the wider community.

The following case studies attempted to identify facilitators of and barriers to healthy ageing with further exploration of the spiritual expression identified in chapter 4. During the individual interview, when participants were asked to elaborate about their spirituality, they mainly discussed their connectedness to God and their spiritual responsibilities toward others. In the case study, their connectivity to God was seen as their intrinsic spirituality (IS) and their relationship with others was seen as their extrinsic spirituality (ES). Their intrinsic spirituality was identified when the participants described how they felt connected to God or expressed their wish or needs how to better connected to God. Their extrinsic spirituality was identified when the participants described the state of their relationship with the other people and their expectations of the stated relationship.

The division of spirituality into intrinsic and extrinsic characteristics seems similar to intrinsic and extrinsic religious orientation introduced by Allport and Ross (1967). Allport and Ross (1967) described individuals with extrinsic religiosity as those who use religion as a means to achieve external benefits (such as personal, social or political goals) whereas those with intrinsic religiosity internalise religion as an end

and live with it as a major source of motivation. In this study, the division of intrinsic and extrinsic spirituality specifically focused on their connectedness to God (intrinsic) and with other human beings or creatures (extrinsic), without exploring the motives.

Participants who perceived themselves to be fulfilled both in terms of intrinsic and extrinsic spirituality were classified as spiritually contented. Some participants described unmet intrinsic or extrinsic spirituality. The data suggestive of spiritual expressions in the 23 participants and my interpretation of their spirituality following the individual interview is tabulated in Table 5.4

The cases are presented as narratives. Narrative is a type of discourse that draws together diverse events, happenings and actions of human lives into thematically unified goal-directed process (Polkinghorne, 1995). In narrative inquiry, stories are used to describe human action. Narrative is referred to any kind of prose text (the story) and the particular kind of configuration that generates a story (emplotment). As described by Chase (2005), 'a narrative may be oral or written and may be elicited or heard during fieldwork, an interview, or a naturally occurring conversation' (p. 652). A narrative may be a short topical story about a particular event and specific characters, or an extended story about a significant aspect of life such as schooling, working, during illness or a story of one's entire life from birth to present (Chase, 2005). In this Study 2, the selected case was presented as a short topical story to describe their perspectives on healthy ageing, the facilitators of and barriers to healthy ageing according to themes identified in Study 1, and the role of spirituality in healthy ageing.

Table 5.4.

Spirituality expression and spirituality interpretation of the 23 participants

No.	Initial/age/ gender/ focus group	Quotes from focus group	Spirituality interpretation
1.	Lia/65/F/6	'I initially just followed the others, really enjoyed it each time, friends brought me there [to the mosque], gradually I went to *surau*, mosque more frequent …then I decided to stay here [spiritual retreat]'	Spiritually contented
2.	Anis/ 63/ F/ 6	'…my children ask me to live with them, I don't want to, living alone here at J we can [concentrate to] do *ibadah*, but having grandchildren around, grandma I want that, grandma I want this, however, to be with grandchildren occasionally is acceptable.'	Spiritually contented
3.	Aki/ 74/ M/2	'For us, we regularly go to the mosque, I always live near to a mosque, but the neighbours, the people living in the surrounding area, wherever it is, there is always more people who do not go to the mosque, this is worrying… we can accept if their kids make noise, when we want to sleep, they work on their noisy bikes, that is still acceptable, but [the neighbours] not going to the mosque is a burden [for us]	IS met ES unmet
4.	Az/ 67/ M/ 2	'Eight [grandchildren], treated them better than my own children, I buy whatever they want...'<laugh>	Spiritually contented
5.	Budi/ 95/ M/ 1	'I am always happy now; I don't feel sad as I am seeing the children live peacefully, but if the children are in conflicts, it is hurtful. If it is peaceful, the husband and wife are not quarrelling, smiling, their children are doing well, we as older people we are happy too'	Spiritually contented
6.	Adi/ 68/ M/ 3	'…in the area where I lived, there are 16 houses in each lane, I have lived there for 30 years, only 3 people from one lane went to the mosque. Going back to religious faith, if the parents don't go to the mosque, what about their children?'	IS met ES unmet
7.	Mid/ 63/ M/ 3	'In my opinion, the mother was at fault, too protective, too much,[the child] slept until 12 noon and did not perform dawn prayer but the mother	IS met ES unmet

		defended her child'	
8.	Idi/76/M/3	The problems with the children nowadays are parents' fault. We were poor last time, now with better life, the children live in luxury, parents are not in good term,..it is the mother's fault, just follow whatever the children want…'	IS met ES unmet
9.	Ros/63/F/7	'Not for me, I am not going anywhere; I want to live in my own house 'til I am gone because I have made the preparation since I was much younger. I don't want to disturb my children. If God decides I am to fall ill, there will be a person to look after me, I am not going anywhere'	Spiritually contented
10.	Sal/61/F/7	'...as a Muslim, we are asked to remember death...' 'Sometimes I wonder, how long will I be with the grandchildren, will I be able to see them grow up, thinking of our age...'	Spiritually contented
11.	Ima/ 60/ F/ 7	'When we go out, we do not go off tangent. We go out to the mosque, reading and learning [Quran], learning about *'fardh ain'* [fundamental principles in Islam], that is it. We do not go somewhere else, such as to cinema, watching whatever things, no more'	Spiritually contented
12.	Ida/ 62/ F/ 7	'I do not have to prepare, I have many children and they give me [money]. The first time they gave, I told them, in the future when I live there [spiritual retreat], they have to pay the monthly fees, I am not going to cook, I want prepared food paid for me'	Spiritually contented
13.	Sam/87/M/2	'I have to find a way, I am so used to it, I always wake up at 3.30am.'	Spiritually contented
14.	Nori/72/F/5	'…for me, I don't have enough strength to go to the shop, so when they pass by, they will ask whether I want to buy anything'	Spiritually contented
15.	Mat/62/M/3	'If I can cover the five components of happiness as I described earlier, i.e. physical [health], social in term of family and friends, emotionally not stressed, spiritually well developed, that is the most secured. Financial is not as [important], there are times when we do not have enough money but not as stressful…'	IS met ES unmet
16.	Seha/67/F/5	'We supplicate to Allah after each prayer, (we) even wake up for *tahajud* [late night] prayer and continue with supplication, and it is really a test, to	IS met ES unmet

		test our patience…'	
17.	Atan/72/M/2	'…don't really need because we go to the mosque every day, in the mosque all are friends, friends are all those in the mosque'	Spiritually contented
18.	Aji/62/M/2	' Once we retired, we should strive to prepare for afterlife. So, one is health and another thing is faith… Health and strong religious faith, good health so you can do good deeds, strong faith motivates you to do that'	IS met ES unmet
19.	Din/65/M/3	I have 6 children, 5 of them are university graduates...since I separated with my wife, they never visited me, hardly…'	IS met ES unmet
20.	Hani/60/F/7	'…it is not that we just sit there and wait, we do other things too but we remember [death] more'	Spiritually contented
21.	Jan/63/F/5	'I use to share my feelings with those I cared for during their childhood, I am closed to them, have been looking after them since birth'	Spiritually contented
22.	Dewi/ 65/ F/ 7	'I am now at peace too, livings in my own house, not alone, nothing to worry. I am happy as he is at home too, we go out together, no problem, *Alhamdulillah [thanks to Allah]'*.	IS met (partly) ES unmet (partly)
23.	Tina/ 73/ F/ 5	'I wish for a house, my responsibility towards this grandson is not over yet, that is why I keep applying, what is going to happen to him once I am gone, he is 17 years old, …'	IS unmet ES unmet

The selected cases

The demographic characteristics of the selected cases are tabulated in Table 5.5. The

selected cases included two men and four women with age ranged from 65 to 87 years

old. Their demographic characteristics were fairly representative of the 23 interviewed

participants. The six cases were information-rich participants that could elucidate my

topic of interest to describe facilitators of and barriers to healthy ageing, specifically

the role of spirituality in healthy ageing

The first two cases (Adi and Sam) strongly agreed they aged well. Adi was selected as he scored 4 on the GDS, which warranted further exploration for possible psychological issues that might be incongruent to his perception of ageing well. Sam, the second case scored well in all sections except that financially he just had enough which can be a barrier or a neutral factor to age well. He was fairly quiet during the focus group but was very expressive during the individual interview.

The third and fourth cases (Nori and Seha) somewhat agreed they aged well despite a lowest IADL score (12) among all participants for Nori and high GDS score (9) which was suggestive of depression as well as lowest DSSI of 20 for Seha. Both cases were chosen to demonstrate how limitations in physical function, social support and poor psychological function seemed incongruent to support the perception of healthy ageing.

The last two cases (Dewi and Tina) somewhat disagreed that they aged well. Dewi had good GDS score of 2 and fairly good scores in other domains, yet perceived she somewhat not aged well. The last case (Tina) somewhat disagreed that she aged well, had poor financial satisfaction and had high GDS score (9).

Case 2 and 6 demonstrated that self rated healthy ageing statuses were congruent with the findings in most the other domains, whereas the other 4 cases demonstrated some unparallel findings to support their perception of healthy ageing status.

Table 5.5.

Characteristics of the selected cases

Pseudonym	Adi	Sam	Nori	Seha	Dewi	Tina
Characteristic	**Case 1**	**Case 2**	**Case 3**	**Case 4**	**Case 5**	**Case 6**
Gender	Male	Male	Female	Female	Female	Female
Age (years)	68	87	72	67	65	73
Years of education	16	4	4	1	5	3
Marital status	Married	Widowed	Widowed	Widowed	Married	Widowed
Income (RM/month)	1200	500	200	300	300	500
Number of children	3	13	1	5	9	8
Household number	7	5	2	13	2	4
Work status	Pensioner	Part time	Part time	Part time	Housewife	Full time
Housing status	Own	Rent	Rent	Rent	Own	Rent
SRHA	1	1	2	2	3	3
SRH	Excellent	Very good	Fair	Fair	Fair	Fair
IADL(0-16)	16	16	12	15	16	16
Financial satisfaction	1	2	3	3	2	3
GDS(0-15)	4	0	1	9	2	9
DSSI(11-33)	33	29	28	20	33	27
-Interaction(4-12)	11	8	7	4	11	10
-Support (7-21)	21	21	21	16	21	17

SRHA *(Self rated healthy ageing):   1= strongly agree aged well,   2= somewhat agree aged well, 3 = somewhat disagree aged well, 4 = strongly disagree aged well*

SRH *(Self rated health): options provided were 'excellent', 'very good', 'good', 'fair', 'poor'.*

IADL – *ability to independently perform eight tasks, each task was given 2 marks if able to perform independently, 1 mark if need some help and 0 mark if completely unable to perform the task.*

Financial satisfaction: 1=comfortable, 2=just enough, 3=not enough.

GDS *(Geriatric Depression Scale): Cut off point more than 4 suggestive for possible depression and need further assessment.*

DSSI – higher score indicates higher levels of social support

Case Study Reports

Case 1: Adi
Strongly <u>agrees</u> he is ageing well

BARRIERS TO HEALTHY AGEING	THEMES	FACILITATORS FOR HEALTHY AGEING
	Health	Physically independent
Feeling lonely at home Feels neglected	Peace of mind	Not depressed
Expect others to embrace his spiritual approach. (unfulfilled extrinsic spirituality)	Spirituality	Gain strength from prayers and other religious activities. (Fulfilled intrinsic spirituality)
Lack emotional support	Family	
	Financial	Comfortable
	Living environment	Living in his own house Near to mosque Freedom to attend activities

Figure 5.1. Facilitators of and barriers to healthy ageing in Case 1 (Adi)

Adi is a 68-year-old pensioner. He previously worked as a bank officer after completing his tertiary education. He is married and is blessed with two daughters and

a son. He lives in his own house in a suburban area with his wife, his unmarried son, his daughter, son-in-law and two grandchildren. Financially he is comfortable. He is actively involved in the community, which includes religious activities in his neighbourhood and senior citizen association. During my three months' interaction with the senior citizen association, he was very helpful, easy going and always willing to share his views. He perceived himself as ageing well as he is financially stable, physically healthy and socially active.

Adi, however, expressed his unhappy feeling towards his wife and family. He felt he was being neglected as she was busy attending to their grandchildren and entertaining their children. In his view, as the children are now working and able to financially support their mother, his role as provider of financial and other support seemed almost redundant. He felt his needs and contributions to the family were not being appreciated. He also attributed the lack of income following his retirement as a cause for the deterioration in his marital relationship:

> '…there is a big difference in the way of life for older people nowadays compared to last time, …retirement age can be very different, while working, it was a luxurious life, once retired, the income lessen, so is the love…less love due to reduced income. Last time, people had everlasting love, till death' (Adi, aged 68, group 3).

His faith in God seems to give him the strength to appreciate whatever he has in life. He repeatedly conveyed that he accepted his situation as being destined as a test by God. This attitude describes the concept of 'ridho' as discussed in the spirituality section in Chapter 4. At the same time he sought advice from friends and

professionals while quietly he prayed for a better relationship in his family life. He managed to keep himself busy by his active involvement in the senior citizen association, religious activities and working on his farm.

In terms of spirituality, he regularly attended the mosque for prayers and actively participated in many religious activities in the community. He felt he has given the best in his relationship with God. However, he shared his concerns about the people in his neighbourhood particularly the attitude of the younger generations and the role of parents in promoting spirituality as seen in the following quote:

> '…in the area where I lived, there are 16 houses in each lane, I have lived there for 30 years, only 3 people from one lane went to the mosque. Going back to religious faith, if the parents don't go to the mosque, what about their children?'(Adi, aged 68, group 3).

The quote conveys the value he places on spirituality in his life and in the community as a whole. He is adamant that parents should be the role model to incorporate appropriate spiritual practices in their offspring. This sentiment was also illustrated in another quote,

> '…young or old now we can't say anything to them, when I was small, if I am not back by *maghrib* (sunset prayer time) my dad will say, 'even chicken know to go back to their shed'. [Nowadays] a mum won't bother if the children don't come back for 2-3 days…number one, when there is a call for prayer, *Allahu Akbar, Allahu Akbar,* can see even those in 60's going to night market…' (Adi, man, aged 68, group 3).

It was seen here that Adi felt he had fulfilled his intrinsic spiritual needs by his active involvement in religious activities and having a strong faith in God. On the other hand he had a high expectation towards the other people in the community to embrace his spiritual approach. This unmet spiritual expectation might affect his relationship with others and can be seen as a barrier in ageing well. This was evidenced by his ongoing expression of dissatisfaction with others.

In conclusion, Adi is grateful to God for giving him good physical, financial and social connections for him to age well. Spiritually, he seemed to fulfil his intrinsic spirituality in connecting to God but had unmet spiritual expectation towards other people in the family and community. This unmet expectation in his external spirituality might affect his relationship with others and cause some psychological distress in him. Despite perceiving that he was ageing well, his spirituality appeared to act both as a facilitator and barrier to ageing well.

```
┌─────────────────────────────────┐
│         Case 2: Sam             │
│                                 │
│  Strongly agrees he is ageing well │
└─────────────────────────────────┘
```

BARRIERS TO HEALTHY AGEING	THEMES	FACILITATORS FOR HEALTHY AGEING
Musculoskeletal pain	Health	Physically independent
Lonely	Peace of mind	Not depressed
	Spirituality	Gain strength from prayers and other religious activities Easy going and celebrated his relationship with others. (Fulfilled intrinsic and extrinsic spirituality)
	Family	Emotional and physical support from his children/ family.
Have just enough	Financial	
No own house Extended family - lack of autonomy - lack of authority	Living environment	Near to mosque Freedom to attend activities

Figure 5.2. Facilitators of and barriers to healthy ageing in Case 2 (Sam)

Sam, 87 year-old, widowed for 5 years with 13 children. He had four years of primary

education. He is currently living in a 2-bedroom rental unit with his son, daughter-in-

law and two school going grandchildren. He considered himself as partly retired and was doing a cleaning job in the nearby mosque with RM500 monthly salary, which he considered just enough for his financial needs. Other than musculoskeletal pain, he had no chronic medical illnesses and was not on any regular medications. He was able to independently do all eight IADL tasks.

Psychologically he did not experience any depressive symptoms as seen in his GDS score of 0. Despite being in the low socioeconomic group and not owning a house, he was spiritually strong. He was well adapted to his life situation. He shared stories of how he survived the hardship during the Japanese invasion and was consequently very grateful with whatever he has in life now.

As he was living with his son's family, having his grandchildren around is a source of happiness for him, despite awareness of his need for companionship. His inner feeling of longing for companionship by a wife was expressed during the individual interview following the unanswered conversation in the earlier focus group (Study 1) as follows:

> F: ...How do you feel without the grandchildren around?
>
> Sam: It is a bit weird, so quiet.
>
> Azmi: How about without your wife around?
>
> Aji: If you have to choose, not having a wife or grandchildren with you?
>
> F: That's interesting, how is it? Is it a sensitive question?
>
> Sam: <laugh> Hey... I don't know what to say.

During the individual interview, he addressed the above issue by expressing his desire to find a wife as his companion; however with his current living arrangement, it was not feasible to have another member in the household. On the other hand, financially

he cannot afford to rent a unit on his own. At the same time he felt, emotionally he was been well supported by his children. Hence, he devoted his life by contributing his energy and time towards spiritually related activities. He was always the first to come to the mosque in the morning and among the last to go back in the evening. His devotion can be seen in the following conversation (in the focus group interview):

> F: Sam, talking about health and mobility, what would you do if you are not able to ride your bike to the mosque?
>
> Sam: I will ask my son to send me.
>
> Atan: Sam always comes to the mosque by 4 am.
>
> Aji: It is not easy to ask a son to send us that early morning.
>
> Sam: I have to find a way, I am so used to it, I always wake up at 3.30am.

Sam seemed spiritually contented. Sam trusted that his sons would always be ready to help him if needed. He calmly addressed potential difficulties and believed that he would always identify solutions. His commitment to prepare the prayer hall and its surrounding area in terms of cleanliness and related housekeeping issues for the five obligatory prayers kept him busy throughout the day. He did not talk much during the focus group session and tended to agree with the group members' opinion.

During the individual interview, he was calm, forthcoming, easily expressed his opinions, had nothing to complain about and maintained his agreement to the views exchanged in the group. He repeatedly expressed his gratitude to God for whatever he had now, which was not seen during the group session. He enjoyed his role in the mosque as he managed to contribute his energy and time to gain God's blessing. In

terms of relationship with others, he was happy with his family and his social connections. He felt his inner (intrinsic) spiritual needs and his spiritual expectation towards others (extrinsic) had been fulfilled.

In conclusion, despite some adversities, Sam is ageing well with strong spirituality and grateful of his current life situation as compared to the difficulties he has gone through in his younger days. He seemed spiritually contented in term of his connectivity with God and relationship with the others, which can be seen to facilitate healthy ageing.

Case 3: Seha
Somewhat <u>agrees</u> she is ageing well

BARRIERS TO HEALTHY AGEING	THEMES	FACILITATORS FOR HEALTHY AGEING
Chronic illness	Health	Physically independent
Depressed Lonely	Peace of mind	Multiple ways of coping.
Unmet spiritual expectation towards other people (Unfulfilled extrinsic spiritual)	Spirituality	Gain strength from prayers and other religious activities. (Fulfilled intrinsic spirituality)
Lack emotional support	Family	Some physical support
Cannot make ends meet	Financial	
No own house Extended family - lack of autonomy - lack of authority	Living environment	Near to mosque Freedom to attend activities Some freedom to meet friends

Figure 5.3. Facilitators of and barriers to healthy ageing in Case 3 (Seha)

Seha, a 67 year old woman, widowed for the past 30 years. She had five adult children. She lived in a rental unit with her extended family (sons, daughter in law and

her grandchildren). They were 13 household members cramped into the small 3-bedded unit attached to their food stall. She earned about RM300 per month by helping at her son's food stall; which was not enough to meet her financial needs. She underwent a thyroid operation many years ago and had regular follow-up at the nearest hospital (15 kilometres away) for thyroid replacement therapy. She considered herself as somewhat ageing well compared to other more unfortunate people as she was physically healthy; she still has family members around and she at least had a place to live.

Despite living with so many family members in the household, she felt lonely and cried a few times during the interview. Her GDS score of 9 was strongly suggestive of her having depression. As I urged her to get medical treatment from the nearby health centre, she shared her ways of coping with her depression. She used to go to the nearby mosque to attend the religious teaching session almost every week. She feels relaxed and peaceful by doing so, as listening to the contents of the teaching motivated her to move on with life. She never had any suicidal ideation as she was aware it is prohibited by the religion.

She also used to stroll around at the nearby garden as a relaxation method. She sometimes went out with her limited circle of friends on a public bus to the city. Being away from her place at times provided her the peace of mind from thinking about the problems in the family. There were times when she felt she would want to stay somewhere else, as expressed during the focus group:

'we just hope that they (the children) do not send us to live in the old folks
home but when we were so hurt, I sometimes feel like going to the old folks
home...'. (Seha, aged 67, group 5).

Despite her strong commitment to strengthen her connection to God, Seha shared her
concerns for the future of her next generation and her frustration of their inappropriate
behaviours as follows,

'One thing that makes me angry is a ringing phone while preparing for
maghrib (dusk) prayer. I always tell my grandchildren to switch off their
phone during this time, they can always use it after that' (Seha, aged 67, group
5).

As spirituality is an integral part in her life, she wished her grandchildren to be more
responsible in adopting spirituality in their life too. This unmet spiritual expectation in
her relationships with others was being counterbalanced by her fulfilled intrinsic
spirituality. She fulfilled her obligatory prayers, performed a lot of additional prayers
and supplications to strengthen her connectivity to God. Tired of preaching to them,
she never fails to pray for them as illustrated in the following comment:

'we supplicate to Allah after each prayer, (we) even wake up for tahajud
[optional late night] prayer and continue with supplication, and it is really a
test, to test our patience…' (Seha, aged 67, group 5).

Her determination and patience in facing the challenging issues in her family life were
being addressed by her full submission to God. However, despite her strength in
facing the test, her spiritual expectation towards others was a source of stress. Her

strong desire for others, especially her family members, to submit to her spiritual perspective further challenged their family relationships.

In sum, the difficult life situations experienced by Seha might contribute to her depression but she considered that she was somewhat ageing well compared to other less fortunate people. Despite the emotional pain, she faithfully depended on her strong spiritual determination and fulfilled her intrinsic spirituality in her connection with God. Her fulfilled intrinsic spirituality seemed to act as a facilitator for ageing well, and contributed to her perception that she was ageing well. On the other hand, she had some unmet spiritual expectations in her relationship with others which was possibly acting as a barrier and to some extent contributed to her psychological distress.

Case 4: Nori

Somewhat <u>agrees</u> she is ageing well

BARRIERS TO HEALTHY AGEING	THEMES	FACILITATORS FOR HEALTHY AGEING
Chronic illness Some limitations in IADL	Health	Physically independent
	Peace of mind	Not depressed
	Spirituality	Gain strength from prayers and other religious activities. Humble and celebrated her relationship with others. (Fulfilled intrinsic and extrinsic spirituality)
	Family	Good family support and relationship
Cannot make ends meet	Financial	Received some financial support from agency
No own house	Living environment	Supportive neighbourhood

Figure 5.4. Facilitators of and barriers to healthy ageing in Case 4 (Nori)

Nori is a 72 year old woman, widowed for the past 4 years. She lived in a rental unit with her only son who was doing odd jobs. Nori had hypertension with renal impairment which needed regular and frequent follow up once or twice a month. She was on six types of medications including for her lipid derangement. She frequently experienced musculoskeletal pain which limited her ability to use stairs. She scored 12 out of 16 for her IADL. She needed someone to help her get to the places out of walking distance, for her groceries shopping and paying her bills. Despite those limitations, she was somewhat agreed that she aged well as she perceived her situation was better compared to other less fortunate people.

For Nori, illness experiences seemed to strengthen her connection to God. Despite a wish not to have any illness, she expressed her gratitude to God as she had less number of illnesses compared to other people, as in following quote, '…if possible we do not want any kind of illnesses, thanks to Allah for what He has given, *Alhamdulillah* I have only this [illness]…' (Nori, woman, aged 72, group 5). She described her spiritual connectedness to God by frequently reading or reciting the verses from the Holy Quran, doing private prayers and meditations.

Nori is a very humble and a nice person to talk to that always makes others at comfort in relating to her. Despite her poor socio-economic status, she was grateful as she received some formal and informal assistance to manage her needs. She ran small business selling goodies at her house as her part time activity. She lived in a caring neighbourhood as described here, '…for me, I don't have enough strength to go to the shop, so when they pass by, they will ask whether I want to buy anything' (Nori, woman, aged 72, group 5).

She loved gardening to keep her physically fit and celebrated her relationship with others as seen in the following conversation in group 5,

> Nori: Next to my rental unit, there is a small piece of land; I plant tapioca, flowering plants, pandanus, all for our own use. At least I sweat a bit and if I feel tired or develop backache, I lie down to rest.
>
> Sara: Similar to me.
>
> Nori: My son and my neighbours scolded me for not taking a break. They said, I am old and just being discharged from hospital, I should get enough rest and do not be so active. They (neighbours) provided and cooked some food for me.

The supportive family and neighbourhood facilitated her to experience the peace of mind observed during the interview as well as her low GDS score of 1. Her fulfilled intrinsic spirituality in term of her connectedness to God and her extrinsic spirituality in term of her relationship with others facilitated her ageing experience despite some disadvantages in other domains. Her multiple medical problems, some limitations in her instrumental activities in daily living and poor economic status might be seen as barriers for Nori to age well. However, in her perspective, she seemed to overcome the barriers by taking a positive approach in comparing her situations with the less fortunate others, hence she somewhat agreed that she aged well.

In conclusion, illness and some functional limitations can be seen as barrier in an individual healthy ageing experience. However, positive attitude and spirituality might help older people to cope well with the illness and functional limitations. Spiritual

contentment, supportive family, having peace of mind and caring neighbourhood are facilitators that might outweigh the barriers to healthy ageing experienced in Nori.

| | Case 5: Dewi

Somewhat <u>disagrees</u> she is ageing well | |

BARRIERS TO HEALTHY AGEING	THEMES	FACILITATORS FOR HEALTHY AGEING
Chronic illness Some physical limitation	Health	
	Peace of mind	Not depressed Supportive husband
Unsupported intent to live in a spiritual retreat. Restricted time to attend religious classes. (Partly unfulfilled intrinsic and extrinsic spirituality)	Spirituality	Gain strength from prayers and other religious activities. (Partly fulfilled intrinsic spirituality).
Provided physical support by caring for her grandchild Husband's health deteriorates	Family	Supportive husband
Have just enough	Financial	
Restricted freedom	Living environment	Living in own house Near to activity centre

Figure 5.5. Facilitators of and barriers to healthy ageing in Case 5 (Dewi)

Dewi is a 65-year old housewife. She is actively involved in the senior citizen activities despite her multiple medical problems. She has asthma, hypertension and diabetes, and is on four medications. She is well supported by her husband, Halim, a 77-year old government pensioner who earns RM300 monthly, which they considered just enough for both of them. They live together in their own house. Halim would drive Dewi to the activity centre despite his deterioration in physical health. Halim has coronary artery disease and currently experiences recurrent chest discomfort even with minimal physical exertion. Both of them attended nearby government health clinics every 2 months but were not happy with services provided. Due to poorly controlled asthma, Dewi also sought treatment from a private clinic which drained out their financial resource.

Despite the difficulties, they were not depressed but regularly use positive thinking, prayers and supplication to cope. Their new responsibility of caring for their 16 months old grandchild while the parents were at work resulted in more restrictions in their outdoor involvement and drained their physical energy. During the interview, both of them were aware they were not physically fit to look after the baby due to their illnesses. The difficulties faced by older people taking care of their grandchild were discussed in her focus group (Study 1) as follows:

> Dewi: I cannot look after the grandchild, it is not suitable as we are not that capable. The child might just pick anything here and there, anything can happen, I am so worry, the child might fall, picking things...

> Ida: Yes...(we are) worried of choking

Dewi: Not that we are lazy...it is a difficult task to look after a small child

F: Any suggestion?

Ida: That is why we want to go to J (spiritual retreat), <laugh> cannot send in grandchildren. At this old age we do not have the strength to lift up a child; we just want to do our own activities.

Sal: Yes, we cannot look after them; I do not have enough strength to lift them up.

During the focus group session, Dewi was one of the participants who repeatedly expressed her intention to live in the spiritual retreat. Her intention was not well supported by her children. The following quote described her response when the group discussed about living in a spiritual retreat:

'That is it, I want to buy a unit there [by selling their current house]. My children were making noise about it [my intention]…' (Dewi, woman, aged 65, group 7).

The following quote, again, demonstrated her intention to fulfil her inner spiritual needs of living in a spiritual retreat to learn more about spirituality but the intention was not supported by her children:

'I want to buy a unit there but my children keep pestering me to hold on, again and again. It [the place] is not far, quite near. Not that I want to seclude myself there, I still care about their updates, I can come back during holidays or if there is a need. I want to go there to learn.' (Dewi, woman, aged 65, group 7).

She described her spiritual needs in strengthening her connection to God by learning as much from spiritual/religious teachings. She desired the freedom to attend spiritual learning sessions at any time. Hence, having to look after her grandchildren had restricted her freedom for doing so. Currently, her husband has been very supportive to keep her company, going out together and to learn together. During the focus group, she declared that her supportive husband as one of the reasons for her to feel peaceful, as seen in the following conversation:

> F: Dewi, do you think living in the spiritual retreat will bring you happiness/peaceful life?

> Dewi: I do not know, I have not being there yet. I am now at peace too, living in my own house, not alone, nothing to worry. I am happy as he is at home too, we go out together, no problem, *Alhamdulillah [thanks to Allah]'*.

Despite her feeling of peaceful life during the focus group, the deterioration in their physical function and exhaustion experienced in taking care of the grandchild changed her perception during the individual interview. Dewi somewhat disagreed that she was ageing well due to her limited physical health but psychologically she was not depressed. She was trying her best to join the senior citizen group exercises and other activities. The most important activity that Dewi would not want to miss was the weekly religious teaching session near to her house. She makes sure that her daughter comes back in time to fetch her granddaughter for her to attend the session.

Dewi, again, expressed her wish to sell her house and live in a spiritual retreat to strengthen her spiritual knowledge and practice without much family interruption to fulfil her intrinsic spirituality. At the same time, her expectations to gain

understanding and support from her children to fulfil her inner spiritual needs were still unmet.

In conclusion, deteriorated physical health and her limited ability to look after her small grandchild were the reasons for Dewi to consider that she was somewhat not ageing well. She, however, appreciated her life as peaceful by having her own house and supportive husband. Her priority in life was to gain as much religious knowledge and to strengthen her spirituality. Despite saying she was not ageing well, she demonstrated her strong spiritual determination by trying to attend scheduled religious classes. She had unfulfilled intrinsic spiritual needs to live in spiritual retreat. In terms of her relationship with others, despite getting consistent support from her husband, there were some unmet expectations in her relationship with her children. Thus it appears that the barriers in relation to spirituality outweigh its role in facilitating her to age well.

BARRIERS TO HEALTHY AGEING	THEMES	FACILITATORS FOR HEALTHY AGEING

Case 6: Tina

Somewhat <u>disagrees</u> she is ageing well

Chronic illness	Health	Physically independent
Depressed Lonely	Peace of mind	
Illiterate, hope to learn to read Quran but felt shy to learn at her age. Poor relationship with family members. (Unfulfilled intrinsic and extrinsic spirituality)	Spirituality	
Lack emotional support Limited financial support Limited physical support	Family	
Cannot make ends meet Have to work full time	Financial	Some support from agency
No own house No freedom to join activities	Living environment	Near to mosque

Figure 5.6. Facilitators of and barriers to healthy ageing in Case 6 (Tina)

Tina, a 73-year old woman, has been widowed for 7 years with 8 children. She is

illiterate and only had three years of primary education. She lived in a 2-bedroom rental flat with her 17-year old grandson and two other relatives. Her total monthly income was around RM500 made up of RM350 monthly assistance from religious agency and her full time work at her food stall. Financially, she cannot make ends meet with such income for her and her school going grandson. She had hypertension, hypercholestrolaemia, gastritis and gallstone and is on regular follow up from the nearby government clinic. She was able to independently do all eight IADL tasks. She somewhat disagreed she was ageing well.

Socially she was in a very disadvantageous situation with poor family support and financial strain as seen in the following quote,

> 'I have 10 children, 2 died and I am left with 8. They cannot even afford to support themselves, how are they going to support me? Occasionally they did give me some [money]' (Tina, woman, aged 73, group 5).

During the individual interview, she revealed her unhappiness related to her financial constraints and her poor relationship with her children. She claimed that all her children except one son, neglected her, but the caring son was not able to help her much as he has a big family to fend for. Her responsibility to her grandson had also contributed to her stress in handling family and financial issues as seen in the following quote:

> 'Three of my grandchildren left by their father, the mother then re-married and did not bother about them, I looked after them, two were done, both married, this [last] one causing me headache, "grandma give me money", each time asking for money…'(Tina, woman, aged 73, group 5).

She cannot afford to pay for her utility bills for many months and her monthly RM100 stall rental to the council had not been paid for the last nine months. She longed to get her own house from the government's housing project for the poor and this was intensely expressed during the focus group (Study 1) as follows,

> 'I wish for a house, my responsibility towards this grandson is not over yet, that is why I keep applying, what is going to happen to him once I am gone, he is 17 years old, …' (Tina, woman, aged 73, group 5).

Psychologically she was not at peace with a GDS score of 9 and during the individual interview she sadly expressed her unfulfilled spiritual needs to learn to read the Quran. Despite living very near to the mosque she claimed she was too busy mending her stall and she felt so shy to learn and read the Quran at 'this old age'. She described her spirituality by fulfilling her daily obligatory prayers but did not elaborate further about her connectedness to God. It seems that the daily obligatory prayers were part of rituals in her life instead of a way to describe her intrinsic spirituality.

In conclusion, Tina considered herself as not ageing well due to her multiple social, financial and psychological adversities. Despite the awareness of her intrinsic spiritual desire, she had difficulty in motivating herself to fulfil her spiritual needs. In terms of relationship with others, she described many unmet expectations. Her spiritual development was restricted by her attitude and social circumstances. There were so many barriers for her to age well and her restricted spirituality was part of them.

Discussion

The cases discussed were not selected for generalisation or representativeness. The cases were chosen to explore individual variations in healthy ageing, the barriers to

and facilitators of healthy ageing and the role of spirituality in healthy ageing. At an individual level, healthy ageing was not necessarily only achieved by those with 'perfect score' in each domain. The interaction and equilibrium of factors facilitating and hindering healthy ageing should be considered.

During focus groups sessions, spirituality was identified as an important facilitator for healthy ageing. The participants discussed how spirituality supported their life journey by giving them opportunities for lifelong learning, the use of prayer and supplication to cope with adversities in life, to enhance the sense of hope for them and their loved ones, to strengthen their level of acceptance in life and as preparation for a good death. Spirituality touched every aspect of their lives and was associated to each additional factor found to be integral for their healthy ageing.

Expressions of spiritual needs were discussed prolifically in the focus groups, particularly when their needs were seemingly fulfilled. However, unfulfilled spiritual needs that caused distress were more commonly spoken about during the individual interviews. The prolific expression of spirituality in the focus groups raises questions about the influence of other group members' values and ethics, commonly known as 'groupthink' (Turner & Pratkanis, 1998). Antecedent conditions hypothesised to lead to consensus-seeking characteristics include having a highly cohesive group, being insulated from experts, limited searching and appraisal of information, operating under directed leadership and experiencing conditions of high stress with low self-esteem (Turner & Pratkanis). Given that these were not prominent characteristics of the focus groups in this study, the likelihood that groupthink was responsible for the salience of spirituality is not great. Furthermore, spirituality was also a major and

spontaneous issue discussed during the individual interviews, where the potential for groupthink did not exist.

In the cases presented, there was strong evidence to indicate that older people thought and talked about spirituality. However, the intensity of spirituality discussion in their conversation varied. The expression could be centred towards inner individual needs such as to learn and read the holy Quran (Case 6 - Tina). Reading and understanding the holy Quran is one way to feel connected to God. Inability to read it can act as a barrier but the effort to learn and to understand it can be a rewarding experience in connecting to God. Her attitude of feeling ashamed to learn and to talk about her spiritual needs can act as another barrier in fulfilling her intrinsic spirituality. Her extrinsic spirituality clearly became the barrier for her due to many unsettled relationships issues in her life. Her perceptions that she somewhat disagreed that she aged well was consistent with her unfulfilled spiritual needs and her other disadvantages.

On the other hand, Dewi (Case 5) readily expressed her multiple spiritual needs and the challenges she had. She managed to get the opportunity to regularly attend religious classes but was affected by the need to balance her role to care for her grandchild and the freedom of attending the classes. Her wish to live in a spiritual retreat is expected to facilitate her connectedness to God but has been dampened by lack of support by her children. Dewi has fulfilled some of her intrinsic spirituality but still needs to overcome the barrier to fulfil it extrinsically.

In comparison, fulfilled intrinsic spirituality was seen in Adi, Sam, Seha and Nori; however this did not necessarily translate into peace of mind. Adi had a lot of

complaints in his relationship with others. He was not happy with his family members and had unmet expectations towards others to agree with his spiritual perspectives. Despite unfulfilled extrinsic spirituality, which posed a barrier to ageing well, Adi felt he aged well.

Seha had strong intrinsic spirituality evidenced by her frequent expression of her connectedness to God either by prayers, supplication, regular and continuous effort to attend religious classes and her ways of addressing tribulations as tests from God. She used spirituality to cope with her depression, however, she experienced stressful family relationship and part of it was due to her unfulfilled expectations of spiritual obligation within her family members. This resulted in a vicious cycle of psychological distress which has negative implications for the role of spirituality in facilitating healthy ageing.

Sam seemed to experience some dissatisfaction in terms of financial and companionship; however, spiritually he was contented in his connectedness to God and relationship with others. His adaptability and tolerance to changes seemed to be his strength. Whether this strength was a product of his life experiences or part of his spirituality, it deserves further exploration. Similarly, Nori had some health, physical function and financial disadvantages but was spiritually contented. Her humble ways of addressing challenges in life by strengthening her connectedness to God and celebrating her relationship with others resulted in peace of mind. Both Sam and Nori strengthened their spirituality to adapt well to the challenges in their life. This possibly explained the concept of 'ridho' described in the spirituality section in Chapter 4 and addressed as transcendent acceptance in Chapter 5.

Most of the spirituality issues addressed in Study 2 were related to these two domains of connectedness to God and relationship with others. It was consistent with an anthropological and philosophical stand that humans are 'intrinsically spiritual' and 'a notion of the human person as a being in relationship' (Sulmasy, 2002, p.25).

Spirituality plays an important role in the life of older Malays in Malaysia. In this study, there is evidence that spirituality is being used to cope with challenges in life, as part of continuous learning, as a way to devote their time with self fulfilling activities and to strengthen their life journey. The role of spirituality as a protective factor in healthy ageing might be seen in those who embrace its entirety. Spirituality is not just connectivity with God; it also incorporates the celebration of relationship with other creatures in appreciation of life.

Spirituality as a barrier to healthy ageing was also seen in the cases discussed. They were seen as unmet intrinsic spirituality in terms of connectivity with God and unfulfilled extrinsic spirituality in relation to expectations in their relationship with others. Spirituality might have a role as a protective factor for healthy ageing; however this role needs further evaluation in a larger study.

Earlier in chapter 4, a question arose about whether those in lower income strata attributed lower priority to spirituality/religion. Further exploration in Study 2 indicates that those individuals from a low income stratum do give high priority to spirituality (Table 5.3 and 5.4) as seen in Lia, Sam and Nori who are spiritually contented. For Seha and Dewi, despite some unhappiness in their life, they actively use spirituality to cope."

Identification of appropriate instruments to measure spirituality is another issue to be addressed before embarking on the further study of this area. Sulmasy (2002) suggested four categories in assessing spirituality and religion, namely religiosity, spiritual or religious coping and support, spiritual well-being as part of a dimension of quality of life, and spiritual needs. The lack of instruments to assess spiritual needs was mentioned.

Hermann (2007) used a newly developed instrument, the Spiritual Needs Inventory (SNI) among hospice patients to distinguish between met and unmet spiritual needs. The need to pray was met by 96% participants. Five needs perceived as met by 80% or more participants were to sing or listen to music, use inspirational materials, talk about day-to-day things, see the smiles of others and use phrases from a religious text. The least met spiritual need was to go to religious service which was only perceived as met by 30% of the participants. The next four perceived needs met by 64 to 65% of participants were the need to laugh, read a religious text, be with family and be with friends. Socioeconomic status (basic financial needs met or unmet) did not affect spiritual needs. Women, those with lower educational status and residing in nursing homes or inpatient hospice units reported higher unmet spiritual needs. It was concluded that assessment of spiritual needs is important and should be individualised to address variable needs. While the SNI may have been useful in this specific context, the applicability of the checklist could be limited in its ability to capture the range of individual variability in spiritual needs.

The identification of the role of spirituality as a barrier and/or a facilitator in addressing healthy ageing and as an expansion of spirituality expression was

presented in Chapter 4. The model was described and explained in Chapter 4. The model is further expanded as seen in Figure 5.7 with four windows of spirituality expressions. The two extreme categories were those that fulfilled both intrinsic spirituality in terms of connectedness to God and extrinsic spirituality linked to their relationship with others (spiritually contented) and the other category of those unable to fulfil both. The other two categories were those fulfilled either intrinsic or extrinsic spirituality only. This categorisation is not meant as a discrete group, it can also be described in continuity as seen in Dewi and Tina. Despite being in the same group, Dewi was obviously in a better spiritual situation as she had fulfilled some of her intrinsic spirituality compared to Tina.

In the cases described, there was no example of a situation where extrinsic spirituality was fulfilled, but intrinsic spirituality unfulfilled. Reflecting on the 23 participants in the individual interviews, it even seemed that the spiritual priority among the participants was towards connectivity to God. This might be explained by their religious faith to believe in God. In my postulation, in the situation where spirituality was expressed mainly by relationship with others, fulfilled extrinsic spirituality alone might be identified.

A pattern seen in the cases was for those strongly agreed or somewhat disagreed that they aged well; they seemed to have at least fulfilled their intrinsic spirituality (i.e. perceived good connectivity to God). This pattern was also observed in the other 21 participants involved in the individual interviews who perceived that they aged well.
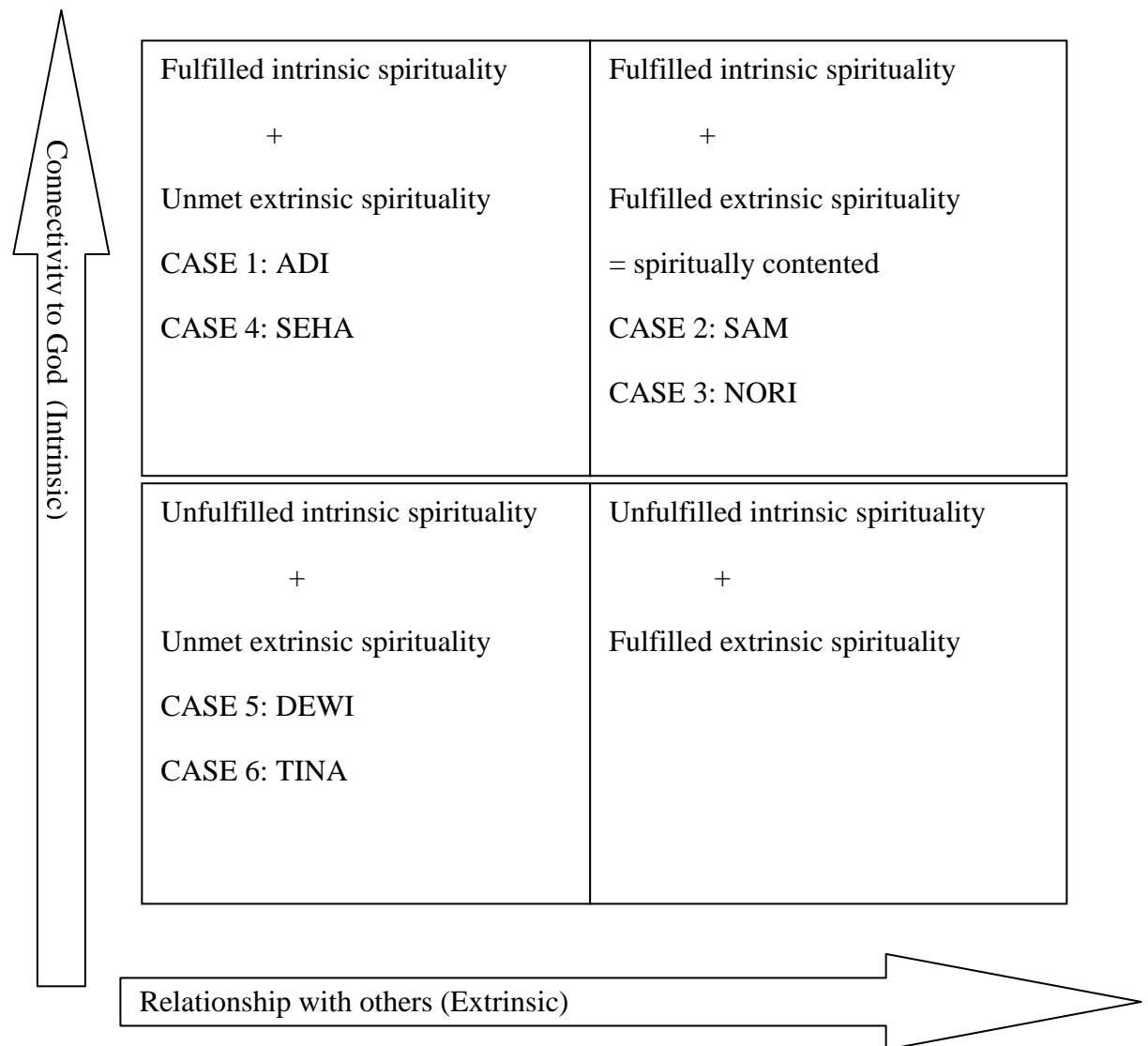
Figure 5.7. Windows of spiritual expression

On the other hand, both cases that somewhat disagreed that they aged well demonstrated both unfulfilled intrinsic and extrinsic spirituality. Specifically the following questions need to be addressed: Is fulfilled intrinsic spirituality associated with greater perceptions of ageing well? Are both unfulfilled intrinsic and extrinsic spirituality associated with poorer perceptions of ageing well?

Conclusion

Study 2 has explored the facilitators of and barriers to healthy ageing in relation to the six main themes identified in Study 1. It also addressed the specific question, 'can spirituality explain participants' perception of healthy ageing or ageing well?' The participants did not directly imply that spirituality affected their perception of healthy ageing but they shared the impact of spirituality in their lives. Spirituality can facilitate their perception of ageing well particularly by the fulfilment of their connectedness to God as well as their relationship with others. At the same time unfulfilled spiritual needs in their connectedness to God and in their relationship with others can be a barrier for them in ageing well.

In the evaluation of methods used in this thesis, the advantage of a focus group approach to allow free flow discussion was observed. The focus group interview managed to identify the healthy ageing conceptualisation in the community studied. At the same time, having identified the domains of the healthy ageing concept, the individual interviews managed to address some of the areas which the participants might not feel so comfortable in discussing in a group, such as unfulfilled spiritual needs.

In sum, spirituality can serve as both a facilitator and a barrier in addressing healthy ageing in the population studied. There is a need for more studies to investigate the role of spirituality in healthy ageing and to address spiritual needs in older people in this community. At the same time, service providers and policy makers should consider inclusion of spirituality in identifying and addressing multiple issues in the older people.

Chapter 6

Discussion and Conclusion

This chapter discusses the integration, meaning and implications of the findings from Studies 1 and 2. The first section revisits the justification, research questions, methods and key findings of this thesis. The following section aligns the findings with the available literature. The next section discusses the strengths and limitations of the thesis, followed by its implications for future research and discussion of the application of the thesis findings to the development of services for older people in Malaysia, particularly in clinical practice and policy development. The last section provides a summary of the chapter and conclusion to the thesis.

Revisiting the justification, research questions and methodology

Healthy ageing concepts have been mainly defined by researchers and policy makers. In Malaysia, the multidimensional concept of healthy ageing is under researched. Specifically, there is no reported study that explores the perspectives of older people in Malaysia in addressing healthy ageing. Hence, this thesis aims to explore healthy ageing conceptualisations and its related concepts amongst older Malays in Malaysia. The cultural values explored in this thesis are expected to provide an avenue to expand the guiding concepts and principles in service provision for older people; to make them relevant to the local context in Malaysia.

This thesis addresses the following research question, what is healthy ageing from the perspective of older Malays? Specifically, the research question is divided into two parts:

1. What factors are important in conceptualising healthy ageing from the perspective of older Malays and how are the factors being expressed?

2. What are the barriers to and facilitators of healthy ageing in the community studied?

This thesis uses focus groups followed by case studies to answer the above research questions. The first study, Study 1, was the major part of this thesis that investigated healthy ageing perspectives of older Malays in Malaysia via focus group interviews. The second part of the study, Study 2, involved individual case studies selected using self rated healthy ageing status, to further examine the facilitators of and barriers to healthy ageing according to the themes identified in Study 1, particularly the role of spirituality, a key theme emerging from Study 1. The cases were used to construct the individual perspectives of healthy ageing using converging data from a structured interview and open ended qualitative responses, focus group interviews (Study 1), and observations and reflections of the interaction with the participants throughout the study period.

Research aims and findings

The broad aims of the thesis were to:

- examine conceptualisations of healthy ageing in older Malays living in Malaysia,

- identify facilitators of and barriers to healthy ageing in older Malays living in Malaysia, and

- translate the thesis findings into recommendations for service design for older Malays living in Malaysia.

This thesis addressed the aims and answered the research questions. In Study 1, six interconnected themes captured healthy ageing concepts from the perspectives of older Malays in this study. Firstly, spirituality was the driving force followed by peace of mind as the ultimate aim for healthy ageing in late life. Physical health and function, family, financial independence, and living environment were further key themes that greatly affected the ability of older Malays to achieve healthy ageing in this study.

In Study 2, facilitators of and barriers to healthy ageing were further explored according to the six themes identified in Study 1, with specific attention to the role of spirituality in healthy ageing. The individual cases demonstrated that their healthy ageing perceptions involved the dynamic process of adaptation, prioritisation and self transcendence in balancing the barriers and facilitators for healthy ageing which was unique for each individual and cultural context.

The following section discusses the summary of the main findings from both studies.

Seven key findings

1. *Older Malays uphold spirituality as a driving force to achieve healthy ageing.*

In Study 1, spirituality was particularly discussed in terms of continuous religious learning, prayer and supplication and a quest for the highest level of acceptance in their connection to God. Continuous religious learning was seen as part of their way

of life particularly at older age, as a way to serve their purpose in life and as a means to intensify their preparation to accept death and afterlife. Prayers and supplications were regularly practiced to express their hopes and to cope with challenges in life. Prayers and supplications were used to express their desire for their own well being and that of others. Spirituality was also described as their quest to achieve the highest level of acceptance in their connection with God, hence preparing them for a peaceful end of life journey.

In the community studied spirituality was intricately connected in some way to each of the other themes. Hence, spirituality was not restricted to their connectivity to God; it involved their relationship with others. Spirituality and spiritual activities seemed to be intricately connected to their relationship with their family members. The older Malays regarded that they have continuous spiritual and even material responsibilities towards their family members. Despite feeling less responsible for their adult children, they continuously supplicated for the happiness and well being of their descendants. A good relationship with neighbours was an integral part of the Islamic teaching, hence receiving and giving assistance among neighbours has a spiritual implication.

These two main domains in spirituality were more prominent in Study 2 where the role of spirituality in healthy ageing was further explored in the selected cases. Spirituality was mainly seen as their connectedness to God (intrinsic spirituality) and their relationship with others (extrinsic spirituality). In the event that they cannot fulfil their expectations in both domains, the cases mainly prioritised their connectedness to God.

Spiritual contentment was achieved once they satisfied both their connectedness to God and their relationship with others. The feeling of connectedness to God was seen to facilitate healthy ageing; however, at the same time they may face challenges in their relationship with others which acted as a barrier to healthy ageing. In addressing challenges in life, some cases coped by strengthening their connectedness to God by prayers, meditations, supplication or listening to religious talks.

Awareness of one's limited ability to influence their relationship with others might be used to facilitate their acceptance and adaptation to overcome the potential barrier in healthy ageing. On the other hand, inability to cope or adapt to the challenges in relationships with others can act as a barrier to healthy ageing and might cause psychological distress. Hence, it is imperative to assess and address the individual's spiritual needs to facilitate healthy ageing and overcome these barriers. In sum, spirituality by itself was important for participants to achieve healthy ageing and it has a significant role in supporting the adaptation process to obtain it.

2. *Peace of mind is the ultimate aim in healthy ageing.*

Peace of mind was described in a few ways such as happiness, having nothing to worry about, and free of fear and grief. The prerequisites for peace of mind consisted of an ability to focus on spiritual endeavours, freedom from major responsibilities, feeling of contentment, having optimum physical function, a peaceful living environment, adequate financial resources, having a supportive spouse and filial children, and being well prepared to reach old age.

In Study 2, lack of emotional support, as well as feeling lonely, neglected and depressed were the perceived barriers to achieving peace of mind and subsequently

healthy ageing. The feeling of connectedness to God, support from spouse or family members and multiple ways of coping were used to overcome some of those barriers to facilitate healthy ageing.

3. *Physical health and function is an important dimension in healthy ageing.*

Good physical health and function was described as an invaluable asset to support participants to age well. They accepted a certain degree of physical illness and deterioration as long as it did not limit their mobility. On the other hand, they described the importance of adaptation in the event of restricted mobility. Regardless of their health and functional ability, participants regarded maintaining their usual activities and having continuous learning opportunities as priorities. They were also aware of some lifestyle modification such as appropriate diet, physical activities and falls prevention as approaches for preventive health. Importantly, having good physical health allowed participants to fulfil their spiritual obligations, particularly enabling them to carry out their religious activities.

In Study 2, chronic disease was potentially perceived as a barrier to healthy ageing, but recurrent pain and limitation in functional status was a bigger barrier. Hence, independence in physical function seemed to serve as a stronger facilitator to healthy ageing. Participants appeared to have adapted well to multiple chronic illnesses and did not have the same effect on their perceptions of ageing well as did functional limitations.

4. *Family plays an important role in the lives of older Malays to support healthy ageing.*

Family, particularly their wellbeing, was perceived as intricately related to the participants' healthy ageing. The spouse is the closest individual an older person usually relies upon; hence tolerance, compromise and understanding were all perceived as vital qualitites to support their relationships. Supportive companionship provided by a spouse seemed imperative in contributing to peace of mind as part of healthy ageing experiences. In addition, having caring and supportive children was also seen to promote healthy ageing. Grandchildren provided them with further meaningful experiences and gratification concerning their intergenerational relationships. The older Malays maintained continuous spiritual and even material responsibilities towards their family members.

In Study 2, more specific issues particularly barriers to family relationship were discussed. Supportive spouse and/or family members in terms of emotional, instrumental and financial support were clear facilitators of healthy ageing. Feelings of happiness generated by being in close proximity to their grandchildren facilitated healthy ageing. In contrast, full responsibility for the care of grandchildren was a barrier for their healthy ageing. A feeling of being neglected or not being appreciated by a spouse or family members was another barrier described. Unfulfilled expectations in their relationships with family members also acted as a barrier and were a potential source of psychological distress for older people in the study.

5. *Financial independence is vital.*

Being prepared financially was vital to the experience of healthy ageing in the community studied. In particular, the role of a pension was highlighted whereas older people without a pension may have to struggle to make ends meet unless they have made adequate preparations. Their own savings and children's contribution were other possible financial resources; however, having no choice but to work at older age was seen as detrimental to their healthy ageing experiences.

In Study 2, the perception of having a comfortable income obviously facilitated healthy ageing whereas inadequate income acted as a barrier. However, perceiving income to be "just enough" for the individual can be a facilitator for healthy ageing if the individual was happy and well adapted to their financial circumstances. It can be a barrier if the individual looked at it negatively and were concerned about their inability to spend extra money for other needs. At the same time, financial satisfaction alone did not determine overall life satisfaction or perception of healthy ageing in the cases studied. The support received either in terms of emotional, physical and spiritual perspectives seemed more important than financial satisfaction.

6. *Living environment enhances the healthy ageing experience for the older Malays.*

The living environment refers to the place they lived, their living arrangements (who they lived with) and their neighbourhood. Living in an environment which supports their spiritual needs was the priority for most of them. The decision to live in certain places was influenced by a strong sense of belonging, the need for support and/or spiritual needs. Most participants preferred to live in their own houses whereas some

accepted the need to move in with their children once the need arose and some chose or wished to live in a spiritual retreat. In their neighbourhood, participants desired a feeling of comfort in terms of their relationships with others, as well as a sense of security and easy accessibility to places where they could fulfil their spiritual needs.

In Study 2, the selected cases mainly lived near a mosque or activity centre, hence providing them the opportunity for spiritually strengthening activities which acted as facilitators for healthy ageing. However, despite the easy access, some cases experienced hindrances due to limited freedom to participate in the activities offered. In some cases, spirituality strengthening activities were carried out despite living far from an activity centre or being unable to access group activities. Spirituality strengthening activities were done at the individual level (in their own home) that enhanced their connectedness to God and acted as a facilitator for them to age well. Not having one's own house and restricted autonomy due to the extended family living arrangements were seen as barriers to healthy ageing for some cases. On the other hand, supportive family members who lived together or caring neighbours facilitated healthy ageing experiences.

7. *Healthy ageing at the individual level – a dynamic adaptation, prioritisation and transcendent acceptance (aDAPTA).*

The earlier key findings are the themes identified in Study 1 and the last key finding is the integration of results for Study 1 and 2. Consistent with grounded theory inquiry, Study 2 is also used to refine the ideas for the healthy ageing framework developed in Study 1 (Charmaz, 2000). Using the similar thematic analysis approach as well as an iterative process of constant comparison with the framework developed in Study 1, we

identified additional themes to refine the earlier healthy ageing framework. This last key finding informed the revision of the healthy ageing model presented in Chapter 4 of this thesis. In Study 1, six themes informed the healthy ageing model, based on the perspective of older Malays. In Study 2, the cases shared their experiences of balancing the facilitators of and barriers to healthy ageing. At the individual level, healthy ageing seemed to involve a *dynamic adaptation, prioritisation and transcendent acceptance* (aDAPTA) in addressing the facilitators and barriers derived from the six themes.

A *dynamic adaptation* is a continuous process of coping and adapting to biological (internal) and environmental (external) changes or challenges to achieve the acceptable situation to achieve healthy ageing. The acceptable situation to describe healthy ageing is interpreted differently according to the individual and cultural context.

Prioritisation is the ability to identify and arrange factors according to their relative importance to achieve healthy ageing. In addressing the many challenges or barriers to healthy ageing, prioritisation is part of the adaptation process for the individuals to choose the more important factors to determine their healthy ageing experience.

Transcendent acceptance is the description of individual's spiritual experience of acceptance or any experience of acceptance beyond usual abilities that support and provide them the strength to adapt and accept their biological or environmental changes. This highest level of acceptance (*ridho*) has been described in the spirituality section in Chapter 4. While its earlier description was related to acceptance of death, it seemed applicable to describe their transcendent experience in healthy ageing. As

described in Chapter 4, '*Ridho* is a sense of acceptance of any event (not only death), whole heartedly (with a pure clean heart) and to feel at peace with it'. This concept was re-visited in Chapter 5 to describe the spiritual approach in adaptation to life challenges to achieve healthy ageing.

The healthy ageing model presented in Chapter 4 was revised and the adaptation process of a Dynamic Adaptation, Prioritisation and Transcendent Acceptance (aDAPTA) is incorporated to demonstrate its role in healthy ageing. In the earlier model (Figure 6.1), the themes identified as important by the older people were constructed conceptually like a tree with spirituality as the root or foundation, the driving force to support its growth. Peace of mind is representative of the main trunk to support the branches and bringing all the supplies to and from the root. Being able to focus on spiritual endeavours is a prerequisite for peace of mind. It is easier to fulfil their spirituality if they are in good physical health. However, even without good physical health, older people can become more spiritually focused; as a coping or adaptive strategy. In terms of financial independence and spirituality, better socioeconomic status seems to provide more opportunity for spiritual enhancement and working at older age might hinder spiritual development. Being spiritually contented has also been alluded to help lower materialistic expectations. Family relationship has very strong spiritual link; particularly the continuous spiritual responsibility towards family members and the importance of family support to enhance spirituality. For the living environment, older people wished for a spiritually supportive neighbourhood. The living place as well as a companion to support spiritual strengthening was important for the older people.
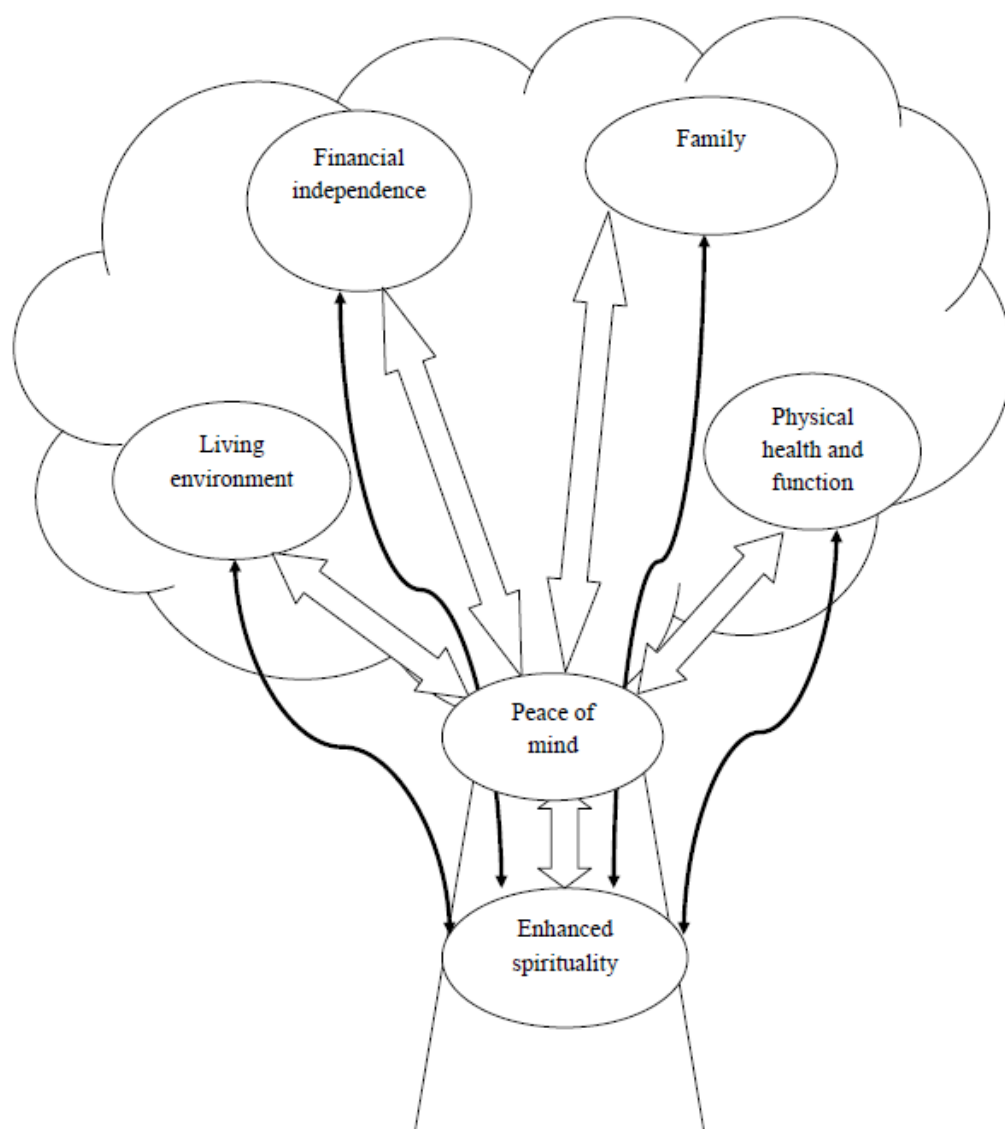
Figure 6.1.The initial healthy ageing model

The aDAPTA addition to the model is the psychological process that supports the growth of the 'healthy ageing tree' (Figure 6.2). This psychological process helps the person to adapt to the environment; the biological ageing and the external barriers and

facilitators including social support. In the situation where the psychological process of adaptation is not optimised, the 'healthy ageing tree' might have difficulty to survive or might survive in sub-optimal conditions (the analogy of the need for adequate water, sunlight and air for a tree to grow).

The dynamic adaptation was a continuous process applied by the older people in balancing the facilitators and barriers to achieve healthy ageing. In balancing the facilitators and barriers, older people need to prioritise the factors that might affect their quest for healthy ageing. For example, some older people chose to live in a spiritual retreat; they forewent the convenience of living in their own house to prioritise their spiritual endeavours. Fulfilling their spiritual quest was a priority for them to achieve healthy ageing. Addressing their continuous adaptation process and prioritisation, the older people had to identify their optimum situation when their acceptance of their biological or environmental changes is guided by a transcendence experience. The importance of a transcendent acceptance is the feeling of being at peace with it. This acceptance is not related to the feeling of frustration or pessimism that nothing more can be done. In transcendent acceptance the older people are appreciative of the residual strengths that they have and try to make the best of it. For instance, despite limited mobility due to illness, the older people peacefully accept their limited capacity for some extrinsic spiritual activities and are appreciative of the ability to strengthen their intrinsic spirituality.
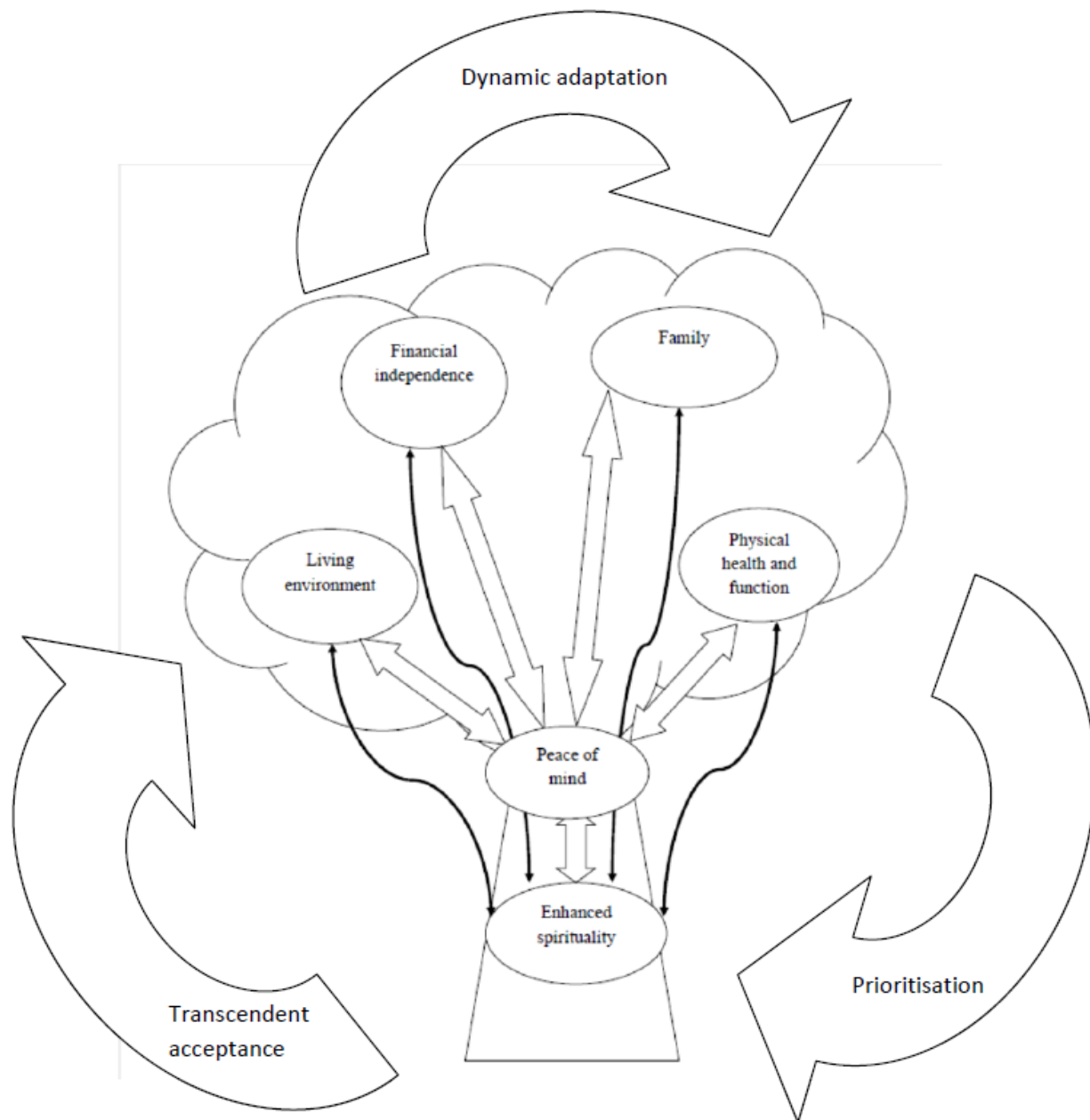
Figure 6.2.The revised healthy ageing model

Discussion

The findings from this thesis contribute to a better understanding of the multidimensional concepts in healthy/successful ageing particularly from lay perspectives, which demonstrate the integration of bio-medical and psychosocial concepts to define healthy ageing. This integration has been reported and discussed by others as an attempt to arrive at a mutually agreed definition of healthy ageing (Bowling, 2006; Bowling & Iliffe, 2006; Martin et al., 2012).

The six themes constructed in Study 1 to describe healthy ageing conceptualisation among older Malays in Malaysia demonstrated some similarities to studies conducted in Hong Kong and Taiwan (Chong et al., 2006; Hsu, 2007). Spirituality, family, financial and health were mentioned by Hsu (2007); whereas family, financial, living environment and health were described by Chong et al. (2006). Other multidimensional findings consistent with this thesis came from a study conducted in the United Kingdom among community dwelling people aged 50 and above (Bowling, 2006).

Similar to this thesis, the multidimensional themes identified in the study integrated both bio-medical and psycho-social models. The themes were physical and mental health functioning, psychological factors, social roles, financial circumstances and living situation, neighbourhood and community, and social relationships (Bowling, 2006). Spirituality was not included in the report but was described in the other paper as being mentioned much lower down in the list of important factors in healthy/ successful ageing (Bowling & Dieppe, 2005). Family was not implicitly mentioned, however it might be considered as part of social roles and social relationship.

Health and physical function were themes consistently found in all studies of lay perceptions of healthy ageing.. In addition to health and physical function, adaptation has been consistently found to be integral to healthy ageing (Boudiny, 2013; Hung et al., 2010; Martin et al., 2012). Boudiny (2013) in his review, proposed active ageing from a life course perspective upheld by three principles of adaptability, considering the human factor (their preferences in choosing the relevant activities in continuous engagement and the removal of barriers that are exclusively based on age or dependency (Boudiny, 2013).

A review of 26 qualitative studies of lay person perspectives which focused specifically on successful ageing highlighted the multidimensional nature and strong role of psychosocial dimensions in successful ageing, followed by biomedical and external components (Cosco et al., 2013). Psychosocial components were identified in all studies which include acceptance, adjustment, maintenance, spirituality, community, social roles, quality of life, independence, prevention and remediation, self awareness, perspective and engagement (Cosco et al., 2013). Following the classification described in the review, in this thesis, the psychosocial components identified are adaptation, prioritisation, transcendent acceptance, spirituality, peace of mind and family. Physical health and function represent the biomedical component, whereas living environment and financial independence describe the external components.

Another review of 34 studies compared key domains in healthy ageing according to researcher or lay views. Family, adaptation, financial security, personal growth and spirituality were five domains used by lay people but were never included in

academic/clinical domains of healthy ageing (Hung et al., 2010). Four out of the five domains were in agreement with the findings in this thesis.

This thesis did not totally reject the bio-medical model of healthy ageing as introduced by Rowe and Kahn (1987), because health and physical function were clearly important issues for participants. However, the three dimensions of *low probability of disease, high cognitive and physical functioning, and active engagement with life* were insufficient to describe healthy ageing as experienced by the participants. The participants also perceived spirituality, peace of mind, financial independence and living environment similarly, if not more important than the bio-medical approach proposed by Rowe and Kahn (1987).

This thesis' findings confirmed the important role of spirituality in healthy ageing as proposed by Crowther et al. (2004). This is consistent with gerotranscendence theory introduced by Tornstam (1997), which stated that living into old age is characterised by 'a shift in metaperspective from a materialistic and pragmatic view of the world to a more cosmic and transcendent one, normally accompanied by an increase in life satisfaction' (p.143). Gerotranscendence, seen as a positive development process involving redefinition of the self and relationships to others and a new understanding of fundamental existential questions, was used to describe the influence of spirituality in the study among older black Americans (Troutman, Nies & Mavellia, 2011).

This thesis demonstrated the importance of addressing the perspectives of older people themselves in assessing healthy ageing and possibly in identifying appropriate interventions. It supported the view that healthy ageing is interpreted differently according to personal or policy goals (von Faber et al., 2001). Similar to this study,

von Faber et al. (2001) suggested that at individual level, assessment should focus on the individual needs and capacity to adapt to change, which can be very different from the priorities of policy makers. Hence, adaptation is the generic concept in addressing healthy ageing; however, based on the thesis findings, the adaptation process should consider the individual and cultural context.

The similarity of the thesis findings to the psychological model of successful ageing introduced by Baltes and Baltes' (1990) demonstrates the importance of adaptation in ageing well. Known as the SOC (selection, optimisation and compensation) model of ageing, successful ageing involves reaching the goals that the person has selected as important. In the SOC model, the adaptation process is more related to cognitive and biological ageing, where as in this thesis the dynamic adaptation process involved balancing the barriers to and facilitators of healthy ageing in the six themes identified in the earlier focus groups. The SOC model discussed adaptation in functional capacities, however, the adaptation and prioritisation identified in this thesis involved a more holistic bio-psycho-social-spiritual approach towards the older people as a person.

The functional adaptation to suitable physical activities can be described by the SOC model but the holistic adaptation was better described by a dynamic adaptation, prioritisation and transcendent acceptance (aDAPTA) introduced in this thesis. For example, in the event of deteriorating functional status, the older people in this study used spirituality, family support and caring neighbours to adapt to the situation and to strengthen their emotion. At this juncture the older people prioritised their spirituality, emotional health, family relationship and supportive neighbourhood instead of

focusing on the deterioration in physical function. This dynamic adaptation resulted in the transcendent experience of acceptance, tranquillity, feeling at peace with God and peaceful relationship with others.

Despite the similarities, however, in this thesis, the successful adaptation process is experienced mainly by those spiritually contented and to a certain extent by those who feel strongly connected to God, which were not explored in the studies by Baltes and Baltes (1990) and von Faber et al. (2001) described above.

Browning and Thomas (2007) in their review proposed the definition for successful (healthy) ageing as *'a process whereby people can achieve or maintain the best possible state of physical, cognitive and mental health and well being, meaningful and positive engagement with people, community and institutions, and a personal sense of security, choice and autonomy, with active adaptation to ageing processes from the individual, familial and societal perspectives'.* The difference in this model as compared to the earlier ones was in its capacity to acknowledge the dynamic nature of healthy ageing as a process, which is consistent with the findings in this thesis. In this thesis, outcomes for participants were not static, but were subject to change. Healthy ageing was seen as a dynamic process of adaptation. A dynamic adaptation in the life course perspective should consider personal and cultural contexts. Hence, harmonious integration of the bio-medical and psycho-social models is integral for understanding healthy ageing.

It is timely to revisit the recent review of successful ageing by Martin et al. (2012). I would like to respond to questions posed by Martin et al. (2012) in the conclusion of their review in understanding successful ageing; '1) What are the minimal definitions

needed to describe successful ageing? 2) How do we reconcile the various models of successful ageing in our research? 3) How important are individual perceptions in the measurement of successful ageing?

I would propose to use the perceptions of older people themselves to define and measure healthy ageing. I define healthy ageing at the individual level as a dynamic process of adaptation, prioritisation and transcendent acceptance (aDAPTA) to achieve or maintain the best possible state of acceptable life situations appropriate to individual and cultural contexts. In the community studied, their perspectives of healthy ageing reflected the cultural context. Healthy ageing in this community involved spirituality as the driving force, peace of mind as the ultimate aim, the importance of physical health and function, the supportive role of family, the need for financial independence, and the living environment, that can enhance their healthy ageing experience. This thesis has strongly indicated the important role of individual perceptions of older people to inform the measurement of healthy ageing, as well as models of healthy ageing more broadly.

The contribution of knowledge from this thesis

Prior to this thesis, there has been no previous study that reported healthy ageing conceptualisations from the perspective of older Malaysians, particularly older Malays. Even though there were studies exploring lay people perspectives of healthy ageing, they were conducted in countries with different cultural settings. Hence the six themes constructed to describe the healthy ageing perspectives and the aDAPTA concept of the psychological process to support its growth produced new knowledge

for the population studied and contributed to the body of knowledge in healthy ageing from cross cultural perspectives.

The findings contributed to the evidence base around the need to consider multidimensional perspectives in healthy ageing conceptualisations. The integration of biomedical and psycho-social models demonstrated the breadth and the depth of the importance of lay perspectives in healthy ageing. Multidimensional perspectives in healthy ageing rarely include or explore spirituality in the discussion. The concept of spirituality has proven difficult to articulate, if indeed it is mentioned at all. Hence, this thesis contributed to our further understanding of the role of spirituality in healthy ageing.

The spiritual dimension described in the thesis goes beyond Crowther's proposition to include positive spirituality as the fourth factor in Rowe and Kahn's biomedical model (Crowther et al., 2004). In this community, spirituality is more important than that, it is the driving force for healthy ageing and is instrumental in understanding healthy ageing in the Malaysian community, particularly for older Malays. Literature discussing spirituality in older people, particularly in how it impacts healthy ageing is mainly conducted in western countries with religious preponderance towards Christianity. Hence, the thesis finding provides important new knowledge to guide research in other communities or cultures which have strong religious affiliation, particularly among the Muslim communities in constructing their healthy ageing perspectives.

At an individual level, this thesis contributed to a new perspective in our understanding of adaptation processes in healthy ageing. A dynamic process of

adaptation, prioritization and transcendent acceptance (aDAPTA) demonstrated a more holistic approach in balancing the facilitators of and barriers to healthy ageing with consideration of personal and cultural contexts.

The thesis findings contributed to the knowledge gap as highlighted in a recent review of 26 qualitative studies of lay perspectives in successful ageing which concluded that the majority of studies reviewed had a strong Anglophone bias and poor representation of non-Western countries in the samples (Cosco et al., 2013).

Strength and Limitations of Study 1

The strength of the focus groups was the in depth understanding of healthy ageing conceptualisations in the community studied. The participants' diversity either in terms of age, educational level and socioeconomic status within each group represented different older people in the community (Stewart et al., 2007). The participants in the focus groups were generally those older people who were healthy and more mobile. Almost 20 per cent of older people in Malaysia were home bound according to latest NHMS report, which indicates that the voice of this group might not have been heard in the current study (Institute for Public Health, 2008b). In acknowledgment of the fact that many older people would not be easily recruited to take part in the study (e.g. those in employment, and those older people with limited or selective community involvement), specific groups were purposefully arranged to include them: such as group 1 (older age), group 5 (low socioeconomic women) and group 8 (financially comfortable women). This approach was beneficial as the participants from the specifically arranged group added richness and variation in the data obtained.

Another lesson learnt in conducting focus groups with older people was their eagerness to participate and contribute their ideas should be well appreciated, so much so we have to allow flexibility in terms of number of participants for each focus group, time arrangement and even the selection of focus group members. This should not be seen as a violation to the purposeful sampling, as the participants' diversity can always be achieved by specifically identifying the group of older people at risk of being left out as described earlier. Involvement of only two participants in focus group 1 could potentially influence the quality and nature of the data collected as there is concern that it could not generate diverse views. In analysing their discussions about healthy ageing, the two participants talked about all six themes from their experiences or observations, generating rich descriptions. In focus group 1, the two participants demonstrated more agreement to each other as compared to the other larger focus groups where more disagreement and diverse views were observed.

The results cannot be generalised to represent all the views of older Malays in Malaysia; nevertheless it is fundamental in the first instance to investigate the aspirations of some older Malays about healthy ageing, which can then inform future larger scale studies. This study explored the perspectives of older Malays from their own ageing experiences. This cohort of older Malays has experienced many difficulties in their earlier lives such as Japanese invasion and low educational opportunities. Accessing a different cohort of younger or middle aged groups, particularly those born after independence may have resulted in different perspectives due to better educational and social circumstances. Further exploration within this cohort would be beneficial to expand our understanding of healthy ageing concepts.

Malaysia is comprised of three main ethnic groups and this study only explored the older Malays' perspectives. Expansion of this study to involve perspectives of other older ethnic groups would gather richer information, relevant to the whole population.

The older Malays involved in this study were mainly those from rural and suburban areas within western Peninsular Malaysia. The views of older Malays with different lifestyles, such as those living in urban areas and in remote areas such as in East Malaysia, the east coast or the northern region of Peninsular Malaysia, would further inform our understanding of healthy ageing in Malaysia.

Strengths and Limitations of Study 2

The focus group approach in Study 1, which allowed for a free flowing discussion, was clearly enjoyed by many participants. The rapport established with the researcher during the focus group might also have benefitted the subsequent individual interview. However, the follow up individual interviews carried out in Study 2 managed to produce a much better and detailed insight as some participants were much more comfortable in speaking more personally about their life experiences and specifically about their spirituality. In particular, the participants appeared much more at ease in expressing the not so positive aspect or barriers they experienced related to healthy ageing. It was also used as an opportunity for a member check of what had been said in the earlier focus groups and had a role as a de-briefing session. The complementary roles of focus groups, selective follow up individual interviews and direct observation were like putting together the jigsaw pieces to see the full picture.

The limitation identified was the inability of the spirituality scale to differentiate their spirituality. In the community with well established religious affiliation to believe in

God, addressing religious attitude might be difficult. In terms of the spiritual practice subscale, its suitability in this community should be assessed in a bigger sample. Another option is to use the religiosity scale as seen in a reported study among older Malays in Malaysia (Momtaz et al., 2011). The questionnaire used was a modified internal/external religiosity questionnaire which involved two factors, personal religiosity and social religiosity. On the other hand, these questions would not be able to identify individual's intrinsic and extrinsic needs addressed in the cases studied. MacKinlay (2006) argued that identification of spiritual needs is complex but is not impossible. She insisted assessing spiritual needs in older people admitted into an aged care facility is important as well as being aware that older people who live independently also have spiritual needs (MacKinlay, 2006).

The use of self-rated healthy ageing was subject to individual's interpretation as seen in the selected cases. Despite its subjectivity, it is expected that the 'healthy agers' in this study would comprise a larger proportion of older people than would be found using a biomedical definition of healthy ageing. As this study is investigating the perspectives of older people, respecting their views of how they perceive themselves in terms of healthy ageing status was regarded as important and was further clarified during the individual interview. This is consistent with the findings reported in Leiden 85-plus study, in which 22 out of 27 participants involved in the follow up in-depth interviews described themselves as content with their lives and successfully aged (von Faber et.al, 2001). The study concluded that 'from the perspective of the elderly persons, ageing and successful ageing are adaptive processes that are personal and

context bound. Character and attitude (making the best of it) were mentioned as the main instruments in overcoming limitations' (von Faber et.al, 2001, p.2699).

The strengths and limitations of the case study (Study 2):

1. The strength of a case study is its reliance on variety of sources which strengthen its construct validity (Yin, 2009). In Study 2, the evidences were collected from interviews and direct observation. The interviews involved focus groups followed by individual structured and focused open ended interview. The approach of guided conversations in the individual interviews differentiates it from the formal survey study and direct observation provides additional information about the case studied (Yin, 2009).

2. The screening for the candidate cases involved collecting relevant quantitative data with the used of defined relevant criteria namely SRHA to stratify the candidates. The suggested screening of querying people knowledgeable about each candidate (Yin, 2009) was limited in this case study as the study involves individual's own perspectives of healthy ageing in their real life context. However, as I was the sole interviewer during their focus groups and I had the opportunity to interact with them prior or after the sessions, hence, I had the advantage of knowing each candidate. Aware that my screening decision can be affected by my personal bias, the use of defined criteria from the quantitative data strengthens the robustness of case selection.

3. Involvement of a single researcher provides standardise and consistent approach in the data collection process strengthen the reliability of this case study. However, I am aware of the potential bias that can occur during the data

interpretation; hence I regularly discussed my interpretation with my supervisor and research colleague.

4. The sources of evidence were reviewed and analysed together to allow convergence of information from different sources to describe the case study findings. The convergence of evidence from focus groups, structured interview, focused open ended interview and observational data described the strength of data triangulation for Study 2.

5. I acknowledge that the use of any single research method has its own limitations and strengths. I am aware that the use of multiple methods complements each other, provided that the methods are carefully selected to address the different needs and specific research questions. I believe this case study is the most appropriate method to complement the earlier focus group study by further investigating at the individual level the healthy ageing concepts constructed in Study 1.

Strengths and Limitations of the thesis

There are a number of strengths and limitations in this thesis project. The exploratory approach using focus group and individual case studies was the important strength of this thesis in our quest to understand the healthy ageing conceptualisation. Despite the limitations, this thesis contributed to better understanding of the role of spirituality in healthy ageing.

Generalisability in qualitative research is not objectively measurable; it is described as transferability and extrapolation (Patton, 2002). As described in Chapter 3, transferability is explained by the degree of congruence between different contexts,

where the findings in one setting may be applicable in another context (Guba & Lincoln, 1985 in Patton, 2002). The strength of this thesis is in its thick description of the research process at all stages of the study which enhanced the transferability of the study, enabling other researchers to compare their work in different contexts. In depth individual exploration in Study 2 was also used to examine the degree of congruence in different contexts; in groups and at an individual level to demonstrate transferability.

The participants lived in the community was the key similarity of study participants in this thesis compared to the general study populations upon which healthy ageing models were developed (Baltes & Baltes, 1990 ;Rowe & Kahn, 1997). The main differences were that health ageing models are based on studies conducted in western and more advanced countries using deductive hypotheses according to researchers' interpretation of healthy ageing (Baltes & Baltes, 1990 ;Rowe & Kahn, 1997). This thesis used an exploratory inductive approach to understand older peoples' lay perspectives of healthy ageing. Compared with other reviewed studies addressing older people's perspectives in healthy ageing, the findings of this thesis are potentially transferable to other communities of older people assuming that the geographic and cultural context is acknowledged (Cosco et al., 2013; Hung et al., 2010).

In this thesis, selection of three different geographical areas and a range of participant characteristics demonstrated our effort to promote transferability and extrapolation. Extrapolation involves logical and thoughtful application of the findings beyond the data, in similar but not identical situations (Patton, 2002). The participants were selected in order to obtain a varied sample in terms of socioeconomic status, rural-

urban residence, living arrangements and health status. The final sample included older people with varying characteristics. However, home-bound older people with severe disabilities were not included as participants in this study. Their physical disabilities led to logistic issues in attending the focus group discussions. A future study employing in-depth interviews is planned to gather their perceptions.Using multiple data collection methods can strengthen the credibility of a research study (Patton, 2002). In part, this is done by comparing the findings from different methods which serves to reduce systematic biases. By using triangulation in this thesis, consistencies in the healthy ageing framework were tested, and in doing so more themes were revealed. Given their own personal time, the participants' openness in sharing their individual stories was very beneficial. This triangulation of the qualitative data sources (Patton, 2002) by comparing what the participants said in the focus groups and what they said in the in depth individual interview; complemented by the observational data is illuminative.

Member checking is a kind of analytical triangulation (Patton, 2002). An example of member checking was when I checked with Dewi who described during the focus group that she was ageing well but at the same time sharing her difficulties of having to cope with looking after a small grandchild. She was able to clarify that to have her supportive husband around was necessary for her to age well, and off-set the stress she experienced as a result of her care-giving role.

The single-perspective interpretations biases were overcome by regular discussions with supervisors and presentations to other ageing research colleagues. Specifically, my supervisors reviewed the initial transcripts prepared and compared the codes

(units), the categories (subthemes) and the themes identified across the transcripts. The selected extracts were checked by the supervisors to ensure their appropriateness to the unit, subtheme and theme identified. This intensive process helped me to maintain the analytical process as the interpretation of the participants' perspectives rather than putting my personal preferences into the interpretation. The possible biases of the supervisors were addressed by discussions and explanations of why such interpretations were chosen instead of what was originally suggested. We then reviewed and agreed on the most appropriate interpretations after considering the possible opinions of both parties.

The audit trail conducted throughout the research consisted of a record of the chronological progress of data collection and analysis particularly the evolution of the units, subthemes and themes into a theoretical model (Creswell 2007, pg 291). I used a journal to write notes of decisions made and my thoughts. The decisions and thoughts were discussed with my supervisors and colleagues. The journal functioned as an audit trail that helped to increase the dependability of this research

The contribution of each method to produce the overall findings of this thesis was unique and complementary. The flexibility that a qualitative research approach provides might have been both strength and a weakness depending from which lens it is viewed. However, the most important role of the methods is to answer the research questions (Patton, 2002), and the research methods chosen to answer the research questions were appropriate.

An additional strength of this thesis was the use of multiple methods to address the research questions. The outcomes of the focus group study (Study 1), which were used to construct the healthy ageing framework appropriate to the community studied, were complemented by the latter case study (Study 2). Specifically, the case study was used to further identify facilitators of and barriers to healthy ageing, with particular attention to the role of spirituality in healthy ageing at the individual level. Older people themselves are best positioned to describe the healthy ageing phenomenon, as well as its facilitators and barriers.

The findings of this exploratory study revealed that older Malays in Malaysia viewed healthy ageing within a much broader context than that promoted by policy makers. The studies reported in this thesis are the first reported studies to explore healthy ageing from the perspectives of older Malays in Malaysia. It is imperative to explore these perspectives in other ethnic groups in Malaysia in order to gain a fuller picture of cultural influences on healthy ageing. Despite its limited generalisation to the whole older population of Malaysia, it should not deter policy makers or service providers from considering the findings of the thesis in addressing healthy ageing issues in the Malaysian community.

As qualitative research is fairly new for the health and medical fraternity in Malaysia, I had limited contact and resources to assist me during the research process. The short time available for data collection restricted my capacity to train another researcher. Hence, I conducted all the interviews and prepared most of the transcripts on my own. The experience of doing all those definitely was invaluable. By doing so, I had a very good grasp of my data which had helped me tremendously for data analysis. This

experience taught me that extensive understanding of the data obviously strengthened the validity and reliability of the study.

Implications of the findings for future research

Healthy ageing conceptualised in this study is not meant as a static concept. It supports the earlier opinion that healthy ageing is a process and needs an individualised approach (Browning & Thomas, 2007). It might change with time in different cohorts of older people. However, it would be interesting to explore the views of other older Malays in the different parts of the country particularly in areas with different cultural and socioeconomic profiles such as the east and north coasts of peninsular Malaysia or even to East Malaysia in Borneo. Further exploration should also include those older people with severe illness and very limited physical function, their caregivers and service providers.

In addition, research that explores the perspectives of older Malays in other countries is imperative. Reflecting on my pilot study among the Malays in Melbourne, where I first discovered spirituality as an important factor for healthy ageing and adaptation, it would be interesting to examine if the Malays who have migrated to other countries have similar perspectives.

Healthy ageing might be conceptualised differently by older people from other ethnic groups in Malaysia. Hence, it would be beneficial to explore how older Chinese, Indians and may be the minority ethnic groups in Malaysia conceptualised healthy ageing, particularly the role of spirituality in healthy ageing. As previously reported in a qualitative study among older people to describe how cultural values shape the nature of learning in older adulthood in Malaysia, the study revealed that learning was

spiritually and philosophically driven among Muslims, Christian, Hindu, or Buddhist participants (Merriam, 2002).

The adaptation model (aDAPTA) described in this thesis needs further exploration of its applicability in a larger population and multi-cultural communities.

Another area to explore is the perspective of service providers as well as the older people themselves in discussing spirituality. Which service providers should explore older people's spirituality? Would health care providers be comfortable to do this? How do the older people feel if spirituality is being discussed by their health care providers?

Implications for policy and practice

The findings supported the multidimensional needs of older people, particularly older Malays, to achieve healthy ageing. The psychological process (aDAPTA) model that incorporated the six themes of physical health and function, peace of mind, family, financial, living environment and spirituality fulfilled the bio-psycho-social-spiritual approach which should be considered in service provision for older people.

Spirituality has been identified and included in the plan of action in the Policy for Older People in Malaysia since1995. The policy statement in 1995 was *'to ensure the social status, dignity and well being of older persons as members of the family, society and nation by enabling them to optimise their self potential, have access to all opportunities and have provision for care and protection'* (Department of Social Welfare Malaysia, 2007). To ensure the integration and participation of the older people in the country's development, the Technical Committee formed six sub-committees to address the major concerns of the Plan of Action. The sub-committees

were for social and recreation, health, education, training and religion, housing, research and publicity (Department of Social Welfare Malaysia, 2007).

Spirituality was supposed to be addressed by the education, training and religion sub-committee. Despite awareness of the need for multidisciplinary collaboration in the care for older people, this division in responsibilities might have resulted in spirituality issues being handled by the religious authority or the community in isolation. Hence, its importance might be neglected if it is not being incorporated into the overall perspective in the lives of older people.

Interestingly, spirituality was not addressed in the action plan for the latest National Policy for Older People in Malaysia endorsed by Malaysian Government in the year 2011. The latest policy statement described the policy as *'the government's commitment to create a conducive environment for older persons to establish a society of older people who are independent, dignified, possessed a high sense of self-worth and respected by optimising their self-potential through a healthy, positive, active, productive and supportive ageing to lead a well-being life [sic]'* (Department of Social Welfare Malaysia, 2012)

The agencies responsible for the implementation of the policy addressed various aspects of ageing such as education, employment, participation, recreation, and transport, among others (Department of Social Welfare Malaysia, 2012). Unfortunately, the role of spirituality was not explicitly described in the policy.

Despite emerging evidence of increasing importance of spirituality in the aged, assessment of older people is usually focused towards physical health and function, psychological health and social support (Koenig, George & Titus, 2004). The role of

spirituality is difficult to assess due to multiple factors. Spirituality can be used as a coping strategy in facing adverse life events; hence a spirituality score can be high in some participants with psychological distress. Highly spiritual people are expected to experience inner peace; however they may still experience psychological distress due to other factors or even due to spiritually-related factors such as failure to fulfill spiritual needs. Inclusion of formal spiritual assessment in the services provided for older people is a rare occurrence. The subjectivity of spiritual interpretation hindered the development of a widely acceptable spirituality questionnaire. Spirituality seems too personal and service providers may have some reservations in exploring this area due to feelings of inadequacy to handle the spiritual issues (Phillips et al., 2009).

In my opinion, the use of spirituality measures might be helpful but individual assessment should be considered. I support the inclusion of spirituality as part of whole person approach in the care for older people which should include assessment of spiritual status, identification of spiritual needs and options for spiritual interventions (Phillips et al., 2009). Incorporation of spirituality within bio-psycho-social assessment by the primary health care providers and well coordinated multidisciplinary interventions might result in a better quality of life for older people. Suggestion of how to integrate spirituality in the patient care has been proposed recently (Koenig, 2012). Further exploration, particularly in relation to action research is needed in this area to assess its suitability in the local context.

There is one study of patients' and primary care physicians' perspectives about discussing spirituality in clinical practice. Ellis, Campbell, Detwiler-Breidenbach, and Hubbard (2002) explored family physicians' views of spiritual assessment. The study reported that some physicians reported infrequent spiritual assessment as spiritual

issues were viewed to have lower priority than other medical concerns. For those who regularly addressed spiritual issues, the justifications were that spirituality is central to life and scientific evidence supported the link between spirituality and health. A patient-centred approach to spiritual assessment was supported but physicians should maintain their sensitivity, integrity and not abuse their position.

In Malaysia, the point of entry for formal service for older people is mainly through the primary health care system. Hence, the primary health care providers should be able to identify the multiple needs of older people and coordinate the care for older people for multidisciplinary interventions (Krishnapillai et al., 2011.) Older people attending public health clinics have more opportunity for organised assessment whereas those who cannot come to the health clinics will be left out. On the other hand, multiple health-related issues in older people and long queues of patients may deter holistic assessment in the clinic.

Inclusion of even one question in the clinical interview may be able to identify the role of spirituality in ageing well (Ng, 2009). The decision to include spiritual assessment as part of holistic management in the care of older people should be supported by evidence of its benefit to their wellbeing in all major ethnic groups in Malaysia. Hence, the role of spirituality to the overall wellbeing of older people renders further investigation. A local study among older Malays reported participants with high level of religiosity (particularly personal religiosity) with or without chronic medical conditions demonstrated significantly higher mean of psychological wellbeing (Momtaz et al., 2011). Depression or poor psychological wellbeing had been associated with low spirituality or use of spirituality to cope with poor mental health. Spiritual distress or unfulfilled spiritual needs may contribute to poor

psychosocial wellbeing and should be addressed in the management plan. The commonly used spirituality instruments mainly address spiritual attitude, well being and practice without assessment of spiritual needs (Sulmasy, 2001; MacKinlay, 2006). Moreover, researchers who advocated for the assessment of spiritual needs limited their consideration to those in palliative care or aged care (Hermann, 2007; MacKinlay, 2006; Sulmasy, 2001).

Addressing spiritual needs of older people in the community while they are relatively physically and cognitively healthy can be considered part of a preventive care approach. It would be much easier to fulfil the spiritual needs of more mobile older people with good cognitive function in the community rather than those in the aged care or at the end of life care. Yet, as spiritual needs may change in response to alteration in individual's bio-psycho-social-spiritual profile, assessment of spiritual needs should be considered as part of continuous and comprehensive care plan provided for older people so long as they agree to be a part of it. This option should be offered to older people as we are aware of the wide range of individual spiritual status, similar to our approach in assessing their nutritional status, identifying their nutritional needs and offering them nutritional intervention.

Older people should develop appropriate skills for adaptation and prioritisation to support them to age well. Their awareness of the role of spirituality may facilitate their path towards healthy ageing. The service providers should further address ways to recognise and support older Malaysians to age well, particularly related to spirituality issues.

Conclusion

The different cultural values explored in this thesis as compared to the available literature may provide an avenue to expand the guiding concepts and principles in service provision for older people in Malaysia. More importantly the findings described the perspectives and aspirations of the older people in Malaysia, the main user of the service. Hence, the findings should be further explored and used to strengthen service provision for older people. The role of spirituality is fundamental in addressing healthy ageing in this community. The aDAPTA psychological process is the overarching approach in integrating bio-psycho-social-spiritual domains in understanding healthy ageing. Generating evidence from the selected community has contributed to the more relevant findings for the local context; both in relation to policy development and service provision for the older people in Malaysia.

References

Abolfathi Momtaz, Y., Hamid, T. A., Ibrahim, R., Yahaya, N., & Abdullah, S. S. (2012). Moderating effect of Islamic religiosity on the relationship between chronic medical conditions and psychological well-being among elderly Malays. *Psychogeriatrics, 12*(1), 43-53. doi: 10.1111/j.1479-8301.2011.00381.x

Alavi, K., Rahim M.S., Khairuddin I., Asnarulkhadi A.S., & Chan, C. (2011a). Emotional support needs in caring for the elderly parents by the adult children. *e-BANGI Journal of Social Sciences and Humanities*, 6(1), 102- 114.

Alavi, K., Rahim M.S., Khairuddin I., Asnarulkhadi A.S., & Omar, M. (2011b). Living Arrangement Preference and Family Relationship Expectations of Elderly Parents. *Pertanika J. Soc. Sci. & Hum.* 19, S65 – 73. Retrieved from http://www.pertanika.upm.edu.my/Pertanika%20PAPERS/JSSH%20Vol.%2019%20%28S%29%20Oct.%202011/15%20Pg%2065-73.pdf

Alavi, K. (2013, April). Intergenerational Relationships between Aging Parents and their Adult Children in Malaysia. Paper presented at the 20th Association of Asian Social Science Research Councils (AASSREC) Biennial General Conference, Cebu City, Philippine. Retrieved from http://aassrec20th.files.wordpress.com/2013/04/k-alavi-full-paper.pdf

Allport, G. W., & Ross, J. M. (1967). Personal religious orientation and prejudice. *Journal of Personality and Social Psychology, 5*, 432–443.

Almeida, O. P., & Almeida, S. A. (1999). Short versions of the Geriatric Depression Scale:A study of their validity for the diagnosis of a major depressive episode according to ICD-10 and DSM-IV. *International Journal of Geriatric Psychiatry*, 14, 858-865

Andrews, K. (2002). *National Strategy for an Ageing Australia: An older Australia, challenges and opportunities for all*. Canberra: Commonwealth of Australia.

Andrews, G., Clark, M., & Luscz, M. (2002). Successful ageing in the Australian Longitudinal Study of Ageing: Applying the Mac Arthur model cross-nationally. *Journal of Social Issues*, 58, 749-765.

Angrosino M.V. (2005). Recontextualizing observation – Ethnography, Pedagogy, and the prospects for a Progressive Political Agenda. In Denzin N.K and Lincoln Y.S.(Eds), *The SAGE Handbook of Qualitative Research* (3rd ed., pp. 729-745).Thousand Oaks. California

Angus, J., & Reeve, P. (2006). Ageism: A threat to "aging well" in the 21st century. *Journal of Applied Gerontology, 25*, 137-152.

Ardelt, M., & Koenig, C. S. (2006). The role of religion for Hospice patients and relatively healthy older adults. *Research on Aging*, 28 (2), 184-215.

Arokiasamy, J. T. (1997). Malaysia's ageing issues (editorial). *Medical Journal of Malaysia, 52*(3), 197-201.

Australian Government (2013). *Strategic Research Priorities.* Retrieved from http://innovation.gov.au/research/Documents/SRP_fact_sheet_web.PDF

Baltes, P. B., Dittmann-Kohli, F., & Dixon, R. A. (1984). New perspectives on the development of intelligence in adulthood: Toward a dual-process conception and a model of selective optimization with compensation. In P. B. Baltes & O. G. Brim, Jr.

(Eds.), *Life-span development and behavior* (Vol. 6, pp. 33-76). New York: Academic Press.

Baltes, P. B., & Baltes, M. M. (1990). Psychological perspectives on successful ageing: The model of selective optimization with compensation. In P. B. Baltes & M. M. Baltes (Eds.), *Successful ageing: perspectives from the behavioral sciences* (pp. 1-34). Cambridge: University of Cambridge.

Baltes, P. B., & Smith, J. (2003). New Frontiers in the Future of Aging: From Successful Aging of the Young Old to the Dilemmas of the Fourth Age. *Gerontology, 49*(2), 123-135.

Bassett, R., Bourbonnais, V., & McDowell, I. (2007). Living long and keeping well: elderly Canadians account for success in aging. *Canadian Journal On Aging, 26*(2), 113-126.

Bazeley, P. (2007). *Qualitative data analysis with Nvivo.* SAGE Publication Ltd. London.

Bekelman, D.B., Dy, S.M., Becker, D.M., Wittstein, I.S., Hendricks, D.E.,Yamashita, T.E. & Gottlieb, S.H. (2007). Spiritual well-being and depression in patients with heart failure. *J Gen Intern Med.* 22(4),470-7.

Berkman, L. F., Seeman, T. E., & Albert, M. (1993). High, usual and impaired functioning in community dwelling elderly: MacArthur successful aging field studies. *Journal of Clinical Epidemiology, 46*(10), 1129-1140.

Bishop, B. (1999a). *The National Strategy for an Ageing Australia: Healthy aging discussion paper*. Canberra: Commonwealth of Australia.

Bishop, B. (1999b). *The National Strategy for an Ageing Australia: Background paper*. Canberra: Commonwealth of Australia.

Boudiny, K. (2013). 'Active ageing': from empty rhetoric to effective policy tool. *Ageing and Society*, 33, 1077-1098. doi:10.1017/S0144686X1200030X

Bowling, A. (1993). The concepts of successful and positive ageing. *Family Practitioner ,* 10(4), 449-453.

Bowling, A. (2006). Lay perceptions of successful ageing: findings from a national survey of middle aged and older adults in Britain. *European Journal of Ageing, 3*(3), 123-136. doi: http://dx.doi.org/10.1007/s10433-006-0032-2

Bowling, A. (2008). Enhancing later life: How older people perceive active ageing? *Aging & Mental Health, 12*(3), 293-301. doi: http://dx.doi.org/10.1080/13607860802120979

Bowling, A. (2009). Perceptions of active ageing in Britain: divergences between minority ethnic and whole population samples. *Age & Ageing, 38*(6), 703-710. doi: 10.1093/ageing/afp175

Bowling, A., & Dieppe, P. (2005). What is successful ageing and who should define it? *British Medical Journal*, *331,* 1548-51.

Bowling, A., & Iliffe, S. (2006). Which model of successful ageing should be used? Baseline findings from a British longitudinal survey of ageing. *Age & Ageing*, *35*(6), 607-14.

Bowling, A., & Iliffe, S. (2011). Psychological approach to successful ageing predicts future quality of life in older adults. *Health and Quality of Life Outcomes, 9* (13). doi: 10.1186/1477-7525-9-13

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychological. *Qualitative research in psychology*, 3, 77-101.

Browning, C., & Kendig, H. 2004. Maximising health and well-being in older people. In Moodie, R. and Hulme, A.(eds), *Hands on Health Promotion* (pp. 374-88*)*. IP Communications, Melbourne.

Browning, C., & Thomas, S. (2007*). Definition and predictors of successful ageing and related concepts.* Victorian Department of Human Services, Melbourne.

Charmaz, K. (2000). Grounded Theory – Objectivist and Constructivist Methods. In Denzin, N. K., & Lincoln, Y. S. (Eds). *The SAGE handbook of qualitative research*. (2nd ed., pp. 509-535).Thousand Oaks CA: Sage Publications.

Charmaz, K. (2013). Grounded Theory Methods in Social Justice Research. In Denzin, N. K., & Lincoln, Y. S. (Eds). *Strategies of qualitative inquiry*. (4th ed., pp. 291-336).Thousand Oaks CA: Sage Publications.

Chase, S.E., (2005). Narrative Inquiry: Multiple lenses, approaches, voices. In Denzin N.K and Lincoln Y.S. (Eds), *The SAGE Handbook of Qualitative Research* (Third Ed) (pp. 651-679).Thousand Oaks. California

Chong, A. M., Ng, S., Woo, J., & Kwan, A. Y. (2006). Positive ageing: the views of middle-aged and older adults in Hong Kong. *Ageing and Society*, *26*, 243-65.

Chou, K. L., & Chi, I. (2002). Successful aging among the young-old, old-old, and oldest-old Chinese. *International Journal of Aging & Human Development, 54*(1), 1-14.

Chung, S., & Park, S. J. (2008). Successful ageing among low-income older people in South Korea. *Ageing & Society, 28*(8), 1061-1074. doi: http://dx.doi.org/10.1017/S0144686X08007393

Cosco, T.D., Prina, A.M., Perales, J., Stephan B.C.M., & Brayne, C. (2013). Lay perspectives of successful ageing: a systematic review and meta-ethnography. *BMJ Open*, 3:e002710. doi:10.1136/bmjopen-2013-002710

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches*. Thousand Oaks CA: Sage Publications.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches*. Los Angeles: Sage Publications.

Crowther, M. R., Parker, M. W., Achenbaum, W. A., Larimore, W. L., & Koenig, H. G. (2002). Rowe and Kahn's model of successful aging revisited: positive spirituality--the forgotten factor. *Gerontologist*, *42*(5), 613-20.

Dalby, P. (2006). Is there a process of spiritual change or development associated with ageing? A critical review of research. *Aging & Mental Health*, *10*(1), 4-12.

Denzin, N. K., & Lincoln, Y. S. (2005). *The SAGE handbook of qualitative research*. Thousand Oaks: Sage Publications.

Department of Education Science and Training (2003). *Australia's national research priorities: Promoting and maintaining good health*. Retrieved from http://www.dest.gov.au/priorities/good_health.htm

Department of Social Welfare Malaysia (2007). *Social Welfare Policies and Services for the Elderly: A Country Report: Malaysia.* Retrieved from http://www.mhlw.go.jp/bunya/kokusaigyomu/asean/asean/kokusai/siryou/dl/h19_mal aysia2.pdf

Department of Social Welfare Malaysia (2012). *National Policy for the Elderly.* Retrieved from http://www.jkm.gov.my/index.php?option=com_content&view=article&id=86&Itemid=1019&lang=en.

Department of Statistics Malaysia (2008). Kuala Lumpur.

Department of Statistics Malaysia (2009).*Time series data: Population statistics*. Retrieved from http://www.statistics.gov.my/portal/images/stories/files/ArchiveTimeSeries/Perangkaan_Penduduk.pdf

Department of Statistics Malaysia (2011). Retrieved from http://www.statistics.gov.my/portal/download_Population/files/census2010/Taburan_Penduduk_dan_Ciri-ciri_Asas_Demografi.pdf.

Department of Statistics Malaysia (2013). Retrieved from http://www.statistics.gov.my/portal/download_Population/files/population_projections/Population_Projection_2010-2040.pdf

Depp, C. A., & Jeste, D. V. (2006). Definitions and predictors of successful aging: a comprehensive review of larger quantitative studies. *American Journal of Geriatric Psychiatry, 14*(1), 6-20.

Donatti, C., Moorfoot, L., & Deans, D. (2005). Defining productive ageing – Engaging consumers. Retrieved from http://www.productiveageing.com.au/PDFs/Discussion%20Paper%20PA.pdf

Ellis, M. R., & Campbell, J. D. (2004). Patients' views about discussing spiritual issues with primary care physicians. *Southern Medical Journal, 97*(12), 1158-1164.

Erikson, E. H. (1985). *The life cycle completed: A review*. W.W. Norton & Co, New York.

Erikson, E. H. (1997). *The life cycle completed: A review - extended version*. W.W. Norton & Co, New York.

Esposito, N. (2001). From Meaning to Meaning: The Influence of Translation Techniques on Non-English Focus Group. *Qualitative Health Research*, *11*(4), 568-579

European Commission (2007). *Healthy Ageing- A Challenge for Europe*. Retrieved from http://ec.europa.eu/health/archive/ph_projects/2003/action1/docs/2003_1_26_frep_en.pdf

Evert, J., Lawler, E., Bogan, H. & Perls, T. (2003). Morbidity profiles of centenarians: Survivors, delayers, and escapers. *Journal of Gerontology, Medical Sciences,* 58A, 232-237.

Fernández-Ballesteros, R., García, L. F., Abarca, D., Blanc, L., Efklides, A., Kornfeld, R., Lerma, A. J., Mendoza-Nuñez, V. M., Mendoza-Ruvalcaba, N. M., Orosa, T., Paúl, C. & Patricia, S. (2008), Lay Concept Of Aging Well: Cross-Cultural Comparisons. *Journal of the American Geriatrics Society*, 56, 950–952. doi: 10.1111/j.1532-5415.2008.01654.x

Fernández-Ballesteros, R., García, L., Abarca, D., Blanc, E., Efklides, A., Moraitou, D., & Patricia, S. (2010). The concept of 'ageing well' in ten Latin American and European countries. *Ageing & Society,* 30, 41–56. doi:10.1017/S0144686X09008587

Ferraro, K. F., & Su, Y. (1999). Financial strain, social relations, and psychological distress among older people: a cross-cultural analysis. *The Journals of Gerontology. Series B, Psychological Sciences And Social Sciences, 54*(1), S3-S15.

Fillenbaum, G. G. (1985). Screening the elderly - A brief instrumental activities of daily living measure. *Journal of the American Geriatrics Society, 33*(10), 698-706.

Garfein, A.J., & Herzog, A. (1995). Robust ageing among the young-old, old-old and oldest-old. *Journal of Gerontology*, 50B, S77-87.

Goodger, B., Byles, J., Higganbotham, N., & Mishra, G. (1999). Assessment of a short scale to measure social support among older people. *Australian and New Zealand Journal of Public Health, 23*(3), 260-265. Retrieved from http://search.proquest.com/docview/215709410?accountid=41453

Government of Canada (2006). *Healthy Aging in Canada: A New Vision, A Vital Investment From Evidence to Action. A Background Paper Prepared for the Federal, Provincial and Territorial Committee of Officials (Seniors).* Retrieved from http://www.health.gov.nl.ca/health/publications/vision_rpt_e.pdf

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, *18*(1), 59-82.

Guba, E.G. and Lincoln Y.S. (2005). Paradigmatic Controversies, Contradictions and Emerging Confluences. In N. K. Denzin & Y. S. Lincoln (Eds.),*The Sage handbook of qualitative research* (3rd ed., pp. 191-215). Thousand Oaks, CA: Sage.

Hairi, N.N., Bulgiba, A., Cumming, R.G., Naganathan, V., & Mudla, I. (2010). Prevalence and correlates of physical disability and functional limitation among community dwelling older people in rural Malaysia, a middle income country. *BMC Public Health*, 10:492. doi: 10.1186/1471-2458-10-492.

Hamid, T.A., Krishnaswamy, S., Abdullah, S.S., & Momtaz Y.A. (2011). Sociodemographic risk factors and correlates of dementia in older Malaysians. *Dement Geriatr Cogn Disord.*, 30(6), 533-9. doi: 10.1159/000321672. Epub 2011 Jan 20.

Hamid, T.A., Momtaz, Y.A., & Ibrahim, R. (2012). Predictors and prevalence of successful aging among older Malaysians. *Gerontology, 58*(4), 366-70. doi: 10.1159/000334671.

Health Canada. (2001). *Workshop on healthy aging*. Retrieved from http://www.hc-sc.gc.ca/seniors-aines/pubs/healthy_aging/intro_e.htm

Hermann, C.P. (2007). The Degree to Which Spiritual Needs of Patients Near the End of Life Are Met. *Oncology Nursing Forum, 34*(1), 70-78.doi: 10.1188/07.ONF.70-78

Hill, P. C., & Pargament, K. I. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist*, *58*(1), 64-74

Holstein, M. B., & Minkler, M. (2003). Self, society and the "New Gerontology". *The Gerontologist, 43*(6), 787-796.

Hung, L., Kempen, G. & De Vries, N.K. (2010). Cross-cultural comparison between academic and lay views of healthy ageing: a literature review. *Ageing and Society,* 30, 1373–1391. doi:10.1017/S0144686X10000589

Hsu, H.C. (2007). Exploring elderly people's perspectives on successful ageing in Taiwan. *Ageing & Society*, *27*(1), 87-102.

Hsu, H.C. (2011). Impact of morbidity and life events on successful aging. *Asia Pacific Journal of Public Health.*23(4), 458-69. doi: 10.1177/1010539511412575. Epub 2011 Jul 3.

Iezzoni, L.I. (2006). Make no assumptions: communications between persons with disabilities and clinicians. Assistive Technology, 18, 212-219.

Inglehart, R. and Baker, W. 2000. Modernization, cultural change and the persistence of traditional values. *American Sociological Review,* 65 (1), 19–51.

Institute for Public Health, (2008a). The Third National Health and Morbidity Survey 2006 (NHMS III): Volume I, Ministry of Health, Malaysia.

Institute for Public Health, (2008b). The Third National Health and Morbidity Survey 2006 (NHMS III): Volume II, Ministry of Health, Malaysia.

Jackson, N.O. (2004). *Population ageing in plain language: an analysis in four dimensions,* Occasional Paper 1, Demographic Analytical Services Unit, University of Tasmania.

Jang, S. N., Choi, Y. J., & Kim, D. H. (2009). Association of socioeconomic status with successful ageing: differences in the components of successful ageing. *Journal of Biosocial Science*, *41*(2), 207-19.

Jariah, M., Sharifah, A.H., & Tengku Aizan, H. (2006).Perceived Income Adequacy and Health Status among older persons in Malaysia. *Asia Pacific Journal of Public Health,* 18, S2-8.

Katz, S. (1983). Assessing self-maintenance: Activities of daily living, mobility and instrumental activities of daily living. *Journal of the American Geriatrics Society*, 31(12), 721-726.

Kellehear, A. (1993). Chapter 7: The role of observation. In Kellehear, A. (Ed), *The Unobtrusive Researcher: A Guide to Methods* (pp. 115-138). Allen and Unwin. Sydney, Australia.

King, M.B., & Koenig, H.G. (2009). Conceptualising spirituality for medical research and health service provision. *BMC Health Service Research,* 13 (9),116. doi: 10.1186/1472-6963-9-116.

Knight, T., & Ricciardelli, L. A. (2003). Successful aging: Perceptions of adults aged between 70 and 101 years. *International Journal of Aging & Human Development, 56*(3), 223-245.

Koenig,H.G, Westlund, R.E., George, L.K., Hughes, D.C., Blazer, D.G., & Hybels, C. (1993). Abbreviating the Duke Social Support Index for Use in Chronically Ill Elderly Individuals. *Psychosomatics, 34*(1), 61-69.

Koenig, H. G. (2006). Religion, spirituality and aging. *Aging & Mental Health*, *10*(1), 1-3.

Koenig, H. G. and Pritchett, J. (1998).. Religion and psychotherapy. In Koenig, H. G. (ed) *Handbook of Religion and Mental Health* (pp.323-36). Academic Press, San Diego, CA.

Koenig, H. G., George, L. K., & Titus, P. (2004), Religion, Spirituality, and Health in Medically Ill Hospitalized Older Patients. *Journal of the American Geriatrics Society*, 52: 554–562. doi: 10.1111/j.1532-5415.2004.52161.x

Koenig, H.G. (2012). Religion, Spirituality, and Health: The Research and Clinical Implications. *ISRN Psychiatry*. Published online 2012 December 16. doi: 10.5402/2012/278730

Kooshiar, H., Yahaya, N., Hamid, T.A., Abu Samah, A., & Sedaghat, J.V. (2012). Living Arrangement and Life Satisfaction in Older Malaysians: The Mediating Role of Social Support Function. *PLoS ONE,* 7(8): e43125. doi:10.1371/journal.pone.0043125

Krause, N. (2006). Gratitude toward God, stress, and health in late life. *Research on Aging*, *28*(2), 163-83.

Krishnapillai, S. A., Ramli, A., Ariaratnam, S, Tohit, N., Clearihan, L., & Browning, C. (2011). Bridging the gap in ageing: Translating policies into practice in Malaysian Primary Care*. Asia Pacific Family Medicine, 10*(2)*,* doi:10.1186/1447-056X-10-2

Krueger, R.A., and Casey M.A., 2000. *Focus Group: A Practical Guide for Applied Research (3rd edition).* Sage Publications. Thousand Oaks CA

Kubzansky, L. D., Berkman, L. F., Glass, T. A., & Seeman, T. E. (1998). Is educational attainment associated with shared determinants of health in the elderly? Findings from the MacArthur Studies of Successful Aging. *Psychosomatic Medicine*, 60(5), 578-85.

Lamb, V. L., & Myers, G. C. (1999). A comparative study of successful aging in three Asian countries. *Population Research and Policy Review, 18*(5), 433-449.

Lawler-Row K.A. & Elliott J. (2009) The role of religious activity and spirituality in the health and well-being of older adults. *Journal of Health Psychology*, 14 (1), 43-52. doi: 10.1177/1359105308097944

Lawton, M. P. (1971). Functional Assessment of Elderly People. *Journal of the American Geriatrics Society, 19*(6), 465-481.

Lawton, M. P., & Brody, E. M. (1969). Assessment of older people - Self maintaining and Instrumental Activities of Daily Living. *Gerontologist, 9*(3P1), 179-186.

Lewin F.A. & Thomas E. (2000) Gerotranscendence and life satisfaction: studies of religious and secular Iranians and Turks. *Journal of Religious Gerontology*, 12, 17–41.

Li, C., Wu, W., Jin, H., Zhang, X., Xue, H., He, Y., Xiao, S., Jeste, D. V., & Zhan, M. (2006). Successful aging in Shanghai, China: Definition, distribution and related factors. *International Psychogeriatrics*, 18(3), 551-63.

Liamputtong, P., Ezzy, D. (2005). *Qualitative Research Methods*, 2nd edition, Oxford University Press, Melbourne.

Loh, K. Y., Khairani, O., & Norlaili, T. (2005).The prevalence of functional impairment among elderly aged 60 years and above attending Klinik Kesihatan Batu 9 Ulu Langat, Selangor. *Medical Journal of Malaysia, 60*(2), 188-93.

Loke, S.C., Abdullah, S.S., Chai, S.T., Hamid, T.A., & Yahaya, N. (2011). Assessment of Factors Influencing Morale in the Elderly. *PLoS ONE*, 6(1): e16490. doi:10.1371/journal.pone.0016490.

Low, W.Y., Khoo, E.M., &Tan, H.M. (2006). Health, Lifestyles and Social Support of Ageing Men. *Asia Pacific Journal of Public Health,*18, S54-59.

McCann Mortimer, P., Ward, L. & Winefield, H. (2008), Successful ageing by whose definition? Views of older, spiritually affiliated women. *Australasian Journal on Ageing*, 27, 200–204. doi: 10.1111/j.1741-6612.2008.00305.x

MacKinlay, E. (2006). Spiritual Care: Recognising Spiritual Needs of Older Adults, *Journal of Religion, Spirituality and Aging,* 18 (2), 59-71.

Martin, P., Kelly, N., Kahana, E., Kahana, B., & Poon, L.W. (2012). Defining Successful Aging: A Tangible or Elusive Concept? Retrieved online 22 July 2013 from http://healthyandsuccessfulaging.wordpress.com/.

Matsubayashi, K., Ishine, M., Wada, T., & Okumiya, K. (2006). Older adults' views of 'Successful Aging': Comparisons of older Japanese and Americans. *Journal of American Geriatrics Society*, 54(1), 184-7.

Mehta, K. K. (1997). The impact of religious beliefs and practices on aging: A cross-cultural comparison. *Journal of Aging Studies*, 11(2), 101-14.

Mehta, K.K. (2011). The challenges of conducting focus-group research among Asian older adults. *Ageing & Society*, 31, 408–421. doi:10.1017/S0144686X10000930

Menec, V. H. (2003). The relation between everyday activities and successful aging: A 6-year longitudinal study. *Journals of Gerontology Series B-Psychological Sciences and Social Sciences, 58*(2), S74-S82.

Ministry of Health, Malaysia. (1997). *Report of Second National Health and Morbidity Survey (NHMS II) Conference*, Kuala Lumpur.

Ministry of Health, Malaysia. (2006). *Garispanduan Melaksanakan Perkhidmatan Kesihatan Warga Emas di Peringkat Daerah, Klinik Kesihatan dan Penglibatan Komuniti (Guideline for Health Care Services for Older People within Health Clinics, Districts and Community Involvement).*

Minkler, M., & Fadem, P. (2002). "Successful aging": A disability perspective. *Journal of Disability Policy Studies, 12*(4), 229-35.

Merriam, S. B. (2002). *Qualitative research in Practice: examples for discussion and analysis.* San Francisco; Jossey-Bass

Momtaz, Y. A., Hamid, T. A., & Ibrahim, R. (2012). Unmet needs among disabled elderly Malaysians. *Social Science & Medicine, 75*(5), 859-863. doi:10.1016/j.socscimed.2012.03.047

Momtaz, Y. A., Ibrahim, R., Hamid, T. A., & Yahaya, N. (2011). Sociodemographic predictors of elderly's psychological well-being in Malaysia. *Aging & Mental Health, 15*(4), 437-445. doi: 10.1080/13607863.2010.536141

Montross, L. P., Depp, C., Daly, J., Reichstadt, J., Golshan, S., Moore, D., Sitzer, D., & Jeste, D. V. (2006). Correlates of self-rated successful aging among community-dwelling older adults. *American Journal of Geriatric Psychiatry, 14*(1), 43-51.

Morgan, D. L. (1997). *Focus groups as qualitative research* (2nd ed.). Thousand Oaks, USA: Sage Publications.

Mowat, H. (2006). Ageing, health care and the spiritual imperative: A view from Scotland. *Journal of Religion, Spirituality & Aging*, 18(2), 3-17.

Mowat, H., & Ryan, D. (2002). Spiritual issues in health and social care: Practice into policy? *Journal of Religious Gerontology*, 14(1), 51-67.

Nagalingam, J. (2007). Understanding successful aging: A study of older Indian adults in Singapore. *Care Management Journals*, 8(1), 18-25.

Nagi, S. (1976). An epidemiology of disability among adults in the United States. *Milbank Memorial Fund Quarterly*, 54, 439-467.

National Health and Hospitals Reform Commission, Commonwealth of Australia (2009). *A Healthier Future for All Australians – Final Report of the National Health and Hospitals Reform Commission – June 2009* (Publication Number: P3 -5499). Retrieved from http://www.health.gov.au/internet/nhhrc/publishing.nsf/content/nhhrc-report

Ng, T. P. (2009). Determinants of successful ageing using a multidimensional definition among Chinese elderly in Singapore. *The American Journal of Geriatric Psychiatry*, 17(5), 407-16.

O'Shea, E. (2006). Developing a healthy ageing policy for Ireland: The view from below. *Health Policy, 76*(1), 93-105. doi: 10.1016/j.healthpol.2005.05.001

Office for senior citizens (2007). *Highlights from the New Zealand positive ageing report and plan 2006-2008*. Retrieved from http://www.osc.govt.nz/documents/nz-positive-ageing-strategy-highlights-0608.pdf.

Ong, F.S. (2002). Ageing in Malaysia: A review of national policies and programmes. In Phillips D.R., & Chen A.C.M., (Eds.), *Ageing and long term care – National policies in the Asia Pacific* (pp.107-49), Singapore: Institute of Southeast Asian Studies and the International Development Research Centre.

Pargament, K. I., & Brant, C. R. (1998). Religion and coping. In H. G. Koenig (ed), *Handbook of Religion and Mental Health* (111-28), San Diego, CA: Academic Press.

Parker, M. W., Fuller, G. F., Koenig, H. G., Bellis, J. M., Vaitkus, M. A., Barko, W. F., & Eitzen, J. (2001). Soldier and family wellness across the life course: A developmental model of successful aging, spirituality, and health promotion, Part II. *Military Medicine*, 166, 7, 561-70.

Parker, M. W., Bellis, J. M., Bishop, P., Harper, M., Allman, R. M., Moore, C., & Thompson, P. (2002). A multidisciplinary model of health promotion incorporating spirituality into a successful aging intervention with African American and white elderly groups. *Gerontologist*, **42**, 3, 406-15.

Parker, M., Roff, L. L., Klemmack, D. L., Koenig, H. G., Baker, P., & Allman, R. M. (2003). Religiosity and mental health in southern, community-dwelling older adults. *Aging & Mental Health*, **7**, 5, 390-97.

Patton, M.Q. (2002). *Qualitative Research and Evaluation Methods*. 3rd edition, Sage Publications. Thousand Oaks, CA.

Peel, N. M., Bartlett, H. P., & McClure, R. J. (2004). Healthy ageing: how is it defined and measured? [Review]. *Australasian Journal on Ageing, 23*(3), 115-119.

Phelan, E. A., & Larson, E. B. (2002), "Successful Aging"—Where Next? *Journal of the American Geriatrics Society*, 50: 1306–1308. doi: 10.1046/j.1532-5415.2002.50324.x

Phelan, E. A., Anderson, L. A., LaCroix, A. Z., & Larson, E. B. (2004). Older adults' views of "successful aging"--how do they compare with researchers' definitions? *Journal of the American Geriatrics Society*, 52(2), 211-6.

Phillips L.L., Paukert A.L., Stanley M.A., & Kunik M.E. (2009). Incorporating religion and spirituality to improve care for anxiety and depression in older adults. *Geriatrics.* 64(8), 15-8.

Pitts, M., & Smith, A. (2007). *Researching the margins : strategies for ethical and rigorous research with marginalised communities*. Basingstoke [England] ; New York: Palgrave Macmillan.

Poi, P.J., Forsyth, D.R., & Chan, D.K. (2004). Services for older people in Malaysia: issues and challenges. *Age and Ageing,* 33(5), 444-6.

Polkinghorne D. E. (1995). Narrative configuration in qualitative analysis. In Hatch, J.A., & Wisnieski, R. (Eds), *Life history and narrative* (pp.5-23). London: Taylor and Francis Ltd.

Pope, C., Ziebland, S., & Mays, N. (2000). Qualitative research in health care - Analysing qualitative data (Reprinted from Qualitative Research in Health Care). *British Medical Journal*, 320,114-6.

Ranzijn, R., & Luszcz, M. (2000). Measurement of subjective quality of life of elders**.** *International Journal of Aging and Human Development*, 50, (4), 263-278

Reed P.G. (1986). Religiousness among terminally ill and healthy adults. *Res Nurs Health,* 9(1),35-41.

Reichstadt, J., Depp, C. A., Palinkas, L. A., Folsom, D. P., & Jeste, D. V. (2007). Building blocks of successful aging: a focus group study of older adults' perceived contributors to successful aging. *American Journal of Geriatric Psychiatry,* 15(3), 194-201.

Roos, N., & Havens, B. (1991). Predictors of successful aging: a twelve-year study of Manitoba elderly. *American Journal of Public Health, 81*, 63-68.

Rowe, J. W., & Kahn, R. L. (1987). Human Aging: Usual and Successful. *Science, 237*(4811), 143.

Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *The Gerontologist*, 37(4), 433-40.

Sadler, E., & Biggs, S. (2006). Exploring the links between spirituality and 'successful ageing'. *Journal of Social Work Practice*, 20(3), 267-80.

Seeman, T. E., Bruce, M. L., & McAvay, G. J. (1996). Social network characteristics and onset of ADL disability: MacArthur studies of successful aging. *Journals of Gerontology Series B-Psychological Sciences & Social Sciences*, 51(4), S191-200.

Seeman, T., McAvay, G., Merrill, S., Albert, M., & Rodin, J. (1996). Self-efficacy beliefs and change in cognitive performance: MacArthur Studies of Successful Aging. *Psychology & Aging, 11*(3), 538-551.

Seeman, T., & Chen, X. (2002). Risk and protective factors for physical functioning in older adults with and without chronic conditions: MacArthur Studies of Successful Aging. *Journals of Gerontology Series B-Psychological Sciences & Social Sciences*, 57(3), S135-44.

Shahar, S., Earland, J., & Abd Rahman, S. (2001).Social and health profiles of rural elderly Malays.*Singapore Medical Journal, 42*(5), 208-13.

Shapiro, J., Mosqueda, L., & Botros, D. (2003). A caring partnership: expectations of ageing persons with disabilities and their primary care doctors. *Family Practice*, 20, 635-642.

Sharifah Azizah,H., Nurizan,Y., Laily, P., Tengku Aizan,H., Zumilah, Z., Ma'rof, R., Sharifah Norazizan, S.A.R., & Asnarulkhadi,A.S. (2006). Living Arrangements of Older Persons on Welfare: Implications on Health, Economic Well Being and Life Satisfaction. *Asia Pacific Journal of Public Health,*18**,** S26-34.

Sheikh, J. I., & Yesavage, J. A. (1986). Geriatric Depression Scale (GDS): Recent evidence and development of a shorter version. *Clinical-Gerontologist*, 5,165-173.

Sherina, M.S., Rampal, L., & Mustaqim, A. (2004a). Cognitive impairment among the elderly in a rural community in Malaysia. *Medical Journal of Malaysia,* 59(2), 252-7.

Sherina, M.S., Rampal, L., & Mustaqim, A. (2004b). The prevalence of depression among the elderly in Sepang, Selangor. *Medical Journal of Malaysia,* 59(1), 45-9.

Sherina, M.S., Rampal, L., Hanim, M.A., & Thong, P.L. (2006). The prevalence of depression among elderly warded in a tertiary care centre in Wilayah Persekutuan. *Medical Journal of Malaysia* 61(1), 15-21.

Silverman, D. (Ed.). (2004). *Qualitative Research: Theory, Method and Practice*. London: Sage Publications.

Simons, H. (2009). *Case study research in practice*. London. SAGE Publications.

Stake, R. (2005). Qualitative case studies. In N. K. Denzin & Y. S. Lincoln (Eds.), The Sage handbook of qualitative research (3rd ed., pp. 443-466). Thousand Oaks, CA: Sage.

Stewart, D. W., Shamdasani, P. N., & Rook, D. W. (2007). *Focus Groups: Theory and Practice* (2nd ed.). Thousand Oaks, CA: Sage.

Strawbridge, W. J., Cohen, R. D., Shema, S. J., & Kaplan, G. A. (1996). Successful aging: predictors and associated activities. *American Journal of Epidemiology*, 144(2), 135-41.

Strawbridge, W. J., Wallhagen, M. I., & Cohen, R. D. (2002). Successful aging and well-being: self-rated compared with Rowe and Kahn. *Gerontologist, 42*(6), 727-733.

Sulmasy D.P. (2002). A biopsychosocial-spiritual model for the care of patients at the end of life. *The Gerontologist,* 42, 24-33

Tate, R. B., Lah, L., & Cuddy, T. E. (2003). Definition of successful aging by elderly Canadian males: The Manitoba follow-up study. *The Gerontologist, 43*(5), 735-744.

Teddlie, C., & Tashakkori, A. (Eds.). (2009). *Foundations of mixed methods research: Integrating quantitative and qualitative approaches in the social and behavioral sciences*. Sage Publications Inc.

Tengku Aizan, H., Chai, S. T., Jariah, M., & Nurizan Y. (2006). Socioeconomic Status and Health among Older Women in Malaysia. *Asia Pacific Journal of Public Health*, 18, S 42-53.

Teshuva, K., Kendig, H. & Stacey, B. (1997). Spirituality, health and health promotion in older Australians. *Health Promotion Journal of Australia*, **7**, 3, 180-84.

Tohit, N., Browning, C. J., & Radermacher, H. (2012). We want a peaceful life here and hereafter: Healthy ageing perspectives of older Malays in Malaysia. *Ageing & Society, 32*(3), 405 - 424.

Tornstam, L. 1997. Gerotranscendence: The contemplative dimension of aging. *Journal of Aging Studies*, 11, 2, 143-54.Troutman, M., Nies, M.A., & Bentley, M. (2011). Measuring successful aging in southern Black older adults. *Education Gerontology*, 37, 38–50.

Turner, M.E., & Pratkanis, A.R. (1998). 25 years of Groupthink Theory and Research: Lessons from the Evaluation of a Theory. *Organizational Behaviour and Human Decision Processes.* 73 (2/3), 105-115.

Vaillant, G. E. (2002). *Aging well*. New York: Little, Brown and Company.

Vaillant, G. E. (2002). *Ageing well: surprising guideposts to a happier life from the landmark Harvard study of adult development*. Melbourne: Scribe Publications.

Vaillant, G. E., & Mukamal, K. (2001). Successful aging. *The American Journal of Psychiatry*, 158 (6), 839-47.

Von Faber, M., Bootsma-van der Weil, A., van Exel, E., Gussekloo J., Lagaay A.M., van Dongen E., Knook D.L., van der Geest S., & Westendorp R.G. (2001). Successful aging in the oldest-old: Who can be characterised as successfully aged? *Archives of Internal Medicine, 161 (24)*, 2694-2700.

Walker, A. (2002). A strategy for active ageing. *International Social Security Review, 55*, 121-139.

Wilcock, A.A., van der Arend, H., Darling, K., Scholz, J., Siddal, R., Snigg, C., & Stephens, J. (1998). An Exploratory Study of People's Perceptions and Experiences of Wellbeing. British Journal of Occupational Therapy, 61 (2), 75-81.

Wilson, K. & Luker, K.A. (2006). At home in hospital? Interaction and stigma in people affected by cancer. *Social Science & Medicine*, 62, 1616-1627

World Health Organisation (WHO) (1952). Constitution of the World Health Organisation. In *World Health Organisation Handbook of Basic Documents* (5th ed). World Health Organisation, Geneva.

World Health Organisation (WHO) (2002). *Active aging: A policy framework*. World Health Organisation, Geneva.

World Health Organisation (WHO) (2006), Malaysia, http://www.who.int/countries/mys/en/. Viewed 19 December 2006.

WHO (2010). World Health Statistics. Part II: Global Health Indicators. Retrieved from http://www.who.int/whosis/whostat/EN_WHS10_Part2.pdf.

Wu, Z. H., & Rudkin, L. (2000). Social contact, socioeconomic status, and the health status of older Malaysians. *Gerontologist, 40*(2), 228-34.

Yin, R.K. (2009). *Case study research: Designs and methods.* 4th edition. Thousand Oaks, CA. SAGE Publications.

Zaiton, A., Nor Afiah, M.Z., & Latifah, A.L. (2006). Functional status of the elderly residing in public funded shelter homes in Peninsular Malaysia. *Asia Pacific Journal of Public Health,* 18, S60-63.

Appendices

Appendix 1

Studies of ageing in Malaysia by domain

Domain	First author/ year/ participants	Instrument	Results/ Remarks
Physical function	Wu 2000 (n=1357)	MOS	No limitation 22-34%
	Shahar 2001 (n=350)	5 item-Chula IADL	Unable to use public transport 18%
	Sherina 2004 (n=223)	Barthel ADL	Dependence 15%
	Sherina 2005 (n=300)	Barthel ADL	Impaired 23%
	Loh 2005 (n=260)	IADL	Impaired $\geq$ 1, 34%
	Zaiton 2006 (n=1081)	Barthel ADL	Impaired $\geq$ 1, 27%
	Aizan 2006 (n=866)	13-item ADL+IADL	Independent 79%
	Shahar 2007 (n=820)	IADL	Independent 87%
	Hairi 2010 (n=765)	Tinetti	Limitation 20%
		Barthel ADL	Impaired $\geq$ 1, 25%
	Momtaz 2012 (n=2980)	PADL,IADL	Impaired $\geq$ 1, 13.4%
	Hamid 2012 (n=2749)	ADL, IADL	Impaired 25%
Self rated health	Wu 2000 (n=1357)	Self report (Good/very good)	35-48%
	Shahar 2001 (n=350)		71%
	Aizan 2006 (n=866)		62%
	Jariah 2006 (n=1776)		69%
	Low 2006 (n=351)		78%
Chronic illness	Shahar 2001 (n=350)	Self report (Absence)	32%
	Sherina 2004 (n=223)		40%
	Sherina 2005 (n=300)		51%
	Zaiton 2006 (n=1081)		32%
	Low 2006 (n=351)		14%
	Hamid 2012 (n=2749)		41%

	Shahar 2001 (n=350)	Self contentment	Contented 94%
Depressive symptoms/ psychological well being		Self satisfaction	Satisfied 95%
	Sharifah Azizah 2006 (n=1081)	Life satisfaction	Low satisfaction 57%
	Sherina 2004 (n=223)	GDS 30	Depressive 7.6%
	Sherina 2005 (n=300)	GDS 30	Depressive 6.3%
	Sherina 2006 (n=198)	GDS 30	Depressive 54%
	Hairi 2010 (n=765)	GDS 15	Depressive 22.7%
	Momtaz 2011 (n=1415)	PGC	Mean 11.5 (moderate)
		WHO-5 well being index	Younger age, male gender, married and higher income predictwellbeing
	Kooshiar 2012 (n=1880)	PGC	Mean range 9.58-12.22
Cognitive function	Sherina 2004 (n=223)	ECAQ	Impaired 22.4%
	Sherina 2005 (n=300)	ECAQ	Impaired 8.3%
	Hairi 2010 (n=765)	ECAQ	Impaired 3.5%
	Hamid 2010 (n=2,980)	GMS	Dementia 14.3%
Financial strain/ adequacy	Ferraro 1999 (n=976)	Comfortable to not enough (1 to 3)	Mean = 1.9
	Shahar 2001 (n=350)	Self report	Inadequate income 39%
	Aizan 2006 (n=866)	Self report	Inadequate 16%
			Adequate for basic needs 39%
Social integration	Wu 2000 (n=1357)	Daily contact with child	Yes 50-57%
	Shahar 2001 (n=350)	Participation in community	Yes 87%
Social exchange	Ferraro 1999 (n=976)	Provision child care	Not reported
		Receive financial help	Not reported
	Low 2006 (n=351)	Provide financial help	64%
		Receive financial help	37%

Social support	Loke 2011 (n=1880)	DUSOC	Not reported
		MOS Social support	Not reported
	Kooshiar 2012 (n=1880)	MOS Social support	Mean range 46.51-66.67
Living arrangement	Sharifah Azizah 2006 (n=386)		Living alone 45%
	Kooshiar 2012 (n=1880)		Living alone (9.3%), living with spouse only (15.5%), living with children (71.3), living with others (3.8)
Religiosity	Loke 2011 (n=1880)		Religiosity influenced morale.
	Momtaz 2012 (n=1415)	Intrinsic/extrinsic religiosity	Religiosity moderated relationship between chronic medical illness and psychological well being.

Note: ADL= Activity of Daily Living, IADL= Instrumental Activity of Daily Living, MOS = Medical Outcome Survey, PADL= Physical Activity of Daily Living, GDS= Geriatric Depression Scale, PGC= Philadelphia Geriatric Morale Scale, ECAQ= Elderly Cognitive Assessment Questionnaire, GMS = Geriatric Mental State, DUSOC= Duke Social Support Scale.

Appendix 2

Studies included in the major reviews

Phelan and Larson (2002)	Peel, McClure and Bartlett (2005)	Depp and Jeste (2006)	Browning and Thomas (2007)
11 studies of different successful ageing definition (no exclusion for year of publication)	8 longitudinal studies (1985-2003) -more than one component to define healthy aging - behavioural determinants	28 quantitative studies (1978 -2005) Single component and multidimensional definition.	17 longitudinal studies (1989-2006) Used two or more domains to define outcome measure -Modifiable predictors
Havighurst and Albrecht 1953 Williams and Wirth 1965 Palmore 1979* Ryff 1982 Butt and Beiser 1987 Rowe and Kahn 1998* Baltes and Baltes 1991 Roos and Haven 1991* Schulz and Heckhausen 1996 Strawbridge et al 1996* Perls and Silver 1999	Guralnik and Kaplan 1989 Strawbridge et al. 1996 Reed et al. 1998 Leveille 1999 Ford et al 2000 Vaillant and Mukamal 2001 Haveman-Nies 2003 Newman et al. 2003	Palmore 1979 Guralnik and Kaplan 1989 Roos and Haven 1991 Berkman et al. 1993 Day and Day 1993 Garfein and Herzog 1995 Strawbridge et al. 1996 Baltes et al 1997 Jorm et al. 1998 Reed et al. 1998 Avlund et al. 1999 Grundy et al. 1999 Hogan et al. 1999 Lamb and Myers 1999 Leveille et al. 1999 Ford et al 2000 Burke et al. 2001 Vaillant and Mukamal 2001 VonFaber et al 2001 Andrews et al. 2002 Strawbridge et al 2002a Strawbridge et al 2002b Liang et al. 2003 Menec 2003 Newman et al. 2003 Uotinen et al 2003 Montross et al 2005 Almeida et al. 2006	Guralnik and Kaplan 1989 Roos and Haven 1991 Berkman et al 1993 Seeman 1994 Seeman 1995 Strawbridge et al. 1996 Freund and Baltes 1998 Reed et al. 1998 Ferucci et al.1999 Leveille et al. 1999 Mendes de Leon 1999 Unger 1999 Ford et al 2000 Vaillant and Mukamal 2001 Newman et al. 2003 Menec 2003 Haveman-Nies 2003 Almeida et al. 2006 Willcox et al 2006 Kaplan et al. 2007

Appendix 3

Qualitative Pilot Study – Healthy ageing conceptualisations among older Malays in Melbourne, Australia

The pilot study aimed to explore the cultural and group dynamics of older Malays participating in a focus group. It tested the semi-structured interview questions in preparation for Study 1. The interviews conducted in the pilot study were also used to test the analytical process. While the intention was to collect the pilot data via focus groups, circumstances required a combination of approaches as detailed below

Ethics approval

Ethics approval for conducting the qualitative study was received from the Monash University Standing Committee on Ethics on 23 April 2008 (Appendix 3A).

Study setting and recruitment

To examine how older Malays view ageing well, purposive sampling was used to identify information-rich participants (Patton 2002). As older Malays comprise a minority population in Australia, access to the potential participants for the pilot study was through personal contacts and community groups. In Melbourne, I engaged an ethnic specific community group namely Khairat Melayu Islam Victoria (KMIV) to introduce me to potential older Malays. Information sessions were arranged with interested individuals either over the telephone, via e-mail or face to face, according to their preferred approach.

The interview schedule

The interview started with introductory questions (Krueger and Casey 2007) requesting participants to clarify which term participants preferred to describe older people using the

following question: "In your routine conversation, what words do you use to describe 'old people'?"

The participants were then asked to share their perspectives in identifying older people in their community. Further questions were then posed (as listed below) but were not necessarily asked in order as sometimes participants answered the questions during the course of discussion without being prompted:

(1) how older people understood healthy ageing from their perspective,

(2) their definition of the ideal (expected) old age and how they prepared for it,

(3) how their life experiences affected their current life situation, and

(4) what they needed to achieve healthy ageing.

Appendix 3B lists the issues and questions for the focus group. The interview usually took about 60 to 90 minutes.

On conclusion of the discussion, I thanked the participants for their contribution, informed them of the expected time of release of the study findings, and asked whether they wished to review the transcript. I also asked whether it was acceptable to contact the participants again by phone or email to clarify any details at a later date. After the session, the participants were usually treated with some Malay food and drinks. The participants were not given any payment or financial provision to participate in this study.

Data collection

On arrival at the focus group, participants were provided with a written explanatory statement to keep and a consent form to sign (Appendix 3B and 3C). All participants signed

a consent form and completed a socio demographic data sheet. The interviews were conducted in Malay, English or a mixture of both languages depending on participants' preferred language**.**

Four semi structured interviews were conducted between May and July 2008. Two interviews were conducted as a small group consisted of three participants in each group, whereas another two were conducted as individual interviews. The difference in the data collection approach was due to the following reasons:

1. The participants were living at different places in Melbourne and to bring them together at one time was a challenge. To accommodate this, they were encouraged to select their preferred time and arrange their own group for the interview. For those who could not attend at the proposed time and venue, an individual interview was offered.

2. Some of the participants were willing to be involved in the study but were not comfortable to talk as part of a group.

The interviews were audio recorded, transcribed and translated into English. The English translation of the transcripts were checked and confirmed by a linguistic lecturer from Malaysia doing her PhD in Monash University.

Data management and analysis

The data were analysed using a thematic analysis approach (Braun and Clarke 2006). As this research explored unknown perspectives, the thematic analysis process was 'inductive in nature and data-driven and provided a rich thematic description of the entire dataset' (Braun & Clarke, 2006, p.83)

The six phases carried out in the thematic analysis process are described below, as outlined by Braun and Clarke (2006):

1. Data familiarisation – this process started as early as during the interview itself. Transcribing and translating the interviews helped me to immerse myself in the data, yet I still listened to the interviews and read the transcripts several more times. Meanings and patterns were then compared to my field notes during and after each focus group.

2. Generating initial codes – Detailed listening to the interviews and reading into the transcripts usually resulted in the generation of broader initial codes. In addition to manually listed codes, I started using the Nvivo8 software (Bazeley, 2007). Coding involved 'fracturing' and 'slicing' selected passages from the transcript to describe the ideas expressed in them (Bazeley, 2007). Similar ideas from different passages were categorised in the same coding, given a description to describe the idea and recorded as a free node. Free nodes are used to store coding that 'do not presume any relationships or connections' (Bazeley, 2007,p.83)

3. Identifying the themes – During and after each focus group, I usually identified general ideas for the potential themes. I reviewed the free nodes and re-categorised them as necessary Identifying connections between the free nodes, they were then transformed into tree nodes to form key themes, which was carried out manually and using the software. Tree nodes provide a way to organise the data into a hierarchical branch structure connecting them into categories and sub-categories (Bazeley, 2007).

4. Reviewing themes – the themes identified were reviewed for possible overlap and their degree of importance as a theme in its own right or as a sub theme was assessed.

5. Defining and naming themes – as the context for each theme became clearer after repeated reviews and rearrangement of themes and subthemes, each theme was then defined by assigning them with a label.

6. Producing the report - the themes and subthemes were finalised following discussion with my supervisors and the findings were prepared in the report.

Findings from the pilot study

Participants were 8 older Malays (3 men and 5 women) in Melbourne aged 60 to 78 who were living independently in the community (see Table 3.2). They had lived in Australia for an average of 34 years, ranging from 20 to 47 years. All were still able to converse in Malay language but some preferred to converse in English (particularly those who had completed tertiary education). All the women were fully retired whereas all three men were still working.

The themes identified are listed below and are illustrated by extracts from the interviews:

- Spiritual, mental and physical well being

- Hope and purpose

- Independence

- Adaptation/ Acceptance/ Selective relationship

- Living environment

- Continuous learning

- Preparation

Table 3.2.

Pilot study participants' characteristics

ID*	Age	Gender	Education	Marital status	House ownership	Household number	Financial satisfaction
P1	74	F	Tertiary	Widowed	Own	1	Comfortable
P2	78	F	Secondary	Separated	Rent	1	Just enough
P3	65	F	None	Divorced	Own	1	Comfortable
P4	61	M	Tertiary	Married	Own	3	Just enough
P5	60	M	Tertiary	Married	Own	4	Comfortable
P6	64	M	Secondary	Married	Own	6	Comfortable
D7	67	F	Primary	Divorced	Own	3	Comfortable
D8	65	F	Primary	Married	Own	2	Just enough

*P-for participants in focus group, D- for individual interview

Spiritual, mental and physical wellbeing

The desire to achieve a peaceful life was expressed when one participant described coming to terms with the experience of pain, 'I don't mind some knee pain, as long as other senses are peaceful' (P1). Participants concern with well being was mainly related to their spiritual needs and peaceful life as seen in the following conversation:

P3: I told her bluntly, we are 'hungry' for religious teacher.

P2: Of course, religious teacher, there is no one to teach us here. At this age, it is more spiritual than material.

P1: For me the main thing is peacefulness, to be able to pursue my interest, if possible   with Allah's blessing, in English I put it, peace, tranquility and happiness.

Hope and purpose

Being grateful and thankful to God was shared by the following participant where her days started and ended with hope and prayer:

'I always think every day is just another day, when I wake up, I am grateful to Allah, really appreciate it, before I go to sleep I pray for a peaceful sleep, sleep in faith and wake up in faith…'(D8).

Independence

Healthy ageing was related to the sense of being independent for as long as possible, both physically and financially into later life. This was strongly expressed with the intention not to be a burden on the family as shared below:

P4: Comfort, money, income, be able to get enough, enough to get the lawn mowed, enough to make ends meet, I am taking a short cut here.

P5: Social network…

P4: Golf, Not just play golf everyday and do nothing because at the end of the day, to grow old at this environment, the pace is so fast, I see myself in old age home, I need to stop myself to go there as long as I can. As long as I can I would not burden my family to take care of me, that's the bottom line, I would not rely on Mary and Tan to take care of me if I become incapacitated.

Adaptation/ Acceptance/ Selective relationship

A change in attitude towards life and to be more selective in their communication with others were described as part of their adaptation at older age guided by spiritual awareness and death as illustrated here,

> '…as an older person, only a short time left, after our prayer, then reciting the Quran, we are not keen to get involved in any conversation…most of my friends stay quietly in their room after the night prayer, meditating…'(D7).

Living environment

Participants reported that a limited availability of a culturally or spiritually relevant nursing home was a concern, 'there is only one basically Islamic nursing home, in Lysterfield, all *halal* and other thing, when you are in the nursing home, every Sunday there is a chaplain, you just sit down… '(P6).

Continuous learning

Continuous learning was regarded as particularly important for healthy ageing, particularly as part of an ongoing effort to pursue a spiritual path, 'do a lot of good deeds, if you don't know, you learn, continuous learning to tomb, as long as you are alive' (P2).

Preparation

A balanced life in terms of the physical, social, psychological and spiritual was illustrated as a preparation for good ageing:

> 'I will structure my life, find balance between exercise, doing some voluntary work, spend some time with the family, go to the mosque, keep my mind active. Here we

have the Forbes group, this is where the older people meet one another, they meet once a month or once a fortnight, they even organize trips...'(P5).

In summary, the attributes associated with healthy ageing expressed by participants in this pilot study were multidimensional and broadly consistent with the lay model (Bowling and Dieppe 2005). This demonstrates their familiarity with healthy ageing issues depicted by the policy but were individualised according to their culture and life experiences. Interestingly there was an emphasis towards spiritual reconciliation, which might have been neglected by healthy ageing policy and research. This warrants further exploration of the role of spirituality in healthy ageing among culturally and linguistically diverse groups in Australia.

The findings from the pilot study demonstrated the ability of the semi-structured interview to gain rich data particularly in the focus groups as compared to individual interviews. At the same time, it raised the importance of careful selection of participants to encourage group cohesiveness and positive group dynamics. The feasibility of the analytical process using thematic analysis was confirmed; however it did raise concerns about the challenges in managing an extensive dataset. The lessons learnt from the pilot study are further described in the next section.

Lessons from the pilot study

Focus groups or individual in depth interviews?

The opportunity to run two small focus groups and conduct two individual interviews was a very useful exercise. It enabled me to see how participants' life stories emerged via individual interviews and formed a data-rich source, yet it was somewhat limited in relation to the range of issues discussed. On the other hand, group interactions spontaneously expanded the richness and range of the data. The group participants seemed to enjoy the

multidirectional interactions as an avenue to generate, modify or challenge their views. For example, when the men's group talked about a place to live, they started talking about living in their own house for as long as possible with their spouse or children, then they talked about reasons to modify their house or down-sizing it according to their functional ability and their children's status. This extension of the theme may not have occurred via an individual interview and arose with very minimal moderator involvement. Generating equivalent data during an individual interview would require much more time and more interviewer directed interaction.

Group membership

Another issue was the group compatibility and cohesiveness. Both groups were formed by the participants themselves and they decided the place and time for the interview according to their own availability. I was happy to agree to this decision as it is part of the Malay culture to respect the wishes of older people. As the Malay community in Melbourne is very small, to get strangers to form a group was almost impossible. However, at times it also proved difficult to bring some people together who were known to each other as they were seemingly uncomfortable to have certain people in the same group. In one instance, after the completion of one focus group session, I was informed of two other potential participants with a cautionary note that they may not welcome me to interview them. To my surprise when I called them, they gladly accepted to be interviewed and I was warmly welcomed to their houses for individual interviews.

During both individual interviews, each participant expressed their unwillingness to be interviewed in a group with certain people. I am not sure whether it was the culture or just an isolated case, nevertheless this invaluable experience encouraged me to be sensitive and cautious in my future attempts to organise focus groups among older Malays. This

experience guided my approach to recruiting participants for the focus group study in Malaysia. I specifically asked each participant in person whether they were comfortable sharing their views with other group members. If they were uncomfortable expressing themselves within a group, but still interested to express their views, I offered them a follow up visit for further in depth exploration.

Terminology and questions

The pilot study also assisted me to understand and identify more appropriate terminology to use with the older Malays. The interviews were conducted both in Malay and English, with some of the participants still retaining their Malay regional dialect. This meant that some participants helped each other to understand the context and I learned more lay terms of Malay words in the process. In English, the use of healthy ageing or ageing well was more easily understood as compared to its Malay translation of *penuaan sihat* or *penuaan sejahtera.*

I also contacted another researcher in the Gerontology Institute in Malaysia to obtain the currently used lay terminology and was informed that most of my identified terms were researcher-based terminology while at the same time they were working on a glossary of terms related to active ageing and as all terms were fairly new, they may not be suitable for lay older person interaction. So I decided to use the terms ideal ageing or good ageing translated into Malay as *penuaan yang ideal* and *penuaan yang baik*. The pilot study allowed me to identify various ways of asking the question: 'What do you think ideal ageing/ good ageing looks like?' Most participants were able to comprehend the question well, but a few alternatives were also used effectively:

1. What does good life at old age mean to you?

2. What are important things in life to have once people become older?

3. What are the things you don't want to happen to you once you are old?

4. What are the problems at old age?

Thematic analysis

The process used for thematic analysis tested in this pilot study seemed feasible and practical to formulate the healthy ageing concepts expressed by the participants.

Conclusion

The quest to explore older people's perspectives of healthy ageing, and its facilitators and barriers led to the construction of a two stage study design consistent with a constructivist paradigm. This pilot qualitative study explored the main research method and the lessons learnt from it was crucial particularly to manage potential challenges in completing this thesis.

Appendix 3A: Ethics approval for qualitative study

Subject: Monash Human Ethics - CF07/1518 - 2007000453

Date: Wed, 23 Apr 2008 16:08:45 +1000

From: scerh

To: Colette Browning

Cc: Farzad Sharifian, Shane Thomas, Hui Yang, Noorlaili Tohit

---

```
PLEASE  NOTE:  To  ensure  speedy  turnaround  time,  this
correspondence is now being sent by email only. SCERH will
endeavour  to  copy  all  investigators  on  correspondence
relating to this project, but it is the responsibility of
the  first-named  investigator  to  ensure  that  their  co-
investigators   are   aware   of   the   content   of   the
correspondence.


Prof Colette Browning
Inst of Health Services Research
Faculty of Med Nursing & Health Sciences
Teaching Hospitals Monash Medical

23 April 2008

CF07/1518  -  2007000453:  Cultural  conceptualisations  of
healthy and successful ageing

Dear Researchers,

Thank you for submitting your Request for Amendment form
with respect to the above named project.

This is to advise that the following amendments dated 9
April 2008 have been approved and the project can proceed
according to your approval given on 31 May 2007.
1.  Include  student  researcher  Noorlaili  Tohit  on  the
project.
2.  Add  a  further  4  groups  in  the  qualitative  data
collection.
3.  Include  additional  selection  procedures  in  the
recruitment.
4.  Engage  the  Chinese  Association  Victoria  (CAV)  for
introduction purposes – Group 13.
```

5. Engage Khairat Masyarakat Islam Victoria (KMIV) for introduction purposes – Group 14.
6. Recruit Groups 15 and 16 through on on-going study on wellness among older adults in Malaysia.
7. Alter Section 2.6d to include detail on obtaining contact details.
8. Include community setting in Malaysia as a place for data collection in Section 5.2.
9. Trained student researcher (Noorlaili Tohit) to run the focus groups.
10. Noorlaili Tohit and a Malay doctorate student in the School ofLanguages, Cultures and Linguistics to act as translator for all documents.

Thank you for keeping the Committee informed.

Professor Ben Canny
Chair, SCERH

Cc: Dr Farzad Sharifian; Prof Shane Thomas; Mr Hui Yang; Dr Litza
Kiropoulos; Noorlaili Tohit

--
Ms Coral Lindupp
Senior Administrative Officer
Human Ethics Office
Building 3E, Room 111
Monash University, Clayton 3800

Appendix 3B: Focus Groups themes and questions.

Panduan tema dan soalan untuk temubual berkumpulan

(Focus group themes and questions)

1. Dalam perbualan harian anda, apakah perkataan-perkataan yang anda gunakan untuk 'orang tua'?   *(In your routine conversation, what words do you use to describe 'old people'?)*
2. Atas dasar apa anda menggolongkan seseorang sebagai 'tua'? Apakah jenis pengkelasan yang anda gunakan untuk penuaan?   *(What kind of people do you classify as 'old people'? What kind of classification do you use to refer to 'old people'?)*
3. Apakah perkataan-perkataan lain yang digunakan untuk menerangkan tentang 'orang tua'? Pada pendapat anda adakah perkataan-perkataan tersebut baik atau tidak?   *(Do you find other people use different words to describe 'old people'? Do you think those words are good or bad (personal judgment)?)*

1. Apakah perkara-perkara penting yang perlu apabila seseorang mencapai usia emas/tua? (PANDUAN: kewangan yang selesa, kesihatan, keupayaan melakukan sesuatu dengan sendirinya dan lain-lain)   *(What are the most important things to have when someone reaches old age? (PROBE: financial security, health, ability to do things for yourself, etc.))*   2. Apakah yang dikatakan penuaaan yang baik dan berjaya?   *(What does healthy and successful ageing look like?)*   3. Bagaimanakah cara kita boleh mencapai usia tua yang baik? (Apakah keadaan usia tua yang baik dan apa ertinya keadaan tersebut?   *(How can we achieve a 'happy old age'? What are the conditions of a happy old age,   and what are the meanings of these conditions?)*   *4.* Pada pendapat anda, apakah yang patut dilakukan semasa usia muda sebagai persediaan bagi mencapai usia tua yang baik (kewangan, kesihatan, senaman, makanan yang baik atau lain-lain) dan mengapa?   *(How should young people prepare for a 'happy old age' (finance, health, exercise, good food, etc), and why?)*

1. Bagaimanakah keadaan hidup anda sekarang? (PANDUAN: kewangan, taraf kesihatan, jagaan hidup harian, suasana persekitaran, rakan-rakan, senaman, pemakanan dan lain-lain).

(Can you tell us about your current living situation? (PROBE: financial security, health status, routine life care, living environment, friendships, exercise, eating etc.))

2. Apa yang mempengaruhi kehidupan anda sekarang sebagai warga emas? (PANDUAN: kewangan, senaman, makanan yang baik, rakan yang baik, keluarga bahagia, anak yang berjaya, jagaan kesihatan, berupaya membuat sesuatu untuk diri sendiri dan lain-lain)

(What affects how well you live your life now as an older person? (PROBE: finance, exercise, good food, good friends, happy family, successful children, health care, able to do things for yourself etc))

3. Pernahkah anda mengalami sebarang pengalaman buruk (peristiwa yang tidak dapat dilupakan) yang boleh di kaitkan dengan usia tua?

Adakah peristiwa tersebut memberi kesan yang penting terhadap   kehidupan anda sekarang? Jika ya, apa dia peristiwa tersebut dan kesannya?

(Do you associate any negative (unforgettable) experiences with old age, which have significant impact on your current life? If yes, what would they be?)

Soalan tambahan jika berkesempatan *(Possible additional question):*

- Apakah perkataan-perkataan yang anda gunakan (atau lebih suka) apabila bercakap mengenai penuaan yang sihat dan sejahtera?
  (What words do you use (or prefer to hear) when talking about healthy and successful ageing?)

Appendix 3C

MONASH University

May 2007

Explanatory Statement for Focus Group Participants

*Title: **Cultural conceptualisations of healthy and successful ageing***

(This information sheet is for you to keep)

My name is Colette Browning and I am a Professor in the Monash Institute of Health Services Research at Monash University.

Who are the participants?

After reading our advertisement you contacted us to participate in the project. We have chosen you to participate in this study as we are interested in comparing how people from different cultural backgrounds think about ageing. We have chosen people to participate who are able to communicate verbally.

The purpose of the research

The aim of this study is to compare the ways in which people from different cultural backgrounds of over 65 interpret "successful ageing".

Possible benefits

The results will help both communities understand cultural differences that may exist in understanding successful ageing.

What does the research involve?

The study involves focus groups discussions. You will be asked questions about your opinions of successful ageing. Your answers will be audiotaped and later transcribed for analysis.

How much time will the research take?

The focus groups will run for about 45 to 60 minutes.

Inconvenience/discomfort

You should not experience any distress or discomfort when answering the questions. If you do become distressed we will stop the focus group and contact your next of kin or doctor if you are agreeable.

Can I withdraw from the research?

Being in this study is voluntary and you are under no obligation to consent to participation. However, if you do consent to participate, you may only withdraw prior to the beginning of the focus group.

Confidentiality and privacy

Everything will be done to protect your right to privacy. The data will be kept without participant names identified. The data will be published in summary format and without identifying individuals. If there would be a need for providing a name in a quote, a pseudonym will be used.

Storage of data

Storage of the data collected will adhere to the University regulations and be kept on University premises in a locked cupboard/filing cabinet for 5 years. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

Results

If you would like to be informed of the aggregate research finding, please contact Professor Colette Browning ■ ■ ■ ■ ■ ■ ■ ■ ■ ▬▬▬▬▬▬▬▬▬

The findings are accessible from December 2007 until May 2008.

If you would like to contact the researchers about any aspect of this study, please contact the Chief Investigator:	If you have a complaint concerning the manner in which this research Project Number xxxxx is being conducted, please contact:
Professor Colette Browning Monash Institute of Health Services Research,Faculty of Medicine, Nursing and Health Sciences Postal address: Monash Medical Centre, Locked Bag 29, Clayton, VIC 3168. Physical address: 43-51 Kanooka Grove, Clayton, VIC 3168. ██████████████ ██████████████	Human Ethics Officer Standing Committee on Ethics in Research Involving Humans (SCERH) Building 3e Room 111,Research Office Monash University VIC 3800 ████████ ████████ █████████████████

Thank you.

Signed:

Name: Colette Browning

Appendix 3D

MONASH University

Februari 2008

Penerangan untuk peserta temubual berkumpulan

Tajuk: Konsep penuaan sihat dan sejahtera

(Kertas penerangan ini adalah untuk simpanan anda)

Nama saya Colette Browning dan saya ialah Professor di Monash Institute of Health Services Research, Universiti Monash.

Siapa peserta kajian?

Setelah membaca iklan kami (menerima jemputan kami), anda telah menghubungi kami untuk menyertai kajian ini. Kami memilih anda untuk menyertai kajian ini kerana kami berminat untuk melihat perbandingan pendapat orang ramai dari pelbagai latar budaya mengenai peningkatan usia. Kami memilih peserta yang boleh berkomunikasi secara lisan.

Tujuan kajian

Kajian ini bertujuan untuk melihat perbandingan pandangan warga yang berusia 65 tahun ke atas dari pelbagai latar budaya mengenai penuaan sejahtera.

Faedah yang boleh diperoleh

Hasil kajian akan membantu masyarakat memahami perbezaan budaya yang mungkin wujud dalam usaha memahami penuaan sejahtera.

Bagaimana kajian ini dijalankan

Kajian ini melibatkan perbincangan secara temu bual berkumpulan. Anda akan diminta memberi pendapat anda mengenai penuaan sejahtera. Jawapan anda akan dirakamsuara dan kemudian dicatat untuk analisa seterusnya.

Berapa lama masa kajian?

Temubual berkumpulan akan berlangsung antara 45 hingga 60 minit.

Kesukaran/ketidakselesaan

Anda tidak sepatutnya mengalami sebarang tekanan atau berasa tidak selesa sewaktu menjawab soalan-soalan. Sekiranya anda berasa tertekan, kami akan menghentikan temubual berkumpulan ini dan menghubungi waris anda atau doktor sekiranya anda bersetuju.

Bolehkah saya menarik diri daripada kajian ini?

Menyertai kajian ini adalah secara sukarela. Bagaimanapun, sekiranya anda telah bersetuju menyertai kajian ini tetapi ingin menarik diri kemudian, anda hanya boleh berbuat demikian sebelum temubual berkumpulan dimulakan.

Kerahsiaan dan hak peribadi

Langkah-langkah yang perlu akan diambil untuk menjaga hak peribadi anda. Maklumat akan disimpan tanpa nama peserta yang boleh dikenali. Maklumat akan disiarkan dalam bentuk ringkasan dan tanpa pengenalan individu. Sekiranya diperlukan, kami akan menggunakan nama samaran sebagai tanda pengenalan bagi anda.

Penyimpanan maklumat

Penyimpanan maklumat yang diperolehi adalah mengikut peraturan Universiti dan akan disimpan dalam almari/kabinet berkunci di Universiti selama 5 tahun. Laporan kajian ini mungkin akan dihantar untuk penerbitan, tetapi setiap peserta tidak akan dikenalpasti dalam laporan tersebut.

Hasil kajian

Sekiranya anda ingin dimaklumkan mengenai hasil kajian secara keseluruhan, sila hubungi Professor Colette Browning di talian ████████████████████████ ████████████████████████████ Hasil kajian boleh diperolehi dari bulan August 2008 hingga May 2009.

Sekiranya anda ingin menghubungi para penyelidik mengenai sebarang aspek berkaitan kajian ini, sila hubungi Ketua Penyelidik:	**Sekiranya anda mempunyai aduan mengenai cara kajian ini (Nombor Projek xxxxx) dijalankan, sila hubungi:**
Professor Colette Browning Monash Institute of Health Services Research Faculty of Medicine, Nursing and Health Sciences Postal address: Monash Medical Centre, Locked Bag 29, Clayton, VIC 3168. Physical address: 43-51 Kanooka Grove, Clayton, VIC 3168. ████████████████████ ████████████████████	Human Ethics Officer Standing Committee on Ethics in Research Involving Humans (SCERH) Building 3e Room 111 Research Office Monash University VIC 3800 ████████████ ████████ ████████████████

Terima kasih.

Tandatangan:

Nama: Colette Browning

Appendix 4A (Malaysia)

MONASH University

Februari 2008

Penerangan untuk peserta temubual berkumpulan

Tajuk: **Konsep penuaan sihat dan sejahtera**

(Kertas penerangan ini adalah untuk simpanan anda).

Nama saya Colette Browning dan saya ialah Professor di Monash Institute of Health Services Research, Universiti Monash.

Siapa peserta kajian?

Setelah membaca iklan kami (menerima jemputan kami), anda telah menghubungi kami untuk menyertai kajian ini. Kami memilih anda untuk menyertai kajian ini kerana kami berminat untuk melihat perbandingan pendapat orang ramai dari pelbagai latar budaya mengenai peningkatan usia. Kami memilih peserta yang boleh berkomunikasi secara lisan.

Tujuan kajian

Kajian ini bertujuan untuk melihat perbandingan pandangan warga yang berusia 65 tahun ke atas dari pelbagai latar budaya mengenai penuaan sejahtera.

Faedah yang boleh diperoleh

Hasil kajian akan membantu masyarakat memahami perbezaan budaya yang mungkin wujud dalam usaha memahami penuaan sejahtera.

Bagaimana kajian ini dijalankan

Kajian ini melibatkan perbincangan secara temu bual berkumpulan. Anda akan diminta memberi pendapat anda mengenai penuaan sejahtera. Jawapan anda akan dirakamsuara dan kemudian dicatat untuk analisa seterusnya.

Berapa lama masa kajian?

Temubual berkumpulan akan berlangsung antara 45 hingga 60 minit.

Kesukaran/ketidakselesaan

Anda tidak sepatutnya mengalami sebarang tekanan atau berasa tidak selesa sewaktu menjawab soalan-soalan. Sekiranya anda berasa tertekan, kami akan menghentikan temubual berkumpulan ini dan menghubungi waris anda atau doktor sekiranya anda bersetuju.

Bolehkah saya menarik diri daripada kajian ini?

Menyertai kajian ini adalah secara sukarela. Bagaimanapun, sekiranya anda telah bersetuju menyertai kajian ini tetapi ingin menarik diri kemudian, anda hanya boleh berbuat demikian sebelum temubual berkumpulan dimulakan.

Kerahsiaan dan hak peribadi

Langkah-langkah yang perlu akan diambil untuk menjaga hak peribadi anda. Maklumat akan disimpan tanpa nama peserta yang boleh dikenali. Maklumat akan disiarkan dalam bentuk ringkasan dan tanpa pengenalan individu. Sekiranya diperlukan, kami akan menggunakan nama samaran sebagai tanda pengenalan bagi anda.

Penyimpanan maklumat

Penyimpanan maklumat yang diperolehi adalah mengikut peraturan Universiti dan akan disimpan dalam almari/kabinet berkunci di Universiti selama 5 tahun. Laporan kajian ini mungkin akan dihantar untuk penerbitan, tetapi setiap peserta tidak akan dikenalpasti dalam laporan tersebut.

Hasil kajian

Sekiranya anda ingin dimaklumkan mengenai hasil kajian secara keseluruhan, sila hubungi Professor Colette Browning di talian ███████████████████ ████████████████████████████

Hasil kajian boleh diperolehi dari bulan August 2008 hingga May 2009.

Sekiranya anda ingin menghubungi para penyelidik mengenai sebarang aspek berkaitan kajian ini, sila hubungi wakil Ketua Penyelidik:	Sekiranya anda mempunyai aduan mengenai cara kajian ini (Nombor Projek xxxxx) dijalankan, sila hubungi:
Professor Madya Dr. Tengku Aizan Hamid Pengarah, Institut Gerontologi, Universiti Putra Malaysia, 43400 UPM Serdang, Selangor, Malaysia. ████████████ ████████████ ████████████████	Human Ethics Officer Standing Committee on Ethics in Research Involving Humans (SCERH) Building 3e Room 111 Research Office Monash University VIC 3800 ████████ ████████ ████████████

Terima kasih.

Tandatangan:

Nama: Colette Browning

Appendix 4B

MONASH University

Borang Keizinan– *Peserta Temubual Berkumpulan*
(Tajuk: Konsep Penuaan Sihat dan Sejahtera)

NOTA: Borang keizinan ini akan disimpan oleh penyelidik Universiti Monash untuk rekod.

Saya bersetuju untuk menyertai projek penyelidikan Universiti Monash-UKM seperti dinyatakan di atas. Saya telah mendapat penerangan mengenai projek tersebut dan telah membaca Kertas Maklumat yang kini dalam simpanan saya untuk rujukan.

Saya faham dengan bersetuju menyertai kajian ini bermakna :

1. Saya bersetuju untuk menyertai temubual berkumpulan.
2. Saya bersetuju temubual berkumpulan tersebut dirakamsuara.

Saya faham bahawa penyertaan saya adalah secara sukarela, bahawa saya boleh memilih untuk tidak menyertai sebahagian atau keseluruhan projek, dan saya boleh menarik diri sebelum temubual berkumpulan dimulakan tanpa sebarang denda atau kesukaran dalam sebarang cara.

Saya faham bahawa sebarang maklumat yang diperolehi oleh penyelidik untuk digunakan dalam laporan atau penerbitan hasil kajian tidak akan, dalam apa cara sekalipun, mengandungi nama atau ciri-ciri yang boleh dikenali.

Saya faham bahawa sebarang maklumat yang saya berikan adalah sulit, dan tiada maklumat yang boleh menjurus kepada pengenalan diri seseorang didedahkan dalam sebarang laporan projek tersebut, atau kepada orang lain.

Saya faham bahawa maklumat dari temubual berkumpulan yang dirakamsuara ini akan disimpan secara selamat dan hanya boleh dicapai oleh kumpulan penyelidikan. Saya juga faham bahawa maklumat tersebut akan dimusnahkan selepas 5 tahun melainkan saya mengizinkan untuk ia digunakan dalam penyelidikan lain dimasa hadapan.

Nama peserta: _____

Tandatangan:_____   **Tarikh:**_____

Appendix 4C

KAJIAN KONSEP PENUAAN SIHAT SEJAHTERA

MAKLUMAT ASAS PESERTA TEMUBUAL BERKUMPULAN

(Sila isi tempat kosong atau bulatkan jawapan yang betul)

1. JANTINA : Lelaki/ Perempuan

2. UMUR : _____ tahun

3. TAHUN LAHIR: _____

4. UMUR SEMASA MULA BERSEKOLAH : _____ tahun

Tidak pernah bersekolah...................1

5. UMUR SEMASA MENAMATKAN PERSEKOLAHAN: _____ tahun

6. SEJAK TAMAT SEKOLAH, ADAKAH ANDA MEMPEROLEHI SEBARANG SIJIL, DIPLOMA ATAU SEBARANG KELAYAKAN? Ya............1

Tidak........0

7. PILIH DARI SENARAI BERIKUT BAGI MENUNJUKKAN KELULUSAN TERTINGGI ANDA.

Ijazah sarjanamuda atau lebih tinggi..........................1

Sijil/Diploma...2

Sekolah Menengah...3

Sekolah Rendah...4

Lain-lain (nyatakan):_____

8. PILIH DARI SENARAI BERIKUT MENGENAI STATUS PERKAHWINAN ANDA?

Masih berkahwin.................................1 (terus ke nombor 10)

Balu..2 (terus ke nombor 09)

Bercerai..3 (terus ke nombor 09)

Berpisah..4 (terus ke nombor 09)

Tidak pernah berkahwin......................5 (terus ke nombor 12)

Lain-lain (nyatakan):_____

9. TELAH BERAPA LAMA ANDA (MENJADI BALU/ BERCERAI/ BERPISAH)?

_____tahun

10. ADAKAH ANDA MEMPUNYAI ANAK (yang masih hidup)? Ya/Tidak

11. BERAPA ORANG ANAK PEREMPUAN? _____ orang.

12. BERAPA ORANG ANAK LELAKI? _____ orang.

13. STATUS RUMAH KEDIAMAN ANDA?

Rumah sendiri..1

Rumah sewa...2

Lain-lain (nyatakan):_____

14. SIAPAKAH YANG BIASANYA TINGGAL BERSAMA ANDA? (boleh pilih lebih dari satu)

Pasangan 1

Anak (termasuk menantu) 2

Cucu 3

Ibubapa (termasuk mertua) 4

Adik beradik 5

Lain-lain saudara 6

Kawan 7

Pembantu bergaji 8

Lain-lain (nyatakan):_____

Jumlah ahli isi rumah (termasuk anda): _____ orang

15. PADA MASA INI, ANDA MENGANGGAP DIRI ANDA:

Bersara sepenuhnya.................................1

Bekerja sambilan.....................................2

Bekerja sepenuh masa.............................3

Lain-lain (nyatakan:_____)

16.APAKAH KERJA UTAMA ANDA SEKARANG ATAU SEBELUM BERSARA?

_____

17. APAKAH PUNCA PENDAPATAN UTAMA ANDA? (Boleh pilih lebih dari satu)

Pencen Kerajaan atau ganjaran...........................1

Gaji...2

Pendapatan dari perniagaan atau hartabenda...3

KWSP/PERKESO...4

Dividen...5

Lain-lain (nyatakan)_____

18. BERAPAKAH ANGGARAN PENDAPATAN BULANAN ANDA (DAN PASANGAN ANDA)? RM _____ sebulan

19. MENGENAI KEDUDUKAN KEWANGAN ANDA, PADA PANDANGAN ANDA:

Tidak dapat memenuhi keperluan harian............1

Sekadar cukup memenuhi keperluan harian......2

Selesa...3

20 . ADAKAH ANDA MEMPUNYAI INSURANS KESIHATAN SWASTA? Ya / Tidak

TAMAT

TERIMA KASIH

Appendix 5A

MONASH University

February 2009

Explanatory Statement for Survey Participants

Title: ***Healthy Ageing Initiative 2009***

This information sheet is for you to keep.

My name is Colette Browning and I am a Professor in the Monash Institute of Health Services Research at Monash University.

Who are the participants?

You have been invited to participate in this project. We have chosen you to participate in this study as we are interested to know what factors affecting healthy and successful ageing. We have chosen people to participate who are able to communicate verbally.

The purpose of the research

The aim of this study is to compare the health and functional status among older adults aged 60 and above, then investigating factors affecting healthy and successful ageing.

Possible benefits

The results will help the communities understand the healthy ageing concepts and factors affecting it.

What does the research involve?

The study involves face to face interview about healthy ageing and associated factors. Your answers will be written in a survey questionnaire for analysis later.

How much time will the research take?

The interview will take place for about 45 to 60 minutes.

Inconvenience/discomfort

You should not experience any distress or discomfort when answering the questions. If you do become distressed we will stop the interview and contact your next of kin or doctor if you are agreeable.

Can I withdraw from the research?

Being in this study is voluntary and you are under no obligation to consent to participation. However, if you do consent to participate, you may only withdraw prior to the beginning of the interview.

Confidentiality and privacy

Everything will be done to protect your right to privacy. The data will be kept without participant names identified. The data will be published in summary format and without identifying individuals. If there would be a need for providing a name in a quote, a pseudonym will be used.

Storage of data

Storage of the data collected will adhere to the University regulations and be kept on University premises in a locked cupboard/filing cabinet for 5 years. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

Results

If you would like to be informed of the aggregate research finding, please contact Professor Colette Browning on ████ ████ ████ ██ ████ ████ ████ █
████████████████████████

 The findings are accessible from August 2009 until May 2010.

If you would like to contact the researchers about any aspect of this study, please contact the representative for Chief Investigator:	If you have a complaint concerning the manner in which this research Project (No. CF07/1518 – 2007000453) is being conducted, please contact:
Associate Professor Dr Khairani Omar Ketua Jabatan Perubatan Keluarga, Pusat Perubatan UKM, Jalan Yaakob Latif, Bandar Tun Razak, 56000, Kuala Lumpur ██████████████ ████████████ ████████████████	Chua Khong Wai Research Manager Sunway Campus Research Office Jalan Lagoon Selatan, Bandar Sunway, 46150, Selangor Darul Ehsan, Monash University ██████████ ███ ███████████████

Thank you.

Colette Browning

**Appendix
5B**

MONASH University

Februari 2009

Penerangan untuk peserta kaji selidik

Tajuk: **Inisiatif Usia Emas Sejahtera (Healthy Aging Initiative 2009)**

Kertas penerangan ini adalah untuk simpanan anda.

Nama saya Colette Browning dan saya ialah Professor di Monash Institute of Health Services Research, Universiti Monash.

Siapa peserta kajian?

Anda telah menerima jemputan untuk menyertai kajian ini. Kami memilih anda untuk menyertai kajian ini kerana kami berminat untuk mengetahui perkara-perkara yang mempengaruhi penuaan yang sihat sejahtera. Kami memilih peserta yang boleh berkomunikasi secara lisan.

Tujuan kajian

Kajian ini bertujuan untuk melihat perbandingan fungsi dan status kesihatan warga yang berusia 60 tahun dan lebih, serta perkara-perkara yang mempengaruhi penuaan sihat sejahtera.

Faedah yang boleh diperoleh

Hasil kajian akan membantu masyarakat memahami konsep penuaan sejahtera serta perkara-perkara yang mungkin mempengaruhi penuaan sihat sejahtera.

Bagaimana kajian ini dijalankan

Kajian ini melibatkan temubual mengenai penuaan sihat sejahtera dan factor-faktor berkaitan. Jawapan anda akan dicatat ke dalam borang soal selidik untuk analisa seterusnya.

Berapa lama masa kajian?

Temubual akan berlangsung antara 45 hingga 60 minit.

Kesukaran/ketidakselesaan

Anda tidak sepatutnya mengalami sebarang tekanan atau berasa tidak selesa sewaktu menjawab soalan-soalan. Sekiranya anda berasa tertekan, kami akan menghentikan temubual ini dan menghubungi waris anda atau doktor sekiranya anda bersetuju.

Bolehkah saya menarik diri daripada kajian ini?

Menyertai kajian ini adalah secara sukarela. Bagaimanapun, sekiranya anda telah bersetuju menyertai kajian ini tetapi ingin menarik diri kemudian, anda hanya boleh berbuat demikian sebelum temubual dimulakan.

Kerahsiaan dan hak peribadi

Langkah-langkah yang perlu akan diambil untuk menjaga hak peribadi anda. Maklumat akan disimpan tanpa nama peserta yang boleh dikenali. Maklumat akan disiarkan dalam bentuk ringkasan dan tanpa pengenalan individu.

Penyimpanan maklumat

Penyimpanan maklumat yang diperolehi adalah mengikut peraturan Universiti dan akan disimpan dalam almari/kabinet berkunci di Universiti selama 5 tahun. Laporan kajian ini mungkin akan dihantar untuk penerbitan, tetapi setiap peserta tidak akan dikenalpasti dalam laporan tersebut.

Hasil kajian

Sekiranya anda ingin dimaklumkan mengenai hasil kajian secara keseluruhan, sila hubungi Professor Colette Browning di talian ████████████████████████ atau ██████████████████████████████████ kajian boleh diperolehi dari bulan August 2009 hingga May 2010.

Sekiranya anda ingin menghubungi para penyelidik mengenai sebarang aspek berkaitan kajian ini, sila hubungi wakil Ketua Penyelidik:	Sekiranya anda mempunyai aduan mengenai cara kajian ini (Nombor Projek CF07/1518 - 2007000453) dijalankan, sila hubungi:
Associate Professor Dr Khairani Omar **Ketua Jabatan Perubatan Keluarga,** **Pusat Perubatan UKM,** **Jalan Yaakob Latif, Bandar Tun Razak,** **56000, Kuala Lumpur** ████████████████ ████████████ ████████████████	**Chua Khong Wai** **Research Manager** **Sunway Campus Research Office** **Jalan Lagoon Selatan, Bandar Sunway, 46150, Selangor Darul Ehsan,** **Monash University** ██████████ ███ ████████████████

Terima kasih.

Colette Browning

**Appendix
5C**

MONASH University

Consent Form –*Survey participants*
Title: Healthy Aging Initiative 2009

NOTE: This consent form will remain with the Monash University researcher for their records

---

I agree to take part in the Monash University research project specified above. I have had the project explained to me, and I have read the Explanatory Statement, which I keep for my records. I understand that agreeing to take part means that:

1. I agree to be involved in a face-to-face interview

2. I agree to allow the information given being written down in the survey questionnaire

3. I agree to allow the researcher to check my health record for further details of my health status.

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw prior to the beginning of the interview without being penalised or disadvantaged in any way.

I understand that any data that the researcher extracts from the survey for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

I understand that any information I provide is confidential, and that no information that could lead to identification of any individual will be disclosed in any reports on then project, or to any other party.

I understand that the data from the survey will be kept in a secure storage and accessible to the research team. I also understand that the data will be destroyed after a 5 year period unless I consent to it being used in future research.

Participant's name:_____

Signature:_____   **Date:**_____

**Appendix
5D**

MONASH University

Borang Keizinan– *Peserta Inisiatif Usia Emas Sejahtera*

(Healthy Aging Initiative 2009)

> *NOTA: Borang keizinan ini akan disimpan oleh penyelidik Universiti Monash untuk rekod.*

Saya bersetuju untuk menyertai projek penyelidikan Universiti Monash-UKM seperti dinyatakan di atas. Saya telah mendapat penerangan mengenai projek tersebut dan telah membaca Kertas Maklumat yang kini dalam simpanan saya untuk rujukan.

Saya faham dengan bersetuju menyertai kajian ini bermakna :

1. Saya bersetuju untuk ditemu bual.
2. Saya bersetuju mengizinkan maklumat tersebut di isi dalam borang soal selidik yang disediakan.
3. Saya bersetuju mengizinkan penyelidik meneliti rekod kesihatan saya untuk maklumat lanjut mengenai status kesihatan saya.

Saya faham bahawa penyertaan saya adalah secara sukarela, bahawa saya boleh memilih untuk tidak menyertai sebahagian atau keseluruhan projek, dan saya boleh menarik diri sebelum soal selidik dimulakan tanpa sebarang denda atau kesukaran dalam sebarang cara.

Saya faham bahawa sebarang maklumat yang diperolehi oleh penyelidik untuk digunakan dalam laporan atau penerbitan hasil kajian tidak akan, dalam apa cara sekalipun, mengandungi nama atau ciri-ciri yang boleh dikenali.

Saya faham bahawa sebarang maklumat yang saya berikan adalah sulit, dan tiada maklumat yang boleh menjurus kepada pengenalan diri seseorang didedahkan dalam sebarang laporan projek tersebut, atau kepada orang lain.

Saya faham bahawa maklumat dari soal selidik ini akan disimpan secara selamat dan hanya boleh dicapai oleh kumpulan penyelidikan. Saya juga faham bahawa maklumat tersebut akan dimusnahkan selepas 5 tahun melainkan saya mengizinkan untuk ia digunakan dalam penyelidikan lain dimasa hadapan.

Nama peserta: _____

Tandatangan: _____   **Tarikh:**_____

Appendix 5E: Ethics approval for individual interview for Study 2

From: MRO Human Ethics Team██████████████████████

██████████████████████████

Date: Fri, 27 Mar 2009 10:41:42 +1100

Subject: Monash Human Ethics - CF07/1518 – 2007000453: Cultural conceptualisations of healthy and successful ageing

PLEASE NOTE: To ensure speedy turnaround time, this correspondence is now being sent by email only. SCERH will endeavour to copy all investigators on correspondence relating to this project, but it is the responsibility of the first-named investigator to ensure that their co-investigators are aware of the content of the correspondence.

Prof Colette Browning
Inst of Health Services Research
Faculty of Medicine, Nursing & Health Sciences
Monash Medical Centre Campus

27 March 2009

CF07/1518 – 2007000453: Cultural conceptualisations of healthy and successful ageing

Dear Researchers,

Thank you for submitting your Request for Amendment to the above named project.

This is to advise that the following amendments have been approved and the project can proceed according to your approval given on 31 May 2007.

1.   Changes to section 2, Recruitment.

2.   Addition of one organisation from Malaysia, Department Family Medicine, University of Kebangsaan Malaysia (UKM).

3.   Changes to section 5, Collection of data materials and procedures.

4.   Changes to section 7, Feedback and debriefing procedures.

Thank you for keeping the Committee informed.

Professor Ben Canny
Chair, SCERH

Cc: Dr Farzad Sharifian; Prof Shane Thomas; Mr Hui Yang; Dr Litza Kiropoulos; Dr Kathryn Gilson; Dr Noorlaili Tohit
==================

Human Ethics
Monash Research Office
Building 3E, Room 111
Monash University, Clayton 3800

Appendix 5F: Healthy Ageing Survey (English)

Monash University-UKM

Healthy Ageing Initiative 2009

Survey Questionnaire

(Please write the answer or mark (√) where appropriate)

A. BACKGROUND DATA

1. Year of birth: _ _ _ _

2. Gender:
    - Male
    - Female

3. Ethnic:
    - Malay
    - Chinese
    - Indian
    - Other, specify :_____

4. Current marital status:
    - Married
    - Never married
    - Widowed (go to 4a)
    - Divorced (go to 4a)
    - Separated (go to 4a)
    - Other, specify :_____

    4a. About how long ago were you (widowed/divorced/ separated)?

    _____ years

5. Educational level:
    - No formal education
    - Primary school (go to 5a)
    - Secondary school (go to 5a)
    - College
    - University

    5a. How old were you when you started and left school?

    _____ and _____ years old

6. Do you have any living children?
    - Yes (go to 6a)
    - No

    6a. If yes, how many? _____

7. Housing status
   - Your own house
   - Rental house
   - Other, specify _____

8. Total household members (including you) _____ persons

9. Who usually lives with you?
   - Spouse
   - Children (including in-laws)
   - Grandchildren
   - Parents(including in-laws)
   - Siblings
   - Other relatives/ friends
   - Paid helper
   - Other, specify : _____

10. Employment status
    - Fully retired
    - Partly retired (from paid job)
    - Working full time

11. Your main occupation (current or before retirement): _____

12. Main source of income
    (multiple choice)
    - Government pension
    - Wages or salary
    - Income from own business/ property
    - KWSP/PERKESO
    - Children
    - Other, specify:_____

13. Estimated monthly income (you and your spouse) RM _____
    - Less than RM 500.00
    - RM 500-999
    - RM 1000- 1499
    - RM 1500- 1999
    - RM 2000 or more

14. Thinking about your money situation, would you say:
    - I can't make ends meet
    - I have just enough to get along on
    - I am comfortable

15. In general, would you say you are ageing successfully (or ageing well)?

- Strongly agree
- Somewhat agree
- Somewhat disagree
- Strongly disagree

B. HEALTH AND WELL BEING

1. In general, would you say your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

2. How would you rate your health compared to the past 1 year?

- Better
- About the same
- Worse

3. How would you rate your health compared to the other people of your age?

- Better
- About the same
- Worse

4. Medical conditions (please state):

5. Prescribed medications (please state):

6. Estimated number of government clinic visits for past 1 year. _____ times

7. Estimated number of visits to other clinic(s) for past 1 year. _____ times

8. Hospitalization past 1 year _____ times

9. Smoking status
- Non-smoker
- Ex-smoker (Duration stopped smoking: _____)
- Current smoker (Number of cigarettes per day: ___)

12. Alcohol consumption
- No
- Yes (Type and quantity per week:_____
  _____)

13.Physical activity
- Sedentary
- Under active

(refer RAPA sheets)
- Active

C. FUNCTIONAL STATUS

Instrumental Task

1. Can you use the telephone?

- Without help (including looking up numbers and dialing)
- With some help (can answer phone or dial operator in an emergency, but need a special phone or help in getting the number or dialing)
- Completely unable to use telephone

2. Can you get to places out of walking distance?

- Without help (can travel alone on buses, taxis or drive   own car)
- With some help (need someone to help or go along when traveling)
- Completely unable to travel

3. Can you go shopping for groceries or clothes? (assuming you have transportation)

- Without help (taking care of all shopping needs yourself)
- With some help (need someone to go with you on all shopping trips)
- Completely unable to do any shopping

4. Can you prepare your own meals?

- Without help (plan and cook full meals yourself)
- With some help (can prepare some things but unable to cook full meals yourself)
- Completely unable to prepare any meals.

5. Can you do your housework?
- Without help
- With some help (can do light housework only)
- Completely unable to do any housework

6. Can you take your own medication?

- Without help (in the right doses at the right time)
- With some help (able to take medication if someone prepares it for you and/or reminds you to take it.)
- Completely unable to take your medication

7. Can you handle your own money?

- Without help (write checks, pay bills, etc.)
- With some help (manage day to day buying but need help with managing checkbook and paying bills)
- Completely unable to handle money

8. Can you go up and down the stairs?

- Without help
- With some help
- Completely unable to go up or downstairs

Personal care

1. Can you eat?

- Without help (able to feed yourself completely)
- Need some help (need help with cutting, etc)
- Completely unable to feed yourself

2. Can you dress and undress yourself?

- Without help (able to pick out clothes, dress and undress)
- With some help
- Completely unable to dress and undress

3. Can you take care of your own appearance (e.g. combing)?

- Without help
- With some help
- Completely unabl

4. Can you walk?

- Without help (except with a cane)
- With some help from a person or with the use of a walker or crutches.
- Completely unable to walk

5. Can you get in and out of bed?

- Without any help or aid
- With some help (either from a person or a device)
- Totally dependent on someone else to lift you

6. Can you take a bath or shower?

- Without help
- Need some help
- Completely unable to do by yourself

7. Do you ever have trouble getting to the bathroom on time?

- No
- Yes (How often do you wet or soil yourself in a week? _____)
- Have a catheter or colostomy

D. SOCIAL

Social network	
Number of family members within 1 hour that participant can depend on or feel close to.	
Number of times past week spent time with someone not living with	
Number of times past week talked with friends/relatives on telephone	
Number of times past week attended meetings of clubs, religious groups or other groups that you belong to (other than at work)	

Subjective support	Most of the time	Some of the time	Hardly ever
Do family and friends understand you?			
Do you feel useful to family and friends?			
Do you know what's happening with family and friends?			
Do you feel listened to by family and friends?			
Do you feel you have a definite role in family and among friends?			
Can you talk about your deepest problem?			
How satisfied are you with the kind of relationships you have with your family and friends?	**Satisfied**	**Somewhat dissatisfied**	**Very dissatisfied**
(If respondent indicated that best response is different for family than for friends, the answer coded should reflect the *most* support)			

E. PSYCHOLOGICAL WELLBEING

Geriatric Depression Scale

Choose the best answer for how you feel over the past week.

ITEM	YES	NO
1. Are you basically satisfied with your life?		
2. Have you dropped many of your activities and interests?		
3. Do you feel that your life is empty?		
4. Do you often get bored?		
5. Are you in good spirits most of the time?		
6. Are you afraid that something bad is going to happen to you?		
7. Do you feel happy most of the time?		
8. Do you often feel helpless?		
9. Do you prefer to stay at home, rather than going out and doing new things?		
10. Do you feel you have more problems with memory than most?		
11. Do you think it is wonderful to be alive?		
12. Do you feel pretty worthless the way you are now?		
13. Do you feel full of energy?		
14. Do you feel that your situation is hopeless?		
15. Do you think that most people are better off than you are?		
Total score		

G. SPIRITUALITY

1. In talking with your family or friends, about how often do you mention spiritual matters?

- Not at all
- About once a year
- About once a month
- About once a week
- About once a day
- More than once a day

2. How often do you share with others the problems and joys of living according to your spiritual beliefs?
- Not at all
- About once a year
- About once a month
- About once a week
- About once a day
- More than once a day

3. How often do you read spiritually-related material?
- Not at all
- About once a year
- About once a month
- About once a week
- About once a day
- More than once a day

4. How often do you involve in religious or spiritually related activities?
(for example, listening, watching or attending religious classes/activities)

- Not at all
- About once a year
- About once a month
- About once a week
- About once a day
- More than once a day

5. How often do you pray privately or meditate?
   - Not at all
   - About once a year
   - About once a month
   - About once a week
   - About once a day
   - More than once a day
   - More than five times a day

6. Please indicate how much you agree or disagree with the following statements:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Forgiveness is an important part in my life.					
I seek spiritual guidance in making decisions in my everyday life.					
My spirituality is a significant part of my life.					
My spirituality is especially important to me because it answers many questions about the meaning of life.					
My spiritual belief strongly affects my life.					
I frequently feel very close to God in prayer or at important moments in my daily life.					

THANK YOU FOR YOUR PARTICIPATION.

Appendix 5G: Healthy Ageing Survey (Malay)

Monash University - UKM

INISIATIF USIA EMAS SEJAHTERA 2009

[BORANG SOAL SELIDIK]

Noorlaili Tohit
2009

(Sila tulis jawapan atau tanda (√) bagi jawapan yang sesuai)

A. MAKLUMAT ASAS

1. Tahun lahir: _ _ _ _

2.Jantina:
- Lelaki
- Perempuan

3.Bangsa:
- Melayu
- Cina
- India
- Lain-lain, nyatakan :_____

4. Status perkahwinan terkini:
- Berkahwin
- Tidak pernah berkahwin
- Kematian pasangan (sila ke soalan 4a)
- Bercerai (sila ke soalan 4a)
- Berpisah (sila ke soalan 4a)
- Lain-lain, nyatakan :_____

4a. Anggaran telah berapa lama bercerai/berpisah/kematian pasangan?

_____tahun

5. Tahap pendidikan tertinggi:
- Tiada pendidikan formal
- Sekolah rendah (sila ke soalan 5a)
- Sekolah menengah (sila ke soalan 5a)
- Kolej/maktab
- Universiti

5a.Berapa umur anda semasa mula dan tamat sekolah?_____ dan _____ tahun.

6. Adakah anda mempunyai anak yang masih hidup?
- Ya (sila ke soalan 6a)
- Tidak

6a.Jika ya, berapa ramai? _____

7. Status rumah kediaman
- Rumah sendiri
- Rumah sewa
- Lain-lain, nyatakan: _____

8. Jumlah ahli isi rumah (termasuk anda) _____ orang

9. Siapa yang tinggal bersama anda?

- Pasangan
- Anak (termasuk menantu)
- Cucu
- Ibu bapa (termasuk mertua)
- Adik beradik
- Saudara mara/ kawan
- Pembantu yang diupah
- Lain-lain, nyatakan: _____

10. Status pekerjaan

- Bersara sepenuhnya
- Separa bersara (dari kerja bergaji)
- Bekerja sepenuh masa

11. Pekerjaan utama anda (kini atau sebelum bersara): _____

12. Sumber pendapatan utama
    (boleh berbilang jawapan)

- Pencen dari kerajaan
- Upah atau gaji
- Hasil perniagaan atau harta anda
- KWSP/PERKESO
- Anak-anak
- Lain-lain, nyatakan: _____

13. Anggaran pendapatan bulanan
    (anda dan pasangan)

    RM _____

- Kurang dari RM 500.00
- RM 500-999
- RM 1000- 1499
- RM 1500- 1999
- RM 2000 atau lebih

14. Apa pendapat anda mengenai situasi kewangan anda?

- Tidak cukup untuk penuhi keperluan
- Sekadar cukup makan sahaja
- Rasa selesa

15. Secara keseluruhannya, adakah anda merasakan anda melalui alam penuaan dengan baik/ sejahtera?

- Sangat setuju
- Agak bersetuju
- Agak tidak bersetuju
- Sangat tidak setuju

B. KESIHATAN DAN KESEJAHTERAAN DIRI

1. Pada keseluruhannya, apa pendapat anda mengenai kesihatan anda?

- Cemerlang
- Sangat baik
- Baik
- Sederhana
- Teruk

2. Apa penilaian anda mengenai kesihatan anda berbanding satu tahun yang lepas?

- Lebih baik
- Agak sama sahaja
- Lebih teruk

3. Bagaimana anda menilai kesihatan anda berbanding orang lain yang sebaya dengan anda?

- Lebih baik
- Agak sama sahaja
- Lebih teruk

4. Masalah kesihatan (sila catatkan):

5. Preskripsi ubat-ubatan (sila catatkan):

6. Anggaran kedatangan ke klinik kerajaan setahun yang lepas. _____kali

7. Anggaran kedatangan ke klinik swasta setahun yang lepas. _____ kali

8. Bilangan kemasukan ke wad dalamasa setahun lepas. _____ kali

9. Status merokok

- Tidak merokok
- Bekas perokok (Jangkamasa berhenti: _____tahun)
- Perokok (Bilangan rokok sehari: ___ batang)

12. Pengambilan minuman keras

- Tiada
- Ya (Jenis dan jumlah dalam seminggu: _____
_____)

13. Aktiviti fizikal

(rujuk maklumat RAPA)

- Sedentari
- Kurang aktif
- Aktif

C. FUNGSI FIZIKAL

Aktiviti instrumental

1. Bolehkah anda menggunakan telefon?

- Tanpa bantuan (termasuk melihat nombor dan mendail)
- Dengan bantuan (boleh jawab telefon tapi perlu bantuan untuk mendail)
- Tidak boleh langsung menggunakan telefon

2. Bolehkah anda pergi ke sesuatu tempat yang jauhnya di luar jangkauan untuk berjalan kaki?

- Tanpa bantuan (boleh pergi sendiri menggunakan bas, teksi atau memandu)
- Dengan sedikit bantuan (perlu seseorang untuk membantu atau menemani)
- Langsung tidak boleh pergi dari satu tempat ke tempat lain

3. Bolehkah anda pergi membeli belah untuk barang keperluan dapur atau pakaian? (dengan anggapan adanya pengangkutan)

- Tanpa bantuan (menguruskan semua barangan keperluan sendiri)
- Dengan sedikit bantuan (perlu seseorang untuk membantu atau menemani)
- Langsung tidak dapat untuk membeli belah

4. Bolehkah anda menyediakan makanan anda sendiri?

- Tanpa bantuan (merancang dan memasak semua hidangan sendiri)
- Dengan sedikit bantuan (boleh menyediakan sesuatu bahan makanan tetapi tidak dapat memasak kesemua hidangan sendiri)
- Tidak dapat langsung menyediakan sebarang hidangan makanan sendiri

5. Bolehkah anda membuat kerja-kerja rumah?

- Tanpa bantuan
- Dengan sedikit bantuan (boleh buat kerja rumah yang ringan)
- Langsung tidak dapat buat sebarang kerja rumah

6. Bolehkah anda memakan ubat-ubatan anda sendiri?

- Tanpa bantuan (mengikut dos dan masa yang sepatutnya)
- Dengan sedikit bantuan (jika ada orang yang menyediakannya atau mengingatkan)
- Langsung tidak dapat mengambil ubatan-ubatan dengan sendiri

7. Bolehkah anda mengendalikan kewangan anda sendiri?

- Tanpa bantuan (membayar bil, menulis cek dan seumpamanya)
- Dengan sedikit bantuan (mengendali belian harian tetapi perlu bantuan seseorang untuk membayar bil dan mengendali buku cek)
- Langsung tidak dapat mengendalikan wang

8. Bolehkah anda naik dan turun tangga?

- Tanpa bantuan
- Dengan sedikit bantuan
- Langsung tidak dapat naik dan turun tangga

Penjagaan diri

1. Bolehkah anda makan

- Tanpa bantuan (boleh makan sendiri)
- Perlu sedikit bantuan (perlu bantuan untuk memotong dsb).
- Langsung tidak boleh makan dengan sendiri

2. Bolehkan anda memakai dan menanggalkan pakaian sendiri

- Tanpa bantuan (boleh mengambil, memakai dan menanggalkan pakaian sendiri)
- Perlu sedikit bantuan
- Langsung tidak boleh memakai atau menanggalkan pakaian sendiri.

3. Bolehkah anda mengurus penampilan diri sendiri (seperti menyikat rambut)

- Tanpa bantuan
- Perlu sedikit bantuan
- Langsung tidak boleh

4. Bolehkah anda berjalan

- Tanpa bantuan. (kecuali dengan tongkat)
- Perlu sedikit bantuan dari seseorang atau dengan bantuan alat atau tongkat
- Langsung tidak boleh berjalan

5. Bolehkah anda turun dan naik ke atas katil

- Tanpa bantuan
- Perlu sedikit bantuan (samada seseorang atau alatan)
- Bergantung sepenuhya kepada orang lain untuk mengangkat anda

6. Bolehkah anda mandi sendiri

- Tanpa bantuan
- Perlu sedikit bantuan
- Langsung tidak boleh jika sendiri

7. Adakah anda mempunyai sebarang masalah untuk ke tandas?

- Tidak
- Ya (berapa kerap anda terlepas buang air kecil/besar dalam satu minggu? ___kali)
- Ada kateter atau kolostomi

D. SOSIAL

Hubungan sosial	
Bilangan ahli keluarga yang tinggal dalam lingkungan satu jam perjalanan yang boleh diharap atau anda rasa rapat.	
Berapa kali dalam minggu lalu anda menghabiskan masa dengan seseorang yang tidak tinggal dengan anda?	
Berapa kali dalam minggu lalu anda berbual dengan rakan atau saudara mara melalui telefon?	
Berapa kali dalam minggu lalu anda menghadiri perjumpaan ahli persatuan, perkumpulan agama atau sebarang perkumpulan yang anda ikuti (selain dari tempat kerja)?	

Sokongan subjektif.	Kerapkali	Kadang-kadang	Jarang sekali
Adakah keluarga dan kawan-kawan memahami anda?			
Adakah anda merasa berguna kepada keluarga dan kawan-kawan?			
Adakah anda mengetahui apa yang berlaku kepada keluarga dan kawan-kawan anda?			
Adakah keluarga dan kawan-kawan anda mendengar pandangan anda?			
Adakah anda merasa mempunyai peranan tertentu dikalangan keluarga dan kawan-kawan?			
Bolehkah anda bercakap mengenai masaalah anda yang paling teruk?			
Adakah anda berpuashati terhadap hubungan anda dengan keluarga dan kawan-kawan?	**Puas hati**	**Agak puas hati**	**Sangat tidak puas hati**
Jika responden memberi respons berbeza bagi keluarga lebih dari kawan-kawan, jawapan mesti dikodkan mengikut sokongan yang *lebih banyak*.			

E. KESEJAHTERAAN PSIKOLOGI

Skala kemurungan warga emas

Pilih jawapan yang paling tepat mengenai perasaan anda dalam minggu lepas.

ITEM	YA	TIDAK
1. Pada asasnya adakah anda berpuas hati dengan hidup anda?		
2. Adakah anda meninggalkan banyak aktiviti dan perkara –perkara menarik yang anda minati?		
3. Adakah anda merasa kehidupan anda kosong?		
4. Adakah anda selalu merasa bosan?		
5. Adakah anda mempunyai semangat yang tinggi pada kebanyakan masa?		
6. Adakah anda takut sesuatu yang buruk akan berlaku kepada anda?		
7. Adakah anda merasa gembira selalu?		
8. Adakah anda selalu merasa buntu?		
9. Adakah anda lebih memilih untuk duduk di rumah daripada keluar dan membuat perkara-perkara baru?		
10. Adakah anda mempunyai masalah ingatan lebih dari masalah lain?		
11. Adakah anda fikir ianya amat baik yang anda masih hidup?		
12. Adakah anda berasa anda tidak berguna apabila melihatkan keadaan diri anda sekarang?		
13. Adakah anda merasa anda mempunyai banyak tenaga?		
14. Adakah anda merasa tiada harapan dalam situasi anda?		
15. Adakah anda merasa orang lain lebih baik dari anda?		
Skor keseluruhan		

G. KEROHANIAN/ SPIRITUALITI

1. Apabila bercakap dengan keluarga atau kawan-kawan, berapa kerap agaknya anda bercakap mengenai perkara-perkara kerohanian/keagamaan?

   - Tidak langsung
   - Kira-kira sekali setahun.
   - Kira-kira sekali sebulan.
   - Kira-kira sekali seminggu
   - Kira-kira sekali sehari.
   - Lebih dari sekali sehari.

2. Berapa kerap anda berkongsi masalah dan kegembiran kehidupan dengan orang lain mengikut kepercayaan kerohanian anda?

   - Tidak langsung
   - Kira-kira sekali setahun.
   - Kira-kira sekali sebulan.
   - Kira-kira sekali seminggu
   - Kira-kira sekali sehari.
   - Lebih dari sekali sehari.

3. Berapa kerap anda membaca bahan-bahan berkaitan dengan kerohanian/ keagamaan?

   - Tidak langsung
   - Kira-kira sekali setahun.
   - Kira-kira sekali sebulan.
   - Kira-kira sekali seminggu
   - Kira-kira sekali sehari.
   - Lebih dari sekali sehari.

4. Berapa kerap anda melibatkan diri dalam aktiviti keagamaan/kerohanian? (contohnya mendengar, menonton atau menghadiri aktiviti kerohanian)

   - Tidak langsung
   - Kira-kira sekali setahun.
   - Kira-kira sekali sebulan.
   - Kira-kira sekali seminggu
   - Kira-kira sekali sehari.
   - Lebih dari sekali sehari.

5. Berapa kerap anda sembahyang, berdoa atau bermeditasi sendirian?

- Tidak langsung
- Kira-kira sekali setahun
- Kira-kira sekali sebulan
- Kira-kira sekali seminggu
- Kira-kira sekali sehari
- Lebih dari sekali sehari
- Lebih dari lima kali sehari

6. Sila nyatakan sejauh mana anda setuju atau tidak setuju dengan kenyataan berikut.

	Sangat tidak setuju	Tidak setuju	Neutral	Setuju	Sangat setuju
Kemaafan adalah satu perkara penting dalam kehidupan saya.					
Saya mengambil panduan kerohanian apabila membuat sebarang keputusan dalam kehidupan seharian saya.					
Kerohanian saya adalah sesuatu yang amat penting dalam kehidupan saya.					
Kerohanian saya adalah sesuatu yang amat penting kepada saya kerana ia menjawab banyak soalan mengenai makna kehidupan.					
Pandangan kerohanian saya telah mempengaruhi kehidupan saya.					
Saya selalu merasa sangat rapat dengan Tuhan semasa bersembahyang atau dalam detik-detik berharga dalam kehidupan seharian saya.					

TERIMA KASIH ATAS KERJASAMA ANDA