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INTERGENERATIONAL FAMILY SUPPORT AND THE HEALTH AND WELL-BEING OF OLDER ADULTS IN SUB-SAHARAN AFRICA

A systematic review

Mark A. Aviisah, Hinke H. Haisma, and Tobias C. Vogt

Introduction

Population ageing is occurring globally and sub-Saharan Africa (SSA) is no exception. Sub-Saharan Africa's population aged 60 and older was estimated at 52 million as of 2019 and is projected to increase three-fold to 158 million by 2050 (UNDESA, 2019). This means that this share of SSA's population will increase from 4.8% to 7.4% in the next three decades. Compared to all United Nations Sustainable Development Regions, SSA witnesses the largest gains in life expectancy at birth since 2000 and will remain the leader in life expectancy gains until 2040 (UNDESA, 2019). Despite these improvements, significant disparities in life expectancy at birth and age 60 exist, both for gender and across the sub-region (UNDESA, 2019). For instance, average life expectancy at birth in the Central African Republic stood at 53 years in 2019 as opposed to 75 in Mauritius (UNDESA, 2019). In spite of the fact that older adults in SSA are still an important source of support for the younger generation, an increasing number of people who survive beyond 60 years and advance in age will experience dependency (Aboderin & Hoffman, 2015; Ardington et al., 2010; Uwakwe et al., 2009). An increasing number of studies indicating an increasing prevalence of chronic conditions and functional disabilities among older people in SSA may deepen this dependency (Mugisha et al., 2016; Wandera, Ntozi, & Kwagala, 2014). This will inevitably lead to an increased need for support by older adults to survive, and to continue to participate physically and socially in society.

Older adults in African families are regarded as essential partners in the generational support system, where they provide and receive support, normally in settings of considerable economic and infrastructural limitations (Hoffman & Pype, 2016; Lloyd-Sherlock, 2010; Therborn, 2006). Despite this pivotal role played by older adults in families, public support for the welfare of the younger generation (e.g. educational subsidies and youth employment programmes) takes precedence over support for the older generation in SSA (Aboderin,

2010; Adamchak, 1989). Given that public support in terms of pensions and health insurance is largely non-existent for the majority of older people in SSA, family support remains the main (if not the only) source of support for many older persons across the region (Hoffman & Pype, 2016; Unanka, 2002). Families may help older family members by providing different forms of support – instrumental, emotional, and structural (Rossi & Rossi, 1990; Seeman & Berkman, 1988). Typically, instrumental support includes practical forms of support such as providing financial or material support, help with household chores, and personal care, as well as informational support (Rossi & Rossi, 1990; Shumaker & Brownell, 1984). In contrast, emotional support involves providing love, affection, care, companionship, identity, and belonging (Rossi & Rossi, 1990; Vaux, 1988). However, the distinction (whether instrumental or emotional support) between some support behaviours may not always be straightforward since some may accomplish multiple functions simultaneously (Shumaker & Brownell, 1984). Structural forms of support encompass the social network of individuals available who may provide support such as frequency of contact, size of social network, and proximity of relations and friends (Seeman & Berkman, 1988; Barrera, 1986). Intergenerational family support principally refers to the provision of either instrumental or emotional support by the older to the younger generation (downwards); but also includes support by the younger to older generation (upwards) within the family (Attias-Donfut, Ogg, & Wolff, 2005; Litwin, 2004). These forms of support are mostly reflected in parent-child or grandparent-grandchild relations (Merz, Consedine, Schulze, & Schuengel, 2009; Grundy & Henretta, 2006).

Family support provided to older people has been associated with the health and well-being outcomes of older people in different countries (Bélanger et al., 2016; Nyirenda et al., 2015; Teerawichitchainan, Pothisiri, & Long, 2015; Chen & Silverstein, 2000). Previous research on associations between family support received in later life and indicators of health and well-being has produced mixed findings (Mao, Chi, & Wu, 2019; Teerawichitchainan et al., 2015; Zunzunegui, Béland, & Otero, 2001; Silverstein & Bengtson, 1994). While some studies suggest beneficial effects of family support received on the well-being of older people (Teerawichitchainan et al., 2015; Silverstein, Chen, & Heller, 1996), others suggest family support received has little or a negative influence on well-being in later life (Merz & Consedine, 2009; Lowenstein, Katz, & Gur-Yaish, 2007). Different aspects of family support like support intensity, normative expectations, and attachment security have different effects on health and well-being in later life and may explain the contrary findings reported (Merz & Consedine, 2009; Chen & Silverstein, 2000). Despite these contradictory findings, the majority of studies suggest beneficial effects of family support depending on the type of support provided and the health and well-being outcomes examined (Teerawichitchainan et al., 2015; Cong & Silverstein, 2008).

The effect of various types of family support received by older adults have been associated with reduced depressive symptoms (Bélanger et al., 2016; Cong & Silverstein, 2008), self-rated health (Mao et al., 2019; Bélanger et al., 2016; Zunzunegui et al., 2001), mental health (Davey & Eggebeen, 1998), and functional health status (Liu, Liang, & Gu, 1995) of older adults. For instance, Cong and Silverstein (2008) found that assistance with household chores and personal care from daughters-in-law reduced depressive symptoms of rural older Chinese adults. Likewise, other studies have also found the receipt of instrumental family support by older people to be positively associated with better mental health in later life (Silverstein et al., 1996; Silverstein & Bengtson, 1994). Other researchers, however, have found instrumental family support received by older adults associated with deterioration in

subjective health among older adults (Zunzunegui et al., 2001; Seeman, Bruce, & McAvay, 1996). The provision of instrumental support has been shown to accompany feelings of dependence, subsequently inducing poor subjective health status of older adults (Zunzunegui et al., 2001; Seeman et al., 1996). Emotional and financial support received from family members have been found to be positively related to improved self-rated health, lower levels of depression, and better psychological health in later life (Bélanger et al., 2016; Teerawichitchainan et al., 2015; Guo, 2014; Silverstein, Cong, & Li, 2006; Zunzunegui et al., 2001). For example, financial transfers from adult children improved psychological health among Thai, Vietnamese, and Myanmar older adults (Teerawichitchainan et al., 2015). Financial support is more likely to directly act as a resource for health service use and indirectly reduce stress for optimal cognitive health (Lee, Lyu, Lee, & Burr, 2013). Social family support has been found to be associated with the recipient's health-related behaviours and health status (Thoits, 2011; Cohen, 1988). It is argued that lack of social support and social isolation is related to an increased risk of cognitive decline (Green, Rebok, & Lyketsos, 2008). Emotional and financial support provided by family to older adults have been positively linked with higher levels of subjective well-being in older adults (Bélanger et al., 2016; Lee et al., 2013; Merz & Consedine, 2009; Chen & Silverstein, 2000). In contrast, other researchers have found that older adults who were only recipients of support from adult children and did not provide any support in return reported lower life satisfaction than their counterparts who provided some support (Merz et al., 2009; Lowenstein et al., 2007). Studies indicate that receiving support in old age can have negative consequences on well-being due to the desire of older persons to maintain self-esteem and to stay autonomous (Lee et al., 1995; Lieberman and Tobin 1983;). Chen and Feeley (2014) argue that social support from children indirectly improved subjective well-being through the absence of loneliness. Social support received may help one to de-stress and reduce loneliness thereby indirectly leading to improved well-being (Choi, Park, Cho, Chun, & Park, 2016). Generally, studies from very different cultural and socioeconomic backgrounds suggest that family support to older people has mainly positive effects for the health and well-being of the elderly.

There has been a steady growth of research on the effect of support provided by older people to the younger generation in the past two decades in SSA, particularly in the context of HIV/AIDS, labour migration, and poverty (Ardington et al., 2010; Ferreira, 2006; Posel, Fairburn, & Lund, 2006). In comparison to these studies, relatively little attention has been paid to studies on family support from younger to older people in SSA and its effects on their health and well-being as opposed to support from older to younger people. What forms of support do older people in SSA receive from their family and wider network of relatives and how does it affect their health and well-being? Are there any inconsistencies in the health and well-being effects of the support older people receive? Therefore, the aim of this systematic review is to provide an overview of intergenerational family support provided to older adults in SSA and summarize its effects on their health and well-being. Given the rapid population ageing occurring in SSA, there is the need to systematically analyze existing work on family support provided to older people living in SSA and its association with their health and well-being. Bringing these to the fore will fill a gap by highlighting the health and well-being effects of family support in later life in this context. Also, it may drive the urgently needed policy change and public discourse on family support for older people, triggering appropriate policy and programmatic action. At the population level, the impact of this systematic review on policy and interventions may contribute towards an improved health and well-being, and the general welfare of the older adult population of SSA.

Methods

Study design and review framework

This systematic literature review was conducted according to the recommendations outlined in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement (Moher, Liberati, Tetzlaff, Altman, & Group, 2009).

Search strategy and screening

A three-stage search strategy was used in this review. A limited search in Web of Science and Scopus databases was initially conducted to identify key words and indexing terms used in the titles and abstracts of relevant articles. Thereafter, a second search using all identified key words and indexing terms was undertaken across all selected databases. The databases searched were MEDLINE (EBSCO), PsycINFO (EBSCO), SocINDEX (EBSCO), Web of Science core collection, Scopus, PubMed, ProQuest Social Services Abstracts, and African Journals Online. Medical Subject Headings (MeSH) term categories were applied across all index terms in the PubMed search to ensure that all relevant publications were identified. Some of the main keywords and MeSH terms and their combinations used were ‘family support’, ‘social support’, ‘social capital’, ‘intergenerational relations’, ‘intergenerational transfers’, ‘financial support’, ‘activities of daily living’, ‘caregiving’, ‘older adults’, ‘elderly’, and ‘sub-Saharan Africa’. **Box 37.1** shows the complete list of the main key words and index terms applied across all databases in the review.

A search for unpublished studies and reports was undertaken in the World Health Organization library (WHOLIS), World Bank electronic library, ProQuest Dissertations and Theses Global, and HelpAge International. Searches were also conducted to retrieve unpublished works such as government reports, government white papers, reports of ministries of health, and reports of seminars and conference proceedings. All records identified were imported into Endnote and exported into an Excel file. Two authors (MAA, TCV) initially screened the titles and abstracts of all identified publications and thereafter independently carried out full-text assessment for eligibility and inclusion. Disagreements over eligibility and inclusion were resolved by a third author (HH). Finally, the reference lists of eligible publications were hand-searched for additional publications. Figure 37.1 shows the PRISMA flow diagram illustrating screening of studies for inclusion in the review.

Inclusion and exclusion criteria

Studies published in English and conducted among community-residing (or non-institutionalized) older people living in SSA between January 2000 and May 2020 were included. All sub-Saharan African countries were included in the database searches. Studies of any design and methodology examining the association between intergenerational family support received by older adults on measures of their health and well-being were included: primary empirical quantitative, qualitative and mixed methods, theoretical studies, working papers, and reports. Studies that exclusively focussed on family support provided to older adults or received by older adults in the context of HIV/AIDS were excluded.

Definition of concepts

Intergenerational family support in this review was conceptualized as the provision of instrumental, emotional, and structural forms of support to older adults by family or kin. SSA

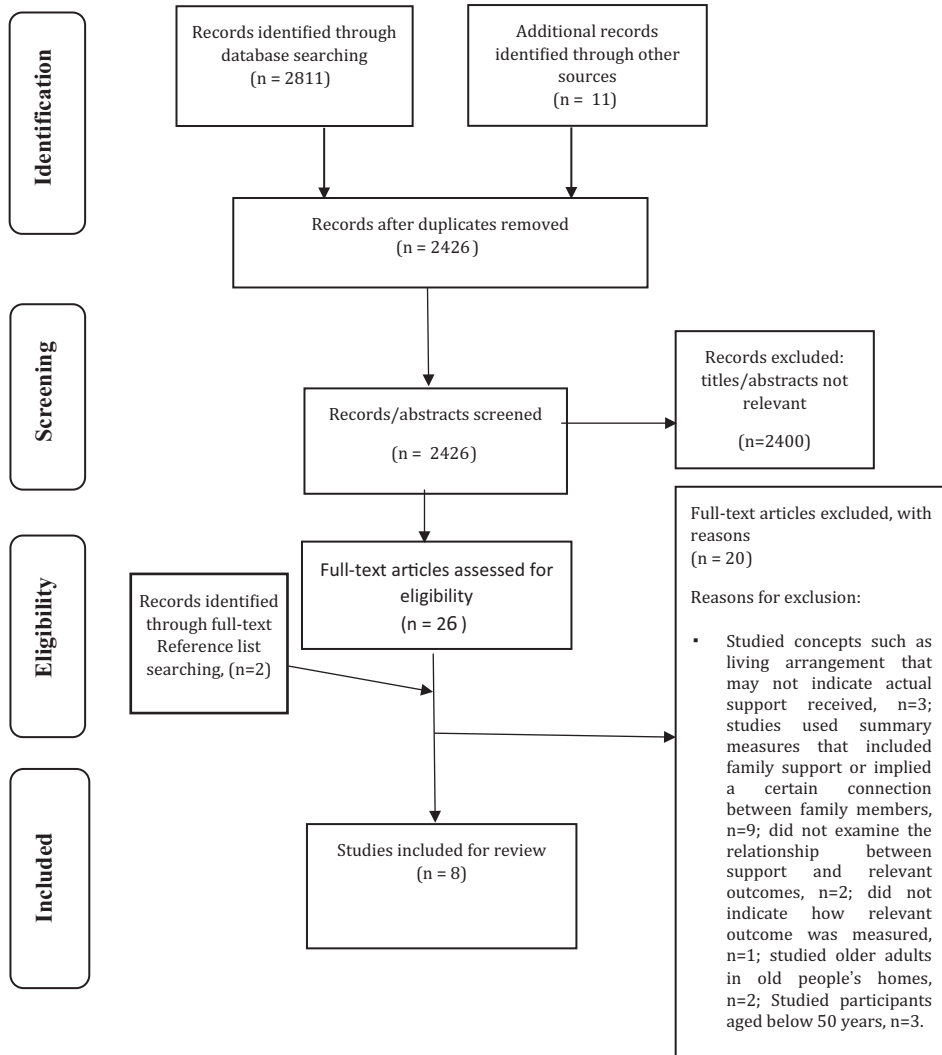


Figure 37.1 PRISMA flow diagram illustrating screening of studies for inclusion in the review.

region refers to countries south of the Sahara based on the United Nations' classification of countries (UNDESA, 2019). Although older people in sub-Saharan Africa are defined as persons aged 60 years and older in line with the United Nations' recommended cut-off for defining an older person globally, this review considers persons aged 50 and older as older people given the relatively short remaining life expectancy at age 50 (23 years) in the sub region (UNDESA, 2019; McIntyre, 2005). Moreover, most ageing studies in Africa but also other countries or regions focus on individuals aged 50 and older (Kunna, San Sebastian, & Stewart Williams, 2017). Therefore, focussing on studies that investigated older adults aged 50 and older was considered appropriate and ensured more studies met the eligibility criteria for the review.

Box 37.1 Complete list of the main key words and index terms applied across all databases in the review

Family OR relative OR relations OR kin AND support OR social support OR emotional support OR material support OR monetary support OR financial support OR personal support OR instrumental support OR practical support OR health support OR activities of daily living OR instrumental activities of daily living OR intergenerational support OR intergenerational transfers OR financial transfer OR cash transfer OR intergenerational relation OR intergenerational reciprocity OR family support OR family network OR kin networks OR kin support OR social capital OR social networks OR caregiving OR care OR needs AND older people OR older adult OR older person OR seniors OR elderly person OR elderly OR geriatric OR later years OR later life AND Africa OR sub-Saharan Africa OR African country OR Western Africa OR Eastern Africa OR Central Africa OR Southern Africa

*UN-listed SSA countries: Burundi, Comoros, Djibouti, Eritrea, Ethiopia, Madagascar, Malawi, Mauritius, Mozambique, Rwanda, Seychelles, South Sudan, Somalia, Uganda, Tanzania, Zambia, Zimbabwe, Angola, Cameroon, Central African Republic, Chad, Congo, DRC, Equatorial Guinea, Gabon, Sao Tome and Principe, Botswana, Swaziland, Lesotho, Namibia, South Africa, Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Togo.

Data extraction

Data from eligible studies was extracted on authors, publication year, study country, study title, study design and population, research methods, support provided, findings on support received and association with indicators of health and well-being, and study limitations.

Quality assessment

Assessment of the methodological quality of included studies was conducted based on the National Institute of Health (NIH) Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies (NIH, 2014). This is an instrument that has 14 criteria and is used to critically appraise the internal validity of quantitative studies. The 14 criteria include: research question, study population, sample recruitment and eligibility criteria, sample size justification, exposure and outcome assessment, follow-up rate, and statistical analysis. Each criterion was rated 'yes', 'no', 'cannot determine', 'not applicable', or 'not reported'. Using these criteria, we provide an overall quality rating (Good, Fair, Poor) for each study assessed. None of the studies that met all selection criteria used qualitative methods.

Synthesis of findings

A narrative synthesis was used to summarize the findings of the included studies. It is the preferred method of quantitative data synthesis when statistical synthesis is not possible as was the case in our review given the heterogeneity of concepts and variables. A narrative synthesis

is a textual approach to synthesizing findings from included studies (Popay et al., 2006). Two authors (TCV, HH) cross-validated the synthesized findings.

Results

Study characteristics

A total of 2,811 records were identified through database searching, while an additional 11 were identified through other sources. Extending the search time frame before year 2000 did not result in more suitable publications. After duplicates were removed, 2,426 records were screened, and 2,400 that had titles or abstracts not relevant to the review aim were excluded. Consequently, 26 full-text articles were retrieved and assessed for eligibility. Two records were identified through hand-searching the reference list of full-text articles retrieved. Twenty (20) studies were excluded based on reasons such as studies using summary measures that included family support or implied a certain connection between family members but not support (9), examining the effect of living arrangement (3), assessing the effects of family support on participants aged below 50 years (3), and others (5). Finally, eight studies met all eligibility criteria and were included in the review. Three of the quantitative studies included in the review were from cross sectional surveys, while the remaining five were from longitudinal surveys. Four studies were conducted in Nigeria and two each from Kenya and Ghana. Study participants were mainly recruited from the general population residing in both urban and rural areas. The sample sizes of the studies ranged from 350 to 2,608. Table 37.1 shows characteristics of included studies.

Effect of family support on health and well-being of older adults in SSA

Findings on the effect of family support provided to older adults on their health and well-being are presented in Table 37.2. Four studies examined frequency of contact with family members (Gyasi, Yeboah, Mensah, Ouedraogo, & Addae, 2019; Ojagbemi, Bello, & Gureje, 2018; Gureje, Kola, Afolabi, & Olley, 2008; Gureje, Oladeji, & Abiona, 2011), three assessed the effect of financial support (Gyasi, Phillips, & Abass, 2018; Kodzi, Gyimah, Emina, & Ezeh, 2010, 2011), while one study analyzed the effect of social support from family members (Olagunju, 2015). Six studies examined the association between family support provided to older adults and indicators of their health. Five studies found a positive relationship between the health of older adults and family support provided to or received by the elderly, while one reported a non-significant association. Two studies from Ghana suggest that older adults' psychological well-being benefited from their frequent contact with family and receiving regular remittances from distant adult children (Gyasi et al., 2018, 2019). Compared to having no contact, frequent contact with family reduced psychological distress by almost 3 ($\beta = -2.975$, $SE = 1.024$, $p < 0.005$) among lonely older adults (Gyasi et al., 2019), while regular remittances from distant adult children increased good psychological well-being ($\beta = 0.484$, $p < 0.005$) of older adults (Gyasi et al., 2018). Similarly, two studies from Nigeria suggest social support and frequent contact with family members was associated with lower risk of depression in later life (Ojagbemi et al., 2018; Olagunju, Olutoki, Ogunnubi, & Adeyemi, 2015). For instance, Ojagbemi et al. (2018) found that older women ($HR = 2.2$, $95\% CI = 1.0-4.7$) with no regular contact with family had a two-times higher risk of the onset of major depressive disorder than older women with regular contact. Older adults receiving material or financial support from extended family members reported better self-rated health in a study in Kenya (Kodzi et al., 2010). In this

Table 37.1 Characteristics of Included Studies

<i>Author(s)/Year/ Study country</i>	<i>Study title</i>	<i>Design and Methods</i>	<i>Sample Size (Male; Female %)</i>	<i>Study population and setting</i>	<i>Overall Quality Rating</i>
Ojagbemi et al., 2018; Nigeria	Gender differential in social and economic predictors of incident major depressive disorder in the Ibadan Study of Ageing	Design: longitudinal study, Ibadan Study of Ageing (ISA), 2003–2009. Methods: multi-stage cluster probability sampling, Kish table selection method, sample weighting, Chi-square test, actuarial adjustment approach, Kaplan– Meier Analyses, and Cox regression models.	1,394 (M 51.6%; F 48.4%)	People aged 65 years and older. Setting: 8 states in southwest and north-central regions of Nigeria (Ondo, Ekiti, Osun, Lagos, Ogun, Oyo, Kogi, and Kwara) in urban and rural areas. Mean age: 74.6 years	Good
Olagunju et al., 2015; Nigeria	Late-life depression: Burden, severity, and relationship with social support dimensions in a West African community.	Design: Descriptive cross-sectional Methods: multi-stage random sampling, Kish method, Chi-square test.	350 (M 47.1%; F 52.9%)	People aged 60+ years. Setting: Ethnically diverse densely populated urban area (Mushin ^a LGA, Lagos). 65% of participants aged below 70 years	Poor
Gureje et al., 2011; Nigeria	Incidence and risk factors for late-life depression in the Ibadan Study of Ageing.	Design: longitudinal study (ISA), 2003–2007. Methods: multi-stage cluster probability sampling, Kish table selection method, sample weighting, Chi-square test, t-test, Cox proportional hazards regression, logistic regressions.	1,408 (M 59.6%; F 40.4%)	People aged 65 years and older. Setting: 8 states in southwest and north-central regions of Nigeria (Ondo, Ekiti, Osun, Lagos, Ogun, Oyo, Kogi, and Kwara) in urban and rural areas. Mean age: 72.4 years	Fair

(Continued)

Table 37.1 (Continued)

<i>Author(s)/Year/ Study country</i>	<i>Study title</i>	<i>Design and Methods</i>	<i>Sample Size (Male; Female %)</i>	<i>Study population and setting</i>	<i>Overall Quality Rating</i>
Gureje et al., 2008; Nigeria	Determinants of quality of life of elderly Nigerians: results from the Ibadan Study of Ageing.	Design: longitudinal study (ISA), 2003–2004. Methods: multi-stage stratified area probability sampling, linear regression modelling.	2,152 (not stated)	People aged 65 years and older. Setting: 8 states in southwest and north-central regions of Nigeria (Ondo, Ekiti, Osun, Lagos, Ogun, Oyo, Kogi, and Kwara) in urban and rural areas. Mean age: not stated	Fair
Gyasi et al., 2019; Ghana.	Neighbourhood, social isolation, and mental health outcome among older people in Ghana.	Design: Cross-sectional study, Aging, Health, Psychological Well-being, and Health-seeking Behaviour project, 2016–2017. Methods: Multi-stage stratified area probability sampling with over sampling of older adults, Pearson correlations, Ordinary Least Square (OLS) regression modelling.	1,200 (M 36.8%; F 63.2%)	Adults aged 50+ years. Setting: study population stratified by geographical, sociocultural, and rural-urban settlements in the Ashanti Region of Ghana. Mean age: 66.2 years	Good
Gyasi et al., 2018; Ghana	Social support networks and psychological well-being in community-dwelling older Ghanaian cohorts.	Design: Cross-sectional study, Aging, Health, Psychological Well-being, and Health-seeking Behaviour project, 2016–2017. Methods: multi-stage stratified area probability sampling with an oversample of older adults, Pearson correlations, multivariate logit regression models.	1,200 (M 36.8; F 63.2)	Adults aged 50+ years. Setting: study population stratified by geographical, sociocultural, and rural-urban settlements in the Ashanti Region of Ghana. Mean age: 66.2 years	Good

Kodzi et al., 2011; Kenya	Understanding ageing in sub-Saharan Africa: exploring the contributions of religious and secular social involvement to life satisfaction.	Design: longitudinal study, Nairobi Urban Health and Demographic Surveillance System (NUHDSS), 2006/2007. Methods: census, OLS regression models.	2,608 (M 66.1%; F 33.9%)	Adults aged 50+ years. Setting: two informal settlements (slum) communities in Nairobi, Kenya. Mean age: 59 years	Good
Kodzi et al., 2010; Kenya	Religious Involvement, Social Engagement, and Subjective Health Status of Older Residents of Informal Neighbourhoods of Nairobi.	Design: longitudinal study, Nairobi Urban Health and Demographic Surveillance System (NUHDSS), 2006/2007. Methods: census, Ordinal Logistic Regression models.	2,608 (M 66.1%; F 33.9%)	Adults aged 50+ years. Setting: two informal settlements (slum) communities in Nairobi, Kenya. Mean age: 59 years	Good

Note: ^aLocal Government Area

Table 37.2 The Effect of Family Support Provided to Older Adults in SSA on Their Health and Well-Being Indicators

<i>Studies</i>	<i>Family support provided</i>	<i>Indicator for measuring support</i>	<i>Health/well-being measure (s) studied</i>	<i>Main findings on association with health/well-being</i>	<i>Study limitations</i>
Ojagbemi et al., 2018	Frequency of contact with family members not residing with respondent.	Regular contacts with family, assessed based on World Mental Health (WMH) survey version of the World Health Organization's (WHO) Composite International Diagnostic Interview (CIDI) (Kessler & Ustun, 2004). Response options were: 1 = nearly every day, 2 = 3–4 days per week, 3 = 1–2 days per week, 4 = 1–3 days a month, 5 = less than once in a month, 6 = never; dichotomized into contacts less than once and more than once in a month.	Major Depressive Disorder (MDD), assessed based on WHO's Composite International Diagnostic Interview (CIDI) (Kessler & Ustun, 2004) and Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV criteria (APA, 1994). Control variables: socio-demographic characteristics (e.g. age, sex, etc.)	Lack of regular contact with family members is a risk factor for the onset of MDD for older women (^a HR = 2.2, 95% ^b CI = 1.0–4.7) and not for older men.	51.5% attrition. Participants who dropped out of study were more likely to belong to lower economic standing, and more women than men belonged to this category.
Olagunju et al., 2015	Social support from family.	Multidimensional Scale for Perceived Social Support (MSPSS) (Zimet, Dahlem, Zimet, & Farley, 1988); MSPSS scores below the mean score of 4.95 ± 0.96 was considered as low social support.	Depression based on the Geriatric Depression screening (GDS) scale (Yesavage et al., 1982); presence of depression considered as mild based on an 11–20 score and severe at 21–30 score.	High social support from family members (Chi = 4.434, p = 0.035) was protective against depression among older adults and vice versa.	Inability to control for bidirectional relationship between social support and depression due to cross-sectional design. Lack of control of effects confounding variables. Prevalence of depression may be higher because of the use of GDS instead of clinically defined standard diagnostic criteria.

Gureje et al., 2011	Frequency of contact with family members not residing with respondent.	Frequency of contact assessed based on WMH WHO CIDI (Kessler & Ustun, 2004). Response options dichotomized into no contact at all and contact once per month to daily.	Major Depressive Disorder (MDD) assessed based on the WMH survey version of the WHO Composite International Diagnostic Interview (CIDI) (Kessler & Ustun, 2004) and diagnosis based on DSM-IV criteria (APA, 1994). Control variables: socio-demographic (e.g. age, sex).	Regular contact with family was not significantly associated with new onset of MDD among older people.	Self-reporting may be associated with recall bias that could affect rate of depression. Rate of depression may have been underestimated due to assessment method.
Gureje et al., 2008	Frequency of contact with family members not residing with older adult.	Frequency of contacts assessed based on WMH WHO CIDI (Kessler & Ustun, 2004). Response options dichotomized into less than once in 6 months vs. more than once.	Quality of life assessed based on the WHO Quality of Life (WHOQOL-BREF); which contains 4 domains (physical, psychological, environmental, and social) (WHOQOL-Group, 1998). Control variables: socio-demographic, health-related factors.	Contact with family members was significantly related to quality of life in the psychological ($\beta = -14.20$; $p = 0.003$), physical ($\beta = -12.70$; $p = 0.009$) and environmental ($\beta = -15.52$; $p = 0.001$) domains but not the social ($\beta = -2.98$; $p = 0.612$) domain among older persons.	Eliciting information by self-reporting (e.g. chronic health conditions) could lead to misreporting. Causal inference cannot be made due to cross-sectional design. The accuracy of information from older adults with mental health problems could be affected.

(Continued)

Table 37.2 (Continued)

<i>Studies</i>	<i>Family support provided</i>	<i>Indicator for measuring support</i>	<i>Health/well-being measure (s) studied</i>	<i>Main findings on association with health/well-being</i>	<i>Study limitations</i>
Gyasi et al., 2019; Ghana	Social connectedness.	Social connectedness, made up of frequency of family contact, social engagements (responses rated on a 5-point scale: 1= never, 2=less frequently, 3=frequently, 4=very frequently, and 5=every day; dichotomized into 1=frequently [frequently/very frequently/every day] and 0=not frequently [never/less frequently]), and emotional bonds with at least one person (responses coded as 1=yes, 0=no).	Psychological Distress (PD) assessed based on Kessler Psychological Distress Scale (KPDS-K10) (Kessler et al., 2002). Question: In the last 4 weeks did you feel (a) tired out for no good reason? (b) nervous or uneasy? (c) so nervous that nothing could calm you down? (d) hopeless or lonely? (e) restless or fidget? (f) so restless you could not sit still? (g) depressed? (h) that everything was an effort? (i) so sad or bored that nothing could cheer you up? and (j) worthless or having no value? (five response categories: 1 = none of the time, 2 = a little of the time, 3 = some of the time, 4 = most of the time, 5 = all of the time) Scores ranged from 10–50; a cut-off score ≥ 20 was used to denote PD. Control variables: socio-demographic and health-related variables.	Frequent contact with family ($\beta = -2.975$, ${}^d\text{SE} = 1.024$, $p < 0.005$) significantly decreased psychological distress among lonely older adults. Similar effects were found for frequent family contact ($\beta = -0.118$, $\text{SE} = 1.129$, $p < 0.05$) among older adults who lived alone.	No causal or directional inferences can be made as a result of the cross-sectional nature of the study. Self-reporting of data can be prone to measurement bias and can affect the reliability of findings.

Gyasi et al., 2018	Regular remittances from distant adult children.	Regular remittances (responses coded as: 1= remittances received and 0= no remittances)	Psychological well-being (composite 10-item questions adapted from Kessler Psychological Distress Scale [KPDS-K10]) (Kessler et al., 2002). [same items and scale as Gyasi et al., 2019] Control variables: socio-demographic, socio-economic, and health-related covariates.	Remittances received by older adults was positively associated with good psychological well-being ($\beta = 0.484$, $p < 0.005$) even in the presence of other relevant factors, particularly among urban residents.	Self-reporting of data is prone to under or overestimation of measures. The effect of changing support patterns on psychological well-being could not be estimated.
Kodzi et al., 2011	Social engagement, composed of number of close friends (sociability), support from relatives other than children (material or financial), and social participation index.	Receiving support (material or financial) from relatives (response options: 1=yes, 0=no).	General life satisfaction index, derived from three questions: (1) taking all things together, how satisfied are you with life as a whole these days? (2) How would you rate your overall quality of life? (Responses rated on a 5-point scale: 1= very dissatisfied, 2= dissatisfied, 3= neither satisfied or dissatisfied, 4= satisfied, 5=very satisfied) (3) Taking all things together, how happy would you say you are these days? (Responses rated on a 5-point scale: 1=very unhappy, 2=unhappy, 3=neutral, 4= happy, 5=very happy) Control variables: socio-demographic, socio-economic, and health-related variables.	Receiving material support from extended family members exerted strong positive effects ($\beta = 0.081$; $p < 0.001$) on general life satisfaction in later life even amidst other important factors such as health status.	Social desirability may result in over estimation of positive life satisfaction in face-to-face interviews. Self-reporting prone to recall bias. Quality of social relationships, support, and personal religious devotion which could affect life satisfaction were not estimated.

(Continued)

Table 37.2 (Continued)

<i>Studies</i>	<i>Family support provided</i>	<i>Indicator for measuring support</i>	<i>Health/well-being measure (s) studied</i>	<i>Main findings on association with health/well-being</i>	<i>Study limitations</i>
Kodzi et al., 2010	Social engagement, composed of number of close friends (sociability), support from relatives other than children (material or financial), and social participation index.	Receiving support (material or financial) from relatives (response options: 1=yes, 0=no).	Self-rated health, measured based on a single question: (1) In general, how would you rate your health today? (Responses rated on a 5-point likert scale: very good, good, moderate, bad, or very bad) Control variables: socio-demographic, socio-economic, and health-related variables.	Receiving material or financial support from relatives independently contributed (OR = 1.36; p < 0.05) to better self-rated health of older adults.	Social desirability may result in overestimation of positive life satisfaction in face-to-face interviews. Self-reporting prone to recall bias. Quality of social relationships, support, and personal religious devotion which could affect health status were not estimated.

Note: ^a HR=Hazard Ratio; ^b CI=Confidence Interval; ^c β=unstandardized regression coefficient; ^d SE=Standard Error

study, the odds of older adults who received material support from family experiencing better self-rated health was 36% (OR = 1.36; $p < 0.05$) higher than those who did not. The findings of the studies included in our review show that family support has a positive effect on subjective well-being. The studies found that having less than once in six months contact with family members strongly decreased quality of life among older Nigerians by up to 15.52 ($\beta = -15.52$; $p = 0.001$), while material or financial support ($\beta = 0.081$; $p < 0.001$) from extended family members independently contributed to high satisfaction with life among older Kenyans (Gureje et al., 2008; Kodzi et al., 2011).

The effect of other related support concepts on health and well-being of older adults in SSA

While our review solely focused on the effect of support provided by only family or kinsmen to older adults, we identified other studies that examined other support related concepts or sources of support in SSA such as social capital, social relations, social support network, and living arrangement and their effects on health and well-being of older persons (e.g. Gyasi, 2019; Ralston, Schatz, Madhavan, Gómez-Olivé, & Collinson, 2019; Macia, Duboz, Montepare, & Gueye, 2015; Ramlagan, Peltzer, & Phaswana-Mafuya, 2013). Also, we were unable to disentangle the effect of family support components from some studies because summary measures were used. For example, social connectedness in Gyasi et al. (2019) was derived from combining variables such as frequency of contact with family, social engagements, and having an emotional bond with at least one person. These studies did not meet our inclusion criteria. Nonetheless, we found that higher social capital (Ramlagan et al., 2013), social support networks (Gyasi, 2019), social relations (Macia et al., 2015), and residing in two-generation linear-linked multi-generational households (Ralston et al., 2019) were generally positively related to better health and well-being in later life.

Quality of included studies

According to the NIH quality assessment tool, five of the eight eligible studies included were rated to be of good or high quality. They clearly described the recruitment process for participants, provided detailed description of the study design and methods used, described processes and justification for required sample size, statistically adjusted key potential confounding variables for their effect on the outcome variables, and presented findings clearly. Studies that were rated to be of fair or poor quality ($n=3$) failed to account for the effect of key confounding variables on the outcome variable. These weaknesses are likely to increase the risk of bias and affect the internal validity of the studies. Table 37.3 shows quality assessment of included studies.

Discussion

Our review sought to provide an overview of the studies on family support provided to older adults in SSA and to summarize the effects on health and well-being in later life, considering the increasing number of older adults in SSA. We identified only eight studies that met all eligibility criteria and were included in the review. The few studies identified is a clear indication of a gap in the literature that needs to be filled. We found that instrumental (i.e. financial support), emotional (i.e. social support), and structural (frequent contact with non-coresident family) support provided to older adults were beneficial to their health and well-being. Specifically, social support and frequent contact with non-coresident family members

Table 37.3 Quality Assessment of Included Studies

<i>National Institute of Health (NIH) Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies/Studies included in review</i>	<i>Olagunju et al., 2015</i>	<i>Gureje et al., 2008</i>	<i>Kodzi et al., 2010</i>	<i>Ojagbemi et al., 2018.</i>	<i>Kodzi et al., 2011</i>	<i>Gureje et al., 2011</i>	<i>Gyasi et al., 2018.</i>	<i>Gyasi et al., 2019</i>		
1 Was the research question or objective in this paper clearly stated?	Y	Y	Y	Y	Y	Y	Y	Y		
2 Was the study population clearly specified and defined?	Y	Y	Y	Y	Y	Y	Y	Y		
3 Was the participation rate of eligible persons at least 50%?	Y	Y	Y	Y	Y	Y	Y	Y	Key	
4 Were all the subjects selected or recruited from the same or similar populations (including the same time period)? Were inclusion and exclusion criteria for being in the study prespecified and applied uniformly to all participants?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Yes
5 Was a sample size justification, power description, or variance and effect estimates provided?	Y	N	N	N	N	N	Y	Y	N	No
6 For the analyses in this paper, were the exposure(s) of interest measured prior to the outcome(s) being measured?	N	N	N	Y	N	Y	N	N	NA	Not Applicable
7 Was the timeframe sufficient so that one could reasonably expect to see an association between exposure and outcome if it existed?	N	N	N	Y	N	Y	N	N	NR	Not Reported
8 For exposures that can vary in amount or level, did the study examine different levels of the exposure as related to the outcome (e.g., categories of exposure, or exposure measured as continuous variable)?	NA	NA	NA	NA	NA	NA	NA	NA	CD	Cannot Determine
9 Were the exposure measures (independent variables) clearly defined, valid, reliable, and implemented consistently across all study participants?	Y	Y	Y	Y	Y	Y	Y	Y		
10 Was the exposure(s) assessed more than once over time?	NA	NA	NA	Y	NA	N	NA	NA		
11 Were the outcome measures (dependent variables) clearly defined, valid, reliable, and implemented consistently across all study participants?	Y	Y	Y	Y	Y	Y	Y	Y		
12 Were the outcome assessors blinded to the exposure status of participants?	NA	NA	NA	NA	NA	NA	NA	NA		
13 Was loss to follow-up after baseline 20% or less?	NA	NA	NA	N	NA	N	NA	NA		
14 Were key potential confounding variables measured and adjusted statistically for their impact on the relationship between exposure(s) and outcome(s)?	N	Y	Y	Y	Y	Y	Y	Y		
OVERALL RATING (GOOD, FAIR, POOR)	POOR	FAIR	GOOD	GOOD	GOOD	FAIR	GOOD	GOOD		

were protective against poor psychological health and protective of general well-being and quality of life of older adults (Gyasi et al., 2019; Ojagbemi et al., 2018; Olagunju et al., 2015; Gureje et al., 2008). These findings corroborate previous observations on the buffering effects of social support networks and social relationships of older adults against poor mental health outcomes in low- and middle-income countries (Miao, Wu, & Sun, 2019; Teerawichitchainan et al., 2015) and high-income countries (Roh et al., 2015; Thompson & Heller, 1990). Our review suggests that very little is known about family support provided to older adults and the effects on health and well-being in later life compared to other regions of the world. Social support is considered to act as a resource for coping with adverse mental health events (Cohen & Wills, 1985). For example, frequent in-person meetings and phone contact with non-coresident adult children was associated with a reduced risk of depression among older adults in Korea (Roh et al., 2015), while Thompson and Heller (1990) observed social support from family members improved the psychological well-being of older women in the USA. Since studies suggest that the family is the main source of social support for older adults in SSA, this finding is not unexpected (Unanka, 2002; Van der Geest, 2016). In many societies in SSA, families tend to reside in proximity in order to share resources between generations within multigenerational households and to support one another through difficult times. This encourages intergenerational family interdependence in the face of limited economic security and social services, typical of most low-resource settings (Pelcastre-Villafuerte, Treviño-Siller, González-Vázquez, & Márquez-Serrano, 2011; Peil, 1991). This social integration into the extended family system widens one's social network and increases the chances of receiving social support from kinsmen.

Our review found financial support from non-coresident adult children and extended family members positively related to better psychological, self-rated health and subjective well-being among recipient older adults. This finding is in line with other studies in similar non-Western contexts such as Thailand, Vietnam, and Brazil (Bélanger et al., 2016; Guo, 2014; Teerawichitchainan et al., 2015). In this context, where public support for older adults is hardly available, financial support from family members especially adult children may help older parents utilize health services and cope with financial stress for better health outcomes and well-being. Additionally, receiving financial support from one's adult children can be culturally desirable, because it is often interpreted as being 'successful' in life, and may boost one's social status in society, which could lead to an older adult experiencing greater life satisfaction (Teerawichitchainan et al., 2015). Furthermore, society considers providing support to older parents by adult children their moral duty and it also fits into the assertion that children are old-age economic security in SSA (Aboderin, 2004; Apt, 2002). It should be noted however that in this context, financial support from adult children to older parents is usually motivated by the needs (e.g. health care costs) of older parents (Hogan, Eggebeen, & Clogg, 1993). In contrast, while beneficial effects of financial support from adult children to older parents have been reported in Western contexts (Zunzunegui et al., 2001; Silverstein & Bengtson, 1994), some other studies associate financial support from adult children with poor psychological well-being of older parents (Lowenstein et al., 2007). It is argued that older persons who receive financial support in Western contexts normally prefer to remain functionally independent and may feel dependent on adult children, causing distress and subsequently deterioration in well-being (Pyke & Bengtson, 1996). The differences in the effect of receiving financial assistance from adult children in the two scenarios above may be explained by the socio-cultural perspective.

Review contribution and strengths

We believe that our review contributes to the ageing literature in SSA in two different ways. Firstly, a considerable number of research studies have been conducted on support provided by older adults in SSA (reflecting the role of the elderly in African families) and the effects on health and well-being, but limited research on support provided to older adults and the effects on their health and well-being. It is worth iterating that there is quite some evidence for support provision to older people and its effect on health and well-being in later life in other world regions, including low- and middle-income countries, but it's not really clear how much we know about SSA (Teerawichitchainan et al., 2015; Lowenstein et al., 2007; Lee, Netzer, & Coward, 1995). Our review therefore highlights the positive effects of family support on the health and well-being of older sub-Saharan Africans. To the extent that the family plays a central role in the social protection of majority of older people in SSA, and given that the population is rapidly ageing, coupled with the high cost of establishing and running social welfare programmes for the elderly, for now, countries in SSA may be better off implementing programmes that motivate families to continue their support functions.

Secondly, while our findings suggest the need for more research on the topic in SSA, it also draws scholarly attention on the need to differentiate the forms (instrumental or emotional) and source of family support in research as these are known to exhibit distinct effects on the health and well-being of older people (Merz & Consedine, 2009; Silverstein et al., 2006; Cong & Silverstein, 2008). In the study by Olagunju et al. (2015) the relationship of the provider and specific social support provided (e.g. emotional or instrumental) was not indicated, while in the case of Kodzi et al. (2011) the researchers failed to indicate the relationship of the provider. For instance, the provision of instrumental support (e.g. help with household chores) by daughters and daughters-in-law and financial support by sons and sons-in-law to older parents is considered customarily appropriate in African society, hence may exert different effects on health and well-being than a support relationship viewed as customarily inappropriate as found in other low-resource settings (Okoye, 2012; Coe, 2011; Cong & Silverstein, 2008). For example, a study in China reported help with household chores from daughters-in-law resulted in reduced depressive symptoms of older parents compared to their counterparts who received support from sons (Cong & Silverstein, 2008). This suggests that future research should be mindful of this in order to detect a more nuanced picture of the relationship between family support received and the health and well-being of older persons.

This review presents evidence regarding the effect of various types of family support provided to older adults in SSA on their health and well-being. To the best of our knowledge, this is the first systematic review on the topic in SSA. The evidence presented is based on a systematic search of eight databases, including searches in other sources for unpublished works.

Review limitations

It was not feasible to conduct a meta-analysis as a result of the different types of family support and varied measures used to assess support (e.g. different response scales were used in assessing frequency of contact with family) and health or well-being in this review. This review may miss evidence from French-speaking SSA countries. But, if there were many of them at all, we

would have identified them through the bibliography of other articles. Also, this review could not account for the extent to which socio-demographic, socio-cultural, health-related, and country-level factors influenced the effect of family support on the health and well-being outcomes of older adults within and between countries, since these are known to moderate support effects.

Conclusions

As our review shows, currently, the evidence indicates a beneficial relation between family support (i.e. frequent contact, social support, financial support) provided and the health and well-being of recipient older adults in SSA. We found frequent social contact with family and social support provided to older adults positively associated with better psychological well-being and quality of life among older adults. In addition, this review evinces that financial support from non-coresident adult children and extended family members to older adults relates to their better psychological well-being, self-rated health, and greater satisfaction with life. Despite our findings, so far, not much empirical work has been done on this topic in SSA. The findings are based on eight studies and suggest that more research, both quantitative and qualitative, needs to be undertaken to examine the relationship between family support provided and the health and well-being of older sub-Saharan Africans. In light of an ageing SSA population and poor resource context, sub-Saharan African governments must recognize the enormous support burden on families, raise awareness on the importance of family support, and promote interventions that motivate families to meet the support needs of older persons. One way to achieve this is to pay allowances or grant tax reliefs to poor families who maintain an older person. Another way may involve using campaigns to promote family support towards older adults. For instance, campaigns that aim to encourage families to stay socially connected and to use social events such as festivals, marriage ceremonies, and naming ceremonies to 'honour' and to engage older members may benefit their well-being.

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Author contributions

MAA, HH, and TCV conceptualized the study. MAA undertook the literature search. MAA and TCV screened publications and assessed full text for eligibility and inclusion. MAA extracted the data and synthesized the findings. TCV and HH cross-validated synthesized findings. MAA drafted the manuscript. HH and TCV provided supervisory support in drafting and revising the manuscript. All authors read and approved the final manuscript.

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