



Capacity of Old-Age Homes to Meet the Needs of Older Persons in Namibia: Analysis of Quality and Care Gaps

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ABSTRACT

Background: The population of older persons is increasing, while the Traditional Joint Family System (TJFS) is declining, often leaving older persons isolated and vulnerable. This may increase the demand for old-age homes, underscoring the need to understand the capacity and limitations of these facilities in Namibia.

Objectives: This study evaluated the capacity of old age homes to accommodate the needs of Namibia's older population aged 60 years and above in three selected regions of Namibia.

Methods: A mixed-methods, cross-sectional survey design was employed in this study, utilising a checklist to assess the old-age homes and interview guides for the social workers and heads of facilities. Quantitative data were analysed using Statistical Package for Social Sciences version 30 at significance ($P < 0.05$). Qualitative data were analysed manually and presented in themes.

Results: Old age homes in Namibia are scarce, urban-concentrated, and operating at (or near) full capacity. Private old-age homes are generally better resourced and rated, while public homes are lower-cost but face significant deficits in infrastructure, staffing, and accessibility. The voices of key informants highlight chronic funding shortfalls, transportation issues, and the need for renovations and additional staff.

Conclusion: There is an insufficiency of old-age homes, and disparities exist in facilities between publicly and privately run homes.

Unique Contribution: This study is one of the current Namibian triangulated analyses that link structural capacity, and staff perspectives in both the public and private old-age homes. It addresses a reported evidence gap in institutional long-term care in Namibia and offers context-specific insights to the broader literature on ageing and residential care.

Key Recommendation: The study recommends a phased expansion and decentralisation of old-age homes, prioritising the need for attention to the northern regions, alongside targeted investment to upgrade public old-age homes and strengthen regulatory oversight.

Keywords: Older persons, old age homes, long-term care, residential care facilities



INTRODUCTION

Population ageing is a defining global demographic trend. Today, most people can anticipate reaching their 60s and beyond, and in every country, the size and the proportion of older persons are rising (World Health Organization, 2024). According to the Namibia 2023 Population and Housing Census, the population aged 60 years and above reached 206,675 in 2023, compared with 113,303 in 2011, an increase of 29 per cent over 12 years, which constitutes 6.8% of the population aged 60 years and above (Namibia Statistics Agency, 2012, 2024b). The ageing population has far-reaching effects on both the older person and society, and Namibia is no exception. Not only are people living longer, but they are living longer in poor health, which may necessitate more extensive medical care, at times even long-term care (Institute for Health Metrics and Evaluation, 2017). However, data on the health and care of older persons in low- and middle-income countries, such as Namibia, are scarce, and efforts to collect information on these issues are required (Chatterji et al., 2016). Namibia is particularly underrepresented, as it is not among the African countries that publish research on ageing-related issues most frequently (Adamek et al., 2022). Reflecting the wider data gaps on older persons, Namibia is also not included among the 96 countries ranked in the Global Age Watch Index 2015, a tool that highlights persistent weaknesses in age-disaggregated information systems worldwide (Help Age International, 2015).

Historically, older care in Namibia, like much of sub-Saharan Africa, has been rooted in extended family systems. Urbanisation, declining birth rates, and migration have altered household structures, frequently weakened the availability of kin caregivers, and increased the share of older people living as household heads or in smaller family units (Indongo & Sakaria, 2016). The decline of the joint family system and the rise of nuclear families have left older individuals isolated (Bhat, 2021; Maharaj, 2020). Based on this view, the need for old-age homes became clear, and it continues to become increasingly apparent as time passes (Bhat, 2021). During the national consultation meeting, conducted from 15 to 17 November 2022 (the latest meeting publicly available online, on this specific policy), the National Policy on the Rights, Protection, and Care of Older Persons in Namibia was reviewed, and recommendations were made regarding the draft policy (World Health Organization, 2022). During this meeting, Dr Charles Sagoe-Moses, WHO Representative to Namibia, remarked on advancements in the care of older persons in Namibia, including the provision of pensions for all older persons, and the availability of 17 long-term care facilities registered in the country, though all these are private; the other seven are publicly owned and not registered (World Health Organization, 2022). These facilities are concentrated in urban areas and are scarce in the northern regions, where the majority of older people reside (See Table 1 on the distribution of older persons and Table 2 for the distribution of old-age homes in Namibia). He further cautioned that the increase in the number of older persons renders these facilities inadequate, and thus advised the country to move from the centralised approach to a more decentralised approach (World Health Organization, 2022).



Furthermore, existing literature predominantly emphasised the living arrangements and household-level conditions of older persons, using census data, without examining the capacity or quality of formal care institutions (Indongo & Sakaria, 2016). Earlier research on institutional care, such as Dima's thesis on models of old-age homes, employs a comparable methodology to this study; however, it is now outdated (Dima, 2003). The study by Kloppers et al. on experiences of older persons and their caregivers in old-age homes interviewed caregivers and older persons only (Kloppers et al., 2015). More recent Namibian studies have also been conducted on older persons, but they are either totally qualitative (Zamuee, 2022) or focused on awareness and attitudes towards old-age homes among older persons, rather than assessing the structural readiness of the homes themselves (Haufiku-Weyulu et al., 2025). This constellation of gaps, including the limited system-level mapping of old-age homes, a lack of up-to-date information on public private disparities, and minimal triangulation of facility capacity with provider and resident perspectives, constitutes the objective of this study: to assess the capacity of existing old-age homes and to understand the challenges they face. This objective forms part of an ongoing PhD study conducted in Namibia that aims to develop a community-based model to improve the well-being and care of older persons. It builds on an earlier published objective that examined awareness and attitudes toward old-age homes among older persons in Namibia (Haufiku-Weyulu et al., 2025). In this study, long-term care is used, specifically focusing on long-term care for older persons provided in institutional settings. Hence, the term long-term care is used interchangeably with old age homes and residential care facilities for older persons.

METHODS

Study Design and Setting

The study utilised a mixed-methods approach using a cross-sectional survey methodology. Data were gathered from three Namibian regions chosen to exemplify the country's principal geographic clusters: Ohangwena in the north, Khomas in the centre region, and Hardap in the south.

Study Population and Eligibility Criteria

The study focused on the old-age homes available in the selected regions, where consent was obtained. The key informants were recruited based on their willingness to participate in the study. The old-age homes and key informants outside the three regions, as well as those who were unwilling to participate, were excluded from the study.

Sample Size and Sampling Procedures

In the three study regions, there were no old age homes in the Ohangwena region, there was one in the Hardap region, and six in the Khomas region (seven facilities in total). Of these, six facilities were evaluated; one facility was excluded because it had not granted ethical approval. Of the six assessed institutions, four were privately owned, and two were public. Regarding the qualitative component, purposive and convenience sampling were employed



to recruit 16 key informants (until saturation was reached), comprising 14 Social workers and two heads of old-age homes.

Data Collection Instruments, Procedures, and Quality Control

A structured checklist written in English was used to evaluate the old age home's capacity and service readiness. A checklist is defined as a list of factors, properties, aspects, components, criteria, tasks or dimensions that a respondent evaluates and documents (as present/absent or scored for quantity) during its completion (Mathison, 2005). The instrument consisted of 23 closed-ended questions covering various items, including capacity, staffing, fees and admission, hygiene, indoor conditions, safety and security, accessibility, recreation and activities, health services, and overall ratings. Options to select the correct response upon satisfaction with the researcher's observation were provided on the checklist, including Yes, No, N/A, and an option for comments. There were different study guides for the social workers and that for the heads of old age homes. The data collection tools were shared with the study supervisors and experts in the field for review, and errors, ambiguities, and redundancies identified were addressed through necessary adjustments. Interviews were conducted in-person at participants' workplaces, lasting between 20 and 45 minutes, and audio-recorded with participants' consent. All non-English interviews were translated prior to transcription, and the inclusion of key informants with substantial field experience enhanced the credibility of the data.

Data Processing and Analysis

Quantitative data were analysed using IBM SPSS Statistics, version 30. Descriptive statistics were used to compare public and private old age homes in terms of staffing levels, monthly fees, care services, living conditions, and overall quality ratings. A scatter plot was constructed to examine the relationship between facility capacity and the number of older persons accommodated. Qualitative data were manually analysed using Braun and Clarke's thematic analysis framework. The procedure included familiarisation with the data, transcription and translation where necessary, coding, and the generation of themes. Themes were subsequently reviewed, refined, and clearly defined to ensure they coherently and accurately reflected participants' responses (Braun & Clarke, 2006).



RESULTS

Table 1: Older person distribution in Namibia (n = 206,675)

Regions	Older person distribution n (%)
Northern regions	
Ohangwena	27 116 (13%)
Omusati	32 794 (16%)
Oshana	16 884 (8%)
Oshikoto	21 232 (10%)
Kunene	8 483 (4%)
Zambezi	7 723 (4%)
Kavango West	8 822 (4%)
Kavango East	13 478 (7%)
Central regions	
Erongo	13 991 (7%)
Khomas	20 782 (10%)
Omaheke	7 246 (4%)
Otjozondjupa	12 601 (6%)
Southern regions	
Hardap	8 946 (4%)
//Kharas	6 577 (3%)

Table 1 outlines that the demographic distribution of older persons is significantly concentrated in the northern regions, which collectively comprise around two-thirds (66%) of the older population. In contrast, the central regions collectively contribute about 27% of older persons, while the southern regions account for only 7%, recording the smallest proportions nationally.

Table 2: Distribution of old age homes in Namibia

Region	Number of old age homes
Khomas	4x Private, 2x Public
Erongo	4x Private, 2x Public
Otjozondjupa	4x Private
Karas	3x Private, 1x Public
Omaheke	1x Private, 1 x Public
Hardap	1x Private
Kunene	1x Public
Total	24



Table 2 illustrates that the distribution of old age homes in Namibia is uneven across regions, with a predominance of privately owned facilities. Khomas and Erongo are the most resourced, together accounting for half of all 24 old-age homes, while Otjozondjupa and Karas also have several facilities, mostly private. In contrast, Omaheke, Hardap, and Kunene have only one or two homes each, and the remaining seven regions (Kavango East, Kavango West, Ohangwena, Omusati, Oshana, Oshikoto, and Zambezi) have no old-age homes at all, highlighting significantly limited institutional care options across large parts of the country. The capacity of the old-age homes is displayed in Figure 1 below.

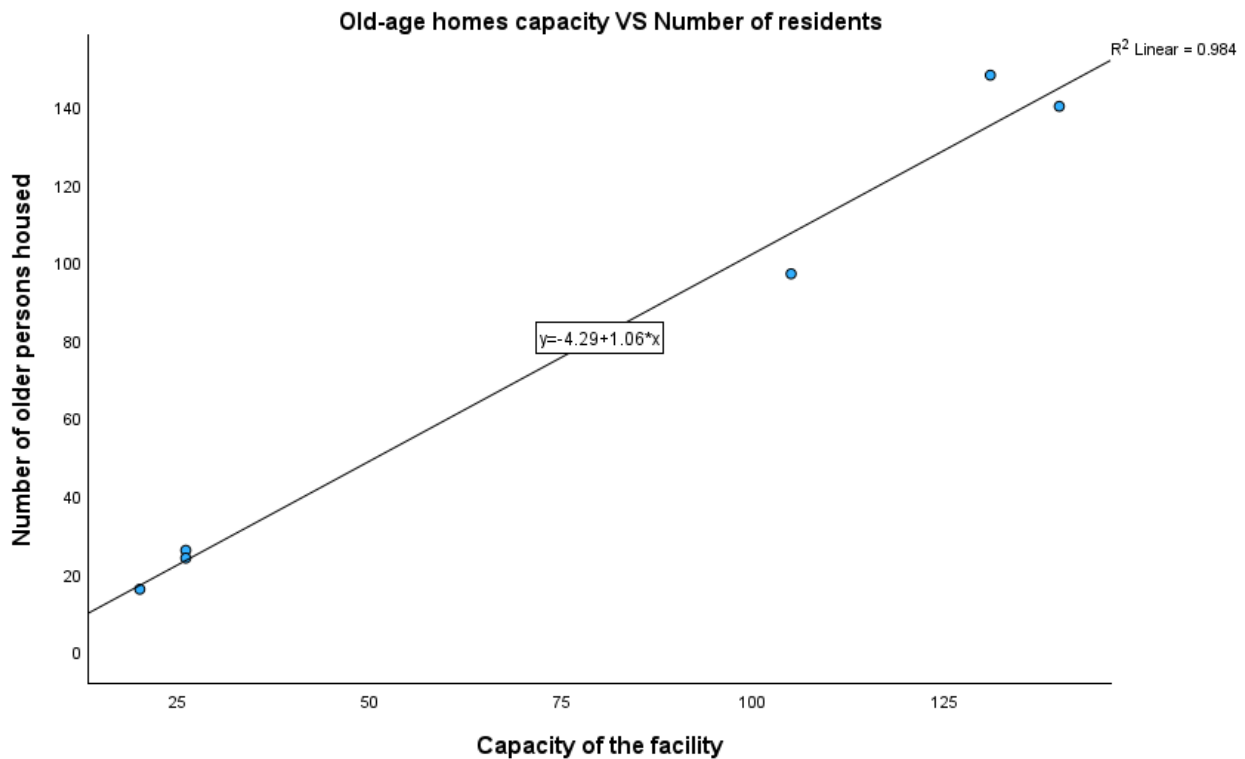


Figure 1: Old age homes capacity vs the number of older persons residents.

Figure 1 above shows a scatterplot that demonstrates a near- perfect linear relationship between facility capacity and the number of older persons accommodated across the six homes ($R^2 \approx 0.98$). The fitted line ($\hat{y} = -4.29 + 1.06x$) has a slope slightly greater than one, indicating that occupancy increases approximately in direct proportion to reported capacity, and in several cases, marginally exceeds it. Overall, the pattern suggests limited space capacity as most facilities operate at or near full occupancy, with some evidence of overcapacity in the larger homes, underscoring potential pressure on available beds. The comparison of old-age homes is presented in Table 3 below.



Table 3: Comparison of private and public old age homes

Variable	Category	Private Old-age homes N (%)	Public Old-age homes N (%)
Number of staff	1-3		2 (100.0)
	4-7	2 (50.0)	
	8 and above	2 (50.0)	
Payment per month (NAD)	0-299		2 (100.0)
	300-999	1 (25.0)	
	1000-5000	1 (25.0)	
	5001 and above	2 (50.0)	
First aid and sick bays are available	Yes, both first aid, social welfare, and health care	4 (100.0)	
	Yes, first aid and social welfare only		2 (100.0)
Emergency preparedness is in place	Yes	3 (75.0)	2 (100.0)
	No	1 (25.0)	
The house is safe (lockable doors, neighbourhood watch, perimeter fencing)	Yes, rooms with locks only, no neighbourhood watch and an electrical fence	1 (25.0)	
	Yes, with locks, gates locked, and an electrical fence	3 (75.0)	2 (100.0)
Anti-slippery floor	Yes	3 (75.0)	2 (100.0)
	No	1 (25.0)	
Provisions made for people with disabilities.	Yes	3 (75.0)	
	No	1 (25.0)	2 (100.0)
Provision of railings at the steps of the house	Yes	2 (50.0)	
	No	2 (50.0)	2 (100.0)
Overall quality of care	Very good	2 (50.0)	
	Good	2 (50.0)	
	Neither poor nor good		2 (100.0)
Improvements needed	No action needed	2 (50.0)	
	Significant upgrade	2 (50.0)	
	Extreme renovations/service gaps		2 (100.0)

* Data are descriptive only. Due to the small number of facilities (N = 6), no inferential statistics were conducted. NAD = Namibian dollar.

Table 3 above illustrates the comparison between private (n = 4) and public (n = 2) facilities, revealing that private homes consistently have greater resources and higher ratings. All public



homes reported having just 1–3 staff members, whereas all private homes employed four or more staff members. Private institutions had a more extensive service infrastructure, including (first aid + social-welfare + healthcare/sick-bay available in all four), whereas public homes reported only first aid and social welfare. Emergency preparedness measures, including fire extinguishers, assembly points, fire alarms, and basic security, were present in most sites. However, one private home lacked emergency preparedness, and another was equipped solely with room locks. Accessibility gaps were prevalent in the public sector: neither public home had disability provisions (such as raised toilet seats, walking and standing aids, ramps for wheelchairs, etc.) or stair railings at the front and rear of the facilities, while most private homes did. The perceived quality mirrored these disparities, private homes were rated “good/very good,” while public homes were deemed “neither poor nor good” and improvement needs diverged sharply, with both public homes classified as needing “extreme renovations/service gaps having cracks, some non-functional bathrooms, fire extinguishers are there, but they were due for service, requiring high priority),” in contrast to private residences, which were split between “no action (routine maintenance only) and ” and “significant upgrade (medium priority).” However, public homes fell exclusively in the lowest monthly fee band (N\$0–299), while private homes charged N\$300 or more, with half in the highest rate band. Apart from what is shown in Table 3, all six old age homes have gender-segregated rooms, toilets, and bathrooms with grab bars, adequate provision of safe drinking water, sufficient lighting in all areas, and available recreational facilities, including TVs, books, and newspapers.

QUALITATIVE ANALYSIS

Characteristics of the participants

To triangulate the data, interviews were conducted with the social workers and the head of old-age homes. All fourteen (14) interviewed social workers were female (100%) and concentrated in early to mid-career age bands, with 21.4% aged 20 – 29; 35.7% aged 30 – 39, while the remaining participants were evenly distributed between the ages of 40 – 49 (21.4%) and 50 – 59 (21.4%). Educational attainment was significant: 78.6% possessed a bachelor’s degree, 14.3% a master’s degree, and 7.1% a diploma. The participants were primarily based in Khomas (57.1%), with additional representation from Ohangwena (21.4%) and Hardap (21.4%). Professional experience demonstrated indicated a balanced skills mix, with 35.7% reporting ≥ 10 years in practice and a further 28.6% with 5 – <10 years, while 14.3% had 3 – <5 years, 14.3% had 1 – <3 years, and 7.1% had 6 months’ experience. Five themes and five subthemes emerged from the interviews with social workers. Among the two heads of old-age homes interviewed (N = 2), both were female and employed full-time; one was aged 40 – 49, and the other was 50 – 59. Educational achievement was split, with one individual possessing a secondary education and the other holding a master’s degree. Occupational roles included those of Administrative Officer and General Manager. Professional experience in older care revealed that one respondent had 3 – <5 years and another had 5 – <10 years. Seven themes and six subthemes emerged from the interviews with the head of old-age homes. See the thematic tables below:



Table 4: The social workers' thematic table

Theme	Subthemes	Sample quotes
Insufficient capacity and regional disparities	No homes in some regions; long waiting lists; limited spaces open only when someone leaves; insufficient dementia centres.	“We do not have old-age homes in the north, and that is why I wish the government would come in, as they did in the southern and central regions.” (Social Worker 2) “It is insufficient; we can only take 5-6 from the yearly waiting list as the houses are full. Spaces are only available when someone dies or gets sick and is unable to take care of themselves, and thus, their family members come to take them.” (Social Workers 10)
Financial constraints and affordability	Fees insufficient; reliance on donations; utilities costly; need government/NGO/private support.	“The 300 paid by the old people is not enough.” (Social Worker 8) “Private old age home charges so much because of utilities, salaries; state ones are not maintained on time.” (Social Worker 14)
Abuse and housing conditions	deplorable living conditions	“The older persons face rejection, neglect, and abuse, and some houses are in depleted situations.” (Social Worker 7)
Policy/guideline gaps and uneven implementation	Outdated/insufficient policies.	“The older person policy we are using is outdated.” (Social Worker 6) “The Ministry of Health and Social Services is currently drafting a Policy on the Rights, Care and Protection of Older Persons in Namibia; there is no other policy in place.” (Social Worker 14)
Staffing and training needs	Staff shortages and training needs.	“Training of staff with special skills is needed.” (Social Worker 4) “We need to recruit more staff, such as nurses, physiotherapists, a cook, and some cleaners.” (Social Worker 8)



Table 5: The head of old-age homes thematic table

Theme	Subthemes	Sample quotes
Funding and sustainability constraints	Lack of sponsors and reliance on resident fees	“We do not have sponsors; the old age home depends entirely on the payment of the old people accommodated here.” And “We do not pay the caregivers enough.” (Head of old age homes 1)
Capacity limits and waiting lists	Demand exceeds supply	“We have a very limited capacity here.” (Head of old age homes 1) “We can accommodate up to 140 older people, but we are currently full with a long waiting list. It is sad because they need these services now and not when they are dead.” (Head of old age homes 2)
Dementia care gaps	Caregivers often lack dementia-specific skills.	“It is also difficult for the old people with dementia as caregivers do not have qualifications on how to deal with dementia older persons.” (Head of old age homes 2)
Affordability and pricing model		“They pay depending on the type of room they are accommodated in and the amount of care they need. Prices range between N\$4,280 and N\$14,590 per month.” (Head of old age homes 2)
Night care and shift patterns	No night-shift caregivers	“We are unable to provide night care as we have day caregivers only.” (Head of old age homes 1)
Infrastructure and facility upgrades	physio room and physiotherapist; infrastructure support	“We also want a physiotherapist and a physio room” (Head of old age homes 1)
Community perceptions and family engagement	Negative perceptions; low family visitation; stigma (“only for white people”); outreach via churches and rural talks	“People are always negative; most families never come to visit their old people here.” (Head of old age homes 1) “Some community members also believe old age homes are only for white people, which is not valid. We need to speak mostly to the rural community about the benefits of old age homes.” (Head of old age homes 2)

Tables 4 and 5 summarise the interviewees' responses in themes and sub-themes supported by quotes from the participants.



DISCUSSION

The study aimed to assess the capacity and readiness of existing old-age homes in Namibia and to explore the challenges they face, as perceived by key informants. Quantitative findings reveal that old-age homes are scarce, concentrated in urban areas, and operate at or near full occupancy. Moreover, private facilities are generally better resourced and more highly rated than public homes. Furthermore, capacity roughly aligns with actual occupancy, leaving a minimal buffer for increasing demand. Qualitative results from social workers and facility managers corroborate these patterns, highlighting funding constraints, staff shortages, gaps in dementia care, and infrastructural deficits.

About two-thirds of Namibia's older population reside in northern regions, whereas old-age homes are concentrated in central and southern urban centres. This mismatch is also captured by one social worker, who noted: "We do not have old-age homes in the north, and that is why I wish the government would come in, as they did in the southern and central regions." (Social Worker 2). This urban bias is consistent with previous Namibian research that documented rural-urban disparities in living conditions and service accessibility for older persons (Indongo & Sakaria, 2016; World Health Organization, 2022). Old-age homes were also generally found to be scarce and mostly privately owned. This aligns with findings from a study in Kenya, which reported that the capacity of old-age homes is similarly limited, with an estimated 16 residential care facilities nationwide, most of which are run by religious organisations (Murage, 2022). Together, these findings highlight a significant gap in the provision of both long- and short-term care for older persons.

The finding that private facilities are typically better resourced and more highly rated than public homes echoes patterns reported in other countries; for instance, in Ethiopia, government-funded homes for older persons are typically characterised by limited resources and overcrowding, hindering their ability to provide adequate care (Dawud et al., 2022). Similarly, a study in Malaysia comparing public and non-governmental facilities found that government-owned homes tended to be financially driven and failed to provide high-quality services (Wagiman et al., 2016). It was further discovered that in developing countries, residential facilities for older persons are often not subject to systematic regulation or monitoring by state authorities (Dawud et al., 2022). Consistent with this pattern, this study found that only private old-age homes in Namibia are registered and therefore subject to mandatory inspection. As one social worker explained in relation to policy, "The Ministry of Health and Social Services is currently drafting a Policy on the Rights, Care and Protection of Older Persons in Namibia; there is no other policy in place" (Social Worker 14, See Table 4). At the regional level, WHO reports that in many sub-Saharan African countries, formal long-term care systems are largely absent (World Health Organization, 2017). The near-perfect alignment between capacity and occupancy observed in this study indicates that old-age homes are operating as tightly constrained bottlenecks rather than flexible components of a wider long-term care system. This pressure on capacity was further vividly described by one facility manager: "We can accommodate up to 140 older people, but we are currently full, with a long waiting list. It is sad because they need these services now and not when they are dead" (Head of old age homes 2, See Table 5). In the Namibian context,



this likely reflects both increasing demand driven by demographic ageing and changing family structures.

The documented emergency preparedness and accessibility deficiencies revealed from some old-age homes in this study, such as expired fire extinguishers, missing alarms and assembly points, and the absence of ramps, handrails or adaptive toilets in public homes, are inconsistent with WHO guidance on age-friendly infrastructure, which recommends elevators, ramps, wide doorways to accommodate wheelchair users, suitably graded stairs with handrails, non-slip flooring and resting areas with comfortable seating (World Health Organization, 2015).

By triangulating the perspectives of key informants with facility assessments, the study extends prior Namibian research that focused primarily on awareness and attitudes towards old-age homes (Haufiku-Weyulu et al., 2025), shifting the discourse from whether old-age homes are acceptable to how they are distributed, resourced and governed in practice.

CONCLUSION

Based on the results, this study concludes that Namibia's old-age homes are insufficient to meet the current and future long-term care needs of its rapidly ageing population. The evidence shows that facilities are too few, concentrated in urban centres far from where the majority of older persons reside, and operating at or beyond capacity, with public homes in particular facing significant staffing, infrastructure, and accessibility challenges. Concurrently, key informants clearly articulate feasible improvements, including enhancements to staffing and infrastructure capacity, as well as adjustments to fees and policy implementation. This study concludes that Namibia requires a deliberate, equitable strategy to expand and decentralise old-age homes, while bridging the quality disparity between public and private homes. In the absence of these measures, the country risks deepening regional and socio-economic inequalities in the access of older persons to safe and dignified care.

Ethical clearance

Ethical consent was obtained from the Ministry of Health and Social Services in Namibia (reference 22/3/1/2), the managers of the old-age homes, and the participants involved in this study. They were informed that the exercise was purely for academic purposes and that their participation was voluntary.

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Conflict of Interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Authors' Contributions

Mouyelele Haufiku conceived the study, including its design, and wrote the original manuscript, while Dr Mahalie and Dr Aku-Akai guided the data collection and analysis. All authors have critically reviewed and approved the final draft and are responsible for the content and similarity index of the manuscript.

Availability of data and materials

The datasets on which conclusions were made for this study are available on reasonable request.

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