Social Support among Older South Africans during COVID-19

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Abstract

COVID-19 had a significant impact on older South Africans' experience of social support. This cross-sectional study explored possible risk and protective factors of social support among community-dwelling older adults ($N = 118$). Social support pre- to during COVID-19 decreased significantly; however, overall social support was greater for those who were older, had more face-to-face contact, and had a greater number of friends or relatives. From a socio-ecological perspective on resilience, greater opportunities for older adults to create connections, such as classes or community events, are recommended to facilitate desired social supports, which in turn supports greater health and well-being.

Keywords: COVID-19; older adults; social support; South Africa; gerontological social services

Social Support among Older South Africans during COVID-19

In March 2020, the World Health Organization (WHO) declared the outbreak of a novel coronavirus, COVID-19, which causes mild to moderate respiratory illness. Since March 2020, South Africa had 4.06 million positive cases of COVID-19 and over 102,000 deaths (population = 60.6 million; South Africa, Department of Health [SADoH], 2023). Vaccinations started in February 2021 for healthcare workers, frontline workers, and older adults (i.e., people 60 years and older; South Africa, National Institute for Communicable Diseases [SANICD], 2022), but rates of vaccination remained low with only 19.48 million of the population fully vaccinated (SADoH, 2023). Hence, business openings, social gatherings, and in-person education, especially at universities/colleges, were much slower than in the developed world.

The South African government announced a state of emergency in March 2020 and introduced a five-level alert system, which included physical distancing, compulsory wearing of face masks, stay-at-home orders, restricted business, closure of schools and universities/colleges for in-person education, a ban on social gatherings, and a ban on the sales of legal drugs (e.g., alcohol and cigarettes; SADoH, 2023). Although the protective measures were applied to all citizens, older adults were particularly affected due to their age and susceptibility to COVID-19 infection (Sattari & Billore, 2020). A particular challenge in South Africa, as well as other collectivistic cultures, is the strong inclination to 'flock together' during times of distress (Ebersöhn, 2019). Hence, these protective measures left many people feeling lonely and socially isolated. Social support can be a particularly important protective factor for older people, especially during a pandemic when their health is at risk (Fuller & Huseth-Zosel, 2021). A dearth of research was identified as it pertains to the social circumstances of South African older adults during COVID-19. Given the cultural differences with Western nations where much of the

current research is produced, this study sought to ascertain the levels of social support experienced by South African older adults during the more restrictive times of COVID-19, including the risk and protective factors associated with social support. The experience of adequate social support promotes the mental health and well-being of older adults during times of prolonged health and/or natural disasters (Kenkmann & Burkard, 2022).

Literature Review

Social welfare services for older adults in South Africa

Approximately 9.1 percent (± 5.5 million) of the South African population is considered older adults with a life expectancy of 62.4 years (Statistics South Africa [StatsSA], 2020). A history of colonialism and racial segregation (i.e., Apartheid) left numerous inequalities among older adults. Despite 29 years of democracy, older adults experience numerous challenges, such as food insecurity, inadequate finances for retirement, lack of access to basic health services, lack of affordable accommodation, poverty as well as human rights violations, such as gender inequality, hate crimes against LGBTIQA+ members, and elder abuse (Lombard & Kruger, 2009; Noyoo, 2017; Patel, 2015).

Many households rely on the 3.1 million beneficiaries of the means-tested "older person's grant" (ZAR 2080, ±US$ 114 per month) to sustain their livelihoods (South African Social Security Agency [SASSA], 2023). More than half of older adults live in a household with unemployed members (StatsSA, 2020), which is amplified by an unemployment rate of 32.7 percent (StatsSA, 2023).

After democratization, South Africa adopted a developmental approach to welfare (Patel, 2015). In terms of gerontological social services, this meant a shift from "care for the aged" to "aging" where old age is considered positive and a normal life stage (Lombard & Kruger, 2009).

Gerontological social services are mandated by the South African Constitution (1996), the South African Policy for Older Persons (2005), and the Older Persons Act 13 of 2006. More affluent older adults make use of private doctors and hospitals through their medical scheme benefits. However, those that are socioeconomically disadvantaged often rely on local clinics and public hospitals with less than optimal service delivery (Lombard & Kruger, 2009). Social services include statutory intervention in the case of elder abuse or support services at luncheon clubs and service centers.

COVID-19 and its impact on older adults in South Africa

The virus had both a direct and indirect impact on older adults (Garfin, 2020). The *direct impact* of COVID-19 includes that older adults were encouraged to practice physical distancing as they are at greater risk for contracting COVID-19 with fatal consequences, especially if they had comorbid conditions making them more susceptible to infection (Fuller & Huseth-Zosel, 2021). South African older adults commonly live with arthritis, diabetes, and hypertension (StatsSA, 2017), which makes them vulnerable to contracting the virus. The social-emotional consequences were, among others, that many older adults do not have regular contact with children, grandchildren, and significant others as well as limited social connections (e.g., attending church, and social groups) – all of these had the potential to impact negatively on their mental health and social well-being (Gorenko et al., 2021; Kenkmann & Burkard, 2022; Vahia et al., 2020). Research in the US points to the stress and fear that COVID-19 has created for older adults, particularly those experiencing poor physical health (Authors, 2022). Furthermore, COVID-19 had a particular impact on the type, quality, and quantity of social support older adults experienced as many were not allowed to have contact with significant others (Sepúlveda-

Loyola et al., 2020). For example, Authors (2021) found that many older adults experienced increased loneliness during COVID-19 in the US.

The *indirect impact* of COVID-19 included older adults experiencing trauma as a result of continuous exposure to media reports on COVID-19 as well as secondary stressors, such as reduced income (Garfin, 2020). It could be argued that one strategy to cope with the social restrictions caused by COVID-19 is an increased reliance on Information and Communication Technology (ICT). Among the ICT that older adults could use to maintain social support amidst COVID-19 included social media, and visual chat/video calls (Garfin, 2020; Smith et al., 2020). It should, however, be noted that older adults did not grow up with ICTs and hence they may not be eager to adopt them (Lim & Bowman, 2022). In fact, South African research revealed that older adults are especially not keen on using ICTs (Chipps & Jarvis, 2017), in part due to the unavailability of reliable internet connections and the high cost of data (Payi, 2019).

Social Support in Older Adults and Resilience Theory

From an evolutionary perspective, humans need to be part of a group. Not only were social-emotional needs met in the group, but also survival was based on this group membership. That is, food, safety, and shelter were provided within the group, and as such, this need for other people is inherently part of our genetic makeup. As such, providing help to others as well as receiving help is an essential aspect of human coping skills. Adequate social support in old age can contribute to active or successful aging whereby older adults can have greater choice and freedoms as they self-determine (Vlachantoni et al., 2022).

Past findings substantiate the importance of social support in helping people maintain health and well-being and build greater resilience (cf. Burnette et al., 2017; Kenkmann &

Burkard, 2022; Vlachantoni et al., 2022). For example, quality of life amongst older adults was found to be associated with perceived social support, self-esteem, and self-efficacy while anxiety, loneliness, depression, and anxiety were found to be significant risk factors (Eva et al., 2015). Evidence also suggests that social support is important during times of crisis. In a recent Israeli study, social support was found to be among the protective factors against psychological distress during COVID-19 among participants (Oryan et al., 2021). Similarly, social support and social network size are protective factors for health and depression in a study of older individuals of the LGBTIQA+ community (Fredriksen-Goldsen et al., 2013), and high levels of social support also provide a protective factor for abuse (Melchiorre et al., 2013). Moreover, those who were living with a partner in a large household or with other people were more likely to report high levels of support (Melchiorre et al., 2013). In terms of partners, the quality of the relationship provides the most impact on individual health (Umberson et al., 2006) and well-being (Sherwood et al., 2014). A partnership of high quality can help mediate stressors, including greater resilience when coping with significant illness (Walker & Luszcz, 2009).

Thus, underpinning this study was resilience theory, which is increasingly considered valuable in informing gerontological social services and research (Angevaare et al., 2020). Utilizing a salutogenic approach lends to the exploration of the levels of social support and not only pathogenic processes, such as adversities, risks, and problems during the pandemic. Equal attention was given to abilities, internal and external promotive and protective factors and processes (PPFPs), and resources that enable older adults to thrive in the face of adversities, specifically those related to COVID-19 (Ungar & Theron, 2020; Van Breda, 2019). Resilience can be defined as

> [T]he capacity of a biopsychosocial system (this can include a person, a family, or a

> community) to navigate to the resources necessary to sustain positive functioning under stress as well as the capacity of systems to negotiate for resources to be provided in ways that are experienced as meaningful (Ungar, 2019, p. 2).

Consequently, resilience is not narrowly understood to be a trait, specific outcome, or ultimate goal, but rather a process where older adults navigate toward resources and individually (or collectively) negotiate for resources that they consider meaningful amidst the pandemic (Ungar, 2011).

Adopting a socio-ecological perspective on resilience according to which older adults are considered bio-psycho-social-spiritual beings who interact with their environment (both the social and physical environment; Van Breda 2019) to navigate towards better-than-expected outcomes. Considered from a socio-ecological perspective on resilience, the research explores the interactions of the micro-, mezzo-, macro-, and chrono-systems that could either be sources of adversities or risks that inhibit resilience (e.g., acute adversity, such as direct and indirect exposure to COVID-19 and/or living with comorbid conditions), or systems which could be PPFPs (e.g., social support, both face-to-face and online/virtual with significant others, social interaction in groups/organizations, good physical and mental health) that enable mediating processes where older adults could achieve their desired outcomes amidst the pandemic (Ungar, 2019; Ungar et al., 2013; Van Breda, 2018). Hence, the implications for gerontological social services that this paper highlights, should be considered as potential mediating processes that could enable older adults to navigate towards better-than-expected outcomes.

This study aimed to answer the following research questions among a sample of community-dwelling older adults in South Africa:

1. What is the self-reported level of social support (emotional/informational; tangible; affectionate; positive social interaction; overall social support) pre- and during COVID-19?
2. Is there a statistically significant difference in self-reported social support pre- to during COVID-19?
3. To what extent do different types of social contact, the number of close friends/relatives, physical health, mental health, and socio-demographics contribute to (a) emotional/informational support; (b) tangible support; (c) affectionate support; (d) positive social interaction; and (e) overall social support during COVID-19?

Materials and Methods

Figure 1 offers a brief visual presentation of the materials and methods that informed the study.

---- Insert Figure 1 here ----

Setting and Sample

In this quantitative study, the data were collected through a cross-sectional research design operationalized through an online questionnaire of South African older adults in 2021 (Babbie, 2017). The study population comprised community-dwelling older adults who were registered volunteers of a welfare organization in South Africa with a footprint over five of the nine provinces of South Africa. Potential participants of 60 years and older (i.e. total population sampling) received an e-mail from the organization with an invitation to complete an online survey following a link to Qualtrics^{XM} (Total population sampling, 2012). A total of 139 participants completed the survey from a potential population of 874 older adults. A higher

response rate than 15.9 percent would have been welcomed (Adler & Clark, 2015). The authors did not contact any participants directly to ensure their privacy and confidentiality. In an attempt to improve the response rate, the invitation was repeated three times following initial recruitment. Participants had to meet the following inclusion criteria to be recruited: the older adults had to be on the database of volunteers of the welfare organization, aged 60 years or older; older adults had to have access to a smartphone or computer and e-mail address to be contacted; older adults had to be able to read and write either Afrikaans or English (i.e. two of the 11 official languages of South Africa); no limitations were applicable in terms of gender or race, and older adults had to provide informed consent before accessing the survey. A disadvantage of the online survey was its restriction on older adults having access to data and the Internet (Maree & Pietersen, 2020). However, face-to-face or paper-based surveys were not an option due to lockdown restrictions

No identifying information (e.g., name, contact details) was recorded during survey completion. All participants were informed that social workers employed by the welfare organization were available for debriefing should they experience any emotional harm after completing the survey. The management of the welfare organization reviewed the research proposal and questionnaire before written permission was granted to conduct the study. Thereafter, ethical clearance was obtained from the Research Ethics Committee of the university where the South African author is employed (Ref.: HUM003/0321).

Instrumentation

The survey instrument utilized Sherbourne and Stewart's (1991) concept of "functional support," which includes emotional support (e.g., encouragement, empathy); informational support (e.g., information or feedback); tangible support (e.g., material or behavioral assistance);

positive social interaction (e.g., people to do fun things with); and affectionate support (e.g., love and affection). Their work points to the multidimensional nature of social support, and further research suggests its importance for the promotion of health and well-being (Smith et al., 2020; Vlachantoni et al., 2022). Thus the author-constructed questionnaire consisted of 55 items that measured social support, types of social contact (e.g., face-to-face; online/virtual; groups/organizations), number of close friends/relatives, subjective physical health, subjective mental health, direct and indirect exposure to COVID-19, and sociodemographics of age, gender, home language, area of residence, province, highest qualification, employment status, relationship status, living arrangements, number of children, and religious or spiritual beliefs.

Dependent Variables

The MOS Social Support Survey (Sherbourne & Stewart, 1991), which is in the public domain, measures the availability of support across four domains and a total social support score, which served as the dependent variables in this study. The instrument asks, "How often was each of the following kinds of support available to you if you needed it?" and then lists 19 statements. Eight statements measure emotional/informational support (e.g., "Someone to give you good advice about a crisis"), four statements measure tangible support (e.g., "Someone to help you if you were confined to a bed"), three statements measure affectionate support (e.g., "Someone who shows you love and affection"), and three statements measure positive social interaction (e.g., "Someone to have a good time with"). The scale asks participants to indicate how often each of the supports is available to them (1 = *Never* – 5 = *Always*). Mean scores are calculated for each of the four subscales and the overall scale with higher scores indicates higher support. Finally, the means of the four subscales and overall scale were transformed into a 0 – 100 scale with higher scores indicating higher social support. If a participant had at least one valid

response on any subscale, then they were included in the analysis of the individual subscales (Sherbourne & Stewart, 1991). Cronbach's alpha indicated a high level of internal consistency in this study for the emotional/informational support subscale ($\alpha = .97$), the tangible support subscale ($\alpha = .90$), the affectionate support subscale ($\alpha = .89$), the positive social interaction subscale ($\alpha = .95$), and the overall social support scale ($\alpha = .98$).

Independent Variables

Three different types of social contact were assessed individually by asking the following questions: "On average, how many days per week do you have *face-to-face contact* with others (family, friends)?"; "On average, how many days per week do you have *online/virtual via text message or video* with others (family, friends)?"; and "On average, how often do you have contact with *groups or organizations* (hobby group, social club, church) per week?". The participants were asked to indicate the number of close friends/relatives by answering the question, "How many close friends and/or close relatives do you have (people you feel at ease with and can talk to about what is on your mind)?" Two additional independent variables explored the extent to which physical and mental health contributed to social supports along with type and quantity of contacts. Physical health and mental health were measured through self-report by completing the following two questions: "How would you describe your physical health?" and "How would you describe your mental health?" (1 = *Very poor* – 6 = *Excellent*).

Finally, exposure to COVID-19 was assessed through two questions: "Did you experience any *direct exposure* to COVID-19 (e.g., infected yourself, know someone close to you who was infected)?" and "Were you affected through any *indirect exposure* to COVID-19 (e.g., being traumatized through the media)?" with possible responses of yes, no, and unsure.

Data Analysis

The data were analyzed in IBM SPSS, version 27, software using descriptive statistics to determine percentages, frequencies, and measures of central tendency for the sociodemographic variables and the items measuring social support, types, and quantity of social contact, physical and mental health, and exposure to COVID-19. Bivariate analyses were run to explore the relationship between two variables, for example, the relationship between social support and relationship status, and the relationship between social support pre- and during COVID-19. Before conducting ANOVAs, descriptive statistics were examined to ensure at least five cases within each category; if there were less than five cases in a specific category, the specific categories of the variable were combined to create an "other" category. Post-hoc comparisons using Fisher's LSD test were performed to assess specific differences between groups (Field, 2013).

The variables found to be significant ($p < .05$) at the bivariate level were included in five separate ordinary least squares (OLS) regressions analyses to determine which factors contributed to emotional/informational support, tangible support, affectionate support, positive social interaction, and overall social support. The predictor variables were relationship status (1 = (re)married/Partnered; 0 = all other relationship types), area of residence (1 = Urban; 0 = Rural), physical health, mental health, face-to-face contact, online/group contact, group/organization contact, and the number of close friends/relatives. The outcome variables were overall emotional/informational support, tangible support, affectionate support, positive social interaction, and overall social support. The variables were entered simultaneously. Missing data were addressed through list-wise deletion. Alpha was set at .05.

Results

Sample Sociodemographics

A total of 118 participants were included in the data analysis after removing 21 cases due to missing items. The mean age of the participants was 72.6 (*SD* = 7.1) years with a range from 60 – 90 years. Seventy-two percent of participants identified as a woman, 92.3% identified their home language as Afrikaans, 85.3% resided in urban or semi-urban areas, and 50% reported living in the Gauteng Province. Nearly 70% of participants qualified with a B degree/Honors Degree/Professional Degree, Grade 12/Matric, or National Diploma, and 79.5% were retired/pensioners. The largest percentage of participants were married/partnered (45.3%) and were living with a spouse/partner (46.6%) followed by 40.5% of participants who were living alone. The mean number of children for the participants was 2.8 with a range of 0 – 11 children. Nearly 98% of the participants reported Christianity as their religion or spiritual belief. Table 1 reports the sociodemographics of the sample.

----- Insert Table 1 here -----

Health, Exposure to, and Social Contacts during COVID-19

Table 2 reports the descriptive statistics for self-reported physical and mental health, exposure to COVID-19, and types and quantity of contacts during the pandemic. The participants reported their physical health (*M* = 4.4; *SD* = .92) and mental health (*M* = 4.7; *SD* = .92) to be between good and very good at the time of completing the questionnaire. Nearly 52% of participants reported direct exposure to COVID-19 and 28.4% reported indirect exposure. The mean number of days the participants had face-to-face contact was 5.3 days, yet the participants had a slightly higher mean number of days in online/virtual contact at 5.9 days. The participants

reported only a mean of 2.5 days of contact via groups and organizations. Finally, the participants reported a mean of 7.1 close friends or relatives with a range of 0 – 50.

----- Insert Table 2 here -----

Social Supports Pre- and During COVID-19

Table 3 reports the descriptive statistics of the MOS social support subscales and overall social support scale both pre- and during COVID-19. Emotional/informational support, tangible support, affectionate support, positive social interaction, and overall social support decreased from pre- to during COVID-19 among the sample with the least amount of support during COVID-19 coming from positive social interaction (M = 67.8; SD = 29.3) followed by emotional/informational support (M = 69.4; SD = 26.6). Paired-samples t-tests indicated the observed decreases pre- to during-COVID-19 were statistically significant at $p < .001$ – $p = .04$. The effect sizes for these changes in social supports were small (d = .2 - .3) according to Cohen's (1988) guidelines.

----- Insert Table 3 here -----

Relationship between Sociodemographics, Risk and Protective Factors, and Social Support

Table 4 reports the bivariate analyses between sociodemographics, risk and protective factors, and the different types of social support. There were no statistically significant relationships between gender, living arrangement, highest qualification, employment status, and the number of children with any of the types of social support. Relationships were found between age, relationship status, area of residence, physical health, mental health, face-to-face contact, online/virtual contact, group/organizational contact, and the number of close friends/relatives with at least one or more types of social support. In particular, the findings revealed a statistically significant weak, positive relationship between age and emotional/informational support (p =

.04), affectionate support ($p = .02$), positive social interaction ($p < .05$), and overall social support ($p = .05$).

There was a statistically significant difference in relationship status and different types of social support. For tangible support, post hoc comparisons using Fisher's LSD test revealed: (a) divorced participants had higher levels of tangible support compared to participants who were single ($p = .02$) and widowed ($p = .05$); (b) divorced/widowed and remarried/partnered participants had higher levels of tangible support compared to participants who were single ($p = .018$) and widowed ($p = .04$); and (c) married/partnered participants had higher levels of tangible support compared to participants who were single ($p = .04$).

For affectionate support, post hoc comparisons revealed: (a) divorced participants had higher levels of affectionate support compared to participants who were single ($p = .02$); (b) divorced/widowed and remarried/partnered participants had higher levels of affectionate support compared to participants who were single ($p < .01$); and (c) married/partnered participants had higher levels of affectionate support compared to participants who were single ($p = .03$).

For positive social interaction, post hoc comparisons revealed: (a) divorced participants had higher levels of positive social interaction compared to participants who were single ($p = .01$) and widowed ($p = .01$), and (b) divorced/widowed and remarried/partnered participants had higher levels of positive social interaction compared to participants who were single ($p = .03$).

Finally, for overall social support, post hoc comparisons revealed: (a) divorced participants had higher levels of social support compared to participants who were single ($p = .01$) and widowed ($p = .03$); (b) divorced/widowed and remarried/partnered participants had higher levels of social support compared to participants who were single ($p = .01$) and widowed

(p = .04); and (c) married/partnered participants had higher levels of social support compared to participants who were single (p = .04).

Area of residence was only statistically significant with emotional/informational support. Post hoc comparisons revealed participants who resided in urban areas had higher levels of emotional/informational support compared to participants who resided in rural areas (p = .01).

There was a positive, weak correlation between physical health and affectionate support (p = .04) and positive social interaction (p <.01), and a positive, weak correlation between mental health and emotional/informational support (p <.01), affectionate support (p = .01), and overall social support (p = .02).

For the different types of contact, there was a positive, weak correlation for both face-to-face contact and online/virtual contact with emotional/informational support (p <.01), tangible support (p <.01; p = .04), affectionate support (p <.01; p = .02), and overall social support (p < .01), and groups/organizations was only positively correlated with affectionate support (p = .03).

Finally, the number of close friends/relatives had a positive, weak correlation with emotional/informational support (p < .01), tangible support (p = .01), and overall social support (p = .01).

----- Insert Table 4 here -----

Risk and Protective Factors Contributing to Social Support

----- Insert Table 5 here -----

Emotional/Informational Support

The results of the regression analysis for emotional/informational support indicated that four variables explained 46% of the variance. As Table 5 depicts, living in an urban area, better subjective mental health, more face-to-face contact, and a higher number of close

friends/relatives were associated with higher levels of emotional/informational support. Collinearity diagnostic tests indicated no problems with multicollinearity in this model (Durbin-Watson = 2.22, tolerance >.2, variance inflation factor <10; Field, 2013).

Tangible Support

The results of the regression analysis for tangible support indicated that two variables explained 16% of the variance. As Table 5 reflects, more face-to-face contact and a higher number of close friends/relatives were associated with higher levels of tangible support. Collinearity diagnostic tests indicated no problems with multicollinearity in this model (Durbin-Watson = 2.12, tolerance >.2, variance inflation factor <10; Field, 2013).

Affectionate Support

For affectionate support, the regression analysis revealed three variables to explain 27% of the variance. As Table 5 signals, being older, married/partnered, and having more face-to-face contact were associated with higher levels of affectionate support. Collinearity diagnostic tests indicated no problems with multicollinearity in this model (Durbin-Watson = 1.98, tolerance >.2, variance inflation factor <10; Field, 2013).

Positive Social Interaction

The results of the regression analysis for positive social interaction indicated that two variables explained 17% of the variance. As Table 5 indicates, being older and having better subjective physical health were associated with higher levels of positive social interaction. Collinearity diagnostic tests indicated no problems with multicollinearity in this model (Durbin-Watson = 2.07, tolerance >.2, variance inflation factor <10; Field, 2013).

Overall Social Support

For overall social support, the regression analysis revealed three variables to explain 25% of the variance. As Table 5 reports, being older, having more face-to-face contact, and having a higher number of close friends/relatives were associated with higher levels of overall social support. Collinearity diagnostic tests indicated no problems with multicollinearity in this model (Durbin-Watson = 2.09, tolerance >.2, variance inflation factor <10; Field, 2013).

Discussion

Irrespective of whether considered pre- or during COVID-19, the majority of participants experienced relatively high levels of all types of social support. Nonetheless, as could be expected with the social limitations associated with the protective measures announced during the pandemic, the self-reported levels of all types of social support among older adults decreased statistically significantly during the pandemic. In particular, affectionate support (thus, limited experience of affection and love), positive social interaction (e.g., having fun with others), and overall social support were particularly negatively affected. Based on self-reported physical and mental health, most participants indicated 'good' or 'very good', even though more than half had *direct exposure* to COVID-19, and just over a quarter had *indirect exposure* to the virus. It can thus be concluded that older adults experienced acute adversity during the pandemic (Van Breda, 2018). Holistically seen, the results indicated that participants enjoyed face-to-face contact or online/virtual contact more than five days a week, and participated in groups/organizations for 2.5 days per week, as such, the relatively high levels of social support make sense. It would seem that participants, specifically community-dwelling older adults, had access to PPFPs during the pandemic despite the hard lockdown regulations. Furthermore, it underscores the tendency of South Africans, largely a collectivist society, to ‘flock together’ to support one another during times of distress (Ebersöhn, 2019). Smith et al. (2020) found in their study among older adults in

the US that both the quantity and quality of social interactions positively influenced physical health and well-being. All types of social support decreased statistically significantly when comparing pre-and during COVID-19 data. As such, the findings corresponded with a study in Canada reporting that limited social interactions brought about by COVID-19 protective measures negatively impacted all types of social support (Menec et al., 2020).

The bivariate analyses between sociodemographics, risk, protective factors, and the types of social support confirmed the findings from studies in the global North. It should, however, be noted that from the extant literature, it was found that very few studies explored the social support of older populations during COVID-19 using the MOS Social Support Survey. Hence, direct comparisons are difficult. Age was found to have a statistically significant positive relationship with all types of social support. It is comprehendible that chronologically older adults would require, and hopefully, experience increased social support. A golden thread in the present study's findings is that being single resulted in lower levels of self-reported tangible support, affectionate support, positive social interaction, and overall social support. This stands in contrast to peers who are married, remarried, partnered, or divorced. Similarly, Holt-Lunstad (2017) identified that being single (i.e. living alone, being socially isolated) is a risk factor for lower levels of social support. Participants who resided in urban areas reported higher levels of emotional/informational support. In the South African context, one explanation could be that urban areas afforded better access to stable electrical supply (thus, to listen to the radio and watch TV), and the Internet (to access online news) and resultantly in increasing one's experience of being emotionally and informationally supported. It is, however, interesting that older adults living in rural areas did not experience, amongst others, more tangible and positive social interaction. Rural areas are usually characterized by greater social support and

connectedness among residents (Monmat & Rigg, 2018). A positive correlation was identified between self-reported physical health and affectionate support and positive social interaction. Furthermore, a positive correlation was found between self-reported mental health and three types of social support, namely emotional/information support, affectionate support, and overall social support.

Burnette et al. (2017) found that older adults in the US who experienced less social support reported poorer physical and mental health. Face-to-face and virtual contact showed a positive correlation with all four types of social support. In their study among older adults in the United Kingdom, Vlachantoni et al. (2022) also found evidence that regular contact with others acted as a protective factor against social isolation and decreased social support. Older adults who were involved in groups and organizations only showed a positive correlation with affectionate support. Likewise, Menec et al. (2020) found that socially isolated older adults (i.e. not belonging to groups and organizations) experienced less affectionate support. It could therefore be concluded that all face-to-face contact, virtual contact, and interaction with groups/organizations functioned as PPFPs that enabled the participants to navigate toward better-than-expected outcomes during the pandemic (Ungar & Theron, 2020).

Emotional/information support, tangible support, and overall social support were found to have a positive correlation with the number of close friends/relatives reported by the participants. In contrast, Menec et al. (2020) found that the size of older adults' social networks was not associated with tangible support. Holt-Lunstad (2017) opined that having few friends and strained relationships should be identified as risk factors for decreased social support among older adults. Among older adults of the LGBTIQA+ community, an increased social network

(e.g., more friends) was found to be a protective factor for improved health and fewer symptoms of depression (Fredriksen-Goldsen et al., 2013).

Regression analyses shed light on interesting combinations of variables that featured as PPFPs towards higher levels of self-reported social support during the pandemic. Four variables (i.e. living in an urban area, good self-reported mental health, more face-to-face contact, and more close friends/relatives) were associated with higher levels of emotional/informational support. Higher levels of tangible support were associated with more face-to-face contact and more friends/relatives. Chronologically older participants, married/partnered, and who reported more face-to-face contact were found to have higher levels of affectionate support. Two variables (i.e. being older and having better self-reported physical health) are associated with higher levels of social interaction. Lastly, higher levels of overall social support are associated with being older, enjoying more face-to-face contact, and having more close friends/relatives. From the analyses, it would appear that increased face-to-face contact and reports of having more close friends/relatives are two distinct protective factors against decreased levels of social support.

Better physical and mental health also facilitated emotional/information support and positive social interaction. Furthermore, increased levels of affectionate support, positive social interaction, and overall social support were found to be associated with older chronological age. Considered from a socio-ecological perspective on resilience, it would appear that PPFPs on the micro and mezzo systemic levels enabled older adults to navigate toward better-than-expected outcomes during the pandemic (Ungar, 2011; Van Breda, 2019). To the best of our knowledge, no previous studies explored the interactions of these specific variables with the different types of social support as measured by the MOS Social Support Survey. As such, these findings offer

novel insights into PPFPs that featured as buffers against limited social support within a global South context, specifically South Africa, during the COVID-19 pandemic. In sum, when rendering gerontological social services, older adults should be helped to capitalize on their partners, friends, close relatives, and face-to-face contact (if permissible) as protective factors to enable them to navigate towards better-than-expected social support amidst crises and pandemics (see Table 6).

---- Insert Table 6 here ----

Study findings should be considered in the context of some limitations. First, the sample is limited to participants associated with one welfare organization albeit spread over five provinces, thus results cannot be generalized. This sample was limited to older adults with access to ICTs who are Afrikaans or English-speaking. Future research would be needed to understand how social support was impacted by COVID-19 for South Africans living in poverty without access to ICTs and for other major language groups (e.g. isiZulu, isiXhosa, and Sesotho). Relatedly, our sample was relatively small and thus did not capture the wide-ranging experience of a representative sample of South African older adults. Nonetheless, this is the first study of its ilk in South Africa to explore the experience of social support among older adults during COVID-19. Second, the explained variances in the regressions were small in some analyses pointing to the need to include more variables in future research. These findings provided a first step in the ongoing investigation of how social support is utilized amongst older people to promote their social well-being.

Implications for gerontological social services

Melchiorre et al. (2013) aptly opined that high levels of social support could be considered a protective factor to lower the vulnerability of older adults and decrease their risk for

elder abuse. Therefore, gerontological social service providers, policymakers, and researchers should develop classes for older people, establish opportunities that facilitate friendships via social functions, and draft policies/protocols to enable older adults to navigate toward better-than-expected outcomes during acute or prolonged public health and/or natural disaster crises and pandemics (Ungar et al., 2013). A multi-faceted approach that considers micro, mezzo, and macro changes is necessary to create a system that focuses on the whole person. Table 7 provides a summary of key findings and implications.

-----Insert Table 7 here -----

Many countries in the global South, such as South Africa, are classified as developing countries; hence, the unique characteristics of older populations and human and other resource constraints need to be taken into consideration when proposing context-appropriate gerontological social services. Considered from a developmental approach, as the adopted welfare approach in South Africa (and many other developing countries), social services should be embedded in principles of accessibility, right to self-determination, equality, non-discrimination, and the promotion of human rights (Patel, 2015). Whenever social contact is allowed, technology classes could be offered to teach older adults to use, for example, WhatsApp, Facebook, and Twitter to stay connected during times of physical distancing (Conroy et al., 2020). Older adults should also gain the skills to access online spiritual/religious services, join online social clubs, play (online) games to stimulate their brains, stream music for stress/anxiety reduction, or watch uplifting videos/movies through streaming services (Conroy et al., 2020; Garfin, 2020; Kenkmann & Burkard, 2022; Sepúlvedaa-Loyola et al., 2020).

At the micro level, additional training and education are needed across professional sectors to provide the best possible services for older people that are free from bias and support

self-determination. Through dedicated curriculum at colleges/universities, including continuing professional development (CPD), social service professionals (e.g., clergy, counselors, nurses, occupational therapists, social workers, psychologists) could be equipped to improve the social support of older adults while specifically targeting the different systemic levels with which they interact. Gerontological social service providers may not have the knowledge and skills to use ICTs to render services during pandemics, such as COVID-19. Therefore, on a macro level curricula and CPD training should equip professionals to comprehend the ethics, practicalities, and appropriate policies/protocols in using ICTs to promote the social support of older adults (Gorenko et al., 2021). Equally important is the maintenance of contact with older adults during crises and pandemics. For example, during physical distancing older adults could have doorway visits, while support services such as Meals on Wheels could be delivered to their doorsteps (Conroy et al., 2020). In so doing, their need for emotional/informational and tangible support is potentially addressed.

In the collectivist societies of the global South, older adults often prefer face-to-face contact, they experience poor access to the internet, and financial constraints hinder them from owning and using smartphones and computers (Jarvis et al., 2020). Hence, the utilization of ICTs and different virtual platforms is not always appropriate in the promotion of older adults' social support during crises and pandemics. Therefore, at the exo level, changes in agency policies and practices are needed to address potential technological barriers. That is, the use of telephones and printed material may be essential for the support of older adults (Conroy et al., 2020; Gorenko et al., 2021). Telephonic services could include periodic assessments of their physical and social well-being as well as formal services such as mindfulness-based interventions to reduce stress and cognitive behavioral therapy (Conroy et al., 2020; Garfin, 2020). Family and friends should,

or volunteers could also be mobilized, to routinely have telephonic conversations with older adults to increase their opportunities for socializing, especially for those who are single. Similarly, creating community support that facilitates these connections is a key mezzo-level intervention to improve social support for older adults. To bridge the digital divide, awareness campaigns could motivate citizens to donate unused smartphones and computers to agencies serving older adults who could distribute devices to deserving older adults (Conroy et al., 2020; Gorenko et al., 2021; Smith et al., 2020). Printed material, in different official languages, should use big font sizes and terminology that is sensitive to the different levels of education among older adults. These shifts in approach could ideally attend to older adults' need for emotional/information and affectionate support and positive social interaction.

Relatedly, low-technology alternatives could be used by securing donations from the community and then distributing things like books and magazines, and puzzles (Lin et al., 2022; Sepúlvedaa-Loyola et al., 2020), or recommending readily available television programming. Additional psychoeducation efforts in the community could be part of this overall effort. For example, low-technology options to promote physical well-being could be included to motivate older adults to do light physical exercises at home, such as light gardening or a leisure walk in their garden or neighborhood (Sepúlvedaa-Loyola et al., 2020). These community services have the potential to cater for many types of social support that older adults may need.

At the macro level, a policy that actively seeks to support older people is essential to meaningful change. Without guidelines and funding, agencies and gerontological service providers cannot adequately resource efforts that aim to enhance social support specifically and health and well-being more broadly. For example, government officials could begin with public service announcements that stress the deadly impact of social isolation and loneliness to raise

awareness across the age spectrum. This type of psychoeducation should be followed by realistic recommendations that older people (and others) can implement even if they experience technological barriers. In addition, local policy change could create a role for a community organizer who seeks donations from citizens, helps organize social events, and helps gerontological service providers implement classes that address social support, health, and well-being.

The services recommended here should not be considered limited to COVID-19. They could equally be valuable during any type of crisis or pandemic. Given the increase in natural disasters and pandemics, service providers must be geared to ensure that services are continuously delivered and older service users are empowered to make use of ICTs, or low-technology alternatives, to address all their needs for social support during crises and pandemics and enable them to navigate towards their desired outcomes. Thus, preparedness management is essential to plan for future pandemics and ensure that potential barriers are proactively mitigated (cf. Lim & Bowman, 2022).

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Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Ethics approval

The study received ethics approval from the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria, South Africa (Ref.: HUM003/0321). The research was undertaken with the appropriate informed consent of all participants.

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Figure 1: Visual Presentation of Materials and Methods

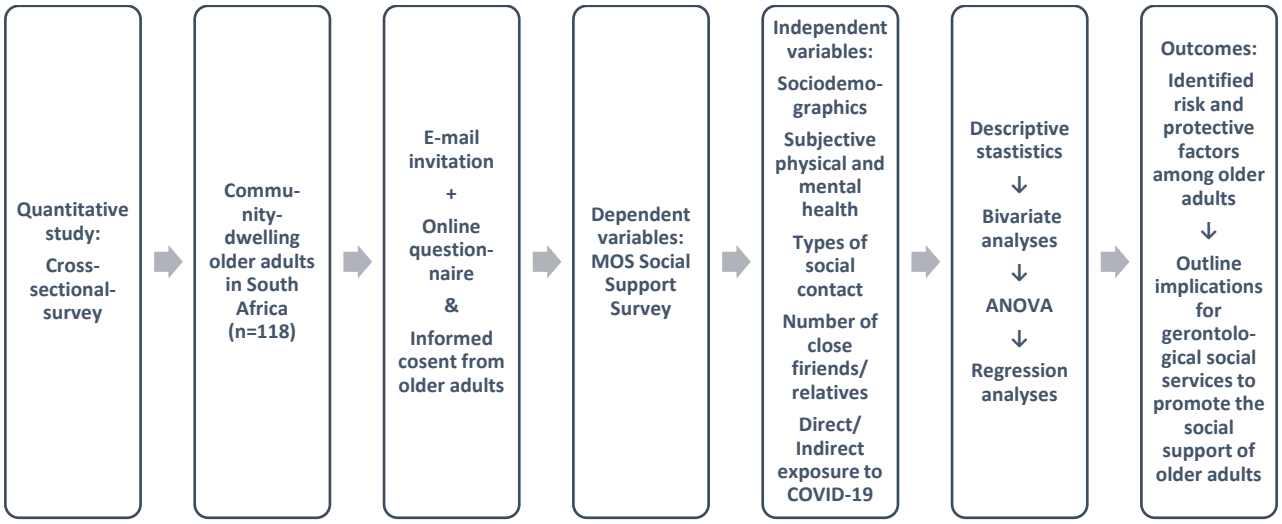

Table 1: Sample Sociodemographics ($N = 118$)

Variable (n)	M (SD)	% (f)
Age (116)	72.6 (7.1)	
Gender		
Female		72.0% (85)
Male		28.0% (33)
Home Language		
Afrikaans		92.3% (108)
English		6.8% (8)
Setswana		0.9% (1)
Area of residence		
Urban Area		43.1% (50)
Semi-urban Area		42.2% (49)
Rural Area		14.7% (17)
Province		
Gauteng		50.0% (58)
North West		36.2% (42)
Limpopo		5.2% (6)
Mpumalanga		4.3% (5)
KwaZulu-Natal		3.4% (4)
Other: Free State		0.9% (1)
Highest Qualification		
B degree/Hons. degree/Professional degree		27.1% (32)
Grade 12/Matric		21.2% (25)
National Diploma		21.2% (25)
Higher Certificate		13.6% (16)
Some High School Training		8.5% (10)
Postgraduate qualification		8.5% (10)
Employment Status		
Retired/Pensioner		79.5% (93)
Employed		12.8% (15)
Self-employed/Entrepreneur		5.1% (6)
Unemployed		2.6% (3)
Relationship Status		
Married/Partnered		45.3% (53)
Widowed		39.3% (46)
Divorced		6.8% (8)
Single		4.3% (5)
Divorced and Remarried/Partnered		2.6% (3)
Widowed and Remarried/Partnered		1.7% (2)
Living Arrangement		
Spouse/Partner		46.6% (54)
Live Alone		40.5% (47)
Adult Child in my House		3.4% (4)
Adult Child in their House		2.6% (3)
With Sister		2.6% (3)
Roommate		0.9% (1)

Immediate Family (spouse, son's family)		0.9% (1)
Sister's Child in my House		0.9% (1)
Extended Family		0.9% (1)
With Caretaker		0.9% (1)
Number of Children (110)	2.8 (1.4)	
Religious or Spiritual Beliefs		
Christian		97.5% (115)
Agnostic		0.8% (1)
Buddhist		0.8% (1)
I'm spiritual, but not religious		0.8% (1)

Table 2: Health, Exposure to and Social Contacts during COVID-19 (N = 118)

Variable (n)	M (SD)	Range	% (f)
Physical Health (117)	4.4 (.92)	1 – 6	
Mental Health (118)	4.7 (.92)	1 – 6	
Direct Exposure to COVID-19			
Yes			51.7% (61)
No			44.9% (53)
Unsure			3.4% (4)
Indirect Exposure to COVID-19			
Yes			28.4% (33)
No			62.1% (72)
Unsure			9.5% (11)
Face-to-Face Contact (111)	5.3 (1.9)	0 – 7	
Online/Virtual (116)	5.9 (1.5)	0 – 7	
Groups/Organizations (116)	2.5 (1.9)	0 – 7	
Close Friends/Relatives (114)	7.1 (7.3)	0 – 50	

Table 3: Social Support Pre- and During COVID-19 ($N = 118$)

Variable	Pre-COVID-19	During COVID-19				
	M (*SD*)	*M* (*SD*)	Range	*t*	*p*	*df*
Emotional/Informational Support	72.8 (24.9)	69.4 (26.6)	0 – 100	2.6	**.01**	116
Tangible Support	74.7 (25.7)	71.5 (28.9)	0 – 100	2.1	**.04**	115
Affectionate Support	78.6 (24.1)	73.2 (27.9)	0 – 100	3.6	**<.001**	115
Positive Social Interaction	74.9 (25.9)	67.8 (29.3)	0 – 100	3.6	**<.001**	115
Overall Social Support	74.2 (23.8)	69.8 (25.6)	0 – 100	3.5	**.001**	116

Table 4: Bivariate Analyses: Risk and Protective Factors and Social Support during COVID-19 ($N = 118$)

	Emotional/Informational Support				**Tangible Support**			
	M (*SD*)	*F/t/r*	*df/n*	*p*	*M* (*SD*)	*F/t/r*	*df/n*	*p*
Variable								
Age		.18	115	**.04**		.16	114	.09
Gender		1.1	115	.27		1.4	114	.16
Female	67.7 (27.6)				69.1 (29.2)			
Male	73.8 (23.9)				77.5 (27.7)			
Relationship Status		2.1	4, 111	.09		2.8	4, 110	**.02**
Married /Partnered	70.8 (25.8)				75.2 (25.2)			
Widowed	64.9 (28.2)				64.7 (31.9)			
Divorced	83.2 (18.9)				85.9 (18.3)			
Single	51.3 (24.9)				48.8 (35.5)			
Divorced/Widowed and Remarried/Partnered	89.1 (10.9)				93.8 (12.5)			
Living Arrangement		.66	3, 111	.58		1.5	3, 110	.21
Live Alone	66.0 (28.0)				66.0 (31.4)			
With Adult Child	78.6 (25.7)				79.5 (26.7)			
Spouse/Partner	71.6 (26.3)				77.0 (25.0)			
Other	71.5 (21.6)				64.6 (37.5)			
Area of residence		2.9	2, 112	**.05**		1.5	2, 111	.24
Rural Area	56.8 (27.4)				69.4 (26.3)			
Semi-Urban Area	69.6 (29.9)				67.7 (33.6)			
Urban Area	74.4 (20.3)				77.2 (22.0)			
Highest Qualification		1.0	5, 111	.42		.89	5, 110	.49
Some High School	63.4 (40.6)				62.3 (32.8)			
Grade 12/Matric	65.9 (28.1)				72.8 (27.9)			
Higher Certificate	80.0 (16.7)				82.6 (26.3)			
National Diploma	64.8 (26.8)				65.4 (32.2)			
B Degree/Hons Degree Professional Degree	70.0 (23.9)				72.8 (25.1)			
Postgraduate Qual.	77.5 (26.0)				71.9 (34.3)			
Employment Status		.43	2, 110	.65		.18	2, 109	.84
Employed	72.9 (20.3)				75.5 (25.6)			
Retired/Pensioner	68.6 (27.9)				71.4 (29.8)			
Self-Employed/ Entrepreneur	60.9 (26.5)				67.7 (29.7)			
Number of Children		-.03	109	.73		-.04	108	.72
Physical Health		.15	116	.12		.04	115	.70
Mental Health		.25	117	**<.01**		.12	116	.19
Face-to-Face Contact		.28	110	**<.01**		.26	103	**<.01**
Online/Virtual Contact		.25	115	**<.01**		.19	114	**.04**
Group/Organization Contact		.14	115	.14		.04	114	.64
Close Friend/Relatives		.29	113	**<.01**		.24	112	**.01**

	Affectionate Support				Positive Social Interaction			
	M (*SD*)	*F/t/r*	*df/n*	*p*	*M* (*SD*)	*F/t/r*	*df/n*	*p*
Variable								
Age		.21	114	**.02**		.19	114	**<.05**
Gender		1.5	74	.14		1.9	74	.06
Female	71.0 (29.4)				64.9 (30.8)			
Male	78.8 (23.2)				75.0 (24.3)			
Relationship Status		3.0	4, 110	**.02**		2.9	4, 110	**.02**
Married /Partnered	77.7 (23.9)				71.1 (27.3)			
Widowed	67.8 (29.7)				60.4 (30.5)			
Divorced	79.2 (28.9)				86.5 (19.9)			
Single	43.3 (35.1)				47.5 (35.8)			
Divorced/Widowed and Remarried/Partnered	93.8 (12.5)				87.5 (14.4)			
Living Arrangement		1.7	3, 110	.17		.79	3, 110	.50
Live Alone	67.3 (30.6)				63.7 (30.3)			
With Adult Child	80.9 (26.2)				73.8 (30.2)			
Spouse/Partner	78.8 (24.3)				64.3 (31.8)			
Other	77.4 (20.2)				68.2 (29.2)			
Area of residence		2.2	2, 111	.11		2.3	2, 111	.11
Rural Area	61.3 (31.5)				56.4 (30.7)			
Semi-Urban Area	74.2 (30.2)				66.9 (32.7)			
Urban Area	77.2 (21.7)				73.3 (23.1)			
Highest Qualification		2.2	5, 110	.06		1.6	5, 110	.17
Some High School	60.0 (34.9)				57.5 (41.1)			
Grade 12/Matric	69.8 (32.5)				62.0 (31.8)			
Higher Certificate	90.5 (16.9)				83.3 (16.7)			
National Diploma	70.0 (30.5)				66.8 (30.6)			
B Degree/Hons Degree Professional Degree	71.4 (22.7)				65.9 (26.2)			
Postgraduate Qual.	85.0 (18.3)				79.2 (23.9)			
Employment Status		1.0	2, 109	.36		1.1	2, 109	.34
Employed	77.8 (20.6)				76.1 (20.1)			
Retired/Pensioner	72.9 (29.3)				66.3 (30.6)			
Self-Employed/ Entrepreneur	58.3 (25.3)				56.9 (30.9)			
Number of Children		-.06	109	.56		-.15	109	.12
Physical Health		.19	115	**.04**		.26	115	**<.01**
Mental Health		.23	116	**.01**		.16	116	.09
Face-to-Face Contact		.28	109	**<.01**		.17	109	.07
Online/Virtual Contact		.22	114	**.02**		.17	114	.08
Group/Organization Contact		.21	114	**.03**		.11	114	.27
Close Friend/Relatives		.18	112	.06		.07	112	.49

Variable	Overall Social Support Scale			
	M (*SD*)	*Ft//r*	*df/n*	*p*
Age		.18	115	**.05**
Gender		1.5	115	.14
Female	67.6 (26.5)			
Male	75.4 (22.9)			
Relationship Status		3.1	4	**.02**
Married /Partnered	72.6 (23.7)			
Widowed	63.9 (26.8)			
Divorced	83.7 (20.2)			
Single	48.8 (29.0)			
Divorced/Widowed and Remarried/Partnered	90.6 (11.1)			
Living Arrangement		1.1	3	.34
Live Alone	65.5 (26.7)			
With Adult Child	78.6 (25.4)			
Spouse/Partner	73.7 (24.2)			
Other	67.6 (26.9)			
Area of residence		2.4	2, 112	.09
Rural Area	59.9 (26.7)			
Semi-Urban Area	68.9 (28.8)			
Urban Area	75.1 (19.5)			
Highest Qualification		1.2	5, 111	.33
Some High School	61.1 (34.8)			
Grade 12/Matric	67.4 (27.4)			
Higher Certificate	80.8 (20.1)			
National Diploma	65.8 (27.1)			
B Degree/Hons Degree Professional Degree	69.7 (22.1)			
Postgraduate Qual.	78.2 (23.8)			
Employment Status		.60	2, 110	.55
Employed	74.6 (19.9)			
Retired/Pensioner	69.0 (26.9)			
Self-Employed/ Entrepreneur	61.4 (24.9)			
Number of Children		-.06	109	.52
Physical Health		.17	116	.07
Mental Health		.22	117	**.02**
Face-to-Face Contact		.29	110	**<.01**
Online/Virtual Contact		.25	115	**<.01**
Group/Organization Contact		.14	115	.14
Close Friend/Relatives		.24	113	**.01**

Table 5: Risk and Protective Factors Social Support (N = 118)

Variable		*B*	*SE B*	*ß*	*t*	*p*
Emotional/Informational						
Age		.01	.01	.05	0.44	.663
Urban		.74	.25	.36	2.99	**.004**
Mental Health		.35	.12	.33	2.90	**.005**
Face-to-Face		.16	.07	.29	2.39	**.021**
Online/Virtual		-.12	.09	-.17	-1.28	.205
Close Friends/Rel		.03	.01	.28	2.60	**.012**
Adjusted R^2	.39					
F	7.40**					
Tangible						
Married/Partnered		.36	.21	.16	1.72	.089
Face-to-Face		.14	.06	.24	2.25	**.026**
Online/Virtual		.01	.08	.02	0.15	.880
Close Friends/Rel		.34	.02	.21	2.22	**.029**
Adjusted R^2	.13					
F	4.84*					
Affectionate						
Age		1.1	.36	.29	3.12	**.002**
Married/Partnered		11.98	5.02	.22	2.39	**.019**
Physical Health		3.63	2.94	.13	1.24	.220
Mental Health		4.26	3.05	.14	1.38	.166
Face-to-Face		3.88	1.48	.27	2.63	**.010**
Online/Virtual		-.61	2.09	-.03	-.29	.773
Group/Org		.85	1.31	.06	.65	.52
Close Friends/Rel		.46	.36	.12	1.27	.207
Adjusted R^2	.21					
F	4.41**					
Positive Social Interaction						
Age		1.31	.38	.32	3.45	**.001**
Married/Partnered		9.48	5.23	.16	1.81	.073
Physical Health		10.45	2.85	.34	3.68	**<.001**
Adjusted R^2	.15					
F	7.79**					
Overall Social Support						
Age		.79	.31	.23	2.53	**.013**
Married/Partnered		8.45	4.56	.17	1.85	.067
Mental Health		4.13	2.66	.15	1.56	.123
Face-to-Face		3.50	1.32	.27	2.65	**.009**
Online/ Virtual		.55	1.84	.03	.29	.77
Close Friends/Rel		.66	.32	.19	2.08	**.040**
Adjusted R^2	.21					
F	5.48**					

Note: B = unstandardized beta; SE B = standard error for the unstandardized beta.
**p < .001; *p = .001

Table 6: Protective factors per type of Social Support

Type of Social Support	Protective Factors
Emotional/Information Support	* Living in an urban area * Better subjective mental health * More face-to-face contact * Higher number of close friends/relatives
Tangible Support	* More fact-to-fact contact * Higher number of close friends/relatives
Affectionate Support	* Being older * Married/partnered * More face-to-face contact
Positive Social Interaction	* Being older * Better subjective physical health
Overall Social Support	* Being older * More face-to-face contact * Higher number of close friends/relatives

Table 7: Key Findings and Implications

Finding	Implication
1. Overall social support for older people decreased during COVID-19 with the least amount of support coming from positive social interactions and emotional/informational support.	Older people should be provided with information and opportunities for social interaction and ways in which to engage in accessing information during times of crisis and isolation that is relevant to people in South Africa, such as the use of telephone or printed material, or psychoeducation through television and radio.
2. Social support during COVID-19 varied based on the sociodemographics of older people, with higher age, being married/partnered, higher mental health, more face-to-face contact, more online/virtual contact, and more close friends and relatives associated with more social support.	Older people are heterogenous and a comprehensive assessment of sociodemographics could assist in identifying potential risk and protective factors for social support.
3. More face-to-face contact and more close friends and relatives were significant contributors to emotional/informational support, tangible support, affectionate support, and overall social support.	Classes and opportunities to learn how to engage in virtual/online interactions through the use of donated smartphones could assist in linking older people with their support systems during times of crises. Psychoeducation for older people through television programs and news messages can assist in providing tips and ways in which to remain active and engaged when faced with social isolation. Psychoeducation of the community could assist in alternative and creative ways in which to engage, such as securing donations and distributing resources, such as books, magazines, and puzzles. Classes and free training for older people to engage in virtual/online venues can enhance their ability to access online social support.