PERCEIVED QUALITY OF LIFE AND SOCIAL SUPPORT RECEIVED BY THE ELDERLY IN IBADAN NORTH LOCAL GOVERNMENT AREA, OYO STATE, NIGERIA

BY

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DEDICATION

This work is dedicated to God almighty, the author and the finisher of my faith; my parents Prince and Mrs Awobiyi and my late cousin, Owoeye, Samuel Olatayo, rest on my dear.

CERTIFICATION

I certify that this work was carried out by AWOBIYI, Damilola Olawumi in the department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan under my supervision

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ABSTRACT

The elderly (people aged 65years and above) constitute over 3% of the Nigerian population. The increasing number and vulnerability to numerous geriatric health and social problems associated with this age group make their well-being and Quality Of Life (QOL) an important issue. However, few studies exist on social support and the different aspects of QOL among the elderly in Nigeria. This study was therefore designed to explore the perceived QOL and social support received by the elderly in Ibadan North Local Government Area, Oyo State, Nigeria.

A descriptive cross-sectional design was adopted. Twenty communities were randomly selected and 613 respondents were selected using the purposive sampling technique. Data were collected using an interviewer administered semi-structured questionnaire. The questionnaire included a 68-point perceived QOL. Questions on physical and psychological health, level of independence and social relationship/environment were included. Scores of 0-34, 35-50 and 51-68 were rated poor, moderate and good QOL respectively. Questions relating to the role of children, family and community were also asked on social support. Six Focus Group Discussion (FGD) sessions were conducted. Data were analysed using descriptive statistics and Chi-square and independent t-test at 0.05 level of significance, while thematic approach was used to analyse FGD data.

Respondents' mean age was 70.7±5.6years, 53.3% were females and 83.5% were Yoruba. About half (55.8%) of the respondents belonged to nuclear families. Almost all (98.9%) had children and of these, 81.8% had children who visit them regularly. Few (6.2%) of the respondents lived alone while 81.6% lived with their families. Those from nuclear families (55.8%) significantly received more social support than those from extended families (44.2%). Few respondents (5.7%) had poor QOL, 47.5% had moderate QOL and 46.8% had good QOL. Concerning physical health domain, 54.3% felt physical pains, 55.6% did not perform exercises regularly and 43.2% had problems with sleeping well. As regards psychological health, 65.6% felt their life was meaningful and 48.9% reported that they sometimes had negative feelings like anxiety and depression. On level of independence, 44.7% reported that age had reduced their ability to perform daily living activities and 42.7% depended a little on medicinal aids to live a normal life. Concerning the social

relationship/environment domain, 63.9% reported that they enjoyed life very much and 50.1% got the emotional support they needed from their families. There was significant difference in QOL between those who lived with people (93.8%) compared with those who lived alone while there was significant difference in QOL between those who had children and those who had none. Majority of the FGD discussants expressed their view on the positive impact of social support which added more quality to lives and also made life worth living.

Social support enhanced the quality of life of the elderly. Health education strategies such as advocacy and awareness programmes on the relevance of social support especially family support should be developed to enhance the quality of life of the elderly.

Keywords: Elderly, Quality of life, Social support.
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DEFINITION OF TERMS

Social Support: Social support is the perception and actuality that one is cared for, has assistance (emotional, informational, tangible and companionship) available from other people, and that one is part of a supportive social network.

Quality of Life: Quality of life is defined as an individual's perception of their position in life. It is a highly subjective measure of happiness that involves the physical health, psychological health, level of independence, social relationships and relationships with the environment.

The Elderly: These are a group of people that have lived past the middle age (40yrs and above) and approaching old age (65yrs and above).

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Aging is commonly understood as the process of maturing or becoming older; it is a broad term which includes several processes: those changes happening along life, individual differences attributed to age and the group of aged or older people (Fernández-Ballesteros and Ivars, 2008). Ageing has become a global phenomenon and indeed a critical policy issue receiving some recognition by governments of developing countries like Nigeria where it is reflected in the government's vital document of economic and social development strategy (Ajomale 2007). In almost all of the regions of the world, the older population is growing faster than the total population (United Nations, 2009).Globally, the greatest increase in the number of older people is occurring in the developing and middle income countries, which are now experiencing rapid shifts from high mortality and high fertility to much reduced fertility and greater longevity. Nigeria is not an exception (Ajomale, 2007). The older population in developing countries has a higher speed of growth than in developed countries. Compared with other regions of the world, the population of Africa is growing older faster, at a rate of 2.27% (United Nations, 2011). While population ageing in developed countries evolved gradually as a result of an earlier decline in fertility and improving living standards for the majority of the population over a relatively long period of time after the industrial revolution, population ageing in developing nations is occurring more rapidly because of rapid fertility decline and an increasing life expectancy (Ajomale, 2007).

In old age there are great differences between individuals in respect to health, physical capabilities, cognitive functioning, and social integration (Clemens, 2012). Old age often brings about health problems and decreasing functional capacity which may affect the sense of wellbeing of an individual (Gureje, Kola, Afolabi and Olley, 2008). In this regard, the goal of health for the elderly in the society may not be that of freedom from diseases but the possibility of having a good life despite illness and decreasing capacities (Lawton, 1991; Nordenfelt, 1991b; Sarvimaki and Stenbock-Hult, 2000). Well-being is a positive physical, social and mental state; it is not just the absence of pain, discomfort, and incapacity. It arises

from not only the action of an individual, but from a host of collective goods and relationships with other people. It requires that basic needs are met, that individuals have a sense of purpose, and that they feel able to achieve important personal goals and participate in societal activities (Steur and Marks, 2004). Feelings about life are subjective and what is considered as important for wellbeing by one person may not be so regarded by another. A chronic health condition occurring in the setting of a developed country may have a lower impact on the quality of life of the patient than the same disease would have in a low income country where resources to ameliorate disability may be scarce. The subjective nature of quality of life and the contextual nature of its assessment inform the World Health Organization's definition of it as: "an individual's perception of his/her position in life in the context of the culture and value systems in which he/she lives, and in relation to his/her goals, expectations, standards and concerns" (The WHOQOL Group, 1995). It seems that all human activities are geared toward making life more meaningful and the desire for happiness has been viewed as a basic and universal human drive (Ho, Cheung, and Cheung, 2008). Thus quality of life reflects a broad view of subjective wellbeing and life satisfaction that encompasses mental and physical health, material wellbeing, interpersonal relationship within and without the family, work and activities within the communities, personal development and fulfillment and active recreation (Niemi, Laaksonen, Kotila and Waltimo, 1988). Life satisfaction connotes the outcome of self assessment, depending on one's expectation. It is determined by one's perception of how things are and how they should be. The smaller the gap, the more satisfied the person becomes (Onyishi, Okongwu and Ugwu, 2012).

Aging in Nigeria is occurring against the background of socio-economic hardship, wide spread poverty, the HIV/AIDS pandemic, and the rapid transformation of the traditional extended family structure (Adebowale, Atte and Ayeni, 2012). Nigeria, like other African countries, sees this emerging issue as a serious future challenge. The family in Nigeria used to consist of members of the extended lineage: parents, grandparents, aunts, uncles, brothers, sisters, cousins, nephews, nieces, etc. – a large family indeed. Before "modernization" came to "destroy" the concept of the extended family system and replace it with the nuclear family, the extended family as a social structural phenomenon served more or less as a form of social insurance (traditional safety net) for old age. Social support is one of most important factors

in predicting the physical health and well-being of everyone, ranging from childhood through older adults. The absence of social support shows some disadvantage among the impacted individuals. In most cases, it can predict the deterioration of physical and mental health among the victims. The initial social support given is also a determining factor in successfully overcoming life stress (Clark, 2005). There is an observable progressive shift in function away from the traditional family. Traditional functions of the family like care and social support to older family members have gradually decreased in the recent past due to economic problems, migration and influence by foreign culture (Ajomale, 2007).

In most developing countries, formal social security systems have only limited coverage and inadequate benefit payments (Bailey; Collin, Turner, Bailey and Latulippe, 2000). With so much attention given to battling diseases in youth and middle age, many developing countries are simply unprepared for the fact that in just two decades, they will have a large number of people whose health needs will not be adequately met (World Report, 2012). As a result, the majority of older people depend on family support networks, a reality that is well appreciated in most parts of sub-Saharan Africa in the past (Van de Walle, 2006; Kaseke, 2004; WHO, 2002). World Health Organization in view of this devoted the year 2012 World Health Day (April 7) to ageing, especially in low resource countries, with an emphasis on improving the quality of life, as well as health, of older people. Nigeria government devotes few resources to health care and primary health care concentrates more on maternal and child health and contagious diseases. The problems of an aging population have not been seen as important in Nigeria because the aged are such a small part of the population (Adebowale, Atte and Ayeni, 2012).

1.2 Statement of the Problem

Elderly population is increasing in all countries of the world. This is due to several factors which include decline in fertility, improvement in public health and increase in life expectancy. Decline in fertility was brought about by more wide spread acceptability of family planning while increase in life expectancy is attributed to improved medical care brought about by technological advancement. As the elderly constitute an increasing proportion of Nigeria's population, it is pertinent to examine their needs and concerns, which have direct impacts on their well being and quality of life (Asiyanbola, 2005).

Other than health problems and functional impairments to which most elderly persons are vulnerable (Clark and Siebens, 1993), old age in Nigeria may predispose one to some social and economic problems. Poverty is rife in the country and elderly persons may be more at risk since they are no longer in the economically active phase of life and there is no national social security to provide economic buffer in old age. Access to health care is severely limited both by paucity of health facilities and manpower and by out-of-pocket payment arrangement. Social network is dwindling and traditional family support is decreasing as urbanization and migration take young members of the family away. Also, social changes are affecting the position of the elderly in the society and leading to a reduction in their social status and influence in the community (Gureje and Oyewole, 2006). All of these factors may affect the quality of life of elderly persons. Given that quality of life is a multi-factorial experience (Hickey, Barker, McGee and O'Boyle, 2005) with sometimes paradoxical import (Albrecht and Devlieger, 1999), it remains to be determined how the receipt of social support relates to different aspects of the quality of life of elderly Nigerians.

Also, little is known about factors that determine the quality of life of elderly persons living in developing societies undergoing rapid social changes (Gureje *et al*, 2008).

1.3 Research Questions

1. What is the knowledge of the elderly in Ibadan North LGA about social support?
2. What are the types and sources of social support received by the elderly?
3. What is the perception of the elderly on the quality of life?
4. What domain/type of quality of life is predominant among the elderly?
5. What is the relationship between social support received and quality of life of the elderly?

1.4 Broad objective

The broad objective of this study was to explore the patterns of social support received and the perceived quality of life among the elderly living in Ibadan North Local Government Area (LGA) of Oyo State.

1.4.1 Specific objectives

The specific objectives of this study were to:

- assess the knowledge of the elderly in Ibadan North LGA about social support.
- document the types and sources of social support received by the elderly.
- explore the perception of the elderly on their quality of life.
- describe the predominant domain/type of quality of life among the elderly.
- describe the relationship between social support received and quality of life.

1.5 Justification of the Study

The quality of life of elderly persons is affected by several factors relating to demography, health, and social network and support (Everard, 2000; Newsom and Schulz, 1996). In a developing country undergoing rapid social changes and where elderly persons may have modest expectations of their health, social factors reflecting engagement may be more important to the wellbeing of elderly persons. In view of the importance of perceived wellbeing to the overall health status of elderly persons, policies aimed at improving the health of elderly persons should be provided and should include the promotion of and opportunity for their social engagement (Gureje, Kola and Afolabi, 2008).

The information generated from this study would be useful in designing evidence based health promotion and education programmes that can address problems relating to social support and quality of life in the elderly. Finally, the information will be useful in explaining the experiences of the elderly towards the receipt of social support and its effect on their quality of life and also suggest areas of research for further studies.

1.6 Scope of study

The study was limited to people of the age 65years and above (WHO definition of the elderly) living in Ibadan North Local Government Area of Oyo State, the social support they receive and their perception on how it affects their quality of life.

1.7 Hypotheses

Four research hypotheses were tested in the study. These are:

$H_0$1 There is no significant association between the age of the elderly and their quality of life.

$H_0$2 There is no significant association between the gender of the elderly and their perceived quality of life.

$H_0$3 There is no significant association between type of family/family structure of the elderly and the type of social support received.

$H_0$4 There is no significant association between social support (having children and staying alone) and perceived quality of life of the elderly.

1.8 Limitations of the Study

The study covered only the elderly people in Ibadan North Local Government Area (LGA). The area is one out of the eleven LGAs in Ibadan and hence the results cannot be generalized. Another major limitation was the difficulty encountered in bringing the elderly people together for the focus group discussions as most of them preferred to be interviewed in their houses or any other place convenient for them. Also, there was sole reliance on reported responses by respondents which may not be verified. The information cannot be reliable because people underreport what they experience and therefore there is no way to corroborate the information.

CHAPTER TWO

LITERATURE REVIEW

2.1 Review of Concepts

2.1.1 The Elderly/Aged

Old age is the closing period in the life span. It is a period when people “move away” from previous, more desirable periods or times of “usefulness”. As people move away from the earlier periods of their lives, they often look back on them, usually regretfully, and tend to live in the present, ignoring the future as much as possible. Age sixty is usually considered the dividing line between middle and old age. However, it is recognized that chronological age is a poor criterion to use in marking off the beginning of old age because there are such marked differences among individuals in the age at which aging actually begins. Because of better living conditions and better health care, most men and women today do not show the mental and physical signs of aging until the mid-sixties or even the early seventies (Elizabeth 2004). According to the World Health Organization (WHO), an elder is a person who is aged 65years and above.

Elderliness is a qualitatively different experience for each subject. It is preponderantly good for some, 'an autumn with deep but bright tonalities' and a bad experience for others. Between these two extremes of good and bad quality, there is probably a continuum (Erikson, 1993). Erikson has referred to the two extreme poles, satisfaction and dissatisfaction, as respectively the pole of 'integration' and of 'despair'. Explaining these Erikson's concepts, Kimmell (1974) summed up in the following way these two possibilities of emotional positioning of the elder facing the old age: 'if the elderly subject manages to build a secure sense of the ego and a perception of his/her legacy, be it through the children or the work, he/she maintain an ego integrity, whereas the incapability to provide for a solution for this conflict results simultaneously in disappointment with his/her own self (with the subject proper) and, therefore, despair'

Whether elderliness will be an enjoyable stage of the vital cycle will depend on objective factors of this subject's life and on the subjective interpretation of this reality by the elderly person. It will depend partially on the subjective interpretation of the elderly and in part on

the objective contingencies of their histories. Therefore, the positive quality of life – as well as the negative – of elderly people depends on the subject's internal variables (his/her emotional attitude facing the facts of life) and on external variables (contingencies, environmental resources) (Xavier, Ferraz, Marc, Escosteguy, and Moriguchi, 2003).

Related to quality of life in old age are the concepts of ageing well represented by the qualifiers such as active, positive, successful or healthy used with ageing, but 'successful ageing' is the most frequently used term. The widely accepted definition of successful ageing by Rowe and Kahn contains three components: low risk of disease and disability high mental and physical function; and active engagement with life (Rowe and Kahn, 1998). The distinction between successful ageing and quality of life lies in the emphasis on physical health for defining successful ageing. However, well-being is often incorporated into the concept of successful ageing and ageing well adds to the quality of life. It might also be possible that there are definitions of health which are akin to that of quality of life, for example, health as going and doing something meaningful. (Depp and Jeste, 2006).

2.1.2 Social support

During the last 30 years, researchers (Ajomale, 2007; Garzadas, 1993; Hale, Hannum and Espelage, 2005) have shown great interest in the phenomena of social support, particularly in the context of health. Prior work has found that those with high quality or quantity of social networks have a decreased risk of mortality in comparison to those who have low quantity or quality of social relationships, even after statistically controlling for baseline health status (Berkman, Glass, Brissette, and Seeman, 2000). In fact, social isolation itself was identified as an independent major risk factor for all-cause mortality. Current research has focused on expanding several areas of knowledge in this area. These include (1) social support influences on morbidity, mortality, and quality of life in chronic disease populations, (2) understanding the mechanisms responsible for such associations, and (3) how we might apply such findings to design relevant interventions. It is important to note that social support in these studies is operationalized in several different ways. Most broadly, support can be conceptualized in terms of the structural components (e.g. social integration: being a part of different networks and participating socially) and the functional components (e.g. different types of transactions between individuals, such as emotional support or favors) (Piferi and Lawler, 2006). How the functional components are measured often varies between studies;

transactions may be summarized by actual support received (often ascertained by asking the support providers), perceived support received or available, or the discrepancy between perceived support and received support (Thong, Kaptein, Krediet, Boeschoten, and Dekker, 2007). Support is often further broken into different types– for instance instrumental support and emotional support—as often people have preferences for different types of aid depending on the circumstances. This diversity of ways in which support is defined is important and can provide greater specificity (context) to research findings.

Social support is widely regarded as a valuable resource comprising tangible and intangible forms of assistance that individuals receive from family and friends. Studies of types of social support (House and Kahn, 1985; Cutrona and Russell, 1990; Wellman and Wortley, 1990) suggested one or more of the following forms: informational support, tangible assistance, emotional support, esteem support and social integration. Informational support refers to the guidance and advice received from others which help the family caregiver to understand and manage stressful situations. Tangible assistance is the instrumental behaviours and goods which directly subsidize the primary caregiver's care giving responsibilities. The emotional support that caregivers receive refers to the behaviours of others that promote the primary caregiver's feelings of comfort, ease, and security.

Social support is a concept that is generally understood in an intuitive sense, as the help from other people in a difficult life situation. One of the first definitions was put forward by Cobb, 1976. The researcher defined social support as 'the individual belief that one is cared for and loved, esteemed and valued, and belongs to a network of communication and mutual obligations'. In the MINDFUL project social support is defined as 'the perceived availability of people whom the individual trusts and who make one feel cared for and valued as a person' (MINDFUL, 2008).

Types of Social Support

Types of social support may vary (House, 1981) described four main categories of social support: emotional, appraisal, informational and instrumental.

- Emotional support generally comes from family and close friends and is the most commonly recognized form of social support. It includes empathy, concern, caring, love, and trust.

- Appraisal support involves transmission of information in the form of affirmation, feedback and social comparison. This information is often evaluative and can come from family, friends, co-workers, or community sources.
- Informational support includes advice, suggestions, or directives that assist the person to respond to personal or situational demands.
- Instrumental support is the most concrete direct form of social support, encompassing help in the form of money, time, in-kind assistance, and other explicit interventions on the person's behalf.

There are also, six criteria of social support that researchers use to measure the level of overall social support available for the specific person or situation (Cutrona, Russell and Rose, 1986). First, they would look at the amount of attachment provided from a lover or spouse. Second, measuring the level of social integration that the individuals are involved with, it usually comes from a group of people or friends. Third, the assurance of worth from others such as positive reinforcement that could inspire and boost the self-esteem. The fourth criterion is the reliable alliance support that is provided from others, which means that the individual knows they can depend on receiving support from family members whenever it was needed. Fifth, the guidance of assurances of support given to the individual from a higher figure of person such as a teacher or parent. The last criterion is the opportunity for nurturance. It means the person would get some social enhancement by having children of their own and providing a nurturing experience.

However, in defining social support a distinction can be made between the qualities of support perceived (satisfaction) and provided social support. Most studies are based on the measurement of subjectively perceived support, whereas others aim at measuring social support in a more objective sense. One could also distinguish between the support received, and the expectations when in need, and between event specific support and general support. The definition in terms of a subjective feeling of support raises the question whether social support reflects a personality trait, rather than the actual social environment (Pierce, Lakey, Sarason, Sarason, Joseph, 1997; Sarason, Sarason and Shearin, 1986). Theorists (Dunkel-Schetter and Bennett, 1990; Thoits, 1995) have argued that perceived social support is conceptually distinct from received social support. Perceived social support generally represents moderately stable cognitive appraisals that support from others will be available

when needed or that connections to others are secure (Sarason *et al*., 1990). In contrast to perceived social support, received social support generally refers to actual administered aid or the behavior of engaging in positive interpersonal social exchanges (Dunkel-Schetter and Bennett, 1990).

Cohen, Gottlieb, and Underwood (2000) stated that social support is often used in a broad sense, referring to any process through which social relations might promote health and well-being; it refers to the social resources that persons perceive to be available or that are actually provided to them by nonprofessionals in the context of both formal support groups and informal helping relations. Definitions of social support fall into two categories. Objective social support indicates what people have actually received or report to have received. The other is a subjective perception, which captures an individual's beliefs about the available support, and which is more persistently and more powerfully related to health and well being than are objective measures (Seeman and Berkman, 1988; Faber and Wasserman, 2002). Meaningful social relationships provide a sense of security and opportunities for companionship and intimacy which are important for the well being of older people (McNicholas, 2002; Fajemilehin, 2009; Giang and Dfau, 2009). Those who provide social supports give advice about health practices, disease prevention and encourage the practice of positive health behavior. This means that social support can influence specific health behavior such as diet, exercise, compliance with medical regime, smoking, drinking of alcohol by providing information about positive health practices and by establishing norms that will encourage good health behavior.

Lack of social support is shown to increase the risk of both mental and somatic disorders, and seems to be especially important in stressful life situations. Poor social support is also associated with enhanced mortality. Social support may affect health through different pathways: health behavioural, psychological and physiological pathways. The social support and physical health are two very important factors that help the overall well-being of an individual. Older adults would be able to ignore the negative effects in their lives with help and reinforcement from others. This is considered a psychological effect. Not enough social support would likely make these individuals notice their daily hassles and life stressors much more clearly (Dalgard, 2009). Socially active individuals who have more relationships are exposed to strong normative pressure and control from friends and family members to

demonstrate healthy behaviour and seek health care whenever necessary. Additionally, a social support network contributes to individuals with multiple sources of information, increasing the probability of access to information that promotes healthy behavior and minimizes situations of risk and stress (Cacioppo and Hawkley, 2003).

In spite of these widely accepted definitions of social support, there is no consensus in the literature about the definition and consequently making concept operational. There is a need for further research, especially about what kind of support is most important for health.

2.1.3 Quality of life

Quality of life is presented as a global, uni-dimensional, and subjective assessment of one's life which has emerged as a focal concern in planning treatments for patients, yet confusion remains over the definition and measurement of this concept. Few studies address quality of life issues in the context of perceived. An improved quality of life often is cited as an outcome of interventions, but the health care literature displays considerable confusion and even contradiction in the meanings assigned to quality of life. Quality of life, health-related quality of life (HRQOL), health status, functional assessment, and even needs assessment have been used indiscriminately to describe the same dimensions and even the same instruments (Smith, Sim, Scharf, and Phillipson, 2004; Lim, Ma, Heng, Bhalla, and Chew, 2007; Netuveli and Blane, 2008). Quality of life often is considered a multidimensional construct, but some arguments supporting this view confound the dimensionality of a concept with the multiplicity of the causal sources of that concept. The many causes of quality of life do not determine the dimensionality of the concept. Until patient data lead researchers to question the existence of quality of life as a uni-dimensional entity, it is consistent to claim that quality of life is both uni-dimensional and multiply caused (Smith *et al*., 2004).

Subjective quality of life has been defined as the satisfaction of needs that are determined by the perceived discrepancy between one's aspirations and achievements (Smith et al., 2004; Hoang et al., 2008; Netuveli and Blane, 2008). Subjective well-being can also be defined as the individual's own perception of general wellbeing or life quality (George *et al*., 1991). Lawton *et al*., (1991) described two-factor view of well-being: the presence of either positive and negative events or feelings. Both aspects constitute a necessary component of psychological well-being. Health perceptions were related to both mortality and an adaptive

psychological profile including high perceptions of control and the use of active coping strategies in dealing with age-related difficulties. While hope in health is described as the process through which a person works to emerge from the life situation at hand toward the resultant state of transcendence, labeled the reformulated self, and becomes a person with re-evaluated priorities and news life perspectives. Hence, health potential of the individual, family and community is the capacity to prevent illness, promote health in balance and maintain or establish health balance. The health resources, vary with individuals be it old or young. The resources are safe water and adequate nutrition continued through to the complex features of health culture. Components of the health culture include health beliefs, the knowledge level of the individuals that may determine behaviors, life styles, and use of services as well as social network factors such as familial support and stability. Within these later features exists more complex concepts such as coping ability, self care and self esteem (Shrestha, 2000; Cutler, 2001; Fajemilehin, 2009).

WHO defines Quality of Life as individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of their environment.

Every one has an opinion about their quality of life, but no one knows precisely what it means in general. John Stewart Mill noted that individual opinion about well-being was 'the best means of knowledge immeasurably surpassing those that can be possessed by any one else' (Netuveli and Blane, 2008).Thus, quality of life is highly individualistic and might even be an 'idiosyncratic mystery' due to the high levels of variability between individuals, making it unsuitable for decision making (Leple´ge and Hunt, 1997). However, cross national audits of welfare or comparisons of different groups of individuals often include a metric of quality of life, underlying which is the assumption that there are group-specific characteristics in quality of life.

There are three major philosophical approaches to determining the quality of life (Brock, 1993). The first approach describes characteristics of the good life that are dictated by normative ideals based on a religious, philosophical, or other system. For example, we might believe that the good life must include helping others because this is dictated by our religious

principles. These approaches to quality of life depend neither on the subjective experience of people nor on the fulfillment of their wishes. This approach to quality of life is most clearly related to the social indicators tradition in the social sciences. The second approach to defining the good life is based on the satisfaction of preferences. Within the constraints of the resources they possess, the assumption is that people will select those things that will most enhance their quality of life. Thus, in this tradition the definition of the quality of life of a society is based on whether the citizens can obtain the things they desire.

People select the best quality of life for themselves that is commensurate with their resources and their individual desires. This approach to utility or the good life based on people's choices undergirds much of modern economic thinking. The third definition of quality of life is in terms of the experience of individuals. If a person experiences her life as good and desirable, it is assumed to be so. In this approach, factors such as feelings of joy, pleasure, contentment, and life satisfaction are paramount. Obviously, this approach to defining the quality of life is most associated with the subjective well-being tradition in the behavioural sciences (Diener and Suh, 1997).

The quality of life depends on the emotional interpretation the subject gives to the facts and events. The quality of life is increasingly acknowledged as an assessment strongly dependent on the person's subjectivity. In the specific field of physical health, for example, there is a great variability between people regarding their capacity of facing up to physical limitations and diseases and their expectations concerning their health. The individual concepts can have a determinant influence in the perception and valuation people have about their health condition. Thus, two persons with the same functional state or the same 'objective' health condition (for example, degree of rheumatic arthritis), can have very different qualities of life due to these subjective aspects (Xavier *et al.*, 2003).

2.1.4 Quality of life in the elderly

Quality of life is essential. Improving the quality of life is now a common aim of international development. However, enjoyment in life and a sense of purpose and happiness can still elude elderly people, making these important problems that need to be solved, especially in one's advanced years (Bloom, Craig and Malany, 2001). It is not easy growing old and most times, depression attacks elderly people, and especially they tend to feel helpless and inactive after retirement, with their role as primary provider having finished. So, they are more negative and sensitive and rely on others, so they should be cared for to achieve a good quality of life. The quality of life of the elder has become relevant with the demographic shift towards an aging society. There are indications that concepts and concerns related to quality of life in elderly people are different from the general population. The majority of the elderly people evaluate their quality of life positively on the basis of social contacts, dependency, health, material circumstances and social comparisons.

Most of the quality of life measures are not developed in elderly populations, although they are capable of thinking and talking about their quality of life. In a survey of individuals aged 65 years or more, the respondents were familiar with the term quality of life and talked about it in both positive and negative terms (Farquhar, 1995). Almost two-thirds of the whole sample described their quality of life as positive or very positive. They evaluated their quality of life positively on the basis of comparison with others, social contacts especially with family and children, health, material circumstances and activities. In making negative

evaluations, they stressed on dependency and functional limitations, unhappiness and reduced social contacts through death of friends and family members. Family, activities and social contacts were the factors, which they thought gave their life quality. Different kinds of losses such as ill health and functional limitations were seen as making quality of life worse. One of the significances of quality of life is that its assessment should include factors other than health. However, in a Brazilian study that used similar methodology, health was the most stated response to most questions on what is currently wrong with and what could increase or decrease their quality of life (Xaviera, Ferraz, Marc, Escosteguy and Moriguchi, 2003). Similarly, in focus groups in deprived areas in England, participants found it difficult to understand the phrase, quality of life itself and mentioned health and finances very frequently (Scharf, Phillipson, Kingston and Smith, 2000). In a national survey of 1999 individuals aged 65 years or more, living in England and Scotland, Bowling and colleagues tried to find older people's concepts about quality of life by asking them (Bowling, Gabriel and Dykes ,2003). Using a content analytical approach to responses to open-ended questions, they identified constituent factors of quality of life as social relationships, social roles and activities, solo activities, health, psychological, home and neighbourhood, financial circumstances, independence, miscellaneous and society/politics in the order frequency of mentioning. The same order stood for factors constituting good quality of life while health and home and neighbourhood came on the top as factors that can take away quality of life.

Aging is perceived to decrease quality of life; however, when controlled for other factors, the effects of age may disappear (Stock *et al.*, 1983). The emergence of the third age demands that we look for predictors of quality of life other than age. Significant events during this stage of the life span include loss of income because of exit from the labour force and the increasing probability of illness. Measures of subjective wellbeing have been shown to be associated with financial situation and health and functioning (Markides and Martin, 1979; Usui *et al.*, 1985).The Berlin aging Study in 1999, found that good health (measured as self reported illnesses and self assessed health) was important for a strong sense of wellbeing in its sample of people aged 70–105 years; an age spread that includes the third age (Smith *et al*, 2002). The study also found that income and satisfaction with income influenced subjective wellbeing in old age (Smith *et al*, 1999). Although life satisfaction does not show

gender differences, the gendered dimension of aging cannot be neglected (Ginn and Arber, 1999). Contextual factors like social capital, social networks, and social participation also can contribute to the quality of life in older ages (Garrat *et al.*, 2002).

Several internal emotional/psychical characteristics influence the possibility of having a pleasant elderliness. Characteristics such as the interpretation of losses, the previous personality and even the beliefs and positions facing aspects like death and separation can help keeping, developing or losing the well-being in elderliness. An internal characteristic highlighted by Rowe and Kahn as the most important one is the 'resilience', the emotional capability of recovering from stressing factors. According to Sadavoy, the greatest developmental task of elderliness is to find 'restitution' for the inevitable biopsychosocial losses associated to this stage of the life cycle (Sardavoy, 1995). In Goethe's words, 'there is no art in getting old, but it is an art to endure elderliness'. For many elderly people, the task of recovering from stressing factors is hampered due to the cumulative effect of losses close in time, when a new loss occurs before enough time had already passed in order to allow the resolution of grief (Goethe, 1993).

Besides these internal aspects, the external contingencies vary enormously from person to person. The loss of independence does not happen to everybody and when it occurs follows different paces. The loss of financial resources is common, although its degree be variable. Many elderly people –in our society frequently more females than males – will have to face up to widowhood. Different 'organic scenarios' are possible: the number, quality and the intensity of their health limits vary for each elderly person, from subjects whose health is kept in the standards of young adults (well-succeeded elderliness) up to those without any social life. Even the age is variable among elderly people, sometimes ranging more than 30 years (Xavier *et al.*, 2003).

To have a preponderantly positive quality of life in the elderly people depends on the internal emotional coordinates and on the external coordinates or on the contingencies. Whether elderliness will be an enjoyable stage in an elder's life depends on the subject's emotional resources as well as on the intensity of stressing factors and resources offered by the environment to the subject (buffers). As these internal and external coordinates may range

from very favorable to intensely unfavorable we can understand how the intersecting or resulting point of these two axis vary from subject to subject. This intersecting point between the external reality and the opinion and feeling about this reality can be called the elder's 'quality of life' (Xavier *et al.*, 2003).

A survey was conducted in 2008 among elderly persons (65years and above) residing in the South-West and North-central parts of Nigeria (Gureje *et al*, 2008). The association of demographic, economic, health and social factors with the quality of life of elderly persons was examined. The relative salience of social factors, compared to economic and health factors, to different aspects of quality of life of elderly persons living in a society undergoing rapid social changes was examined. The results demonstrated that quality of life of elderly persons is determined by demographic, health, and social factors. Among demographic factors, economic status, place of residence and age were the most consistent correlates of quality. Economic status was significantly related to all of four domains of the quality of life examined, age to three and place of residence related to two. Among health factors, self-reported overall health and functional disability were the strongest correlates of quality of life, with both factors being predictive of all the four domains. Self-reported chronic medical conditions and depression were associated with physical and psychological domains while cognitive impairment was related to the psychological and environmental domains.

Among social factors, participation in community activities was related to all domains of quality of life while contact with family, participation in family activities, and availability of emotional support were related to three of the domains Contact with friends was a predictor of psychological and social aspects of quality of life. Availability of instrumental support was not a significant correlate of any domain of quality of life in this sample of elderly persons. In general, and judging by the strength of the associations as indicated by the values of the regression coefficients, social factors were the strongest determinants of quality of life in the psychological, social and environmental domains and were next in importance to health factors for the physical domain. Demographic factors were, as a group, much less related to quality of life than health and social factors (Gureje *et al*, 2008).

2.1.5 Factors/Indicators of Quality of Life in the elderly

For those in the health care field, health factors are sometimes the sole measurement of quality of life when related to the elderly (Hunt, 1997). 1he problem with this approach is that it neglects the "experiences of people in old age" and tends to reduce the elderly to "a medical or a social policy category". Other researchers agree that quality of life measures focusing only on health factors provide an inadequate account of individual quality of life because of the distinct difference between quality of life and health status (Smith and Goldman, 1999; Spiro and Bosse, 2000). Hyde, Wiggins, Higgs and Blane (2003) suggest the use of non-health proxies to develop a broader measure of quality of life based on the degree to which human needs are satisfied. "Social relations, functional ability and activities may influence the quality of life of elderly people as much as health status" (Wilhelmson Anderson, Waern and Allebeck, 2005). Gabriel and Bowling (2004) attempted to develop a conceptual framework about the quality of life using older people's views. Factors enhancing the quality of life were having good social relationships with children, family, friends and neighbours; neighbourhood social capital represented by good relationships with neighbours, nice and enjoyable neighbourhood, comfortable houses and good public services such as free transport facilities; psychological factors such as optimism and positive attitude, contentment, looking forward to things, acceptance and other coping strategies; being actively engaged in social activities such as attending educational classes and volunteering; good health; financial security which brought enjoyment as well as empowerment and having not depend on others.

In a recent study in Sweden, men and women aged more than 67 years were asked what quality of life was for them; responses in rank order were social relations, health, activities, functional ability, wellbeing, living in one's own home, personal finances, and personal beliefs and attitudes (Wilhemson, Andersson, Waern and Allebeck, 2005). For them living in own home and, in the context of severe illness, social relations were important for quality of life. These studies clearly demonstrate that quality of life goes beyond health; other factors such as having good social relations, being active and able to participate in socially and personally meaningful activities and having no functional limitations are sometimes more important for older people (Brown, Bowling and Flynn, 2004). Moreover, this understanding

of quality of life crosses cultural boundaries. It is logical to wonder whether these perceptions are a result of older people living now having less health problems.

Other studies have indicated that factors such as self-esteem, perceived physical health, and locus of control are associated with life satisfaction (Girzadas, Counte, Glandon, and Tancredi, 1993; Rogers, 1999). Still other literature posits that financial security and a sense of closeness and connectedness with others predict life satisfaction (Fisher, 1995; Girzadas et al., 1993; Gray, Ventis, and Hayslip, 1992; Kahana, Redmond, Hill, Kercher, Kahana, Johnson and Young 1995; Levitt, Antonucci, Clark, Rotton, and Finley, 1986; McGhee, 1984; Revicki and Mitchell, 1986; Wing-Leung Lai and McDonald, 1995). Indeed, Kahana et al. (1995) found that short-term problems such as those caused by financial difficulties and changes in relationships through retirement or death may have a significant impact on life satisfaction. Locus of control has been another widely studied construct in relation to life satisfaction among the elderly. Most research has focused on the relationship between internal, external, and chance locus of control and life satisfaction, and conclusions as to the nature of this relationship have been mixed. In an exploratory study conducted by Girzadas et al. (1993), 258 community-dwelling individuals aged 55+ were selected from a larger study that examined the relationship between health status, locus of control, and life satisfaction. The larger study recruited participants from the rolls of Health Maintenance Organizations and private physicians. Results from face-to-face interviews with participants indicated that functional health status was positively associated with life satisfaction. Further, participants who scored high on chance locus of control also scored low on life satisfaction. Specifically, participants who reported poor physical health and who demonstrated a tendency toward believing their health outcomes were based on chance also showed relatively low life satisfaction. Results from other studies suggest that individuals with a tendency toward internal locus of control, particularly with regard to physical health, show higher levels of life satisfaction than those who show a tendency toward external or chance locus of control (e.g., Haber, 1994; Searle, Mahon, and Iso-Ahola, 1995; Wing-Leung Lai and McDonald, 1995). It follows that older adults who are not internally focused may show a tendency toward low life satisfaction. For instance, Park and Vanderberg (1994) found from a sample of 154 individuals aged 58+ that those who demonstrated low levels of personal autonomy and high

levels of dependency tended to be more negatively affected by poor health and showed a need for social support in the form of a confidant than more autonomous and independent individuals. Moreover, Vallerand, O'Connor, and Blais (1989) found that older adults who were living in nursing homes that did not allow for personal autonomy or self-determination showed lower life satisfaction than older adults living in nursing homes that allowed for more personal independence or those living independently in the community. Conversely, some studies have indicated that older adults who demonstrate a tendency towards external locus of control have higher life satisfaction than those with an internal or chance locus of control (e.g., Haber, 1994; Rogers, 1999). It may be that older individuals who are externally focused and who have developed trust in their health care provider actually demonstrate higher levels of life satisfaction than those who rely on themselves or even chance for health care decisions. Specifically, the latter group may experience more guilt or feelings of hopelessness when faced with health problems, poor treatment, or poor decision making with regard to health care (Haber, 1994).

Functional abilities have been found to enhance the quality of life of the aged. Many studies have indicated that functional ability declines with age (Haug and Folmar, 1986; Kane, Saslow, and Brundage, 1991; Logue, 1990; Osberg, McGinnis, DeJong and Seward, 1987). This can lead to stress, isolation, and other harmful effects associated with the impact of physical impairment (Krause and Tran, 1989). Activities of daily living represent basic responsibilities and duties that comprise the individual's daily functioning, such as bathing, dressing, eating, toileting, and transferring. Impairment in activities of daily living is illustrative of a stressful life situation and, in turn, affects the elderly individual's experience of well-being (Revicki and Mitchell, 1990).

Another research findings also provide evidence that supportive social environment is important to an older adult's sense of security and general well-being (Li, *et al*., 2004; Ross & Mirowsky, 2002; Yeh and Lo, 2004). "Physical closeness and a sense of community can promote positive social networks and research should be mindful of the potentially important role played by local neighborhoods in shaping the social ties of older adults" (Krause, cited in Cleak, *et al*., 2000). A strong network of family, other kin and friends (informal supports),

in addition to sources of emotional support from the wider-community, neighbors or church members (external supports), has long been recognized as important to the health and well-being of elderly adults (Barker, Morrow, and Mitteness, 1998; Choi and Wodarski, 1996; Clare, 1997). Studies show that strong social supports have a positive effect on seniors and enable them to maintain productive, meaningful and satisfying lives, which enhance functional independence (Cleak and Howe, 2003; Finchum, 2005; Gustavson and Lee, 2004; Li, Edwards, and Morrow- Howell, 2004). On the one hand, it is well documented that one of the major consequences of increased longevity is that, as people grow older, they are more likely to experience social isolation (Barker, et al., 1998; Cleak and Howe, 2003). On the other hand, loneliness, lack of emotional support and lack of companionship or social support can leave older adults vulnerable to heart and other health problems. For example, Sorkin, Rook, and Lu (2002) found from their survey of 180 men and women ranging in age from 58 to 90 that having just one person for emotional support seemed enough to reduce the risk of heart disease. But, the healthy effects of social support required relationships with multiple individuals. In other words, greater loneliness was found to be associated with an increased probability of having a coronary condition, as were low levels of emotional support and companionship. Yet another study shows that having close friends and staying in close contact with family members offers a protective effect against the damaging effects of Alzheimer's disease (Bennett, Schneider, Tang, Arnold, and Wilson, 2006).

In summary, studies of life satisfaction among elderly have identified several important constructs that may influence this measure. These constructs include the following: social support, physical health, locus of control/level of independence (internal, external, and chance), financial status, psychological health and life events (Soleman, Anissa and Amanda, 2002).

Measures for Quality of Life

Table 2.1: Indicators for measuring the quality of life.

	Overall Quality of Life and General Health
1. Physical health	• Energy and fatigue • Pain and discomfort • Sleep and rest
2. Psychological	• Bodily image and appearance • Negative feelings • Positive feelings • Self-esteem • Thinking, learning, memory and Concentration
3. Level of Independence	• Mobility • Activities of daily living • Dependence on medicinal substances and medical aids • Work Capacity
4. Social relationships	• Social support • Sexual activity • Personal relationships
5. Environment	• Financial resources • Freedom, physical safety and security • Health and social care: accessibility and quality • Home environment • Opportunities for acquiring new information and skills • Participation in and opportunities for recreation/leisure • Physical environment (pollution/noise/ traffic/climate) • Transport
6. Spirituality/Religion/Personal Beliefs	• Religion /Spirituality/Personal beliefs

Source: World Health Organization (WHO) Quality of Life Instruments (1993)

2.2 Review of Empirical Studies

2.2.1 Quality of life and Social Support received by the Elderly

Several studies have examined the relationship between social support and life satisfaction among the elderly. Most of this literature has indicated a positive relationship between social support and life satisfaction. One study conducted by Aquino, Russell, Cutrona, and Altmaier (1996), found that social support was significantly related to life satisfaction. Aquino et al. surveyed 301 community-dwelling elders aged 65 years old and over to determine how demographic variables such as financial status, educational level, and work patterns affect life satisfaction. Results from face-to-face interviews indicated that elders who were working or volunteering showed higher life satisfaction than those who were not working or volunteering. Further, these authors found that participants who engaged in volunteer work had more social supports than those who were not engaged in volunteer work, which in turn led to higher levels of life satisfaction. The findings also indicated that participants who reported low education and socioeconomic levels and who had poor physical health indicated that they had few social supports and low life satisfaction. Consequently, participants who were not functioning well enough to work or volunteer had fewer opportunities to build social networks, which afforded fewer opportunities to engage in satisfying relationships outside of the workplace than participants who were working or volunteering. Though many of the measures used in the aforementioned study were standardized, particularly those measuring social support and life satisfaction, it is unclear whether these instruments are appropriate for use with older adults. In another study conducted by Newsome and Schulz (1996), 201 people aged 65+ were randomly selected from Medicare lists. Participants were surveyed to gather information regarding their social networks, level of functioning, perceived social supports, and life satisfaction. Results indicated that participants who reported decreased physical functioning also perceived their social supports as poor. Furthermore, participants who perceived their social supports as poor reported low life satisfaction. Thus, participants who reported physical difficulties also perceived their social supports to be poor, which may have affected their level of life satisfaction.

Observational epidemiological studies demonstrated that social support is associated with improved survival, avoidance of institutionalization, reduced disability, and improved quality

of life (Bowling and Browne 1991; Steinbach 1991; Mendes de Leon, Glass, Beckett, Seeman, Evans and Berkman, 1999). The way in which social care resources are allocated shows considerable unexplainable variation. For example, in Sweden differences in allocation of resources such as home helps, sheltered housing, and institutional care places were found which could not be explained by differences in need for services (Lagergren and Johansson, 1998). Evidence from controlled trials of the impact of social services schemes to provide social support are fairly rare and tend to be small scale. For example, a trial of outreach management of elderly people discharged from hospital failed to find any difference in quality of life or functional performance (Curtis et al. 1998). Similarly, social support interventions with stroke patients failed to demonstrate any effects (Friedland and McColl 1992). By contrast, an Italian trial of integrated social and medical care with case management did find reduced institutionalization and functional decline (Bernabei, 1998). Interpretation of small, often methodologically unsound, and underpowered negative trials is beset with problems. Much more work is required to develop both theoretically sound interventions and better methods of evaluation of these complex interventions.

Social support is one of the important factors that play a major role in maintaining well-being in the aged. McCauley, Blissmer, Marquez, Lerome and Kramer (2000) indicated that the social relations integral to an exercise environment are significant determinants of subjective wellbeing, including perceived satisfaction in life, in older adults. McCulloch (1995) found social support was a significant predictor of mental health outcome. Similarly, vanBaarsen (2002) indicated that elderly who had lost a partner experienced lower self-esteem, resulting in higher emotional loneliness and social loneliness, that is, the perception of less support. Koukouli *et al* (2002) also suggested that social support appears to play a significant role in explaining differences in subjective functioning; people living alone or only with a spouse, particularly the elderly, seem to be at greater risk for disability problems and should receive particular attention from preventive programs in the community. McNicholas (2002) asserted that social support, self-esteem, and optimism were all positively related to positive health practices; and social support was positively related to self-esteem and optimism.

In the olden days Africa, there was cultural respect and acceptability for the elderly. During the period, the elderly subgroup practiced traditional farming system and polygamy as the vogues of wealth and survival, and hence, enjoyed a level of social support as the relational provision of attachment, social integration, opportunity to nurture, feeling of worth, sense of reliability and guidance which has contributed to quality of life of the elderly in the sub region. Also of concern is the increasing record from the central, south and east Africa that elderly persons' are subjected to various level of abuses rather than being cared for. A positive number of findings/ researchers (HelpAge, 2002; Fajemilehin, 2001, 2009; Giang and Dfau, 2009; Kelley, 2005; Shamas *et al*., 2003) had suggested that social support is antecedent to cultural values, health behavior and positive health practices. Although those aged 60 years and above represent a relatively small fraction of the population of Nigeria, they constitute about 6% and are expected to increase significantly to between 12 to 15% between now and year 2015 (WHO, 2002; Fajemilehin, 2009; Giang and Dfau, 2009). Nigerian society however, like many other developing nations has not paid enough attention to this sub- group of the society. Lack of formal structure of care and social support networks in this part of the world has made older men and women very dependent on the informal traditional family support system and this today, has become weakened (Fajemilehin, 2001).

2.3 Conceptual framework

The model employed in the course of research work was the Ecological Model. The ecological perspective emphasizes the interaction between, and interdependence of, factors within and across all levels of a health problem. It highlights people's interactions with their physical and socio-cultural environments and its addresses five levels of influence; Intrapersonal factors, interpersonal factors, institutional factors, community factors, and public policy. An ecological model is based on the assumption that patterns of health and well-being are affected by a dynamic interplay among biologic, behavioral, and environmental factors, an interplay that unfolds throughout the life course of individuals, families, and communities (Smedley and Syme, 2000). The ecological framework treats the interaction between factors at the different levels with equal importance to the influence of factors within a single level. (WHO, 2004). The ecological model serves to identify multiple points of possible intervention in public health, from the microbiologic to the environmental levels, to postpone the risks of disease, disability, and death; and enhance the chances for health, mobility, and longevity (Smedley and Syme, 2000).

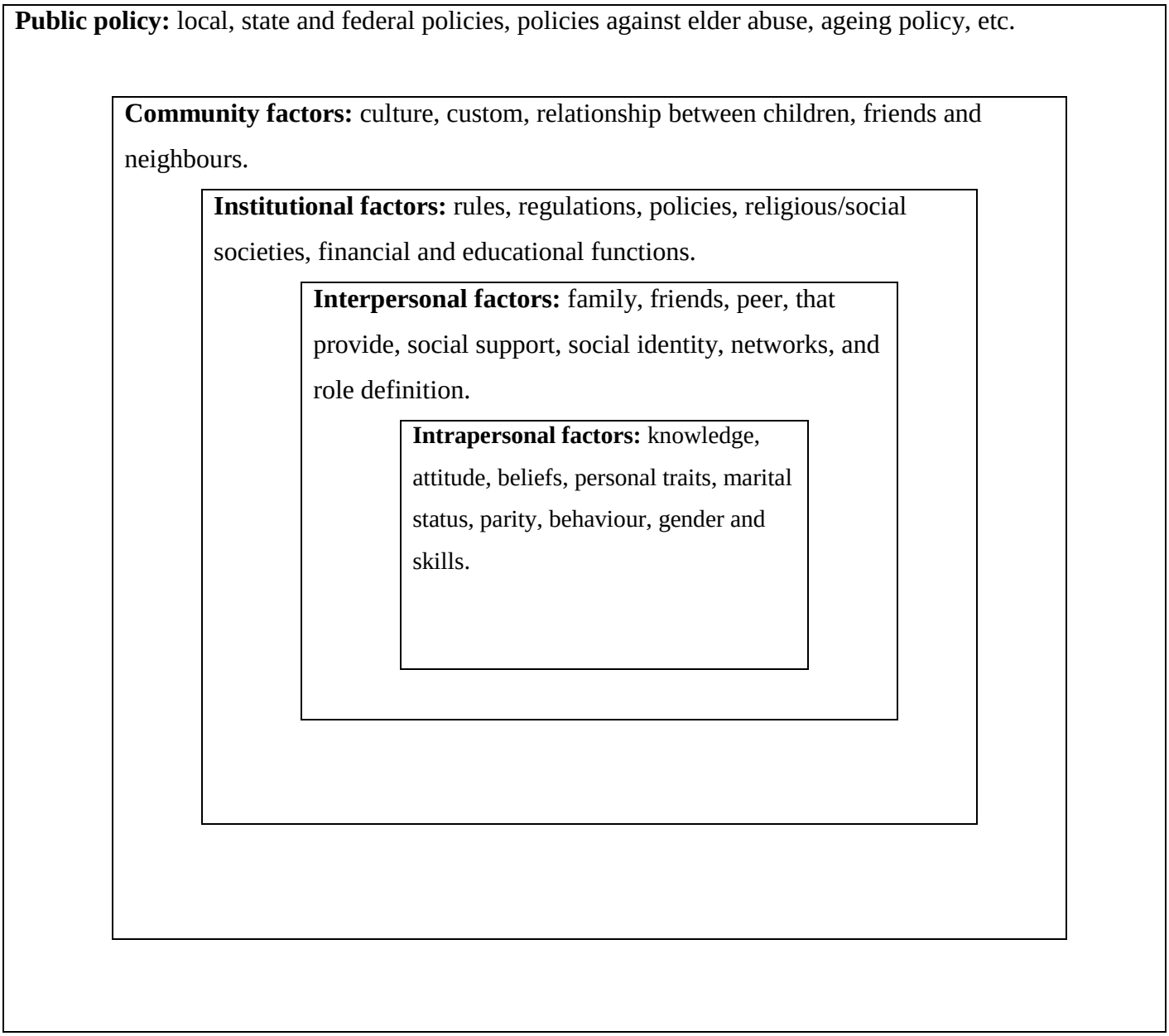

Fig 2.1: An Ecological Perspective: Levels of Influence. Source: (Brieger, W. R. 2000)

1. **Individual/Intrapersonal level**: an elderly may believe that factors like having good social relationships with children, family, friends and neighbours, nice and enjoyable neighbourhood, comfortable houses and good public services such as free transport facilities, contentment, looking forward to things, acceptance, being actively engaged in social activities such as attending educational classes or church activities and volunteering; good health, financial security and so on can enhance their quality of life.
2. **Interpersonal level**: family members provide food, shelter, clothing, drugs and other basic necessities for the elderly. Care provided by the family, friends and neibghours attempts to satisfy the needs of older persons.
3. **Organizational/Institutional level**: provision of social welfare services like recreational clubs or societies, provision of nursing/geriatric homes for the elderly. Some of these older ones in this part of the world do not find it difficult to stay in nursing/old people's home while some see it as a taboo or an insult. Non Governmental Organization (NGOs) and faith-based organizations are also involved to make effective contributions to the service provision to older people through day-care centers, residential homes, libraries, regular medical check-up's and so on.
4. **Community level**: this involves the community's attitude towards care and respect for the elderly. Some cultures may see the elderly as important category of people that should be well attended to and handled with care, while some may see them as irrelevant, useless or as a burden.
5. **Policy level:** this involves the participation of government at all levels, Federal, Regional (States) and Local Councils, in the provision of services to the older person. The elderly may lack access to health services or the state provision for elderly care, which is currently absent in Nigeria. In Nigeria today, social security policies for old age are yet to be formulated (Ajomale, 2007). The families of these older ones play the most important role of providing economic security in old age. Older parents live in their adult children's homes and receive care. The decline in the economy, gradual disintegration of the extended family system, unemployment, increasing female employment to complement family income, as well as rural-urban migration

all contribute to the noticeable decline in the level of care provided by the family in recent times (Ajomale, 2007).

CHAPTER THREE

METHODOLOGY

This chapter describes the methodology that was employed in this study. It contains the study design, description of the study area, research design, study population, sample, sampling technique, the instrumentation and the procedure for the data collection and analysis.

3.1 Study Design

The study was a descriptive and cross sectional research. It was designed to explore the patterns of social support received and the perceived quality of life among the elderly living in Ibadan North Local Government Area of Oyo State.

3.2 Description of the Study Area

Ibadan North Local Government Area (LGA) is one of the five LGAs in Ibadan metropolis. Ibadan is the largest city in black Africa. The Ibadan North LGA was founded by the Federal Military Government of Nigeria on 27th September 1991. This LGA was carved out of the defunct Ibadan Municipal Government along with others. It is a transitional urban area and it consists of multi-ethnic groups, which is predominantly Yorubas. Others include the Ibos, Edos, Urobos, Itsekiris, Ijaws, Hausas, Fulanis and foreigners from Europe, America, Asia and other parts of the world. Majority of the population of the LGA are in the private sector, mainly traders and artisans while a good number of the people are civil servants. There are six major markets in Ibadan North LGA. They are Bodija, Sango, Mokola, Sabongeri, Gate and Ijokodo/Gbaremu markets.

The components of the LGA cover areas between Beere roundabout through Oke – Aare to Mokola, Oke Itunu and Ijokodo. The other component areas from Beere roundabout to Gate, Idi – Ape to Basorun and up to Lagos – Ibadan expressway, Secretariat, Bodija, University of Ibadan and Agbowo areas. The headquarters of the local government is at Bodija. As a result of accommodation problem, LGA headquarters is temporarily accommodated at Quarter 87 at Government Reservation Area at Agodi where the secretariat is located.

The local government is bounded by other local governments. In the North it is bounded by Akinyele LGA. In the West by Ido and Ibadan North West LGAs, and bounded in the South by Ibadan North West and Ibadan South West LGAs. The LGA is bounded in the East by Ibadan North East and also Lagelu LGAs.

The Ibadan North local government area has a population of 306,795 people. The males are 153, 139 while the females are 153, 756. The Ibadan North LGA comprise of 12 wards.

Table 3.1: The 12 wards in Ibadan North LGA

Ward	**Area covered**
1	Beere, Kannike, Agbadagbudu, Oke Aare, and Odo Oye
2	Ode Oolo, Inalende, Oniyarin and Oke Oloro
3	Adeoyo, Yemetu, Oke Aremo, and Oke Alfa
4	Itutaba, Idi Omo, Oje Igosun, Kube, Oke Apon, Abenla, Ali Iwo/Total Garden, and NTA area
5	Basorun, Oluwo, Ashi, Akingbola, Ikolaba, and Gate
6	Sabo area
7	Oke Itunu, Coca Cola, and Ore Meji
8	Sango, Ijokodo
9	Mokola, Ago Tapa, and Premier Hotel area
10	Bodija, Secretariat, Awolowo, Obasa and Sanusi
11	Samonda, Polytechnic and University of Ibadan
12	Agbowo, Bodija market, Oju Irin, Barika, Iso Pako, Lagos /Ibadan Expressway

The projected population of the elderly living in Ibadan North LGA as at 2010 is shown in Table 3.2 below:

Table 3.2: 2006/2010 Projected Population distribution of the Elderly

	2006	**2010**
Male	4833	5493
Female	6334	7199
Total	11,167	12,692

Source: National Population Commission: Ibadan North LGA of Oyo State.

The population distribution was projected using the formula $\mathbf{P_{1=}\ P_0 e^{r\ x\ n}}$ where:

- P_0 is the given data i.e. the population size as at 1991/2006
- e is a constant
- r is the growth rate
- n is the difference between the years.

3.3 Study Population

The research participants were mainly the elderly (65years and above) in Ibadan North Local Government Area of Oyo State.

3.4 Inclusion Criteria

1. Elderly persons aged 65 years and above at the time of the study.
2. Elderly male or female living in from the communities selected for the study and resident for at least 9 to 10 years.
3. Willingness to participate in the study.

3.4.1 Exclusion criteria

Respondents who were not physically fit were not included in the research.

3.5 Sample Size Calculation

The sample size for the study was drawn using male and female elderly in Ibadan North Local Government Area. In order to obtain an appropriate minimum sample size for the study, the Epi Info statistical software was used. The following parameters were used to calculate the sample size:

- Total number of study population - 12,692
- Expected frequency - 57% (Flávio, Xavier, Ferraz, Marc, Escostegu, Moriguchi, 2003).
- Worst acceptable frequency - 57%-5%=52%

At 99% confidence interval, the sample size was calculated to be 613.

The total number of participants used was 653 in all (plus 40 focus group discussion respondents)

3.6 Sampling Procedure

Ibadan North LGA is made up of 12 geo-political wards, which comprises of 42 communities. Out of these communities, 20 communities were randomly selected for the purpose of the study (About half of the communities were chosen because the sample size was large and the study participants were a special group of people that might not be found in large numbers in a particular area). The Multi-stage stratified simple random sampling technique was adopted for the study. This was done to give every member of the target population an equal and independent opportunity of being selected for the study (Araoye, 2003). The following two stage sampling procedure was performed:

Step1: The local governments in Ibadan North were divided into three namely inner core, transitional and the peripheral areas.

Step 2: Eight communities were randomly picked from the inner core areas, six from the transitional and 6 from the peripheral communities using the ballot method. Participants were recruited from each area using the purposive sampling technique, till the target population size was met. More communities were picked from the inner core areas because the area constitutes close to half of the total number of communities in the local government and a majority of the target population (the elderly) was found there.

Table 3.3: Classification into Inner Core, Transitional and Peripheral Communities

The classification is subjective, based on the researcher's view of the communities

Community Type	**Wards Covered**
Inner core	1,2,3, & 4
Transitional	6,7,8, & 12
Peripheral	5, 9, 10 & 11
Study Communities that were randomly chosen	
Inner core	Beere, Yemetu, Oje Igosun, Oke Aare, Inalende, Itu-taba, Oniyanrin, and Isale Alfa areas.
Transitional	Sabo, Oke Itunu, Agbowo, Iso pako, Sango, and Barika areas.
Peripheral	Gate, Bodija, Secretariat, Awolowo, and University of Ibadan and Samonda areas.

Source: National Population Commission: Ibadan North LGA of Oyo State.

3.7 Methods and Instrument of Data Collection

3.7.1 Methods of Data Collection

Qualitative and quantitative methods of data collection were used. The instruments that were used were the focus group discussion (FGD) guide (Appendix II) and questionnaire. A validated semi-structured questionnaire (See Appendix I) was used to elicit responses from participants. The instruments were designed from research questions, conceptual frame work and by reviewing existing literatures extensively.

3.7.2 Instruments of Data Collection

The Focus Group Discussion Guide (FGD)

A focus group discussion guide was developed using the objectives of the study. The instrument which was written in English language was translated into Yoruba by a Yoruba language expert. The guide was made up of two parts: introduction and discussion. The FGD

guide comprised 7 questions in all which include knowledge of what quality of life means in general (its constituents and factors that influences it), how quality of life relates to the elderly, knowledge of social support (types, sources and factors that influence it), receipt of social support and how it affects quality of life, social challenges, measures that should be used to assess quality of life, and how the social support they received affected their quality of life.

The Questionnaire

The quantitative instrument that was used is a semi-structured questionnaire. The questionnaire, which was constructed using the objectives of the study and the five domains of quality of life contained both open and closed ended questions. The five domains of quality of life which were used are as follows:

Physical health
Psychological health
Level of independence
Social relationships
Environment

The questionnaire comprised 45-item questions written in simple English language. The questionnaire was divided into six sections: The questionnaire (Appendix I) consist of both open and closed ended questions with five sections. The sections include;

1. **Section A:** this section deals with the socio-demographic characteristics of respondents which included age, sex, educational status, marital status, religion, ethnic group, type of family, and occupation.

2. **Section B:** consist of questions to find out the types/sources of social support received by the respondents using eleven questions. This section comprises of both closed and open ended questions. Open ended questions were coded appropriately before they were entered into the computer for analysis.

3. **Section C:** questions here addressed the physical health of the elderly. Favourable responses in regards to the health of respondents were scored 3 and 2 points while responses that depicted fair or bad health were scored 1 and 0 point.

4. **Section D:** consist of questions that addressed the psychological health of the respondents. A total number of 6 questions were asked on bodily appearance, ability to recall things, ability to relate with people, aging in relation to level of respect, negative feelings and so on. Questions that were answered as very much, moderately, a little and not at all were scored 3, 2, 1 and 0 points respectively.

5. **Section E:** level of independence of the elderly; had a total number of 5 questions where not at all, a little, moderately and very much responses where scored 3, 2, 1 and 0 points respectively. Questions were asked on ability to perform daily activities, satisfaction of capacity for work, mobility, dependency on medicine/drugs, challenges and social abuse.

6. **Section F**: this section covered the social relationship and environment of the respondents with a total number of 9 questions. Questions that were answered as very much, moderately, a little and not at all were scored 3, 2, 1 and 0 points respectively. Questions were asked on satisfaction with personal relationships, emotional help/support, feeling of safety, leisure activities and so on.

In all, the questionnaires contain 45 variables that were assessed and overall scores were rated as 0-34 (poor), 35-50 (moderate) and 51-68 (good) respectively.

3.8 Validity and Reliability of Instrument

To ensure that the data obtained is reliable, the following measures were carried out:

1. The interviewers were given adequate training.
2. The instruments were translated into Yoruba, the language widely spoken in the study area, which the respondents understand. Translation and back translation were carried out because of the assumption that many of the respondents have limited education and may not be able to communicate fluently in English language.

3.8.1 Validity

Review of literature of previous works, review by experts, medical statisticians, health education specialists and researchers for face and content validity. The instruments were also scrutinized by co-researchers

Also, a pre-testing of the questionnaire and the FGD guide was done among a sample of population similar to the target population (Egbeda local government area) so as to make necessary corrections and modifications to the instruments that were used. The pre-test was conducted using 50 questionnaires for the quantitative data and 2 FGD sessions (1 male, 1 female) were conducted for the qualitative data. Training was conducted for appropriate Field Research Assistants (2 Male and 4 Female) to ensure that they have adequate understanding of the instruments prior to data collection. The training was focused on the objectives of the study, sampling processes, how to secure respondents informed consent, fluency in speaking the Yoruba language and so on. The training was conducted for 2 days to the commencement of data collection in June 2012. A mock assessment was conducted after the training to ensure that the questions were well asked and understood. The field assistants were involved in the pre-testing of the FGD guide and questionnaire to create opportunity for them to get familiar with the instruments.

Following the pretest on two groups, (male and female), adjustments was made to the final guide from responses gotten from the pretest. It was noted that though this set of people (especially the older ones) were to be accorded with a lot of patience, time management had to be improved.

3.8.2 Reliability of the Instrument

This is the accuracy or precision of a research instrument. The reliability of the instruments that were used was done by pre-testing the instruments. The questionnaire was tested for reliability using the alpha-cronbach correlation coefficient of the SPSS (statistical package for social sciences) software, (the closer the correlation coefficient to 1, the more reliable the instrument). The result was 0.65 which is greater than 0.5 was reliable. Reliability was also

ensured by asking the questions in an uncomplicated way with the permission to explain any difficult area for some respondents.

3.9 Procedure for Data Collection

Quantitative data were collected within 3 weeks. Data collection was carried out on a daily basis. Elderly people's personal activities were highly considered and administration of questionnaire was an on-the-spot basis. Data collection commenced from 10am in the morning and ended 4pm every day and each interview session lasted for about 40-45 minutes (maximum). The main and specific objectives of the study were well explained to the participants prior to each interview session so as to ensure that they understood the questions and the intentions of the research. Participants were accorded with due respect as the culture demands and they were thanked after each session. Data were cleaned, edited and coded before they were fed into the computer for analysis. The questionnaire was administered by the interviewer, to ensure the collection of correct and valid data. Research assistants were trained on how to administer the instruments. The researcher monitored the progress of the interviews while daily review meetings were held. Challenges faced during the research were dealt with and ways to make the interview sessions easier were devised. Some of the respondents were reluctant to participate in the research, some asked for money and other incentives before response, some complained of time wasting and so on. These issues were resolved by explaining issues properly to the respondents in a loving manner and before starting the interviews and interviews were stopped whenever respondents insisted that incentives should be given.

Six focus group discussions were conducted in all. Two discussions each were conducted among male and female elderly in communities that were randomly selected from the inner core (Oke Aare and Oje Igosun communities), transitional (Sabo and Iso pako communities), and peripheral (Bodija and Gate communities) areas of Ibadan North Local Government. The discussions comprised of at least 6 and at most 8 participants for each session. The discussions lasted for one hour or one hour and few minutes in all the sessions. A team of three persons consisting of the moderator, an observer and a note take were involved in the focus group discussions. All participants were allowed to express themselves without

interruptions. Refreshments were served as the discussions progressed. At the end of each session, participants were thanked and guided back to their residences if need be.

3.10 Method of Data Management and Analysis

The quality of data collected was checked thoroughly on the field. This entails reviewing the pattern of responses of each participant as recorded in the questionnaire. A serial number was assigned to each of the questionnaires for easy identification and recall of any instrument with problem. A coding guide was developed and administered questionnaires were coded using the guide.

Data were analyzed using the SPSS statistical software (version 17.0) and results are presented using both inferential and descriptive statistics (mean, frequencies, chi-square and t-test) at 0.05 level of significance. Contingency table/tables were constructed and analyzed using Chi-square tests were applicable to compare dependent and independent variables. Descriptive statistics was used to analyze the socio demographic variables and all domains of quality of life. The mean age of the respondents was also analyzed. Association between selected demographic variables was analyzed using the Chi-square test as well as associations between type of family and social support received, while the Independent t-test was used to analyze the association between social support and quality of life (living alone and having children). Questionnaires were well secured by properly entering them into statistical software and the raw papers were kept safe in a file, they will be kept for some period of time until after the defense of the dissertation for reference purposes before being discarded.

The tape recorded from FGD sessions were transcribed verbatim and used to update record's report. The FGD was manually analyzed by the researcher to generate qualitative information. Content and context analysis using the thematic approach which involved grouping together of synonymous themes in the transcripts was done for the FGDs after translating the Yoruba language recordings to English language in writing.

3.11 Ethical Consideration

The study followed the ethical principles guiding the use of human participants in research. The following activities were performed on ethical grounds;

1. Adequate information on the study was given to the respondents
2. Informed consent was sought from the individual participating in the research
3. Assurance was given to all the respondents on the confidentiality and anonymity of the data that will be collected.
4. Participants were handled with special care as they are regarded to as senior citizens and should therefore be given due respect as their culture demands.
5. Respondents were also informed on their freedom to stop the interview at any stage that they were no longer comfortable with it.

Permission to carry out the study was obtained from the community leaders of each community in order to gain access to the community. Ethical approval was sought and obtained from the Oyo State Ministry of Health Research Ethical Review Committee.

CHAPTER FOUR

RESULTS

The qualitative and quantitative findings of this study are presented in this chapter. These contain results from focus group discussions and the survey conducted. The findings are organized into the following sections:

- Socio-demographic characteristics
- Social Support received by the Elderly
- Respondents' Perception of their Physical Health
- Respondents' Perception about their Psychological Health
- Respondents' Perception about their Level of Independence
- Respondents' Perception about their Social Relationship/Environment

4.1 Socio-demographic Characteristics of the Respondents

Table 4.1 shows the frequency and percentage distribution of the respondents with respect to their socio-demographic characteristics. More than half of the respondents 327 (53.3%) were females and 286 (46.7%) were males. A large majority, 491 (80.1%) were between 65 and 74 years of age; while 105 (17.1%) were between 75 and 84 years and a few, 16 (2.6%) were between 85 and 94 years of age. Only 1 (0.2%) was between 95 years and above. The mean age of the respondents was 70.71±5.6 years. Majority of the respondents 462 (75.4%) were married; while less than one quarter 123 (20.1%) were widowed. A few of the respondents 22 (3.6%) were divorced; while very few 4 (0.7%) were single and 2 (0.3%) were separated. Regarding the respondents' education, more than a quarter 165 (26.9%) had secondary education; while 155 (25.3%) had no formal education, almost one quarter 152 (24.8%) had primary education; while 138 (22.5%) had tertiary education and 3 (0.5%) had postgraduate education.

About half of the respondents 305(49.8%) were Muslims, 299 (48.8%) were Christians and 9 (1.5%) were traditional worshipers. A large majority 512 (83.5%) were Yorubas, 51 (8.1%) were Igbos, 36 (5.9%) Hausas and 14 (2.3%) were from other tribes in Nigeria. The

distribution of the respondents by occupation showed that more than one quarter 170 (27.7%) of the respondents were into private business (self employment); 158 (25.8%) were retired workers; 152 (24.1%) were traders; 61 (10%) were civil servants and 45 (7.3%) were doing nothing. As to the type of family of the respondents more than half 342 (55.8%) belonged to nuclear families; while 141 (23%) belonged to polygynous families and 130 (21.2%) of the respondents were from extended families.

The number of respondents that were present for the focus group discussions were 19 females (7 respondents from the inner core, 6 from the transitional and 6 from the peripheral areas) and 21 males (8 respondents from the inner core, 7 from the transitional and 6 from the peripheral areas) respondents in all.

Table 4.1 Socio-demographic attributes of Respondents N=613

Demographic variable	Frequency	Percentage (%)
Age (in years)		
65-74	491	80.1
75-84	105	17.1
85-94	16	2.6
95 and above	1	0.2
Marital status		
Single	4	0.7
Married	462	75.4
Divorced / Separated	24	3.9
Widowed	123	20.1
Educational level		
Primary Education	152	24.8
Secondary Education	165	26.9
Tertiary Education	138	22.5
None/Arabic education	158	25.8
Religion		
Christianity	299	48.8
Islam	305	49.8
Others	9	1.5
Occupation		
Trading/private business	152	24.8
Civil servant	60	9.8
Farmer	27	4.4
Retired	176	28.7
None	198	32.3

4.2 Social Support received by the Elderly

Findings from the survey showed that almost all of the respondents 606 (98.9%) had children; while 7 (1.1%) did not have children. 496 (81.8%) of the 606 who had children, reportedly had their children visit them regularly, while the remaining 110 (18.2%) said their children do not visit them regularly. Reasons adduced by the 110 (18.2%) whose children do not visit them regularly included lack of money or employment 12 (10.7%), 29 (25.9%) gave reasons that their children were too busy, 64 (57.1%) said their children were abroad, 4 (3.6%) did not know why their children do not visit them regularly. Also, a large majority 556 (91.7%) of those who had children have their children provide means for their basic needs regularly.

A large majority of the respondents 575 (93.8%) were not living alone, while 38 (6.2%) were living alone. Those who were not living alone 575 (93.8%) were living with either their family 500 (87%), family and helper 66 (11.5%) or helper alone 9 (1.6%). While a few 38 (6.2%) were living alone. Majority of the respondents 418 (68.2%) said their family helped them with domestic chores; while the remaining claimed that their helper 131 (21.4%), or their neighbours 9 (1.5%) help them with their daily domestic jobs. Only a few 55 (9.0%) said they do their domestic chores themselves. More details are shown in Table 4.2.

Many of the discussants in all the focus group discussions said that social support simply means care emotionally, financially and physically from those you love or those who love you. Most of the discussants agreed that social support comes mainly from the family. One of them said: *"Help comes from the family, but this is peculiar to a family that is good and caring"* Others agreed that social support means getting support just like it is called in all aspects of life. But support can be received from others only through a reciprocated gesture. A male respondent reported thus: *"He who pours water on the ground before stepping on it will experience comfort."*

About half of the discussants said that social support means being a part of a community of people who love, care for, think well of and value you. They explained that social support is an important aspect of quality of life and that life can not be lived alone. A female discussant

said: *"If there is no one a human being can call friend, then that person's life is meaningless."* Discussants from the inner core areas described social support as loving and being loved in return. They emphasized that the most important type and source of social support is the one gotten from one's family and that people can only give social support when they are comfortable themselves. A discussant stated thus: *"You can't expect someone who is emotionally disturbed or does not have food to eat to give you any kind of support".*

Social support according to discussants from the peripheral areas is mainly gotten from those an individual spends most of his/her time with (a person or people with whom you spend most of your time with is/are responsible for providing you with most of the support you get). According to the respondents, mostly when those times are spent with no one, especially if an individual is not the type who has friends or mixes with people around, then he/she gets no support. A female respondent said: *"Children of nowadays believe that once they provide their parents with money, they've taken care of them, but what they don't know is that visiting their parents regularly gives them so much joy".*

Table 4.2: Social Support received by the Elderly N=613

Social support received	Frequency	Percentage (%)
Do you have children		
Yes	606	98.9
No	7	1.1
Do your children visit you regularly (N= 606)		
Regularly	496	81.8
Irregular	110	18.1
Presence of children, neighbours……..makes you happy		
Yes	604	98.5
No	9	1.5
Are you involved in any kind of social network		
Yes	463	75.5
No	150	24.5
Do you participate in community activities		
Yes	505	82.4
No	108	17.6

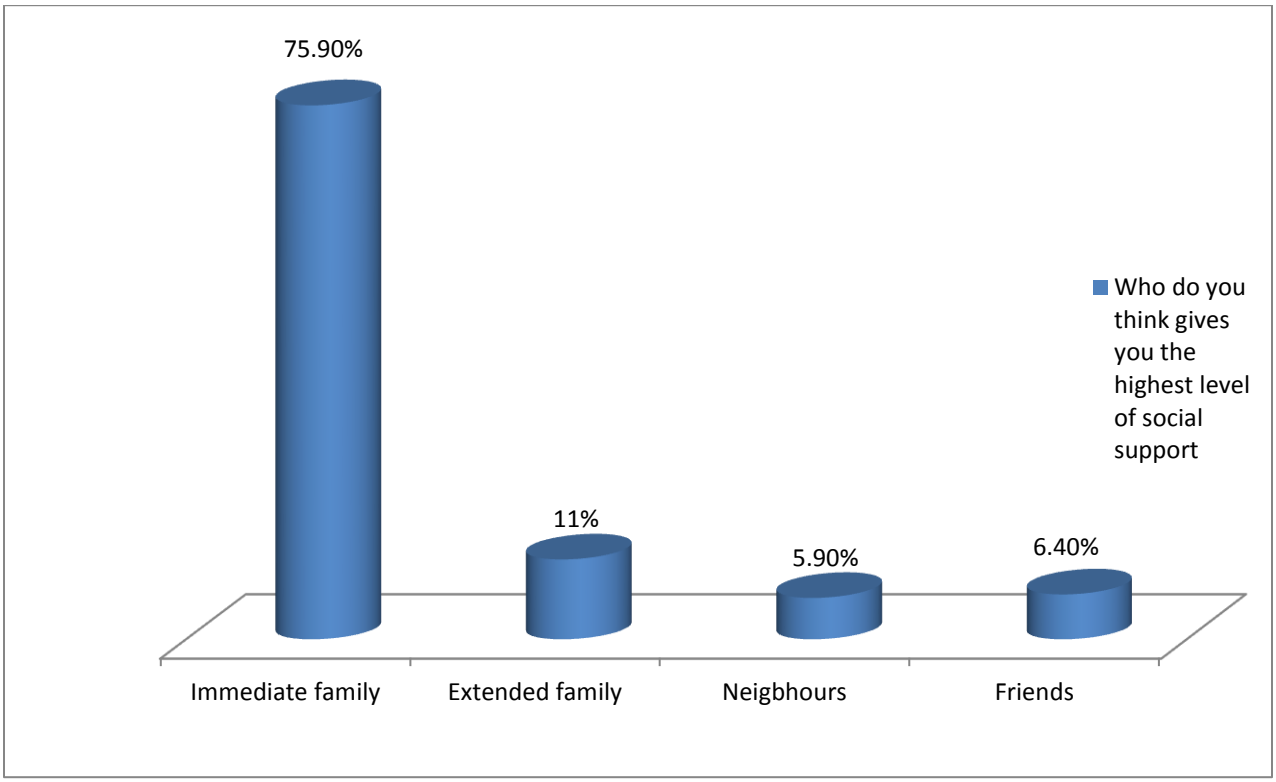

Fig 4.1 Respondents Perception of who gives them the highest level of support.

4.3 Respondent's Perception of their Physical Health

Findings from the survey according to the respondents' perception showed that 168 (27.4%) had poor physical health, close to half 289 (47.1%) had moderate physical health and 156 (25.4%) had good physical health. Some of the variables that were used to measure the perceived physical health of the respondents include ability to sleep well 348 (56.8%), presence of physical pains 344 (55.5%) and performance of regular exercises 272 (44.4%). Table 4.3 and Fig 4.4 show more details of the respondents' perceived quality of life.

Majority of the respondents in the focus group discussions said that sound health, easy assess to medical attention, availability of basic needs and amenities and having a good relationship with God are measures that can be used to assess the quality of life of an elderly. A male respondent reported thus:

"Health is wealth. Without good health, no one can boast of a quality life".

Table 4.3: Respondents' Perceived Physical Health N=613

Perception of physical health	Frequency	Percentage (%)
Do you feel physical pains that prevent you from doing what you need to do		
Yes	334	54.5
No	279	45.5
Do you perform exercises regularly		
Yes	272	44.4
No	341	55.6
Do you have enough energy for everyday life		
Yes	541	88.3
No	72	11.7
Do you have any problem with sleeping well		
Yes	265	43.2
No	348	56.8

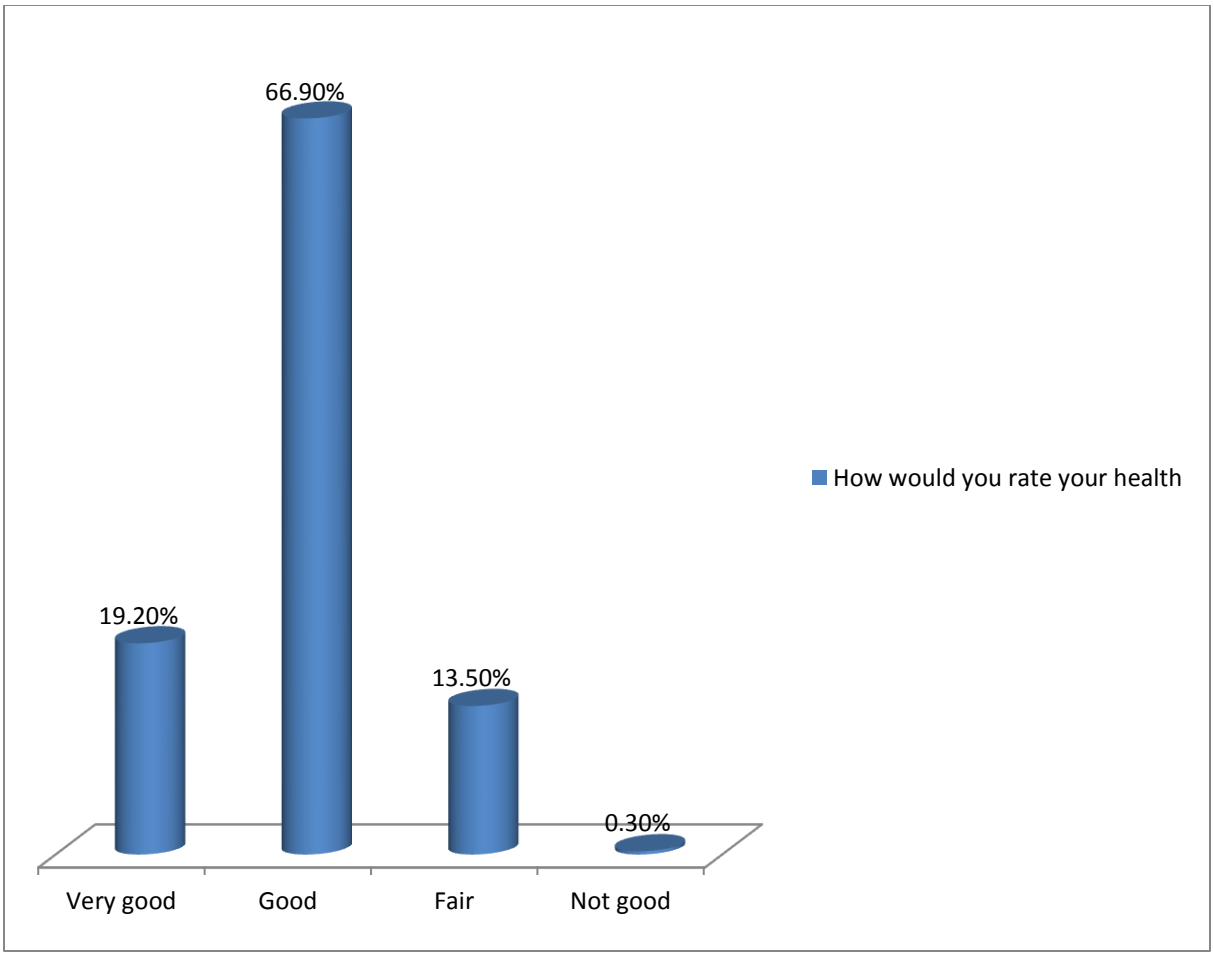

Fig 4.2 Respondents' rating of their Physical Health

4.4 Respondent's Perception about their Psychological Health

Table 4.4 shows how the respondents perceived their psychological health. Only few of the respondents 17 (2.8%) had poor psychological health, 281 (45.8%) had moderate psychological health and 315 (51.4%) had good psychological health. Majority of the respondents 402 (65.6%) perceived that their life was very much meaningful, 322 (52.5%) have very good ability to recall things and a large majority 533 (86.9%) said aging has not reduced the level of respect they receive from people.

Majority of the respondents in the group discussions said that an individual can only live a life of quality when he/she is living a life of contentment. A male respondent stated thus: *"You shouldn't be aiming at being the president of Nigeria when you are not even a school certificate owner! If you are not content with whatever you have, you can never live a life of quality".* Some of the discussants, both male and female also informed that having freedom from mental or emotional anxiety means living a life full of quality. Quality of life, according to the discussants is a very complex kind of word that has a lot of meaning but any type of meaning given to it will make no sense at all if having rest/peace of mind is left out. A male respondent explained thus: *"Nothing can be compared to having peace of mind. For example, I once had a very troublesome child. This child gave me so much trouble that it made every other thing meaningless to me. At least I could say that I had a lot of the good things that life had to offer but I didn't have rest of mind because my child gave me so much trouble".*

Majority of the discussants expressed their view that an elderly who has no quality in his/her life will find existing in life very frustrating and meaningless. They agreed that only a life full of quality makes an elderly happy and that an elderly who lives a quality life will live long. One of the respondents said: *"There was a man who used to live near my house. Before his death, he used to live alone. There was no one to care for him. When he died, no one knew until the second day. I felt very bad because he lived a very miserable life."*

Table 4.4: Respondents' perceived psychological health N=613

Perception of psychological health	Frequency	Percentage (%)
How often do you have negative feelings like despair, anxiety, and depression		
Not at all	158	25.8
A little	300	48.9
Moderately	105	17.1
Very much	50	8.2
Are you able to accept your bodily appearance		
Not at all	7	1.1
A little	47	7.7
Moderately	167	27.2
Very much	392	63.9
Do you find it difficult to relate with people around you		
Not at all	524	85.5
A little	45	7.3
Moderately	28	4.6
Very much	16	2.6

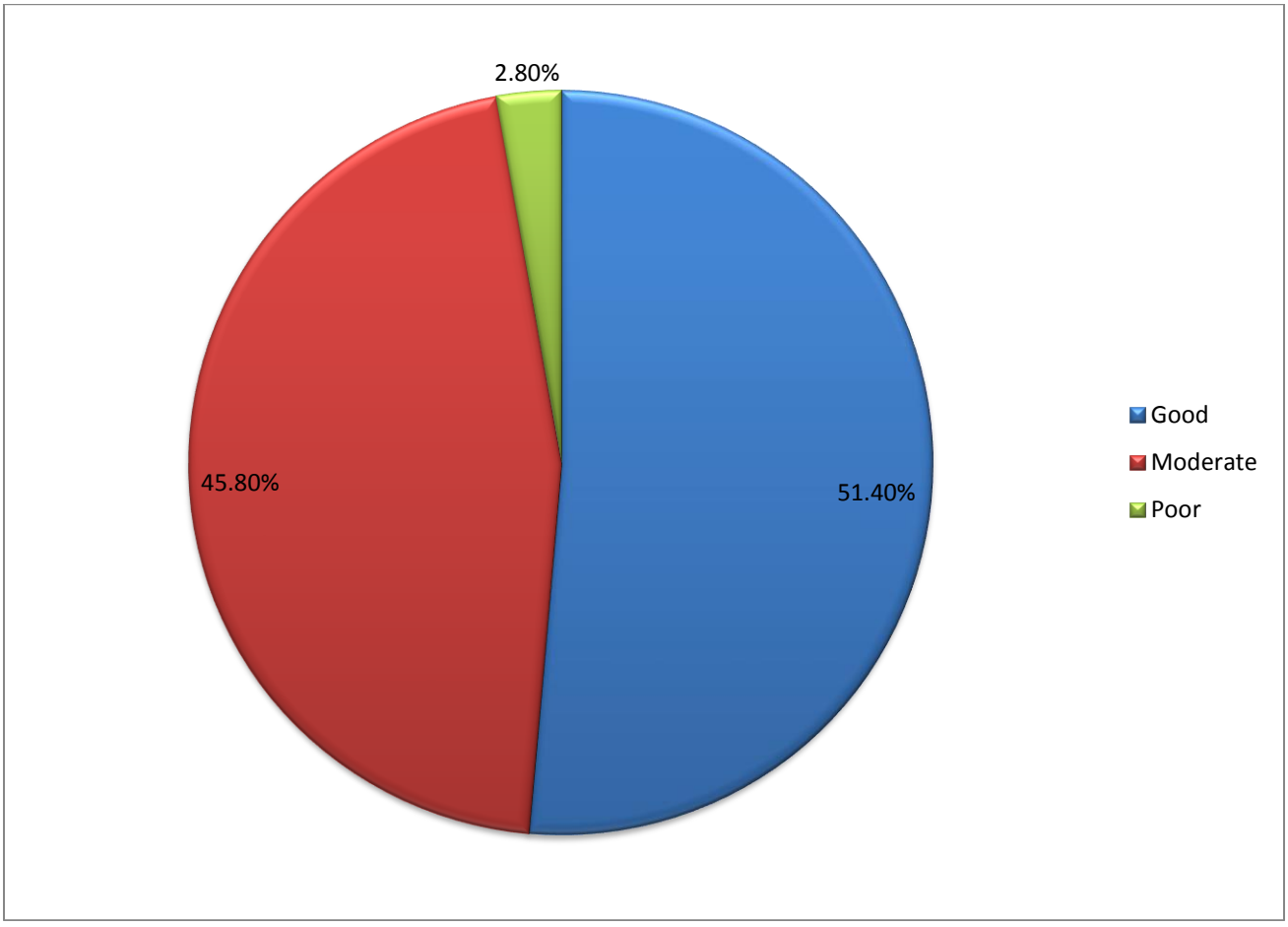

Fig 4.3 shows respondents' overall perceived Psychological Health

4.5 Respondents' Perception about their Level of Independence

Respondents' level of independence, rated at good, moderate and poor is 197 (32.1%), 362 (59.1%) and 54 (8.8%) respectively. Of all the respondents, only 42 (6.9%) said they have serious problems with mobility, 247 (40.3%) said that they were not dependent on medicinal aids to live a normal life and 436 (71.1%) which is a majority did not face any kind of social abuse/challenge in their day to day activities. 292 (47.6%) and 198 (32.3%) said they were moderately and very much satisfied with their capacity for work respectively (Table 4.5).

Respondents in the group discussions stated that having the basic needs in life like money, basic amenities and good health depicts living a life full of quality. About half of the discussants said that they experience abuses like lack of respect and nonchalant attitude from community residents, especially the younger ones. They also said that the elderly faces abuse like theft, threats and being duped. They said all these occur because people see the elderly as weak and vulnerable so they treat them any how. Most of the discussants from the inner core areas also complained of lack of basic amenities like water and electricity. A female respondent reported thus: *"We don't have water in this community. I always have to go to a stream that is a few kilometers away from my house to fetch water. This is quiet challenging for me as it is not easy caring water from there to my house".* Quiet a number of the respondents said that one of the major challenges the elderly in the communities visited face is neglect, especially from the family and mostly from the children. A respondent stated thus: *"I have seen elders like me and even older than I am, being neglected and maltreated by their own children. If those children can behave that way, then outsiders should not be blamed"*

Some residents of the transitional and peripheral areas laid more emphasis on loneliness as the challenge they face on a day to day basis as most of their family members are no more with them. They are either abroad, working in another part of the country, married, nonchalant or dead.

Table 4.5 Respondents' Perceived level of Independence N=613

Perceived level of independence	Frequency	Percentage (%)
Has aging reduced your ability to perform daily living activities?		
Not at all	200	32.6
A little	274	44.7
Moderately	92	15.0
Very much	47	7.7
Do you have any problem with mobility (moving around)?		
Not at all	307	50.1
A little	211	34.4
Moderately	53	8.6
Very much	42	6.9
Do you face any kind of social abuse or challenges in your day to day activities?		
Not at all	436	71.1
A little	149	24.3
Moderately	24	3.9
Very much	4	0.7

4.6 Respondents' Perception about their Social Relationship/Environment

Of all the respondents, 67 10.9%) had poor social relationship and environment, a large majority 522 (85.2%) had moderate social relationship/environment and 24 (3.9%) had good social relationship/environment. Of all the respondents, only 59 (9.6%) said they very much had enough money to meet their needs and 336 (54.8%) were moderately satisfied with the condition of their living places. Table 4.6 shows more details of the respondents' perceived social relationship and environment. Majority of the respondents 462 (75.4%) however reported that their country (Nigeria) has put in place no measures/policies to address the needs of the elderly.

Majority of the respondents in all the group sessions were of the opinion that quality of life means living a healthy, emotionally sound, and financially balanced, God centered and successful life. However, the respondents informed that the most important aspect of living a life full of quality is when an individual is receiving adequate care and support from people around, most especially the family. They also emphasized on the fact that only a happy person can live a life of quality. Some of the discussants reported thus: *"A rich and healthy man with no care and support will definitely be unhappy. No happiness, no good life".* A few male discussants emphasized that quality of life means having a good and caring wife, respectful children and all together a loving family; while a few female discussants said that being physically healthy, having a good relationship with God, and having successful children depicts a life full of quality. One of the respondents stated thus: *"As for me at this point in my life, seeing my children do well is enough for me".* A few of the respondents also reported that most of the time, the elderly live in poor housing and environment conditions because no one cares to take care of their environment for them.

Some of the discussants across the group reported that no individual can live a life of quality without good governance. In that, the kind of government running in any country that an individual belongs to will determine the kind of life that person will have. A few male discussants reported thus: *"The life of individuals living in developed countries can not be compared with that of those of us living in Nigeria. In those countries there are job opportunities, security, good and subsidized health care services, sound basic and social*

amenities and so on. But here, we have virtually nothing". Respondents from the inner core areas emphasized on the need for money and security. They said that an elderly who has no money can never live a comfortable life and that feeling safe in day to day living is very important. A female discussant said: *"Money answereth all things. No money, no happiness".*

Table 4.6 Respondents' Perceived Social Relationship/Environment N=613

	Frequency	Percentage (%)
How much do you enjoy life?		
Not at all	1	0.2
A little	37	6.0
Moderately	183	29.9
Very much	392	63.9
How satisfied are you with your personal relationships?		
Not at all	6	1.0
A little	34	5.5
Moderately	256	41.8
Very much	317	51.7
To what extent do you have opportunity for leisure activities?		
Not at all	48	7.8
A little	229	37.4
Moderately	206	33.6
Very much	130	21.2
How safe do you feel in your daily life?		
Not at all	19	3.1
A little	37	6.0
Moderately	202	33.0
Very much	355	57.9

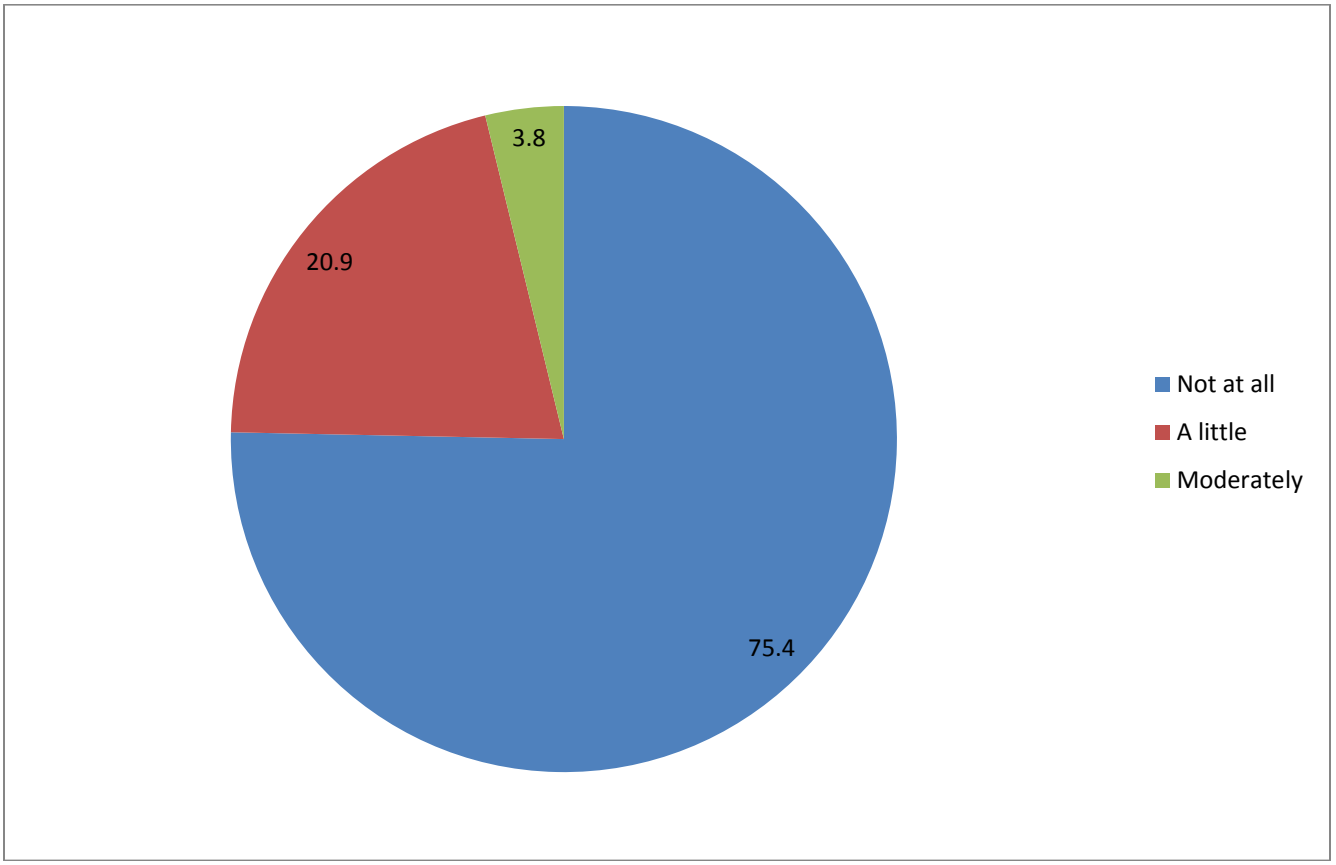

Fig 4.4 Respondents' report of their country's involvement in helping the elderly

4.7 Test of Hypotheses

Hypothesis 1 and 2: There is no significant association between the age and sex of the elderly and their perceived quality of life.

Table 4.7 shows the quality of life of respondents by selected socio-demographic characteristics. The selected characteristics are age, sex and marital status respectively. Taken as a whole, the results show that age, sex and marital status has significant association (p=0.05) with the quality of life of the elderly.

Table 4.7 Respondents' perceived quality of life by selected socio-demographic characteristics

	Quality of life scale (%)					
Variable	**Poor**	**Moderate**	**Good**	**Total**	**X^2**	**p value**
Age						
65-74	3.3	37.5	39.3	80.1		
75-84	2.1	8.5	6.5	17.1	9.7	0.002
85-94	0.3	1.3	1.0	2.6		
95 and above	0.0	0.2	0.0	0.2		
Total	5.7	47.5	46.8	**100**		
Sex						
Male	1.8	21.2	23.7	46.7	4.9	0.026
Female	3.9	26.3	23.1	53.3		
Total	5.7	47.5	46.8	**100**		
Marital status						
Single	0.2	0.2	0.3	0.7		
Married	2.9	34.3	38.3	75.4	16.8	0.000
Divorced/separated	0.8	1.1	2.0	3.9		
Widowed	1.8	12.1	6.2	20.1		
Total	5.7	47.5	46.8	**100**		

Hypotheses 3: There is no significant association between type of family/family structure of the elderly and the type of social support received.

Table 4.8 here shows the relationship between the type of family of respondents and the social support they receive. Test at p=0.05 shows that respondents from the nuclear family significantly received more social support than those from the extended family.

Table 4.8 Respondents' type of family is related to receipt of social support

	Type of Family (%)				
Variable	**Nuclear family**	**Extended family**	**Total**	**X^2**	**p value**
Who do you think gives you the highest level of social support?					
Immediate family	48.1	27.8	75.9		
Extended family	1.8	9.7	11.4	5.2	0.022
Neighbours	1.6	4.2	5.9		
Friends	4.1	2.3	6.4		
Others	0.2	0.4	0.5		
Total	**55.8**	**44.2**	**100**		

Majority of the discussants reported that care from the immediate family is the main thing to show that an elderly is living a good life. Social support according to them is the number one measure for quality of life in the elderly. A male respondent stated thus: *"If a man has all the money in the whole world and he doesn't have any one to care for him, he will most likely die earlier than normal".*

Hypotheses 4: There is no significant association between social support (having children and staying alone) and perceived quality of life of the elderly.

Results from independent t-test (Table 4.9) shows that quality of life was significantly better among those who had children (M= 48.7, SD= 7.8) than those who did not have (M= 42.5, SD= 11.8). Quality of life was also significantly better among those who were living with people (M=42.9, SD= 11.05) compared with those who were living alone (M= 49.5, SD= 7.5).

Table 4.9: Association between the quality of life of respondents who were staying alone, those who had children and those who were not

Variable	**Quality of life score (equal variances not assumed)**				
	Mean	**Standard Deviation**	**Significance (p. value)**	**95% confidence interval of the difference**	
Do you have children?				**Lower**	**Upper**
Yes	606	48.75	7.83	0.033	0.293	12.065
No	7	42.57	11.88			
Are you living alone?						
Yes	38	42.97	11.09	0.000	-8.640	-3.526
No	575	49.05	7.50			

P≤0.05

Majority of the respondents in the focus group discussions agreed that the social support they receive affects their life positively and that without social support, an elder's life can not be rated being full of quality. One of the discussants said thus:

"*Can an abandoned elderly say he/she is happy"?*

In conclusion, majority of the discussants in all male and female group sessions expressed the view that social support is an important aspect of quality of life and that social support affects their lives positively.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Discussion of Findings

Findings from this study show that there is a significant association between age and quality of life of respondents. In line with this, results from the research conducted by Adebowale *et al*, 2012 also show a strong association between age and wellbeing of respondents. Results also show that social support influences quality of life. This is consistent with the findings from a study carried out in Ibadan, Nigeria, that social factors were the strongest determinants of quality of life in the psychological, social and environmental domains and were next in importance to health factors for the physical domain (Gureje *et al*, 2008). Results from the study also show that the most important factors contributing to quality of life in the social domain were contact with friends, participation in community activities, availability of emotional support, and participation in family activities (Gureje *et al*, 2008). Similarly Golden, Rona´n, Conroy, Bruce, Denihan, Greene, Kirby and Lawlor, (2009) examined self-rated life satisfaction and happiness as key indices of hedonic wellbeing. Living, alone and being lonely was associated with a lower probability of being very happy or being satisfied with one's life.

5.1.1 Socio Demographic Characteristics of Respondents

The age distribution of the respondents showed that most of the elderly were aged 65-74 years, which corresponds with active ageing population by United Nations as those over 60 years of age. A few (2.6%) were between the ages 85- 94 years of age while only one (0.2%) was between the ages of 95 years and above. Although the life expectancy in Nigeria is put at 43 years by UNDP (2005), many Nigerians still live very long. The fact that majority (83.5%) were Yoruba is expected because of the study location. Ibadan is in Southwest Nigeria and is predominantly Yoruba. The proportion of elderly married, widowed, or unmarried were found to be in contrast with the study conducted by Singh, *et al* 1994. 24.8% of the respondents had primary education, (26. 9%) had secondary education, (22.5%) had

tertiary education and (25.8%) had none/Arabic education. A study by Lena et al in 2009 showed that almost half of the respondents were illiterate and around 37% had education up to the primary level. Padda, *et al.* , 1998 reported 38.6% illiteracy at Amritsar, while it was 78% in a study conducted in Tamil Nadu by Elango, 1998 and Singh, *et al* reported 80.2%.More than half (55.8%) were from nuclear families. This is in contrast study by Lena *et al* where almost more than half of the respondents who were interviewed were from joint families (56.8%), while 33% were from a nuclear family. Various studies by Padda, *et al.*, Singh, *et al.,* and Sivamurthy *et al.,* have brought out similar findings. The higher prevalence of nuclear families could be because of the urban study area.

5.1.2 Social Support

Factors that connote isolation, including participation in family and community activities as well as contact with family members and with friends, are the most germane social factors for the quality of life of elderly persons. These factors reflect the need of the elderly for social network, support and engagement (Bowling, 1994). It is likely that such factors are taking on increasingly more significant meaning for the elderly as social changes affect the structure of the traditional extended family and economic pressures lead to family members leaving for the cities. Results from this study shows that majority of the elderly were not living alone. Most of those who were not living alone were living with there families. This is similar to the findings of the study by Asiyanbola 2005, that majority of the elderly in Ibadan, Nigeria lives among their family but not in agreement with the study by Lena *et al*, 2009 that half of the people interviewed felt neglected by their family members.

However, this should not be interpreted as if the moral of care would be unchanged and the family would still function as before. Social and economic changes currently occurring have put into doubt the continued viability of traditional arrangements of care for the elderly. Findings on the change from traditional value and support for the elderly person and support system in this study agreed with the findings of several studies (Rahman and Barsky, 2003; Kowal *et al*., 2010; Smith and Goldman, 2007; Alberg-Yngwe *et al*., 2001) that stability in family contracts, socio economic status of the elderly accounts for the possibility that a reciprocal of relationship would exist between the elderly and their family members, and

ability to purchase needs in the culture where the studies were conducted. Another study also showed the fact that social support influences quality of life. Korean elderly are believed to have a family-based support system.

However, many studies have indicated that social contact with friends and participation in club or church activities made a greater contribution to improved quality of life (Lennartsson *et al*., 2003).The study deduced no significant relationship between education and perceived social support/QOL in contrast to the statement by Cornman *et al*, (2001) that the elderly who have a higher education are more likely to have consistently positive perceptions about available support and Piyathida et al, (2007) found that educated elders perceived higher levels of social support compared with elders who had had no schooling by a statistically significant difference ($p < 0.05$). Similarly, a study of Suwonnaroop (2002) found that education had direct influence on health-promoting behaviors, through social support among American older adults.

5.1.3 Physical Health

Physical incapacity is common for the elderly people (Sheela and Jayamala, 2008). Findings from the study revealed that only (25.4%) had good physical health. One of the respondents during the FGD sessions reported thus: *"Health is wealth. Without good health, no one can boast of a quality life".* This is in contrast with the study by Adebowale *et al*, 2012 which was conducted in North-Central Nigeria, that majority (59.0%) of the respondents have physical well-being classified as good. Results from the study by Olayiwola (2003) showed that self reported health status is such that 13% categorized themselves into poor health status, while 32% rated their health as good compared to others in their age groups whilst the majority scored themselves as fair (54%).

More than half (54. 5%) of the respondents reported that they had physical pains that prevent them from activities. It was found in a study conducted by Lawrence *et al* (1998) that musculoskeletal problems were the third most common morbidities found amongst the respondents. In previous studies amongst elderly African communities, osteoarthritis was one of the commonly observed problems (Ogunniyi *et al*., 2001; Clausen *et al*., 2000; Bella *et al*.,

1993). Osteoarthritis compromises mobility and consequently tends to impair social and occupational functioning (Clausen *et al*., 2000). It leads to dependency on others, especially family members. A study found out that many of its participants complained of joint and back pains (Nidhi and Bharti, 2009). This study which was on the physical needs and adjustment of the elderly also found that majority of the participants performs exercises regularly. This is in contrast with the findings of this study where less than half (44.4%) of the respondents performed exercises regularly. This could be because of physical changes in the body of the elderly and also the normal reduction in energy as the body grows old. Nidhi and Bharti also found that a sizeable (66%) proportion of their study participants had sleeping disorders which is in line with findings from this study. A similar study conducted by Pallesen (1998) show that (19.1%) of both elderly men and women were unsatisfied with their sleep, (11.3%) were neither unsatisfied nor satisfied and (69.6%) were satisfied with their sleep and Lasisi and Gureje, (2011) reported that 473(36.3%) of respondents had any symptom of insomnia.

5.1.4 Psychological Health

Overall only few of the respondents 17(2.8%) had poor psychological health, while 51.4% had good psychological health. This agrees with the study by Adebowale *et al*, 2012 that 53.3% of respondents had good psychological wellbeing. In addition to physical changes, elderly individuals also experience psychological and social changes. Some individual cope with these changes effectively but others experience extreme frustration and mental distress. It is important for the family members to be aware of the psychosocial changes and stresses experienced by the elderly (Sheela and Jayamala, 2008). Majority of the respondents 402(65.6%) in this study perceived that their life was very much meaningful, this do not agree with findings by Lena et al, 2009 that 47% of their participants felt unhappy in life.

An overwhelming proportion (85.5%) perceived no difficulty in relating with people around them. This could be because of the fact that quiet a number of the respondents were involved in community activities and social networks. More than half of the respondents (52.5%) had very good ability to recall things, this is in contrast with the study by Nidhi and Bharti where majority of the study participants had memory lapse.

5.1.5 Level of Independence

Activities of daily living are important indicators of the functional status and wellbeing of older persons (Maestre *et al.,* 2004). The loss of independence that functional disability connotes for elderly people is a common cause of life dissatisfaction for them (Gureje *et al,* 2008). Less than half (32.6%) of the respondents reported that aging has not reduced their ability to perform daily living activities. Findings from the study by Gureje et al, reported that cognitive impairment was not likely to affect quality of life in this environment. Whereas, Lena *et al* reported that almost 98% of the respondents felt that old age had affected their day-to-day life, among these, 86.4% felt that age had partially affected their daily activities. Financial problems add to the misery of the aged.

Having spent all their hard earned money on children's education and marriage, they are generally demoralized when their offspring refuse to give them shelter. No doubt, economic security is vital for the elderly. Only 59(9.6%) said they very much had enough money to meet their needs but in the study by Lena *et al,* around 56.3% were deprived of financial security. However very often this gets undue attention at the expense of psychological, social, occupational and cultural needs. 50.1% of the respondents perceived no problems with mobility. This is similar to findings deduced from a study carried out by Bohannon, 2006 and Tiago da Silva, 2009. Abuse of the elderly is a serious problem that is not well known although it is global. The issue is often complex and linked with other problems in the society such as age-discriminating attitudes. It is unacknowledged and regarded as a taboo to discuss in the open. When reported it is often dismissed as family or domestic issue that should be resolved in the home (Ajomale, 2007). This probably explains why majority of the respondents (71.1%) perceived no social challenge or abuse in their day to day activities. Less than half (42.7%) of the respondents reported of being a little bit dependent on medicinal aids to live a normal life.

5.1.6 Social Relationship and Environment

Findings from this study show a significant relationship between supports from the children and quality of life. This agrees with a Japanese study that determined that support from one's children is associated with positive mental health outcomes, more so than support from other

sources including spouses and friends. This finding contrasts with an earlier result from a study of older persons in the United States and India, where emotional support from a spouse is more important in determining well-being than is support from one's children (Venkatraman, 1995). Gureje et al, 2008 reported that the most important factors contributing to quality of life in the social domain were contact with friends, participation in community activities, availability of emotional support, and participation in family activities. Another study reported that affectionate support and positive social interaction had the most explanatory power on self-rated health status (Lim *et al*., 2003). It can be suggested that social support system should be extended and strengthened through the family system.

More than half (54.8%) were moderately satisfied with the conditions of their living place while a majority of the elderly are living in a deplorable housing condition in the study conducted by Asiyanbola in 2005. A total of 607 subjects mentioned at least one aspect that could improve their quality of life. The most mention is care for the elderly by the government (44.5%). This could be due to prevalence of family disintegration, in that the elderly now thinks the best way out is to plead with the government rather than wait for infeasible support from their families. Majority of the respondents 462(75.4%) reported that their country (Nigeria) has put in place no measures/policies to address the needs of the elderly. While it was observed in the study by Lena *et al* that only 35.7% were aware of the government welfare schemes for the elderly.

The relevance in personal relationships was observed during FGD sessions in accounts such as: "*As for me at this point in my life, seeing my children do well is enough for me"; If there is no one a human being can call friend, then that person's life is meaningless".* These observations are in accordance with the results reported by Vecchia and Bowling. Vecchia *et al*., 2005 found that 49% of the interviewees considered interpersonal relationships to be important, while Bowling *et al*., 2003 concluded that 81% of the interviewees made reference to the importance of social relationships for a positive quality of life. According to WHO, adequate social support for the elderly is connected to the reduction of morbidity and mortality and psychological disorders, as well as an increment in general health and wellbeing. Moraes and Souza, 2005 suggest that psychosocial support is one of the

significant and independent variables for successful aging. The financial aspect was another factor pointed out as important to quality of life. Majority (65.3%) reported that they had enough money to live everyday life. This is in contrast with the study conducted by Adebowale *et al* that only 20.5% of participants had enough money to meet their daily and health needs.

In Moraes and Souza's study, material comfort was one of the predictors for successful aging among elderly women, a premise corroborated by the present study; *"Money answereth all things. No money, no happiness".* Acquiring material goods during life can indicate more peace of mind in old age, as money can contribute to meeting the needs of the elderly and their family members, such as food, transportation, clothing, medical assistance and medication (Vecchia *et al*., 2005; Bowling *et al*., 2003).

5.2 Conclusion

This study has shown that quality of life of elderly persons is determined by demographic, health, physical, psychological and especially social factors. The condition of the aged has recently surfaced as one of the foremost social problems. Nigeria like many other developing countries in the world is presently witnessing the rapid growth of her population. Urbanization, modernization and globalization have led to change in economic structure, the erosion of social values, and the weakening of social institution such as the joint family. In this changing economic and social milieu, the younger generation is searching for new identities and the traditional sense of duty and obligation of the younger generation towards the older/aged generation is being eroded.

Like other members of the human race the basic and essential needs of the elderly such as food, adequate housing, healthcare, security, love and access to income in old age must be provided for the problems of elder to be solved. Policies should be formulated and resources allocated to provide for the well being of older persons. Ageing is a natural process and the right to live in dignity, free from all forms of abuse and exploitation are all that are required from the society. The isolated, lonely life troubled probably by illness makes the elderly vulnerable as targets for fraudulent schemes and violent crime. Therefore an enabling

environment where the older person can feel free from fear, abuse, violence, neglect and abandonment must be created. It is not a crime to grow old. It is even more of a privilege with the life expectancy of Nigerians put at 49 years for men and 53 years for women. The need to capitalize on the skills, wisdom, experience and resourcefulness of our elderly cannot be overemphasized. They remain the source of wise counseling and our link to the past. Without them the future is not secure. For there to be continuity in the human race the elderly should be accorded the proper respect and put in the right position. They should therefore live in dignity without fear, abuse and exploitation.

5.3 Implications for Health Promotion and Education

A crucial problem is the general assumption in Nigerian society that care for older people has always been provided by the extended social/family system – and that this provision of care services has always been adequate. This assumption is wrong. Families these days are no longer as integrated as before. An elderly without care will most likely have not only social, but health problems.

1. Old Age brings with it reduced capacity for work, as well as difficulties in accessing health care and other essential services, increasing the likelihood of older persons becoming and remaining poor. Some of the participants of this study reported of not being able to afford quality medical care due to inadequate availability of money. This is another issue that can pose a threat to the wellbeing of the elderly.

2. In Nigeria today, social security policies for old age are yet to be formulated. There is an increasing need in the wake of the apparent decline in the adequacy of material family support that has been occurring. Some of these elderly people are being exposed to loneliness and poverty. The lack of a social security system for older people worsens this situation.

3. The present economic realities of Nigeria with a harsh government reform programme, with little or no consideration for the older people has created a lot of elderly beggars.

4. The standard in the care homes in Nigeria is inadequate; most of them are owned by religious organizations such as the Catholic Church. Some of these homes are hospices where young people with terminal diseases or babies with life-threatening diseases are also kept (Ajomale, 2007). This could pose a threat to the health of the elderly and thereby shorten their life span

5.4 Recommendations

The decline in the economy, gradual disintegration of the extended family system, unemployment, increasing female employment to complement family income, as well as rural-urban migration all contribute to the noticeable decline in the level of care provided by the family in recent times. The participation of government at all levels, Federal, Regional (States) and Local Councils, in the provision of services to the older person is minimal. The Nigerian government and political leaders believe that the provision of care is the responsibility of families. Policy emphasis is more on young people, women and children. Based on the findings from this study, the following recommendations are made thus:

1. In Nigeria, a national policy on the care and welfare of the elderly with sections on elder care should be put in place with local, state and Federal Governments.

2. The society should be made to know that the elderly constitute a positive force in the society. Primary intervention and prevention methods can be established to build a society where elderly persons live in dignity and respect have access to the basic needs of life and with opportunities for self fulfillment.

3. The government should make available, state provision of elder care in Nigeria, to provide the needs for the survival of the older people so as to ease their families of sole provision of basic needs and care. Government need to pay more attention to the elderly health care need and other needs of the elder by setting up social security programme that adequately caters for the health and other needs of the older population.

4. Non Governmental Organizations and faith-based organizations should make effective contributions to the service provision to older people through day-care centres, residential homes, libraries, regular medical check-up's, creating a forum for raising the awareness on older people's rights and avenues to seek redress when necessary.

5. There is a need for health insurance for the older people to ease the pressure of elder health care expenses on the family income or pensions. These will greatly reduce the burden of elder health expenditure on the family income and hence make more resources available for other family consumables which will in effect reduce pressure on the elders in the family and hence allow them to live longer.

It is important to recognize that older persons are not a homogeneous group. They have different interests, needs, hopes and fears. Social and economic programmes must take into account the elderly as individuals, rather than the aged as a proportion of the total population, in order to ensure that the diverse needs of older people are met (Population ageing 2002)

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APPENDIX I

QUESTIONNAIRE

PERCIEVED QUALITY OF LIFE AND SOCIAL SUPPORT RECEIVED BY THE ELDERLY IN IBADAN NORTH LOCAL GOVERNMENT AREA, OYO STATE.

Dear respondents,
My name is Awobiyi Damilola Olawumi, a Master of Public Health (MPH) student of the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Oyo State. This questionnaire is an instrument designed to investigate the types and level of social support that the elderly in Ibadan North Local Government Area receive and their perceived quality of life. This will help Public Health professionals plan ways of enabling/empowering the elderly to improve their health/wellbeing. Your consent to participate and to give full, honest and correct information will be appreciated.

Please be informed that there is no right or wrong answers to the questions I will ask you. Also, I wish to inform you that participation is voluntary, your identity, responses and opinions will be kept confidential and your name is not required in filling the questionnaire. You are also free to ask questions as the survey progresses.

Thank you Sir/Ma for your cooperation

Interviewer: If respondent agrees to participate, please mark this box ☐

Date	
Name of community	
Identification No	
Interviewer code	

NOTE: Please mark the appropriate options, thank you.

Serial Number _____

SECTION A: SOCIODEMOGRAPHIC VARIABLES

1. Age_____(in years)
2. Sex i. Male ( ) ii. Female ( )
3. Marital Status i. Single ( ) ii. Married ( ) iii. Divorced
   iv. Widowed ( ) v. Others (specify)……..
4. Educational Status i. Primary education ( ) ii. Secondary education ( )
   iii. Tertiary education ( ) iv. None ( ) v. Others (specify)…….

5. Religion i. Christianity ( ) ii. Islam ( ) iii. Traditional
   iv. Others (specify)……..
6. Ethnic group i. Yoruba ( ) ii. Igbo ( ) iii. Hausa ( )
   iv. Others (specify)……
7. Type of Family i. Nuclear family ( ) ii. Extended family ( )
   iii. Polygamous family ( )
8. Occupation i. Trading ( ) ii. Civil Servant ( ) iii. Farmer ( )
   iv. Private Business ( ) v. Retired ( ) vi. Others (please specify)……
9. How long have you lived in this community? _____ Full years.

SECTION B: TYPES/SOURCES OF SOCIAL SUPPORT RECEIVED

10. Do you have child/children? i. Yes ( ) ii. No ( ) [If no, go to question 14]
11. If yes do your child/children visit you regularly? i. Yes ( ) ii. No ( )
12. If your answer is no, why do you think they don't? _____
13. Do your children provide means for your basic needs regularly? i. Yes ( ) ii. No ( )
14. Are you living alone? i. Yes ( ) ii. No ( )
15. If no, who are you living with? _____
16. Who helps you with your daily jobs, e.g. shopping and cleaning? _____
17. Do you feel you need more help from people? i. Yes ( ) ii. No ( )
18. Presence of children, neighbors, members of extended family e.t.c, makes you feel happy, healthy and loved? i. Yes ( ) ii. No ( )
19. Are you involved in any kind of social network like being a member of a social club or society? i. Yes ( ) ii. No ( )
20. Do you participate in community activities? i. Yes ( ) ii. No ( )

SECTION C: PHYSICAL HEALTH

21. How would you rate your physical health? i.Very good ( ) ii.Good ( ) iii. Fair ( )
    iv. Not good ( )
22. Do you feel physical pains that prevent you from doing what you need to do?
    i. Yes ( ) ii. No ( )
23. Do you perform exercises regularly? i. Yes ( ) ii. No ( )
24. Do you have enough energy for everyday life? i. Yes ( ) ii. No ( )

25. Do you have any problem with sleeping well? i. Yes ( ) ii. No ( )

SECTION D: PSYCHOLOGICAL HEALTH

	Not at all	**A little**	**Moderately**	**Very much**
26. To what extent do you feel your life to be meaningful?				
27. How often do you have negative feelings such as, despair, anxiety, depression?				
28. Are you able to accept your bodily appearance?				
29. How well are you able to recall things?				
30. Do you find it difficult to relate with people around you?				
31. Has aging reduced the level of respect you receive from people?				

SECTION E: LEVEL OF INDEPENDENCE

	Not at all	**A little**	**Moderately**	**Very much**
32. Has aging reduced your ability to perform daily living activities?				
33. Are you satisfied with your capacity for work?				
34. Do you have any problem with mobility (moving around)?				
35. Are you dependent on medicinal aids to live a normal life?				
36. Do you face any kind of abuse/social challenges in your day to day activities?				

SECTION F: SOCIAL RELATIONSHIP/ENVIRONMENT

	Not at all	A little	Moderately	Very much
37. How much do you enjoy life?				
38. How satisfied are you with your personal relationships?				
39. Do you get the emotional help and support you need from your family?				
40. How satisfied are you with the conditions of your living place?				
41. To what extent do you have the opportunity for leisure activities?				
42. How safe do you feel in your daily life?				
43. Do you have enough money to meet your needs?				
44. To what extent do you think your country has put in place measures or policies that could address the quality of life of the elderly?				

APPENDIX II

FOCUS GROUP DISCUSSION GUIDE

INTRODUCTION

I greet you Sirs/Mas for accepting to participate in this discussion. My name is Awobiyi Damilola Olawumi and I will be moderating our discussion. This discussion is a research study that intends to assess the perceived quality of life and social support received by the elderly people. During this discussion, any view(s) expressed by the study participants will not be judged right or wrong and everybody is free to express views on any issue pertinent to the discussion.

The discussion will be kept confidential and will only be used for the purpose of the research work to effect policy formulation. Thank you for your anticipated co-operation.

DISCUSSION

1. In your own point of view, what do you understand by quality of life: constituents and factors that influence it?
2. In your own point of view, how does quality of life relate to the elderly?
3. What do you understand by social support: types, sources and factors that influence it?
4. In what ways does social support being received by an elderly affect his/her quality of life?
5. What social challenges do you think the elderly in this community face on a day to day basis and how does it affect them?
6. What measures in your own opinion, should be used to assess the quality of life of an elderly?
7. In your own perception, do you think the social support you receive affect your quality of life positively? (probe further).

Thank you for taking your time to participate in this discussion.

APPENDIX III

ITOSONA AKOJOPO IFOROJOMITORO ORO LAARIN EGBE

Ifaara

Eku owuro, osan tabi ale. A dupe lowo yin fun akoko ti e fi sile lati wa nibi fun ise Pataki yii. Oruko mi ni **Awobiyi Damilola Olawumi**, eni to yoo gba oro sile ni _____
Ile iwe agba ti ilu ibadan ni a ti wa. A si gbagbo wipe e ti ni imo ti o kun nipa **ibabgepo ti awon abalagba nri gba ati iru oju ti won fin wo iru aye ti won gbe**. Nipase eyi, afe ki e ba wa jiroro. Gbogbo awon oro ti e ba fun wa ni a o lo fun iwadii ni eyi ti a gbagbo pe yoo ran awon ti o gboye ninu eto eko ilera gbogbogbo lati seto ona ti won yoo fun awon agbalagba ni igunpa lati mu ilera won dara si. Ejowo, e turaka lati so gbogbo ohun ti o ba wa lokan yin, e si le ma faramo ohun ti apa keji ba so ni akoko iforowero. Ki a to te siwaju, mo da labaa ki a fi ara wa han lati ma se le gbagbge ohun gbogbo ti a ba so. Ni akoko iforojomitoro oro yii a o ko ohun ti e ba so sile.

Oluforowanilenuwo: Ti eni ti yoo da o lohun ibeere re ba gba lati da si eko yii, fa ila si inu akamo yii ☐

Bayii, n o te siwaju ninu awon ibeere yii.

IFOROJOMITORO ORO

1. Ni ero tire, kini o mo ton je igbe aye iderun, atipe awon ohun wo lale so pe o je eroja ati agbateru fun?
2. Ni ero tire, bawo ni iru igbe aye yii se je mo ti agbalagba?
3. Kin ni o mo ti o nje atileyin ti o je mo ibakegbepo : iru re, orisun ati awon ohun ti o n se agabateru fun ?
4. Ni ona wo ni atileyin ibakegbepo ti agbalagba n ri gba se ni ipa lori igbesi ayee re ?
5. Ipenija wo ti o je mo ibakegbe ni o ro wi pe awon agbalagba ni agbegbe yii n dojuko ni ojoojumo ati pe ba wo ni ose ni ipa lori won to ?
6. Kin ni o ro wi pe o le je osuwon ti a gbodo lo lati mo iru aye ti agbalagba ye kio gbe ?
7. Ni imo tabi ikiyesi tire, nje o ro wi pe atileyin ikegbepo ti o n ri gba n ko ipa to ni itumo lori igbe aye re ni ona to to ? (Se iwadi siwaju sii).

Ese fun akoko yin ti e fi sile lati je alabapin ninu iforowero yii.

APPENDIX IV

IBEERE FUN IWADII LORI IRU ATI IPELE IBAGBEPO TI AWON AGBALAGBA NRI GBA ATI IRU OJU TI WON FIN WO IRU AYE TI WON GBE NI IJOBA IBILE TI ARIWA IBADAN NI IBADAN, IPINLE OYO.

Iya tabi baba tia n ba jiroro,

Oruko mi ni **Awobiyi Damilola Olawumi** ti mo n kekoo gboye ni eka ti ilera gbogbogbo, akekoo tie ka ti itesiwaju ati eko ti ilera, eka ti ilera gbogbogbo ti ile eko ti ilera ti yunifasiti ti ti ilu Ibadan. A gbe ibeere kale gege bi elo lati se iwaadi **iru ati ipele ibagbepo ti awon agbalagba ni Ibadan, ni ijoba ibile ti ariwa ti Ibadan, ti won n ri gba ati iru oju ti won fin wo iru aye ti won n gbe**. Eleyii yoo ran awon ti o gboye ninu eto eko ilera gbogbogbo lowo lati seto ona to won yoo fi fun awon agbalagba ni igunpa lati mu ilera won dara si. Ifohunsokan yin lati je alabapin ati lati fun wa ni koko oro ti o kun ati eyi ti o tona ni inu wa yoo dun si lopolopo.

Jowo mo daju wi pe ko si idahun ti o tona tabi ti o kuna si gbogbo ibeere ti n o bi yin. Bakan naa, mo tun fe so fun o pe jije alabapin kii se dandan, idanimo re, idahun re ati gbogbo oro re ni a o fi si ipamo, ko si nilo ki o ko oruko re sori iwe ibeere yii. O fun ni anfaani lati beere ibeere bi a ba se n te siwaju ninu ise yii. Ese Sa/Ma fun ifowosopo yin.

Oluforowanilenuwo : Ti olufe yii ba gba lati je alabapin ninu ise yii je ki o fa igi beeni sinu akamo yii ☐

Nonba idanimo_____

Ojo _____

Idanimo oluforowanilenuwo_____

Oruko agbegbe _____

Nonba bi o se telera _____

Akiyesi Pataki: Jowo fagi si eyi ti o ba tona. E se

ABALA AKOKO : ORO TI O JE MO AGBEGBE ATI IWO FUNRARE

1. Ojo ori _____ (ni odun)
2. Okunrin tabi Obirin i.Okunrin ( ) ii. Obirin ( )
3. Ipo igbeyawo i. Adawa ( ) ii. Oti gbeyawo tabi oti wole oko ( )
   iii. Oti fi iyawo tabi oko re sile ( ) iv. Opo ( ) v. Omiran ( )
4. Ipo Eko i. Alakobere (piramiri) ( ) ii. IIe eko agba sekondiri ( )
   iii.Ile eko giga yunifasiti ( ) iv. Oo kawe rara ( ) v. Omiran ( )
5. Esin i. Kirisitiani ( ) ii. Musulumi ( ) iii. Aborisa ( ) iv. ( ) Omiran ( )
6. Iran re i. Yoruba ( ) ii. Ibo ( ) iii. Hausa ( ) iv. Omiran ( )
7. Iran ebi re i. Oko kan, aya kan ati awon omo ( )
   ii. ( ) Oko, iyawo, omo, ati awon ebi miran ( ) iii. Olopo iyawon ( )
8. Ise re i. Owo sise ( ) ii. Osise ijoba ( ) iii Onise ile ( ) iv Agbe ( )
   v. Ise ara eni ( ) vi. Osise feyinti ( ) vii. Omiran ( )
9. Igba wo ni o ti n gbe ni agbegbe yii? _____ (iye odun)

ABALA KEJI: IRUFE/ORISUN IRANLOWO ATI IBANIGBEPO TI AWON AGBALAGBA N GBA

10. N je o ni omo/awon omo bi? i Beeni ( )
    ii Beeko ( ) [ti o ba je beeko lo si ibeere kerinla]
11. Ti o ba je beeni n je omo/awon omo re n be o wo loorekoore bi?
    i Beeni ( ) ii Beeko ( )
12. Ti ibeer e re ba je beeko, kini idi re ti o fir o pe won kii fi be o wo? _____
13. N je awon omoo re n pese jije mimu fun o loorekoore ati awon ohun ti o nilo fun gbigbe re? i Beeni ( ) ii Beeko ( )
14. Se o n dagbe ni? I Beeni ( ) ii Beeko ( )
15. Ti o ba je beeko, iwo ati ta le jo n gbe abi talo n gbe lodo re? _____
16. Talo n ran o lowo lati se ise ilee re lojoojumo tabi nidi okowo re (oja tita)? _____

17. N je o n darapo lati ba won se egbe ti o je mo ibagbepo abi boya o tile je okan ninu omo egbe naa? i Beeni ( ) ii Beeko ( )
18. N je o maa n darapo lati jo sise agbegbe re bi? i Beeni ( ) ii Beeko ( )

ABALA KETA: ILERA AGO ARA

19. Kin ni o le so nipa ilera re? i Odara gan-an ( ) ii O dara ( ) iii Odara die ( ) iv Ko dara rara( )
20. N je o maa n ni awon irora kan ni ago ara re eyi ti o maa n dena re lati se awon ohun ti o nilo lati se? i Beeni ( ) ii Beeko ( )
21. N je o n se idaraya loorekoore? i Beeni ( ) ii Beeko ( )
22. N je o ni okun ti o to fun gbogbo igba bi? i Beeko ( ) ii Beeko ( )
23. N je o ni isoro pelu orun sisun? i Beeni ( ) ii Beeko ( )

ABALA KERIN: ILERA TI O JE MO ERO

	Rara	**Die**	**Niwonba**	**Gan-an-ni**
24. Bawo ni o se ro wi pe aye re nitumo si?				
25. N je o gba bi o se ri ni ago ara re bi?				
26. Bawo ni o se maa n ri ni ago ara re ti won ba fowo ba o, eyi ti o n fa ero ti ko dara dani boya bii aniyan, ainireti tabi irewesi?				
27. Bawo ni o se maa n ranti nnkan daradara si?				
28. N je didagba si re n din ibowo fun re ku lati odo awon eniyan?				
29. N je o ni isoro lati ni ajosepo pelu awon eniyan ti o yi o ka bi?				

ABALA KARUN-UN: IPO OMINIRA

	Rara	**Die**	**Niwonba**	**Gan-an-ni**
30. N je didagbasi re n din ati se ohun ti o ye kio o se ku?				
31. N je agbara ti o fin sise te o lorun bi?				
32. N je o ni isoro nipa lilo kaakiri bi? (nipa lilo moto, wiwo takisi abi fifi ese rin)				
33. N je o gbekele awon oogun kan ni ilana ti isegun oyinbo lati gbe igbe aye re bi?				
34. N je o dojuko awon eebu kanti o je mo ibagbepo eyi ti o n mu awon ipenija kan ba o ninu igbe aye re lojoojumo?				

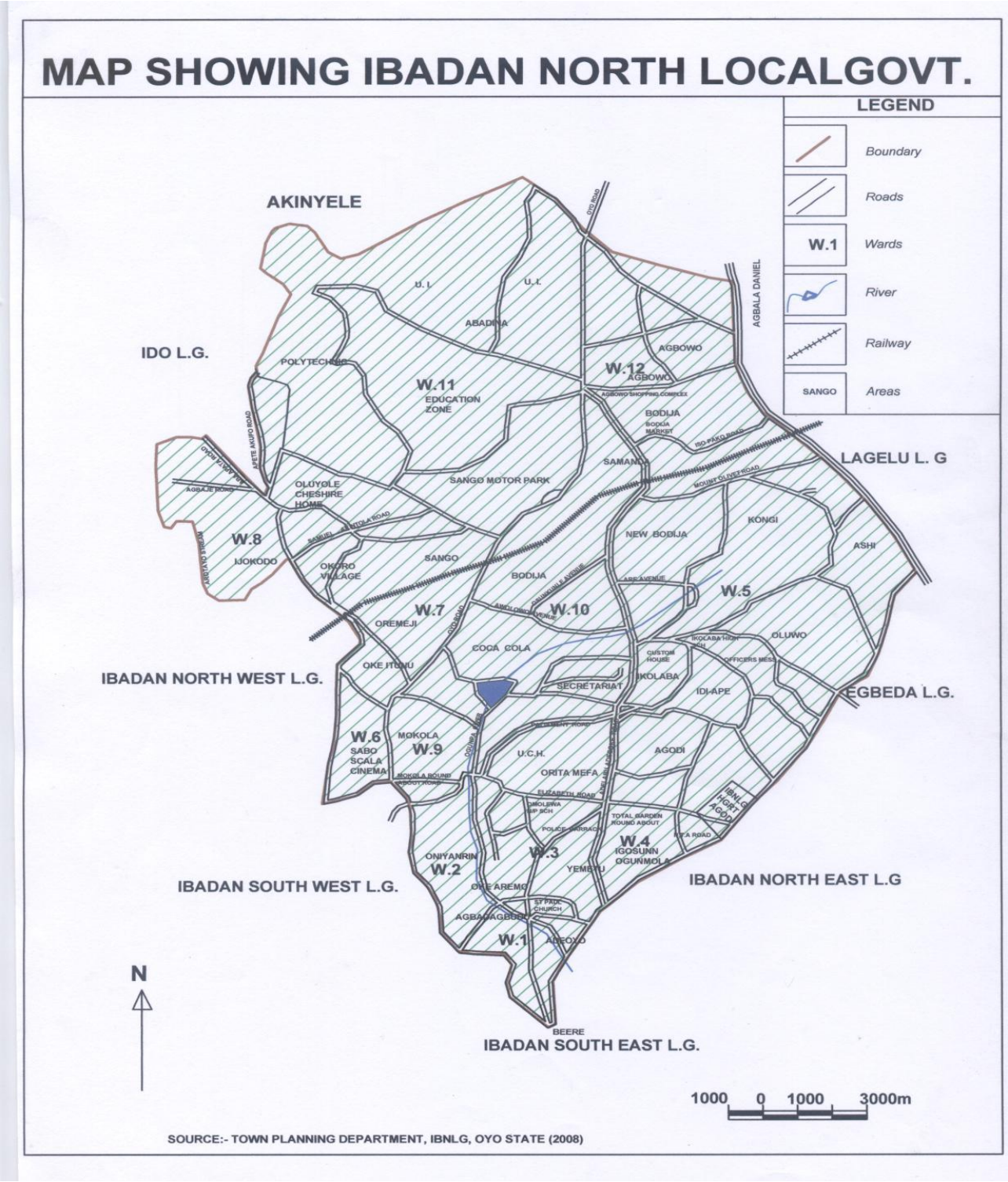
ABALA KEFA: AJOSEPO/AYIIKA TI O JE MO IBAGBEPO

	Rara	**Die**	**Niwonba**	**Gan-an-ni**
35. Bawo ni o se n gbadun aye re si?				
36. N je ajosepo re pelu awon eniyan te o lorun?				
37. N je on ri iranlowo gba lori imi edun re ati aduroti ti o ye lodo awon ebi re?				
38. Wiwa awon omo o re, alabagbepo re, awon ebi re ti o gbooro (egbon, baba, iya, aburo, ati beebelo) maa nmu o dunnu, wa ni ilera abi nje ki o gboorun ife?				
39. N je ibi ti o n gbe te o lorun bi?				
40. N je o ni anfaani fun awon nnkan miiran ti o mu igbe aye derun ati pe bawo ni o se ni anfaani naa si?				

41. N je o leero wi pe aabo wa fun o ni ojoojumo ayee re?				
42. N je o ni owo ti o to lati gbo bukata re?				
43. Se o ni anfaani fun sise awon nnkan ti o maye derun?				
44. Nibi ni o mo ti orile ede re tabi igbese wo ni o mo ti orile ede re ngbe lati dasi iru igbe aye ti awon agbalagba n gbe?				

APPENDIX V

STREET MAP OF IBADAN NORTH LGA



TELEGRAMS.....

TELEPHONE.....

MINISTRY OF HEALTH

DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION

PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. .....

All communications should be addressed to the Honourable Commissioner quoting

Our Ref. No: AD 13/479/158

Date: 19th October, 2011

The Principal Investigator,
Department of Health Promotion & Education,
Faculty of Public Health,
College of Medicine,
University of Ibadan,
Ibadan.

Attention: Awobiyi, Damilola Olawumi.

Ethical Approval for the Implementation of Your Research Proposal in Oyo State.

This acknowledges the receipt of the corrected version of your Research Proposal titled *''Perceived Quality of Life and Social Support Received by the Elderly in Ibadan North Local Government''.*

The Committee has noted your compliance with all the ethical concerns raised in the initial review of the proposal. In the light of this, I am pleased to convey, to you, the approval of the committee for the implementation of the Research Proposal in Oyo State, Nigeria.

Please, note that the committee will monitor, closely, and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of the findings as this will help in policy making in the health sector.

Wishing you all the best.

OYO STATE RESEARCH ETHICAL REVIEW COMMITTEE
Signature & Date
MINISTRY OF HEALTH, IBADAN

Mrs V.A. Adepoju
Director, Planning, Research & Statistics
Secretary, Oyo State Research Ethical Review Committee.