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Predictors of Quality of Life among the Elderly in Ibadan Metropolis, Oyo State

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Abstract
This study examined the extent to which depression, social support, socioeconomic status, and religiosity predicts quality of life among the elderly in Ibadan metropolis. Descriptive survey research design of correlation type was used in the study.
Six major communities were randomly selected within Ibadan metropolis and three hundred elderly men and women with mean age of 70.7years comprising of 187(62.3%) females and 113 (37.7%) males selected using purposive sampling technique participated in the study. Instruments used for data collection were,; Zung Self-rating Depression Scale (.73), Perceived Social Support Scale (.81), Spirituality Scale (.79), World Health Organization Quality Life Questionnaire (WHOQOL BRIEF .89), Socio-economic Status Scale (.73). Data analyzed using Pearson Product Moment Correlation (PPMC) and Multiple regression analysis at 0.05 level of significant.
Social support made the most significant contribution to the prediction of quality of life (β = .408, $p<.05$), socio-economic status (β=.277, $<p.05$), religiosity (β=.232, $p<0.05$) while depression yielded (β= .013 $p<0.05$). Precisely the predictors contributed 51.8 %(adjusted R^2 = 0.518) to the variance of the criterion variable. Based on the findings, it was recommended that social support network of the elderly should be strengthened through the family system .to enhance their quality of life

Keywords: Elderly, Depression, Quality of life, Religiosity, Social support, Socio-economic status

Introduction

In the light of United Nations (2011) report of a rapid increase in the population of the elderly and an estimation that the number of older persons would exceed the number of children by 2045 in most developing countries compared to developed countries; 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 (Sarvimaki and Stenbock-Hult, 2000). Therefore, apart from maintaining health and social participation, improving the quality of life of the elderly in developing countries has become one of the public health challenges of the 21st century. Quality of life (QOL) is used to evaluate the general well-being, meaning and value of individuals and societies. However, it is worthy of note that within different societies there are widespread core values and their absence or presence provides a means for the measure of QOL.

Quality of life is a subjective and multidimensional concept, defined as dynamic interactions between the external conditions of an individual's life and the internal perceptions of those conditions (Browne, et al., 1994). It incorporates in a complex way the persons' physical health, psychological state, level of independence, social relationships, personal beliefs and their relationships to salient features of the environment. According to World Health Organization (WHO, 2011) quality of life (QOL) is an individual's perception of his/her status in life in the context of the individual's environment, belief systems and goals. Minayo, (2003) provided a comprehensive indices of QOL as including motivations and social indicators, such as functional position (activities of self care, mobility, physical activities and performance of roles), disease and symptoms related to the treatment, social functioning (social activities and relationships), mental health (mood, self- esteem, well-being perception), spiritual and existential development, cultural values, environment security (suitable residence, economic income), love, freedom, happiness, satisfaction, among others. Simply put, QOL examines how people live, feel and understand their daily lives.

Consequently, quality of life is the extent to which objective human needs are fulfilled in relations to personal or group perceptions of subjective well-being which reflects an interaction of human needs and

a broad view of subjective perception of their fulfilment. Given its comprehensive nature and close link to an individual's feeling and perceptions, quality of life has an intrinsic and intuitive value. It is closely related to one of the basic desires of humans, which is to live well and feel good (Fleck, 2008). In sum, quality of life is an indicator of well-being and involves the process of optimizing health and enhancing active ageing of the elderly while mindful of differences between individuals in respect to health, physical capabilities, cognitive functioning, and social integration in old age (Clemens, 2012).

Depression is a serious condition which impacts every area of life. Depression is a debilitating and globally common mental disorder affecting an estimated 350 million people worldwide (WHO, 2012). It is characterized by sadness, loss of interest in activities and by decreased energy, fatigue and excessive tiredness, as well as with psychomotor changes and projected to become the third leading cause of disability world-wide by 2020. It is differentiated from normal mood changes by the extent of its severity, the symptoms and the duration of the disorder (WHO, 2011). In addition depressive symptoms and disorders are frequent causes of emotional and physical suffering and are associated with elevated risks of impaired quality of life. This may be attributed to deteriorating body functioning in older adults which is presumed to increase biological vulnerability to depression (Dan, Blazer, and Hybels 2005). The prevalence of depression increases with age as more issues were found in older adults. Studies have reported that there is a relationship between depression and quality of life and that presence of depressive symptoms lowers the quality of life and low quality of life increases chances of developing depressive symptomatology (Stordal, Mykletun, & Dahl 2003; Dan, Blazer, and Hybels 2005;Gureje, Ademola, & Olley, 2008; Miedzianowski, 2015).

In addition, extant studies reported that meaningful social relationships; in other words, social support are vital for elderly who may likely depend on others to perform salient routine activities and also provide a sense of security and opportunities for companionship and intimacy needed for their well-being (Melendez-Moral, Charco-Ruiz, Mayordomo-Rodriguwz & Sales-Galan, 2013; McNicholas, 2002; Fajemilehin, 2009; Giang and Dfau, 2009). Social support is widely regarded as valuable resources comprising tangible and intangible

forms of assistance that individuals receive from family and friends. 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 an individual perceive to be available or that are actually provided to them by non-professionals in the context of both formal support groups and informal helping relations. This implies that two categories of social support can be deduced - objective and subjective social support. Objective social support indicates what people have actually received or report to have received while on the other hand is the subjective perception, which captures an individual's beliefs about the available support (Faber and Wasserman, 2002). The need for support and the amount of support received by old people is of a major concern as older people become the beneficiaries of reciprocity within a network of mutual dependence. Studies have shown that positive social relationship (with family, friends, and neighbours) promotes quality of life. In contrast, decreased social contacts which could occur through loss of members of a social network is significantly associated with poor quality of life (Sok,& Choi, 2012; Chan,et.al.2006), Higher levels of social support has also been linked to reduced risk of mental disorders, diseases, mortality and improved quality of life (Reblin, & Uchino, 2008).

Socioeconomic status (SES) is an economic and sociological combined total measure of a person's work experience and of an individual's or family's economic and social position in relation to others. It is a broad perspective involving a myriad of psychological and sociological mechanisms. It is mostly assessed based on income, education and occupation (National Center for Educational Statistics, 2008). According to Karcharnubarn, Rees, & Gould (2007) the socioeconomic situation of the elderly in developing countries is generally lower than those in developed and economically vibrant countries. However, low socioeconomic status has been reported to negatively affect quality of life and ability to live independently in old age. The variations in quality of life resulting from low SES also lead to unfavourable course in several health outcomes with an indication that lifetime poverty since childhood has a strongly negative impact on health outcomes later in life, particularly in late adulthood and old age. This is attributed

to increased earlier onset of health challenges and invariably a poor quality of life (Herd, Goesling, & House 2007; Moody-Ayers, Lindquist, Sen, & Covinsky, 2007). Also, elderly people who have adequate income do not have to worry about finances, they are confident and live comfortably, they have time to participate in social activities, sports and health care activities which gives room for improved QOL. While others with low economic power have to source for money even at old age hence have to worry about meeting financial obligation and in effect haw poor or lower QOL.

Furthermore, having a sense of financial independence and security and attaining financially independence has been described as a function of SES which gives an individual a sense of worth, pride and value. Therefore, inability to achieve the desired financial independence and security negatively affects the quality of life especially when the elderly is grossly dependent on significant others for everyday living. Low and Molzalin, (2007) reported that elderly with high socioeconomic status tend to enjoy more financial security than those in lower and middle levels of socioeconomic status. Gureje and Oyewole (2006) avers that social changes arising from dwindling finances and poor SES may affect the position of the elderly in the society and lead to a reduction in their social status and influence in the community and which may have negative impact on the quality of life.

With respect to religiosity, previous studies maintained that religious practices bring a heightened sense of effectiveness, credibility, and dignity in older age and improve older people's decisiveness around seeking out meaningful and satisfying activities (Pargament et al., 2000; Low & Molzahn, 2007; Sturz & Zografos, 2014). In addition, as people age, a sense of mortality tends to increase, and the tendency to depend on religious organizations to fulfil the physical, emotional, and social needs also increases. Therefore, many turn to religious activities in order to deal with the heightened sense of mortality in the face of the inevitable problems associated with aging. According to Hill and Pargament (2008) religiosity is traditionally conceptualized as the degree to which one adheres to an organized system of beliefs, practices and rituals intended for facilitating closeness to the sacred or a higher power. Allport and Ross (1967) argued that people can live with both personally and socially oriented religiosity and proposed two

types of religiosity: intrinsic and extrinsic religiosity. Intrinsic religiosity involves internal spiritual beliefs, general attitudes or values toward religion and spirituality, or other religious and spiritual practices that are personal. In contrast, people with extrinsic religiosity consider religion as an instrumental means to solace and sociability that involves religious membership, social activities, or preference for their own religion.

Moreover, in old age, religious institutions such as churches, temples and mosques apart from being a place of worship, serves as a focal point for interaction where friends meet, families gather, and exchange of supportive activities take place. As stated by Agli, Bailly and Ferrand (2015), religious practices provide significant opportunities for meaningful social interaction in older age by integrating families and providing encouragement for an active family life. This implies that since for most elderly people there are limited opportunities for socialization hence, close and meaningful connections through engaging in religious activities become extremely important as a source of enjoyable activity (Anabere & DeLilly, 2013; Andresen & Puggaard, 2008). In essence, relationship with God and nurturing this relationship through engaging in religious activities becomes an important way to experience the desired intimacy. Ironically, despite the benefits of religiosity, certain aspects of religiosity may create more harm than good for several reasons. First, religion may induce anxiety when it fosters psychologically harmful feelings such as guilt and shame or when it promotes adverse attitudes towards others and encourages unquestioning devotion and obedience or beliefs that tend towards being fanatical (Chatters, 2000; Nooney & Woodrum, 2002). Second, strained interactions with fellow church members could lead to depressive outcomes (Krause, Ellison, & Wulff, 1998). That being said, religious doubt or a feeling of uncertainty towards religious beliefs has been associated with negative mental health outcomes (Krause &Wulff, 2004).

From the fore-going, it suggests that with increased life expectancy of the elderly is the challenge of ensuring having a population of elders with positive quality of life which will make living worthwhile. However, there is a tendency that an elderly who is depressed will be vulnerable to negative quality of life. Likewise, the dwindling nature of

family cohesiveness and the erosion of the extended family system have created a society of socially isolated people. Also, with majority of the elderly grappling under the weight of unpaid pensions after serving the country in various capacities makes the dream of financial independence and security a mirage. Little wonder that majority revert to religion for solace in the face of the myriads of challenges. Therefore, this study seeks to investigate the predictors of quality of life among elderly in Ibadan metropolis.

Objectives of the Study

The main objective of this study is to examine the extent to which depression, social support, socioeconomic status, and religiosity will predict quality of life among the elderly in Ibadan metropolis. The specific objectives are to;

- Examine the relationship that exists between depression, social support, socioeconomic status, and religiosity and quality of life of the elderly in Ibadan metropolis.
- Ascertain the joint contribution of depression, social support, socioeconomic status, and religiosity to quality of life of elderly in Ibadan metropolis.
- Determine the relative contribution of depression, social support, socioeconomic status, and religiosity to quality of life of elderly in Ibadan metropolis.

Research Questions

1. Is there any relationship among the independent variables (depression, social support, socioeconomic status, and religiosity and quality of life of the elderly in Ibadan metropolis?
2. What is the joint contribution of depression, social support, socioeconomic status, and religiosity and quality of life of the elderly in Ibadan metropolis?
3. What is the relative contribution of depression, social support, socioeconomic status, and religiosity to quality of life of the elderly in Ibadan metropolis?

Methodology

Research Design

The study adopted the descriptive survey research design of correlational type, which relies mainly on primary data. The opinion, perception and reactions of the elderly within the age bracket of 65 years and above in selected areas within the Ibadan Metropolis. The study population also embraced different categories of the aged in Ibadan which include the retirees, those who are still actively engaged in one activity or the other e.g. business but who are in the stipulated age bracket

Sample and Sampling Techniques

The sampling techniques used in selecting the samples for the study were non-probability sampling technique. In this technique, normal distribution of the population is not assumed unlike the probabilistic sampling. In this present study, for the purpose of clarity, purposive or judgmental sampling which is one form of non-probabilistic techniques was used. It involves the use of participants that were available during the time or period of research investigation. Purposive sampling technique was employed in this study. This is because the aim was to obtain information from a particular type of element. Elderly people who have attained the age of sixty-five (65) years and above in selected areas within Ibadan metropolis were randomly selected. A total sample of three hundred respondents was selected from the target population based on their willingness and availability to respond to the questionnaire.

Measures

The questionnaire designed for data collection include a bio-data section which was used to get information such as age, gender, religious affiliation, marital status, level of education, number of children, physical disability and work status. In addition, six standardized instruments were used. These include:

Zung Self-Rating Depression Scale (1970)

This instrument was developed to measure depression. It contains 20 items with a 4-point response rating ranging from "A little of the time (1)" to "Most of the time (4)". Example of an item in the scale states

that "I feel down-hearted and blue." The scale reported an internal reliability co-efficient of .73 when pilot tested.

Perceived Social Support - Zimet, Dahlem, Zimet & Farley (1988)

This scale measures the frequency and intensity of perceived social support. The scale is made up of 12 items sub-divided into three subscales of support from family, friends and significant others. An example of the items contained in the scale is "There is a special person who is around when I am in need." The participants responded to a 5-point response format ranging from Strongly Disagree (1) to Strongly Agree (5) with high scores indicating a positive overall social support. The scale reported a high internal consistency reliability coefficient Cronbach's alpha (α) = .81 when pilot tested.

Spirituality Scale - Delaney (2003)

This scale was developed by Delaney (2003) to measure individual's level of religiosity/spirituality. This scale contains 23 items response format ranging from Strongly Disagree (1) to Strongly Agree (5). An example of item on the scale is "I have a relationship with a Higher Power". The original internal reliability co-efficient was reported as.87, however when pilot tested, the scale reported a reliability coefficient of -79.

World Health Organization Quality of Life Questionnaire-WHOQLQ (BRIEF) (1996)

This scale was used to assess the subjective perception of QOL among elderly. The WHOQOL-BREF includes 26 items; the first two questions assess the self-perceived quality of life and satisfaction with the person's health. The remaining 24 questions were categorized in the following four domains: physical (7 items); psychological (6 items); social relationships (3 items) and environment (8 items). Each of these 26 items was assigned scores that ranged from 1 to 5. The scale reported a high internal consistency reliability coefficient (Cronbach's alpha (α) =.89.

Socio-economic status Scale

This is a self developed to measure the socio-economic status of the elderly. It contains 15 items with a 5-point response format ranging from strongly agree (5) to strongly disagree (1). An example of item on the scale is "I regularly spend more money than I have by using credit

or borrowing from others". The reliability coefficient value when pilot tested was reported as .73.

Procedure of Data Collection

The researcher and his assistants were at different places to distribute the questionnaires to respondents. We visited markets, mosques, elders in churches and we also went to government establishments where pensioners gathered. Copies of the questionnaires were also given to the elderly living in the neighbourhood. The respondents were asked to kindly and honestly respond to the questions and were assured that information provided will be treated with utmost confidentiality as it is strictly for the purpose of research. However, the researcher sought the assistance of a translator from the Linguistic Department of the University of Ibadan who translated the items to Yoruba for those who do not understand English language.

Method of data analysis

Pearson Product Moment Correlation was used to test the relationship among the independent variables and the dependent variable while Multiple Regression Analysis was used to analyse the joint contribution and the relative contribution of the independent variables on the dependent variable.

Results

Table 1: Demographic characteristics of the respondents

Age	Frequency	Percentage
65-69 Years	142	47.3
70-74 Years	45	15.0
75-79 Years	22	7.3
80-84 Years	40	13.3
85-89 Years	18	6.0
90+ Years	33	11.0
Total	300	100.0
Gender		
Female	187	62.3
Male	113	37.7
Total	300	100.0

Religion		
Christianity	173	57.7
Islam	127	42.3
Total	300	100.0
Marital Status		
Married	170	56.7
Divorced/Separated	13	4.3
Widow	44	14.7
Never Married	73	24.3
Total	300	100.0
Level of Education		
No Formal Education	50	16.7
Primary School	166	55.3
Secondary School	55	18.3
Tertiary Institution	29	9.7
Total	300	100.0
Working Status		
Retired	111	37.0
Still in active work	163	54.3
Self Employed/Still in business	26	8.7
Total	300	100.0
Number of Children		
1-5 Children	218	72.7
6-10 Children	69	23.0
11-15 Children	9	3.0
21+ Children	4	1.3
Total	300	100.0

Research Question 1:

What relationship exists between depression, social support, socio-economic status and religiosity and quality of life of the elderly in Ibadan metropolis?

Table 2: Zero Order Correlation matrix showing the relationship that exist between depression, social support, socio-economic status, religiosity and quality of life among elderly in Ibadan metropolis

	Quality of Life	Depression	Social Support	Religiosity	Socio economic Status	Mean	S.D.
Quality of Life	1					79.35	14.34
Depression	-.077 .182	1				43.22	8.28
Social Support	.636** .000	.001 .989	1			51.45	16.06
Religiosity	.496** .000	-.343** .000	.430** .000	1		85.24	13.19
Socio economic Status	.544** .000	.038 .515	.465** .000	.336** .000	1	50.51	8.26

** Sig. at .05 level

Table 2 showed that there were positive significant relationships between quality of life and social support ($r = .636$, $p<.05$), Religiosity ($r = .496$, $p <.05$) and socio-economic status ($r = .544$, $p<.05$) however, the result indicated that there was no significant relationship between quality of life and depression ($r = -.077$, $p >.05$).

Research Question 2:

What is the joint contribution of depression, social support, socio-economic status and religiosity on quality of life among the elderly in Ibadan metropolis?

Table 3: ANOVA showing the joint contribution of depression, social support, socio-economic status and religiosity on quality of life of the elderly in Ibadan metropolis

R	R^2			Adjusted R^2	Std. Error of the Estimate	
.724	.524			.518	9.9541	
A N O V A						
Model	Sum of Squares	DF	Mean Square	F	Sig.	Remark
Regression	32231.924	4	8057.981	81.324	.000	Sig.
Residual	29230.023	295	99.085			
Total	61461.947	299				

Table 3 showed that the joint contribution of depression, social support, socio-economic status and religiosity on quality of life among elderly in Ibadan metropolis was significant. It revealed also a coefficient of multiple correlation of R = .724 and a multiple adjusted R^2 of .518. This means that 51.8% of the variance in quality of life among the elderly was accounted for by the prediction of the independent variables when taken together at $p<.05$ level of significance. The ANOVA results from the regression analysis also attests to the causal relationship of the independent variables on the dependent variable; $F(4, 295) = 81.324 < p.05$. This implies that the joint contribution of the independent variables to the dependent variable was significant and that other variables not included in this model may have accounted for the remaining variance.

Research Question 3:
What is the relative contribution of depression, social support, socio-economic status and religiosity to quality of life among the elderly in Ibadan metropolis?

Table 4: Summary of Relative contribution of depression, social support, socio-economic status and religiosity to quality of life of the elderly in Ibadan metropolis

Model	Unstandardized Coefficient		Standardized Coefficient	t	Sig.
	β	Std. Error	β Contribution		
1 (Constant)	13.820	6.397		2.161	.032
Depression	2.304E-02	.075	.013	.306	.760
Social Support	.364	.043	.408	8.392	.000
Religiosity	.253	.053	.232	4.769	.000
Socio-Economic Status	.481	.080	.277	6.016	.000

Table 4 revealed the relative contribution of each of the variables; depression, social support, socio-economic status and religiosity to quality of life among the elderly in Ibadan metropolis. The result showed that Social Support (β = .408, t= 8.392, p<.05) made the highest significant relative contribution, followed by socio-economic status (β = .277, t= 6.016, p<.05) and religiosity (β = .232, t= 6.016, p<.05). However, the result revealed that Depression (β = .013, t=.306, p>.05) had no significant relative contribution to the quality of life among the elderly in Ibadan Metropolis. This implies that social support, socio-economic status and religiosity were the only potent predictors of quality of life in this study. In essence, the support derived from family, friends, neighbours and other people around, the extent of financial independence and security and close relationship with the Supreme Being were the reasons for quality of life among the elderly. In effect, feeling depressed has no impact on quality of life of the elderly.

Discussion

This study examined the extent to which depression, social support, socioeconomic status, and religiosity predicts quality of life among the

elderly. More specifically it examined the relationship, joint and relative contributions of depression, social support, socio-economic status and religiosity to quality of life among the elderly. The findings provided evidence that there was a significant relationship between social support, religiosity, socioeconomic status and quality of life. This corroborates the findings of (Okumagba 2011; who reported that family support has impact on quality of life of the elderly and that poor quality of life is an indication of absence of necessary social support from family members. This implies that social relationship promotes quality of life through the benefits created, particularly when such relationships are meaningful and engaging. Particular note should be made of the setting of this present study, which can be said to be a social environment with deep rooted cultural norms and perception regarding the family and where family networks continue to be the major source of psychosocial support for the elderly. Hence the family is traditionally viewed as the major source of support and caregiver for the elderly. However, contemporary changes in the structure of the family in recent times have greatly affected the availability of such family support in old age in most communities.

With regards to socio-economic status, the result of this study agrees with previous studies (Breeze et al 2004; Everad et al 2008, Gureje, Kola, Afolabi & Olley 2008) report that socioeconomic status has significant impact on QOL of the elderly The effect of poverty is more likely to be felt by the more vulnerable sections of the society which include the elderly. Elderly persons are clearly at an elevated risk for the consequences of poverty, especially in a country where there is no adequate provision for the care of the elderly in terms of social security and prompt payment of pensions. Another plausible explanation for the effect of socio economic status on QOL is that elderly who have higher educational level, adequate income and social resources are better able to engage in age appropriate health activities which invariably enhance QOL. This finding also implies that individual's socio economic status reflected through educational background, income and social resources contribute in no small measure to the attainment of positive quality of life. This further underscores the serious impact of mass poverty on the growing population of elderly persons in the country.

However, depression was found not to have any significant relationship with quality of life. This is perhaps partly an unexpected result because extant literature has previously documented that depression correlated negatively with quality of life (Gureje, Kola, & Afolabi, 2007; Ibrahim et al., 2013) which showed that people with depression had impaired quality of life. The plausible explanation for the finding in this study may be attributed to the report that deteriorating mental status, such as dementia and depression are perceived as a part of normal ageing in some societies and culture thereby majority fail to avail prompt treatment that will improve the quality of life among the elderly. Or that depression among aged may often go undiagnosed, especially in societies such as Nigeria, where symptoms of mental illnesses are entangled with myths, superstitions, taboos and ignorance. Moreover psychiatric illness causes considerable stigma that strip them off their dignity and results in isolation and hopelessness. (Lievesley, Hayes,Jones, & Clark 2009; Kishore, Gupta, Jiloha, & Bantman 2011; Holm, Lyberg, & Severinsson 2014). Also it may be an issue of living in denial or the complexities attributable to religiosity where people are encouraged to be hopeful in any situation and not confess negative words concerning life challenges encountered. In fact, Idler, Mclaughlin & Kasl, (2009) reported that those with deep religious commitment showed greater sociability, better health, lower depression scores and found life more exciting compared with less religious elderly..

The relationship of religiosity to QOL found in this study is in consonance with what previous studies suggest (Lee, Nezu, & Nezu, 2014; Skevington, Gunson, & O'Connell, 2013; Vitorino et al., 2015) that the elderly tend to deeply value their religious beliefs and through engaging in religious activities they derive strategies to cope with the challenges of growing old thus improving their QOL. This implies that religiosity may directly or indirectly affect health because it generally provides an extensive social support network, a reduction of unhealthy behaviours such as alcohol, smoking and drug abuse, the lowering of blood pressure and muscle tension, and the promotion of positive emotional states. Also involvement in religious activities, especially saying prayers may lessen depression and being deeply religious gives a greater likelihood and opportunity of having more friends and better

self-rated health hence better QOL. Therefore, religion can be a powerful resource for the health care of older adults, leading them to improved quality of life.

Implication of the study

The relationship and contribution of depression, social support, socioeconomic status and religiosity to Quality of Life among the elderly cannot be over emphasized. Therefore, this study has contributed to the existing literature in gerontology and is useful for reference purposes. In view of the reported increase in life expectancy in Nigeria and globally, there is the need for the government to urgently put in place mechanism for the care of the elderly in the society in order to improve the socio-economic status and thus reduce the spate of poverty and hardship among the populace and by extension the elderly for a better QOL. The rise in the cost of living and high inflation has often made it difficult for the family to give the necessary care and support for the elderly. Also, the advantages of religiosity could be further explored beyond how it is harnessed into life and living of the people since religious beliefs provides motivation for adherents to form friendship with each other to the exclusion of other relationships which has been found to have a positive effect on the emotional and mental health.

This study also reflects the need of the elderly for social network, support and engagement. It shows that contact with family members, friends and participation in community activities are germane to providing social support and networks for the QoL of elderly people. It is likely that such factors are taking on increasingly more significant meaning for the elderly as the contemporary social changes affect the structure of the traditional extended family and economic pressures lead to unavailability of family members to provide the age long connectedness families are known to provide. This leads to social isolation of the elderly in our settings to the extent that some have started considering engaging the not so popular residential care facilities in taking care of the elderly a practice that is not yet common in our setting.

Conclusion

The findings clearly show that quality of life of the elderly population in Nigeria is becoming an important issue, on account of the growing number of the elderly people in the population. Therefore, myriads of factors affecting the QOL of the elderly people must be monitored and used to achieve a better outcome in line with the Nigerian culture which emphasizes the respectful treatment of the elderly. It is therefore necessary that efforts must be made to strengthen financial independence and security and the support systems for taking care of the elderly population.

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