ANALYSIS OF THE LIVING CONDITIONS OF THE ELDERLY IN LAFIA LOCAL GOVERNMENT AREA, NASARAWA STATE, NIGERIA

BY

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FACULTY OF SCIENCE,

AHMADU BELLO UNIVERSITY, ZARIA.

MAY, 2016.

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M.Sc/ SCIE/45954/2012-2013
(M.Sc DEMOGRAPHY AND POPULATION STUDIES)

A DISSERTATION SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES, AHMADU BELLO UNIVERSITY, ZARIA, NIGERIA IN PARTIAL FULFILMENT FOR THE AWARD OF MASTER OF SCIENCE OF DEGREE IN DEMOGRAPHY AND POPULATION STUDIES

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MAY, 2016.

DECLARATION

I hereby declare that the work in this thesis dissertation "Analysis of living conditions of the elderly in Lafia Local Government Area, Nasarawa State, Nigeria" was carried out by me Anda Simon Ashelo in the Department of Geography under the supervision of Professor M. M. Mamman and Professor J.G. Laah. The information derived from the literature has been duly acknowledged in the text and in the list of references cited.

Ashelo Simon ANDA _____ _____

Name of Student **Signature** **Date**

CERTIFICATION

This Dissertation titled "ANALYSIS OF THE LIVING CONDITIONS OF THE ELDERLY IN LAFIA LOCAL GOVERNMENT AREA OF NASARAWA STATE, NIGERIA" by Ashelo Simon ANDA meets the regulations governing the award of degree of Masters of Science, (Demography and Population Studies) of Ahmadu Bello University, Zaria, and is approved for its contribution to knowledge and literacy presentation.

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DEDICATION

This work is dedicated to Almighty God for His love, favours and mercies upon my life and to my lovely parents Mr. and Mrs. Simon A. Anda for their encouragements and support during my study.

ACKNOWLEDGEMENTS

My profound gratitude goes to Almighty God for keeping and sustaining me. I want to thank immensely my team of supervisors; Prof. M.M. Mamman and Prof. J.G. Laah, thank their patience, painstaking corrections and incisive comments. I also want to thank my examiners both external (Prof. Bala Dogo) and internal (Dr. R. O. Yusuf and Dr. B. Abdukarim) for taking their time to read this work.

My deep appreciation goes to my parents Mr and Mrs A.S Anda thanks for your prayers and support, to my siblings; Agnes, Ovey, Patrick and Patricia. I appreciate you all. I am indebted to all the academic and non-academic staff of department of Geography, Ahmadu Bello University, Zaria, and to Dr. N.D Marcus of Nasarawa State University, Keffi for his constructive criticism.

Finally, I want to say a big thank you to my friends, family members and well-wishers, Ruth Aaron, Mariah, Ene, Toyosi, Dabo, Peace Karik, Khalid, Ummi, Babiyo, Anna, Chioma, Samira, Iye, Doose, Rita, Ojonoka, Charisma, Halima, Brenda, Mariam James, Chinonso, Florence, Mr. and Mrs. Fwangkwal, Shehu, Esla Madaki, Mrs. Nate Bello, Mr. Ojo, Anzaku Usman, Doowuese, Grace and Edna Ekoja, Aisha Daibu, Chibuzor, Priscilla, Prof. A.A Braimah, Mr. Philip Edhudu, Mr. and Mrs. Adeshina, Adeniyi, Mr.and Mrs. Ali Anda, Mr.and Mrs. Daniel Anda, the Ambi's family, Mr. and Mrs. Randong, Mr. and Mrs. Dennis, Mr. and Mrs. Gbadejoko, Mrs. Raji, Mrs Olugbojo, Mr. n Mrs. Choji, Dr. Uchua Kenneth, Mr. and Mrs. Leo Onimisi, Blessing Udoh, Mafo, Sim Buzu, Stella, Julie, Ife, Mardiya, Mary Lawson, Grace, Glory, Jummai, Aunty Rhoda, Aunty Ruth, Ezekiel, Anzaku, Aunty Omata, Aunty Meg, Aunty Officer, Aunty Rejoice, Christie, Usi, Ruth, Ekaette, Fatika Maryam, Talatu Victor and lots more, for their advices, proof reading and prayers.

ABSTRACT

The elderly in Nigeria are denied resources by formal institutions towards retirement and comfort to life in advanced stage of their existence. Yet, they are the custodians of culture and tradition, mediators during conflict resolution and contributors in enforcing peace in their various communities. Thus, their living conditions is of paramount importance especially in Lafia local government area because it comprises of varying diverse cultures and traditions which can only be held confidential and transferred to the younger ones when they are due, by the elderly persons. This study therefore examined the general living conditions of the elderly, factors affecting their living conditions, types and sources of support as well as the coping strategies of the elderly in Lafia Local Government Area, Nasarawa State, Nigeria. The study used their social, economic and health conditions as indicators. Purposive sampling technique was adopted and a structured questionnaire was administered to 399 respondents from six wards in the Local Government Area. In addition, Focus Group Discussions were held and In-depth Interviews were conducted on the subject matter to complement the quantitative data. Data were analyzed with both descriptive and inferential statistics using the Statistical Package for Social Science (SPSS). The study showed that 77% of the respondents are in the early elderly (65-74) age group in which female respondents constitute 59.1% and males 40.9%. Farming and trading constitute the most important occupations engaged by the elderly with about 67.9%. However, majority of the elderly constituting 63.7% generate less than ₦ 16,000 per month. The result of the principal component analysis (PCA) showed that factors such as health and nutrition of the elderly (11.50 eigenvalue), support given to the elderly (0.78 eigenvalue) and socialization and family association (0.60 eigenvalue) are the major factors influencing the living conditions of the elderly in Lafia. Majority of the support for the elderly is gotten from the children with 49.1%, and the nature of support for the elderly appeared to be mainly financial support with about 49.1% in the study area. Going by this, the living standard of the elderly is concluded to be generally low. The study recommends that there is need for health insurance schemes for the elderly, special supply of food supplements for the old and also the provision of geriatric healthcare facilities like specialized hospital and old people's homes either by Nasarawa State government or private individuals. There is also need for stakholders to design policies that will ensure the elderly are financially secured in their old age so as to improve their standard of living.

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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Conventionally, “elderly” has been defined as a chronological age of 65 years old or older, while those from 65 through 74 years old are referred to as “early elderly” and those over 75 years old as “late elderly (Hajime *et al.*,2006). However, the evidence on which this definition is based is unknown. Ageing is referred to as the regular changes that take place in biologically matured individuals as they advance through life cycle (Harris and Cole, 1980; Gorman, 2000). Ageing is a relentless, biological imperative that begins with both male and female. No one escapes it. It is a process of getting old and all people affected by this process are regarded as the elderly. It is defined legally, socially and culturally (Nicholas, 1980; Okumagba, 2005).

Living conditions of old people are a reflection of the living conditions of society as a whole (Rosenmayr, 1979; Orire, 2015). The definition of level of living has been based on either needs or resources. According to Drewnowski (1974), the level of living of a population is the level of satisfaction of its needs attained per unit of time as a result of the goods, services and living conditions which the population enjoys in the unit of time. In talking about living conditions the term "standard of living" is widely used and it is sometimes seen merely as an economic concept, a measure of material wellbeing. The term living condition is most often used with the same meaning as standard of living. The living standard of the elderly is mainly based on the capability of the next generation to meet their needs materially, financially and otherwise (Newman, 2003).

The global population is said to be ageing and it is ageing at an unprecedented rate of 2.8% annually. These facts have been subsequently recognized and affirmed (Asiyanbola, 2009). Both the number and proportion of people aged 65 years and above are increasing, although at different rates in different parts of the world. The number of older adults has risen more than threefold since 1950, from approximately 130 million in 1950 to 419 million in 2000, with the elderly share of the population increasing from 4 percent to 7 percent during that period (Waite and Hughes, 2004). It is worthy of note that political, social, health and economic factors determine to a very great extent, the living conditions of the elderly. The needs of elderly people in Nigeria has traditionally been the concern of the Federal, State, Local Governments and voluntary agencies (Anthea, 1991).

Adebowale, Atte and Ayeni (2012), noted that globally, the population of elderly is increasing and their well-being is becoming a public health concern. In Nigeria, poverty is widespread and elderly persons are at higher risk as a result of their age which reduces their working ability and leads to their retirement. Unfortunately, the Nigerian Government does not provide social security to the elderly and the supports from the family are fading out, hence, the well-being of elderly is compromised. Lafia Local Government Area of Nasarawa state has a good picture of such compromise as the elderly persons are really relying on the younger persons (Marcus 2007).

In some more advanced countries of the world like France, problems of the elderly such as social and medical issues are solved through provision of old people's homes, free medical and health care delivery. Many of them are put into institutions, even though they are capable of active employment and life in the community. Not only is this very costly, but putting someone

into a hospital bed and leaving them there often leads to psychological problems and chronic illness. Instead of aid being given to keep people at home, the disabled and elderly are treated as medical cases and kept in hospitals and institutions (Jean, 1980).

Old age as asserted by Bosanquet (1978), is considered to start from 60 years of age. It is worth noting that the physical changes that come with old age vary and do not necessarily develop at the same time in each old person. The United Nations (UN) held the First World Assembly on Ageing in Vienna in 1982 (United Nations, 1982). It recognized and affirmed that the global population was ageing and that it was ageing at an unprecedented rate. The United Nations then designated 1999 as "*The Year of the Older Person*". In the second UN Assembly on Ageing in Madridin 2002, the Assembly adopted an International Plan of Action on Ageing, and a political declaration, recommending that older persons must be full participants in the development process in the 21st Century (United Nations, 2002). In addition to these specific Assemblies on older persons, population ageing has been prominent in the major international population conferences as well as in other key UN declarations during the past twenty five years.

Newman (2003), in a study of the living conditions of the elderly using the 1995 National American Housing Survey (AHS), noted that roughly 14% of elderly individuals had a housing-related disability, 49% had at least one dwelling modification, and 23% had an unmet need for modifications. Because half of those with dwelling modification also reported unmet needs, the match between disabling condition and modification, not the presence of modifications is the key.

In Nigeria, those aged 65 years and above make up about 4.3 percent of the total population which was put at 140,431,790 million according to 2006 population exercise (National Population Commission, 2009). The population of elderly (age 65+) in Nigeria is on the increase as the crude mortality rates are gradually reducing (NPC and ICF Macro, 2009). The problems of an ageing population have not been seen as important in Nigeria because the aged are such a small proportion of the population. In most developing countries, formal social security systems have only limited coverage and inadequate benefit payments (Bailey, 2000; Colin, Turner, Bailey and Latulippe, 2000). 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). However, it is recognized that traditional social security systems are evolving, attenuating and rapidly disappearing due to pressures from urbanization and industrialization (Tostensen, 2004). Youths migrate to cities while the elderly move back to the rural areas. Elderly persons in Nigeria reside more in rural communities, particularly those who have retired from their place of work (Tostensen, 2004).

Ageing in Nigeria is occurring against the background of socio-economic hardship, wide spread poverty, the HIV/AIDS pandemic, and the collapse of the traditional extended family structure. The roles of elderly in nation building at the various stages of their life cannot be over-emphasized. They are the custodians of culture and tradition, are mediators during conflict resolution and contributors in enforcing peace in their various communities (Asiyanbola, 2008). The younger generation will know little or nothing about culture and tradition if the elderly who are to educate them are not been properly preserved. The elderly have served their motherland when they were young and active (Asiyanbola, 2009).

Many elderly reach retirement age after a lifetime of poverty and deprivation, poor access to health care and poor dietary intake that is usually inadequate in quality and quantity. These situations leave them with insufficient personal savings to meet their daily needs (Charlton and Rose, 2001). They are most at times denied of their right to receive their pension resulting on their poor well-being due to poverty and poor medical attention. The living conditions of the elderly is of paramount importance (Kimokoti and Hamer, 2008), especially in Lafia LGA as the area comprises of varying diverse cultures and traditions which can only be held confidential by the elderly and transferred to the younger ones when they are due. It is against this background that this research was embarked upon. There is the need to understand the wellbeing of the elderly in Lafia local government because the role of elderly person in every society is of utmost importance.

1.2 Statement of the Research Problem

The attitudes of government towards the elderly in our contemporary society is not encouraging, as there exist no special resources directed to aid in making life better for them in the rural and urban Centre. The health care systems in most developing countries are appalling as government spend a small fraction of the budget on treating older adult illness and access to care is limited and not a policy priority (Poullier, Hernandez and Kawabata, 2003; Tollman, Doherty, and Mulligan, 2006). The attitudes of health care providers towards older people make their situations even more difficult. Many older people do not access health services due to inability to prove their age, aggravated by the limited availability of health services, equipment and expertise.

Although, declarations and plans have presented great opportunities for countries to mainstream ageing within the context of current global development initiatives, the recognition of population ageing by governments is still limited. This is the situation, especially in African countries, where other pressing priorities command most of the attention of policy makers, even though the process of population ageing is already visible in these countries.

In Nigeria, poverty is rife and elderly persons are more at risk since most of them are no longer in the economically active phase of life and there is no national social security to provide economic support in old age (Gureje, Lola, Ebenezer and Benjamin, 2008). 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 takes 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).

A recent study by Okoye (2004) explored how Nigerian youths feel about care-giving for the elderly and their views about traditional ways of taking care of the elderly. The author observed in the study that the youngsters are not willing to live with their aged parents; neither are they willing to send their wives nor their children to the village to live with their aged parents. An earlier work examines the link between social support/networks, urban condition and physical wellbeing of the elderly (Asiyanbola, 2004).

In Nigeria, poverty and poor infrastructural development which perpetrated rural communities where most elderly people reside, constraint them from achieving good living conditions. Traditionally, the elderly are expected to rely primarily on their families for economic and emotional support. At times if family support mechanism fails, community help may be available. However, the collapse in family ties and structure also have negative effects on elders who are used to enjoying support from extended families where traditionally the elders are respected and properly catered for(Ajala and Olorunsaiye, 2006; Asiyanbola, 2009).

Due to the youthful nature of Nigeria age structure, government believes that the health problems that manifest among children and youths need more attention than that of the elderly. As a result, very little consideration is given to the elderly in Nigeria by both the research community and policymakers. Average household sizes are large and a substantial proportion of older adults live alone (Adebowale, Atte and Ayeni, 2012). The economies of the elderly (65 years and above) in Lafia Local Government Area are predominantly supported by subsistence agriculture, which provides little or no pension coverage and limited health care services.

In Nasarawa state, the population of the elderly was 4.6% of the entire population in 2005. It was estimated that old people would be 63,539 in 2005, 65,006 in 2007 and 70,909 in 2010. Despite the relatively small number of old people, it is expected that it will rise in the future. Adequate facilities for the treatment of geriatric diseases should be planned (Marcus, 2005).

In assessing and determining the nature of the living condition of the elderly in localities, regions and countries, a lot of research work has been carried out to give better understanding about the

subject matter. These are seen in the works of Adebowale et al (2012), who studied elderly wellbeing in a rural community in north central Nigeria. The study was designed to determine the prevalence and identify predictors of elderly well-being in a rural community in Nigeria. It was cross-sectional in design and adopted multi-stage sampling procedures to select 1217 elderly people aged 65 and above. Well-being was captured using scores from four domains; social, psychological, physical and environmental and the data were analyzed using descriptive statistics, Chi-square and logistic regression models.

Asiyanbola (2005) in a study in Ibadan explored the link between elderly's family care, daily activities, housing condition and physical wellbeing. The data used were from a larger household survey, simple frequency analysis, ANOVA, correlation and regression statistical techniques were used to analyze the data. The result shows that majority of the elderly are living in deplorable housing conditions. Analysis of the daily activities of the elderly revealed that they are generally more involved in service to others, followed by domestic chores, household maintenance and social activities. In the categories of domestic chores, household maintenance and service to others, more elderly women are involved than elderly men. In the category of social service more elderly men than elderly women are found to be involved. Results show that, there is significant variation in elderly family care and physical wellbeing. Policy implication suggests that quality of life of elderly could be improved through the socio-economic empowerment of families and provision of efficient and effective social welfare/health, amenities and services.

Machu (2005) carried out a research on socio economic and health conditions of the elderly in Kaduna State. From the findings of this research, it is clear that social conflict theory goes a long way in explaining the conditions of the elderly in Kaduna metropolis. Social conflict theory explains factors like retirement, inequality, age stratification, unproductively which are characteristics of the aged in the Nigerian society and Kaduna metropolis in particular. The theory also explains how the aged have less power and prestige and a higher risk of poverty. Luka (2006) examined the socio-economic condition of the elderly in Chikun LGA of Kaduna State. The study adopted a two theoretical frame work namely; Social conflict theory and Structural functionalist perspective. The study concluded that different age categories have different opportunities and different access to social resources thereby creating a system of age stratification which is in agreement with the social conflict theory.

Abdulraheem and Abdulraham (2008) did a retrospective study on morbidity pattern amongst the elderly population in a Nigerian tertiary health care institution. The study sought to determine the relationships between morbidity and socio-demographic and health characteristics in Nigerian elderly hospital attendees at the University of Ilorin Teaching Hospital, Ilorin. A hospital based retrospective study was undertaken from January 2000 to December 2005. Hospital case folders of all patients 60 years and above were selected and studied. From their findings, women reported more health problems than men. There is a tendency for the elderly to seek assistance from relations, established clinics and other health facilities for their health problems. The findings from this study improved understanding of the patterns of health problems among Nigerian elderly and also contributed to the development of appropriate interventions. The study did not look at the living condition of the elderly which this study will do, also the researchers

used hospital based data only and thus did not reach out to the elderly to get first-hand information. This study will use questionnaire to cover this gap.

Olaniyan, Olayiwola and Odubunmi (2011) studied the impact of health expenditure on the elderly in Nigeria. The research investigated the effects of the burden of health care expenditure on the elderly adults aged 65 years and above using a growth factor model methodology. The analysis showed that per capital health expenditure of the elderly is higher than the per capita health expenditure of the other age groups in Nigeria. This puts more pressure on family income and reduces the consumption of other goods, the effect of which is increase in old age related disease and quickens the death rate of the elder. Hence, it was suggested that an adequate social security program and health insurance be established for the elderly adults to ease the pressure of health expenditure on family income, pensions and transfer earnings. The researchers adopted the growth fact model method of analysis whereas this study will adopt descriptive statistics method of data analysis, also only impact of health issues on finance of the elderly was looked at in the later study but in this study their living conditions will be considered.

Orire (2015) also carried out a research on the spatio-temporal analysis of population aging in Kwara State. The study attempts a spatial concentration of the elderly segment of the population of Kwara State, Nigeria, using data from 488 copies of questionnaire. The data collected were summarized by means of descriptive and inferential statistical analysis. Factor analysis identified 14 component variables which altogether explained 63.95% of the variance explanation. Stepwise Regression analysis however revealed that only ten (social wellbeing, income, support, economic factor, disability, diseases, health insurance, residential quality, recreational factor and safety nets) out of the identified fourteen variables were actually important in the explanation,

and they all contributed 53.4% explanation to the pattern of aging in Kwara State. The above study was limited to spatio-temporal pattern of the aging population and not their living conditions and besides it was conducted in Kwara State not in Lafia. It is the gap in knowledge that this study intends to fill. The study will address the following research questions:

i. What is the general living condition of the elderly in Lafia Local Government Area?
ii. What are the factors affecting the living conditions of the elderly in Lafia Local Government Area?
iii. How are the elderly coping with their social, economic and health conditions in Lafia Local Government Area?
iv. What are the sources of support for the elderly in Lafia Local Government Area?
v. What kind or type of support do elderly people receive in Lafia Local Government Area?

1.3 Aim and Objectives of the Study

The aim of this research is to examine the living conditions of the elderly with emphasis on their social, economic and health conditions in Lafia Local Government Area of Nasarawa State, Nigeria. The aim will be achieved through the following specified objectives which are to:

i. examine the general living conditions of the elderly in Lafia Local Government Area
ii. analyze the factors affecting the living conditions of the elderly in the study area
iii. assess how the elderly cope with their social, economic and health conditions inthe study area
iv. assess the kind or type of support elderly people receive in the study area
v. identify the sources of support for the elderlyin the study area

1.4 The Scope of the Study

The study evaluated the general living conditions of the elderly persons in Lafia LGA. Special consideration was given to health status of the elderly, their nutritional status and their supporting system which ranges from the source, nature and frequency of the support. For the purpose of this study, six (6) wards were purposively selected namely; Akurba/ Bakin Rijiya, Chiroma, Gayam, Makama, Shabu/ Kwandere and Zanwa of the thirteen (13) wards in Lafia local government which is also the state capital of Nasarawa State. The selection of the six wards is to have a high degree of coverage of the area and also have enough sample population. It is in these six wards that in-depth study will be carried out. This area was selected by the researcher due to the peaceful condition of the areas as against other areas that are still in conflict in the local government. It is within the temporal scope of this study to exhaust a period of six (6) months beginning from December 2014 to May 2015. The study was based on data obtained in the field using questionnaire survey which shall be answered by the elderly persons in the study area.

1.5 Justification of the Study

This study is very significant to an understanding of the living conditions of the elderly. The findings may be helpful to decision and policy makers on the elderly especially as it relates to the developmental process particularly in Nigeria. It is best convenient for the society to understand, identify and appreciate the factors responsible for the living conditions of the elderly in any given society.

CHAPTER TWO

CONCEPTUAL ISSUES, THEORETICAL FRAMEWORK AND LITERATURE REVIEW

2.1 Introduction

This chapter focus on conceptual issues, theoretical framework and review of relevant literature. The conceptual issues encompasses aging and its characteristics and the theoretical framework considered theories of aging, conflict analysis, role, activity, structural functional perspective, disengagement, mutation accumulation and modernization. The review of related literatures considered population aging, its determinantsand socio-economic profile of the elderly, their health profile, Nigeria family structure, effects of population aging as well as the coping strategies of the elderly.

2.2 Conceptual Issues

2.2.1 Aging and Nature of the elderly

Aging is a gradual and spontaneous change resulting in maturation through childhood, puberty and young adulthood and the decline through middle and late ages (Okunola, 2002; Adedokun, 2010). It is also seen as the organic process of growing older and showing the effects of increasing age. Aging is a lifelong process and varies in its effects from individual to individual. Changes such as grey hair, baldness and failing health occur in human life but not all changes are however deleterious as aging can be characterized by increased wisdom and experience. Okunola (2002) believed that were maturation ends and decline begins are not perceptibly discernible as at one end is adolescence and at the other is senescence. The elderly according to authors like Broekington and Lampert (1966); Kaiser and Camp (1993); Adebayo (2006) are those who have attained the ages of 60 and above.

Aging is referred to as the regular changes that take place in biologically mature individuals as they advance through life cycle (Cole and Harris, 1980). It is a process of getting old and all people affected by this process are regarded as the elderly and is defined legally, socially and culturally (Nicholas, 1980). In the process of aging, the skin wrinkles, power of seeing and hearing diminish, hair turns white and is gradually lost, reflexes show and the body organ deteriorate. It is to this premise that Hendricks *et al*. (1986) submitted that aging involves a pattern of changes not only in the structure and functioning of the body but also in the adjustments and behavior of the person. In line with the later assertions, aging can be viewed as a sequence of events that take place during an individual's life course.

Aging varies not only among persons but also within a person. Changes also occur in sensory activities with age, long sightedness is common as are cataracts. Hearing ability declines with a gradual loss of the ability to hear frequencies. In light of this, Cole and Harris (1980) presented that there is no fixed time in a person's life when he or she becomes old. To them, aging is a gradual and sometimes almost imperceptible process, thus the most noticeable changes are that the heart pumps less blood and the lungs take in less air, there is a decrease in the production of digestive juices in the intestine and the filtering rate of the kidney is often reduced by half and also little change in mental ability. However, it should be noted that under most circumstances, the ability to learn does not change with age. Old people constitute a minority group in the society. They are relatively powerless, their behavior and traits are stereotyped and regularly depreciated and devalued by the dominant group and most important because of their age, the elderly are signed out for differential and unfair treatment. So, it is obvious that growing old is a dynamic change redefinition of social identities and adjustments in psychological functioning (Harris and Cole 1980).

Age is a cultural category and its meaning and significance vary both historically or culturally (Okumagba, 2005). In traditional African societies, the care of the elderly is the basic responsibility of the family. The elderly are supported by a strong kinship network and extended family system; in which, the elderly are highly respected and are seen as repositories of knowledge and custodians of culture.

The impact of an elderly population has generated considerable debate in recent times. This emerged against a background of the rapid change in the environment and peculiar circumstances facing the elderly in contemporary society. There has been a growth in public awareness and interest in aging issues, as well as increased pressure on elderly people in the workplace, combined with the rapid growth in early retirement. Marshall (1998), described aging as the physiological process of becoming elderly. In the author's analysis, this process has vital social and cultural dimensions, which affects what is generally seen as a biological inevitability.

2.2.2 Age structure

Categorization of the population of communities or countries by age groups is referred to as age structure. The age structure of a population affects a nation's key socio-economic issues. Countries with young population (high percentage, under age 15) need to invest more in schools, while countries with older populations (high percentage ages 60 and above) need to invest more in the health sector, because the risk of health problems rises precipitously in very old age (Adebayo, 2006). Also this will have tremendous impacts on economic growth, savings, investments, taxation, housing, intergenerational transfers and consumption etc.(United Nations, 2002).

The age structure can also be used to help predict potential political issues. For example, the rapid growth of a young adult population unable to find employment can lead to unrest. Given that large shifts in age structure are being compressed into a relatively short period in developing countries, meaning, they will have less time than the developed countries to adapt to the problems posed by the changing age structure (United Nations, 2001). Therefore, rapid changes in age structure may be more difficult for developing nation's societies to adjust to than changes that occur over a longer period of time. This has important implications for public policies on health care, pension schemes and economic prosperity (Ajomale, 2007).

2.3 Theoretical Framework

A theory is said to be a guiding principle towards understanding the social world. According to Welfgang and Ferracuti (1962), a theory consists of a logically integrated set of propositions about the relations of variables, these reactions are conception that should be systematically connected to one another. In describing the living conditions of the elderly in a Nigerian society, a theoretical framework is needed and so therefore, social theories of aging, structural functional perspectives and the symbolic interaction analysis are adopted for the purposes of this study.

2.3.1 Social theories of aging

2.3.1.1. Social conflict analysis

A social conflict analysis as propounded by Karl Marx, is based on the idea that different age categories have different opportunities and different access to social resources, creating a system of age stratification. This analysis lays so much emphasis on aging and inequality. Age stratification is one focus of social conflict analysis. To conflict theorists, age based hierarchy is inherent in an industrial-capitalist society. In line with Marxist thought, Spitzer (1980) points out

that a profit oriented society devalues any category of people that is economically unproductive. To the extent that older people are less productive, then, our society labels them as mildly deviant. Social conflict theory adds to an understanding of the aging inequality and explaining how capitalism devalues the elderly. The geography of inequality determines who gets what and in which location (Smith, 1974).

In this sense, any space occupied by the aged usually lacks similar facilities found in areas occupied by the youthful population. This is contrary to welfarist approach in geographical analysis, that every member of the society should not be deprived based on race, socio-economic status or the place they occupied (Oyebanji, 1986). This implies that rural areas where the elderly reside in many developing countries should not be deprived. However, the social conflict perspective can be described as that with the least disposition towards providing adequate coping structure for the elderly because of their low productivity.

2.3.1.2 Role theory

This is one of the prominent and oldest gerontological theories, dating back to the 1940s (Cottrell, 1942). Role theorists have shown that feeling in control of life and having social power and prestige is associated with better health (Krause, Herzog, and Baker, 1992). One of the major components of role theory is role loss. This usually occurs as people age; they start losing roles as active parents, employees, and spouses. Individuals play a variety of roles during their lives as children, adult, spouse, parent, employer, employee, grandparent and retiree. These roles are often sequential, some are concurrent and individuals lose and gain roles through life.

2.3.2 Activity theory

This analysis as the name suggests, is concerned with the interaction which means action between individuals. The inter-actionist perspective seeks to understand this process and it suggests that action is meaningful to those involved and therefore understand an action refuses an interpretative meaning which actions give to their activities. Activity theory is one of the starts of this perspective propounded by Havighurst (1968) and lays emphasis on ageing and activity. It states that a high level of activity enhances satisfaction in old age. The theory suggests that people need to find a new role to replace those they leave behind and it is noted that elderly people who maintain high level of activity derive most satisfaction from their lives. Old people are diverse with highly variable interests, needs and physical abilities, therefore the activities people pursue and the pace at which they pursue them is always an individual matter.

Thus, activity theory shifts the focus of analysis from the needs of the elderly themselves. It emphasizes the social diversity among elderly people as an important consideration in formulating any government policy. However, a limitation of this approach from a structuralism point of view is the tendency to exaggerate the well-being and competence of elderly. Hence, this study do not want to depend on the elderly to perform crucial roles as such the social conflict analysis was examined.

2.3.3 Disengagement theory

This theory suggests that society's stability is assured when social roles are passed on from one generation to another through an inevitable act of mutual withdrawal or disengagement, resulting in decreased interaction between the aging person and others in the social system to which they belong (Cumming and Henry, 1981). Disengagement is a strategy to ensure orderliness in the

operation of the society by removing aging or elderly people from productive roles while they are still able to perform those roles. This change paves way for young workers to replace the disengaged old ones. The idea that the society enhances its orderly operation by disengaging people from positions of responsibility as they reach old age is a welcome development to structuralist functionalist. However, this analyst fails to address the side effect on the aged such as inability of older workers to disengage from paid employment because they do not have financial resource to fall back on, while many of them regardless of their financial circumstances do not wish to disengage from their productive roles.

Consequently, as older people are disengaged they become vulnerable to socio-economic ills when there is no income to support them and interaction with the society diminishes. Hence, ability to cope is undermined further compounding their problems.

2.3.4 Mutation accumulation theory of aging

This evolutionary theory, suggested by Peter Medawar (1946, 1952), considers aging as a by-product of natural selection. According to this theory, aging is a non-adaptive trait because natural selection is negligent of events that occur in a few long-lived animals that provide little additional contribution to offspring numbers. This explanation of aging is similar to the evolutionary explanation of vision deterioration and ultimate blindness of cave animals, if some function cannot be used to provide reproductive advantage, it will not be supported by selection pressure and maintained in future generations (Bengston, 2009).

The probability of an individual reproducing depends on the age and is zero at birth and reaches a peak in young adults. Then it decreases due to the increased probability of death linked to various external (predators, illnesses, accidents) and internal (senescence) causes, in such

conditions, deleterious mutations expressed at a young age are severely selected against due to their high negative impact on fitness (number of offspring produced). On the other hand, deleterious mutations expressed only later in life are relatively neutral to selection because their bearers have already transmitted their genes to the next generation. Note that mutations can affect fitness either directly or indirectly. For example, a mutation increasing the risk for leg fracture, due to a low fixation of calcium, may be indirectly as deleterious to fitness as a mutation directly impairing the eggs nesting in the uterus (Le Bourg, 2001). From an evolutionary perspective, it does not really matter if the organism is at risk not to reproduce because many spontaneous abortions occur, or because it becomes an easy prey for a predator (in nature) or a criminal (in society).

According to this theory, persons loaded with a deleterious mutation have fewer chances to reproduce if the deleterious effect of this mutation is expressed earlier in life. For example, patients with progeria (a genetic disease with symptoms of premature aging) live for only about 12 years (Turker, 1996) and, therefore, cannot pass their mutant genes to subsequent generations. In such conditions, the progeria stems only from new mutations and not from the genes of parents. By contrast, people expressing a mutation at older ages can reproduce before the illness occurs, such as the case with familial Alzheimer's disease. As an outcome, progeria is less frequent than late diseases such as Alzheimer's disease because the mutant genes responsible for the Alzheimer's disease are not removed from the gene pool as readily as progeria genes and can thus accumulate in successive generations (Le Bourg, 2001). In other words, the mutation accumulation theory predicts that the frequency of genetic diseases should increase at older ages (Bengston, *et al.*, 2009).

Mutation accumulation theory allows researchers to make several nontrivial testable predictions. In particular, this theory predicts that the dependence of progeny lifespan on parental lifespan should not be linear, as is observed for almost any other quantitative trait demonstrating familial resemblance (for example, body height). Instead, this dependence should have an unusual nonlinear shape with an increasing slope for the dependence of progeny lifespan on parental lifespan for longer-lived parents. This prediction follows directly from the key statement of this theory that the equilibrium gene frequency for deleterious mutations should increase with age at onset of mutation action because of weaker (postponed) selection against later-acting mutations (Charlesworth, 1994). The term equilibrium gene frequency refers here to the ultimate, time-independent gene frequency, which is determined by mutation-selection balance (equilibrium between mutation and selection rates).

According to the mutation accumulation theory, one would expect the genetic variability for lifespan (in particular, the additive genetic variance responsible for familial resemblance) to increase with age (Charlesworth, 1994). The additive genetic variance refers here to variance of additive genetic origin (variation due to the additive effects of genes on a particular trait in a genetically heterogeneous population), and this variance increases with an increase in mutation frequencies (Charlesworth, 1994). The predicted increase in the additive genetic variance could be detected by studying the ratio of additive genetic variance to observed phenotypic variance. Tins ratio {the so-called narrow-sense heritability of lifespan) can be easily estimated as the doubled slope of the regression line for the dependence of offspring lifespan on parental lifespan (Falconer and Mackay, 1996; Lynch and Walsh, 1998).

Thus, if the ages at death were indeed determined by accumulated late-acting deleterious mutations, one would expect this slope to become steeper with higher parental ages at death

(Gavrilova, *et al*., 1998). This prediction was tested through the analysis of genealogical data on familial longevity in European royal and noble families, data well known for their reliability and accuracy. It was found that the regression slope for the dependence of offspring lifespan on parental lifespan increases with parental lifespan, exactly as predicted by the mutation accumulation theory (Gavrilova, *et al.*, 1998; Gavrilov and Gavrilova, 2001; Gavrilova and Gavrilov,'2001). The current status of the mutation accumulation theory could be characterized as a productive working hypothesis pending further validation.

2.3.5 Modernization theory

In the influential modernization model of aging, the social and economic changes associated with modernization produce a relative decline in the status and welfare of older people. Demographic forces are thought to play a role here as well, not only in the putative link between small proportions of old people in the population and their high status in the past but also in a somewhat more complicated fashion. The fact that women bore children until they were about 40, combined with the fact that people presumably did not live as long in the past, meant that there was no old age distinct from middle age (Haber, 1983). In this view, with increase in longevity, the limitation of childbearing to the younger fecund years, and the increased movement of adult children away from the parental home, a distinct period of old age became established, one in which the elderly were increasingly isolated and powerless.

The tendency of old people to become more isolated from work and family with modernization has, however, been denied by many scholars (Dupaquier *et al.*, 1981; Smith, 1984; Sokolovsky, 1997). Criticisms come primarily from two sources; first of all, historians have identified past Western societies in which old people were not provided support by kin and suffered from

economic privation, secondly, anthropologists and others have demonstrated that not all small-scale societies accorded high status to the old. They have shown that in many non-western societies today, urbanization has not undercut heavy reliance on extended kin relations. On the contrary, such ties continue to provide older people in the societies with security, and status.

Part of the confusion in all this stems from the imprecise or muddled nature of the modernization concept. Modernization has been identified variously with urbanization, industrialization, the demographic transition, the spread of public, secular schooling, the spread of stale-run well are institutions, the advent of modern medicine, and many other developments. There is no clear reason why all of these forces should be thought to have the same impact on the status or welfare of older people. One of the most common claims of the modernization and aging literature is that in the past old people were provided a secure existence through co-residence with their children (a scenario still common in Africa and most developing countries). Such co-residence was often associated with households that were economic units, providing older people both with continued work roles and with control over property that placed them in a position of authority over their adult children.

Critics of the modernization model have jumped at the evidence coming in from the work ofLaslett, (1972) which seems to suggest that extended families were not in fact common in the Western past. The most striking criticism of the modernization model sprang from the startling discovery that the nuclear household was the predominant form in preindustrial western societies. This discovery, led to the conclusion that the aged could not have exercised power through an extended family (Gratton, 1986). It is not at all certain that older people in general lived apart from their children in the European past, nor even that they do in all places today. Characterization of living arrangements in Austria is of interest here. In harmony with the

traditional modernization model, the authors argue that historically speaking, the isolation of the aged ... is a relatively recent phenomenon. It is mainly a result of industrialization and urbanization. The authors bolster their case by pointing to contemporary Lower Austria, contrasting the high proportion (44%) of people over age 60 in the rural population who live with one of their married children to the low proportion (14%) among the non-rural population (Mitterauer and Sieder, 1982).

2.4Review of Related Literatures

2.4.1 Population aging

As the study of population aging is often driven by a concern over its burdening of retirement systems, the aging of population is often measured by increases in the percentage of elderly people of retirement ages (Gavrilov and Heuveline, 2003). The definition of retirement ages may vary (for instance retirement age of 70yrs for Supreme Court Judges and Professors in Nigeria) but a typical cutoff is 65 years, and nowadays a society is considered relatively old when the fraction of the population aged 65 and over exceeds 8-10%. By this standard, the percentage of elderly people in the United States stood at 12,6% in 2000, compared with only 4.1% in 1900 and a projected increase to 20% by the year 2030 (Gavrilov and Heuveline, 2003).

A related measure of population aging is the elderly dependency ratio (EDR): the number of individuals of retirement ages compared to the number of those of working ages. For convenience, working ages may be assumed to start at age 15, although increasing proportions of individuals pursue their education beyond that age and remain, meanwhile, financially dependent, either on the state or, increasingly, on their parents or bank managers. The ratio of the elderly dependent population to the economically active (working) population is also known as

old-age dependency ratio, age-dependency ratio or elderly dependency burden and is used toassess intergenerational transfers, taxation policies, and saving behavior,

Another indicator of the age structure is the aging index (sometimes referred to as the elder-child ratio), defined as the number of people aged 60/65 and over per 100 youths under age 15. In 2000, only a few countries (Germany, Greece, Italy, Bulgaria, and Japan) had more elderly than youth (aging index above 100). By 2030, however, the aging index is projected to exceed 100 in all developed countries, and the index of several European countries and Japan are even expected to exceed 200. To date, aging indexes arc much lower in developing countries than in the developed world, but the proportional rise in the aging index in developing countries is expected to be greater than in developed countries (Gavrilov and Heuveline, 2003).

These indicators of population aging are mere head-count ratios (HCR), that is, they simply relate the number of individuals in large age categories. These indicators fail to take into account the age distribution within these large categories, in particular among the elderly. When the fertility and mortality trends responsible for population aging have been fairly regular over time, the population growth are positively correlated with age (i.e., the oldest age groups arc growing fastest). This implies that if the proportion of the population over age 65 is increasing, within that 65-and-over population the proportion over, say, age 80 is also increasing. As health financial situation and consumption patterns may vary greatly between 65 year-olds and 80 year-olds, simple ratios conceal important heterogeneity in the elderly population. Increasingly, attention is paid to the oldest olds (typically age 80 and over). A long-time subject of curiosity, the number of centenarians is growing even faster. Estimated at 180,000 worldwide in 2000, it could reach 1 million by 2030 (United Nations, 2001).

The second class of indicators for population aging is the group of statistical measures of location (median, mean and modal ages of population). The median age: the age at which exactly half the population is older and another half is younger is perhaps the most widely used indicator.- For the year 2000, the median age in the United States was 36 years, typical age for most developed countries and twice the median age for Africa (United Nations 2001), Because it is more sensitive to changes at the right-hand tail of the age distribution (i.e., the oldest old ages), the mean age of population might in fact be preferred to the median age to study the dynamics of population aging (Gavrilov and Heuveline, 2003).

Since population aging refers to changes in the entire age distribution, any single indicator might appear insufficient to measure it. The age distribution of population is often very irregular, reflecting the sears of the past events (wars, depression etc.), and it cannot be described just by one number without significant loss of information. Were the age distribution to change in a very irregular fashion over the age range, for instance, much information would be lost by a single-index summary. Therefore, perhaps the most adequate approach to study population aging is to explore the age distribution through a set of percentiles, or graphically by analyzing the population pyramids. Demographers commonly use population pyramids to describe both age and sex distributions of populations. Youthful populations are represented by pyramids with a broad base of young children and a narrow apex of older people, while older populations are characterized by more uniform numbers of people in the age categories.

The current level and pace of population aging vary widely by geographic region, and usually within regions as well, but virtually all nations are now experiencing growth in their numbers of elderly residents. The percentage of world population aged 60 and over only increased from 5.2% in 1950 to 6,9% in 2000. In Europe, however, the proportion is 14.7% in 2000. For a long

time, the highest proportions where found in Northern Europe (e.g., 10.3% in Sweden in 1950), but had moved South by 2000 (18.1% in Italy). The proportions of elderly are lower outside of Europe with the notable exception of Japan where it increased from 4.9% in 1950 to 17.2% in 2000. In Africa it was 5.2% by 2005 (Kinsella and Velkoff, 2001; UN, 2005). The age structure of the United States continues to be marked by the large birth cohorts of the baby boom (people born from 1946 through 1964), not yet aged 65. The proportion of the elderly population in the U.S., 12.3% in 2000, hence remains low compared to the developed-country standards (Gavrilov and Heuveline, 2003).

2.4.2 Determinants of agingpopulation

To understand the demographic factors that cause population aging, demographers often refer to stable populations (Preston *et al*. 2001; Gavrilov and Heuveline, 2003). This population aging determinant model assumes that age-specific fertility and mortality rates remain constant over time, and this result in a population with an age distribution that stabilizes and eventually becomes time invariant as well. Conversely, this theoretical model suggests that any change in age structure, and population aging in particular, can only be caused by changes in fertility and mortality rates. The influence of changes in fertility rates on population aging is perhaps less intuitive than that of mortality rate (Gavrilov and Hauvellno, 2003), Everything else constant, however, a fertility decline reduces the size of the most recent birth cohorts relative to the previous birth cohorts, hence reducing the size of the youngest age groups relative to that of the older ones.

The effects of changes in mortality rates on population aging appear more intuitive, but are in fact more ambiguous. If increases in the human life span are correctly linked to population aging,

reductions in mortality rates do not necessarily contribute to population aging. More specifically, mortality declines among infants, children and persons younger than the population mean age tend to lower the population mean age. A moment of thought suggests that indeed a reduction of neonatal mortality (i.e., death in the first month of life) adds individual at age zero and should lead to the same partial alleviation of population aging as an increase in childbearing.

Population aging is thus related to the demographic transition that is the processes that lead a society from a demographic regime characterized by high rates of fertility and mortality to another one with lower fertility and mortality rates (Gavrilov and Heuveline, 2003). In the course of this transition, the age structure is subjected to different influences. In the typical sequence the transition begins with successes in preventing infectious and parasitic diseases that benefit infants and young children most. The resulting improvement in life expectancy at birth occurs while fertility tends to remain unchanged, thereby producing large birth cohorts and an expanding proportion of children relative to adults. Other things being equal, this initial decline in mortality generates a younger population age structure.

After initial and sometimes very rapid gains in infant and child mortality have been achieved, further mortality declines increasingly benefit older ages and are eventually accompanied by fertility declines. Both changes contribute to reverse the early effect of mortality decline on the age structure, and this synergy is known as the double aging process. This corresponds to the experience of most developed countries today, but further decomposition suggest that their history of declining mortality is the dominant factor in current aging (Preston, Himes and Eggers, 1989). Mortality decline continues in these countries and the decrease in mortality rates among the oldest-old (85+ years) has actually accelerated since the 1950s (Gavrilov and Gavrilova,

1991). This latest phase of mortality decline, which is concentrated in the older age group, is becoming an important determinant of population aging particularly among women.

The rate of population aging may also be modulated by migration, immigration usually slows down population aging (in Canada and Europe, for example), because immigrants tend to be younger and have more children. On the other hand, emigration of working-age adults accelerates population aging, as it is observed now in some Caribbean nations. Population aging in these countries is also accelerated by immigration of elderly retirees from other countries, and return migration of former emigrants who are above the average population, age. Some demographers expect that migration will have a more prominent role in population aging in the future, particularly in low-fertility countries with stable or declining population size (Gavrilov and Heuveline, 2003). The effects of migration on population aging are usually stronger in smaller populations, because of higher relative weight (proportion) of migrants in such populations.

2.4.3 Socio-economic profile of the elderly

The worsening economic situation affects the level and living conditions of the entire population and in particular, the elderly as the most unreliable segment. Elderly people today are significantly less lively to participate in the labour force than they were in the past (United Nations, 2002). The growing cost of living during to soaring retail prices, inflation and how pensions has led to a bigger gap between the economic prevention of pensioners and the changing living standards of the growing population. Thus, Bezrukov *et al*., (1995) reported that aged persons have acquired some negative aspects under condition of economic crisis production restructuring accompanied by a growing unemployment has pushed out from the labour market

those citizens who in accordance with existing legislation, are entitle to receive pension after retirement. As a result of this, they have been deprived of any opportunity to improve their material wellbeing, in other words there has been an increase in the number of ageing people who are fully dependent on the level and quality of social security in the country.

Older people's access to sources of income is usually far below what is necessary to secure self-sufficiency, while their continued participation in the labour force, for a long time a necessity rather than an opportunity, may be endangered by rapid economic change and growing obsolescence of human capital. The long arrangements of older people are normally an important determinant of their quality of life in line with this, Contterars and Lehr (1989) reported that it is likely that rapid processes of social and economic transformation have had important impacts on the household structures and on the positions of elders within them. Sherlock (1999) found out that significant proportion of older residents had migrated when already old often to gain access to superior health facilities or to accompany younger relatives.

According to the United Nation (2001), there is the reduction among men in labour force participation from 55percent in the labour force in 1950 to 30percent in 2000. Among women, the reduction was considerably smaller from 14percent in the labour force in 1950 to 30 percent in 2000.Traditionally, the population of older men that are economically active has been notably higher than the population of older women (National Research Council, 2001). It is not surprising therefore, to find that among the world's major areas, Africa has by far the highest proportion of economically active people among those 60 years and above (United Nations, 200la).

Living arrangements of older persons are of interest for both policy and scientific reasons. First, living arrangements may influence the material and psychological well being of and health status of the older generation. Correspondence with older parents may also affect the well being of other family members typically about children and grandchildren. A second major reason for policy concern is the potential tradeoff between public e.g. social security and private family - based support for older persons. Traditionally, family support has been developed within a co-resident family unit, and a decline in such arrangements is likely to coincide with a rising demand for public provision of some of the services formerly provided by family members. More generally, individuals micro decisions about co-residence have in the aggregate, macro effects in such areas as demand for social services and energy, water and other resource consumption; that is a trend towards the establishment of more numerous but smaller households can be expected to increase consumption and associated privately and publicly borne costs. Finally, there is a broader scientific interest in understanding major shift in family and household compositions. Over time and place and in trying to understand how family relationships are affected by economic and other social-changes in the course of development.

Data on living arrangements need to be supplemented by other information in order to understand the implication of changing residential patterns for older and younger person's welfare. But first there is need to know about preferences of older persons and of their next of kin. Secondly, for a comprehensive picture of support provided within the family, it is important to investigate the role of next of kin living elsewhere, since relatives and every non-relative long nearby may be an important source of emotional support and sometimes even distant kin may provide significant financial assistance. It is often difficult to argue convincingly what is best for older persons in terms of residential arrangements and, so between alternative policies options

(UN, 2001). At present, even on apparently self-evident matters such as the relationship between cc--residence and feelings of loneliness and isolation, we have no decide data.

It is also difficult to determine the effects of living arrangements on health, since ill health almost certainly affects living arrangements for only those who remain in moderately good health are likely to be able to live independently. The findings from (NPC 1998:159) stated that two thirds of all elderly persons (66%) were in labour force and this race of participation in the labour force more than twice the rate for the total national population which is 31%. Thus, the elderly participate more in the labour force than the total population is highest among the youngest of the elderly those aged 60 - 69 and gradually declines with increase in age. In Nigeria and Kaduna metropolis there are large numbers of old workers in agriculture and related sectors and a large majority of them are self-employed. In line with this, NPC (2002) reported that majority of the elderly were employed in agriculture and related occupations with about 44% of them in the area of study. Thus the finding also noted that Nigerians' greatest contribution to agricultural production is made by the elderly population.

It is obvious that the option of institutionalization is often ignored in discussions of living arrangements of older persons UN (2001) yet the issue is of great relevance and important to older persons everywhere. For the younger old, institutionalization was linked to health problems, while for the oldest old it was more often related to social situations, including a lack of potential family care givers. This is because the needs of the older persons who are in firm and deliberated may out ship the resources of members in a joint family, long term care and institutionalization will only become alternative for some people and this too is a matter for design of adequate policies. There are creative alternatives to both home based care and

institutionalization. This, for example, in some places older persons are beginning to reside in communities specially designed to them.

Older persons should have a say in determining the location and functioning of these communities for instance, a location near Downtown as may be preferred because it provides easier access to cultural activities and a range of shops and services. These communities help resolve some of the social integration problems referred to earlier. However, whether they become widespread or not will depend on social, economic and -ultimately cultural conditions (UN, 2001).

At present, living with children and either kin may be the only option available to the majority of older persons especially in Nigeria and those who lack this option may face destitution although co-residence is not a panacea to the extent that older persons contribute to the household joint living arrangements may be tolerated and considered advantageous to all members of the household. But as older persons' contribution began to decrease and as they become more a source of demand for services, there is reason for concern that co-residence arrangements may begin to weaken. When co-residence becomes increasingly difficult or is simply not an option, for some people will necessarily have to enter institutions. Although the long arrangements of older persons have always been an important dimension of the study of ageing it is only recently that a strategic point has been reached as regards to it in the end in accumulation of the knowledge that enables us to make certain statements with confidence (UN 2001).

2.4.4 Health profile of the elderly

Health is a matter of prime importance for the elderly because it is staying reasonably well, among other things that help them to remain independently. According to World Health

Organization (WHO, 1989), health is been defined as a state of complete, physical, mental and social wellbeing and not merely the absence of disease or infirmity it should enable people to lead socially and economically productive life, and it is on this basis that it was noted that health states is a dynamic multidimensional concept of varying on a continuum from one extreme of ill health (death) to the other perfect health. The health status of the elderly will depend on two conditions. The first is access to satisfactory health or medical care. Health status will be worse for population with limited access to health or medical care and better elsewhere. The second condition is the composition of the population at any age according to risk profiles. This is a complex result of three factors. Early childhood exposure that is pen-natal and first five years growth and development, lifetime behavioural risk profiles (smoking, drinking, diet and exercise), and past purchase of health inputs possibly dependent on occupation and assets.

Although there are some knowledge about the effects of each of these factors on health status and mortality, we know virtually nothing about their prevalence. About half of the rate of increase of the population in this age group is associated with mortality decline in early childhood. These would be increasingly dominated by individuals who during their early childhood may have been exposed to conditions that would have been fatal several years earlier. To the extent that exposure to and contracting of conditions early in life has a physiological effect that endures and plays out many years later (Fogel, 1986; Fogel and Costra, 1997, Barker, 1997), we should expect that the health status will deteriorate. These effects are likely to be stronger among population that are more vulnerable or have less opportunity to purchase adequate health inputs.

As documented by Pailoni, DeVos and Pelaez (1999), important functions of the elderly will live in rural areas and will belong to the lowest social classes where they will be exposed to

conditions characterized by little or no access to satisfactory health care facilities and to mediocre informal care. The examples of respiratory tuberculosis, osteoporosis and dementia are cited as three conditions tightly linked to health status in the past that are likely to affect the health status of the elderly in the near future to a larger extend than they do now or than they ever did.

Hodikson (1975) also asserted that elderly persons or patients have a multiplicity of diseases partly accounted for by the accumulation of non-lethal diseases such as osteo-arthritis and deafness as well as infective hepatitis. This is in addition to the diseases mentioned earlier. This, health of older people has been approached from two different perspectives by Rowe (1991). The biomedical gereontological and geriatrics model commonly held by physicians and other medical commonly held by physician s and other medical personnel define health in terms of the related diseases and the presence or absence of disease. The functional model on the other hand defines health in terms of older people's level of funding and it is best summarized in a report by a world advisory group (1982). Health in the elderly is best measured in terms of functioning. Degree of fitness rather than extent of pathology, may be used as a measure of the amount of services the elderly will need from the community (WHO, 1989).

It has also been submitted by Harper (1998) that elderly Africans tend to perceive their health according to their inability to perform activities of daily living and not according to laboratory or X - ray findings. Based on this notion, it should be noted that elderly person's perception to their health in both cases contributes to their frequent delay in seeking care or reporting discomfort. Hence, because of the incidence of chronic illness that increases with age, the longer one lives, the more likely one is experience illness. Chronic illness increases the likelihood that many very old people will no longer be able to live independently but will require care. Consequently crisis

such as the need to change living arrangement financial problems and inability to perform self-care activities are ubiquitous events among the very old in Nigeria and in Nasarawa state particularly.

2.4.5 Need for concern of population aging

People are living longer and in some parts of the world, healthier lives. By 2030, 1 billion people are expected to be aged 65years and older. While this is a major achievement of the last century, significant challenges now confront us. Societal aging may affect economic growth, family sustainability, and international relations. Nigeria, with a population of about 140 million (NPC, 2006) has about 76 million constituting the dependent population made up of both the children below age 18 and the elderly above 60 years and above (NBS, 2007). This figure shows that about 54% of population is dependent and this is expected to increase over the years going by the population transition demographic theory (Olaniyan *et al.*,2011).

Several studies have also shown that per person expenses are greater among the elderly than the younger (Waldo and Freeman, 1989; Cutler and Meara, 1997; Hitiris and Posnett, 1992). In addition, Ried (1996) suggested that more is spent on the elderly on a per capita basis with a ratio of 2.9 in Sri Lanka. In most developing nations with the extended family system still common, the elderly live under the care of their children and financial support remains their main source of funding (Mosley *et al.,* 1993). The elderly proximity to death was also found to exert significant positive effects on healthcare expenditure. This is the case when Hitiris and Posnett (1992) estimated that per capita personal health expenditures among the oldest (85 years and above) were three times higher than those in the age group 65-74 years and twice those in the age group 75-84 years in the United States. Another reason why population aging matters,

especially in developing world, and most especially Nigeria, is the dynamics in the family structure over the years.

2.4.6 Nigerian family structure

The Nigerian family used to consist of members of the extended lineage, parents, grandparents, aunts, uncles, brothers, sisters, cousins, nephews, nieces, etc. a large family indeed. Before westernization came to weaken the concept of the extended family system and replace it with the nuclear family, the extended family as a social structure served more or less as a form of social insurance (traditional safety net) for old age (Ajomale, 2007).

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. Family members however are unable to effectively cope with the challenges of daily living. Emphasis is now on the nuclear family of me, my wife and my children at the expense of other members of the wider family network, especially the older ones who look up to the younger generation to provide them with economic security in old age. The government does not provide social security for older persons. These changes in family structure in Nigeria have caused gradual disintegration of the extended family and of the communal sense of living in Nigerian society (Ajomale, 2007).

Neglect of filial obligations due to these structural changes has further impoverished older people and created more physical and social distance between family members. A lot of these older people have resolved to beg in order to survive or getting employed as cleaners, security guards, load carriers, or petty traders. It is gratifying to note that social support traditionally

given to older persons still exists, daughters and daughters-in-law coming to the rescue of older people though sometimes with adverse effects to their own health and domestic relationships. In Nigeria, the family is charged with the responsibility for the provision of care and support for the older person. Such care and support are voluntary and reciprocal, without any form of compensation. Family members, especially adult children, form the bulk of informal support for older persons. The care of the older relative is a value which is culturally rooted and highly respected.

2.4.7 Challenges posed byagingpopulation

Population aging generates many challenges and sparks concern about the pace of future economic growth, the operation of financial integrity of healthcare and pension systems and the wellbeing of the elderly.

2.4.7.1 The size and quality of workforce

Economic prosperity depends crucially on the size and quality of workforce. As people pass through the 50s and beyond, their labour force tends to decrease (Bloom et al., 2011). The stock of assets could also decrease as the elderly increasingly rely on their savings to finance their spending. The combination of possible labour market tightening and dissaving raises concerns that the steeply aging countries will experience slower economic growth (Boersch-Supan and Ludwig, 2009; Bloom *et al.*, 2011). Some countries may even face the shrinkage of their economies.

2.4.7.2 Labour force participation

Labour force participation declines with age, especially after age 50, but work patterns for older people vary among and within countries (Kinsella and Phillips, 2005). Older people in more developed countries are generally less likely to work than those in less developed countries. Only 20% of men aged 65 and older participate in the labour force in some countries, whereas more than one-half are economically active in certain less developed countries. National differences in labour force activity associated with societal wealth (Kinsella and Phillips,2005). Wealthier countries tend to have much lower labour force participation rates among older residents than do low-income countries (Clark *et al.,* 2000).Older men and women in less developed countries are much more likely to work than those in industrialized nations. Older people in predominantly rural agrarian societies often work out of necessity. Retirement may be a luxury reserved for urban elites. More than 50% of all older men are considered economically active in countries like Bangladesh, Indonesia, Jamaica, Pakistan, Mexico and Zimbabwe (Kinsclla and Phillips, 2005). Older women workers in less developed countries work in agriculture (OECD, 2000).

2.4.8 The economic impacts of population aging

2.4.8.1 The importance of age structure

Models and perspectives on the determinants of economic growth are plentiful in the academic literature. The importance of improved productivity within all sectors, and the need for sectoral shifts, i.e., the reallocation of labour from the low productivity agricultural sector to the higher productivity industry and service sectors were highlighted. For instance, Tyres and Shi, (2007) emphasize the contribution to growth of techno logical progress, human capital, institutions and governance, macroeconomic and trade policies, and random shocks. Still others stress feedback

effects that run from economic growth to technical progress and human capital accumulation, which in turn influence economic growth. Tyres and Shi (2007) introduce demographics (population size and age, sex, and skill composition) into a dynamic computable general equilibrium model of the world economy with exogenously-determined age patterns of labor force participation, consumption, and savings. Their work indicates that accelerated population aging (via lower fertility) tends to enhance real per capita income growth in regions with very young populations and slows it in regions with older populations and low rates of labour force participation among the elderly (e.g., Western Europe). Based on a model that is similar in spirit, though demo-graphically less fine-grained. McKibbin, (2006) reaches qualitatively similar conclusions, but also highlights the implications of global demographic change for international trade and capital flows and therefore for domestic economic performance.

As noted Paul Krugman has expressed a dim view of such concerns in so far as they apply to the Social Security system in the United States, because its critics misrepresent its financial stability and are motivated by concerns that go far beyond Social Security itself. The key premise here is that changes, in population age structure may exert a significant influence on economic growth. We adopt a life cycle perspective, based on the fact that people's economic needs and contributions vary over the various stages of life. Specifically, the ratio of consumption to production tends to be high for the youth and elderly and low for working-age adults. This means that key drivers of economic growth such as aggregate labor supply, productivity, consumption, and savings will lend lo vary depending on where most people fall in the life cycle. Among these factors, it is well understood that labour supply and savings are higher among working age adults than among those aged 60 or above. Other things equal, therefore, a country with large cohorts of

youth and elderly is likely to experience slower growth than one with a high proportion of working-age people.

The value of this approach can be seen in an analysis of the impact of changing age structure on East Asia's remarkable economic growth in the second half of the 20th century (Bloom andWilliamson, 1998). Rapid declines in infant and child mortality in the region began in the late 1940s, and these declines triggered a subsequent fall in fertility rates; the crude birth rate dropped from over 40 births per 1,000 people in 1950 to just over 20 by 1980. The lag between falling mortality and fertility created a baby boom generation, which was larger than the cohorts that preceded and followed it. As this generation reached working age, it boosted savings rates and also the size of the labor force from 1965 to 1990, the working-age population grew by 2.4 percent annually and the dependent population by just 0.8 per cent. Bloom and Williamson (1998), Bloom, Canning, and Malaney (2000) estimate that this demographic dividend explains up to one-third of East Asia's economic miracle between 1965 and 1990. Bloom, Canning, and Sevilla (2003) provide a more extensive exposition of this phenomenon, while Bloom and Canning (2008) emphasize the importance of appropriate institutions and policies in bringing about the demographic dividend.

2.4.8.2 Accounting effects of population aging

If age-specific behaviour with respect to labor supply and savings were fixed, labor supply and savings per capita would tend to decline with a rising elderly share of the population. Keeping all other factors such as productivity and migration equal, this would imply lower growth in income per capita. This frame of reference appears to underlie the rather alarmist views of commentators

such as Peter Peterson, who has argued that, global aging could trigger a crisis that engulfs the world economy and may even threaten democracy itself (Peterson, 1999).

2.4.8.2 Living arrangements and family relationships

In the past, and still today in many less developed countries, the higher status of the elderly was tired partly to the fact that as old age approached, they were situated in their own housing unit.Even if they live with their children, it was likely that the children (typically a son with his family) were actually living in the parental home, rather than the other way around (Kertzer, 1995; Weeks, 2005). The concept of filial piety, of respect for one's parents, has been a traditional value in most cultures, encouraging children to take care of their parents when the need arises. In high mortality societies, the probability that parents would survive to old age (and the probability that their children would survive to assist them) was low enough so that relatively few people ever had to make good on that concept (Weeks, 2005).

In modern times, society after society has bemoaned the fact that the multi-generational family has been a victim of the movement towards smaller families, the expansion of the female labour market, the geographic mobility of villagers, and the tendency of the young towards individualistic life styles (Sung, 1995). To be sure, not all older people necessarily want to live with their children, especially if they are forced to be dependent on the children. A global phenomenon of intimacy at a distance has been emerging amongst older people (Weeks, 2005), Those who co-reside with children do so out of necessity, not necessarily because they prefer that arrangement (Da Vanzo and Chan, 1994), Although, some elderly people move around the time of retirement, most people age in place. This has led to the creation of what are sometimes called naturally occurring retirement communities (NORCs). A term originally applied to places

that are attractive to older migrants, and then became retirement communities (Hunt, 1984), but over time it has been applied to any apartment building or neighborhood where a high percentage (50% more) of the residents are more than 60 years of age. This is the spatial component of the life course. People are attracted to neighborhoods and particular apartment buildings because of the similarity of other people's demographic characteristics, including the stage of life. Then, perhaps even without people realizing it, the population ages together and becomes a retirement community (Weeks, 2005).It is probably most accurate to say that diversity in living arrangements is as much a part of the lives of older people as it is among the young. In more developed societies, the diversity of living arrangement among the elderly is compounded by patterns of marriage, divorce and remarriage in combination with differences in mortality between males and females (Weeks, 2005). The unbalanced sex ratio at older ages in most societies signals a change in marital status, which in turn means a change in living arrangements for many people as they grow older. In American and European Societies, older people are much more separated from their children than in Asian societies, such as Japan (Kinsella, 1995; Weeks, 2005). In Japan, it has long been the norm for older parents to live with a child (usually the eldest son).

2.4.8.2 Poverty and the aging

There are several factors that contribute to the chronic poverty among the aged in societies. As in most communities, the elderly are the poorest people who have been physically weak and suffer ill health (Bird and Shenyekwa, 2003). Amongst the elderly, the chances of being poor increases with age, and they grow up becoming unrelated individuals. According to National Population Commission (NPC, 2006), a third of the older elderly counted by the commission as unrelated individuals were below poverty threshold. Although, old age in general does not mean being in

absolute poverty, growing beyond sixty-five increases the chances of becoming poor because the older one is, the more their income levels declines (Thompson and Schulz, 1975). Thus growing old means continued income deprivation relative to that of a young person.

2.4.9 Coping strategies of the elderly

Coping strategies are emotional and mental response that helps us deal with stress; they are positive reinforcement and reinforce self-esteem. There are many coping strategies that could be of bad news which often assist in overcoming challenges and increase the likelihood of a sound health (Foundation for Health and Ageing, 2005). Various strategies are adopted by the elderly in order to cope with aging which specifically deals with things like physical disabilities, loneliness, rejection and feeling of worthlessness. The elderly find it difficult to live or cope in a society which views them negatively. Thus, if nothing is done to redress this negativity, the stress of ageing can be one of the most destructive, mental and physical process the elderly often experience in their lives. Because the aged are more prone to stress as they age, and so coping strategies for them are very important for continued health and wellbeing.

The elderly persons adopt some livelihood and coping strategies, some of which are reliance on casual labouring as a livelihood strategy, assisting fishermen, carrying and crushing stones, fetching water etc. This form of labour is poorly remunerated and puts the employee at the mercy of the employer, who often exploits the worker by getting too much done at the cheapest cost. Self-employment is also a livelihood strategy the elderly are involved in, which consists of petty trading, production and sale of local hand crafts and intellectual services etc. Note that regarding coping strategies, most elderly persons in rural areas, are also heavily dependent on remittances from their children mostly inform of cash or kind (Najjumba and Milindwa, 2003). Participation

in community and kinship activities is another form of coping measure adopted by the elderly in most societies. This serves as a major source of personal satisfaction. Being involved plays an important role in improving self-esteem and giving meaning to life. This is true for people of all ages, but is especially important for older adults. Becoming more involved and finding ways to contribute to communal affairs (i.e. participation in group activities, volunteering works, social activities amongst others), also helps to fight depression and improve overall wellbeing of the elderly.

CHAPTER THREE

THE STUDY AREA AND METHODOLOGY

3.1 The Study Area

3.1.1 Location and size

Lafia Local Government Area (LGA) is one of the thirteen Local Government Areas in Nasarawa State. It is located between Latitude 8^0 30' 0"N and 9^0 0' 0"N and Longitude 8^0 10' 0"E and $9^0$0' 0"E (see Figure 3.1) Lafia LGA has a land area of about 2756.44 sq km and shares boundaries with Nasarawa Eggon LGA to the North, Obi LGA to the South, Doma LGA to the West and Plateau State to the East. The LGA is made up of 13 wards namely; Adogi, Agyaragu Tofa, Akurba/ BakinRijiya, Arikya, Ashigye, Assakio, Chiroma, Gayam, Keffi Wambai, Makama, Shabu/ Kwandere, Wakwa and Zanwa. The wards that will form the sampling units for this study include; Akurba/BakinRijiya, Chiroma, Gayam, Makama, Shabu/Kwandere and Zanwa, which have been selected using purposive sampling (Akwa *et al* 2015).

Lafia is a nodal town in the sense that roads from different locations meet in the town. These roads are trunk A roads from Jos, Makurdi, Shendam and Doma. Transportation within and outside the town is aided by the Nasarawa State Urban Mass Transport Agency (NSUMT) as well as other public and commercial transports. Lafia also has a railway line that runs from Kaduna after passing through Ancho, Gudi, Mada Station, Lafia, Yelwa and Kaba before reaching Makurdi (Onosemuode, 2005).

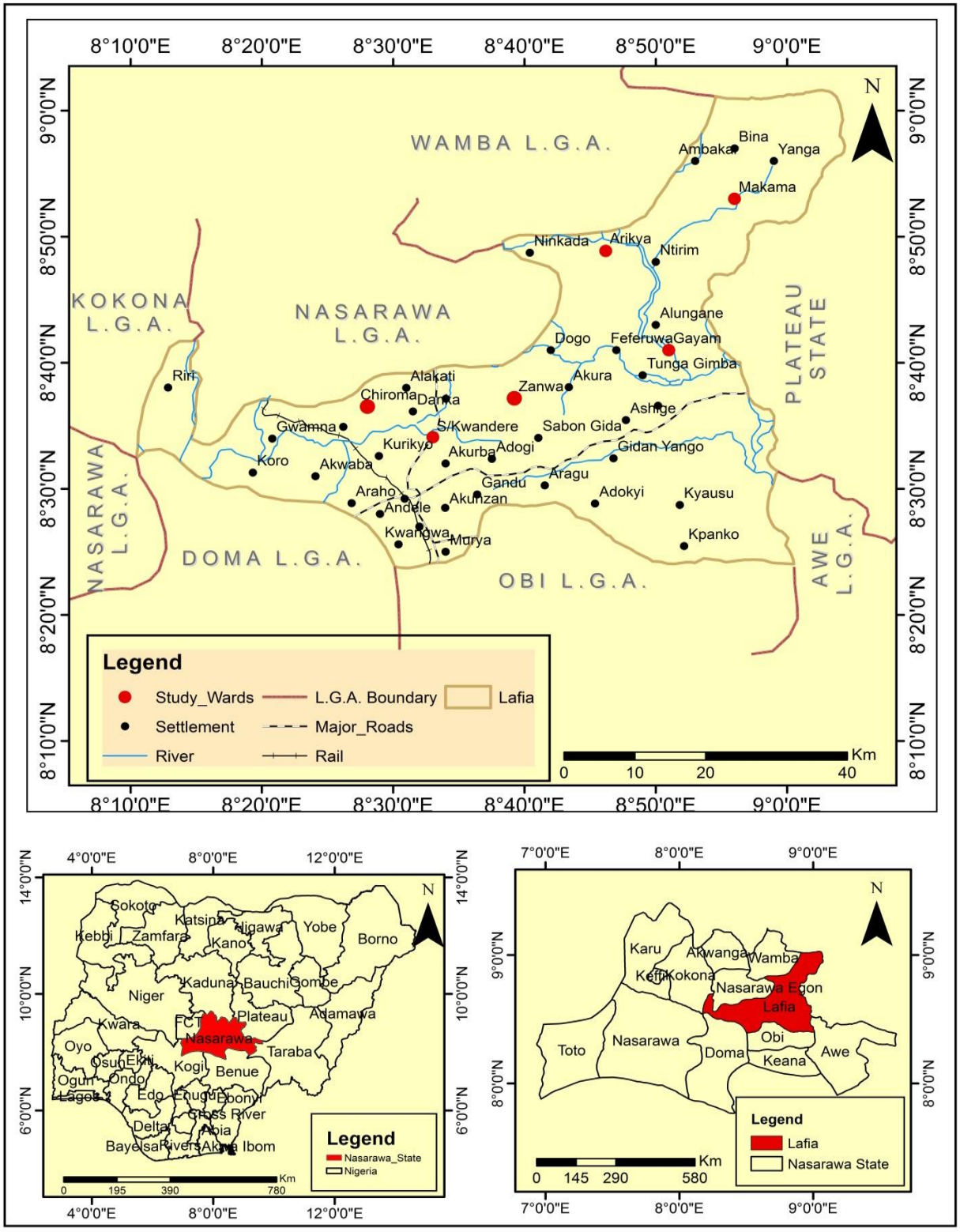


Figure 3.1: Nasarawa State showing the Study area.
Source: Adapted from administrative map of Nasarawa state

3.1.2 Climate

Lafia LGA is characterized by a tropical sub-humid climate with two distinct seasons of wet and dry. The wet season begins in May and ends in October while the dry season begins from November and ends in April. The annual rainfall experienced in this area ranges from 1100mm to about 2000mm and about ninety percent (90%) of this rain falls between the months of May and September with July and August being the months with the highest amount of rainfall. The rain in Lafia comes with thunderstorms of high intensity especially at the beginning and towards the end of the rainy season. Rainfall distribution over time in the area extends from March to October but a false start is often experienced in February which in most cases is the conventional type. The mean annual rainfall of the area ranges from 1250-1500mm which makes the area very conducive for crop cultivation such as cassava, melon, soya beans, and groundnut and so on (Binbol, 2007).

Temperature in this area is generally high during the day particularly in the months of March and April. The monthly temperature of the area can be as high as 34^0c and as low as 20^0c with the hottest months being March and April while the coldest temperature is experienced in the months of December and January (Binbol, 2007). Rainfall and temperature are key determinants of some diseases such as malaria. Therefore the climatic condition of the area can influence the health condition of the elderly either positively or negatively especially as they are said to have a weaker immune system due to old age.

3.1.3 Soils and vegetation

Lafia LGA compose of mostly the sandy loamy soil type which are formed from the sedimentary geology of sand stone, although some lateritic iron pan and associated concretionary gravels

overlie them as a result of marked dry season alternating with a wet season, this lateritic soils are little because root growth and development is very limited, but it is very good for construction purposes. The sandy soil enhances the growth of leguminous plants such as groundnuts and root crops such as cassava (Samaila and Ezeaku, 2007).

Lafia LGA possess the guinea savannah type of vegetation, however, the activities of man such as the clearing of vegetation for farming, for fuel wood, extraction of domestic milling as well as for construction purposes has led to the development of re-growth vegetation at various levels, although gallery forest can still be found along the banks of some river channels in the area. economic trees such as palm tree, locust bean tree and shea butter are present, also grasses of various types such as spear grass, elephant grass (Gambia grass) etc which ranges from tall to short are also available (Samaila and Ezeaku, 2007). Uncontrolled vegetation cover brings about breeding grounds for many disease carriers, pest and vectors. This therefore could bring about poor sanitary condition which may lead to the prevalence of diseases such as malaria and typhoid in the area

3.1.4 Relief and geology

Lafia LGA lies within the belt of low lying gentle undulating to almost flat plains in its landscape. It has low dissected hills, to the rolling hills and densely dissected plateau, which may be measuring up to some few meters above sea level. At some points, the general geology of most part of the area is composed of sand stone and shale cretaceous rocks. A few added rocks are basalt of the younger granites series and alluvium, also some of the basement complex features at some given points. However, the entire region is mostly sandy in nature (Obaje, *et al.*, 2007).

3.1.5 Drainage

Lafia LGA is drained by three major rivers which are the Mada River, Ankwe River and Guma River. Mada River took its source from the Mada hills and flows east to west direction of Lafia, compose of Ahoma and some few seasonal tributaries that drains into river Benue. The Ankwe river which is referred to as the upland river, flows from south to east direction of Lafia thereby supplying water to rivers Ankwe and Dap as well as other small rivers like Antkia Tam, Fete, Akwini, Bill Azara and Asofi rivers. The Guma river which is often called the Guma water shed flows from north to south of the area. The drainage structure and pattern ranges from the medium through coarse dendritic types which feed most residents of Lafia LGA. The main drainage basins of the area are drained by the river Benue and its tributary (Samaila and Binbol, 2007). The importance of proper drainage system to human live cannot be overemphasized. This is because in rural areas it could serve as sources of domestic water supply while in the urban areas, built drainage helps in preventing hazards of flood, breeding sites for vectors and some disease carriers.

3.1.6 Historical background of Lafia LGA

The literal meaning of the name Lafia LGA is well. Lafia derived its name from some immigrant (Kanuris) settlers who found refuge in the area as they migrated from Bornu state. It was acknowledged that these people ran away from the attack of their enemies and found refuge at the place by the end of 18^{th} century. They got access to the place through the elders of the region who formally settled at Doma, which is just few kilometres away from Lafia LGA, thus in the process of authorizing them to settle in peace, well in this region by the elders through the Emir, came about the name Lafia LGA which exist till present day. Since then, there has been a cordial

relationship and interaction between the immigrants and the indigenes in almost all area of life amongst which are culture, intermarriage and social life-style (Dalat and Filaba, 2007).

3.1.7 Population

Lafia Local Government Area based on the 2006 national population census exercise recorded a population figure of 330712 with 169398 male and 161314 female (NPC, 2009). Lafia LGA has a land area of 2797.53km^2 with a population density of 130 persons per km^2. Whereas population of the area going by registered total number of voters is recorded as 243,520 as shown in table 1.1 (NASIEC, 2011). With this figure, it is the most populated Local Government Area in the whole of Nasarawa State.

3.1.8 Education

The literacy rate among the citizenry is fast increasing with the availability of numerous schools in area (Ndabula, 2001). Education in Lafia LGA is organized around a number of levels, the pre-primary, primary and post primary of all types including the universities. There were 158 primary schools with 77927 enrolment, 42 secondary schools and 4 tertiary institutions with 28001 enrolment as at 2005 (SPEB and MOE, 2005).

Schools situated in Lafia LGA include College of Agriculture, Nasarawa State Polytechnic, School of Nursing and Midwifery, Faculty of Agriculture, Nasarawa State University, Keffi located in Habu-Lafia. The aim of all this institutions is to invest in human resources development for much needed states man power. High premium is placed on primary education which is the bed-rock upon which other academic structure can be built (Marcus, 2007). All these when harnessed properly, could lead to literate elderly.

3.1.9 Human activities

The strategic location of Lafia LGA to her neighboring towns' favors their mutual inter relationship, coupled with accessible network of roads linking them together. This enhances her importance as market centre which involves both indigenes and non-indigenes. People from various local governments also come to Lafia LGA to purchase goods. The establishment of a number of factories and industries has also enhanced commercial activities in Lafia LGA, some of which are; Delta prospectus industry, rice mill industry, soya beans processing industry, fertilizer blending plant and other small scale factories. These various commercial economic activities have led to the citing of some commercial institutions such as banks and insurance companies in Lafia LGA (Umaru, 2007).

A lot of agricultural activities take place in the area, one of which is farming. Majority of the population are engaged in subsistence farming, with very few farmers practicing large scale mechanized farming. A wide variety of crops are grown in the area, they include cassava, yam, groundnut, rice, millet, maize, cowpea, soya beans, guinea corn, tomatoes, sugar cane, mangoes, oranges etc. also animal production such as goat, cow, sheep, pig and rabbit rearing and poultry keeping is also common in this region (Labaris, 2007).

3.1.10 Healthcare systems

Health policies and programmes in Lafia LGA are directed towards the creation of a basic infrastructure and adequate manpower for the effective delivery of health services for the rapidly growing population. In 2005, there were 143 government/private healthcare facilities distributed throughout Lafia Local Government Area. This includes 129 primaries, 13 secondary and 1

tertiary health care facilities which are exclusively in the urban areas (Ministry of Health Headquarters Lafia, 2005). Some of the healthcare facilities in the area include Dalhatu Araf Specialist Hospital, Epidemiological Unit, PHC Doma road, PHC, Tudun Gwandara, PHC, Wadata, PHC, New market, PHC, Mana and Model PHC.

Healthcare services in Lafia LGA are provided by both government and private organizations. The policy on health in the area is related to the national policy on heath which takes into account the reality of health of the population as generally poor, resulting from inadequacies in this existing organization of healthcare services. Thus primary healthcare (PHC) was established with emphasis on prevention of diseases such as diphtheria, tuberculosis (TB), whooping cough, measles, poliomyelitis, cerebrospinal meningitis and yellow fever (Marcus, 2007).

3.2 Research Methodology

This section focuses on the various methods adopted in collecting, compiling and analyzing the data. The section will discuss the sources of data, sampling techniques, method of questionnaire administration and the methods of data analysis.

3.2.1 Reconnaissance survey

A reconnaissance survey of the study area was conducted, which enabled the researcher to get acquainted with the area and the wards selected. The reconnaissance survey helped in interacting with the people to know their general living conditions, their types and sources of support and to understand how the issues of the elderly are viewed from both social and cultural perspectives. It was found during the reconnaissance survey that the elderly in the study area need more care than they get at present.

3.2.2 Types of data utilized

The types of data required include;

i. Basic socio-demographic data of the respondents like; sex, age, marital status, religion.
ii. Information on the household socio economic characteristics of the respondents: level of education, household size of the elderly, number of children ever born, number of children surviving, occupation, source and level of income, feeding habits, nutrition, type of accommodation, ownership of accommodation and health care facilities.
iii. Information on respondent's medical history.
iv. Information on the elderly coping strategies.

3.2.3 Sources of data

This study utilizedbasically primary source of data while literature information and materials were from secondary sources.

3.2.3.1 Primary source

The primary data were obtained through the administration of questionnaires to the elderly and the conduct of six in-depth interviews with the Local Government Chairman, Head of Pencom, District heads of three (3) selected wards and one religious leader. Also Focus Group Discussions (FGDs) was employed. Six (6) FGDs (one in each of the selected wards) were conducted with a maximum of12 people per session. The questionnaire was structured based on the aim and objectives of the study, and also contain the general characteristics of the respondents and their living conditions of the elderly. The questionnaire address issues such as demographic characteristics of respondents (age, sex, marital status etc), socioeconomic

condition (nature of support, source of finance, satisfaction of support etc), health profile, and the coping strategy.

3.2.3.2 Secondary source

Secondary data include the total number of registered voters in Lafia LGA was obtained from the Independent National Electoral Commission (INEC). This is because there is no population record according to ward but registered voters has record based on polling unit as such computing the total for all polling units in a ward gave a ward figure. Also map of the study area was gotten from the Ministry of Land and Physical Planning of Nasarawa State. Journals, books, articles, newsletters, magazines, the internet and published and unpublished dissertations/projects, gazette, newspapers, conference papers, seminar papers, published and unpublished dissertation/projects were used to source relevant literatures related to the works for comparison.

3.2.4 Sampling size and sampling techniques

The study population consists of thirteen wards in Lafia Local Government Area. They wards include; Adogi, AgyaraguTofa, Akurba, Arikya, Ashigye, Assakio, Chioma, Gayam, Keffi Wambai, Makama, Shabu/ kwandere, Wakwa and Zanwa. Six wards were purposively selected because the remaining seven wards were having security challenges. These wards were those without any security concerns. The Distribution of Wards using the population of registered voters as shown in Table 3.1

Table 3.1: Distribution of Sample Population by Wards

Wards	Population of Registered voters	Selected Wards	No of Respondents	Percentage
Adogi	12137			
AgyaraguTofa	19379			
Akurba / BakinRijiya	19613	Akurba / BakinRijiya	58	14.5
Arikya	15020			
Ashigye	21004			
Assakio	15913			
Chiroma	43503	Chiroma	128	32.1
Gayam	31322	Gayam	92	23.1
KeffiWambai	11317			
Makama	10165	Makama	30	7.5
Shabu/ Kwandere	19961	Shabu/ Kwandere	59	14.8
Wakwa	13525			
Zanwa	10661	Zanwa	32	8.0
Total	**135225**		**399**	**100.0**

Source: NASIEC Lafia Office (2013).

The computation of the proportion of the questionnaires administered for each of the selected ward is in Table 3.1.

To determine the sample size for this study, the Yamane (1967) formula was used alongside the total number of registered voters (135,225) in the selected wards. The population of registered voters was used to determine the sample size because there was no actual figures of the 2006 population according to wards. The Yamane (1967) formula is given as:

$$Samplesize = \frac{N}{1+N\ (e)^2}$$

Where N - Total population of selected wards

e = error margin = 0.05 or 5%

$$\frac{135{,}225}{1+135{,}225\ (0.05)^2}$$

$$\frac{135{,}225}{135226 \times 0.0025}$$

= 398.9 approximately 399.

Therefore the sample size for this study is 398.9 approximately 399

The number of respondents to be administered with questionnaire is proportionate to the population of each ward.

$$\text{Proportion} = \frac{n}{N} \times 399$$

Where n = population of the selected ward

N = total population of the selected wards.

In each of the selected wards, the questionnaire was randomly administered to one elderly person per household. Two research assistants helped in questionnaire administration. The research assistants were trained on how to administer the questionnaire to respondents that could not speak English.

3.2.5 Method of data analysis

The methods of descriptive and inferential statistics test were used in analyzing the data for this study. All statistical analysis was carried out using Package for Social Science (SPSS version 20). The statistics used in achieving the objectives of the study is as follows:

Objective i, iii, iv, v was achieved through the use of frequency tables and charts where necessary to summarize the living conditions of the elderly, the type of support the receive and their sources of support.

Objective ii was achieved through the use of principal component analysis to determine the factors that mostly determine the living conditions of the elderly.

All the data generated at the end of every Focus Group Discussion and In-Depth Interviews were transcribed on return from the field. Verbatim transcriptions were made for all recorded Focus Group Discussion and In-Depth Interviews. The edited reports of each of the interviews were prepared by headings and the key findings were sorted and classified. This enabled the pooling of similar ideas and statements under a particular code across variables which was used to support the quantitative findings and where appropriate, quotes that best explained the living conditions of the elderly were identified and used in parallel with the quantitative findings to elaborate more on the insights of their conditions in the study area.

CHAPTHER FOUR

RESULT PRESENTATION AND DISCUSSION

4.1 Introduction

This study was carried out to evaluate the living conditions of the elderly in Lafia local government area of Nasarawa state. This chapter presents data obtained from the field. The result is presented in such a way as to address the objectives of the study.

4.2 Socio-Economic Characteristics of the Respondents

4.2.1 Sex

The gender distribution reveals that 59.1% of the respondents are males whereas the females constitute 40.9% as shown in Figure 4.1.

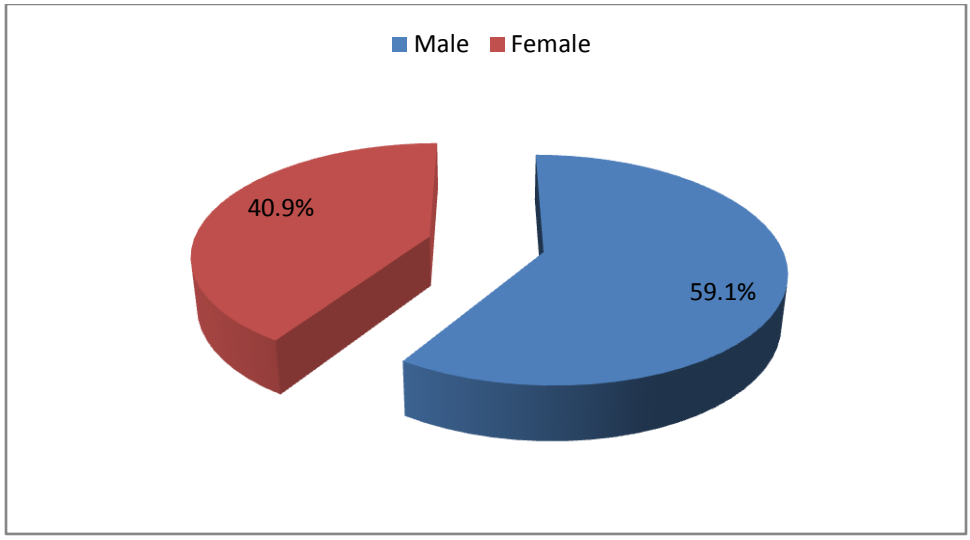


Figure 4.1: Percentage Distribution of the Respondents by Sex
Source: Field Survey, 2015

This finding corroborates that of NPC (2003) which reveals that there are more males than female in all age groups of 60 years and above. The higher proportion of males could be due to the fact that the questionnaire was administered on household basis. And usually, there are more male headed households than females.

4.2.2 Age

Table 4.1 shows that respondents within the age group of 65-69 years have the highest proportion of 47.9%, followed by those aged between 70-74 years with 29.1%. Majority of the respondents are in their early elderly age range of 65-74 years with 77% of the respondents.

Table 4.1: Distribution of Respondents by age group

Age Group	Frequency	Percentage
65-69	191	47.9
70-74	116	29.1
75-79	49	12.3
80 and Above	43	10.8
Total	**399**	**100.0**

Source: Field Survey, 2015

4.2.3 Religion

Figure 4.2 shows the distribution of respondents by religion. It shows that Muslims accounted for 58.4% of the respondents, followed by Christians with 27.1%, other religious adherents make up the remaining 14.5%.

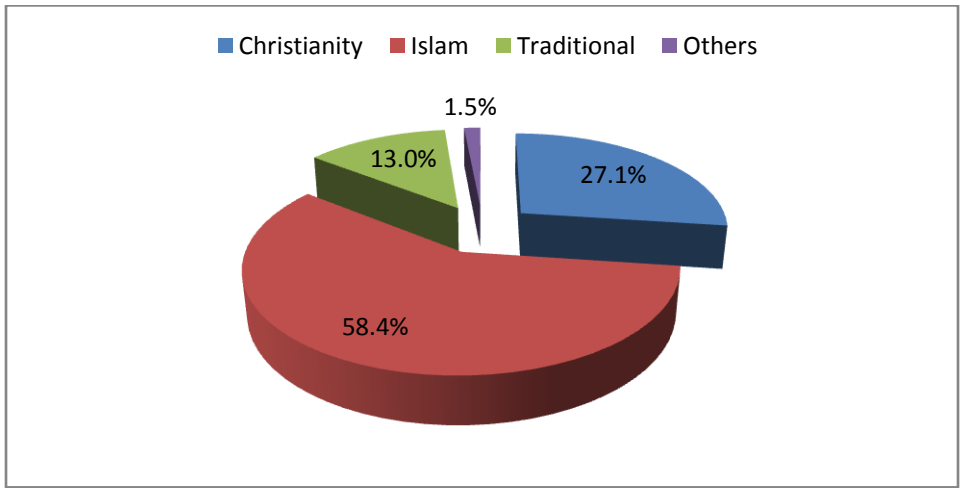


Figure 4.2: Distribution of respondents by religion
Source: Field Survey, 2015

This implies that Islam and Christianity are the major religions in the study area. Religion has the potential to influence the way of life of the people thereby affecting their longevity. The

influence of religion on the elderly was equally reaffirmed by McFadden (2005) as an important factor utilized in coping with the demands of later life by the aged in societies.

4.2.4 Marital status, type of marital union and number of children ever born

The demographic characteristics considered include; marital status, type of marital union and number of children ever born. They are presented in Table 4.2.

Table 4.2: Respondents Marital status, type and number of children

Marital Union	**Frequency**	**Percentage**
Single	18	4.5
Married	313	78.4
Divorced	28	7.0
Widowed	35	8.8
Separated	5	1.3
Total	**399**	**100.0**
Type of Marital Union	**Frequency**	**Percentage**
Monogamy	154	40.4
Polygamy	227	59.6
Total	**381**	**100.0**
Number of Children Ever Born	**Frequency**	**Percentage**
None	25	6.3
1-2	48	12.0
3-4	69	17.3
5-6	96	24.1
7-8	74	18.5
9-10	39	9.8
11 and Above	48	12.0
Total	**399**	**100.0**

Source: Field Survey, 2015

The Table 4.2 reveals that 78.4% of the elderly are married; this is followed by those that are widowed (8.8%), divorced (7.0%), single (4.5%) and separated (1.3%). This clearly implies that the elderly desire to have someone beside them to provide assistance, companionship, reduces boredom and aging associated health problems. This finding agrees with that of Wahab (2013) in a study on the elderly carried out in Ijebu of South Western Nigeria in which 47% of the respondents were in marital union. However, the relatively high percentage of the widowed is

not also surprising given the age of the respondents. It is believed that many would have lost their spouses given the fact that they are advanced in age.

As regards type of marital union, most of the elderly (59.6%) were in polygamous union while 40.4% were in monogamous union. The high number of those into polygamy when the religious distribution of the respondents is being considered, will not be a surprise as the practice can easily be traceable to the influence of both Islamic and cultural norms of the people which allows the practice of polygamy (Najjumba and Milinda, 2003).

It is understood that fertility, which is the occurrence of live birth, is a natural determinant of population (Barrete, 1996; Olorunfemi, 2004). Therefore, an examination of respondent's fertility is very fundamental since it is believed that adult children turn out to carter for their parent at old age. For number of children ever born, Table 4.2 shows that 64.4% of the elderly have had 5 children and above, while, 35.6% have four children and below. This shows that a large proportion of the elderly in the study area are observing the maximum four children as spelt out in the National population policy.

4.2.5 Educational Qualification

Figure 4.3 shows the distribution of respondents by educational qualification. It shows that 33.8% of the respondents have Quranic education, 28.1% have secondary school education, 20.6% have primary education and 13% have tertiary education.

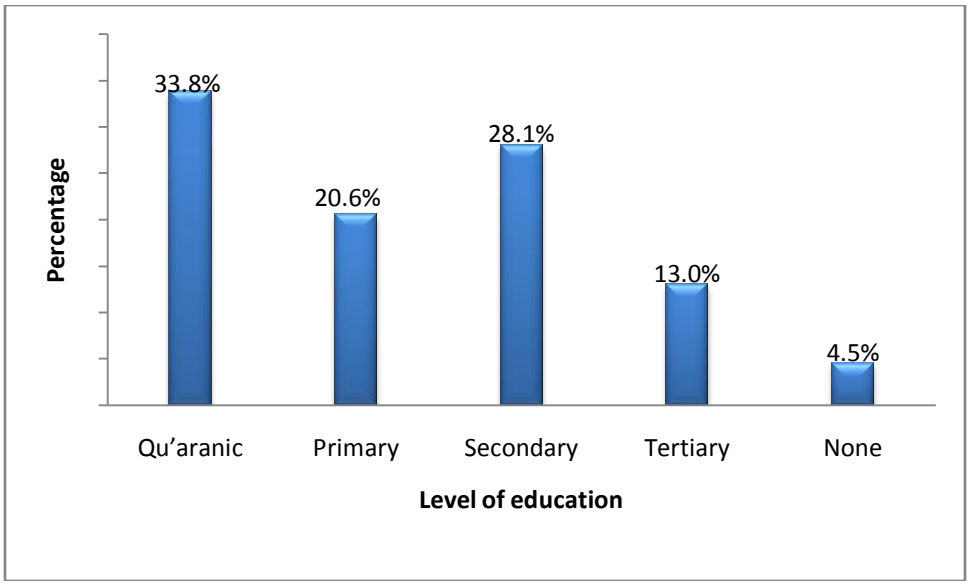


Figure 4.3: Distribution of Respondents by Educational Qualification
Source: Field survey, 2015

This result indicates that the elderly possess one form of education or the other. Those with formal education should be able to guarantee a paid job. But nonetheless, there is high number of those with just Qu'aranic education. This result agrees with the findings of NPC (2006), which shows that 55.5% of Nigerian elderly are not literate but disagree with the findings of Orire (2015) which revealed that a high percent of 31.8% of the elderly in Kwara have no education of any form at all.

4.3 Economic Characteristics and Housing Condition

The economic characteristics and housing conditions of the elderly considered include; occupation, level of income, housing type, ownership as well as living mate of the respondents which were presented below.

4.3.1 Occupation

The distribution of respondents by occupation is shown in Figure 4.4. A general over view of the Figure shows that 35.6% of the respondents are into farming; this is followed by respondents that

are into trading with 32.3%, while civil servants, artisan and others have 23.1%, 5.0% and 4.0% accordingly.

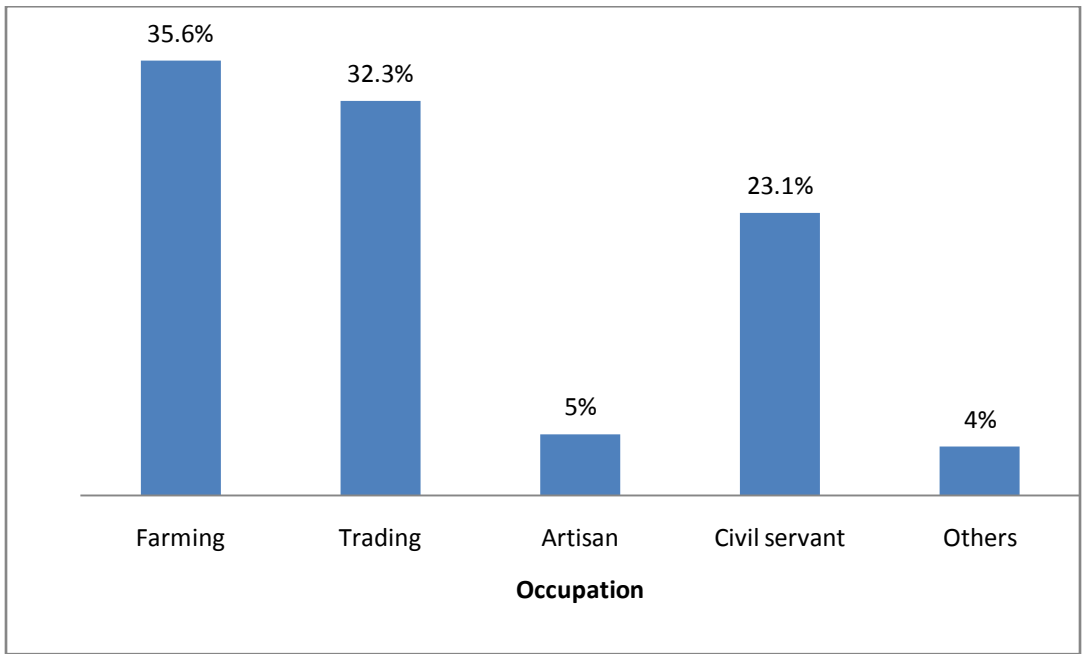


Figure 4.4: Distribution of Respondents according to type of occupation
Source: Field survey, 2015

One of the most important indices in demographic analysis is occupation, when it comes to assessing the living conditions of the elderly. This reveals that the area is most likely full of informal economic activities. Although the high number of farmers is to be expected in the study area because most of the elderly engage in agriculture. It also implies that educational status sometimes reflects the nature of occupation as earlier shown the educational qualification of the respondents to be more of informal education inclined.

4.3.2 Monthly income

The income of the respondents as revealed in Table 4.3 shows that 63.7% of the elderly have an income of less than ₦ 16,000 a month while 21.8% agreed to earn ₦ 21,000 and above monthly.

Table 4.3:Income Level of Respondents

Income Level in Naira	Frequency	Percentage
Less than 5000 Naira	94	23.6
5,000-10,000	119	29.8
11,000-15,000	41	10.3
16,000-20,000	58	14.5
21,000 and above	87	21.8
Total	**399**	**100.0**

Source: Field Survey, 2015

This explains the low income status of the elderly as a result many cannot afford to pay for the desired services they need for their wellbeing. This makes them heavily dependent on remittances from their children mostly in cash or kind. But the high number of those earning ₦16,000 and below can be tied to the fact that most elderly are expected to be retired or have reduced level of participation in active economic activities. Hence, most of them according to Najjumba and Milindwa (2003) are heavily dependent on remittances from their children mostly in cash or kind.

4.3.3 Type of accommodation

Table 4.4 shows the distribution of respondents by type of accommodation. It shows that majority of the respondents (33.6%) live in two room apartments while those living in one room make up 32.3%. Those living in three rooms, flat, bungalow and others constitute 15.0%, 14.0%, 3.8% and 1.3% accordingly.

Table 4.4: Distribution of Respondents according to type of accommodation

Type of Accommodation	Frequency	Percentage
One room	129	32.3
Two rooms	134	33.6
Three rooms	60	15.0
Flat	56	14.0
Bungalow	15	3.8
Others	5	1.3
Total	**399**	**100.0**

Source: Field Survey, 2015

Adebayo (2006) reiterates that a very vital human need which provides both psychological relief and physical shelter is housing. The issue of housing has always been global, which could be because most human activities are done in, on or under it. This implies that house type is greatly influenced by level of income as it can be seen that majority of the respondents earn less than ₦17, 000 monthly. In matters of the elderly, shelter is a major consideration as it is one of the key issue when discussing the welfare of the elderly.

4.3.4 Ownership of accommodation

Table 4.5 shows distribution of respondents by ownership of accommodation. It reveals that 41.9% of the respondents are in self-owned accommodation, 32.6% live in family houses while, 11.8% are in rented accommodation.

Table 4.5: Respondent's Ownership of Accommodation

Ownership of accommodation	Frequency	Percentage
Personal	167	41.9
Family house	130	32.6
Rented	47	11.8
Official quarters	33	8.3
Others	22	5.5
Total	**399**	**100.0**

Source: Field Survey, 2015

This is similar to a study by Asiyanbola, (2005)in Ibadan, where it was found that most of the elderly in Ibadan lived in owner occupier accommodation. The high level of owner occupier type of accommodation among the elderly in Lafia could be a function of educational qualification, type of occupation and above all income level as posited by Orire (2015).

4.3.5 Living mate

Table 4.6 shows distribution of respondents by their living mate. It reveals that majority of the elderly (32.3%) live with their spouses and children while 15.3% live with their spouses alone.

Table 4.6: Distribution of Respondents according to living mate

Respondent Living Mate	Frequency	Percentage
Children	89	22.3
Spouse	61	15.3
Spouse with children	129	32.3
Alone	40	10.0
Relatives	48	12.0
Others	32	8.0
Total	**399**	**100.0**

Source: Field Survey, 2015

When the elderly stay with their children it may improve their social wellbeing because the elderly find pleasure in playing with their grand-children. This support the argument of Mosley *et al,* (1993),that the elderly in most developing countries stay with the extended family thus living under the same roof with their children. Respondents who live with their children, alone, relatives and others constitute 22.3%, 10.0%, 12.0% and 8.0% in that order.

4.4 Living Conditions of the Elderly

In examining the general living conditions of the elderly in the study area, the study considered their nutrition, health condition and social activities. Individual nutrition status according to WHO (2001) and Adamu, Adjei and Kubuga, (2012), depend on the interaction between food eaten, the overall state of health and the physical environment. The nutrition characteristics of the respondents considered include; eating times per day, eating of balanced diet, eating of fruits and vegetables and nature of drinking water, whether boiled or not alongside reasons for non-boiling of water. However, the health characteristics considered include; record of hospital attendance in the last one year, nature of illness, treatment received, disability status/type, payment of hospital bills, and frequency of hospital visit. On the other hand, the activities of the elderly considered include; daily activities, social engagements and available facility found in the community. Social activities are other forms of coping strategies adopted by the elderly in most societies. Being involved plays an important role in improving self-esteem and gives meaning to life also.

4.4.1 Number ofmeals per day

Table 4.7 shows the distribution of respondents by number of times they eat food per day. It reveals that 46.4% and 40.9% of the respondents afford three and two square meals a day respectively while those who afford one square meal a day are 8.3%. The nutritional intake is vital when discussing the living conditions of the elderly in any society. It is obvious from this analysis that food intake among the elderly is fairly good as majority of the respondents (87.3%) are able to get at least two square meals per day.

Table 4.7: Eating times of Respondents per day

Eating Times per Day	Frequency	Percentage
Once	33	8.3
Twice	163	40.9
Thrice	185	46.4
Others	18	4.5
Total	**399**	**100.0**

Source: Field Survey, 2015

For one to have a very good or optimum nutritional status, one must be both food and nutrition secured, however most people are on borderline because it is hard to achieve (Williams and Schlenker, 2003; Adamu *et al*, 2012).

4.4.2 Intake of balance diet

Table 4.8 shows the distribution of respondents by intake of balance diet. It reveals that even out of those who can afford the food at varying number of times per day, 35.1% eat a balanced diet on weekly basis, while 22.8% on daily basis, 24.3% twice weekly, 11.3% three times per week and 6.5% constitute others.

Table 4.8: Respondent's Frequency of Eating Balance Diet

Eating of Balanced Diet	Frequency	Percentage
Daily	91	22.8
Weekly	140	35.1
Twice weekly	97	24.3
Thrice weekly	45	11.3
Others	26	6.5
Total	**399**	**100.0**

Source: Field Survey, 2015

Although, most of the elderly in the study area eat three square meals, but they do not eat balanced diets often. This non-consumption of food that is balanced is expected to have a negative effect on the elderly living condition. Balance diet comprises all the classes of food which includes; Carbohydrates (rice, corn, potatoes, yam), Protein (milk, beans, fish, peas), Vitamins (mangoes, apples, vegetables, strawberries) Minerals (plantain, Carrots), Lipids (Olive

oil, almonds), A diet is only balanced when it contains adequate amounts of all the necessary nutrients requirement for healthy growth and activity (Free Dictionary, 2012) and adherence to this balanced dietary regime is not noted amongst respondents in the study area.

4.4.3 Fruits and vegetable consumption

Table 4.9 shows the distribution of the respondents based on eating of fruits and vegetables, and revealed that all the respondents eat fruits and vegetables, but majority of the respondents eat fruits and vegetables weekly with 27.3%

Table 4.9: Distribution of Respondents on Eating of Fruits and Vegetables

Eating of Fruits and Vegetables	Frequency	Percentage
Daily	88	22.1
Weekly	109	27.3
Twice a week	53	13.3
Thrice weekly	85	21.3
Others	64	16.0
Total	**399**	**100.0**

Source: Field Survey, 2015

From the data presented in Table 4.9, 22.1% of the respondents eat fruits and vegetables on daily basis, 13.3% eat twice a week, 21.3% eat three times a week and 16.0% do not eat fruits regularly. Just a few of the elderly 22.1% do eat fruits and vegetables daily. Eating of fruits and vegetables on a daily basis by majority of the elderly could be due to the fact that prescription might have been given to most of them that suffer from one ailment or the other on the kind of food to eat.

4.4.4 Boiling of drinking water

Another issue very crucial to health and wellness of individuals in our society is the availability and access to portable water for individual needs and wants.

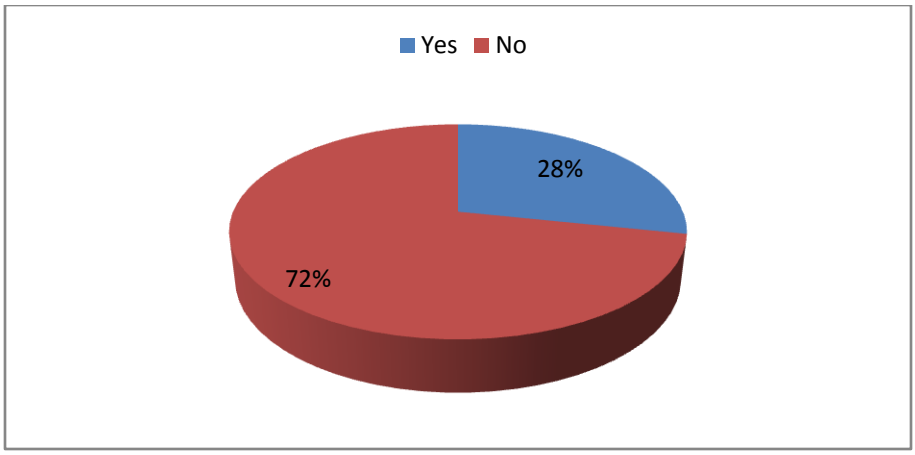


Figure 4.5: Distribution of Respondents by Treating Water before drinking

Source: Field Survey, 2015

Figure 4.5 shows the distribution of respondents by purification of water before drinking. It reveals that 72% of the respondents do not boil their water before drinking. This therefore shows a high reliance on the portability of the sources of water in which most respondents have access to.

4.4.5 Reasons for not boiling drinking water

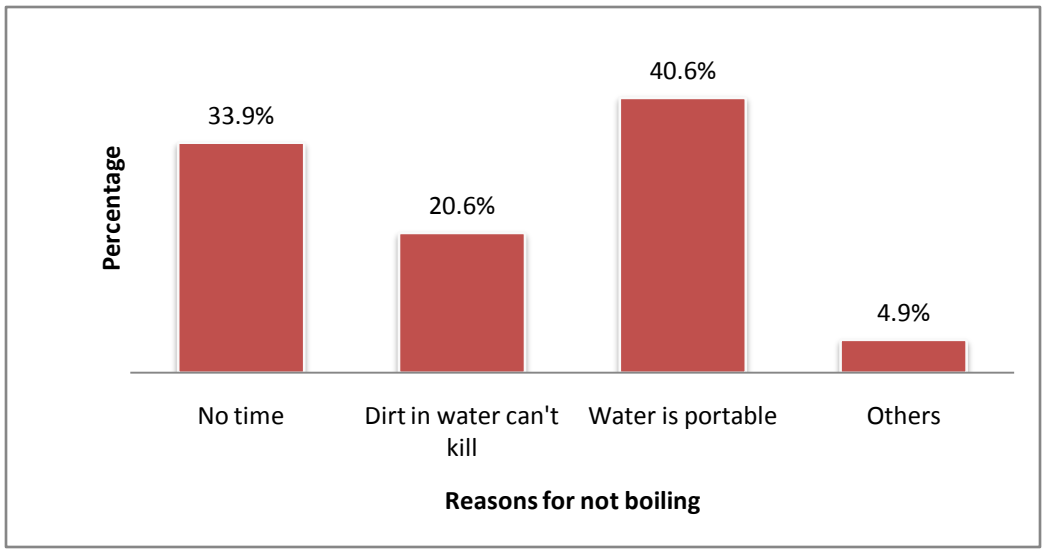


Figure 4.6: Distribution of Respondents by Reasons for not Boiling Drinking Water

Source: Field Survey, 2015

Figure 4.6 shows distribution of respondent by their reasons for not boiling drinking water. Several reasons were provided for not boiling drinking water among which is the feeling that the water is already portable for drink accounting for 40.6% while 33.9% and 20.6% of the respondents say there was no time and 14.8% say that dirty water does not kill. This implies that most of the elderly in the study area might be at risk of contracting water related diseases pending on their source of domestic water supply.

4.4.6 Hospitalization in the Last 12 Months

Figure 4.7 shows the distribution of respondents by hospitalization in the last 12 months. It reveals that most of the respondents (54.1%) have been hospitalized in the last 12 months while 45.9% were not. It is assumed according to Awoyemi, Obayelu and Opaluwa (2011)that good health leads to improvement in life expectancy, which is a robust indicator of human development.

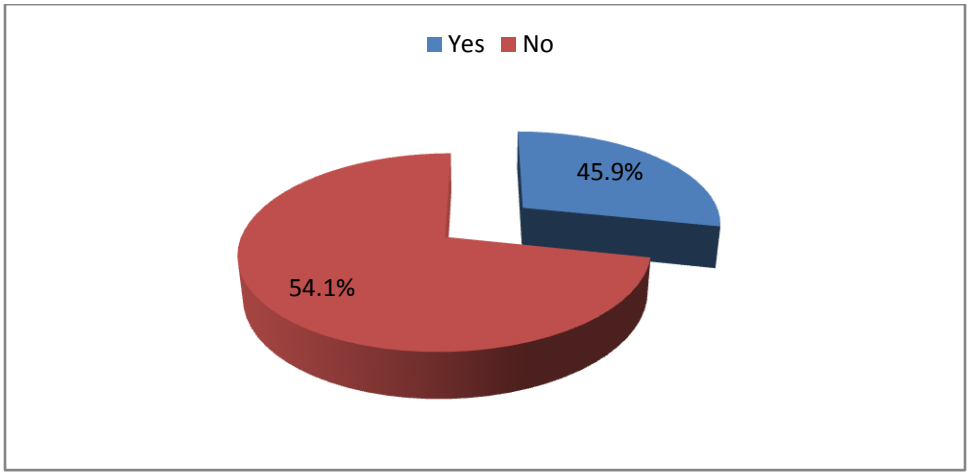


Figure 4.7: Distribution of Respondents by Record of Hospitalization in the Last 1 year
Source: Field Survey, 2015

This is because good health, according to WHO (2011) is key, if older people are to remain independent and to play a part in family and community life. But it is believed that old age

comes along with high frequency of illness as the body system at this time is already becoming weak. Therefore the high level of hospitalization of the elderly in the study area is not surprising.

4.4.7 Having Family Doctor and Frequency of Hospital Visits

Table 4.10 shows the distribution of respondents by having a family doctor and frequency of hospital visit. It shows that 32.8% of the elderly do have a family doctor who often times is readily available to attend to them as well as members of their family. The lack of acquisition of a family doctor by most of the elderly in the area could be attributed to their low income level and maybe illiteracy faced by some of the elderly. Table 4.10 also reveals that 44.4% attend hospital occasionally, 20.3% monthly, 12.5%, 9.8% and 8.3% attend the hospital weekly, daily and quarterly respectively while 4.8% don't even attend at all.

Table 4.10: Respondents Having a Family Doctor and Hospital Attendance

Having a family Doctor	**Frequency**	**Percentage**
Yes	131	32.8
No	268	67.2
Total	**399**	**100.0**
Frequency of Hospital Attendance	**Frequency**	**Percentage**
Daily	39	9.8
Weekly	50	12.5
Monthly	81	20.3
Quarterly	33	8.3
Occasionally	177	44.4
Not at all	19	4.7
Total	**399**	**100.0**

Source: Field Survey, 2015

This occasional visits to hospital is in line with the assertions by Beland *et al*, (1991), that the increase in healthcare utilization by the elderly in the last four decades has been attributed to how the health care system functions rather than to aging. For those that have not been to the hospital

in the last one year, that does not mean that they have not been sick, rather they may have preferred treatment from other sources so to say. This is not surprising as an estimated 75% of Nigerians still prefer to solve their health problems by consulting the traditional healers for reasons such as easy accessibility, cheaper and more holistic than the western alternative (Adesina, 2008; Adefolaju, 2011).

4.4.8 Nature of illness

Table 4.11 shows the distribution of respondents by their nature of illness. It reveals that diabetes dominated with 25.1% of the cases followed by eye problem with 10.0% and accidents has 9.0% of the respondents.

Table 4.11: Distribution of Respondents according to type of illness

Nature of Illness	Frequency	Percentage
Diabetes	100	46.3
Heart related ailments	28	12.9
Eye problem	40	18.5
Accident	36	16.7
Others	12	5.6
Total	**216**	**100.0**

Source: Field Survey, 2015

The high proportion of diabetes cases is not unexpected as another study of the elderly in Kwara State by Orire (2015), found out that diabetes was the major cause of ill-health. Diabetes is one of the sickness that is associated with old age, and therefore is not unusual. Incidence of ailments amongst the elderly is not unexpected, this is because, as posited by Gavrilov *et al,* (2003) and Levy (2012), the prevalence of disability, frailty and chronic diseases is expected to increase dramatically as one age.

4.4.9 Health facility used for treatment

Respondents were asked to indicate where they go for treatment (see Table 4.12). The hospital seems to be the most commonly used facility for treatment of illness as it constitute 76.9% while 12.5% use traditional healers, 7.4% adopt self-medication and 2.8% consult faith based healers.

Table 4.12: Availability of Healthcare Facilities

Health Facility used for Treatment	Frequency	Percentage
Hospital	166	76.9
Traditional healer	27	12.5
Faith-based healer	6	2.8
Self-medication	16	7.4
Others	1	0.4
Total	**216**	**100.0**

Source: Field Survey, 2015

This finding supports Dias *et al,* (2008) who stated that utilization of orthodox healthcare facilities is said to be positively influenced by age. This implies that in Lafia, as far the elderly is concern, hospital patronage is high and most common.

4.4.10 Payment of medical bill

Table 4.13 shows the distribution of respondents by payment of medical bill. It reveals that 57.9% of the elderly who visited the hospital relied on their children for payment of their medical bills, while 23.8% depends on relatives. Respondent's capacity to access and pay for required healthcare service is an issue worth examining.

Table 4.13: Distribution of respondents by Payment of medical bill

Payment of Medical Bill	Frequency	Percentage
Children	231	57.9
Relatives	95	23.8
Government/NGOs	23	5.8
Church/Mosque	22	5.5
Others	28	7.0
Total	**399**	**100.0**

Source: Field Survey, 2015

From the given results, it can be deduced that there is high rate of elderly dependency on their children. This could influence the movement of children out of the area in search of better jobs so as to support their parents.

4.4.11 Disability status and type of disability suffered

Table 4.14 shows the distribution of respondents by disability status and the type of disability suffered. It reveals that 66.7% of the respondents were not suffering from any disability while 33.3% suffer some disabilities. Disability has been defined as a restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being (WHO, 1980; NPC, 2003). From the results of Table 4.14 and the given definition of disability, in can be inferred that in Lafia most of the elderly are normal and thus, can participate in form of job or the other.

The Table 4.14 also reveals that disabilities that appear to be common with the respondents is the knee/limbs problem which makes up 42.1% while past accident deformity forms 18.0%, also 17.3%, 15.8% and 6.8% have eye issues, hearing defects and others (stroke and mental disorder) respectively.

Table 4.14:Disability status and type of Disability Suffered by Respondents

Suffering from Disability	Frequency	Percentage
Yes	133	33.3
No	266	66.7
Total	**399**	**100.0**
Type of Disability Suffered	**Frequency**	**Percentage**
Hearing defects	21	15.8
Eye problem/blindness	23	17.3
Leg/Hand deformity	56	42.1
Deformity due to past accident	24	18.0
Others	9	6.8
Total	**133**	**100.0**

Source: Field Survey, 2015

Disability according to Yu (1991) is said to be related to the deterioration of people as they grow older. This finding contradicts the report of NPC (2003) that blindness was the most common type of disability among the elderly in Nigeria.

4.4.12 Types of social engagements attended

Table 4.15 shows the distribution of respondents by the types of social engagement they attend. It reveals that 30.1% of the respondents attend marriages, 16.0% attend naming ceremonies, 9.3% attend burials and 44.6% attend other types of social engagements which are mostly traditional/cultural activities such as initiations, turbaning /coronations and age grade junction.

Table 4.15:Types of Social Engagements attended by Respondents

Type of Social Engagement Attended	Frequency	Percentage
Marriages	120	30.1
Burials	37	9.3
Naming ceremonies	64	16.0
Others	178	44.6
Total	**399**	**100.0**

Source: Field Survey, 2015

The findings are similar to that by Orire, (2015) who asserted that the most prominent social function amongst people of all ages and the elderly as well, is the celebration of conjugal (marital) unions.

4.4.13 Available facilities for the elderly

Table 4.16 shows the distribution of respondents by availability of facilities for the elderly in the study area. It reveals that most of the respondents (80.7%) have hospital facility in their area, 10.0% said they have old people's home, 3.3% have recreational clubs in their area, while 6.0% have other facilities such as dispensaries, schools and orphanage homes.

Table 4.16: Distribution of Respondents by Available Facility in the area

Available Facility in the Area	Frequency	Percentage
Hospital	322	80.7
Old people's home	40	10.0
Recreational clubs	13	3.3
Others	24	6.0
Total	**399**	**100.0**

Source: Field Survey, 2015

Interestingly, institutional care for the elderly in Nigeria sounds unnatural and may be regarded as taboo by most people (Uwakwe and Modebe, 2007). This ideology on institutional care for the elderly could be tied to the assertion made by these authors ((Uwakwe and Modebe, 2007).

4.5 Factors Affecting Living Conditions of the Elderly

Living conditions of old people are a reflection of the living conditions of society as a whole (Rosenmayr, 1979). The level of living has been based on either needs or resources therefore; the level of living of a population is the level of satisfaction of its needs attained per unit of time as a result of the goods, services and living conditions which the population enjoys in the unit of time (Drewnowski, 1974). Some of the factors that affect the living condition of the elderly are examined to note the most significant among them. The variables considered are absence, nature and frequency of support, type of food and number of square meals, drinking water, nature of illness, treatment received marital union type, type of house, nature of surrounding, social groups, exercise, loss of loved ones and loneliness. Principal Component Analysis was employed to collapse the fifteen specific factors affecting the living condition of the elderly as shown in Tables 4.17 and 4.18.

Table 4.17: Rotated Component Matrix[a]

Factors	Component		
	1	2	3
Absence of support	.339	.714	.438
Nature of support	.414	.793	.151
Frequency of support	.344	.786	.377
Type of food eaten	.651	.644	.268
Number of times you eat daily	.792	.354	.368
Drinking water	.768	.375	.301
Nature of illness	.793	.411	.340
The kind of treatment received	.687	.494	.344
Nature of marital union	.393	.396	.766
Type of house	.620	.305	.655
Nature of surrounding environment	.549	.507	.595
Involvement in social groups and associations	.473	.335	.773
Physical exercise	.375	.708	.785
Loss of loved ones	.540	.336	.706
Loneliness	.411	.347	.687

Extraction Method: Varimax with Kaiser Normalization.

Component 1 has an eigenvalue of 11.50 and accounts for 76.7% of the total explained variance. The component has high positive loadings (0.651, 0.792, 0.768, 0.793 and 0.687) on type of food eaten, square meals per day, drinking water, nature of illness and type of treatment received respectively. These variables describe nutrition and health of conditions the elderly. Thus, component 1 is identified as “health and nutrition of the elderly”.

Component 2 has high and significant positive loadings for absence (0.714), nature (0.793) and frequency (0.786) of support. These variables describe the support the elderly gets in the study area. Component 2 is therefore identified as “support to the elderly” It has an eigenvalue of 0.78 and accounts for 5.2% of the total explained variance.

Component 3 has positive loadings on marriage type (0.766), house type (0.655), environment (0.595), social groups (0.773), and exercise (0.785), loss of loved ones (0.706) and loneliness (0.687) with an eigenvalue of 0.60, and it accounts for4.0% of the total explained variance. Component 3 describes the association, relationship and activities of the elderly in the area. It is, therefore, identified as "family and socialization".

Given the result of the component matrix, it can therefore be concluded that the living conditions of the elderly in Lafia LGA is highly influenced by their health condition and nutritional value.

Table 4.18 shows the principal component analysis with VARIMAX rotation and selection of factor based on the Kaiser criterion.

Table 4.18: Total Variance Analysis

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	11.502	76.678	76.678	11.502	76.678	76.678
2	.779	5.193	81.871	.779	5.193	81.871
3	.598	3.989	85.861	.598	3.989	85.861

Source: Field survey, 2015.

An examination of Table 4.18 indicates that the Percentage of the total variance accounted for by the principal component analysis shows three components. The total variance explained indicates that component one showed an eigenvalue of 11.502 accounting for 76.7% of the total variance explained by the analysis. Similarly, component two reveals an eigenvalue of .779 thereby accounting for 5.2% while component three has .598 as eigenvalue explaining 3.9% of the total variance. This component loading provides a clear indication of the factors affecting the living conditions of the elderly in the study area that have been reduced to three components. The analysis resulted in three component solution, which explained 85.9% of the total variance.

4.6 Support Available tothe Elderly

The nature, frequency, source as well as the sufficiency of the support that is gotten by the elderly in the study area is considered here. They are presented in Tables 4.19.

4.6.1 Nature of support

Table 4.19 presents the nature of support the elderly gets in the study area. Table 4.19 revealed that financial support with 49.1% forms the bulk of the support to the elderly.

Table 4.19: Nature of Support Received by Respondents

Nature	Frequency	Percentage
Money	196	49.1
Foodstuff	101	25.3
Drugs	12	3.0
Clothing	17	4.3
Accommodation	10	2.5
Others	63	15.8
Total	**399**	**100.0**

Source: Field Survey, 2015

This finding agrees with a similar finding by Najjumba and Milindwa (2003) in developing countries where the elderly depended on remittances from children mostly inform of cash or kind. The elderly agreed to get foodstuff support which constitutes 25.3% of the total support.This indicates that food and money is the most common type of support given to the elderly in the study area. Among the support gotten, accommodation accounted for the least (2.5%).According to one of the discussant of one of the FGDs;

> *The only type of support the elderly people get in this ward is in terms of medical attention sometimes we normally have NGOs that come around to attend to some medical conditions pertaining to eyesight, checking their blood pressure and sugar level. So the only type of support the elderly get is in the aspect of health.*
> (Sangari of Shabu, 2015)

To support this, a discussant at Lafia stated;

The support we give the elderly is occasional and is during festive period where we give them foodstuffs and clothing. But in the case of health issues we give support when the need arises.
(In-depth interview with CAN Secretary of Lafia, 2015).

4.6.2 Frequency of support

Table 4.20 presents the frequency of support that elderly get in the study area. The Table 4.20 reveals that majority (42.4%) of the respondents do get their support on monthly basis as against 6.3% who gets on yearly basis.

Table 4.20: Frequency of Support Received by Respondents

Frequency of support	Frequency	Percentage
Daily	98	24.6
Weekly	107	26.8
Monthly	169	42.4
Yearly	25	6.3
Total	**399**	**100.0**

Source: Field Survey, 2015

This could be attributed to the fact that it is the most populous among the wards selected. Also monthly support indicates that majority of the supporters are salary earners or into business as in the case of the daily supporters. This findings can be said to confirm the trending global phenomenon among the elderly which Weeks (2005) called intimacy at a distance. This is also affirmed by a statement during a chat with the district head of Chiroma ward who states that;

The support I give elderly in my ward is mainly during festive periods like Sallah and Christmas even though there are some old people that come to my house on daily basis for assistance.
(District head of Chiroma, 2015)

But a contradicting statement was made by the district head of Akurba/Bakin Rijiya during an interview which goes thus;

The only time the elderly get support in this ward is during elections.

When they partake in the sharing of things that are been brought by the candidates if not there's no any other support. (District head Akurba/Bakin Rijiya)

4.6.3 Source of support

The source of support for the elderly as shown in Table 4.21 indicated that support from children constituted 49.1% of total sources of support gotten by the respondent. This finding is in line with that by Okumagba (2011), in which majority of the elderly in Delta State received support from their children.

Table 4.21: Respondent's Sources of Support

Source of support	Frequency	Percentage
Spouse	78	19.5
Children	196	49.1
Pension	50	12.5
Church/Mosque	11	2.8
Social organization	22	5.5
Others	42	10.5
Total	**399**	**100.0**

Source: Field Survey, 2015

Pension mostly for government retirees accounted for 12.5% while Least of the support comes from the church/mosque with about 2.8%. According to a discussant of Chiroma ward;

God is my only source of support. My support comes when my children remembers that I exist as their mother.
(Jummai in Chiroma Ward, 2015)

This was corroborated by another elder who stated;

My children are my source of support but my problem is they don't have job. Therefore, the support I get from them is not enough to take care of myself and their younger ones.
(Alhaji Umar in Shabu/Kwandere Ward, 2015)

Another male discussant stated;

> *Thank God for the lives of my children because they are the only support I have. The support they give me is frequent and sufficient.*
> (Alhaji Abubakar in Zanwa Ward, 2015)

4.6.4 Level of satisfaction with the support

Figure 4.8 presents the responses of the elderly with regards to satisfaction with support gotten.

The Figure 4.8 shows that 64.9% of the respondents are satisfied with the support they get but 35.1% shown dissatisfaction.

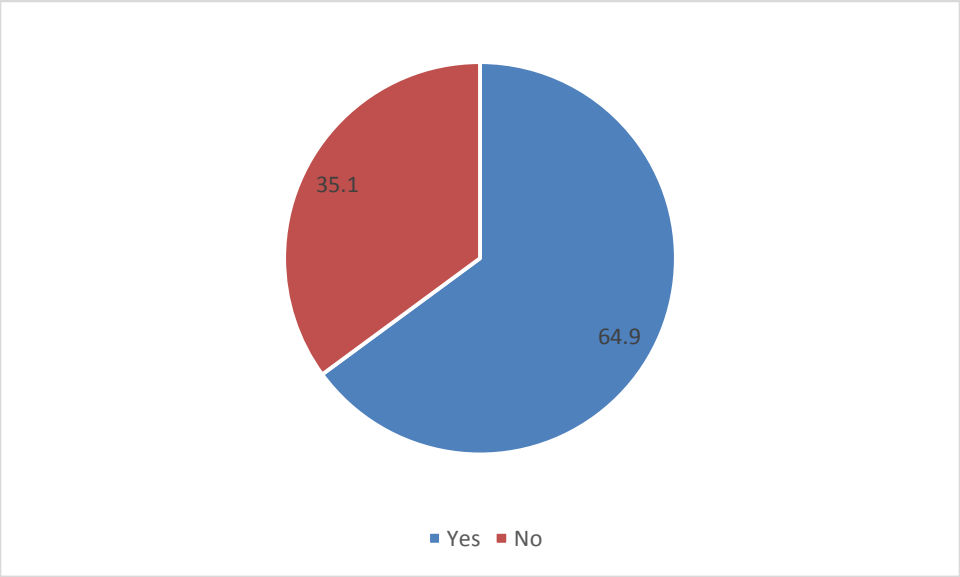


Figure 4.8: Distribution of Respondent's Satisfaction with Support Received
Source: Field Survey, 2015

This may implies that most of the elderly, who gets support in the study area, might be contented.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 SUMMARY OF MAJOR FINDINGS

The aim of this research is to examine the living conditions of the elderly in Lafia LGA of Nasarawa state. Six wards from the LG were purposively selected for the study due to security challenges. Data for the research was obtained using structured questionnaires, interviews and focused group discussions. The study reviews that the elderly plays an important role in the area as a whole because they were found to be the custodians of culture which is been pass from generation to generation.

From the findings, going by the socio-economic variables like income, occupation, religion, level of education, marital status, number of children, type of accommodation and type of ownership is believed to influence the living conditions of the elderly. The findings indicates that the living conditions of the elderly is not encouraging. This is because majority of the elderly are not working and as such their income is low.

It was found that nutrition and health of the elderly constitute 76.7% of the total variance explained, support to the elderly 5.2% and family and socialization of the elderly 4.0% are the key factors affecting the living conditions of the elderly in the study area.

The study revealed that only 47.1% of the elderly are engaged in paid jobs as a strategy for coping with their living conditions. The study reveals that the nature of support for the elderly is mainly financial support with about 49.1% in the study area.Majority of the support for the

elderly is gotten from the children with 49.1%, spouse support with 19.6% while pension support is 12.5% in the study area.

5.2 CONCLUSION

This study established that socio-economic variables like income, occupation, level of education, nutrition and health condition is believed to influence the living conditions of the elderly.

Nutrition and health of the elderly were found to be the key factors affecting the living conditions of the elderly in the study area. The study also established that majority of the support for the elderly is gotten from the children and the nature of the support was mainly financial support for the elderlyin the study area. Therefore given the findings, it can be concluded that the living conditions of the elderly is poor in Lafia LGA, Nasarawa state.

5.3 RECOMMENDATIONS

The following recommendations are proferred in this study to improve the living conditions of the elderly.

i. There is the need to improve access to health care for the elderly since more than half were hospitalized in the past 12 months preceding the study. Health care should not be made expensive, health care providers should be accessible, should offer services at all times and under conditions that are favourable to the elderly. Drugs particularly diabetic drugs should be made available.

ii. Health care provision and advice should include education so as to increase awareness on good nutrition for the elderly, food supplements and adherence to good dietary regime.

iii. There is need for policy makers to ensure the elderly are financially secured in their old age especially for the prompt payments of gratuity for the retirees and to also increase the amount they receive as pension so as to improve their standard of living. This is because in this study, majority of the respondents have a very low income given the present economic situation in the country.

iv. There is the need to provide better housing condition for the elderly since most of the elderly in this study live in a room and two room apartments. This is necessary because housing provides both psychological and physical shelter and increases satisfaction for the elderly.

v. Governments as well as NGOs should give special consideration to the wellbeing of the elderly. This could be achieved by providing the elderly with their basic needs. Legislation should outline the need for adult children especially through empowerment and job creations so as to support their aging parents.

5.4 SUGGESTIONS FOR FURTHER RESEARCH

- There is need for further research to be undertaken on how socio-economic predictors are associated with the wellbeing of the elderly.
- Further research should be carried out on the availability and accessibility of geriatric health care facilities.
- More research is needed to understand non adherence to balanced dietary regime as noted in the study.

REFERENCES

Abdulraheem, I.S. and Abdulrahman, A.G. (2008) Morbidity Pattern among elderly population in a Nigerian Tertiary Health Care Institution: Analysis of a Retrospective Study. *Nigerian Medical Practioner, 54* (2), 32-38.

Abumere, S. I., Okafor, S. I. and Oluwasola O. (2002).*Rural Infrastructure and Development Processing Rural Nigeria*. Research report, No, 36. Development Policy Centre, Ibadan.

Abuzar, M. (1982). The Growing Population of India: A Spatio-temporal Case study of PeninsulaMalaysia, 1957-1970. *Asian Profile, 10*(4), 45-65. Retrieved from www.asianprofile.com

Adamchak, D. J. (1995). Pension and Household Structure of Older Persons in Namibia. *Southern African Journal of Gerontology*,4(2): 1 1-15. Retrieved from www.googlescholar.com

Adamu, A., Adjei, N.K.G. and Kubuga, C.K. (2012). Effects of Dietary Patterns on the Nutritional Status of Upper Primary School Children in Tamale Metropolis. Pakistan *Journal of Nutrition*, 11(7): 591-609. Retrieved from www.googlescholar.com

Adebayo, T.A. (2006). Geriatric Conditions in the Indigenous Areas of Ibadan, Nigeria. *Geo-studies Forum,3*(1&2), 186-196.

Adebowale S.A., Atte O. and Ayeni O. (2012).*Elderly Wellbeing in a Rural Community in North Central Nigeria, Sub-saharan Africa.* Scientific and Academic Publishing.

Adedokun, M.A. (2010). Caring for, the Elderly: Towards A Better Community. *European Journal of Educational Studies* 2(3), pp. 288-291.

Adefolaju, T. (2011). The Dynamics and Changing Structure of Traditional Healing System in Nigeria. *International Journal of Health Research,4*(2), 99-106.

Adesina, K. (2008) Traditional Medicine in Nigeria. Retrieved from http://www.onlinenigeria.com/health.

Ajomale, O. (2007) Aging in Nigeria current state, social and economic implications: ISA RCII, Sociology of Aging in A. Hoff, (2007).*Summer Newsletter 2007 of the Research Committee (RCII) on the Sociology of Aging of the International Sociological Association (ISA),* (pp. 15-20) Oxford: Oxford Institute of Aging.

Akwa, L. (2007).*Geographical Perspective on Nasarawa State.* Keffi, Nasarawa State. Onaivi Printing & Pub CO. Ltd.

Anthea, T. (1991).*Elderly People in Modern Society*. New York Longman Publishing.

Asiyanbola R. A. (2004).*Social support/networks, urban condition and physical wellbeing of the elderly in Africa: a preliminary survey in Ibadan, Nigeria*. Paper presented at the

19th International Conference of Union for African Population Studies. Pretoria, South Africa.

Asiyanbola R. A. (2008). Assessment of Family Care, Housing, Gender, Daily Activities, and Physical Wellbeing of the Elderly in Ibadan, Nigeria. *International Journal of Agricultural Sciences, Sciences Environment and Technology,3*(1), 95-96.

Asiyanbola R. A. (2009). Spatial Behaviour, Care and Well Being **o**f **t**he Elderly in Developing Country, Nigeria. *IFE PsychologIA, 17*(1), 1117-1421.

Awoyemi, T.T., Obayelu, O.A and Opaluwa, H.I. (2011). Effect of Distance on Utilization of Health Care Services in Rural Kogi State. Nigeria. *Journal of Human Ecology,35*(1), 1-9.

Bailey, C. (2000). Governance of social security schemes: social security documentation. *International Social Security Association,21*, 71-113.

Barrette, M. (1996).Fertility and Decline in Punjab.*Indian Journal of Demography, 9*(4), 65-96.

Beland, F., Lemay, A., Philibert, L., Maheux, B and Gravel, G. (1991). Elderly Patient Use of Hospital-Based Emergency Services. *Medical Care,29*(5), 408-418. Retrieved from http://www.jstor.org/stable/3766033.

Bengtson, V.L, (1975).Sociological Approach to Aging. In *Aging Scientific Perspective and Social issues, ed*. Woodruff, D. New York.

Bengtson, V.L., Silverstein, M., Putney N.M. and Gans D.(2009).*Handbook of Theories of Aging 2nd Edition*. Springer Publishing Company, New York. Retrieved from www.springerpub.com

Bezrukov, V. (1995). Status and Conditions of the Elderly within the Family in Ukraine and other countries of Eastern and Central Europe (E.C.E).*The Bold Journal 5*(2), 23-23.

Binbol, N.L (2007).*Geographical Perspective on Nasarawa State*. Onaivi Printing & Pub CO. Ltd, Keffi, Nasarawa State.

Bird, E. and Shinyekwa R. (2003). Vulnerability and Social Security Systems in Developing Countries. *International Social Security Association,22*, 17-33.

Bittner, A.K., Edwards, L and George, M. (2010). Coping Strategies to Manage Stress Related to Vision Loss and Fluctuations in Retinitis Pigmentosa.*J. of Optometry, 81*(9), 461-468. Retrieved from www.nebi.nlm.nih.gov/pubmed/20591747

Bloom, D.E, Boersch-Supan, A., McGee, and Seike A (2011). *Population Aging: Facts, Challenges, and Responses*. PGDA Working Paper No. 71. Retrieved from http://www.hsph.harvard.edu/

Boersch-Supan, A., and A. Ludwig (2009). Aging, Asset Markets, and Asset Returns: A View from Europe to Asia. *Asian Economic Policy Review 4*, 69-92.

Bosanquet, N. (1978).*A Future for Old Age*. London. Maurice Temple Smith Ltd.

Broekington, F. and S. Lampert (1966).*The Social Needs of the Over-80s*. Manchester University Press, Manchester.

Charlesworth, B. (1994). *Evolution in Age-Structured Populations*. Cambridge University Press, Cambridge.

Charton, K.E. and Rose, D. (2001). Nutrition among older adults in Africa the situation at the beginning of the millennium. *Journal of Nutrition,131*, 245-85.

Chiuko, (1996).Social and Economic Factors of the Families Demographic Transformation. In F.U. Charles (2001). *Demographic Advances ed*. National Academy of science of Ukraine, 86-98.

Clark, R.L., York, E.N. and R. Anker (2000). *Retirement and Economic Development: An International Analysis, in Social Policy and the Labour Market*.Manchester University Press, Manchester.

Cohen, B. and J. Menken (2006).*Aging in Sub-Saharan Africa: The Changing Demography of the Region.* Washington (DC): National Academies Press.

Cole, W. and Harris, K. (1980). *Sociology of Ageing*. Houghton Mufflin Company Boston.

Colin, G., Turner, J., Bailey, C., Latulippe, D. (2000). Social security pensions. In: L.S., Cottrell (2002).*Development and reform.* Geneva: International Labour Office. American Sociological Review, 7, 617-620.

Contreras D. L. (1989). Women and Old age: Status of the Elderly Women in Mexico. In A. J. Milton (1999). *Mid-life and Older Women in Latin America and the Caribbean*. Washington D.C Pan- American Health Organization.

Cummings, E. and Henry, W.E. (1981).*Growing Old*: *The Process of Disengagement*. New York; Basic Books.

Cutler. D.M. and MearaE. (1997). *The Medical Costs of the Young and Old: A Forty Year Perspective,* NBER working papers No, 6114. Cambridge. Retrieved from http://www.nber.org/papers/w6 114

Da Vanzo, J. and A. Chan. (1994). Living Arrangements of Older Malaysians: Who Core sides with their Adult Children. *Journal of Demography, 31*(1), 95-113.

Dias, S.F., Severo, M. and Barros, H. (2008). Determinants of Healthcare Utilization by Immigrants in Portugal. *BMC Health Services Research,8*, 207.

De Grey D., Aubrey N. L., Gavrilov, S. J., Olshansky, L.S., Coles, R.G., Cutler, M. and Harman, S. M. (2002). Anti-Aging Technology and Pseudoscience. *Science, 29*,656-656.

DeJong A. F. and Marmor T.R., (2000).*The aging Population of Europe*. Brookfield, VT: Ashgate, 117-146.

Dogo, B. (2002).*A Handbook on Research Projects for Students in Tertiary Institutions*. Core and Action Research, Jos: Nigeria.

Drewnowski, J. (1974).*On Measuring and Planning the Quality of Life.* The Hague and Paris, Mouton. Institute of Social Studies Paperback Series.

Eberstadt, N. (1997).World Population Implosion. *Public Interest, 129*, 3-22. Retrieved from http://www.nber.org/papers/w6 114

Falconer, D.S. and Mackay, T.F.C. (1996).*Introduction to Quantitative Genetics*. Longman, London.

Foundation for Health and Aging. (2005).*Ageing Stress Management and Coping Strategies*. New York Press.

Foundation for Health and Aging. (2005).*Ageing Stress Management and Coping Strategies*. New York Press.

Gavrilov, L.A. and Heuveline, P. (2003). Aging of Population. In P. Demeny and G. Mc Nicoll (Eds.). *The Encyclopedia of Population*. New York, Macmillan Reference USA, 2003. RetrievedfromhttpL//www.galegroup.com

Gavrilov, L.A. and Gavrilova, N.S. (2001).Biodemographic Study of Familial Determinants of Human Longevity.*Population: An English Selection, 13*,197-222. Retrieved from www.thescientificworld.com

Gavrilova, N.S. and Gavrilov, L.A. (2001). When does human longevity start? Demarcation of theBoundaries for Human Longevity. *J. Anti-Aging Med. 4*, 115-124. Retrieved from www.thescientificworld.com

Gavrilova, N.S., Gavrilov, L.A., Evdokushldna, G.N., Semyonova, V.G.,Gavrilova, A.L., Evdokushkina, N.N., and Andreyev, A.Y. (1998). Evolution, Mutations and Human Longevity. European Royal and Noble Families. *Hum. Biol.70*, 799-804. Retrieved from www.thcscientificworld.com.

Gaylene, B. (1980). *Growing Old in Silence*. University of California press Ltd, California.

Gorman, M. (2000). Development and the Rights of Older People. In: J. Randel, *et al*., (Eds). *The ageing and development reports: Poverty, Independence and the world's older people*, pp 23-32. Amsterdam: Earthscan publications Ltd.

Gratton, B. (1986). The New History of the Aged: A Critique. In, D. V. Tassel and P. N. Steams, (Eds.), *Old Age in a Bureaucratic Society*, 3-29. New York: Greenwood Press.

Gruber and Wise, D.A. (1999).*Social Security and Retirement around the World*. Chicago University Press.

Gureje, O., Lola, K., Ebenezar, A. and Benjamin, O. (2008). Determinants of quality of life of elderly Nigerians, results from the Ibadan Study of Ageing. *African Journal of Medical Sciences, 37*(3), 239-247.

Haber, C. (1983).*Beyond sixty-five*. Cambridge: Cambridge University Press.

Hajime, O., Hideki I., Takao S., Atsushi A., Takayuki H. and Motoji, S. (2006). Reviewing the Definition of Elderly. *Geriatrics& Gerontology International, 6*(3), 149-158.

Harper, M.S. (1998).Behavioural Social and Mental Health Aspect of Home Care for Older People.*Home Health Care Services Quarterly,9*(4), 61-124.

Havighurst, R.J. (1968).*Disengagement and Pattern of Ageing in Middle Age and Aging (eds)*. B.L. Neengarten, pp 161-172.

Hendricks, J. and Hendricks D. (1986).*Aging in Mass Society*. Myths and Realities. Boston.

Hitiris, T. and Posnett J. (1992). The Determinants and Effects of Health Expenditure in Developed Countries. *J. Health Econ., 11,*173-187.

Hunt, M.E. (1984).*Retirement Communities: An American Original*. New York: Haworth Press.

Ibrahim, U. (2007).*Geographical Perspective on Nasarawa State.* Keffi, Nasarawa State. Onaivi Printing & Pub CO. Ltd.

Jean, B. (1980).*The Use of Technology in the care of the Elderly and the Disabled: Tools for Living.* London, Francis Pinter Publishers Ltd

Kaiser, A. and Camp H. (1993). The Rural Aged: Beneficiaries and Contributors to Rural community and Economic Development. In Bull Neil (eds) *Aging in Rural America,* Sage Publications, U.K.

Kaseke, E. (2004).*An Overview of Formal and Informal Social security Systems in Africa*. USA and Johannesburg, South Africa: National Academy of Sciences.

Kertzer, D.I. (1995).Towards a Historical Demography of Aging. In D.I. Kertzer and P. Laslett, Berkeley (eds). *Aging in the Past: Demography, Society, and Old Age*. USA, University of California Press.

Kimokoti R.W, Hamer D.H. (2008). Nutrition, Health, and Aging in Sub-Saharan Africa. *Journal of Nutrition,66,* 611-23.

Kinsella, K. and PhillipsD. R. (2005). Global aging: The Challenges of Success. *Population Bulletin, 60*(1), 2005. Retrieved from www.prb.org

Kinsella, K. and Velkoff V. (2001).*Aging World:* 2001 U.S. Census Bureau Series,Government Printing Office, Washington D.C.

Kinsella, K. (1995). Aging and the Family: Present and Future Demographic Issues. In R. Blieszner and V. Hilkevitch (Eds). *Handbook of Aging and the Family*. Bedford Westport, CT: Greenwood Press.

Kipviscusi, W. (1979).*Welfare of the Elderly: An Economic Analysis and Policy Prescription.* Canada, John Wiley and Son Inc.

Krause, N, Herzog, A, R and Baker, E. (1992). Providing Support to Others and Well-being in Later Life. *Journal of Gerontology: Psychological Sciences, 47,* 300-311.

Laslett, P. (1972). Introduction: The history of the family. In Peter Laslett and Richard Wall (Eds). *Household and family in past time*, pp 1-89. Cambridge: Cambridge University Press.

Le Bourg, E. (2001). A Mini-review of the Evolutionary Theories of Aging. Is it the time to accept them? *Demogr. Res, 4*(1), 1-28. Retrieved fromhttp://www.demographic-research.org

Levy, S.(2012). *What are the Most Common Issues of Aging?*Retrieved from (09/08/2015) http://agingcare.com

Llyod-Sherlock, P.(1999). Old age Migration and Poverty in the Shanty Town. *Journal of Development Areas, 32*(4), 491-154.

Lynch, M. and Walsh, B. (1998).*Genetics and Analysis of Quantitative Trails*. Sinauer, Sunderland, MA.

Machu, L.Y. (2005).*The Socio Economic and Health Conditions of the Elderly In Kaduna Metropolis.*(Unpublished B.Sc Project),Ahmadu Bello University, Zaria.

MANR (1998).*Geography Perspective on Nasarawa State*. Department of Forestry, Ministry of Agriculture and Natural Resources, Nasarawa State.

Marcus N. D. (2007).*Climate in Nasarawa State.* Keffi, Nasarawa State. Onaivi Printing & Pub CO. Ltd.

Marshall, G. (1998).*Dictionary of Sociology*. Oxford: Oxford University Press.

Martun, B. and Kinsella B. (1994). Research in the Demography of Ageing in Developing Countries. In: U. S. Bernard (Eds). *Demography of Ageing*, pp 12-25. Washington D. C. National Academy Press.

McFadden, S. (2005). Gerontology and the Psychology of Religion. In C.L Park, and RF. Paloutzian, (Eds).*Handbook of the Psychology of Religion and Spirituality*. New York: Guilford Press. http:// en.wikipedia.org/wiki/ageing.

Medawar, P.B. (1946). Old Age and Natural Death. *Modern Q. 1*, 30-56. Retrieved from www.thescientificworld.com/scibase

Medawar, P.B. (1952).*An Unsolved Problem of Biology*. H.K. Lewis, London.

Mitterauer, M. and R. Sieder (1982).*The European family*. Trans. Karla Oosterveen and Manfred Horzinger. Chicago: University of Chicago Press.

Ministry of Education. (2005).*Educational Facilities in Lafia, Nasarawa State*. Nasarawa state Government, Nigeria.

Ministry of Health Headquarters. (2005).*Health Problems in Nasarawa State*. Nasarawa state Government, Nigeria.

Mosley, W.H., Bobadilla J.L.and Jamison D.T. (1993).The Health Transition: Implications for Health Policy in Developing Countries. In: *Disease Control Priorities in Developing Countries*, (Eds) Oxford University Press, New York, USA.

Muhammad-Lawal, A. and OmoteshoO.A. (2006). Farming Household Food Security in Some RuralAreas of Kwara state. *Geo-Studies Forum, 3*(1 &2); 71-82.

Muir, G. (1980).*Take Care of your Elderly Relatives*. London, Billing and Sons Limited and Kemp Hall Bindery.

Najjumba, H. and MilindaI. (2003).*Chronic Poverty among the Elderly in Developing Countries: Perception, Experience and Policy Issues*. State Press, New York.

NASIEC.(2011).*Voters Registration Report.*Nasarawa State Independent Electoral Commission.

National Population Commission. (1991). Nigeria Population Census 2003 in 1991 Analysis: *The Elderly, 3.* National Population Commission, Abuja.

National Population Commission. (2003).*Nigeria Population Census 1991 Analysis*: Analytical Report, 3. National Population Commission, Abuja-Nigeria.

National Population Commission. (2006).*Population Census of the Federal Republic of Nigeria*.Preliminary Report. United Nations Population Division (2005).

National Population Commission.(2009).*Final results of 2006 Census*. Official Gazette of 2nd February, 2009. National Population Commission, pp 1-327, Abuja, Nigeria.

NPC&ICF Macro. (2009).*National Population Commission Nigeria and ICF Macro, Nigeria Demographic and Health Survey 2008*. National Population Commission and ICF Macro, Abuja, Nigeria.

NBS (2007).*Social Statistics in Nigeria*. 2007 National Bureau of Statistics, Abuja, Nigeria.

NDHS (2008).*Age Structure in Nigeria.*Nigeria Demographic Health Survey, Federal Government of Nigeria.

Newman, S. (2003). The Living Conditions of the Elderly Americans. *The Gerontological Society of America*,*43*(1), 99-109.

Nicholas, J. (1980).*Physical and Cognitive Changes during Adulthood and Old Age*. Oxford Press, London.

NIMET (2005).*Nigerian Climatic Changes.* Nigerian Metrological Services Department, Abuja, Nigeria.

Obaje, N.G., Lar, U.K., Nzebuna, A.I., Moumouni, A., Chaanda, M. S. and Goki, N.G. (2007). *Geology of Nasarawa.* Keffi, Nasarawa State. Onaivi Printing & Pub CO. Ltd.

Obeka, S.S. (2011).*Panacea of Science Education Research*. Ahmadu Bello University Press, Zaria: Nigeria, pp 19.

Odufuwa, B. O. (2010). Vulnerability and Mobility Stress Coping Measures of aged in a Developing City. *European Journal of Social Science*,*13*(1), 25-33.

OECD (2000) *Employment Outlook 2000*. Paris: OECD, 2000.

Okoye, U. O. (2004). *The erosion of traditional forms of care for the elderly and its implication for the elderly in Nigeria*. Paper presented at the International Conference of Union for African Population Studies,UAPS/UEPA Senegal.

Okumagba, P.O. (2005). Preparing for Retirement in Nigeria: A case Study of Academics in Delta state University, Abraka. *IJBSS, 10*(2), 98-109.

Olaniyan, O., Olayiwola, S and Odubunmi, S. (2011). The Impact of Health Expenditure on the Elderly in Nigeria. *Pakistan Journal of Social Sciences*,*8*(4), 212-218.

Onsemuode C. (2007).*Human Activities in Nasarawa State*. Onaivi Printing & Pub CO. Ltd

Olorunfemi, J.F. (2004). Population and Health Planning.*Social Science and Medicine, 17* (9), 597-600.

Orire, I. O. (2015).*Spatio-Temporal Analysis of Population Aging in Kwara State*. (Unpublished Ph.D. Thesis), Ahmadu Bello University, Zaria.

Oyebanji, J.O. (1986).*Coat of Many Colours*. An Inaugural Lecture delivered at University of Ilorin, November, 1986.

Oyebanji, J.O. (2000). Kwara State. In A.B. Mamman, J.O. Oyebanji, S.W. Petters (Eds), *Nigeria: A People United, A Future Assured, 2,* Survey of States. Federal Ministry of Information, Abuja, 2000.

Oyebanji, J.O. (2002).*Giant in the Sun*. Abuja Federal Office of Statistics.

Poullier, J. P., Hernandez, P. and Kawabata, K. (2003).*National health accounts: concepts, data source and methodology*. Geneva

Ried, W. (1996). Willingness to Pay and Cost of Illness for Changes in Health Capital Depreciation. *Health Econs, 5,* 447-468.

Rosenmayr, L. (1979). Problems in socio-gerontological theory. *Aktuella Gerontologie, 8*(9), 163-210.

Samaila, K.I., and Ezeaku, P.I. (2007).*Hydrology in Nasarawa Keffi,Nasarawa State.* Onaivi Printing & Pub CO. Ltd.

Sokolovsky. (1997).*Population Increase in Nigeria*. Retrieved from www.nn.org/esa/popuiation

Spitzer, S. (1980).*Social Conflict Analysis in Sociology*. 8th Edition, New Jersey, Prentice Hall.

Sung, K. (1995). Measures and Dimensions of filial Piety in Korea. *The Gerontologist 35*(2), 240-247.

Suzman, R. and White Rilley, M. (1985).Introducing the Oldest Old Health and Society, 63, (2) In *Population Growth and Demographic Structure*. United Nation Publication.

Thompson, G, and Schulz R. (1975). An Old Problem in New Form. In *The Right to Die with Dignity*. New York: Euthanasia Education Fund

Tollman, S., Doherty, J. and Mulligan, J. (2006). *General Primary Care: Disease control in developing countries 2nd edition*. New York. Oxford University Press.

Tostensen, A. (2004). Towards Feasible Social Security Systems in sub- Saharan Africa. In: M. Grimm, (ed). *African Social Challenges,* Bergen: World Bank; pp. 14.

Tuker, M. (1996). Premature Ageing. In J. E. Birren, (Ed). *Age, Ageing and the Aged,* 2. pp. 341-354, Orlando: Academic press

UN (2005). *Projected Population Aging in Africa*, West Africa and Nigeria.

UNICEF (2005).*Fighting Polio across Niger's Sahara Desert*. United Nations Children Education Fund. Retrieved from http://www.unicef.org/infobycountry/Niger-25017.html

United Nations. (2001).*Population Ageing and Living Arrangement of Older Persons: Critical issues and policy Responses*. Population Bulletin of the United Nations, Special issue. 40-43Sales No. E.01.XI11. 16. (ST/ESA/SER.N/42-43).

United Nations. (2002).*World Population Ageing Agency*. Population Bulletin of the United Nations.ST/ESA/SER.A/207, No.E002. XIII.3

Uwakwe, R. and Modebe, I. (2007). Disability and Care- Giving in Old age in a Nigerian Community. *Nigerian Journal of Clinical Practice, 10*(1), 58-65

Van de Walle, E. (2006). African households: censuses and surveys. *Journal of social science and medicine*, *2*(62), 2411-2419.

Wahab, E.O. (2013). Pension Challenges Facing the Old Persons in Nigeria. *European Scientific Journal*, *9*(8), 235-251.

Wahab, E.O and Isiugo-Abanihe, U.C.(2010). Assesing the Impact of Old age Security expectation on Elderly Persons Achieved Fertility in Nigeria. *Indian Journal of Gerontology*, *24*(3), 357-378.

Waite, L. J and Hughes, M. E. (2004).*The American family as a context for healthy ageing. The Family in an Aging Society: A Multi-Disciplinary Approach*, ed. S Harper. Oxford: Oxford University Press. pp. 176-189.

Waldo, M. and Freeman R. (1989).*Implications of Trend in Elderly Health and Socio-Economic Status for Medicare Expenditures*. Centre for Medicare and Medical Services, Baltimore, USA

Weeks, J.R. (2005).*Population: An Introduction to Concepts and Issues*. Ninth Edition. San Diego State University, Wadsworth, Thomson Learning Retrieved from www.senescene.info/agingdefinition.html

Williams, S.R and Schlenker, E. (2003).*Essentials of Nutrition and Diet Therapy*. 8th Edition, The C.V. Mosby CO., St. Louis.

World Health Organization. (1980).*International Classification of Impairments, Disabilities and Handicaps.* A Manual Classification Relating to the Consequences of Diseases. Geneva,1980.

World Health Organization. (2001).*Water Related Diseases*. Geneva: WHO.

World Health Organization. (2011).*Aging.*Retrieved from(11/08/2011) http://wwww.who.int/topics/aging/en

Yamane, T. (1967).*Statistics: An Introductory Analysis*, NewYork. Harper & Roxy.

Yu, Y. (1991).*The Demography of Disability*. Population Bulletin of the United Nations. New York: United Nations, 30, 61-78.

APPENDIX I

Living Conditions questionnaires (LCQ)

Dear Respondents,

This questionnaire is from a Masters student of Ahmadu Bello University, Faculty of Sciences and Department of Geography who is conducting a research on; Analysis of the living conditions of the elderly in Lafia Local Government Area of Nasarawa State. The exercise is purely for academic purposes and your responses will be treated with utmost confidentiality and anonymity.

Thank you.

SECTION A: DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

1. Sex: Male ( ) Female ( )
2. Age (years): 65-69 ( ) 70-74 ( ) 75-79 ( ) 80 and above ( )
3. Religion: Christianity ( ) Islam ( ) Traditional ( ) Others (specify) _____
4. Marital Status: Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated ( )
5. Type of marital union: Monogamy ( ) Polygamy ( ) c. Others (Specify)_____
6. Number of children ever born: None ( ) 1-2 ( ) 3-4 ( ) 5- 6 ( ) 7-8 ( ) 9-10 ( ) 11 and above ( )
7. Highest educational qualification obtained: Qu'aranic ( ) Primary ( ) Tertiary( ) None ( ) Others (specify)_____
8. Occupation: Farming ( ) Trading ( ) Artisan ( ) Civil servant ( ) Others(specify)_____

SECTION B: SOCIO- ECONOMIC CONDITION OF THE ELDERLY

9. Income level (₦): ≤ 5000 ( ) 5000-10,000 ( ) 11,000- 15,000 ( ) 16,000-20,000 ( ) ≥21,000 ( )
10. What is the nature of the support? Financial ( ) Foodstuff ( ) Drugs ( ) Clothing ( ) Others (specify) _____

11. What is the main source of your financial support? Spouse ( ) Children ( ) Pension ( ) Church/Mosque ( ) Social organization ( ) Others (specify) _____
12. How often do you get support? Daily ( ) Weekly ( ) Monthly ( ) Yearly ( )
13. Are you satisfied with the support you get? Yes ( ) No ( )
14. What type of house do you reside in? A room ( ) Two rooms ( ) Three rooms ( ) A flat ( ) Bungalow ( ) Others (specify)_____
15. Who owns the house? Personal ( ) Family house ( ) Rented ( ) Official quarters ( ) Others (specify)_____
16. Who are you residing with? Children ( ) Spouse ( ) Spouse with children ( ) Alone ( ) Relatives ( ) Others (specify) _____

SECTION C: HEALTH CONDITIONS OF RESPONDENTS

17. Have you been hospitalized during the last 12 months? Yes ( ) No ( )
18. If yes, what is the nature of the illness? Diabetes ( ) Heart related Ailments ( ) Eye problem ( ) Accident ( ) Others (specify)_____
19. What health facility do you use for treatment? Hospital ( ) Traditional Healer ( ) Faith- Based Healer ( ) Self Medication ( ) Others (specify)_____
20. Are you suffering from any disability? Yes ( ) No ( )
21. If yes, what is the nature of disability suffered? Hearing defects ( ) Eye problem/blindness ( ) Knee Problem/ numbness of the limbs ( ) Deformity due to past accidents ( ) Others (specify)_____
22. Who pays your medical bill? Children ( ) Relatives ( ) Government/NGOs ( ) Church/Mosque ( ) Others (specify) _____
23. Do you have a family doctor? Yes ( ) No ( )
24. How often do you visit the hospital? Daily ( ) Weekly ( ) Monthly ( ) Quarterly ( ) Occasionally ( ) Not at all ( )

SECTION D: COPING STRATEGIES

25. Do you engage in any pay job? Yes ( ) No ( )

26. If Yes, what kind of job? Farming ( ) Contract ( ) Politics ( ) NGO ( ) Others (specify)_____

27. How is your average day like? Attending to community needs ( ) Farming/Business ( ) Praying/Religious duties ( ) Others (specify)_____

28. What social engagement do you normally attend? Marriages ( ) Burials ( ) Naming ceremonies ( ) Others (specify) _____

29. Which facilities do you have in your area? Hospital ( ) Old peoples' homes ( ) Recreational clubs ( ) Others (specify)_____

30. How many times do you eat in a day? Once ( ) Twice ( ) Thrice ( ) Others (specify)_____

31. How often do you take fruits? Daily ( ) Once a week ( ) Twice a week ( ) Thrice a week ( ) Others (specify)_____

APPENDIX II

IN- DEPTH INTERVIEW GUIDE

1. What is your assessment of the living condition of the elderly in this area (that is 65 years and above).
2. What can you say about the nature of support given to the elderly in Lafia Local Government Area?
3. Does the Local Government Area/ religious leaders have a package to enhance the wellbeing of the elderly?
4. If yes, what is the package?
5. How many elderly have benefited from the package so far?
6. What further measure do you think if adopted will enhance the welfare of the elderly in Lafia Local Government?
7. What advice do you have for the elderly people in Lafia Local Government Area?

APPENDIX III

FOCUS GROUP DISCUSSION GUIDE

S/No	General Questions	Related Probe Questions
1	What do you think about the living condition of the elderly?	Probe to find out if their living condition is affected by demographic and socio-economic factors.
2	What roles do you play as elders in the community?	Probe on their experiences as elders in the community.
3	How do you cope as elders through these hard times?	Probe for their wellbeing as related to the financial conditions, high cost of living.
4	How much do you know about the Nigerian Policy on the welfare and care of the elderly	Probe for comments on their awareness of the policy, its objectives and area of coverage etc.
5	What form(s) of support do you get from government?	Probe to know if there are any organized pro-aged form(s) of support.
6	How often are these supports?	Probe the reliability of these assistances.
7	Are there dedicated public facilities for the welfare and care of the aged/elderly?	Probe for the availability of specialized infrastructure like; elderly homes, geriatric clinics, sports & recreational facilities
8	What are the prevalence rates of various ailments and chronic conditions among the elderly?	Probe for the prevailing types of ailment/illness commonly suffered in the community, rate of occurrence etc.
9	Do you agree that the older a person becomes, the more the challenges faced by their care givers?	Probe for comments about old age challenges faced and boding anxiety.