ANALYSIS OF THE WELLBEING OF THE AGED IN KAURA LOCAL GOVERNMENT AREA, KADUNA STATE, NIGERIA

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FEBRUARY, 2018

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BY

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(P13SCGS8036)

A DISSERTATION SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES, AHMADU BELLO UNIVERSITY, ZARIA IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF SCIENCE DEGREE IN POPULATION AND DEMOGRAPHIC STUDIES

DEPARTMENT OF GEOGRAPHY AND ENVIRONMENTAL MANAGEMENT,

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ZARIA, NIGERIA

FEBRUARY, 2018

DEDICATION

I dedicate this dissertation to God Almighty, the very essence of my being, my dear parents, Mr. and Mrs. Joseph MagajiYorkings, the ultimate source of my inspiration, my wonderful children, Sonia and Simeon and to my lovely husband, Mr.Nuhu Samson who is my back bone and my strength.

DECLARATION

I declare that the work in this dissertation entitled “Analysisof the Well-being of the Aged in Kaura Local Government Area, Kaduna State, Nigeria” has been carried out by me in the Department of Geography, Ahmadu Bello University, Zaria. The information obtained from the literature has been duly acknowledged in the text and a list of references provided. No part of this dissertation was previously presented for another degree or diploma at this or any other institution.

_____ _____

Queen NuhuSAMSONSignatureDate

CERTIFICATION

This dissertation entitled "Analysisof the Well-being of the Aged in Kaura Local Government Area, Kaduna State, Nigeria" by Queen Nuhu SAMSON meets the regulation governing the award of the degree of M.Sc.Population and Demographic studies of the Ahmadu Bello University, Zaria, and is approved for its contribution to knowledge and literary presentation.

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ACKNOWLEDGEMENTS

Most importantly, I give God Almighty the glory for seeing me throughout the course of my programme. I couldn't have made it considering the challenges that faced me, but his grace suffices.

With a heart full of thanks, I wish to acknowledge the tireless efforts of my supervisors- Prof. M. Mamman and Dr R.O. Yusuf, for their time, attention, suggestions and constructive criticism on my work.I really do appreciate the Head of Department, lecturers and fellow studentsof the Department of Geography, for their academic and moral support.

I will forever remain grateful to my lovely daddy- Mr. Joseph MagajiYorkings and my sweet mummy- Mrs. Rahila Joseph Magaji, for their love, care, encouragement, spiritual, moral and financial support all through the course of my programme. Also, I thank my Dad, who wanted me to obtain my M.Sc. Degree under his roof, but destiny did not allow that. All the same, I am happy your support pushed me to achieve this.

My heartfelt gratitude goes to my beloved husband, Mr. Nuhu Samson, for his kind hearted love, care, encouragement and support both morally and financially. I also want to acknowledge my prince and princess,Simeon Nuhu Samson and Sonia Nuhu Samson for their understanding and prayers toward the success of my programme.

My profound gratitude goes to my siblings Sheba Joseph Magaji, Joy Joseph Magaji, Samson Joseph Magaji and Blessing Joseph Magaji, my In-laws especially my mother-inlaw- MrsRifkatu Samson, friendsand well-wishers for their support, encouragement and immensed prayers toward the success of my programme.

I remain grateful to all my aunts, uncles and cousins for their encouragement, prayers and support all through the course of my programme.Finally, I thank all my respondents for

accepting to be part of this research, thisStudy would not have been possible without all of them.

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ABSTRACT

In Kaduna State, poverty is rife and the aged are more at risk as 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. The study examines the living conditions, coping strategies, the determinants of wellbeing of the aged as well as their type and sources of support in Kaura Local Government Area, Kaduna State, Nigeria. Data on the socio-demographic characteristics and general wellbeing of the aged were collected with the aid of a structured questionnaire, In-depth Interview and Focused Group Discussions (FGDs). Respondents were selected through systematic sampling techniques by picking on every third house except in a situation where an aged person is not found, the next house is picked. A total of 400 aged males and females responded to the questionnaire administered. The data were analyzed statistically using descriptive statistics. Majority of the aged people were grand multiparous females that engage in farming as a source of livelihood. About 49% of the respondents have been hospitalized since their 60^{th} birthday and were without any fixed source of income. About 24.5% respondents were on special diet due to ailments and most of them could not afford their diet as often as required. About 42.3% get their drinking water from mono-pump and only about 21.3% boil the water before drinking. There were no recreational clubs and old people's homes, hence about 53.3% get recreated by strolling, and they live alone, without anybody to take care of them. About 54.5% feed adequately by either collecting food on credit or rely on others for food in order to survive. Food, money and shelter are being provided to the respondents by their children and relatives, so where the children and relative are unsupportive, such aged individuals have to struggle really hard so as to survive. The result of this study reveals that the aged in Kaura Local Government Area are not faring well. This emphasizes the need for the Government and other relevant bodies to formulate and implement policies like free medical care, making available and accessible food and clothes. Further efforts should be made by the government and Non-Governmental Organizations (NGOs) to establish institutions (like old people's homes and generic hospitals) whose primary goal will be to accommodate and cater for the aged in the society, particularly those who are living alone.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

One of the most remarkable demographic developments in modern times is theprogressive ageing of the population itself. In virtually all countries, themost elderly of the older generation (often referred to as the "oldest old") is growing fasterthan its younger segment.Indeed, according to the United Nations Population Division (2002)projections, the average annual growth rate of persons aged 80 years or over (3.8%) iscurrently twice as high as the growth rate of the population over 60 years of age. Moreover,the proportion of those older than 80 is projected to increase almost fourfold over the next 50years to 4.1% in 2050. Currently, in Germany, about six million inhabitants are over theage of 75 (7.1% of the population), a figure projected to increase to over 13 million (18.6% of the population) by 2050.

The elderly or the aged consists of ages nearing or surpassing the average life span of human beings. The boundary of old age cannot be defined exactly because it does not have the same meaning in all societies. Most developed countries have accepted the chronological age of 65 years as a definition of 'elderly' or older person, but like many westernized concepts, this does not adopt well to the situation in Africa. While this definition is somewhat arbitrary, it is many times associated with the age at which one can begin to receive pension benefits. At the moment, there is no United Nations standard numerical criterion, but the UN agreed cutoffis 60+ years to refer to an aged population.

Well-being is a general term for the condition of life of an individual or group, for example their physical, social, economic, psychological, spiritual and medical state of

life. A high level of well-being means in some sense the individual or group is experiencing positive and satisfactory state of living, while low well-being is associated with negative aspect of life. Although, there has not been a clear definition established for wellbeing, it can be defined as "a special case of attitude"(Louis and Shlomit 1982).

Socio-economic hardship, mass poverty, changing social and religious values, influence of western culture are among the factors that have broken down the traditional extended family and community care system that look after the welfare of elderly citizens in Nigeria. Even outside Nigeria, most of the elderly people suffer from some basic human problems such as poor financial support, senile diseases and absence of proper health and medical facilities, exclusion and negligence, deprivation and socio-economic insecurity (Rhaman, 2000). They are most at times not paid their pension resulting in their poor wellbeing and poor medical attention.

Given the assertion by Asiyanbola (2008) that the aged have contributed significantly to the growth and development of their mother land, the physical, social and even the psychological wellbeingof the elderly is of paramount importance (Kimokoti and Hamer, 2008), especially inKaura Local Government Area where like in other African societies, their roles cut across several aspects of life. It is against this background that this research is embarked upon.

1.2 Statement of the Research Problem

In Kaura Local Government Area, poor infrastructural development which characterizes ruralcommunities where most aged people reside, constraintthem from achieving a good well-being. Traditionally, the aged are expected to rely primarily on their families for economicand emotional support. At times if family support mechanism fails, community

help may be available. However, the collapse of family ties and structure also have negative effect on the aged who are used to enjoying support and care from extended families (Ajala and Olorunsaiye, 2006; Asiyanbola, 2009). In Kaura Local Government Area, household sizes are large but a substantial proportion of older adults still live alone. Thelivelihood of the aged (60 years and above) in Kaura Local Government Area is mainly subsistence agriculture, which provide little or no pension coverage and limited health care services.

From time immemorial, care for the aged was within the extended family system(Adeokun, 1986; Anionwu, 1986; and Ekpeyong 1995). The aged arecared for by their children, son's wife and the extended family members, particularly thewomen. There is the practice of marrying young girls by the aged men, and at times theirchildren may marry a young girl for them to take care of their needs. Some parents do send their children home to livewith the grandparents so that they can run errands for them while the grandparent teachesthem cultural and moral values. Within the traditional system, the social obligations of the aged were multi-dimensional in the sense that they encompassedreligion, education, politics, recreation, economic, and prophetic issues. In those days,people looked forward to getting old.

In this contemporary time, social and economic changes currently occurring have threatened such traditional arrangements for the aged. Suchchanges like increased emphasis on smaller family units, migration to urban areas, moreworking wives, new life styles and changing values all have effects on the traditionalforms of care of the aged. Financial difficulties have further made it imperative for mostwomen to now work for

pay outside the home and also the issues of education for theyoung have reduced the caring role of the grandchildren.

In Kaduna State, poverty is rife and aged 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, Kola, Ebenezer and Benjamin, 2008).

In Nigeria, studies that focus on the care of the aged are not many. Such studies focus on issues ranging from the description of the traditional form of care of the elderly, demographic data, government's policy on the elderly, life-satisfaction of the elderly, effects of structural adjustment programme on the elderly, and the nutritional assessment and health status of the elderly (Anionwu, 1986; Adeokun, 1986; Ekpeyong 1995; Bakare*et al.,* 2004; and Okoye, 2004; among others). As reported in most of these studies, caringfor the aged has always been considered as family responsibility with little or no government support.

A study by Okoye (2004) explored how Nigerian youths feel about care-givingfor the elderly and their views about traditional ways of taking care of the elderly. The author observed that the youngsters are not willing to live with their aged parents; neither are they willing to send their wife nor their children to the village to live with their aged parents. Asiyanbola, (2004) examined the link between social support/networks,urban condition and physical well-being of the elderly. Results of the test of stated hypotheses show that there is significant variation in elderly family care and physical well being; there is significant relationship between: (i) elderly family care and household income,

elderly age, age of the youngest child in the household; (ii) elderly daily activities and physical well-being; and (iii) elderly housing condition and physical well-being.

Gee (2000) examined the role of living arrangements in quality oflife in community dwelling elders. A total of 830 persons were interviewed on three dimensions of quality of life-satisfaction, well-being, and social support, for living alone, with spouse, and intergenerational. Findings highlighted the importance of living arrangement and quality of life. Few differences were found for married persons but for widows especially females; quality of life went down significantly with decreasing support. Therefore, thepresent work is an addition to the existing literature which attempt to analyze the wellbeing of the aged in Kaura Local Government Area of Kaduna State and the following questions were focal points of the study:

i.What are the living conditions of the agedinKaura LGA?

ii.What are the determinants of the well-beingof the aged inKaura LGA?

iii.What are the coping strategies of the aged inKaura LGA?

iv. What are the types and sources of support for the aged in Kaura LGA?

1.3Aim and Objectives

The aim of this study is to provide detailed information on the well-being of the aged in Kaura LGA. The specific objectives are to:

i. determine theliving conditions of the agedin Kaura LGA;

ii. access the determinants of well-being ofthe aged in Kaura LGA;

iii. identify thecoping strategies of the aged in Kaura LGA;

iv. identify the types and sources of support for the aged in Kaura LGA

1.4 Scope of the Study

The study focuses onthe well-being of the aged in Kaura Local Government Area, Kaduna State, Nigeria. The Local Government Area is made up of ten wards and five wardswere selected through the systematic sampling techniques on every second ward to give a wide coverage of the area. These wards include Agban, Bondon, Fada, Kadarko, Kaura, Kpak, Kukum, Malagum,Manchockand Zankan respectively.

The study also examined the socio-demographic characteristics of the respondents, the living conditions of the aged, the determinants of wellbeing of the aged, their coping strategies as well as the type and sources of support the aged received in Kaura Local Government Area.The study covers 2011 to 2015, a period of fairly harsh economic condition. This aim to examine how the aged cope under harsh economic environment.

1.5Justification for the Study

In Kaduna State, there are limited research on wellbeing of the aged, especially in rural settings like Kaura local government area where people are most beset by poverty and poor health condition.

The study is very important in bringing an understanding of the well-being of the aged inKaura LGA. This will help decision and policy makers to factor on the plight of the aged as it concerns the developmental process in Nigeria. Studies have revealed that a nation with an ageing population is a developed nation or society as they have the ability to contribute greatly to the development of such nation if given the opportunity. The study will help the society tounderstand, identify and appreciate the factors responsible for the well-being of the aged.

CHAPTER TWO

CONCEPTUAL AND THEORETICAL FRAMEWORK AND THE REVIEW OF OTHER RELEVANT LITERATURES

2.1 Introduction

In this chapter, related works were reviewed underdifferent topics and sub-topics. The first is the conceptual framework where key concepts such as aged, aging, well-being and the concept of copingare elaborately examined. Theoretical issues encompass social network, social support and age stratification theories. The literature review subsections are broken into the global trend of the aged, living conditions of the aged, determinants of quality of life of aged people, coping strategy as well as social support for the aged.

2.2 Conceptual Framework

2.2.1 The aged

In every human society, people are socially classed according to either age or sex. That is, every society makes social distinctions according to age and sex. These distinctions are one of the bases for the differentiation of social roles in society. All societies make clear distinctions between the status of a child and that of adult. Thus, most traditional societies have a simple formula for inducting their youth into adulthood.Social Scientist have long been accustomed to examining categories such as class, ethnicity and race and more recently, they have begun to use gender as a social category as well. But they have been less systematic in their use of age because maintaining a distinction between an “age group” and “aging” as a process is difficult. According to Hareven (1978), age and aging are related to biological phenomena, but the meanings of age and aging are socially and culturally determined.

The aged are social category found in every human society. “Social age” is a relative concept and varies in different cultural contexts. In trying to understand the societal conditions affecting adulthood and old age, it is important to realize that the definitions of aging as well as the social conditions and functions of every age group have not only change significantly over time but are also varied among cultures.

There is no universally accepted definition of the concept, aged. This is because there are no universally accepted criteria for defining certain categories of people as old or aged. Thus, Henrard, (1996) observes “there is no clear definition of later life or consensus if it should be defined by chronological age, functional age or in terms of significant life event such as retirement (or widowhood). Therefore, the categorization or definition of people as old is quite arbitrary and varies from one society to another as ‘well as from time to time within a society’. Old age today has a legal definition, in the sense that it refers to the age at which most people retire from work and claims for particular kinds of welfare benefit such as pensions (Giddens, 1990).

Given its arbitrariness, any age chosen to define “old age” always includes individuals who differ considerably in their physical and mental capacities. For instance, the United State Security Act of 1935 held that the old age occurred at 65 and therefore, pegged retirement at 65 years of age. This was later changed to 70 in 1978 and by 1986 retirement age was abolished altogether. In Britain, retirement age is 65 for men and 60 for women while in Denmark and France, it is 67 and 60 years respectively. In Nigeria, retirement age ranged from 60 years for civil servants to 65 years for University academics (Essien, 1997).

2.2.2 The aging process

Studies have shown that aging is a developmental and continuous process of change in the individual right from conception to death (Beavoir, 1972; Atchley, 1980; Kimmel, 1980; and Cohen, 1994). The concept of aging can be looked at from three mutually related perspectives, viz: physical, psychological and social. According to Atchley (1980), aging is 'a broad concept that includes physical changes that occur in the bodies of an adult; psychological changes in the minds and in the mental capacities; and social changes in how an individual is viewed, what he can expect, or what is expected of him.' From the concept of Atchley (1980), it is clear that there are three aspects of aging - physical (or biological), psychological and social.

2.2.2.1 The physical/biological aspect of aging

Physically, aging is defined in terms of body posture, hair colour, voice and the ability to see and hear. Physical aging refers to body maturation or a period of obvious biological and psychological changes in the individual over time. That is the visible aspect of the aging process. Thus, biological age indicates a person's level of biological development and physical health (Kimmel, 1980).It is common to think of human life in terms of a period of maturation, in which the person develops, a period of maturity in which the person exercises his or her full power and a period of aging in which the person gradually diminishes (Atchley, 1980). This view is based on biological characteristics of life in both animals and plants. However, this view has been criticized for being too simplistic. What this view has failed to consider is that physical, an individual's body does not age in homogeneous fashion, while some parts of it decline very soon, some decline gradually.

2.2.2.2 The psychological aspect of aging

Whenever the psychological effects of passage of time in adulthood is examined, it is realized that some dimensions diminish with aging, some increase, while others remain relatively constant throughout adulthood (Atchley, 1980). For example, visual acuity generally declines with age, vocabulary usually increases, and habits tend to remain relatively constant throughout adulthood. According to Atchley, variability is greater for psychological aging than it is for physical aging.

2.2.2.3 The social and/or cultural aspect of aging

Social age relates to the movement of an individual from one status to another. It also relates to experiences in the course of life and the manner in which an individual relates his aging to his own society. Social age is gauged by social roles and habits (Smith, 1973). The social roles of older persons are defined by the way people at large perceive them (Rogers, 1979). The way individuals respond to people who have retired defines their role in the society. Thus, how the society at large perceives the age is one of the most important factors that determines their social roles. Atchley, (1980) noted that defining social aging is largely an arbitrary process of defining what is appropriate or expected of people of various ages, based very closely on information about what people of various ages are capable of. For example, the age when young people are considered old enough to marry varies from age 13 to 16 among the Fulani, to 20 to 25 among the Yoruba.Kimmel, (1980) conceives of social age as: "that which indicates a person's passage through the socially defined milestones of development such as working full time, marriage, parenthood and grandparenthood.

2.2.3 Well-being

Well-being is a positive outcome that is meaningful for people and for many sectors of the society, because it tells the perception of people about their lives. Good living conditions (e.g., housing, employment) are fundamental to well-being. Understanding these conditions is important for public policy. However, many indicators that measure living conditions fail to measure what people think and feel about their lives, such as the quality of their relationships, their positive emotions and resilience, the realization of their potential, or their overall satisfaction with life, all of which make up their "well-being" (Diener and Seligman,2004; Diener, Scollon and Lucas, 2009). Well-being generally includes global judgments of life satisfaction and feelings ranging from depression to joy (Diener*et al.,* 2009; Frey,Stutzer and Princeton, 2002).There is no single determinant of individual well-being, but in general, well-being is dependent upon good health, positive social relationships, and availability and access to basic needs and resources such asshelter, befitting adequate income and food among others.

Well-being is associated with numerous health, job, family, and economically related benefits.For example, higher levels of well-being are associated with decreased risk of disease, illness, and injury; better immune functioning; speedier recovery; and increased longevity. Individuals with high levels of well-being are more productive at work and are more likely to contribute to their communities.

Previous research lends support to the view that the negative affect component of well-being is strongly associated with neuroticism and that positive affect component has a similar association with extraversion. This research also supports the view that positive emotions—central components of well-being—are not merely the opposite of negative

emotions, but are independent dimensions of mental health that can, and should be fostered. Although a substantial proportion of the variance in well-being can be attributed to heritable factors, environmental factors play an equally if not more important role.

2.2.4Theconcept of coping

The concept of coping was first adopted by psychologists in the 1960s and 1970s and was applied to refer to the struggle of overcoming and managing the stresses of living and adapting (Lazarus and Lazaru, 2006). Different theoretical perspectives have defined coping as personality traits where the way a person copes is determined by the kind of person they are (Moos,1974), and as a process where coping is seen as a situation-specific and flexible state (Lazarus and Lazarus, 2006).

Situational factors may be the changeability or controllability of a situation, and personality factors may include the aspects of self-confidence, self-efficacy (Bandura, 1977) and Locus of Control (LOC) (Rotter, 1996). LOC relates to the generalized expectations regarding who or what is responsible for the outcomes. If the person attributes the outcome to luck or powerful others, the belief is labeled external control, and if the relation is attributed to personal effort, the belief is labeled internal control (Craig, Franklin and Andrew, 1984; Rotter, 1996). Self-efficacy refers to the perception that one has the abilities to enact these responses (Bandura, 1977), and sense of control (SOC) according to Lachman and Weaver, (1998) is understood as the perception of control in a certain situation.

According to a transactional perspective on coping, the person and the environment are understood to be in an ongoing reciprocal relationship, where the stressors in life are evaluated in an appraisal process according to the perceived personal resources (i.e.

control orientation, self-efficacy) and choices available to the coping person to manage the challenges (Folkman and Lazarus, 1980). Coping, as described by Folkman and Lazarus (1980), involves different strategies to alter the stressful situation (i.e. problem-focused coping), as well as efforts to regulate the emotional distress associated with the situation (i.e. emotion-focused coping). The strategies chosen depend both upon situational and individual factors: the coping resources. Other theorists have further developed different concepts of coping related to the coping strategies of Folkman and Lazarus (Folkman, Lazarus, Gruen and DeLongis, 1986; Folkman and Lazarus, 1998), like coping actions and coping style (Xie, 1995; Hayes *et al.*, 2004).

2.3 Theoretical Framework

This section describes some theories related to the well-being of the aged. These theories include the social network theory,social support theory and the age stratification theory.

2.3.1 Social Network Theories

A social network is defined as "the number, frequency and linkages of contacts with other individuals or groups" (Worcester, 1990). Social network theories propose that social interactions between individualslead to heterogeneous relationships that have different levels of supportiveness (Pierce, Sarason, andSarason, 1991). There are two main social network theories: task-specific theory and hierarchical-compensatory theory.

2.3.1.1 Task-specific Theory

This theory categorizes social network groups as primary, informal, and formal groups (Litwak, 1985). According to this theory, each social network has different natures, and because of these different natures of social networks, each network group can optimally manage different tasks (Litwak, 1985; Messeri, Silverstein, andLitwak, 1993). This

theory also emphasizes that most people have various needs, and it is necessary for both formal groups and primary/informal groups to cooperate in most areas of life (Messeri*et al.,* 1993). In addition, the provision of aid varies across different relationships even within the primary groups such as spouses, offspring, relatives, and non-relatives. For example, spouses typically live together. Therefore, they continuously have face-to-face contact, and can provide social support over a long period of time. On the other hand, neighbours live close by and primary contact is face-to-face, but unlike spouses, they typically do not provide long term commitments (Messeri*et al.,* 1993).

2.3.1.2Hierarchical-compensatory Theory

This theory focuses on the importance of recipients' preferences. According to this theory, older adults seeking help have an ordered preference based on "the primacy of the relationship between the caregiver and the aged recipient" (Messeri*et al.,* 1993). Older adults prefer the assistanceof spouses. When they are not available, they turn first to children, second to other relatives, third to friendsor neighbors, and last to formal groups (Cantor, 1991; Messeri*et al.,* 1993). The social network can be categorizedin a hierarchical-compensatory manner. These hierarchical-compensatory patterns are rooted in past relationships and activated when the older adult needs assistance (Cantor, 1991; Messeri*et al.,* 1993).

2.3.2 Social Support Theories

Uchino conceptualized social support as "the functions that are provided by social relationships" (Uchino, 2004). Social support theories have linked the social support provided by social relationships to health outcomes, although each model within social

support theory emphasizes different processes. There are two main theories in social support theories: direct effect theories and stress-related theories.

2.3.2.1 Direct Effect Theories

This theory emphasizes the benefits of receiving social support based on social identity, socialcontrol, or loneliness models (Uchino, 2004). First, according to the social identity model, social support has positive effects on health when individuals are embedded in a social network because it gives individualsmeaningful roles that provide self-esteem and increase the meaning of life, which in turn affects the health of support recipients (Thoits, 1983). Second, according to the social control model, social support also has positive effects on health when an individual is embedded in a social network which can place pressure on people to follow healthier behaviors by giving individuals meaningful roles that enhance an obligation to life (Lewis and Rook, 1999). Third, based on a loneliness model, loneliness is related to poor health outcomes because loneliness affects self-esteem, meaning of life, and obligation to life (Stroebe andStroebe, 1996; Uchino, 2004). This, in turn, may result in negative health behaviors such as smoking and the intake of alcohol (Stroebe andStroebe, 1996). These negative health behaviorsconsequently affect overall health outcomes for the individual.

2.3.2.2 Stress-related Theories

These theories focus on the role of social support in stress-related processes. The buffering model of social support predicts that social support is healthy because it buffers the negative effects of stress on health (Cohen and Herbert, 1996). This model suggests that stressors such as bereavement and daily hassles affect health through Informal Caregivers, the appraisal process which is a psychological process that can be adjusted by

social support (Uchino, 2004). Therefore, based on a buffering model, even when faced with extremely stressful events such as the death of a spouse, social support can help reduce the intensity of the stress response and facilitate coping strategies over the long term (Uchino, 2004). On the other hand, according to the stress-prevention model, social support is healthy because social support may prevent people from exposure to potential stressors such as negative life events (Uchino 2004).

2.3.3 Age Stratification Theory

The age stratification theory begins with the proposition that age is a basis for social differentiation in a manner analogous to stratification by social class (Foner, 1975). The term stratification implies a set of inequalities, and in this case, it refers to the fact that societies distribute resources unequally by age. These resources include not only economic goods but also such crucial intangibles as social approval, acceptance and respect. This theory is not a mere description of status, however; it introduces a dynamic element of recognizing that aging is a process of social mobility. Foner (1975) notes that "as the individual ages, he too moves within a social hierarchy. He goes from one set of age related social role to another and at each level receives greater or lesser reward than before". Contrasted to other forms of social mobility in the age hierarchy is "inevitable, universal and unidirectional in that the individual can never grow younger" (Weeks, 2015).

2.4 Review of Other Relevant Literature

2.4.1Global Trend of the Aged

According to a published United State Bureau Bulletin of the Census and Database on ageing in 1988, the global population was growing at a rate of 1.7% per year. The population aged 55 years and above is increasing by 2.2% per year; and the number of persons aged 65 years and over, is rising by 2.8% annually. The bulletin shows further that every month, the net balance of the World's older population (55 years and over) increases by 1.2 million persons. It is expected that this demographic pattern will continue. Troisi (2004) observed that already one out of every ten persons is now 60 years or above. And by 2050, one out offive will be 60 years or older and by 2150, one out of three persons will be 60 years or older. The author further observed that the older population is ageing, that is,the oldest old (80 years or older) is the fastest growing segment – constituting 11% of the 60 years or older age group and is projected to grow to 19% by 2050. Thenumber of centenarians is projected to increase 15-fold from approximately 145,000 in1999 to 2.2 million by 2050.

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 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 Madrid in 2002, the Assembly adopted an international plan of action on ageing and political declaration, recommending that older persons must be full participants in the development process in the 21st century.

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. Despite the fact that all these declaration 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 government is still limited. This is the situation especially in African countries, where other pressing priorities command most of the attention of policy maker, even though the process of population ageing is already visible in these countries. These socioeconomic hardships have compromised the living conditions of the aged people.

2.4.2 Living Conditions of the Aged

The living condition of the aged is an omnibus term. It can be broken down in to material, physical, social and emotional conditions for proper articulation. This is better discussed as well-being.

2.4.2.1 Material Well-being

Demographic research indicates a strong relationship between the level of wealth and various indicators of well-being, including health and life satisfaction. The Stanford Centre on Longevity (SCL/PRB) Index uses the following indicators of financial resources to measure material well-being:

i. Median household income per capita ($PPP)

ii. Person not in absolute poverty

Both indicators are based on household income as measured in the Health and Retirement Study (HRS) and Study of Health, Aging and Retirement in Europe (SHARE) surveys. In these data, household income estimates are based on the personal income of all household

members as well as household-level income, such as income from assets held jointly and lump sums from insurance, pensions, and inheritances. For the SCL/PRB Index, both the income measure and the absolute poverty threshold used to estimate the percent not in poverty are measured in purchasing power parity (PPP) dollars, which ensures that cross-national differences observed are not the result of price differences between countries.

Measuring income at household levels is important for older adults who may no longer be in the labour force yet live with others, thus, benefiting from income of household members and economies of scale. Financial well-being in old age is largely determined by current and past employment characteristics. Sources of income vary across different groups (men and women; the young-old and the old-old) but generally include public and private pensions, savings, assets, and earnings for persons who remain economically active. The importance of each of these sources of income for older adults varies from country to country. Pension schemes differ across countries with respect to eligibility requirements and funding mechanisms and so does the extent to which these benefits replace pre-retirement income (Gruber and Wise 1999; Bloom, David, Rick, and Macheal, 2007).

Absolute poverty among older adults provides an assessment of whether income sources are enough to meet basic needs such as food, clothing, and shelter. In this study, households with income at or above purchasing power parity (PPP) of the official U.S. poverty threshold for the year in which the data was collected were considered not poor. The U.S. poverty thresholds used take into account household size and income. They range from $9,973, or $27 per day, for a household of one to $40,288, or about $12 per person per day, for a household of nine.

2.4.2.2 Physical Well-being

Health affects one's ability to care for oneself, to stay active and productive, and to live independently in the community. Poor health directly and indirectly diminishes happiness and overall satisfaction in life (Easterlin, 2003). The SCL/PRB Index uses measures of disability, independent living, physical functioning, life expectancy, and obesity to summarize the overall health in older populations across societies. The specific indicators are:

i. Person with no disability

ii. Person with no difficulty taking medications

iii. Person with no difficulty walking a short distance (no functional limitations)

iv. Life expectancy at older ages (50-54, 65-69, or 75-79 depending on the age group)

v. Person not obese

Disability is typically measured by the ability to perform Activities of Daily Living (ADLs), a set of basic daily activities necessary for self-care, such as bathing, dressing, eating, and toileting (Katz, Amasa, Roland, Jackson and Marjorie, 1963). The ability to live independently is often measured with the ability to perform Instrumental Activities of Daily Living (IADLs), a set of activities that are generally more complex and require higher levels of physical or mental abilities than those encompassed by ADLs, such as shopping, preparing meals, managing medication, and using public transportation (Lawton and Brody 1969). For example, managing medication requires keeping track of medications and taking prescribed dosages at correct times. Among the IADLs measured across surveys in different countries, taking medications is one measure that is

consistently asked and that offers similar implications across a variety of cultural contexts. Furthermore, it is correlated with the ability to perform other IADLs.

Physical functioning is measured by whether one can walk a short distance without any difficulty. The exact reference to short distance used is one block in the U.S. survey (HRS dataset) and 100 meters in the European surveys (SHARE dataset).

Life expectancy, the expected number of years remaining in life at a given age (or age group), is a summary measure of population health. Major improvements in sanitation, nutrition, and medicine in the last century have led to large gains in life expectancies at birth through reducing the rates of infectious diseases in much of the world. With future gains from reduction in infectious diseases expected to be much smaller than in the past, the greatest improvement in life expectancies will likely come at older ages and be achieved by reducing rates of chronic diseases. This is especially the case in industrialized countries where overall mortality is low and where most deaths occur among older adults (Deaton 2006).

Obesity has reached epidemic proportions in many countries and is a major contributor to the global burden of chronic disease and disability. Obesity is not an outcome but a risk factor and has numerous serious health consequences, ranging from increased risk of premature death to serious chronic conditions that reduce the overall quality of life, including type II diabetes, cardiovascular disease, hypertension and stroke, and certain forms of cancer. Although being modestly overweight may actually increase the odds of survival among older persons by providing nutritional reserves during recovery from illness (Flegal, Graubard, Williamson and Gail, 2007), obesity is generally shown to elevate the risks of morbidity, functional limitations, and mortality even in old age

(Jenkins 2004; Alley and Chang 2007; Dolan, Kraemer and Kelsey, 2007; Flegal*et al.*, 2007).

2.4.2.3 Social Well-being

The social well-being domain captures social engagement, encompassing involvement with family members, peers, community members, and local institutions. Social engagement in old age is associated with better health and greater life satisfaction. In the SCL/PRB Index, it is measured using two indicators:

i. Person participating in an economic or social activity (e.g., employment, community or religious organizations, social clubs, volunteer work)
ii. Person having contact with at least one child

There are various ways in which social engagement in old age may improve well-being. For example, contacts gained from engaging in social activities have well-documented benefits for health, including lower mortality (House, Landis, and Umberson 1988). Research suggests that being embedded in social networks has a protective influence on physical health. Having a productive role as an employee or a volunteer may also provide emotional gratification and a sense of power and prestige that can have a positive impact on one's wellbeing (Moen, Dempster-Mclain and Williams, 1992). Studies suggest that volunteering even a small amount of time has health benefits among older persons, including better self-rated health and lower mortality (Van Willigen 2000; Morrow-Howell, Joshua, King and Thomas, 2003; Musick and Wilson 2003). The mere physical activity required to participate in activities can also benefit health since physical activity is important for maintaining health in old age (Chambre 1987; Carlson, Seemag, and Fried, 2000).

Contact with family and friends is an important way for older adults both to receive and to provide social support. Children typically make up the largest part of one's social support network and provide the main source of informal caregiving in old age. As widely documented, having close relationships with adult children also has a beneficial impact on psychological well-being (Silverstein and Bengston 1991; Umberson 1992; Connidis and McMullin 1993;Koropeckyj-Cox 2002). The measure used in this study does not distinguish between co-resident and other children. Of course, countries with a higher prevalence of multigenerational households would be expected to report a higher frequency of contact between elderly parents and adult children.

Regardless of the reasons older persons choose to work, work provides an important way in which they remain socially active. Factors affecting one's decision to work in old age are varied. The legal age of retirement in public pension systems plays some role, as do financial incentives related to retirement and the availability of employment opportunities for older workers. Wealth and health status also have some effects, though generally small. Spouse's employment status may also affect retirement decisions of married individuals.

2.4.2.4 Emotional Well-being

Emotional health among older adults may be affected by both physical health and the availability of social support. Indicators in this domain include:

i. Person with no report of depression (non-clinical)

ii. Suicide rate for older adults (reverse coded)

iii. Person thriving (satisfied with current life and future prospects)

Depression is measured with a non-clinical indicator based on whether or not respondents said they felt depressed much of the time over the week prior to the interview. Using a self-reported non-clinical indicator of depression is more appropriate for the elderly because clinical diagnostic tools generally do not take into account common causes of late-life depression, such as bereavement and coping with multiple chronic conditions. Only one to four percent of the elderly population in the United States has major clinical depression as signaled by at least five of the following symptoms: "depressed mood, diminished interest, loss of pleasure in all or almost all activities, weight loss or gain (more than 5% of bodyweight), insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness or inappropriate guilt, reduced ability to concentrate, and recurrent thoughts of death or suicide" (Alexopoulos 2005). After age 70, the prevalence of major depression doubles. Minor clinical depression is more common among older adults than major clinical depression, but the elderly are still slightly less likely than middle-aged adults to exhibit symptoms of minor clinical depression. In the United States, experimental evidence also suggests that compared to middle aged adults, older adults pay more attention to positive information and express more positive sentiments (Carstensen, Mikels and Mara, 2006; Carstensen*et al.,* 2010).

Suicide is commonly used as a measure of serious mental health problems because most suicide cases meet the criteriafor a mental disorder (Harris and Barraclough 1997; Arsenault-Lapierre, Kim and Turecki 2004). Globally, the elderly have also historically accounted for the largest proportion of suicides (Pearson and

Conwell 1996). Depression, chronic and painful illnesses and social isolation are specific risk factors for suicide in this age group. A sense of uselessness, financial hardship, and

multiple losses of loved ones have also been identified as reasons for increases in suicide rates with age (Kennedy 1996; Stillion and McDowell 1996).

Happiness has been measured both in terms of global satisfaction with one's life and based on affective happiness (responses to daily events as positive or negative). Both global and affective happiness start increasing around age fifty, after declining throughout adult life and bottoming out between forty and fifty, (Blanchflower and Oswald 2008; Stone, Schwartz, Broderick, and Deaton, 2010). The SCL/PRB Index uses the indicator on life satisfaction, or whether one is thriving, from the Gallup World Poll to measure happiness. Respondents classified as thriving based on Gallup World Poll data have positive views of their present life situation and of the next five years. According to Gallup analyses, these respondents also report fewer health problems and greater enjoyment and interest in activities.

2.4.3 Determinants of Quality of Life (QoL) of the Aged People

Old age often brings about health problems and decreasing functional capacity which may affect the sense of wellbeing of an individual. In this regard, the goal of health for the elderly in the society may not be that of freedom from diseases but the possibility of having a good life despite illness and decreasing capacities (Lawton, 1991; Nordenfelt, 1991b; Sarvimaki and Stenbock-Hult, 2000). Feelings about life are subjective and what is considered as important for wellbeing by one person may not be so regarded by another. Also, a chronic health condition occurring in the setting of a developed country may have a lower impact on the QoL of the patient than the same disease would have in a low income country where resources to ameliorate disability may be scarce. The subjective nature of QoL and the contextual nature of its assessment inform the World

Health Organization's definition of it as: "an individual's perception of his/her position in life in the context of the culture and value systems in which he/she lives, and in relation to his/her goals, expectations, standards and concerns" (The WHOQOL Group, 1995). Thus QoL reflects a broad view of subjective wellbeing and life satisfaction that encompasses mental and physical health, material wellbeing, interpersonal relationship within and without the family, work and activities within the communities, personal development and fulfillment and active recreation (Niemi, Laaksonen, Kotila and Waltimo, 1988).

Studies conducted among groups of aged persons have shown that QoL and subjective evaluation of life satisfaction are determined by several factors(Jakobsson, Hallberg and Westergren, 2007; Patel, McKevitt, Lawrence, Rudd and Wolfe, 2007). Other than socio-demographic features such as age and financially status, health, including functional disability, and social support and networks are often found to be important in the aged person's assessment of their QoL. In general, the common observation is that elderly persons value independence, financial security, emotional support and social integration (Bowling, 1994; Low and Molzahn, 2007; Richard, Laforest, Dufresne and Sapinski, 2005; Xavier, Ferraz, Marc, Escosteguy and Moriguchi, 2003). An important consideration in studying the factors associated with the QoL of elder persons is the multidimensional nature of the construct and the possibility that determinants of one dimension may be different from those of another dimension. For example, a study among aged patients with stroke suggests that the determinants of health related QoL vary depending on whether physical or psychological aspects are the focus(Patel *et al.*, 2007). Reviewing current approaches to the assessment of QoL, Hickey and colleagues

advocate a broadening of the scope of the measurement instruments to cover various aspects of potential importance to elderly persons(Hickey, Barker, McGee and O'Boyle, 2005).

Age and economic status were the only two demographic factors significantly related to the physical domain of QoL, with economic status being the stronger factor. Gender, marital status, educational level and residence were unrelated to this domain of QoL. Other than dementia, all health items were significantly related to this domain. Functional disability and self-rated health bore particularly strong relationships to the physical domain of QoL. Among social factors, participation in community activities was the most strongly related factor to this domain of QoL, followed by contact with family members. Neither the availability of instrumental support nor that of emotional support was a significant predictor. As a group, health factors were the strongest determinants of the physical domain of QoL followed by social factors (Gureje*et al.*, 2008).

2.4.4 Coping Strategy

This section present literatures which describes how the aged cope with some stressful situations like hunger, health challenges and poor housing among others.

2.4.4.1Coping (and Preventive) Strategies With Seasonal Hunger

Chronic hunger and food insecurity have long been acknowledged as central to global poverty reduction. Both the Millennium Development Goals and the Sustainable Development Goals target hunger (UN, 2016). The Food and Agriculture Organization (FAO) and the World Food Program(WFP), which track global and regional trends in undernourishment, report nearly 800 million people are chronically undernourished worldwide (FAO, 2015; WFP, 2015). Though undernourishment is falling globally,

progress in Sub-Saharan Africa (SSA) has been slow; more than one quarter of the world's hungry now live in SSA as compared to 17% in 1990, and, though the percentage affected by hunger has fallen from 33% to 23%, the total number of hungry in SSA has grown over the same time period (FAO, 2015).

In Sub-Saharan Africa, over 400 million people live in poverty, and 60% of these people live in rural areas (World Bank, 2014a; -World Bank, 2014b). The rural poor are likely to depend on agriculture and, as such, are particularly susceptible to seasonal hunger in the months leading up to the annual harvest. However, the effects of seasonality likely spill over to the urban sphere as well, since food prices rise as food becomes relatively scarce. Despite its growing recognition in the literature, the prevalence of seasonal hunger in rural and urban areas of Africa is poorly understood. No estimates are compiled, and limited evidence exists on how causes and impacts differ between seasonal and chronic hunger.

Seasonal hunger occurs when an individual has limited access to food during the months prior to the annual harvest (Ayalew, 1997; Devereux, 2009; Gebrehiwot and Van der Veen, 2014). Both food and income from crop sales are most plentiful immediately after the harvest; in the lean season months between planting and harvest, food availability is lower, prices are higher, and subsistence households may have run down their stores of grain and savings, yet the energy demands of tending to growing crops may require more calories than at other times of the year. Seasonal hunger can be exacerbated by unusual variations in weather patterns such as flooding or drought, or by a household shock (Barrett, 2010; Bogale, 2012; Gebrehiwot and Van der Veen, 2014; M'Kaibi, Steyn, Ochola, and Du Plessis, 2015). Chronic hunger refers to a longer term food shortage due

to the unavailability or lack of access to food (Ayalew, 1997; Gebrehiwot and Van der Veen, 2014). Chronically hungry individuals may experience hunger in the months prior to the harvest similar to seasonally hungry individuals, but they are also hungry in at least some of the months during or after the harvest. Like seasonal hunger, the prevalence of chronic hunger in a region is affected by weather patterns, especially rainfall fluctuations (Generoso, 2015).

Farm households employ a variety of strategies to smooth consumption between harvests, such as crop diversification that includes planting "off-season" or perennial crops and carrying livestock (Maxwell, 1996; Mayanja,Rubaire-Akiiki, Greiner, and Morton, 2015; Megersa,Markemann, Angassa, and Zárate, 2014); Morris, Mendez, and Olson, 2013; Rademacher-Schulz,Schraven, and Mahama, 2014). Improved agricultural management is another strategy for preventing seasonal hunger (Rademacher-Schulz *et al.*, 2014), including improving irrigation techniques and fertilizer usage as well as other conservation agricultural methods (Nyanga, 2012; Afifi*et al.*, 2015).

Off-farm income opportunities help to fill seasonal income gaps by separating households from some of the risks associated with agriculture (Afifi*et al.*, 2015; Daie and Woldtsadik, 2015; Rademacher-Schulz *et al.*, 2014; Sibhatu, Krishna, and Qaim, 2015). Alternatively, the household may trade labor for money or food, or household members might temporarily migrate to another area in search of work (Afifi*et al.*, 2015; Hadley &Patil, 2008; Maxwell, 1996; Mayanja*et al.*, 2015; Morris *et al.*, 2013; Rademacher-Schulz *et al.*, 2014; Zug, 2006).

In addition to these ex-ante strategies to mitigate or avoid seasonal hunger, when an individual or household does experience food scarcity during periods of either seasonal or

chronic hunger, several common ex-post responses have been reported. Households may eat less preferable foods during the hungry season or rely on collected wild foods to fill caloric gaps (Daie and Woldtsadik, 2015; Edeh andGyimah-Brempong, 2015; Hadley andPatil, 2008; Maxwell, 1996; Mayanja*et al.*, 2015). In other cases, households have been observed to sell assets in order to purchase food (Mayanja*et al.*, 2015; Rademacher-Schulz *et al.*, 2014; Zug, 2006). Seasonally hungry households may borrow food or borrow money to purchase food from either relatives or friends (Edeh andGyimah-Brempong, 2015; Hadley andPatil, 2008; Maxwell, 1996; Mayanja*et al.*, 2015; Morris *et al.*, 2013; Zug, 2006). In some cases, households may skip meals or eat smaller portion sizes to help smaller amounts of food last longer (Edeh andGyimah-Brempong, 2015; Hadley andPatil, 2008; Maxwell, 1996; Mayanja*et al.*, 2015; Rademacher-Schulz *et al.*, 2014).

In addition to the immediate compromised well-being that results from having to respond to seasonal hunger, these responses can reasonably be imagined to have long-term consequences. Many authors find that hunger is associated with nutritional outcomes (Christian and Dillon, 2016; Devereux,Vaitla and Swan, 2008; Devereux, 2009; Hillbruner and Egan, 2008; Lambrechts and Barry, 2003; Longhurst and Payne, 1979; Messer, 1989; Milgroom and Giller, 2013; Vaitla, Devereux, and Swan, 2009; Vaitla,Tesfay, Rounseville, and Maxwell, 2012). Others find that seasonal hunger can lead To limiting caloric intake (with impacts on health and labor productivity (Chambers,Longhurst, and Pacey, 1981; Hadley and Patil, 2008; Lambrechts and Barry, 2003)), and eroding assets and incurring debt (increasing financial vulnerability (Ellis andManda, 2012; Harrigan, 2008; Maxwell, 1996)).

2.4.5 Social Support for the Aged

The aged are persons who are aged 65 years and above. Usually this category of people is the target of government social security packages, including pensions. At times, variations based on gender influence the definition of the elderly. For example, in some developed countries men must be 65 years of age before they are entitled to collect pensions, while their female counterparts are pensionable by the age of 60. Studies have also shown that the interest which the general public in some parts of the world has in old age focuses on the issue of retirement. In any case, living conditions for the elderly, the retirees' financial entitlements such as gratuities and pensions, and their need for support through a solid social network provided by families and friends are relatively neglected (Tunstall, 1966).

Wilkinson and Marmot (2003) established that access to both social support and good social relationships constitute an important building block for healthy living among elderly people. This may be simply because social support has the capacity to enhance the emotional and practical resources greatly needed by the elderly community.Further, a sense of belonging to particular groups, such as families, friends, and community members helps to promote social networking, and it also justifies and improves the ability to communicate, establishes mutual trust, and creates obligations amonginteracting parties with special regard to the needs of elderly people.

There is a question about the extent of support given to the elderly who are childless and have no existing family members. The social support and relationships of childless older people have been given less attention when it comes to research, especially in the area of social work. Elderly people who lack children or siblings to provide basic family support

may obtain comfort through any available kin or through relationships with non-kin individuals. Social support systems for the childless can be more extensive than those of people with only one or two children, although this does not imply that they are more effective. Aside from the issue of family, considerable attention has also been paid to the importance to the elderly of friends and neighbours. This has even led to the findings indicating that friendship can play a more important role in the life of ageing people than their interaction with their own families (Kimmel, 1980).

Bennett (1980) arguedthat social isolation is one of the most common phenomena affecting elderly people in several countries. For instance, reports show that many elderly males live a single life without a wife, and probably an isolated lifestyle without the presence of children. Social isolation is usually caused by the death of their spouse, as was observed in the lives of more than 50 per cent of the lonely elderly persons studied. Living without either children or spouse can have direct consequences for the survival of most elderly people. In the light of this, the situation regarding social support, specifically the care and love received from families and friends, and a society focused on creating healthy living conditions for them are critical to the health and well-being of elderly people.

It is virtually impossible to engage in the discussion of the ability of elderly people to obtain adequate social support, especially from their family members, without considering the age structure of the members of their households. According to Bennett (1980) household organization among elderly people, especially those that fall within the 75–95 age range, is a key determinant in understanding the living conditions of the elderly population. This is important in the sense that there are increasing numbers of

elderly people who are living with younger relatives. This is a particularly common phenomenon in urban areas, where the pressure for housing is greater, which has consequently led asmany as one-third of elderly people to live in households with younger members.

In one study, more than half of widows aged 80 years and above lived with their younger relatives; this analysis demonstrates the importance of children for providing close support for the old. This is especially true if the numbers or percentages of elderly people who are living with their younger relatives are correlated with the number of children in their families. The chancesthat the proportion can increase after age 80 are clear because the majority of parents who are over 80 years and living with either their children or family members expressed great amounts of satisfaction with the support being given (Bennett, 1980).

Demographic variables and socio-economic identifiers can play a significant role in revealing the social structuring across societies. A classic example of how gender determines elderly people's chances of receiving social support is given by who pointed out that in some instances elderly people hardly ever access direct cash from their children or families for personal spending. The problems of income securityand social production are far more acute in the cases of elderly women because in the normal course of events, elderly women have limited control over household resources or limited income. In addition, they represent a marginal proportion of the work force in the organized sector. Therefore, only limited numbers of elderly women have the benefit of an independent pension or financial support from government organizations and agencies.

Furthermore, Bigby (2008)revealed that more women received help or social support than men because women usually maintain better and closer relationships with their families, relatives, and kin than men. However, men are more likely to access stronger social support from friends and neighbours than women. Similarly, in terms of household maintenance, women stand a greater chance of receiving more help from their families and relatives. This is because women had established more intimate relationships with their daughters and sisters than men had established with their sons and brothers.

CHAPTER THREE

STUDY AREA AND METHODOLOGY

3.1 Introduction

This chapter presents and discusses the study area and methodology of the study. It discusses issues such as; the location and size of the study area, the historical background on time of creation, some physical and socio-economic characteristics of the people as well as the methodology of the study (which include reconnaissance survey, types of data utilized, sources of data, sample size and sampling techniques, and the method of data analysis).

3.2The Study Area

3.2.1 Location and Size

Kaura Local Government Area (LGA) is located between latitudes 9° 29'N -10° 08' N of the Equator and between longitudes 8° 11' E - 9° 15' E of the Greenwich meridian. The LGA covers a total land area of about 623km^2. It is bordered to the north by Kauru LGA, to the Northeast and East by Riyom LGA of Plateau State, to the South by Jema'a LGA and to the West and Northwest by ZangonKatafLGA (Fig. 3.1).

3.2.2 Climate

The Local Government Area is located within the tropical continental climate belt of the Aw type according to Koppens climatic classification (1918), with distinct dry and wet seasons that has been slightly modified by the orographic uplift in most part of the LGA. The wet or rainy season last for about seven months (April to October) with a peak in July/August and the dry season lasting for about five months (November to March).

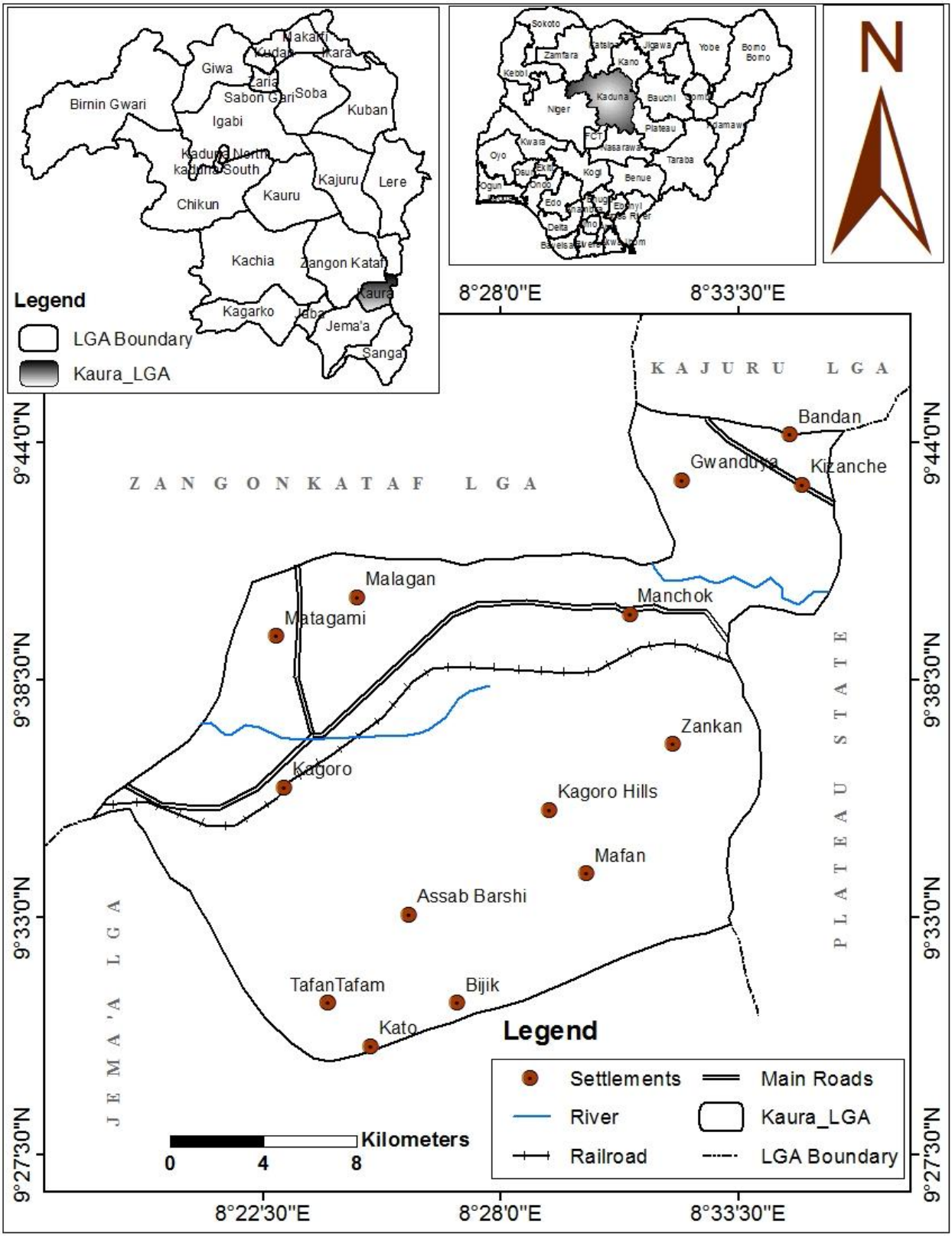


Fig. 3.1: The Study Area

Source: Adapted from the administrative map of Kaura LGA (2015).

The annual rainfall measures up to 1650mm compared to other areas within the same latitude that record only about 1000mm.

The highest temperature is usually recorded in March, ranging between 30^{oc} to 40^{oc} while the lowest is recorded in January ranging between 5^{oc} to 13^{oc}. The annual range of temperature is greater than that found in the temperate region and the diurnal range also places strain on the inhabitants, aggravated by considerable change in humidity which in the dry season may be well below 10% in the afternoon and 30% at down. August is relatively the coldest month but with a midday humidity measuring between 70% to 95% at down (Leckie,1990). This last variation also influences the agricultural practices and the crop production in the area giving rise to a wide variety of crops grown.

3.2.3 Relief and drainage

Kaura Local Government Area falls within the Jos Plateau high plains with topography of rugged terrain and a relief rising up to 912 meters above sea level. Within the area, is a rocky massif of Atakar and Kagoro with a height of more than 1,276 meters above sea level and rises 304 meters above the surrounding land. The hill tops are flat with rich pastoral grasses. The hills are highly dissected by the action of running water that has acted on them over the years resulting in several streams and rivers, such as the Chan-liak and other streams that flow in to the Kagum river. The river Kaduna and some of its tributariestake their sources from these highlands. These relief features enable the cultivation of different crops which provides a variety of food crops to the people. The many streams also provide the main sources of water to the households in the study area.

3.2.4Vegetation

The Local Government falls within the northern extremes of the guinea savanna vegetation, which has been greatly affected by man's activities such as: agriculture, grazing, bush burning and construction work among others. As a result of the activities of man, the vegetation has been reduced from trees to shrubs and patches of scattered trees rising from 6 to 12 meters in height in some localities except for those found around the river valleys and hills sides, for example: around Tsonje in Kagoro and the Hill sides at Mifi, Tachira and Ticham, which grow up to between 20 to 35 meters with little undergrowth, a characteristic of the rainforest vegetation. The present day vegetation of Kaura LGA, like other parts of the Jos Plateau is a product of centuries of destructive exploitation of the original woodland, which is now replaced by open grasslands (Udoh, 1978).

3.2.5 Soil

The soil in most part of the local government area is predominantly the highly leached red tropical soils that are well drained, fine and medium textured. Skeletal soils occur at the foot of rooky hills or along narrow river valleys and represent the earliest stage in soil formation from materials weathered from granite, schist and gneisses (Udoh, 1978). Lateritic soil is found all over the area. Clay soil is found mostly along the wider river/stream valleys and at the foot of hills. Red loamy soils and coarse grain soil are found in most localities in the area. Rice production takes place mostly in the Fadama lands scattered within the area, especially near Zunuruk, along KagoroKafanchan road. The variety of soils provide the agricultural ground to the inhabitants for the production

of different food crops like maize, millet, guinea-corn, cassava yam and potatoes, among others.

3.2.6 Historical Background on Creation

Kaura Local Government Area was created on May, 29th 1989 with the Headquarters at Kaura from the then Jema'a LGA. It is made up of 3 chiefdoms with about seventy-five villages which stem from the three major tribes that make up the LGA. These are Atakar, Kagoro and Moro'a chiefdoms. The three major tribes have both common traditional and cultural affiliations which could have been one of the reasons for the creation of the LGA.

3.2.7People, Population and Culture

Kaura LGA is made up of three major tribes which include Atakar, Kagoro and Moro'a. Other tribes found within the locality include Kataf, Fulani, Igbo and Yoruba among others. According to the 1991 population census, the population was 101,455 with a female population of 49,487 and a male population of 51,968. The estimated population of the aged (60 years +) in Kaura LGA is about 3754 persons (3.7%),with the male population of 1923(51%) and a female population of 1831 (49%)(NPC, 1991).

The Afan festival: Afan is a festival celebrated by the people ofKagoro, one of the three tribes in the LGA. It observes its festival on January first every year by bringing together its people both home and abroad for the purpose of thanksgiving and merriment on all their achievements. First thing in the morning, the natives assemble at the chief palace to take the chief out for a procession round their landscape, after which they all assemble at the village square for the celebration. People from other villages are invited to also showcase their respective cultures as well as high dignitaries who also come to grace the

occasion. The people ofKagoro often cook their native food (beans) natively known as “jinjokudak”alongside other foods and drinks. In order to round up the celebration, there is always a football competition played by the youth of the area.

3.2.8 Household Size

InKaura LGA, most of the households are composed of the extended family system where the aged are living with the family members of their son(s) and/or daughter(s). There are also houses where the aged are seen to live alone under the care and support of either their children who lived separately from them, relatives or the community members.

3.2.9 Economic Activities

The major economic activity that takes place in the area is agriculture which is based on small scale holdings. The major crops produced include maize, guinea corn (sorghum), millet, yam cocoyam, beans, groundnut, acha and cassava. Others include vegetables like spinach, bitter leaf, tomatoes, karkashi and to a lesser extend cabbage and lettuce.

Livestock production in small scale holdingsalso characterize the people except for the Fulani herdsmen that live mostly on the flat hill tops which provide grazing field for the cattle. The animals kept include goat, pig, sheep and local poultry. Keeping of dogs complement the home security and also serve as food to the people.

The civil service also provides a source of livelihood to a good number of the people especially in areas of teaching, medical services, agriculture extension workers and others in the local government secretariat who dwells in the area. Other secondary activities

engaged by the people include petty trading, tailoring, okada, hunting, brewing of local alcohol, carpentryand local craft such as weaving, pottery and carving among others.

3.2.10Social Amenities

Hospitals: Health care institutions are very important in every society especially where the aged are in existence as aging comes with health challenges. The major health institutions in the area include the Rural General Hospital at Kaura and the Turaki Memorial Hospital in Kagoro. Others include the Primary Health Care (PHC) Centers distributed in all the districts and maternal child welfare clinics distributed all over the towns and villages, promoting health care delivery in the area. Apart from the government own health care facilities, a number of privately own health care facilities also provide services in the area. This include among others, the ECWA Dispensaries in Kadarko and Kagoro, Amaks clinic in Kadarko and Moro'a Medical Center, Manchok.

Schools: There is a good number of both primary and secondary schools owned by the Government and individuals in the LGA. The LGA is blessed with 104 public primary schools and14 private Nursery/Primary schools as at 2010. The LGA also have a number of tertiary institutions which include ECWA School of Health Technology and ECWA Theological College in Kagoro which provide a good percentage of the population and with some form of education or the other.

Water supply: Kaura Local Government Area uses rivers and streams as a source of water supply since creation. Later on, wells were dug and some were later discovered to be seasonal. Taps are available but the services are poor. As development sets in, most people within the LGA began to fix bore-holes in their houses and the Government also

provided mono-pumps to the communities which serve as the major source of water to those who cannot afford the bore-hole.

3.3 Methodology

3.3.1 Reconnaissance Survey

A reconnaissance survey was conducted in order to help the researcher get acquaintedwith thearea. During this visit, an unstructured interview with the respondents was also carried out in order to know about their general wellbeing. The researcher intended to know the type of meal the respondents ate that day, when they intend to eat their next meal,if they were ill as of that moment or not, for those ill, what they have done to regain their good health. These respondents were selected randomly as the researcher survey the area on Friday, the 20th and Saturday, the 21st day of March, 2015.

3.3.2Sources ofData

The study collectsdata from both primary and secondary sources

3.3.2.1 Primary Sources

The primary data were derived from observations, in-depth interview with the district head(s) of the wards, questionnaire administration and Focus Group Discussion (FGDs). The questionnaire was used to obtain data on the socio-demographic characteristics of respondents,the living conditions of the aged, determinants of well-being of the aged, their coping strategies as well as their type and sources of support/assistance.

The Focus Group Discussions were conducted with some selected groups of the aged, based on their age cohort who explored various challenges and issues they faced individually or collectively in the society. This technique helped the researcher to gain

their confidence and even obtain more useful information that may seem confidential to them. There were five FGD sessions, one in each of the five selected wards with at most 6 – 10 persons per session,guided by an illustrative discussion guide and probes (see appendix III).The Author was able to mobilize the discussants through the various district heads that passed on the announcement based on the researchers request and the sessions were held on the 4^{th}-7^{th} May, 2016 at the house of the district head of each ward.The medium of communication was English, Hausa and the native language of the selected ward as there wasa field assistant that is proficient in the native language to help reduce language barrier where necessary.

3.3.2.2 Secondary Sources

The secondaryinformation mainly for literature review were obtained from the 1991 census, books, Journals, the internet, published and unpublished dissertations/projects, gazette, relevant maps, conference papers and seminar papers.

3.3.3Sample Size and Sampling Techniques

Kaura Local Government Area (LGA) is made up of ten wards. The wards were arranged in alphabetical order from numbers1-10 and 5 wards were selected through systematic sampling techniques on every second ward to give a wide coverage of the area (Table 3.1). The number of questionnaire that was administered to each of the five wards was based on the population of the aged ineach ward. The respondents were the aged people of the study area only.

To determine the population of age 60+ in Kaura LGA, the percentage of the aged inKaduna Statewas first determined from the 1991 population figures.(The 1991 census was used instead of the 2006 because that of 2006 has not been aggregated).Table 3.2

reveals that there is about 146,656 population of age 60+ in Kaduna State out of the total population of 3,935,618 (NPC, 1991). To find its percentage, 146,656 will divide 3,935,618 and multiplied by 100.

That is, $\frac{146656}{3935618} \times 100 = 3.7\%$

Therefore, there is about 3.7% of those who are age 60+ in Kaduna State.

To determine the population of age 60+ in Kaura LGA, the population figure of each ward is divided by 100 and multiplied by the percentage of the aged in Kaduna State (3.7%). That is: $\frac{\text{The populations of each ward}}{100} \times 3.7\%$

Finally, the population figures for the aged (60 years +) that was determined was projected to 2015 using the projection rate of 3.18% (NPC, 1991), and the formula used was: $P_t = P_o e^{rt}$, Where

P_t = The Projection for 2015

P_o = 1991 population of age 60 + which is 4595

e = exponential e, which is a constant given as 2.718281828

r = growth rate which is 0.0318

t = period of time covered from 1991 to 2015 which is 24 years.

Table 3.1: Population of the Aged According to Wards in Kaura LGA

S/NO.	Ward	Selected ward	General Population 1991	Aged population (60+) 1991	Percentage (%) of Aged	Projected Aged Population	Copies of Questionnaire for Selected

					Population (60+) 1991	2015	ward
1	Agban		6,904	256	6	549	
2	Bondon	Bondon	13,680	506	11	1085	104
3	Fada		29,744	1101	24	2362	
4	Kadarko	Kadarko	11,688	433	9	929	89
5	Kaura		13,222	489	11	1049	
6	Kpak	Kpak	7,365	273	6	586	56
7	Kukum		11,467	424	9	910	
8	Malagum	Malagum	7,342	272	6	583	55
9	Manchock		10,138	375	8	804	
10	Zankan	Zankan	12,604	466	10	1000	96
TOTAL	**10**	**5**	**124,154**	**4595**	**100**	**9857**	**400**

Source: Computation from the 1991 census and 2015 Projection

Table 3.2: Population Distribution by Five Years Age Groups and Sex, Kaduna State

Age Group	Both Sexes	Males	Females
0-59	3,788,962	1,957,429	1,831,533
60-64	46,902	26,821	20,081
65-69	22,343	13,326	9,017
70-74	27,573	15,647	11,926
75-79	12,455	7,347	5,108
80-84	17,160	9,290	7,870
85+	20,223	11,281	8,942
Total	**3,935,618**	**2,041,141**	**1,894,477**

Source: NPC 1991Kaduna State Statistical Table

To determine the sample size for this study, the Yamane, (1967) formula for sample size selection was used. It states that:

$n = N / 1 + N (e)^2$

Where n = sample size

N = Total number of the aged in the selected wards (4183)

e (error margin) = 0.05 or 5%

$n = 4183 / 1 + 4183 (0.05)^2$

$n = 4183 / 4184 (0.0025)$

$n = 4183 / 10.46$

$n = 399.9043977$

$n = 400.$

Therefore, the sample size for this study is400.

Finally, to determine the proportion of respondents sampled in the selected wards, the number of questionnaire administered was made proportionate to the population of the aged in each selected ward (Table 3.1). The formula is:

Proportion = n / N * Sample Size

Where n = population of the aged in each selected ward

N = Total population of the aged in the selected wards (4183).

In order to administer the questionnaire, households were selected systematically by picking every third house in the area except in the case of household in which there was no aged person, the next one waspicked and the procedure of the interval of 3continued until a total of 400respondentswere captured.

3.3.4Data Analysis

Different analytical techniques were employed to analyze the data collected based on the set objectives. The data collected were encoded in to the Statistical Package for Social Sciences (SPSS) software version 20 and analyzed using descriptive statistics.Information's on the socio-demographic characteristics of the respondents were analyzed using frequencies and percentages and the results were presented in tables and charts.

Objective (i), the living conditions of the aged was achieved by analyzing the data using descriptive statistics and cross- tabulation presenting the results in Tables and charts.

Objective (ii), the determinants of well-being of the aged was achieved using the five point Likert Scale of agreement and disagreement, which contains a list of words that has relationship with the issues in question (i.e the determinants). These words are Strongly Agree (SA), Agree (A), Undecided (UD), Disagree (D), and Strongly Disagree (SD). The determinants were analyzed by cross-tabulation with the variables of agein order to establish a relationship between aging and well-being of the respondents. The result is presented ina table.

Objective (iii), the coping strategy of the agedwas achieved by cross-tabulating the variables of 'coping strategies adapted against hunger' with the 'selected wards'in order to establish a relationship between the respondents in each wards and how they cope with hunger. The result is presented in atable.

Objective (iv), the types and sources of assistance for the aged was achieved by analyzing the data using descriptive statistics such as frequencies and percentages, presenting the results in a Table.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents and discusses the findings. It is presented in five sections. The first section presents the result of the socio-demographic characteristics of the respondents. The second section describes the living conditions of the age, discussing their physical health wellbeing, material and social wellbeing. The third section focuses on the determinants of well-being of the aged, while the forth section is on coping measures of the aged, and finally, the last section characterizesthe type and sources of support the aged receive.

4.2 Socio-Demographic Characteristics of Respondents

4.2.1Sex

The distribution of the population according to sex shows that about 48.3% of the respondents were males while 51.8 % were females as shown in Figure 4.1, meaning there are more females to males in the LGA who are above 60 years.

This finding slightly differs from the 1991 population census thatfrom the 3.7% of those who are 60 years +, there are more males (51%) to females (49%) in the LGA. This is probably because menopause has been found to bethe major determinant of life spans of both women and men (William, 2015).

According to United Nations, Sex ratio of world in 2015 is 101.70. It means that World has 101.70 males for each 100 females or 98.33 females for each 100 males. In absolute terms, World has 61,591,853 more males population than females population. 13 countries have sex ratio less than 90.0 and 36 has less than 95.0. 124 countries have more

females than males. 158 countries have better sex ratio than world average.Curaçao has lowest sex ratio of 82.10 followed by Latvia (84.37). Curaçao has 121.8 females per 100 males while Latvia has 118.5 females per 100 males. Martinique (85.08), Lithuania (85.24) and Ukraine (85.35) are at 3rd, 4th and 5thposition, respectively. In the list of top 10 countries having lowest sex ratio, six countries is located in Europe continent, three in North America and one in Asia.

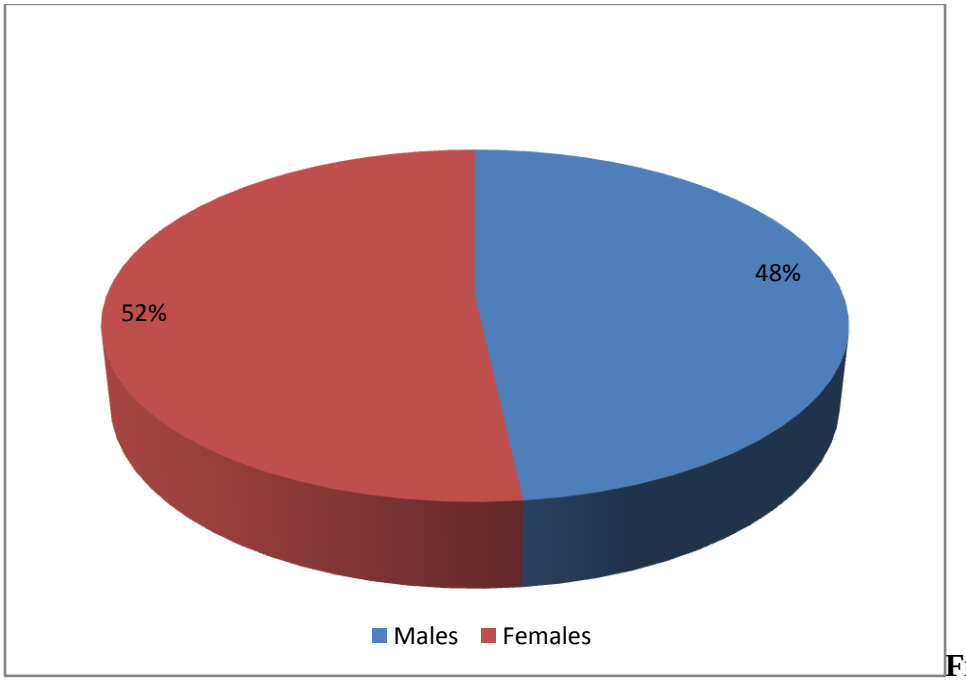


Figure 4.1 Distribution of Respondents by Sex.

Source: Field Survey, 2016.

Studying people who live 100 years and more led Harvard researchersto conclude that menopause is a major determinant of the life spans of both women and men (William, 2015).Women's life span depends on the balance of two forces, according to Thomas Perls, a geriatrician at Harvard Medical School. One is the evolutionary drive to pass on her genes, the other is the need to stay healthy enough to rear as many children as possible. According to Perls (William, 2015), "Menopause draws the line between the

two". It protects older women from the risks of bearing children late in life, and lets them live long enough to take care of their children and grandchildren.As for men, Perls believes "their purpose is simply to carry genes that ensure longevity and pass them on to their daughters. Thus, female longevity becomes the force that determines the natural life span of both men and women" (William, 2015).

4.2.2 Age

Most of the respondents (35.5%) are between 60 and 64 years, 24.5% are between 65-69 years, 19.8% fall between70 -74 years, 10.8 % are within 75 -79 years while the remaining 9.5% are 80 and above (Figure 4.2).

There are three widely recognized age brackets within the aged population. These are the young old, the middle old and the oldest old (Vierckand Hodges, 2003). The young old (60-74years) are the majority in this study forming about 79.8% of the total respondents. The middle old (75-79 years) form about 10.8 % while the oldest old (80 years and above) formed about 9.5%.

Aging is the process of 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). This is evident that the older a person is, the more he experiences frailty and chronic illness that comes with aging. The findings revealed that the majority of respondents are within the young old age group (60-74 years).

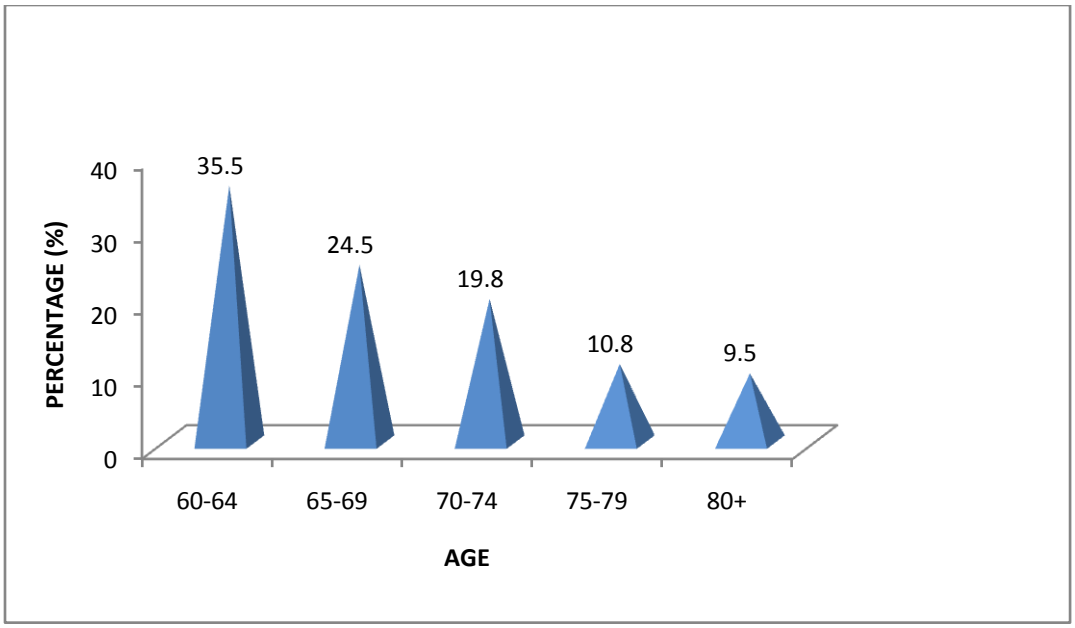


Figure 4.2 Distributionof Respondents According to Age

Source: Field Survey, 2016.

This is because they have not really experience the breakdown of body mechanism that comes with aging. They are still strong, agile and capable of active service and exercise which keeps the body fit compared to the middle and the oldest old age group.The study coincides with that of Schwartz, (2015): people aged 65-75 are 'younger' elderly who usually do not display the multiple medical co-morbidities or frailty or difficulty with activity of daily living or dementia that become much more common after the age of 75 or 80.

4.2.3Other Socio-Demographic characteristics of respondents

About 65% respondents are married, 5% are separated, 6% are divorced, 22.8% are widowed and just a negligible 1.0% are single (Table 4.1).The finding reveals that majority of the respondents are married out of which about 23% of them are widowed. Goldman, Korenman, and Weinstein (1995) asserted that marital status is associated with

health and survival outcomes at the oldest ages, with widowed men being at a higher risk of being disabled than married men. However, unmarried persons at older ages were found to have variations in health outcomes; widowed persons had poorer health but this was not the case among divorced or single persons.

The authors suggests that frail single persons may have died before reaching older ages (the selection effect) and that the surviving older single persons would not have experienced stresses and strains associated with divorce and widowhood. Therefore it is argued that because of their diversity of experiences, the unmarried should not be treated as a homogenous group (Goldman, Korenman, and Weinstein, 1995). In the same vain, Gavrilov and Heuveline (2003), when stating a consequence of lower female mortality in the year 2000 observed that many would have lost their spouses by the age of 60 years. This justified the 22.8% of widowed in the area (Table 4.1).

Considering the percentage of the aged who are married (65.3%), the widowed (22.8%), divorced (6.0%) and those separated (5.0%), the percentage of those whose marital union are monogamous are reported to be 76.8% while those whose marriages are polygamous are 22.3% with only about 1.0% of the aged who are not married and had never been in any marital union.Being a Christian dominated area, the high numbers of monogamous marriages are expected as Christianity encourages the marriage of one man one woman until death (Table 4.1).

Based on the finding, about 7.3% respondents had not more than 2 children, 38.3% had not more than 5 children, 40.3% had not more than 10 children and 12.3% had up to or more than 11 children with just about 2.0% of them who had no child at all. Majority of the respondents has more than five children, leading to a large family size. It

Table 4.1: Distribution of Respondents Base on Other Socio-Demographic Characteristics

Variable	No of Respondents	Percentage (%)
Marital Status		
Single	4	1.0
Married	261	65.3
Separated	20	5.0
Divorced	24	6.0
Widowed	91	22.8
Total	**400**	**100.1**
Nature of Marital Union		
None	4	1.0
Monogamous	307	76.8
Polygamous	89	22.3
Total	**400**	**100.1**
No. of Children Ever Born		
None	8	2.0
1-2	29	7.3
3-5	153	38.3
6-10	161	40.3
11 and above	49	12.3
Total	**400**	**100.2**
Religion		
Christianity	348	87.0
Islam	38	9.5
Traditional	12	3.0
Others	2	0.5
Total	**400**	**100.0**
Highest Formal Educational Qualification		
None	135	33.8
Adult Education	48	12.0
Primary	104	26.0
Secondary	72	18.0
Tertiary	41	10.3
Total	**400**	**100.1**
Occupation		
Civil Service	23	5.8
Trading	76	19.0
Farming	188	47.0
Artisan	53	13.3
None	57	14.3
Others	3	0.8
Total	**400**	**100.2**

Source: Field Survey, 2016

is very clear that fertility, which is the occurrence of live birth, is high among this generation of aged (Barrette,1996, Olorunfemi 2004). Therefore, the possible reason for the lack of child could be infertility amongst couples or the death of spouses.Wahab (2013) found out that in Ijebuland, majority of respondents have large families, with more than four children. This shows a high preference for large family size peculiar to most African cultures and Kaura LGA is not an exception. Also, Mamman and Ogbonna (1993) recorded a mean of 5.2 children among 600 ever married women in Kaduna Metropolis as shown on Table 4.1).

Religion is clearly an important aspect of life formost older people. It has long been recognizedthat at least among the Buddhist majority with advancing age both men and women turn increasingly to religious activities (Cowgill 1968). More recent research confirms that "preparing the spirit" is still a very significant aspect of preparing for old age (Rattanamongkolgul, Sritanyarat and Manderson 2012).The research revealed that about 87% respondents are christians, 9.5% are muslims, 3.0% are traditional worshipers and 0.5% free thinkers. The relatively high percentage of christians is to be expected as it was observed during the reconnaissance survey that the area is a christian dominated area, except for the few who are traditional worshipers (Table 4.2).

Considering the type of education acquired by the respondents, it was seen that about 33.8% had no formal education, 12% had Adult education, 26%had primary education, 18% had secondary education and 10.3% had a tertiary education. The result reveals high percentage of the aged who have little or no formal education with only about 10.3% of them who have gone a little bit higher in education. Kozma*et al.* (1991)

suggests that it is not education itself that is important to an aged person's well-being, but the lifestyle that such education can provide (for example, higher income, better housing and good food among others). Therefore, this implies that, with the low level of formal education in the area, the lifestyle of the aged will expectedly not be pleasurable except for the few who had acquired some tertiary education as shown on Table 4.2.

Regarding the occupation of the respondents, 5.8% engages in civil service work, working with either the Federal, State or Local Government councils as teachers or even cleaners, 19.0% engage in trading, doing one form of business or the other, 47% engage in farming indicating their major occupation in the area,13.3% are artisans (engaging in jobs like pottery, weaving, blacksmithing and fishing among others), 14.3% has no occupation and just about 0.8% are in other forms of occupation such as the vigilante (Table 4.2).

4.3 Living Conditions of the Aged

These were assessed using three indicators of well-being: physical health, material and social well-being.

4.3.1 Physical Health Well-being

The physical parameters generally cover those aspects that have to do with the health and physical fitness of the respondents.

4.3.1.1 Incidence of HospitalizationSince 60th Birthday.

Figure 4.3 reveals that 49%of the respondents have been hospitalized since their 60th birthday while 51% have not.The 51% of those who have notbeen hospitalized does not mean that they were never ill, but rather, they were not faced with the ailment that could result to being hospitalized as aging is characterized by illness.It is generally accepted that the

aged fare best when care is provided in their own homes. However, some conditions require more intensive management than can be provided in the community. The admission of the aged to hospital, their treatment and subsequent discharge can prove challenging. The frail aged need to be identified and services commissioned according to their needs (NHS, 2014).

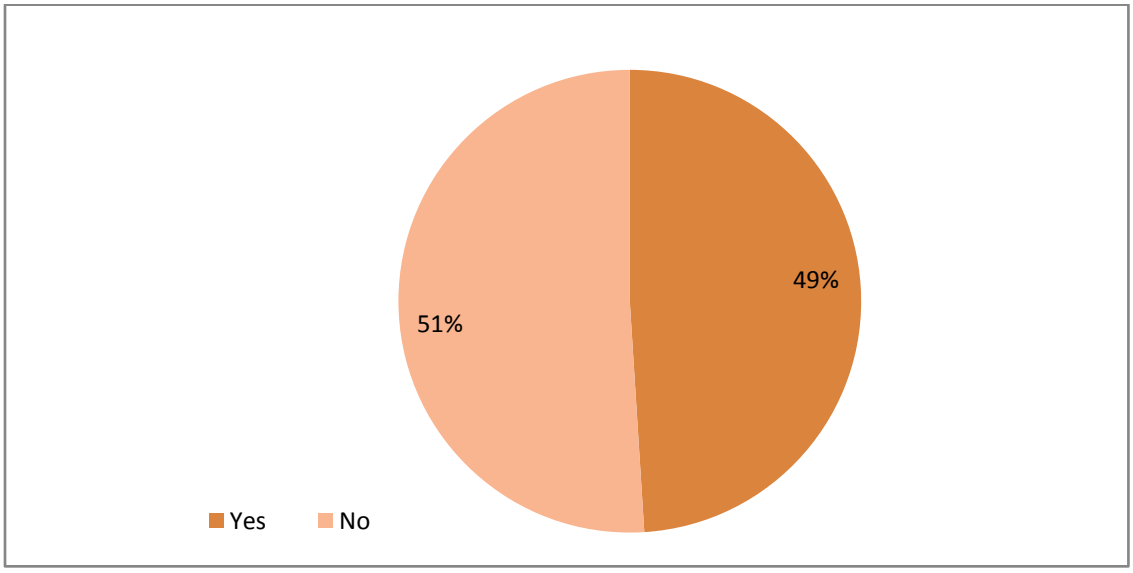


Figure 4.3:Respondents with incidence of hospitalizationsince their 60th birthday

Source: Field Survey, 2016.

4.3.1.2Types of Ailments

In order to analyze the type of ailment that affect the respondents, 25.5% reported having hypertension, 11.5% had diabetes, 9.0% had arthritis, 6.3% had Cataract while others were specified as hepatitis 1.8%, hypotension (Low Blood Pressure) 0.5%, Tuberculosis 0.5, Typhoid 2.0% and Ulcer 4.3%. About 38.8% had no ailment (Table 4.2). The finding revealed that hypertension is the main ailment affecting the aged followed by diabetes and arthritis. This is in line with the study of Gavrilov and

Heuveline, (2003) and Levy, (2012) that the prevalence of disability, frailty and chronic diseases is expected to increase drastically as the person ages.

WHO (2003) defines disability in terms of restrictions in the ability to perform activities of daily living (ADL), or, the inability to function independently in terms of basic ADL (like bathing, dressing, eating and toileting) or instrumental ADL (like shopping, preparing meals, and managing medication).

Table 4.2Distribution of Respondents by Type of Ailments

AilmentsNo. of respondents	**Percentage**
Hypertension	10225.5
Diabetes	46 11.5
Arthritis	36 9.0
Cataract	25 6.3
Hepatitis 7	1.8
Hypotension	2 0.5
Tuberculosis	2 0.5
Typhoid	8 2.0
Ulcer	17 4.3
None	155 38.8
Total	**400100.0**

Source: Field Survey, 2016

The most common causes of disability among older adults are: chronic diseases, injuries, mental impairment, malnutrition, Human Immuno-deficiency Virus/Acquired Immune-deficiency Syndrome (HIV/AIDS) and other communicable diseases. The major chronic conditions of an aging society include: cardiovascular diseases, hypertension, stroke, diabetes, cancer, chronic obstructive pulmonary disease, muscular-skeletal conditions including arthritis and osteoporosis, mental health conditions such as dementia and depression, and blindness and visual impairment. Injuries can be due to road traffic accidents, conflicts, falls, and land mines (McKenna, Michaud, Murray and Marks, 2005). Certain chronic conditions are particularly related to disability including stroke,

diabetes, cognitive impairment, arthritis and visual impairment. (Andrade 2009; Jagger*et al.* 2007a; McGuire, Ford, and Umed, 2006).

Caughey, Vitry, Gilbert and Roughead(2008)reported a prevalence of comorbidity of 80% of elderly population having threeor more chronic conditions in Australia. Naughton, Bennett and Feely (2006)reported that 86% of the elderly population in their study had experienced at least one of nine chronic conditions identified in which cardiovascular conditions were the highest costing disease group in London. Almost 75% of the elderly (aged 65 and over) have at least one chronic illness, while at least 50% have at least two chronic illnesses (Calkins, Boult and Wagner, 1999). Chronic conditions can lead to immediate disabilities, such as hip fractures and stroke, as well as progressive disability that slowly erode the ability of the elderly people to care for themselves (Fied and Guralnik, 1997). In this finding, about 6.1% respondents reported having cataract which is similar to the findings of Abdulraheem and Abdulrahman(2008) whoreported 14.6% blindness among elderly seen in a tertiary health institution in North-central Nigeria (Ilorin).

4.3.1.3Curative Approaches Adopted

Figure 4.4 reveals the distribution of respondents by the type of curative approaches adopted. About 50% used the hospital as a means of cure for their illness, 4.5% use self-medication and 7% use the traditional method of medication due to easy access and affordability. Medication usage refers to the act of consuming medicines for prevention, diagnosis or treatment of diseases. Consumption of correct medication should be monitored by health-care personnel's and patients and any harmful symptoms should be reported back to the health-care personnel who can further diagnose and

prescribe the needed drugs to alleviate the unwanted symptoms. This is usually followed by filling of such drugs at the pharmacy by the pharmacist (Ahmed *et al.*, 2012; Banerjee and Bhadury, 2012). That is the reason why majority of the respondents in this study adopt the use of hospital to cure their ailment(s). As corroborated by a discussant who said:

"*I visit the hospital only when I feel the signs of being ill"*.

(FromMalagum Ward)
(6th May, 2016).

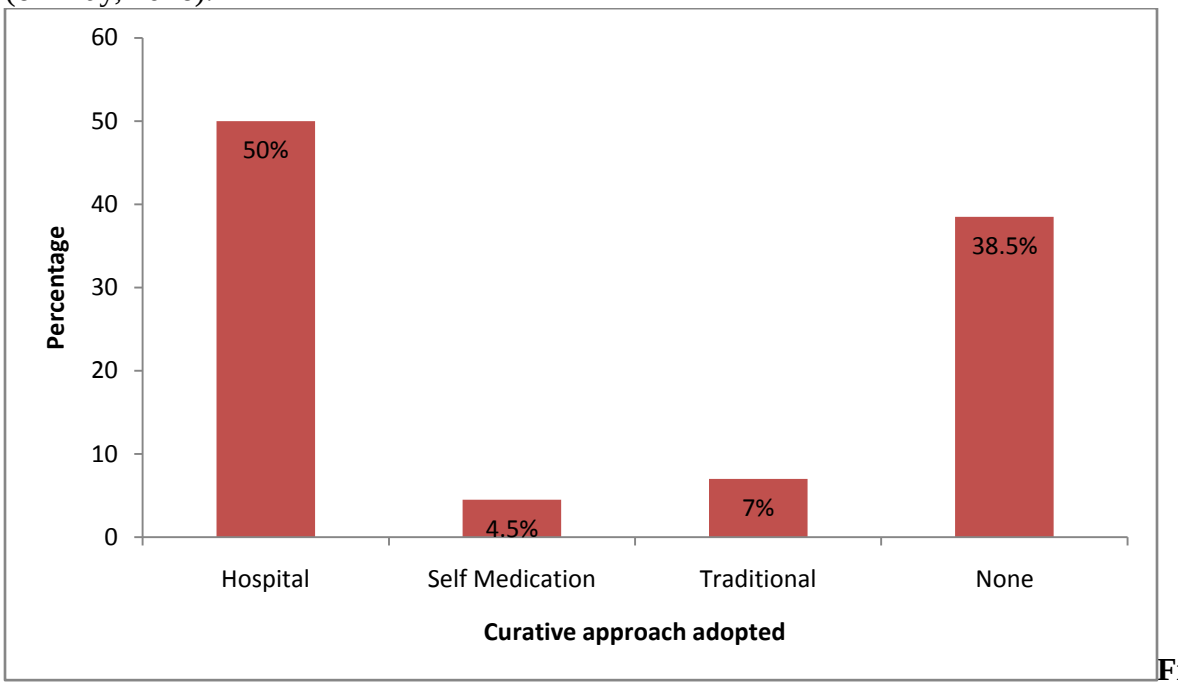


Figure 4.4: Distribution of Respondents by the Type of Curative Approaches Adopted

Source: Field Survey, 2016

A broad consensus has emerged linking consulting behaviour to those actions which emphasize what the patient can do for him or herself as opposed to seeking help from a professional (Dean, 1989). Self-medication is often used as an alternative to seeing a general practitioner (Egan and Beaton, 1987; Martin, Russell, Goodwin,Chapman and

Sheridan, 1991) and patients who believe in the effectiveness of self-treatment are more likely to treat themselves (Segall and Goldstein, 1989). Patients who choose to use self-medication first are less likely to consult the doctor (Robinson andGranfield, 1986;Norman, and Fitter, 1989;Anderson, Buck, Danaher, and Fry, 1977).

Edwards and Popay (1994) suggest that service providers will increasingly encourage people to rely not on formal services but rather to manage problems through informal networks. Given that many primary care consultations are for trivial or self-limiting conditions (Morrell, Avery, and Watkins, 1980) and that the number of such presentations is increasing, the promotion of self-care could have a significant effect on health care utilization (Kemper,Lorig,K.andMettler,1993) Although simple educational materials can reduce the consultation rate for minor illness (Cunningham, and Irvine, 1987), the efficacy of self-care relies upon appropriate and confident self-diagnosis of symptoms. Any move to reduce access to the general practitionerruns the risk of patients overlooking potentially serious symptoms.

According to Adesina (2008) and Adefolaju (2011), about 75% of Nigerians prefer to solve their health problems by consulting the traditional healers. In someAsian and Africancountries, up to 80% of the population relies on traditional medicine for their primary health careneeds. When adopted outside of its traditional culture, traditional medicine is often calledalternative medicine(WHO, 2008).WHO however notes that "inappropriate use of traditional medicines or practices can have negative or dangerous effects" and that "further research is needed to ascertain the efficacy and safety" of several of the practices and medicinal plants used by traditional medicine systems (WHO, 2008).The figure also reveals that about 38.5% had no ailment.

4.3.1.4 Frequency of Seeking for Medical Attention

Figure 4.5 reveals the frequency of seeking medical attention by the respondents. About 2.3% seek for medical help every week possibly due to severe illness, 31.% seek for medical help every month, 18% every quarter while 12.8% seek for it yearly. This is usually for less serious cases or just to make sure the body is fit. As a result, the number of respondents who do not seek for medical attention is about 36%.

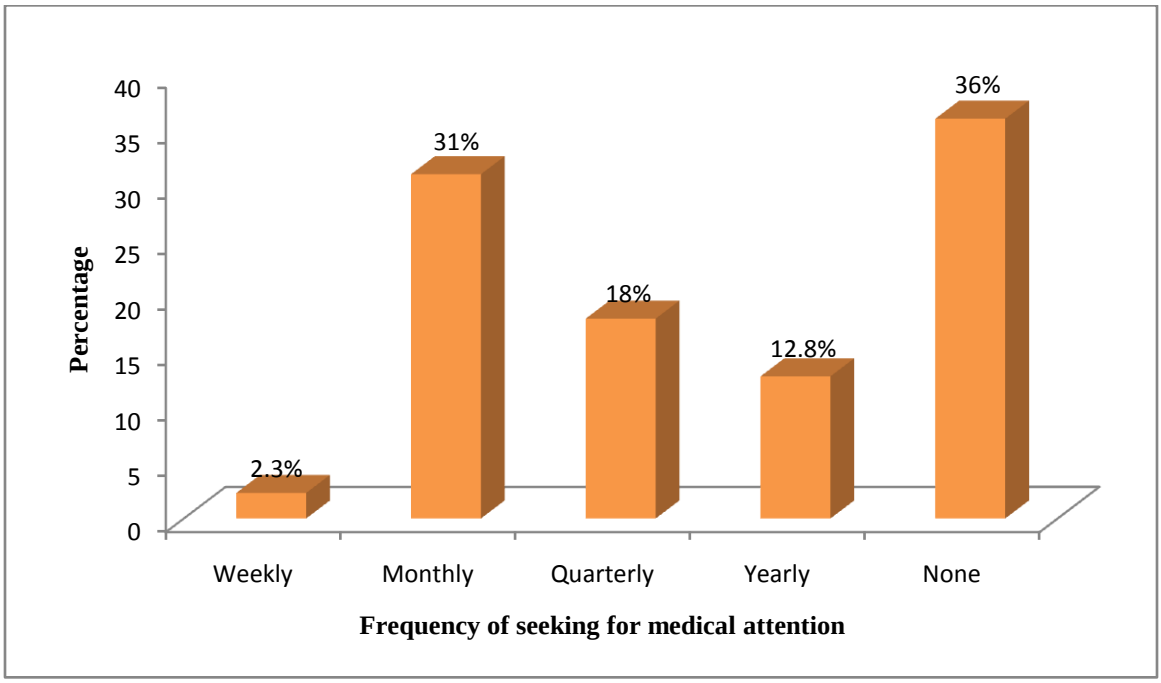


Fig 4.5:Distribution of Respondents by the Frequency of Seeking for Medical Attention

Source: Field Survey, 2016

Symptoms are an everyday part of most peoples' lives and many people with illness do not consult their doctor. The decision to consult is not based simply on the presence or absence of medical problems. Rather it is based on a complex mix of social and psychological factors (like social class, unemployment, perceived susceptibility of illness and perceived severity of illness among others (Campbell and Roland, 1996)).That

is why in this research about 36% respondents do not seek for medical attention, as the decision to consult does not depend on the presence or absence of medical problem.

This is corroborated by a discussant that:

"Every year, my children usually take me to the hospital for general Medical check-up".

(From Kapk Ward)
(5th May, 2016).

4.3.2 Material Well-being

4.3.2.1 Monthly Income

As shown inTable 4.3, about 16.8% reported earning less than five thousand naira (<#5,000) as monthly income, 15% reported earning a monthly income of between #5,999-#10,999, 7.3% answered that they earn between#11,999-#15,999, 6.5% earned between #16,999- #20,000, while about 10.5% earned more than #20,000 as monthly income. Also, about 44% reported not having a fixed amount as monthly income.The finding reveals that majority of the respondents have no fix amount. A high percentage of respondents with no fixed amount and about 16.8% of those who earned less than #5,000 indicate a low level of financial well-being for the aged in the area.

Table 4.3 : Distribution of Respondents by Monthly Income

Monthly Income (#)	No. of Respondents	Percentage
<5,000	67	16.8
5,999-10,999	60	15.0
11,999-15,999	29	7.3
16,999-20,000	26	6.5
>20,000	42	10.5
No Fixed Amount	176	44.0
Total	**400**	**100.0**

Source: Field Survey, 2016

Fajamilehin and Odebiyi, (2011) revealed that financial resources at the disposal of the elderly had significant influence on health status, marital cohesion and ability to obtain support and their behaviour patterns. For instance, most of the aged in the study who happen to operate private enterprises and thus appeared to have a control over large sums of money (Higher Socio-Economic Status, (HSES)) got more care, better housing and nutrition, and support from their children, family members and others, than those with small or no resources (Low Socio-Economic Status, (LSES)) which afterward affect their quality of life.

4.3.2.2 Type of Accommodation

Table 4.4 shows the type and ownership of accommodation as well as the relationship of those who reside with the respondents as at the time of survey. About 9.3% live in a room in multiple tenant apartments, 57.8% live in a room and parlor, 25.3% live in a flatwhile just about 7.8% live in a bungalow.

Table 4.4: Distribution of Respondents by Type and Ownership of Accommodation

Variables	No. of Respondents	Percentage
Type of Accommodation		
A room	37	9.3
Room and Parlor	231	57.8
Flat	101	25.3
Bungalow	31	7.8
Total	**400**	**100.0**
Ownership of Accommodation		
Self- owned house	268	67.0
Rented House	41	10.3
Family House	91	22.8
Total	**400**	**100.0**
Persons the Aged are Residing With		
With sons and daughters	249	62.3
With Relatives	102	25.5
Others	49	12.3
Total	**400**	**100.0**

Source: Field Survey, 2016.

Previous studies from Larson, (1978) found that objective housing (e.g. building characteristics such as size, height, and number of rooms) accounted for a small variance in well-being scores. However, Kozma*et al.* (1991) found that improved housing conditions did increase the well-being among the aged, while possibly eliminating the number of daily hassles associated with dilapidated housing.

4.3.2.3Ownership of Accommodation

About 67.0% reported living in a self-owned house, 10.3% lived in a rented apartment while 22.8% lived in a family house as shown on Table 4.4. This finding is in line with Asiyanbola (2004) in Ibadan, Nigeria.The result shows that majority of the elderly are living in a deplorable housing condition.

4.3.2.4 Person the Aged are Residing With

About 62.3% live with their sons and daughters, which according to Kertzer, (1995) and Weeks (2005): even if the aged live with their children, it is likely that the children (typically a son or unmarried daughter) are living in the family house. About 25.5%reported residing with their relatives. This corresponds withAsiyanbola's finding in 2004that the majority of the elders in Ibadan, Nigeria live among their family members.About 12.3% respondents specified they reside alone due to either lack of children or the children have all moved out of the family house as shown on Table 4.4.

Table 4.4 revealed that majority of the respondents live in a self-own house of room and parlor and they live mostly with their sons and daughters.

During the FGD session, a discussant described his accommodation as:

"*I live in a flat with my son and grandchildren. It is my own house and I have lived there for more than twenty years".*

(From Zankan Ward)

(7^{th} May, 2016).

4.3.2.5 Respondents on Special Diet

The respondents on special diet are 24.5% while 75.5% are not. This is seen clearly in Table 4.5. According to the Oxford English Mini-dictionary (1999), diet is a special restricted course of food adopted to lose weight or for medical reasons.For the purpose of this study, it is called'special diet' because it is specially restricted for medical reasons.Special diet is necessary for some illness in order to remain healthy. Baldwin and Weeks (2007) in a Cochrane review compared the impact of dietary advice

Table 4.5: Distribution of Respondents by Special Diet, Health Conditions that Result to Special Diet and Regularity of Required Diet

Variables	No of Respondents	Percentage
Respondents on Special Diet		
Yes	95	23.8
No	305	76.3
Total	**400**	**100.1**
Health Conditions that Result in Special Diet		
Diabetes	50	12.5
Hypertension	27	6.8
Cancer	5	1.3
None	305	76.3
Others	13	3.3
Total	**400**	**100.2**
Regularity of Required Diet		
Daily	85	21.3
Weekly	3	0.8
Monthly	7	1.8
None	305	76.3
Total	**400**	**100.2**

Source: Field Survey, 2016

to no dietary advice for illness related malnutrition. A variety of outcome was measured which include mortality, change in energy intake, change in weight and readmission to hospital.

4.3.2.6 Health Conditions That Result in Special Diet

Table 4.5 show that some respondents are on special diet due to the following health conditions; diabetes 12.5%, hypertension 6.8%, cancer 1.3% and 76.3% had no need of special diet. About 3.3% respondents are specified as other forms of health condition (example, ulcer).

4.3.2.7 Regularity of Required Diet

Some of the respondents were asked on how regular they require the special diet and their response were, 21.3% require it daily, 0.8% require it weekly, 1.8% require it monthly while 76.3% do not need special diet (Table 4.5). Majority of the respondents reported that they require the special diet on daily basis as human beings need food daily for their survival.

From table 4.6, the findings revealed that, out of the 24.5% respondents who need special diet, more than half of them (12.5%) are diabetic and require their special diet on daily basis.

During the FGD session, a discussant said:

> *"I have diabetes and have been living on special diet for the past ten years. I eat less of carbohydrate or starchy foods and more of protein, fruits and vegetables. I need this diet daily and could afford it on weekly basses".*
>
> (FromKadarko Ward),
>
> (4^{th} May, 2016).

Another discussant added:

> *"As an ulcer patient, I have to deprive myself from eating fried, Pepperish and sour food. I was also advised not to eat late at night".*
>
> (FromBondon Ward),
> (3^{rd} May, 2016).

4.3.2.8 Regularity of Affording Special Diet

The regularity of affording special diet was cross-tabulated with monthly income of the respondents to see the relationship and it thus revealed that, only about 18.2% of those who earn less than five thousand naira (<#5000) could afford their special diet on

daily basis, 20.0% on weekly basis, 24.4% monthly while about 14.3% could not afford it at all. About 9.1% of those who earn between #5,999- #10,999 afford their diet on daily

Table 4.6: Distribution of Respondents According to Regularity of Affording Special Diet(RASD) and Income

RASD / Income	Daily (%)	Weekly (%)	Monthly (%)	Not at all (%)	None (%)	Total (%)
<#5000	18.2	20.0	24.4	14.3	15.4	16.8
#5,999-10,999	9.1	20.0	6.7	0.0	16.7	15.0
#11,999-15,999	36.4	0.0	11.1	7.1	6.2	7.2
#16,999-20,000	9.1	4.0	8.9	21.4	5.6	6.5
>#20,000	9.1	0.0	13.3	0.0	11.5	10.5
No fix amount	18.2	56.0	35.6	57.1	44.6	44.0

SignificantP- Value LevelFreedom	Degree of
0.05.009	20

Source: Field Survey, 2016

basis, 20.0% afford theirs weekly and 6.7 % on monthly basis. For those who earn between #11,999- #15,999, about 36.4% of them could afford their special diet daily, none could afford it weekly, 11.1% could afford it monthly while 7.1% could not afford it at all.

Only about 9.1% of those who earn between #16,999- #20,000, could afford their diet daily, 4.0% weekly, 8.9% monthly and 21.4% could not afford it at all. For respondents that earn above twenty thousand naira (>#20,000), 9.1% of them could afford their special diet daily, none could afford it weekly, 13.3% monthly and also, there

was none among them that could not afford their special diet at all. About 18.2% of respondents with no fix amount could afford their special diet daily, 56.0% weekly, 35.6% monthly and 57.1% could not afford it at all (Table 4.6).It has been observed that majority of the respondents had no fix amount and could not afford their special diet regularly.This gave a p-value of 0.009which means that income has a significant effect on how regular a respondent can afford his or her special diet.

In analyzing the capability of the respondents in affording special diet with respect to their educational qualification, table 4.7 reveals that majority of those with no formal education could afford their special diet daily. Those with adult education could afford theirs weekly as those with tertiary education could also afford theirs monthly.

Table 4.7: Distribution of Respondents According to Regularity of Affording Special Diet (RASD) and Education

RASD / Education	Daily (%)	Weekly (%)	Monthly (%)	Not at all (%)	None (%)	Total (%)
None	54.5	40.0	40.0	7.1	32.8	33.8
Adult Education	0.0	16.0	6.7	7.1	13.1	12.0
Primary Education	27.3	28.0	22.2	50.0	25.2	26.0
Secondary Education	9.1	16.0	11.1	35.7	18.7	18.0
Tertiary Education	9.1	0.0	20.0	0.0	10.2	10.2

Significant Level	P- Value	Degree of Freedom
0.05	.08016	

Source: Field Survey, 2016

Majority respondents with primary and secondary education could not afford their special diet at all. This gave a p-value of 0.080which means that education is not a barrier to how regular a respondent affords his or her special diet. (Table 4.7).

Also, the regularity of affording special diet was cross-tabulated with the occupation of the respondents and it thus revealed that, majority of those in civil service, the traders and farmers could not afford their special diet at all while the artisans and those without occupation could afford theirs only on daily basis. This gave a p-value of 0.424,which means that occupation is not a barrier to how regular a respondent affords his or her special diet (Table 4.8).

Table 4.8: Distribution of Respondents According to Regularity of Affording Special Diet (RASD) and Occupation

RASD / Occupation	Daily (%)	Weekly (%)	Monthly (%)	Not at all (%)	None (%)	Total (%)
Civil Service	0.0	0.0	6.7	7.1	6.2	5.8
Trading	18.2	20.0	20.0	21.4	18.7	19.0
Farming	36.4	68.0	40.0	71.4	45.6	47.0
Artisan	18.2	8.0	8.9	0.0	14.8	13.2
None	27.3	4.0	24.4	0.0	13.8	14.2
Vigilantee	0.0	0.0	0.0	0.0	1.0	0.8

Significant Level	P- Value	Degree of Freedom
0.05	.424	20

Source: Field Survey, 2016

Therefore, the p-values in table 4.7 and 4.8 are more than 0.05 significant level.

They are accepted because special diet can be afforded irrespective of one's educational

or occupational status. But the p-value on table 4.6 is rejected as it is less than 0.05 significant level which means that the income of a respondent can greatly affect the affordability of his or her special diet.

4.3.2.9 Frequency of Eating in a Day

Figure 4.6 shows that about 3.5%respondents eat once a day, 46.0% eat twice a day and 50.5% eat three square meals a day. The frequency of eating among the aged in Kaura LGA is considerably satisfactory to the extent that majority of the respondents eat three times a day. The few people that ate once a day complain of poverty as being the cause. They would have loved to eat more than that but their poor material well-being would not warrant them, for instance Table 4.4 shows that only about 13.8% earn between #11-20,000 while majority has no fix earning.

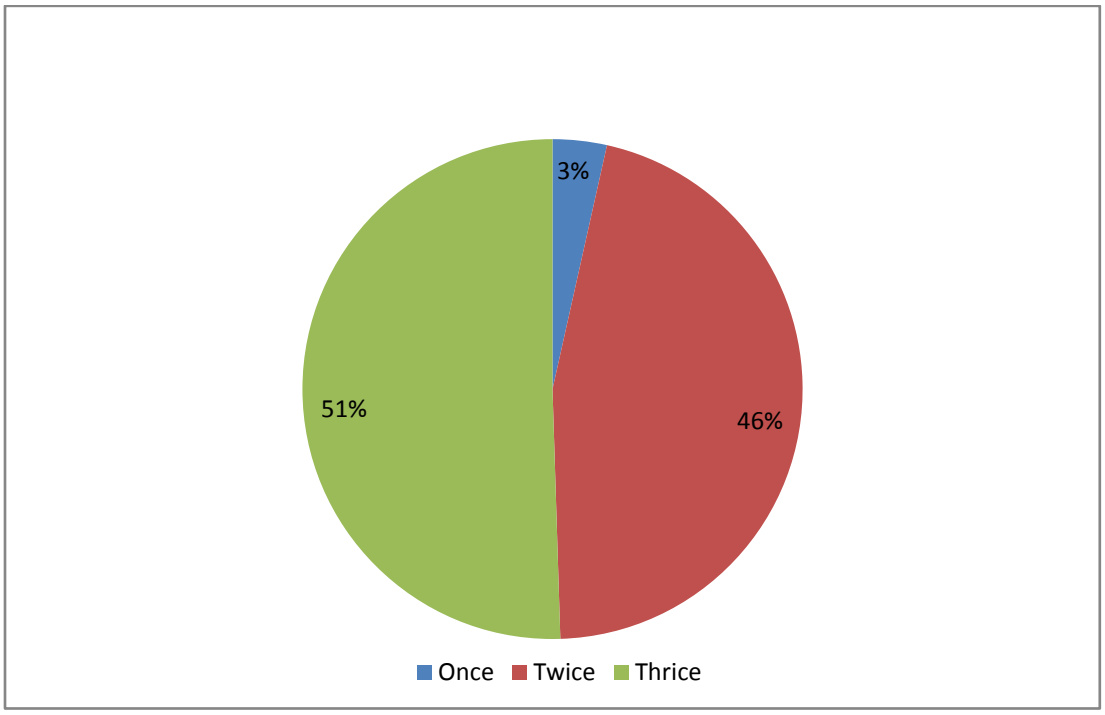


Figure 4.6: Distribution of Respondents by Frequency of Eating in a Day

Source: Field Survey, 2016

The frequency of eating could be influenced by some social and psychological factors which affect the choice of food and eating patterns and thus nutritional status. These factors include poverty, cultural and religious beliefs, education, nutritional knowledge, cooking facilities, food preferences, time, previous food experiences, social isolation, depression and bereavement (Schenker, 2003). These are relevant to older people and have to be considered when devising intervention to improve nutritional status.

4.3.2.10 Source of Drinking Water

In Kaura LGA, sources where water may be obtained include:Ground sources (such as mono-pumps, boreholes, springs and well); Precipitation which is mostly rain;Surface water(such as rivers, streams, and ponds).Springs are often used as sources for bottled waters (Schardt, 2000). Tap water, delivered by domestic water systems in developed nations, refers to water piped to homes and delivered to a tap or spigot.

For these water sources to be consumed safely they must receive adequate treatment and meet drinking water regulations (Hall and Dietrich, 2000). Consuming such water is necessary to sustain physical well-being of the aged. In view of that, the study reveals the sources of drinking water for the respondents in the study area. About 11.0% get their drinking water from the tap, 33.8% get theirs from the well, 13.0% from the stream, and 42.3% get theirs from the mono-pump (Table 4.9). With 42.3%, it clearly indicates that Majority of the respondents get their drinking water from the mono-pumps.

Table 4.9: Distribution of Respondents based on Availability and Utilization of Drinking Water

Variables	No. of Respondents	Percentage
Source of Water		
Tap	44	11.0
Well	135	33.8
Stream	52	13.0
Mono-pump	169	42.3
Total	**400**	**100.0**
Boiling Water Before Drinking		
Yes	85	21.3
No	315	78.8
Total	**400**	**100.0**
Reasons for Not Boiling Water		
No time	86	21.5
Dirt's in water cannot kill	34	8.5
Water is potable enough	195	48.8
None	85	21.3
Total	**400**	**100.0**

Source: Field Survey, 2016

4.3.2.11 Boiling Water Before drinking

While assessing the respondents on whether or not they boil their drinking water, 21.3% responded positively while 78.8% were negative about it (Table 4.9).Most of the water used by the respondents requires some forms of treatment before use, even water from deep wells or springs. The extent of treatment depends on the source of the water. In emergency situations when conventional treatment systems have been compromised, waterborne pathogens may be killed or inactivated by boiling (WHO, 2004) but this requires abundant sources of fuel, and can be very onerous on consumers, especially where it is difficult to store boiled water in sterile conditions.

4.3.2.12 Reasons for not Boiling Water

The 78.8% respondents who do not boil their drinking water were further asked for reasons.Reasons given by about 21.5% were no time to boil their water, 8.5% reported that, dirtin water cannot kill, 48.8% believed the water is potable enough to drink (Table 4.9).

Therefore, the finding reveals that about 42.3% of the respondents get their drinking water from the mono-pump of which more than half of them (78.8%) do not boil before drinking, believing it is potable enough.

The following aresupportive evidences extracted from Focus Group Discussion (FGD) sessions when probing into the reason for not boiling water before drinking. A discussant remarked that:

"*I usually take swanor other bottled water. My children often buy it while visiting me and when it get finished, I asked the person staying with me to boil that of the borehole for me to drink".*

(FromZankan Ward),

(7^{th} May, 2016).

Some discussants from other wards also added that:

"*I don't boil my drinking water because the water looks potable enough for me to drink".*
(From Bondon Ward),
(From, Kadarko Ward),
(FromMalagum Ward),

(3^{rd}, 4^{th} and 6^{th} of May, 2016).

4.3.3 Social Well-being

The social parameters examined were attending social functions, involvement in recreational activities and availability of social institutions.

4.3.3.1 Social Engagement

Social engagement refers to maintenance of social connections and participation in social activities (Bassuk, Glass, &Berkman, 1999).It also measures how people experience their connection and the strength of those relationships.Recent research suggests that older people who are more socially engaged tend to have a higher level of cognitive function compared to less engaged persons (Barnes, Mendes de Leon, Wilson, Bienias, & Evans, 2004; Bassuk*et al.*, 1999).Table 4.10 revealed the most engaged social activity of each respondent. About 29.3% are engaged in the celebration of conjugal union (marriages), 60% prefer to attain burial ceremonies and this indicates the most prominent social function among the aged in the area. About 7.8% engaged in child naming ceremonies while 3.0% admitted participating in birthdays.

Table 4.10: Distribution of Respondents by Social Engagements

Social Engagement	No. of Respondents	Percentage
Marriage	117	29.3
Burial	240	60.0
Naming Ceremonies	31	7.8
Birthdays	12	3.0
Total	**400**	**100.0**

Source: Field survey, 2016

This finding is also in line with Bowling (1994) who workedon some factors that reflect the needs of the elderly for social network, support and engagement. These factors are believed to be urbanization and changes in the structure of the family which lead to social isolation of the elderly.

4.3.3.2 Recreational Activities

Recreation is the activity that is done for pleasure or amusement (Longman, 1995). It is an important quality of life factor for the aged. For example, Hawkins, Foose, and Binkley (2004) found that recreation or leisure makes a significant contribution to overall life satisfaction for older adults in both the United States (U.S.) and Australia. Therefore, it is important that the aged in Kaura LGA engage in multiple recreational activities. However, for ease of analysis, only the most engaged recreation by each respondent was asked as presented in Figure 4.7. About 53.3% engaged in strolling around the community to ease their burden or for pleasure, 38.8% engaged in visiting

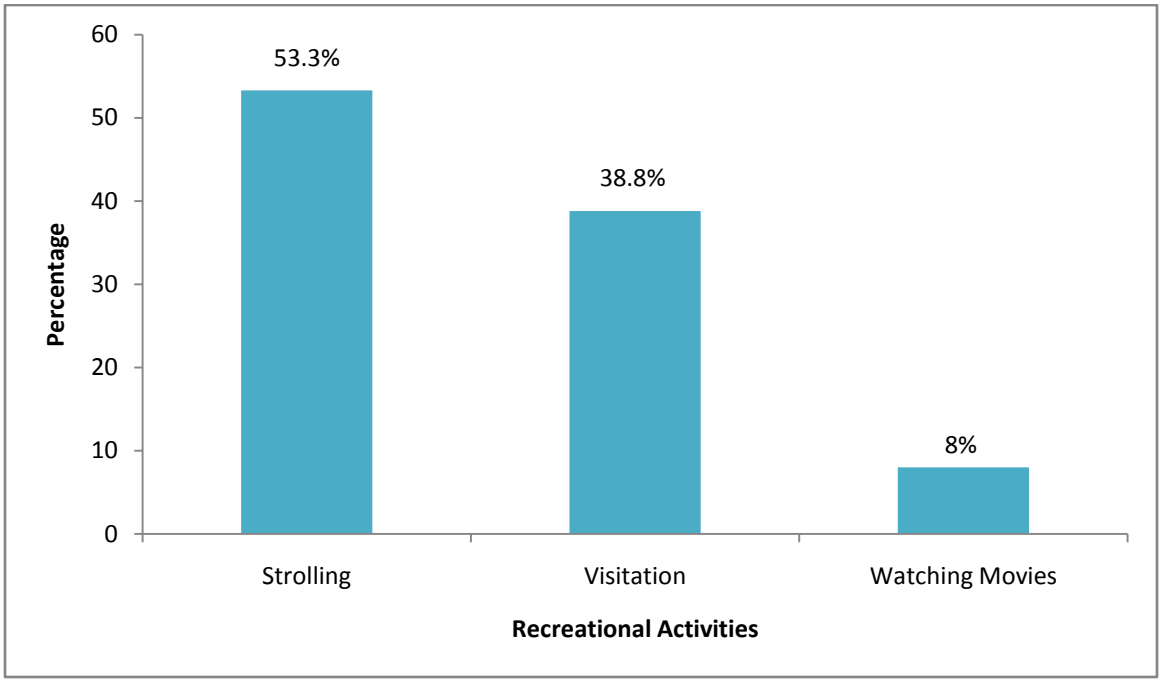


Figure 4.7: Type of Recreational Activities Engaged in by Respondents

Source: Field Survey, 2016

their families, friends and well-wishers. Some also admitted visiting their farmlands at their leisure times to see how well their crops are growing. As few as 8% admitted

watching movies as a preference. It is very obvious that majority of the respondents engaged in strolling within and around the community in order to recreate themselves.

In line with this, Johns Hopkins(2006) found that people who frequently engage in leisure activities such as reading, playing board games, playing a musical instrument, or dancing were less likely to have developed dementia five or more years later. Dancing combines mental and physical activity and was associated with a 76% reduction in dementia.In addition, another research found that retirees who remained active in pursuits such as walking, bicycling, or gardening maintained their mental functioning at a higher level than did inactive retirees (Kolata, 1991).

4.3.3.3Infrastructural Facilities

Sturnieks, St. George and Lord, (2008) observed that it is very important to consider the interest of the aged before introducing them to any coping programme that keeps the body and soul fit. Therefore, the provision of hospitals and recreational institutions for the aged by either Government or private organizations is very important.

Aside Kpak and Malagum that have specialist hospitals, all the other wards had no standard hospitals. Therefore, most people with severe illness in the study area have to go to those two wards or other places so as to access medical care.

Housing or home for senior citizens (the aged) comes in a variety of forms and provides an array of services that cater for both seniors capable of independent life and seniors in need of assistance. Arthur and Micheal (1988) categorize senior citizen housing in to 5 in the U.S. These are (i) Retirement Communities, (ii) Retirement Apartment, (iii) Congregate Housing, (iv) Care Communities and (v) Nursing Communities, each serving

a different function to the aged. Unlike in Western World, there has never been a facility called “old people’s home” in the study area, The aged are usually cared for by their immediate and extended members of their family and even the entire clan where necessary (Abdurahman, 1988, and Ogunbodede, 1997). This study alsoreveals that there are no recreational clubs specifically for the aged in the study area. A visit to recreational clubs helps to reduce stress in the mind and body. The absence of this clearly implies that the physical well-being of the aged in the area may not be objectively compared with other societies.

During the FGD session, a probe to find the availability of these facilities was made and a discussant said:

“We do not have any of such facilities here”.

(FromKpak Ward),

(5th May, 2016).

Another discussant added that:

“We have never seen or heard of anything like that ever existed”.

(From Kadarko Ward),

(3rd May, 2016).

During the interview with the district head of Zankan Ward on the availability of facilities in the area, he said:

> *“On the part of facilities, we do not have any as government’s attention is centered mostly on children (0-5years) except for some few cases where some health workerscome around to check the people (the aged) on maybe hypertension, hepatitis or the eye, after which they refer you to see a doctor if you are found wanting, with little or no assistance”.*
>
> (From Zankan Ward,),
> (7th May, 2016).

4.4Determinants of the Well-being of the Aged

The analysis of the determinant of well-being of the aged for all age groups(ages 60-80+) in Kaura LGA revealsthe relationship between aging and the determinants of well-being as both were cross-tabulated.The result reveals that about 115 respondents strongly agreed that regular access to doctor's consultation determines a healthy well-being of older people, 268 respondents agreed on that, 5 were undecided, 10 disagreed and also 2 other strongly disagreed on that too, given a p-value of 0.000. About 122 respondents strongly agreed that availability of required drugs determines a healthy well-being of older people, 266 respondents agreed on that, 6 were undecided, 5 disagreed and only 1person strongly disagreed with that given it a p-value of 0.124.(Table 4.11).

Table 4.11: Distribution of Respondents by the Determinants of Well-being of the Aged

Determinants	**Response Categories**					**P-Value**	**Significance Level**	**DF**
	SA	**A**	**UD**	**D**	**SD**			
Regular Access to Doctors Consultation.	115	268	5	10	2	0.000	0.05	16
Availability of Required Drugs.	122	266	6	5	1	0.124	0.05	16
Utilization of Traditional Medicine.	34	242	27	83	14	0.006	0.05	16
Food Availability.	83	307	1	5	4	0.409	0.05	16
Access to Comfortable Shelter.	65	301	3	19	12	0.017	0.05	16
Visits by Children and G/Children.	92	256	10	21	21	0.234	0.05	16
Attending Social Functions.	36	238	31	66	29	0.055	0.05	16
Living Around Age mates.	74	198	40	68	20	0.003	0.05	16

Source: Field Survey, 2016

Again, 34 respondents strongly agreed that the utilization of traditional medicine determines a healthy well-being of older people, 242 respondents also agreed, 27 were undecided, 83 disagreed and 14 others strongly disagreed given it a p-value of 0.006.

A question on whether the availability of food determinesmaterial well-being of older people revealed that 83 respondents strongly agreed on that, 307 agreed, 1 person was undecided, about 5 disagreed and 4 strongly disagreed, given a p-value of 0.409.In trying to assess whether access to comfortable shelter determines also the material well-being of older people, about 65respondents strongly agreed, 301 respondents agreed, 3 were undecided, 19 disagreed and 12 strongly disagreed, given a p-value of 0.017. About 92 respondents strongly agreed that regular visitation by children and grandchildren determines the social well-being of older people, 256 agreed, 10 were undecided, 21 disagreed and another 21 respondents strongly disagreed. This gave a p-value of 0.234(Table 4.12).

About 36 respondents strongly agreed that attending social functions (like marriages and burials among others) also determines the social well-being of older people, 238 respondents agreed on that, 31 were undecided, 66 disagreed and 29 strongly disagreed, given it a p-value of 0.055. Finally, a question on whether living around age mate determines the social well-being of older people was asked, about 74 respondents strongly agreed on that, 198 agreed, 40 were undecided, 68 disagreed and 20strongly disagreed, given a p-value of 0.003 (table 4.11).

The result of this findings revealed that age has a significant relationship with the following determinant of well-being; regular access to doctors consultation, utilization of traditional medicine, access to comfortable shelter and living around age mates as their p-

values are less than 0.05 significant levels. While on the other hand, age has no significant relationship with the following determinants; availability of required drugs, availability of food, visits by children and grandchildren and attending social functions. This is because their p-values are more than 0.05 significant levels.

The well-being of the aged person is affected by several factors relating to demography, health and social network and support (Everard, Lach, Fisher and Baum, 2000; Newsom and Schulz, 1996). Some of these factors include mortality, chronic illnesses (like hypertension), and loneliness among others. In a developing country or society like the study area, social factors reflecting engagement may be more important to the well-being of the aged person.

4.5 Coping Strategies of the Aged

In Kaura LGA, there are so many issues the aged cope with like insufficient food, money, clothes, and so on, but for the purpose of this study, the author only describes the ability of the respondents to adapt to the situation of insufficient food.

4.5.1 Adequate Feeding

Figure 4.8 revealed that about 54.5% of the respondents reported being satisfied with the number of times they eat while 45.5% are not.

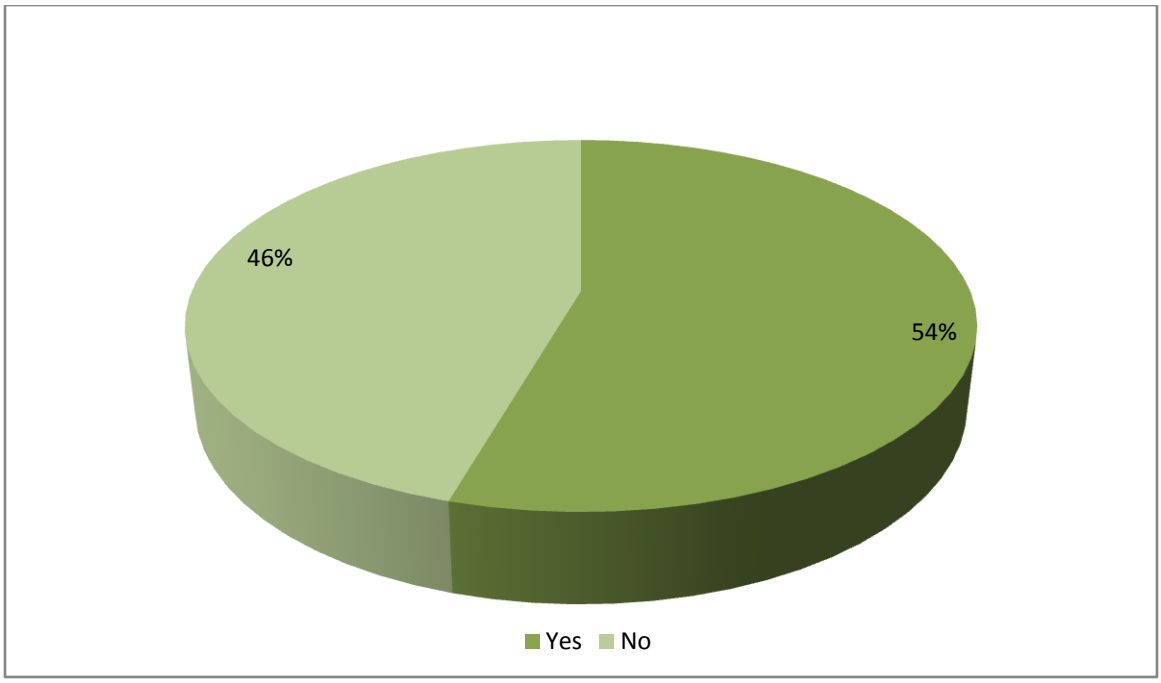


Fig 4.8: Adequacy of Feeding Among Respondents.

Source: Field Survey, 2016.

4.5.2 Coping Strategies Adapted Against Hunger.

The coping strategies adapted against hunger was cross-tabulated with the wards to see how respondents cope with insufficient food (hunger). Bondon ward reported 45.9% begging for food to sustain themselves, 27.1% borrow food and return it whenever they are capable, 25.0% collect food on credit from the sellers and pay back whenever they get the money, 20.0% completely rely on others (like children and relatives) for food while 25.0% claimed they never lack food (Table 4.12).

Table 4.12: Spatial Variation of Coping Strategies According to Wards

Wards	Coping Strategies (%)				
	Beg for food	**Borrow food**	**Collect credit**	**Rely on others**	**Never lack food**
Bondon	45.9	27.1	25.0	20.0	25.0
Kadarko	18.9	16.7	23.8	25.3	20.0
Kpak	2.7	16.7	14.4	15.8	15.0
Malagum	10.8	8.3	11.9	21.1	13.3
Zankan	21.6	31.2	25.0	17.9	26.7

Significance Level	P- Value	Degree of Freedom
0.05	.18916	

Source: Field Survey, 2016

In Kadarko ward, 18.9% reported begging for food, 16.7% borrow food, 23.8% collect credit, 25.3% rely on others as 20.0% never lack food. In Kpak ward, only about 2.7% beg for food, 16.7% borrow food, 14.4% collect food on credit, 15.8% rely on others and 15.0% never lack food. Malagum ward reported 10.8% begging for food, 8.3% borrow food, 11.9% collect food on credit, 21.1% rely on others while 13.3% never lack food.

Finally, in Zankan ward, 21.6% beg for food, 31.2% borrow food, 25.0% collect credit, 17.9% rely on others as 26.7% never lack food.These all together gave a p-value of0.189which means that there is a significant relationship between respondents and how they cope with insufficient food in each ward as the p-value is more than 0.05 significant level (Table4.12).

This finding revealed that majorityof the respondents in Bondon ward (45.9%) beg for food, majorityof them in Kadarko and Malagum ward (25.3% and 21.1%) solely rely on others for their feeding as also, the majorityof those in Kpak and Zankan wards (16.7% and 31.2%) borrow food to survive.However, in the assertion of Fricke *et al.*, (2015), they noted that when experiencing food insecurity, parents may engage in a variety of behaviours to cope with hunger and feeding themselves and their family. These coping strategies include rationing the food supply by eating less, purchasing fewer fruits and vegetables which are often perceived as being too expensive, skipping bill payments and other household expenses, and/or acquiring food through less socially desirable means such as eating discarded food (Hoisington *et al.*, 2002; Kempson*et al.*,2003; Kendall *et al.*, 1996; and Wiig and Smith,2009).

4.6 Types and Sources of Support for the Aged

4.6.1SupportAmong Respondents

While analyzing the respondents to know how many of them receive support, about 60% reported receiving support while the remaining 40% said no (Figure 4.9). The result revealed that most of the respondents receive support as some still claim they do not receive any.

In a probe to find out whether there are organized pro-aged form(s) of support /assistance during the FGD sessions, discussants from four wards gave the same answer all through:

"*We do not have any support/assistance from the Government or any individual*".

(From Kpak ward),
(From Kadarko ward),
(FromZankan ward),
(FromMalagum ward),

(4rd, 5th, 6th and 7th of May, 2016).

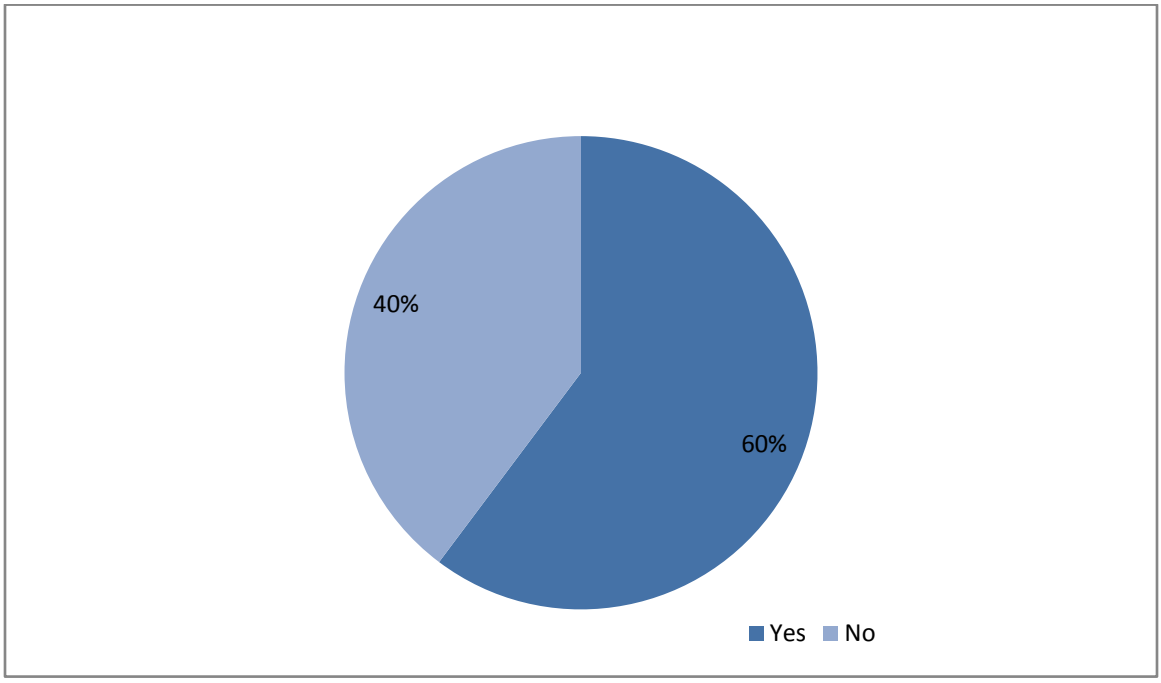


Figure 4.9: SupportAmong Respondents

Source: Field Survey, 2016

A female discussant added:

"*We do not received support/assistance from the government but some wealthy individuals from the community often support us with items like clothes and foodstuffs especially we the widows that are aged".*

(FromBondon Ward),

(3rd May, 2016).

During the interview with the district head of Zankan ward, he said:

> *"The government has not supported the aged of this ward in any way and even in the whole LGA. But the community is able to give some health and moral advice to them especially when they gather for any programme.Sometimes you find a widow whose children are not with her struggling alone. In terms of material assistance, some few individuals within the community assist her to farm or work for her at home, or sometimes, her relations gather foodstuffs for her".*

(From Zankan Ward),

(2nd May, 2016).

Still during the session, the respondents interacted to find out the type of care service they require in the area, a female discussant said:

"*We need good drinking water please, the ones we have here are not potable enough".*

*(*FromZankan ward),
(7th May, 2016).

4.6.2Types and Sources of Support Received

Social support can be measured as the perception that one has assistance available, the actual received assistance, or the degree to which a person is integrated in a social network. Support or assistance can come from many sources, like the family, friends,neighbours, coworkers, organizations, and PETs (Peer Education Trainers) among others. These support can also be in different forms, example it can be tangible (e.g. financial assistance), informational (e.g. advice), emotional (e.g. nurturance), companionship (e.g. sense of belonging) and intangible (e.g. personal advice).

Table 4.13 reveals that for food as a type of supportfor the aged, 42% receive the support of food from their children, 14.5% receive it from their relatives, 3.0% from the politicians, 0.5% from religious leaders while about 40% had no support at all.

Table 4.13: Types and Sources of support Among Respondents.

Types and Sources of support	No. Analyzed	Percentage
Food		
Children	168	42.0
Relatives	58	14.5
Politicians	12	3.0
Religious Leaders	2	0.5
None	160	40.0
Total	**400**	**100.0**
Money		
Children	156	39.0
Relatives	59	14.8
Politicians	23	5.8
Religious Leaders	3	0.8
None	159	39.8
Total	**400**	**100.0**
Shelter		
Children	163	40.8
Relatives	65	16.3
Politicians	9	2.3
Religious Leaders	4	1.0
None	159	39.8
Total	**400**	**100.0**
Advice		
Children	121	30.3
Relatives	77	19.3
Politicians	7	1.8
Religious Leaders	34	8.5
NGO	1	0.3
None	160	40.0
Total	**400**	**100.0**
Entertainment		
Children	142	35.5
Relatives	78	19.5
Politicians	7	1.8
Religious Leaders	10	2.5
NGO	3	0.8
None	160	40.0
Total	**400**	**100.0**

Source: Field Survey, 2016

Considering money as a type of support for the aged, 39.0% receive money from their children, 14.8% receive money from their relatives, 5.8% receive it from politicians, 0.8% from religious leaders and 39.8% had no assistance.

For shelter as a type of assistance for the aged, 40.8% were provided shelter by their children, 16.3% by their relatives, 2.3% by the politicians, 1.0% by their religious leaders, and 39.8% respondents had none.

The findings also indicate that advice and entertainment are also types of support /assistance that the aged receive in the area. Entertainment in this context refer to an activity designed to give pleasure or relaxation to an audience, example is organizing a movie show or games. About 30.3% and 35.5% of the respondents receive advice and entertainment from their children, 19.3% and 19.5% receive advice and entertainment from their relatives, 1.8% receive both advice and entertainment from the politicians, 8.5% and 2.5% receive theirs from their religious leaders, about 0.3% and 0.8% get theirs from the NGO's and about 40% of them do not receive any of such support at all.

It has been observed that majority of the aged receive support mostly from their children (major source) and their relative (second major source), followed by the others. This is similar to Okumagba's study (2011), that majority of the aged in study in Delta state (36.79%), received support from their children.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary of Findings

The study focuses on the analysis of the well-being of the aged in Kaura LGA of Kaduna State, Nigeria. There are no or limited research on well-being of the aged in rural settings especially in Kaura LGA, that is why the present study has been undertaken, viewing the following objectives: to examine the living conditions of the aged; to access the determinants of well-being of the aged; to examine the coping strategies of the aged; and finally, to examine the types and sources of assistance for the aged, all in Kaura LGA of Kaduna State.

The findings on socio-demographiccharacteristics of respondents revealed that majority of the respondents are females within the ages of 60-64 years who have 6-10 children in monogamous marriages. It also revealed that most of the respondents are Christians with no formal education and engaged mostly in farming as their major occupation.

Results on physical health of respondents revealed that about 49% have been hospitalized since their 60^{th} birthday due to certain ailments like hypertension in which most of them uses the hospital as a means of cure or for medical checkup, which is mostly once in a month.Results on material well-being of respondents revealed that most of them had no fixed monthly income and lived in a self-owned house of room and parlor with their sons and daughters.A few numbers of them (about 23.8%) are on special diet due to ailments like diabetesand could hardly afford their special diet regularly due to poor and unstable income. Most of the respondents feed adequately (up to three times a

day) and have the mono-pump as their source of drinking water which they do not boil because it is portable enough for them. Results from the social well-being of the respondents revealed that most of them prefer to attain burial ceremonies as their social engagement and recreate mostly by strolling as recreational clubs and other social facilities are not available in the area.

After cross-examining the determinants of well-being with the age of the respondents, the results revealed that age have a significant relationship on the following determinants: regular access to doctor's consultation; utilization of traditional medicine; access to comfortable shelter and; living around age mates. Also, it does not have any significant relationship on the following determinants: the availability of required drugs; the availability of food; regular visits by children and grand-children and; attending social functions.

It has been revealed that respondents who do not feed adequately in the study area have adapted some coping strategies against hunger according to their wards. In Bondon ward, majority of them beg for food in order to adapt to the situation. In Kadarko and Malagum wards, they mostly rely on others for their food, as in Kpak and Zankan wards, they borrow food to survive.

Finally, the findings revealed that children are the major source of support to their aged parents especially in terms of the provision of food, money, shelter advice and even entertainment.

Thus, the study revealed that the aged in Kaura LGA are generally not faring well and this emphasizes the need for the Government and other relevant bodies to establish

and implement policies that will address the well-being of the aged particularly in their material, physical and social needs.

5.2 Conclusion

The remarkable demographic and progressive aging of the world's population is faced with the challenged of promoting healthy and productive aging in this added later years of life, and to adjust societal practices and structures to include older people as contributors to societal growth. Aging should be viewed as a natural part of life course and not a burden to the family or societies. Giving the opportunity, the aged also have the ability to work for longer periods to help fund a comfortable standard of living in retirement or later life, and also fund more of their own health and social care. Finally, the analysis of the well-being of the aged in Kaura Local Government Area has been done, and the determinants of the well-being of the aged, their coping strategies especially in terms of hunger, and the types and sources of support/assistance the aged received has been examined and established.

5.3 Recommendations

Following the results of this study, these recommendations were specifically made to improve the well-being of the aged people in Kaura LGA and other parts of Nigeria with similar characteristics of aging population:

1. Efforts should be made by the Government to increase the number of health facilities and personnel with specialization in geriatric medicine and to mainstream old age health care into medical practice. This is very important as more than 60% of the respondents have one form of ailment or the other and about 50% uses the hospital as a means of getting cure.2. It was revealed that farming is the major occupation of the

people. They should therefore be given incentives of fertilizers, machinaries and money by the Government to encourage themand also boost their productivity.

3. Programmes should be organized at intervals by the Government, Non-Governmental Organization (NGOs) or relevant bodies in order to support,advice and encourage the aged on how to keep and maintain a healthy well-being, especially in terms of eating and drinking of water and fruits. There should be entertainment (like playing of old school music and movies) during the programme in order to make it lively and interesting.

4. There is the need to encourage recreation and sporting activities among the aged as it will help to keep the body fit by fighting some of the aging ailments and burning of fats from the body which is the major source of hypertension.

5.4Recommendations for Further Research

The following are areas of further research which future researcher can embark upon:

1. Gender variability in population aging. This will help in the understanding of the similarities and differences in the rate and pattern of population aging amongst the male and female gender.
2. The aged and coping strategies after retirement. This will explain how most of them cope with life after retirement.

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APPENDIX I

RESEARCH QUESTIONNAIRE

Dear Respondent,

I am an M Sc. Student of the Ahmadu Bello University, Zaria. I am writing a thesis on the topic "Analysis of the Well-being of the aged in Kaura Local Government Area of Kaduna State". I will be happy if you assist me in this research by answering the following questions. I assure you that any information provided will be treated confidentially.

Thank You.

SECTION A:

SOCIO-DEMOGRAPHIC CHARACTERISTIC OF RESPONDENTS

1) Name of ward _____.
2) Sex: Male ( ) Female ( )
3) Age: 60-64 ( ), 65-69 ( ), 70-74 ( ), 75-79 ( ), 80 and above ( )
4) Marital Status : Single ( ), Married ( ), Separated ( ), Divorced ( ), Widowed ( )
5) Nature of marital union: Monogamous ( ), Polygamous ( ), Others, Specify _____
6) Number of Children ever born: None ( ), 1-2 ( ), 3-5 ( ), 6-10 ( ), 11 and above ( )
7) Religion: Christianity ( ), Islam ( ), Traditional ( ), Others specify _____
8) Highest formal educational qualification: None ( ), Adult Education ( ), Primary ( ), Secondary ( ), Tertiary ( ), Others, specify _____
9) Occupation; Civil Service ( ), Trading ( ), Farming ( ), Artisan ( ), None ( ), Others, specify _____

SECTION B: LIVING CONDITIONS OF THE AGED

- **Physical Health Wellbeing**

10) Have you been hospitalized since your 60th birthday? Yes ( ), No ( )
11) If yes, what type of ailment(s)? Hypertension ( ), Diabetes ( ), Arthritis ( ), Cataract ( ), Others, Specify _____
12) What curative approach do you adopt? Hospital ( ), Self-medication ( ), Traditional medicine ( ), Others, Specify _____

13) How often do you seek medical attention? Weekly ( ), Monthly ( ), Quarterly ( ) Yearly ( ).

- **Material Wellbeing**

14) Monthly income (#): < #5,000 ( ), #5,999-10,999 ( ), #11,999-15,999 ( ), #16,999-20,000 ( ), > #20,000 ( ), No fixed amount ( ).

15) What type of accommodation do you live in? A room in multiple tenant apartment ( ), A Room and parlor ( ), A Flat ( ), Bungalow ( ).

16) Who owns the accommodation? Self-own house ( ), Rented house ( ), Family House ( ) Others, Specify _____

17) Who are you residing with now? With sons and daughter ( ), With relatives ( ), Others, Specify _____

18) Are you on any special diet due to health condition? Yes ( ), No ( )

19) What health condition is that? Diabetes ( ), Hypertension ( ), Cancer ( ), Arthritis ( ), Others, Specify_____

20) How regular do you require the special diet? Daily ( ), Weekly ( ), Monthly ( )

21) How regular can you afford this special diet? Daily ( ), Weekly ( ), Monthly ( ), Not At all ( ).

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

23) What is your source of drinking water? Tap ( ), Well ( ), Stream ( ), Borehole ( ), Others, Specify_____

24) Do you boil your drinking water? Yes ( ), No ( )

25) If no, why? No time ( ), dirt in water cannot kill ( ), water is portable enough ( ) Others, Specify_____

- **Social Wellbeing**

26) What social engagements do you attend most? Marriages ( ), Burial ( ), Naming ceremonies ( ), Birthdays ( ), Others, Specify_____

27) What type of recreational activities do you mostly engage in? Strolling ( ), Visitation ( ), Watching movies ( ), Others, Specify _____

28) Please tick which of this infrastructural facilities is available in your area

- Specialist hospital ___ Yes ( ), No ( )

- Old people's home ____ Yes ( ), No ( )
- Recreational clubs ____ Yes ( ), No ( )

SECTION C: DETERMINANTS OF THE WELL-BEING OF THE AGED

Please tick as appropriate:

Determinants of wellbeing	Strongly Agree (SA)	Agree (A)	Undecided (UD)	Disagree (D)	Strongly Disagree (SD)
29) Regular access to doctors consultation determines a healthy wellbeing					
30) Availability of required drugs determines a healthy wellbeing					
31) Utilization of traditional medicine determines a healthy wellbeing					
32) availability of food determines material wellbeing					
33) Access to comfortable shelter determines material wellbeing					
34) Regular visitation by children and grandchildren determines social wellbeing					
35) Attending social functions (like marriages, birthdays and burials among others) improves social wellbeing					
36) living around age mates improves social wellbeing					

SECTION D: COPING STRATEGIESADAPTED WITH HUNGER

37) Do you consider your feeding as adequate? Yes ( ), No ( ).

38) How do you cope with insufficient food (hunger)? You beg for food ( ), You borrow food ( ), You collect credit ( ), You rely on others ( ), Others, Specify _____

SECTION E: TYPES AND SOURCES OF SUPPORT

39) Do you receive any kind of support? Yes ( ), No ( )

40

Sources of support / Types of support	Children	Relatives	Politicians	Religions leaders	Philanthropists	N.G.O
Food						
Money						
Shelter						
Advice						
Entatainment						

APPENDIX II

IN-DEPTH INTERVIEW GUIDE

1. How can you describe the well-being of the aged in Zankan ward (i.e those within 60 years of age and above)?
2. Does the government support them in any way?
3. If yes, how? Is it materially or non-materially?
4. If no, what has the community done to assist the aged in the absence of government intervention in your ward?
5. Do you have facilities like specialist hospital, old peoples home or recreational club for the aged in your ward?
6. What further measure do you think if adopted will enhance the well-being of the aged in your area?

APPENDIX III

FOCUS GROUP DISCUSSION GUIDE AND PROBES

GENERAL QUESTIONS	RELATED PROBE QYESTIONS
1. What form(s) of support/assistance do you receive from the government?	Probe whether there are any organized pro-aged form(s) of support/assistance.
2. What other source(s) of support/assistance do you have as an elderly person?	Probe for other source(s) and form of support apart from the government.
3. How regular are these support and what type are they?	Probe for the regularity and types of the assistance.
4. What type of care service do you require?	Probe for the immediate relief measures needed as treatment.
5. How often are these care services needed?	Probe for the frequency of these needs.
6. Are there dedicated public facilities for the welfare and care of the aged in your area?	Probe for the availability and specialized infrastructures like: elderly home, geriatric clinics, sport and recreational facilities, etc.
7. Do you boil your drinking water?	Probe for response as to whether or not they boil their drinking water
8.If no why?	Probe for reasons why water is not boiled before drinking
9 What curative approach do you adopt when you are ill?	Probe for the type of curative approach adopted
10 How frequent do you seek for medical attention?	Probe for the frequency of seeking for medical attention
11 What type of accommodation do you live in, the ownership and persons you reside with)?	Probe for response pertaining accommodation
12 Are you on special diet, on what health condition, and how regular do you require and can you afford this special diet?	Probe for response on special diet